

SUMMARY OF BIPARTISAN BUDGET ACT

Public Law 115-123 -- February 9, 2018

APPROPRIATIONS PROVISIONS

TITLE I: BUDGET ENFORCEMENT (p.140):

The Bipartisan Budget Act increases limits on defense and nondefense discretionary spending. It reverses sequestration for each category, and provides an equivalent increase of \$26 billion for each category beyond that level in FY2018 and \$31 billion beyond that level in FY2019.

Fiscal Year 2018: \$629 billion defense, an increase of \$80 billion over current law
 \$579 billion nondefense, an increase of \$63 billion over current law.

Fiscal Year 2019: \$647 billion defense, an increase of \$85 billion over current law
 \$597 billion nondefense, an increase of \$68 billion over current law.

The bill deems the Fiscal Year 2019 levels, in order to ensure the spending levels provided are not reduced via budget resolution.

CHIP PROVISION RELEVANT TO FUTURE APPROPRIATIONS:

While the bill extends the authorization for the Children's Health Insurance Program (CHIP), it eliminates approximately \$25-30 billion in future years (Fiscal Years 2024-2027) that otherwise would be used to fund health and education activities through annual appropriations (p.265).

SECTION 1, DIVISION B: SUPPLEMENTAL APPROPRIATIONS FOR DISASTERS

The Bipartisan Budget Act includes \$89 billion in emergency supplemental appropriations to respond to natural disasters of summer and fall 2017, including Hurricanes Harvey, Irma, and Maria, and wildfires in California.

AGRICULTURE

The Agriculture title of the emergency disaster supplemental includes:

- \$2.36 billion for crop and related agricultural losses from Hurricanes Harvey, Irma, Maria and other hurricanes and wildfires occurring in calendar year 2017.
- \$2.5 million in the Office of Inspector General at USDA for oversight of programs funded in this title.
- \$22 million for Agricultural Research Service, Buildings and Facilities, for damages from Hurricanes Harvey, Irma, and Maria.
- \$400 million for the Emergency Conservation Program for assistance to farmers and ranchers in repairing damages caused by Hurricanes Harvey, Irma, Maria, wildfires occurring in calendar year 2017 and other natural disasters.

- \$541 million for the Emergency Watershed Protection Program to address damages to watersheds from Hurricanes Harvey, Irma, and Maria, wildfires occurring in calendar year 2017 and other natural disasters.
- \$19 million for the Rural Housing Insurance Fund for loans for rehabilitation of certain rural rental housing in areas impacted by Hurricanes Harvey, Irma, and Maria.
- \$165 million for repairs to rural water facilities impacted by Hurricanes Harvey, Irma, and Maria.
- \$14 million for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) for grants to Puerto Rico and the U.S. Virgin Islands to assist in repairing damage to WIC facilities from impacted by Hurricanes Irma and Maria.
- \$24 million for The Emergency Food Assistance Program (TEFAP) for expenses of jurisdictions in areas impacted by Hurricanes Harvey, Irma, and Maria and wildfires occurring in calendar year 2017.
- \$7.6 million for the Food and Drug Administration for costs for repair of facilities and replacement of equipment due to Hurricanes Harvey, Irma, and Maria.

The Agriculture title also includes a provision making changes to the Livestock Indemnity, the Emergency Assistance for Livestock, Honey Bees and Farm-raised fish, and the Tree Assistance programs. It provides that payments under the Livestock Indemnity and Tree Assistance programs are not counted against the statutory cap on supplemental agricultural disaster assistance payments of \$125,000 in any crop year.

COMMERCE, JUSTICE, SCIENCE

The Commerce, Justice, Science title of the emergency disaster supplemental includes:

- \$600 million for the Economic Development Administration for disaster relief, recovery, flood mitigation, and restoration of infrastructure in areas that received a major disaster designation as a result of hurricanes, wildfires, and other natural disasters occurring in 2017
- \$120.9 million for National Oceanic and Atmospheric Administration (NOAA) Operations, Research, and Facilities for weather forecasting improvements; mapping, charting, and geodesy services; marine debris assessment and removal; and repair and replacement of property and equipment
- \$79.2 million for NOAA Procurement, Acquisition, and Construction for improvements to weather supercomputing infrastructure and weather satellite ground services
- \$200 million for NOAA Fisheries Disaster Assistance to mitigate the effects of commercial fishery failures and fishery resource disasters declared by the Secretary of Commerce in 2017, as well as those declared to be a direct result of Hurricanes Harvey, Irma, or Maria
- \$85.2 million total for the Department of Justice for expenses including facility repairs related to damage caused by the 2017 hurricanes. This includes:
 - ✓ \$2.5 million for the United States Marshals Service,
 - ✓ \$21.2 million for the Federal Bureau of Investigation,
 - ✓ \$11.5 million for the Drug Enforcement Administration, and
 - ✓ \$50 million for the Bureau of Prisons
- \$81.3 million for NASA Construction and Environmental Compliance and Restoration for repairs at NASA facilities damaged by hurricanes during 2017

- \$16.3 million for the National Science Foundation to repair facilities damaged by the 2017 hurricanes
- \$15 million for the Legal Services Corporation for mobile resources, technology, and disaster coordinators to support legal aid grantees in areas impacted by hurricanes and the wildfires

The CJS title also includes a provision requiring the Secretary of Commerce to issue a waiver to facilitate certain coastal restoration efforts in Louisiana, a provision that was not carried in the House disaster supplemental.

DEFENSE

The Defense title of the emergency disaster supplemental includes:

- \$416.2 million for Operations and Maintenance accounts for restoration of damaged facilities, outfitting of facilities replaced and reinstalling of equipment removed prior to the Hurricanes' landfall
- \$18 million for Navy Procurement to replace items such as physical security equipment and furnishing for damaged facilities

ENERGY & WATER DEVELOPMENT

The Energy and Water Development title of the emergency disaster supplemental includes:

- \$17.398 billion for the U.S. Army Corps of Engineers, including:
 - \$1.843 billion for damage repairs caused by natural disasters:
 - ✓ \$55 million Construction
 - ✓ \$370 million Mississippi Rivers and Tributaries
 - ✓ \$608 million Operation and Maintenance
 - ✓ \$810 million Flood Control and Coastal Emergencies
 - \$15.555 billion for resiliency efforts
 - ✓ \$135 million General Investigations
 - ✓ \$15 billion Construction
 - ✓ \$400 million Mississippi Rivers and Tributaries
 - \$13 million for the Department of Energy Office of Electricity Deliverability and Energy Reliability for studies on grid resilience and technical assistance for Harvey/Irma/Maria.
 - \$8.716 million for the Strategic Petroleum Reserve for damage to its sites from Hurricanes Harvey, Irma, and Maria.

The E&W title also includes:

- General Provision requiring monthly report on damages to Army Corps of Engineers projects.
- General Provision transferring unusable funds appropriated for Hurricane Sandy within Army Corps of Engineers accounts for other Sandy-related purposes. This provision was not carried in the House disaster supplemental.

The non-federal cost share for all repair, rehabilitation, study, design and construction of Corps projects in Puerto Rico and the U.S Virgin Islands is waived.

FINANCIAL SERVICES & GENERAL GOVERNMENT

The Financial Services and General Government Title of the emergency disaster supplemental includes:

- \$1.65 billion for Small Business Administration Disaster Loan Assistance, which provides low-interest loans to small businesses and homeowners in all affected areas.
- \$126.9 million for the General Services Administration's Federal Building Fund to make necessary repairs and alterations at federal facilities in the affected areas.

HOMELAND SECURITY

The Homeland Security title of the emergency disaster supplemental includes:

- \$25 million for the DHS Office of Inspector General to conduct audits to help prevent the misuse of disaster assistance funding.
- \$104.5 million for the U.S. Customs and Border Protection (CBP) Operations and Support account, primarily for CBP activities in Puerto Rico and the U.S. Virgin Islands that would normally be funded through Puerto Rico and U.S. Virgin Islands customs revenue, which has been significantly curtailed because of hurricane damage to trade infrastructure.
- \$45 million for the CBP Procurement, Construction, and Improvements account to restore CBP's San Juan Customs House to operational condition.
- \$30.9 million for the U.S. Immigration and Customs Enforcement (ICE) Operations and Support account to address minor hurricane damage to ICE facilities; to repair or replace damaged equipment; and to support ICE activities in Puerto Rico that would normally be funded through Puerto Rican customs revenue, which has been significantly curtailed because of hurricane damage to trade infrastructure.
- \$33.1 million for the ICE Procurement, Construction, and Improvements account to repair hurricane-damaged ICE facilities in Puerto Rico.
- \$10.3 million for the Transportation Security Administration (TSA) Operations and Support account to repair or replace access control and security equipment at airports damaged by the hurricanes, and to repair damage to TSA offices and facilities.
- \$112.1 million for the Coast Guard Operating Expenses account to repair minor damage to Coast Guard facilities and equipment in Texas, Florida, Puerto Rico, and the U.S. Virgin Islands, and for personnel disaster response costs.
- \$4 million for the Coast Guard Environmental Compliance and Restoration account for site assessments, sampling for hazards, and cleanup of contaminated materials at 27 Coast Guard sites throughout Texas, Florida, Puerto Rico, and the U.S. Virgin Islands that were impacted by the hurricanes.
- \$718.9 million for the Coast Guard Acquisition, Construction, and Improvements account to restore Coast Guard facilities directly damaged by Hurricanes Harvey, Irma, and Maria to pre-hurricane conditions.

- \$23.5 billion for the Federal Emergency Management Agency (FEMA) Disaster Relief Fund (DRF) for disaster response and recovery activities, including up to \$150 million for cost-sharing loans.
- \$58.8 million for the FEMA Operations and Support account for costs associated with the surge in disaster staffing, additional contract oversight, and other administrative costs.
- \$1.2 million for the FEMA Procurement, Construction, and Improvements account to repair hurricane-damaged emergency communications equipment.
- \$5.4 million for the Federal Law Enforcement Training Centers (FLETC) Operations and Support account for minor facility repairs related to Hurricane Irma at the Glynco, Georgia and Charleston, South Carolina FLETC campuses.
- \$5 million for the FLETC Procurement, Construction, and Improvements account for repair of hurricane-damaged dormitories at the Glynco, Georgia campus and for related mitigation against future disaster damage.

The Homeland Security title also includes the following provisions:

- Expanding the period of time used to calculate revenue lost due to the hurricanes from 180 days to 365 days for the purposes of calculating Community Disaster Loans.
- Allowing certain federal disaster response personnel, funded by the DRF, to receive overtime pay above the normal statutory cap.
- Making Fire Management Assistance Grant recipients eligible for hazard mitigation funding for fiscal years 2017 and 2018.
- Broadening eligibility for FEMA public assistance for house of worship facilities that provide essential social services to the general public.
- Authorizing up to a 90% federal cost-share for 2017 wildfire disasters.
- Authorizing an increase in the federal cost share from 75 percent to 85 percent for states that carry out certain resiliency activities.

INTERIOR & ENVIRONMENT

The Interior, Environment, and Related Agencies title of the emergency disaster supplemental includes:

- \$257.6 million for National Park Service construction (\$207.6 million) and historic preservation (\$50 million).
- \$210.6 million for the U.S. Fish and Wildlife Service for removal of debris and hazardous materials, and repair of facilities, roads and bridges, and water systems.
- \$42.2 million for the U.S. Geological Survey for repair and replacement of streamgages and seismic monitors, collection of high resolution data to inform recovery efforts.
- \$3 million for Office of Insular Affairs for technical assistance.
- \$2.5 million for Office of Inspector General for oversight.
- \$63.2 million for the Environmental Protection Agency Hazard Substances Superfund (\$6.2 million), Leaking Underground Storage Tank Trust Fund (\$7 million), and Hazardous Waste Grants (\$50 million).
- \$119.8 million for the U.S. Forest Service for removal of debris and hazardous materials, repair and rehabilitation of facilities, and assessment of forest damage and forest restoration.

LABOR, HEALTH AND HUMAN SERVICES, EDUCATION

The Labor-HHS-Education title of the emergency disaster supplemental includes:

- \$100 million for the Dislocated Workers Assistance National Reserve to create temporary employment opportunities to assist with clean-up and recovery efforts;
- \$30.9 million for Job Corps centers in Puerto Rico for construction and rehabilitation;
- \$200 million for the Centers for Disease Control and Prevention (CDC) to support mosquito eradication, infectious disease response, environmental health activities, and structural repairs to CDC facilities;
- \$50 million for the National Institutes of Health for repair or rebuilding of biomedical and behavioral research facilities;
- \$650 million for Head Start to help grantees recover and restart program services;
- \$162 million for the Public Health and Social Services Emergency Fund, of which:
 - \$80 million is included for the Assistant Secretary for Preparedness and Response to hire emergency personnel, replace emergency medical supply caches, and upgrade emergency response communications equipment;
 - \$60 million is included for Community Health Centers, including at least \$50 million for renovation, construction, equipment, and other capital costs;
 - \$20 million is included for the Substance Abuse and Mental Health Services Administration to support behavioral health treatment, crisis counseling, and other related activities; and
 - \$2 million is included for the Inspector General to conduct oversight of emergency disaster relief response activities.
- \$2.7 billion to assist in meeting the educational needs of individuals affected by Hurricanes Harvey, Irma and Maria or wildfires in 2017, of which:
 - \$25 million to help local school districts serving displaced homeless children and youth;
 - Up to \$35 million for the Project School Emergency Response to Violence program (Project SERV) to help schools recover from a violent or traumatic event;
 - Up to \$75 million to help institutions of higher education defray the unexpected expense associated with enrolling displaced students;
 - \$100 million for emergency assistance to students and institutions of higher education; and,
 - \$4 million for the Office of the Inspector General and up to \$3 million for Program Administration; and
 - Remaining funds would support immediate aid to restart elementary and secondary school operations and temporary emergency impact aid for displaced students under the same terms and conditions that applied in Public Law 109-148, as amended by this supplemental.

The Labor-HHS-Education title also includes:

- \$4.9 billion for Medicaid programs in Puerto Rico and the U.S. Virgin Islands to support health care services through September 30, 2019. In addition, the requirement for Puerto Rico and the U.S. Virgin Islands to provide matching funds is waived for this period.

- A General Provision authorizing the Secretary of Education to forgive any outstanding balance owed to the Department of Education under the Historically Black Colleges and Universities Hurricane Supplemental Loan program established in Public Law 109-234.

LEGISLATIVE BRANCH

The Legislative Branch title of the emergency disaster supplemental includes:

- \$14 million for GAO for audits and investigations relating to Hurricanes Harvey, Irma, and Maria and the 2017 wildfires.

MILITARY CONSTRUCTION AND VETERANS AFFAIRS

The Military Construction and Veterans Affairs title of the emergency disaster supplemental includes:

- \$721 million requested for Navy and Army National Guard
- \$89.1 million for Veterans Health Administration and Minor Construction for national cemetery in Puerto Rico
- \$4.1 million for a minor construction project for infrastructure repairs at the national cemetery in Puerto Rico.

The Military Construction and Veterans Affairs title also includes a waiver of the non-federal cost-share for National Guard construction projects in Puerto Rico.

TRANSPORTATION AND HOUSING AND URBAN DEVELOPMENT

The Transportation-HUD title of the emergency disaster supplemental includes:

- \$28 billion for Community Development Block Grants - Disaster Recovery, including:
 - \$16 billion for unmet recovery needs from 2017 disasters, of which
 - ✓ \$11 billion is for areas affected by Hurricane Maria and includes \$2 billion for electrical system repairs or enhancements; and
 - \$12 billion for mitigation activities in communities that received CDBG-DR grants in 2014-2017.
- \$114.6 million for the Federal Aviation Administration, including funding for operational expenses and to repair facilities and equipment
- \$1.37 billion for the Federal Highway Administration, Emergency Relief program to reimburse states for damage to roads and bridges
- \$330 million for the Federal Transit Administration, Public Transportation Emergency Relief program to rebuild public transit systems
- \$10 million for the Maritime Administration to repair damaged facilities

The Transportation-HUD title also waives the non-federal cost share for Puerto Rico in FHWA's Emergency Relief program, a provision that was not carried in the House disaster supplemental.

TITLE IV, SUBDIVISION 3: FURTHER EXTENSION OF CONTINUING APPROPRIATIONS (p.134)

The Bipartisan Budget Act extends Continuing Appropriations through March 23rd, including the following anomalies:

- Sec. 157 includes an anomaly for DOE’s Southeastern Power Administration providing \$6,379,000 for operating funds.
- Sec. 158 includes an anomaly for DOE’s Strategic Petroleum Reserve allows DOE to draw down \$350 million in oil from the SPR for modernization of the SPR.
- Sec. 159 includes an anomaly for The Judiciary providing spending flexibility to cover the costs of increased juror usage and associated fees in the current fiscal year.
- Sec. 160 provides additional resources necessary to staff new Indian Health Service facilities.
- Sec. 161 allows the Secretary of Education to continue making account maintenance fees to student loan guarantee agencies.
- Sec. 162 provides authority for the Secretary of Education to allow a community college in an economically distressed county to continue to be eligible for federal student aid despite high cohort default rates.
- Sec. 163 provides new start authority for two military construction projects in Alaska that need a contract award this month in order to be executed.
- Sec. 164 clarifies how the Department of Transportation administers loan subsidy for TIFIA and RRIF loans.
- Sec. 165 extends the authorization for HOPE VI and the Choice Neighborhoods Initiative for the duration of the continuing resolution.

TITLE IV, SUBTITLE B: JOINT SELECT COMMITTEE ON BUDGET & APPROPRIATIONS PROCESS REFORM (p.182)

The Bipartisan Budget Act creates a Joint Select Committee on Budget and Appropriations Process Reform, charged with providing recommendations and legislative language that will significantly reform the budget and appropriations process by November 30, 2018.

Such recommendations must be approved by a majority of both majority and minority House and Senate members of the Committee, in order to be introduced in the Senate and referred to the Senate Committee on the Budget. A motion to proceed is subject to a three-fifths majority vote.

The bill does not specify procedures for consideration in the House.

Health and Human Services Provisions Section-By-Section Summary

TITLE I – CHIP

Sec. 50101. Funding extension of the Children’s Health Insurance Program through fiscal year 2027. This section extends funding for CHIP for four additional years (FY2024 through FY2027), appropriating such sums as are necessary to fund the program based on the program’s existing allotment structure. The section also extends the Child Enrollment Contingency Fund,

the Qualifying States Option, the Express Lane Eligibility option, and continues to require states to maintain eligibility levels for CHIP children through FY2027.

Sec. 50102. Extension of pediatric quality measures program. This section extends funding for the pediatric quality measures program and requires states to report on a core set of pediatric quality measures, which had previously been optional.

Sec. 50103. Extension of outreach and enrollment program. This section extends funding for outreach enrollment grants at \$48 million for FY2024 through FY2027 and allows a portion of the funds to be used for evaluation and technical assistance.

TITLE II - MEDICARE EXTENDERS

Section 50201. Extension of work Geographic Practice Cost Index (GPCI) floor. This section would increase payments for the work component of physician fees in areas where labor cost is determined to be lower than the national average by extending the current 1.0 physician work GPCI floor for two years through December 31, 2019.

Section 50202. Repeal of Medicare payment cap for therapy services; replacement with limitation to ensure appropriate therapy. This section would permanently repeal the annual payment limits (“caps”) for outpatient therapy services, including physical therapy, speech-language pathology services, and occupational therapy, beginning January 1, 2018. It would require continuation of the current practice that a modifier be included on claims over the current exception threshold indicating that the services are medically necessary. It would also lower the targeted manual medical review threshold above which claims may be subjected to review of medical necessity documentation from the current per-beneficiary therapy expenditure amount of \$3,700 to \$3,000.

Section 50203. Medicare ambulance services. This section would extend the temporary increase in ambulance fee schedule rates for all ground ambulance services (i.e., 2 percent urban add-on payment and 3 percent rural add-on payment) and the super-rural ambulance add-on payments for five years through December 31, 2022. It would also require the Secretary of Health and Human Services (HHS), in consultation with stakeholders, to develop a data collection system for ambulance providers and suppliers to collect cost, revenue, utilization, and other information determined appropriate by the Secretary.

Section 50204. Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals. The low-volume adjustment is based on the concept that large hospitals benefit from certain economies of scale that are not available to small hospitals with limited discharges. To account for the higher incremental costs per discharge, certain low-volume hospitals receive a payment adjustment. Specifically, hospitals with 200 or fewer Medicare discharges receive a 25 percent payment increase, decreasing on a sliding scale to 0 percent for hospitals with more than 1,600 Medicare discharges. The Medicare Payment Advisory Commission (MedPAC) has reported that this adjustment is not well targeted because hospitals may have a small number of Medicare patients while also treating a large number of non-Medicare patients. This section would extend Medicare low-volume hospital payments for five years through September 30, 2022. Current law low-volume payments would continue unchanged for one year through September 30, 2018. This provides one year for qualifying

hospitals to transition into a modified low-volume payment adjustment based on total discharges rather than Medicare discharges. The modified payment adjustments based on total discharges would begin October 1, 2018. For fiscal year 2019 through fiscal year 2022, the low-volume adjustment standard would be set at 25 percent for hospitals with 500 or fewer total discharges, decreasing on a sliding scale to 0 percent for hospitals with more than 3,800 total discharges.

Section 50205. Extension of the Medicare-dependent hospital (MDH) program. Medicare-dependent hospitals (MDHs) are rural hospitals with no more than 100 beds that serve a higher percentage of Medicare beneficiaries. These hospitals receive inpatient prospective payment system (IPPS) rates plus 75 percent of the difference between the IPPS payment and a hospital-specific cost per discharge amount that is calculated using base-year costs. This section would extend the MDH program for five years through September 30, 2022. No later than two years after the date of enactment, the GAO would be required to complete a study on the MDH program.

Section 50206. Extension of funding for quality measure endorsement, input, and selection; reporting requirements. Section 183 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required the Secretary of Health and Human Services (HHS) to contract with a consensus-based entity (e.g., National Quality Forum or NQF) to carry out specified duties related to quality measurement and performance improvement. According to the Centers for Medicare & Medicaid Services (CMS), carryover funding allocated under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) remains unobligated and available for expenditure in future years. To supplement those existing funds, this section would provide \$7.5 million for each of fiscal years 2018 and 2019 to ensure CMS has the resources necessary to fulfill the agency's statutory obligations. This section would also institute enhanced transparency of the dollars spent under Section 1890 and 1890A of the Social Security Act (SSA) by requiring new and updated reports to Congress describing how the funds appropriated to the Secretary of HHS are used to help CMS meet Medicare and Medicaid program quality measurement goals now and in the future.

Section 50207. Extension of funding outreach and assistance for low-income programs; State health insurance assistance program reporting requirements. In 1990, the Secretary of HHS was required to establish a beneficiary assistance program, which later became known as the State Health Insurance Assistance Program (SHIP), to help Medicare beneficiaries with information and counseling. Congress has since appropriated funding for this program, in addition to other programs to assist low-income Medicare beneficiaries administered by the Area Agencies on Aging, the Aging and Disability Resource Centers, and the National Center for Benefits and Outreach Enrollment.

This section would extend for two years, at current law levels, funding for outreach and education activities for Medicare beneficiaries, specifically, for the State Health Insurance Programs (SHIPs), Area Agencies on Aging, Aging and Disability Resource Centers, and The National Center for Benefits and Outreach Enrollment. This section would also require the Administration for Community Living to report on the amount and use of funding provided to states.

Section 50208. Extension of home health rural add-on. This section would extend the home health add-on and improve the targeting of future payments in order to protect the Medicare

Trust Fund. Specifically, the add-on would be extended at current levels for 2018. Beginning in 2019, the home health add-on would increase from 3 to 4 percent for counties with a population density of 6 or fewer individuals per square mile. This payment add-on would then phase down to 3 percent in 2020, 2 percent in 2021 and 1 percent in 2022. According to the Medicare Payment Advisory Commission (MedPAC), many rural counties have well above average utilization of home health services and face little barriers to access home health services. In these counties, the home health add-on would be reduced to 1.5 percent in 2019 and 0.5 percent in 2020. In all other rural counties not described above, the home health add-on would be extended at the current law rate in 2019 and then reduced to 2 percent in 2020 and 1 percent in 2021. This section would require, beginning in 2019, home health agencies to submit to CMS the county in which the home health services was furnished. Finally, this section would require the HHS Office of the Inspector General to conduct an analysis of home health utilization and provide to Congress any appropriate recommendations based on this analysis.

TITLE III – CREATING HIGH-QUALITY RESULTS AND OUTCOMES NECESSARY TO IMPROVE CHRONIC (CHRONIC) CARE

Subtitle A – Receiving High Quality Care in the Home

Section 50301. Extending the Independence at Home Demonstration Program. This section would extend and expand the Medicare Independence at Home demonstration to provide a broader base of experience to inform future legislative efforts. Specifically, it would extend the length of the demonstration by two years; increase the cap on the total number of participating beneficiaries from 10,000 to 15,000; and give practices three years to generate savings against their spending targets.

Section 50302. Expanding access to home dialysis therapy. This section would expand the ability of beneficiaries on home dialysis to receive required monthly clinical assessments to monitor their condition using telehealth, beginning January 1, 2019. Specifically, it would expand the number of originating sites from which the beneficiary can have a telehealth assessment with his or her clinician to include freestanding dialysis facilities and the patient's home and eliminate any geographic restriction for all originating sites. Medicare would not provide a separate payment for the originating site fee if the service is furnished in the home. A beneficiary would be required to receive the first three clinical assessments and at least one of every three assessments thereafter through an in person face-to-face encounter. Providers would be allowed to furnish equipment to facilitate telehealth to beneficiaries receiving home dialysis in certain situations.

Subtitle B – Advancing Team-Based Care

Section 50311. Providing continued access to Medicare Advantage special needs plans for vulnerable populations. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) established a new Medicare Advantage (MA) coordinated care plan to provide services for individuals with special needs. Special needs plans (SNPs) are permitted to target enrollment to one or more types of special needs individuals, including those who are (1) institutionalized, (2) dually eligible for both Medicare and Medicaid, or (3) living with severe or disabling chronic conditions. Among other changes, the Affordable Care Act extended SNP authority through December 31, 2013, and temporarily extended authority through

the end of 2012 for dual eligible SNPs without contracts with state Medicaid programs to continue to operate, but in their current service areas. After 2012, dual eligible SNPs, new and renewing, were required to have contracts with state Medicaid agencies. Several subsequent laws have extended SNP authority without interruption; most recently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) extended SNP authority through December 31, 2018.

In this section, the Medicare-Medicaid Coordination Office would be directed to serve as a dedicated point of contact for states to assist with Medicare and Medicaid integration efforts, and the Secretary would be required to work through this office to establish a unified grievances and appeals process for individuals enrolled in a D-SNP. This section would permanently authorize the I-SNP, D-SNP and C-SNP, if certain requirements are met. By 2021, a D-SNP contract would be required to have a unified grievances and appeals procedure in place, and by 2021, a D-SNP would be required to integrate Medicare and Medicaid long-term services and supports and/or behavioral health services by meeting one of three requirements. Failure to meet one of the three integration requirements would result in suspension of enrollment. MedPAC, in consultation with MACPAC, would be required to conduct a study and report to Congress on the quality of D-SNPs. Beginning in 2020, a C-SNP would be required to meet additional requirements to improve care management for the beneficiaries with severe or disabling chronic conditions enrolled in the plan. By January 1, 2022, and every five years thereafter, the Secretary would be required to update the list of chronic conditions eligible for participation in a C-SNP. The updated list must include HIV/AIDS, end-stage renal disease, and chronic and disabling mental illness. The Secretary may consider implementing the quality star rating system at the plan level for SNPs and all MA plans. GAO would be instructed to conduct a study and report on state-level integration between D-SNPs and Medicaid within two years of enactment.

Subtitle C – Expanding Innovation and Technology

Section 50321. Adapting benefits to meet the needs of chronically ill Medicare Advantage enrollees. Under Medicare Advantage (MA) private health plans are paid a per-person monthly amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll. Unlike original Medicare, where providers are paid for each item or service provided to a beneficiary, an MA plan receives the same capitated monthly payment regardless of how many or few services a beneficiary actually uses. The plan is at-risk if aggregate costs for its enrollees exceed program payments and beneficiary cost sharing; conversely, in general, the plan can retain savings if aggregate enrollee costs are less than program payments and cost sharing. Currently, an MA plan must offer the same benefit package to all of its enrollees. The Centers for Medicare and Medicaid Innovations (CMMI) is currently testing a model to allow greater flexibility for an MA plan to meet the needs of chronically ill enrollees. CMS has also proposed a regulation that would permit MA plans to offer a benefit package that includes different cost-sharing requirements or benefits to help MA plans better serve the most vulnerable enrollees.

This section would expand the testing of the CMMI Value-Based Insurance Design (VBID) Model to allow an MA plan in any state to participate in the model by 2020 (during the testing phase) to determine whether savings are achieved without negatively impacting quality.

Section 50322. Expanding supplemental benefits to meet the needs of chronically ill Medicare Advantage enrollees. All Medicare Advantage (MA) plans must offer required

Medicare benefits (except hospice) and may offer additional or supplemental benefits. Mandatory supplemental benefits are covered by the MA plan for every person enrolled in the plan and are paid for either through plan rebates, a beneficiary premium, or cost sharing. Optional supplemental benefits must be offered to all plan enrollees, but the enrollee may choose to pay an additional amount to receive coverage of the optional benefit; optional benefits cannot be financed through plan rebates.

An MA plan must adhere to specific rules regarding the supplemental benefits that it can offer. First, the MA plan cannot design a benefit plan that is likely to substantially discourage enrollment by certain MA eligible individuals. Further, supplemental benefits (a) may not be Medicare Part A or Part B required services, (b) must be primarily health related with the primary purpose to prevent, cure, or diminish an illness or injury, and (c) the plan must incur a cost when providing the benefit. Items that are primarily for comfort or are considered social services would not qualify as supplemental benefits. Examples of supplemental benefits include the following:

1. Additional inpatient hospital days in an acute care or psychiatric facility,
2. Acupuncture or alternative therapies,
3. Counseling services,
4. Fitness benefit,
5. Enhanced disease management, and
6. Remote Access Technologies (including Web/Phone based technologies).

CMS proposed a regulation that would allow MA plans greater flexibility to offer targeted supplemental benefits.

This section would allow an MA plan to offer a wider array of supplemental benefits to chronically ill enrollees beginning in 2020. These supplemental benefits would be required to have a reasonable expectation of improving or maintaining the health or overall function of the chronically-ill enrollee and would not be limited to primarily health related services. The section would allow an MA plan the flexibility to provide targeted supplemental benefits to specific chronically ill enrollees.

Section 50323. Increasing convenience for Medicare Advantage enrollees through telehealth. Telehealth is the use of electronic information and telecommunications technologies to support remote clinical health care, patient and professional health-related education, and other health care delivery functions. While Medicare beneficiaries may receive telehealth services in a variety of settings, under current law (SSA Section 1834(m)), the Medicare program recognizes and pays for only certain Part B telehealth services. These services must be either (1) remote patient and physician/professional face-to-face services delivered via a telecommunications system (e.g., live video conferencing), or (2) non face-to-face services that can be conducted either through live video conferencing or via store and forward telecommunication services in the case of any Federal telemedicine demonstration program in Alaska or Hawaii. Typically, Medicare coverage for remote face-to-face services includes payments (1) to physicians or other professionals (at the distant site) for the telehealth consultation, and (2) to the facility where the patient is located (the originating site).

An MA plan may provide basic telehealth benefits as part of the standard benefit; for example, telemonitoring and web-based and phone technologies can be used to provide telehealth services.

Medicare Advantage Prescription Drug (MAPD) may choose to include telehealth services as part of their plan benefits, for instance, in providing medication therapy management (MTM). However, while there is nothing to preclude Medicare Advantage (MA) from providing telemedicine or other technologies that they believe promote efficiencies beyond what is covered in the traditional Medicare program, those services and technologies are not separately paid for by Medicare and plans must use their rebate dollars to pay for those services as a supplemental benefit.

This section would allow an MA plan to offer additional, clinically appropriate, telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B beginning in 2020. The Secretary would be required to solicit comments on: what types of telehealth services, including but not limited to those provided through supplemental health care benefits, such as remote patient monitoring, secure messaging, store and forward technologies, and other non-face-to-face communication; and the requirements for furnishing those benefits. If an MA plan provides access to a service via telehealth, the MA plan must also provide access to that service through an in-person visit, and the beneficiary would have the ability to decide whether or not to receive the service via telehealth.

Section 50324. Providing accountable care organizations the ability to expand the use of telehealth. While Medicare beneficiaries may receive telehealth services in a variety of settings, under current law (SSA Section 1834(m)), the Medicare program restricts telehealth payments by the type of services provided, the geographic location where the services are delivered, the type of institution delivering the services, and the type of health provider. While there is nothing to preclude ACOs from providing telemedicine or other technologies that they believe promote efficiencies, those services and technologies are not separately paid for by Medicare. Traditionally telehealth has been viewed as a tool to improve access to services, but interest is growing to see if telehealth has the potential to reduce health care costs. Telehealth may have the potential to replace some face-to-face office visits, reduce emergency room visits, and prevent hospitalizations. Telehealth may also keep beneficiaries in closer, more consistent contact with providers.

This section would apply the Next Generation ACO telehealth waiver criterion to the Medicare Shared Savings Program (MSSP) Track II (only if an ACO chooses prospective assignment and remains at two-sided risk), MSSP Track III, and two-sided risk ACO models with prospective assignment that are tested or expanded through the Center for Medicare & Medicaid Innovation (CMMI) as determined appropriate by the Secretary. This provision would (1) eliminate the geographic component of the originating site requirement, (2) allow beneficiaries assigned to the approved MSSP and ACO programs to receive currently allowable telehealth services in the home, and (3) ensure that MSSP and ACO providers are only allowed to furnish telehealth services as currently specified under Medicare's physician fee schedule, with limited exceptions. To be eligible for Medicare payment, the beneficiary must be located at an originating site that is either (1) one of the approved sites listed in Section 1834(m)(4)(C)(ii) of the Social Security Act, or (2) the beneficiary's place of residence. Medicare would not provide a separate payment for the originating site fee if the service is furnished in the home.

Section 50325. Expanding the use of telehealth for individuals with stroke. This section would expand the ability of patients presenting with stroke symptoms to receive a timely consultation to determine the best course of treatment through telehealth, beginning January 1,

2019. Specifically, it would eliminate the geographic restriction as to permit payment to physicians furnishing the telehealth consultation service in all areas of the country. Medicare would not provide a separate originating site payment to newly eligible originating sites.

Subtitle D – Identifying the Chronically Ill Population

Section 50331. Providing flexibility for beneficiaries to be part of an accountable care organization. Medicare fee-for-service beneficiaries are assigned to ACOs based on their utilization of primary care services provided by a physician who is an ACO provider and/or supplier. Beneficiaries currently do not have the option of choosing to participate directly in an ACO (aside from seeking care from a particular provider), but are notified if their primary care provider is an ACO participant. Beneficiaries who receive at least one primary care service from a primary care physician within the ACO may be assigned to that ACO if the beneficiary receives the plurality of his or her primary care services from primary care physicians within the ACO. Beneficiaries who have not had a primary care service furnished by any primary care physician either inside or outside the ACO, but who receive at least one primary care service from any physician within the ACO, are assigned to that ACO if the beneficiary receives a plurality of his or her primary care services from specialist physicians.

The manner in which Medicare fee-for-service beneficiaries are assigned to an ACO affects how the ACO can tailor care for its beneficiaries and how the ACO is evaluated. Under current Centers for Medicare & Medicaid (CMS) rules, Medicare determines the method of beneficiary attribution, rather than giving ACOs the option to choose the assignment methodology that best fits their model of care. Medicare fee-for-service beneficiaries can be assigned to an ACO either retrospectively or prospectively depending on the ACO's track. Prospective assignment allows ACOs to identify beneficiaries for whom they will be held accountable and proactively take steps to connect these beneficiaries to appropriate care, but also holds ACOs accountable for the spending for these beneficiaries even if the ACO providers do not provide the care. Retrospective assignment ensures that ACOs are held accountable for the spending only of those beneficiaries who receive most of their primary care services from ACO providers, but they may not know who those beneficiaries are until the end of the year.

This section would amend Section 1899(c) of the Social Security Act to give ACOs in the MSSP the choice to have their beneficiaries assigned prospectively at the beginning of a performance year. Additionally, this provision would give a beneficiary the option to voluntarily align to the MSSP ACO in which the beneficiary's main primary care provider is participating. The Secretary of HHS would establish a process by which beneficiaries are notified of their ability to make such an election as well as the process by which they may change such election. The beneficiary would retain his or her freedom of choice to see any provider.

Subtitle E – Empowering Individuals and Caregivers in Care Delivery

Section 50341. Eliminating barriers to care coordination under accountable care organizations. ACOs are collaborations that integrate groups of providers, such as physicians (particularly primary care physicians), hospitals, federally qualified health centers, rural health clinics, and others. In the Medicare Shared Savings Program (MSSP) specifically, ACOs are designed to provide incentives to providers to manage care across the continuum by reducing health care costs while meeting quality performance standards. The ACO mission is to ensure

that patients, especially the chronically ill, receive the right care at the right time in the right care setting, while avoiding unnecessary duplication of services and preventing medical errors. Delaying or forgoing preventive care – especially care related to chronic disease management – may lead to increased costs and poor health outcomes. ACOs are accountable for the health outcomes and overall costs of their attributed beneficiaries. As a result, ACO aligned beneficiaries could be encouraged to seek out preventive care or chronic disease management if the cost to access those services is manageable.

This section would establish the ACO Beneficiary Incentive Program. This new program would create a process that allows certain two-sided risk ACOs to make incentive payments to all assigned beneficiaries who receive qualifying primary care services. Eligible ACOs would be allowed to offer a flat payment, of up to \$20 per qualifying service, directly to the beneficiary. This program is voluntary. These ACOs would not be provided additional Medicare reimbursement to cover the primary care incentive payment costs. Permitting this option under a two-sided risk model would give these ACOs an additional tool to achieve better health outcomes for beneficiaries – as well as produce cost savings for both the ACO and the Medicare program. President Obama’s Fiscal Year (FY) 2017 budget contained a similar policy proposal. Additionally, this section requires HHS to conduct an evaluation of the Beneficiary Incentive Program. The report must include an analysis of the impact of this program’s implementation on expenditures and beneficiary health outcomes. A report to Congress is due no later than October 1, 2023.

Section 50342. GAO study and report on longitudinal comprehensive care planning services under Medicare Part B. This section would direct Government Accountability Office (GAO) to submit a report to Congress within 18 months of the date of enactment to inform the development of a payment code describing the formulation of a comprehensive plan of longitudinal care for a Medicare beneficiary diagnosed with a serious or life-threatening illness.

Subtitle F – Other Policies to Improve Care for the Chronically Ill

Section 50351. GAO study and report on improving medication synchronization. This section would direct the Government Accountability Office to submit a report to Congress within 18 months of the date of enactment that would provide information on the prevalence and effectiveness of Medicare and other payer medication synchronization programs.

Section 50352. GAO study and report on impact of obesity drugs on patient health and spending. This section would direct the Government Accountability Office to submit a report to Congress within 18 months of the date of enactment that would provide information on the impact of the use of obesity drugs on patient health and spending.

Section 50353. HHS study and report on long-term risk factors for chronic conditions among Medicare beneficiaries. This section would require the Secretary to submit a report to Congress within 18 months of the date of enactment that would evaluate long-term cost drivers to Medicare, including obesity, tobacco use, mental health conditions, and other factors that may contribute to the deterioration of health conditions among individuals with chronic conditions.

Section 50354. Providing prescription drug plans with parts A and B claims data to promote the appropriate use of medications and improve health outcomes. Under current

law, standalone prescription drug plans (PDPs) provide Medicare's prescription drug benefit to fee-for-service (FFS) beneficiaries. Certain Medicare beneficiaries who meet criteria described in statute are eligible to enroll in medication therapy management (MTM) programs offered by PDPs. MTM's purpose is to coordinate prescription drugs for high-cost beneficiaries. However, PDPs do not have access FFS utilization data that may aid the PDP in coordination efforts. This differs from MA-PDs which are responsible for providing both Medicare's prescription drug benefit but also Medicare Part A and Part B's medical benefits and has access to all relevant data.

This section would require the Secretary to establish a process, beginning in plan year 2020, by which a Part D plan sponsor may submit a request to CMS for claims data under Parts A and B. These data, which would include claims as recent as possible, would be for the purposes of: optimizing therapeutic outcomes through improved medication use; improving care coordination as to prevent adverse health outcomes; and other purposes determined by the Secretary. Plan sponsors would be prohibited from using these data to: inform Part D coverage determinations; conduct retroactive review of coverage indications; facilitate enrollment changes to a different PDP or an MA-PD offered by the same parent organization; market benefits; and for other purposes determined by the Secretary to protect the identity of Medicare beneficiaries and to protect the security of personal health information.

TITLE IV – PART B IMPROVEMENT ACT AND OTHER PART B ENHANCEMENTS

Subtitle A – Medicare Part B Improvement Act

Section 50401. Home infusion therapy services temporary transitional payment. This section would create a temporary payment beginning January 1, 2019 for furnishing a drug or biologic that is infused through an item of durable medical equipment to a beneficiary in the home. This temporary payment would be in place until the permanent benefit for home infusions previously established by Congress is implemented in 2021.

Section 50402. Orthotist's and prosthetist's clinical notes as part of the patient's medical record. This section would ensure that information provided by orthotists and prosthetists, who evaluate and fit the beneficiary, is considered as part of the documentation that supports the medical necessity for the orthoses or prostheses.

Section 50403. Independent accreditation for dialysis facilities and assurance of high quality surveys. This section would allow dialysis facilities to seek the accreditation that is needed to be able to bill Medicare for dialysis services from private organizations approved by Medicare.

Section 50404. Modernizing the application of the Stark rule under Medicare. This section would codify the changes CMS made in regulations to streamline and clarify rules for providers regarding compliance with the Stark law, including leases that were in violation and when signatures were required to document the terms of legal arrangements.

Subtitle B – Additional Medicare Provisions

Section 50411. Making permanent the removal of the rental cap for durable medical equipment under Medicare with respect to speech generating devices. This section would make Medicare coverage of speech generating devices under “routinely purchased durable medical equipment” permanent, as opposed to using the rental item classification that may disrupt beneficiary access in certain situations.

Section 50412. Increased civil and criminal penalties and increased sentences for Federal health care program fraud and abuse. This section would update both the civil and criminal penalties for fraud and abuse in federal health programs that have largely remained static over the past 20 years.

Section 50413. Reducing the volume of future EHR-related significant hardship requests. This section would remove a requirement that CMS make meaningful use standards more stringent over time, increasing the likelihood that providers will be able to comply with those standards.

Section 50414. Strengthening rules in case of competition for diabetic testing strips. This section would require CMS to more rigorously enforce the requirement that durable medical equipment suppliers in the competition bidding program offer at least 50 percent of the diabetes test strip brands used by beneficiaries. It would also codify and enhance the regulatory prohibition against suppliers unduly influencing beneficiaries to switch from their preferred brand of diabetes supplies.

TITLE V – OTHER HEALTH EXTENDERS

Section 50501. Extension for family-to-family health information centers. This section extends Family-to-Family Health Information Center funding through fiscal year 2019 and provides an additional \$1 million for each of fiscal years 2018 and 2019 to support the development of centers in the territories and at least one center for Indian tribes. This program, administered by the Health Resources and Services Administration (HRSA), provides grants to support family-staffed organizations in each state to assist families of children with disabilities and special health care needs.

Section 50502. Extension for sexual risk avoidance education. This section extends abstinence only programs and associated funding through fiscal year 2019, updates the name and purposes of the program, aligns funding policies, and includes a national evaluation. This program provides funds to states to provide education exclusively focused on sexual risk avoidance (meaning voluntarily refraining from sexual activity).

Section 50503. Extension for personal responsibility education. This section extends the Personal Responsibility Education Program (PREP) and associated funding through fiscal year 2019, extends grants, and expands the target population to include youth who are victims of human trafficking. PREP provides states, community groups, tribes, and tribal organizations with grants to implement evidence-based, or evidence-informed, innovative strategies for teen pregnancy and HIV/STD prevention, youth development, and adulthood preparation for young people.

TITLE VI – CHILD AND FAMILY SERVICES AND SUPPORTS EXTENDERS

Subtitle A – Continuing the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

Section 50601. Continuing evidence-based home visiting program. This section continues MIECHV at the current-law level of \$400 million per year for FY2018 through FY2022. This program provides states, territories, and tribes with grants to support evidence-based home visiting programs for at-risk families.

Section 50602. Continuing to demonstrate results to help families. This section requires states continue to show MIECHV is improving the lives of families by demonstrating improvements for the eligible families participating in the program in at least four of six benchmark areas specified in law, as well as develop a plan to improve outcomes if the state fails to demonstrate improvement (current law required states to demonstrate improvement in the first three years after the program was fully implemented—FY2012 through FY2014). This section also clarifies that states need only measure and demonstrate improvements in the benchmark areas the home visiting programs selected by the state are intended to improve to reduce unnecessary tracking and reporting (instead of requiring the state to measure and demonstrate improvements in all areas regardless of whether the model is designed to impact those areas or not).

Section 50603. Reviewing statewide needs to target resources. This section requires states to conduct a follow-up statewide needs assessment by October 1, 2020 to make sure states continue to review where home visiting services are most needed (current law required states to conduct a needs assessment before receiving funds in FY2011 as part of the first authorization of funding). It also specifies the statewide needs assessment can be combined or coordinated with the assessment required to receive Maternal and Child Health Services Block Grant funds to reduce duplication and increase program coordination.

Section 50604. Improving the likelihood of success in high-risk communities. This section requires that states continue to prioritize serving families in communities identified as most in need of home visiting services, while also allowing them to take into account community resources and other service delivery requirements that may need to be developed for communities to operate at least one home visiting program and contribute to the success of a home visiting program in the state.

Section 50605. Option to fund evidence-based home visiting on a pay for outcome basis. This section allows states to use up to 25 percent of their funding to pay for home visiting services on a “pay-for-outcome” basis, where a state would be able to contract with providers so they only pay for services if a rigorous, independent evaluation confirms the services achieved the desired outcomes.

Section 50606. Data exchange standards for improved interoperability. This section adds language previously added to Temporary Assistance for Needy Families, Child Support Enforcement, Unemployment Insurance, and child welfare programs requiring HHS to develop data standards for home visiting programs that will help state agencies and the federal government more easily exchange information to ensure the integrity of programs and improve services for families in need, all while maintaining privacy standards.

Section 50607. Allocation of funds. HHS allocates money for MIECHV based on the share of children under age five in families at or below 100 percent of the federal poverty line living in each state and territory. However, HHS uses U.S. Census Bureau data that does not include data for the territories, so they do not receive an amount proportional to the number of children in poverty. This section would allow HHS to continue to use Census Bureau data for states, making sure they use an appropriate alternative data source when determining funding for territories.

Subtitle B – Extension of Health Professions Workforce Demonstration Projects.

Section 50611. Extension of health workforce demonstration projects for low-income individuals. This section extends the Health Workforce Demonstration Project, which provides funding to help low-income individuals obtain education and training in high-demand, well-paid, health care jobs, through fiscal year 2019 at the current funding level.

TITLE VII – FAMILY FIRST PREVENTION SERVICES ACT

Subtitle A – Investing in Prevention and Supporting Families

Section 50701. Short title. This subtitle may be cited as the “Family First Prevention Services Act”.

Section 50702. Purpose. This section contains the purpose of this subtitle, which is to enable states to use federal funds available under title IV-B and title IV-E of the Social Security Act to provide more effective support to children and families to prevent foster care placements.

Part I – Prevention Activities Under Title IV-E

Section 50711. Foster Care Prevention Services and Programs. This section amends the title IV-E foster care and permanency program to give states and tribes the option of receiving partial federal reimbursement for state expenditures to provide services that enable children to remain safely at home, or with a kin care provider, instead of entering foster care. These prevention activities would include mental health and substance abuse prevention and treatment services (to treat the major reasons children come into foster care today), and in-home parent skill-based programs (including parenting skills training, parent education, and individual and family counseling). This section would also allow small states (with less than 200,000 children) to select from three possible base years when determining their maintenance of effort requirement, clarify that the receipt of prevention services does not disqualify a child from being eligible for IV-E foster care at a later date, and clarify that territories are eligible for prevention funding.

Section 50712. Foster care maintenance payments for children with parents in a licensed residential family-based treatment facility for substance abuse. This section allows states to receive title IV-E foster care maintenance payment support, for up to 12 months, for children in foster care who are placed with their parent in a licensed residential family based treatment facility (preventing the need to separate children and parents and place the child with foster parents).

Section 50713. Title IV-E payments for evidence-based kinship navigator programs. This section allows states to claim a 50 percent federal reimbursement for the cost of operating programs that provide referral services to relatives who take in children so they can avoid being

placed in foster care (called “kinship navigator” programs), provided the HHS Secretary determines the programs are operated in accordance with promising, supported, or well-supported practices.

Part II – Enhanced Support Under Title IV-B

Section 50721. Elimination of time limit for family reunification services while in foster care and permitting time-limited family reunification services when a child returns home from foster care. This section permits the use of capped Promoting Safe and Stable Families (PSSF) funding for family reunification services to be provided to a child in foster care (and to his or her parent(s)/primary caregiver), regardless of the amount of time the child has been in foster care.

Section 50722. Reducing bureaucracy and unnecessary delays when placing children in homes across state lines. This provision requires that, no later than October 1, 2027, a state, territory, or tribe operating a title IV-E program include use of an electronic interstate case processing system as part of its procedures for timely placement of children across state lines. Additionally, this section requires HHS to reserve a total of \$5 million in any FY2018 discretionary funding provided for the PSSF program for states to use for this purpose. Funding remains available until FY2022. States piloting this system have reported children waited on average of one and a half months less to be placed in the right home, and that they saved substantial amounts on printing and mailing costs alone.

Section 50723. Enhancements to grants to improve well-being of families affected by substance abuse. This section requires HHS to continue to award existing competitive “regional partnership grant” funds through FY2021 to provide evidence-based services to prevent child abuse and neglect related to substance abuse, stipulates that partnerships may be established on a statewide basis, and it removes the prohibition on state-agency only partnerships. It also requires that in addition to the state child welfare agency, every funded partnership must include the state agency that administers the federal substance abuse prevention and treatment block grant.

Part III – Miscellaneous

Section 50731. Reviewing and improving licensing standards for placement in a relative foster family home. This section requires HHS to identify reputable model standards for licensing foster family homes not later than October 1, 2018. No later than April 1, 2019 each state is required to submit information to HHS on whether its own licensing standards are fully consistent with the model standards identified by HHS, how they take advantage of the flexibility in current law to waive unnecessary requirements for relatives so children can be quickly placed with them instead of in foster care, and if not, why this inconsistency is appropriate for the state.

Section 50732. Development of a statewide plan to prevent child abuse and neglect fatalities. This section rewrites the existing state plan requirement to require the state child welfare agency to more fully document the steps it takes to track and prevent child maltreatment deaths, as well as explain how they are implementing a comprehensive plan to deal with this problem.

Section 50733. Modernizing the title and purpose of title IV-E. This section changes the formal heading of title IV-E to “Federal Payments for Foster Care, Prevention, and

Permanency,” to reflect the authorization of title IV-E prevention services and programs included in this bill, as well as make other changes to conform underlying law with the new language added by this title.

Section 50734. Effective dates. This section contains the effective dates for this title.

Part IV – Ensuring the Necessity of a Placement that Is Not in a Foster Family Home

Section 50741. Limitation on Federal financial participation for placements that are not in foster family homes. Under this section, title IV-E foster care maintenance payment supports are not available for more than two weeks for an otherwise eligible child who is placed in a setting that is not a foster family home, unless the placement setting is a—

- “Qualified residential treatment program” (provided additional requirements are met);
- Setting specializing in providing prenatal, postpartum, or parenting supports for youth;
- Supervised independent living setting (provided the child is at least 18 years of age);
- Licensed residential family-based treatment center (provided the child was placed with the parent and had not been in this setting for more than 12 months); or
- A setting providing high-quality residential care and supportive services to children and youth who have been found to be, or who are at risk of becoming, sex trafficking victims.

A qualified residential treatment program would be required to have nursing and clinical staff on-site in accordance with the needs of the child as specified the child’s treatment model. These programs would not have to employ these staff through a direct employer to employee relationship.

This section also clarifies that a state can continue to receive federal reimbursement for administrative expenses associated with overseeing a child placed in foster care, even if the child is placed in a congregate care setting for which the state will no longer receive federal reimbursement.

Section 50742. Assessment and documentation of the need for placement in a qualified residential treatment program. For any child placed in a “qualified residential treatment program,” this provision would require states to have additional case review procedures as follows:

- Assessment and determination by qualified individual within 30 days of placement;
- Assemble a “Family and Permanency Team” to work with the qualified individual on placement assessment;
- Court approval or disapproval of placement determination within 60 days of placement;
- Ongoing review of placement setting decision by state agency; and
- Additional oversight for stays beyond specified time periods.

This section also states that children should be placed with their siblings unless there is a finding by the court that such placement is contrary to their best interest, as well as requires the individual conducting the assessment to justify a different placement recommendation if they recommend something different than what the family and permanency team and child prefer.

Section 50743. Protocols to prevent inappropriate diagnoses. This section requires states to include in their plan the state’s established procedures to ensure children are not inappropriately

placed in a non-family setting, due to an inappropriate diagnosis of mental illness, behavioral disorders, medically fragile conditions, or developmental disabilities.

Section 50744. Additional data and reports regarding children placed in a setting that is not a foster family home. This section rewrites the existing reporting requirement to list more types of non-foster family home settings for which specific information must be included in the report and would additionally request information on the gender and race/ethnicity of children placed in these settings, and whether the non-foster family home is the first placement setting for the child or, if not, the number and type of previous placement settings.

Section 50745. Criminal records checks and checks of child abuse and neglect registries for adults working in child-care institutions and other group care settings. This section requires states to conduct background checks of residential facility staff, specifically fingerprint-based checks of national crime information databases and checks of state child abuse registries, unless the state reports alternate checks they conduct and why these two checks aren't appropriate for the state.

Section 50746. Effective dates; application to waivers. This section specifies the effective dates of sections in this title. This section also allows states to delay, at their sole discretion for up to two years, changes to federal reimbursement for group home placements, giving states more time to adapt to this change. States electing to delay these changes would also delay their receipt of federal funds for prevention services by the same length of time.

Part V – Continuing Support for Child and Family Services

Section 50751. Supporting and retaining foster families for children. This section provides services designed to support and retain foster families so they can provide quality family-based settings for children in foster care. It provides an appropriation of \$8 million in FY2018 for HHS to make competitive grants to states or tribes to support recruitment and retention of high-quality foster families.

Section 50752. Extension of child and family services programs. This section extends this same annual level of discretionary and mandatory funding authority for the Child Welfare Services program and the Promoting Safe and Stable Families program through FY2021. This section also extends the entitlement of eligible state highest courts to Court Improvement Program grant funding through FY2021.

Section 50753. Improvements to the John H. Chafee foster care independence program and related provisions. This section permits states to certify that they use CFCIP funds to serve youth who have aged out of foster care and are not yet 23 years of age but only if the HHS Secretary determines that the state has elected to extend federal title IV–E foster care to children up to age 21; or that the state provides comparable assistance with state or other non-title IV–E funds. It permits HHS to redistribute any CFCIP or Education and Training funds that are not spent within the two-year time frame to one or more states (including tribes) that apply for these funds.

Part VI – Continuing Incentives to States to Promote Adoption and Legal Guardianship

Section 50761. Reauthorizing adoption and legal guardianship incentive programs. This section continues state eligibility to earn these incentive payments and extends annual discretionary funding authority at the current law level of \$43 million per year through FY2022.

Part VII – Technical Corrections

Section 50771. Technical corrections to data exchange standards to improve program coordination. This section rewrites these current-law provisions to require HHS to develop regulations concerning the categories of information that state child welfare agencies must be able to exchange with another state agency as well as federal reporting and data exchange required under applicable federal law.

Section 50772. Technical corrections to State requirement to address the developmental needs of young children. This section clarifies that a state must describe in its title IV-B Child Welfare Services plan what it is doing to address the developmental needs of all vulnerable children under five years of age who receive benefits or services under the title IV-B programs or the title IV-E foster care and permanency program (not just children in foster care).

Part VIII – Ensuring States Reinvest Savings Resulting from Increase in Adoption Assistance

Section 50781. Delay of adoption assistance phase-in. States can receive partial reimbursement from the title IV-E adoption assistance program for payments to families who adopt children from foster care (who meet certain requirements) who came from low-income households. The Fostering Connections to Success and Increasing Adoptions Act of 2008 began phasing out the income requirement by age, so after 10 years states would receive partial reimbursement for all children meeting the requirements regardless of the income of the household they were removed from. This provision would delay the final age-related phase out of this income test until July 1, 2024.

Section 50782. GAO study and report on state reinvestment of savings resulting from increase in adoption assistance. This section requires the Government Accountability Office (GAO) to study whether states are complying with the requirement that they spend, for child welfare purposes, an amount equal to the amount of savings (if any) resulting from phasing out the income eligibility requirements for federal adoption assistance and the requirement that not less than 30 percent of any such savings be used for post-adoption or post-guardianship services and services to support and sustain positive outcomes, and permanency, for children who might otherwise enter foster care.

TITLE VIII – SUPPORTING SOCIAL IMPACT PARTNERSHIPS TO PAY FOR RESULTS

Section 50801. Short title. This title may be cited as the “Social Impact Partnerships to Pay for Results Act”.

Section 50802. Social impact partnerships to pay for results. This section provides \$100 million for the federal government to pay for outcomes through Social Impact Partnership projects. Under these projects, state and local governments would raise their own money and pay for a social service, then be repaid by the federal government only if a rigorous, independent evaluation showed the service achieved the intended result.

TITLE IX – PUBLIC HEALTH PROGRAMS

Section 50901. Extension for community health centers, the National Health Service Corps, and teaching health centers that operate GME programs.

Community Health Centers

This section extends and increases mandatory funding for community health centers (CHCs) from \$3.6 billion per year to \$3.8 billion for FY2018 and \$4 billion for FY2019. (Note: \$550 million was provided for the first and second quarters of FY2018 in Public Law 115-96). It also authorizes the Secretary of Health and Human Services (HHS) to award supplemental grants to health centers for implementing evidence-based models that increase access to high-quality primary care. These models could include improving the delivery of care for individuals with multiple chronic conditions, expanding the use of telehealth and other technologies, integrating behavioral health into primary care, and others.

This section prioritizes funding to areas of greatest need by:

- Providing for special consideration of supplemental funding for grant applications that seek to address significant barriers to care;
- Providing for special consideration of expanded service applications that seek to address emerging public health, behavioral health, mental health, or substance use issues;
- Prioritizing new access points to areas that have the greatest unmet need; and
- Ensuring that grants to health centers for homeless individuals include those that will focus innovative programs for outreach to and health services for homeless veterans and veterans at risk of homelessness.

This section improves oversight and accountability of funding provided to health centers by ensuring that health centers are collaborating with other health care providers in the area, such as local hospitals and specialty providers, to improve care coordination and reduce unnecessary hospitalizations and emergency department admissions. This section also adds reporting requirements for the Secretary of HHS to include in its report to Congress information on the distribution of funding for new access points and expanded services among rural and urban areas as well as the rate of closure for health centers and access points. It also maintains a House amendment to authorize and appropriate \$25 million for FY2018 to support participation of the CHCs in enrolling participants in the Precision Medicine Initiative's All of Us Research Program.

National Health Service Corps

This section extends mandatory funding for the National Health Service Corps at the current level of \$310 million for each of fiscal years 2018 and 2019. (Note: \$65 million was provided for the first and second quarters of FY2018 in Public Law 115-96).

Teaching Health Center Graduate Medical Education Program

This section extends and increases funding for the THCGME program from \$60 million per year to \$126.5 million for each of fiscal years 2018 and 2019. (Note: a total of \$30 million was provided for the first and second quarters of FY2018 in Public Laws 115-63 and 115-96). This section also ensures accountability by requiring the Secretary to report to Congress on the number of patients and patient visits treated by residents as well the number of residents who go on to serve in rural areas or health professional shortage areas or medically underserved

communities. In addition, this section calls for a report to Congress on the direct and indirect expenses associated with training residents at teaching health centers.

This section updates the statute and directs the Secretary of HHS to support the maintenance of filled positions at existing approved teaching health centers, as well as the expansion of existing or establishment of new such programs, as appropriate. In awarding grants to establish new teaching health centers, this section also directs the Secretary to prioritize qualified teaching health centers that are located in a rural area or serve a health professional shortage area or a medically underserved community.

Section 50902. Extension for special diabetes programs. This section extends mandatory funding for the Special Diabetes Program for Type 1 Diabetes at the current level of \$150 million for each of fiscal years 2018 and 2019, until expended. (Note: \$37.5 million was provided for the first and second quarters of FY2018 in Public Law 115-96). This section also extends mandatory funding for the Special Diabetes Program for Indians at the current level of \$150 million for each of fiscal years 2018 and 2019, until expended. (Note: \$37.5 million was provided for the first quarter of FY2018 in Public Law 115-63 and an additional \$37.5 million was provided for the second quarter of FY2018 in Public Law 115-96).

TITLE X – MISCELLANEOUS HEALTH CARE POLICIES

Section 51001. Home health payment reform. Under current law, Medicare pays for home health services using 60-day units of payment. Payment amounts for these episodes vary based on patient characteristics, such as clinical information and functional status, as well as the amount of therapy provided to the patient. The Centers for Medicare & Medicaid Services (CMS), the Medicare Payment Advisory Commission (MedPAC), and a Senate Finance Committee staff report have warned that including the amount of therapy as a determination of payment provides misaligned incentives and leaves the Medicare Trust fund vulnerable.

This section would reform the home health payment system beginning in 2020. Specifically, this section would reduce the unit of payment of a home health episode from 60 days to 30 days and would require the Secretary to revise the current home health case-mix system. As part of the revised case-mix system, the Secretary would eliminate the use of the therapy thresholds. Subsequent to the implementation of a revised payment system, home health payments would be adjusted as necessary to ensure the revised payment system is budget neutral. In order to provide the public, beneficiaries, and stakeholders greater transparency in the development of a revised case-mix system, this section would require the Secretary to hold at least one session of a technical expert panel to identify and prioritize recommendations for the revised payment system. Finally, the Secretary would be required to undergo rulemaking to propose and then finalize the revised payment system prior to January 1, 2020.

Section 51002. Information to satisfy documentation of Medicare eligibility for home health services. The Patient Protection and Affordable Care Act (PPACA) requires that a certifying physician must conduct a face-to-face encounter with a Medicare beneficiary before he or she attests that the beneficiary is eligible for home health care services. Initially, to fulfill this face-to-face requirement, the Centers for Medicare and Medicaid Services (CMS) required physicians to write a narrative confirming the beneficiary's homebound status and need for skilled services. In order to alleviate provider confusion and burden from this initial requirement, CMS

subsequently eliminated the narrative requirement for episodes beginning on or after January 1, 2015. The certifying physician is still required to attest that a face-to-face patient encounter occurred and document it as part of the patient's eligibility certification.

This section would allow CMS to determine if a beneficiary is eligible for Medicare coverage of home health services through a review of the entire patient medical record, including the home health agency's patient record. In places where the physician's record may be insufficient to determine eligibility, the home health agency's record could be used as supporting material to attest eligibility for home health services.

Section 51003. Technical amendments to Public Law 114-10 (the Medicare Access and CHIP Reauthorization Act). This section would make technical changes to improve the application of the Merit-based Incentive Payment System (MIPS) that was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). It would (1) limit the application of the performance-based payment adjustment to services paid under the physician payment schedule, consistent with performance incentive programs that were the precursors to MIPS; (2) ensure that the metrics for assessing resource use are relevant and fair; and (3) allow CMS to more gradually raise the threshold on which total performance is assessed. This section would also allow the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to provide initial feedback to stakeholders regarding alternative payment models submitted for consideration.

Section 51004. Expanded access to Medicare intensive cardiac rehabilitation programs. The section would expand access to intensive cardiac rehabilitation (ICR) programs for beneficiaries with stable, chronic heart failure and any future condition for which cardiac rehabilitation is covered, unless the Secretary determines coverage is not supported by clinical evidence.

Section 51005. Extension of blended site neutral payment rate for certain long-term care hospital discharges; temporary adjustment to site neutral payment rates. Beginning in 2016, Congress implemented site neutral payment reforms using specified long-term care hospital (LTCH) patient criteria. Patients who stay three days or more in an Intensive Care Unit (ICU) or patients who require mechanical ventilation services for at least 96 hours receive payment under the LTCH prospective payment system. All other LTCH discharges are paid an amount comparable to Medicare acute inpatient hospital payment system rates or 100 percent of the cost of the case, whichever is lower. These site neutral payments have been phased-in over a two-year period. In both fiscal years 2016 and 2017, LTCH cases that do not meet the specified patient criteria receive a blended rate that consists of one-half the standard LTCH payment and one-half the site neutral payment. Full implementation of the site neutral payment rate began on October 1, 2017. This section would extend the 50/50 payment blend two additional years through fiscal year 2019. This payment relief would also be fully offset by a 4.6 percent reduction in the LTCH specific IPPS comparable per diem amount.

Section 51006. Recognition of attending physician assistants as attending physicians to serve hospice patients. Medicare's hospice benefit was established to provide end-of-life care to beneficiaries who are terminally ill with a life expectancy of six months or less. Hospice care is provided under two 90-day benefit periods and an unlimited number of subsequent 60-day benefit periods. For the first 90-day period of hospice care, the individual's attending physician and the hospice medical director must each certify in writing that the individual is terminally ill

with a life expectancy of six months or less. For a subsequent 90-day or 60-day period of hospice care, the hospice medical director must recertify that the individual is terminally ill based on such clinical judgment. Additionally, Medicare requires that a written plan of hospice care has been established for an individual and is periodically reviewed to ensure hospice care is provided pursuant to the plan by the individual's attending physician (or nurse practitioner) and by the medical director of the hospice program. Further, beginning January 1, 2011, a hospice physician or nurse practitioner must have a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th day recertification and each subsequent 60-day recertification for hospice care, and must attest that such visit took place.

This section would permit physician assistants to serve as the attending physician, which allows them to manage and separately bill for hospice care. This section would also enable physician assistants to act as the attending physician to establish, and periodically review, the hospice plan of care to ensure care is provided pursuant to such plan of care. Finally, this section would clarify that, as with nurse practitioners, physician assistants cannot certify or recertify hospice care for individuals.

Section 51007. Extension of enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2017.

This section would require the HHS Secretary to continue applying, through calendar year 2017, the enforcement instruction providing for an exception to requirements that certain outpatient therapeutic services furnished in critical access hospitals and other small rural hospitals be provided under the direct supervision of a physician in the hospital. Direct supervision, as defined by 42 CFR 410.32, requires a physician or non-physician practitioner to be immediately available to furnish assistance and direction throughout the performance of a procedure.

Section 51008. Allowing physician assistants, nurse practitioners, and clinical nurse specialists to supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs.

This section would revise the current law requirement that a physician supervise cardiac, intensive cardiac, and pulmonary rehabilitation programs by also allowing a physician assistant, nurse practitioner, or clinical nurse specialist to supervise such programs, beginning January 1, 2024.

Section 51009. Transitional payment rules for certain radiation therapy services under the physician fee schedule. This section would extend the requirement that certain radiation therapy services remain at the current payment level through 2019, providing radiation oncologists more time to prepare for a possible alternative payment model.

TITLE XI – PROTECTING SENIORS' ACCESS TO MEDICARE ACT

Section 52001. Repeal of the Independent Payment Advisory Board (IPAB). This section would repeal the Independent Payment Advisory Board that is charged with making recommendations that reduce Medicare spending when per-capita growth exceeds an expenditure growth target. As recommendations from this board of 15 appointed individuals would take effect unless Congress promptly acts to enact its own policies that achieve equivalent spending reduction, repeal of IPAB reaffirms the management of Medicare as fully within the purview of Congress.

TITLE XII - OFFSETS

Section 53101. Modifying reductions in Medicaid Disproportionate Share Hospital (DSH) allotments. Under current law, disproportionate share hospital (DSH) payments are scheduled to be reduced starting in FY2018. This provision would eliminate the DSH reductions in FY2018 and FY2019, maintain the \$4 billion in reductions for FY2020, and set the amount of reductions for FY2021 through FY2025 at \$8 billion per year.

Section 53102. Third party liability in Medicaid and CHIP. This section permanently repeals a provision in the Bipartisan Budget Act of 2013 that would have allowed states to recover medical expense claims from any portion of a Medicaid beneficiary settlement, including money set aside for a beneficiary's future care or living expenses. It also modified Medicaid third-party liability (TPL) rules as it relates to Medicaid payer of last resort requirements. Current law requires states to pay first and seek reimbursement from third parties in some circumstances. This section includes a provision that removes the requirement that states pay providers for prenatal care first before seeking reimbursement by third parties. It also includes a provision to further delay for two years the option for states to delay payment to providers for certain care for children, including Early and Periodic Screening, Diagnostic, and Treatment services, for up to 90 days while seeking reimbursement from third parties. The provision includes a GAO study and report to Congress to examine the effects of these changes. Finally, the section also applies third party liability requirements to CHIP.

Section 53103. Treatment of lottery winnings and other lump-sum income for purposes of income eligibility under Medicaid. This section modifies rules related to qualified lottery and gambling winnings for purposes of income calculations when determining eligibility for Medicaid, specifying the period over which such income would be considered.

Section 53104. Rebate obligation with respect to line extension drugs. Current law imposes an alternative rebate formula for purposes of the Medicaid Drug Rebate Program for drugs that are line extensions of certain single source or innovator multiple source drugs. Under current law drafting, this rebate is the basic rebate or the higher of the additional rebate or line extension rebate. This section adjusts current law to clarify that the rebate for line extension drugs is the greater of either the base rebate plus the additional rebate, or the base rebate plus the line extension rebate.

Section 53105. Medicaid Improvement Fund. This section would rescind \$985 million from the Medicaid Improvement Fund.

Section 53106. Physician fee schedule update. This section reduces the update to the Physician Fee Schedule for 2019 from 0.50 percent to 0.25 percent.

Section 53107. Payment for outpatient physical therapy services and outpatient occupational therapy services furnished by a therapy assistant. This section would reduce payment for outpatient therapy services furnished entirely or in part by a physical or occupational therapy assistant, bringing the payment rate in line with the 85 percent of the amount Medicare would otherwise pay that typically applies for other services furnished with the assistance of an ancillary professional.

Section 53108. Reduction for non-emergency end-stage renal disease (ESRD) ambulance transports. This section would reduce the amount that Medicare would otherwise pay for ambulance transports to and from a dialysis facility in non-emergency situations by 13 percent, in recognition of lower level of readiness associated with these routine, scheduled transports.

Section 53109. Hospital transfer policy for early discharges to hospice care. Medicare currently maintains two different hospital transfer policies that adjust inpatient hospital payments for services furnished to beneficiaries who are discharged early. Medicare severity diagnosis related group (MS-DRG) payments are reduced when beneficiaries (1) have a length of stay at least one day less than the geometric mean length of stay for the MS-DRG, and (2) are transferred to another hospital covered by the acute inpatient prospective payment system (IPPS), or (3) are discharged to a post-acute care setting including skilled nursing facilities (SNF), inpatient rehabilitation facilities (IRF), home health agencies (HHAs), long-term care hospitals (LTCH), and inpatient psychiatric hospitals. Transferring facilities under this policy are paid a per diem rate rather than the full MS-DRG payment consistent with Congressional intent that hospitals should not receive full prospective payments for beneficiaries who are discharged early and subsequently admitted to another clinical setting for additional medical care. In contrast, under current Medicare law, an acute care inpatient hospital payment is not reduced if a beneficiary is discharged early to a hospice program.

This section would establish, beginning on October 1, 2018, a hospital transfer payment policy for early discharges to hospice care. This reform applies the current Medicare hospital transfer payment policy (in effect for early discharges to other hospitals and to post-acute care facilities) to hospitals that discharge Medicare beneficiaries early to hospice care. In a May 2013 report, the HHS Office of the Inspector General (OIG) concluded that enacting a hospital transfer payment policy for early discharges to hospice care “would not cause hospitals a significant financial disadvantage or disproportionately affect any hospital.” The OIG report also noted that “an overwhelming majority of hospital officials stated...that a reduction in hospital payments resulting from a hospice transfer policy would not influence medical practice in a way that increases the health risks for beneficiaries or creates an incentive for hospitals to extend hospital stays.”

Section 53110. Medicare payment update for home health services. Medicare reimbursement for home health agency (HHA) providers will increase by 1.5 percent in 2020.

Section 53111. Medicare payment update for skilled nursing facilities. Medicare reimbursement for skilled nursing facility (SNF) providers will increase by 2.4 percent in fiscal year 2019.

Section 53112. Preventing the artificial inflation of star ratings after the consolidation of MA plans offered by the same organization. In recent years, CMS has encouraged MA organizations to consolidate their MA plans into fewer contracts. An unintended consequence of contract consolidation can be an artificial increase in star ratings, and therefore, quality bonus payments. Earlier this year, CMS proposed new rules related to how contract consolidations affect star ratings to more accurately reflect performance of the surviving and consumed contracts. This section would direct CMS to calculate a weighted average of star ratings across contracts that have been consolidated to more accurately reflect quality and mitigate unwarranted quality bonus payments.

Section 53113. Sunsetting exclusion of biosimilars from Medicare Part D coverage gap discount program. This section would include biosimilars in the Medicare Part D coverage gap discount program. Specifically, it would require manufacturers of biosimilars to provide a discount to remove the incentive to prescribe a brand reference biologic over the biosimilar. Under the current coverage gap structure, the Part D plan and the beneficiary typically pays more for a biosimilar.

Section 53114. Adjustments to Medicare part B and part D premium subsidies for higher income individuals. This section would, starting in 2019, increase the percentage that beneficiaries with a modified adjusted gross income (MAGI) of at least \$500,000 (\$750,000 for a couple filing jointly) pay in Part B and Part D premiums from 80 percent to 85 percent. It would freeze these this new income threshold through 2028, at which point the threshold would be indexed to inflation.

Section 53115. Medicare Improvement Fund. This section would rescind \$220 million from the Medicare Improvement Fund.

Section 53116. Closing the Donut Hole for Seniors. This section would accelerate the closure of the Part D program coverage gap, the phase known as the “donut hole” where beneficiaries are responsible for a greater portion of their prescription drug costs, with the beneficiary contribution decreasing to 25 percent of prescription costs in 2019, instead of 2020 under current law. In addition, it would increase the percentage that a drug manufacturer must discount the cost of prescriptions in this phase from 50 percent under current law to 70 percent, with the plan responsible for 5 percent, starting in 2019, thus reducing federal spending. The 70 percent manufacturer discount would continue to count toward beneficiary true out of pocket cost as under current law.

Section 53117. Modernizing child support enforcement fees. The Deficit Reduction Act of 2005 required that individuals who have never received Temporary Assistance for Needy Families (TANF) benefits be charged an annual fee of \$25 if the state collects more than \$500 in child support on their behalf. This provision would update this policy, requiring a fee of \$35 if the state collects more than \$550 in child support on behalf of an individual.

Section 53118. Increasing efficiency of prison data reporting. Current law prohibits Supplemental Security Income (SSI) payments to individuals while they are in prison. To encourage correctional institutions to report this information, institutions that report information on an individual who before confinement received SSI can earn a payment of \$400 if they report the individual’s information within 30 days, and \$200 dollars if this information is reported between 30 and 90 days after. This provision would require the institutions to report information within 15 days to receive a payment of \$400.

Section 53119. Prevention and Public Health Fund. This section reduces mandatory funding in the Prevention and Public Health Fund (PPHF) by \$1.35 billion over the 10 year budget window in order to generate \$998 million in savings.

SECTION-BY-SECTION

DIVISION B, Subdivision 2: Tax Relief and Medicaid Changes Relating to Certain Disasters

TITLE I—CALIFORNIA FIRES

Section 20101. Definitions. The provision provides disaster designations for areas affected by the wildfires in both Northern and Southern California, based on the dates the wildfires occurred and following Presidential disaster declarations in those areas.

Section 20102. Penalty-Free Access to Retirement Funds. The provision provides an exception to the 10 percent early retirement plan withdrawal penalty for qualified disaster relief distributions (not to exceed \$100,000 in qualified hurricane distributions cumulatively). It allows for the re-contribution of retirement plan withdrawals for home purchases cancelled due to eligible disasters, and provides flexibility for loans from retirement plans for qualified hurricane relief. This provision is estimated to have a negligible revenue effect over the 10-year budget window.

Section 20103. The provision provides a tax credit for 40 percent of wages (up to \$6,000 per employee) paid by a disaster-affected employer to an employee from a core disaster area. The credit applies to wages paid without regard to whether services associated with those wages were performed. This provision is estimated to cost \$7 million over the 10-year budget window.

Section 20104. Additional disaster tax relief provisions

(a): Temporary lift in limitations on deduction for charitable contributions. The Provision temporarily suspends limitations on the deduction for charitable contributions Associated with qualified disaster relief made before December 31, 2018. This provision is estimated to cost \$45 million over the 10-year budget window.

(b): Deduction for Personal Casualty Losses. With respect to uncompensated losses arising in the disaster area, the provision eliminates the current law requirements that personal casualty losses must exceed 10 percent of Adjusted Gross Income to qualify for deduction. The bill would also eliminate the current law requirement that taxpayers must itemize deductions to access this tax relief. This provision is estimated to cost \$223 million over the 10-year budget window.

(c): Special Rule for Determining 2017 Earned Income Tax Credit and Child Tax Credit. For 2017, allows taxpayers to refer to earned income from the immediately preceding year for purposes of determining the Earned Income Tax Credit (EITC) and Child Tax Credit (CTC). This provision is estimated to cost \$164 million over the 10 year budget window.

TITLE II: Tax Relief for Hurricanes Harvey, Irma and Maria

Section 20201. The provision would make corrections to disaster provisions included in P.L. 115-63, the Disaster Tax Relief and Airport and Airway Extension Act of 2017, to conform the

effective dates of certain provisions to the disaster designations. This provision is estimated to cost \$17 million over the 10-year budget window.

DIVISION C: Budgetary and Other Matters

Title III: Suspension of Public Debt Limit. The provision would temporarily lift the public debt limit through March 2, 2019.

Title IV: Joint Select Committees

Subtitle A. Joint Select Committee on Solvency of Multiemployer Pension Plans. The provision establishes a Joint Select Committee on Solvency of Multiemployer Pension Plans (hereafter in this section the "Joint Committee") to improve the solvency of multiemployer pension plans and the Pension Benefit Guaranty Corporation. The Joint Committee will be made up of 16 members to be appointed by House and Senate leaders. The members will include eight Senators and eight House members, equally divided between Republicans and Democrats. The Joint Committee must report a bill by the final week of November 30, 2018. If a majority of the Joint Committee members from each party agree on legislation, it will be considered in both chambers without amendment and under expedited procedures in the Senate. Any member of the Joint Committee may submit, with notice, dissenting or other views to be added to the report. In the Senate, any bill introduced by the Joint Committee must go to the Committees of jurisdiction (Committee on Finance and Committee on Health, Education, Labor, and Pensions). The Committees of jurisdiction may not provide any revisions; instead they will provide a favorable, unfavorable, or no recommendation within 7 days of introduction of the bill. The Joint Committee will be required to hold at least five public meetings or hearings, and at least three public hearings including possible field hearings outside of D.C. The Joint Committee terminates on the earlier of December 31, 2018 or 30 days after submission of the report.

Subtitle B. Joint Select Committee on Budget and Appropriations Process Reform. The provision establishes a Joint Select Committee on Budget and Appropriations Process reform (hereafter in this section the "Joint Committee") to reform the budget and appropriations process. The Joint Committee will be made up of 16 members to be appointed by House and Senate leaders. Two members will be named co-chairs, with one co-chair designated by the Speaker and the Senate Majority Leader, and one co-chair designated by the House and Senate Minority Leaders. The members will include eight Senators and eight House members, equally divided between Republicans and Democrats. The Joint Committee must vote on a report that contains a detailed statement of the findings, conclusions, and recommendations of the Joint Committee, and proposed legislative language to carry out the recommendations of the report by November 30, 2018. The report and proposed legislation is considered approved if it receives the support of a majority of Members of each party. If a majority of the Joint Committee members from each party agree on legislation, it will be considered in both chambers without amendment and under expedited procedures in the Senate. Any member of the Joint Committee may submit, with notice, dissenting or other views to be added to the report. In the Senate, any bill introduced by the Joint Committee must go to the Committee on the Budget, which may not provide any revisions and must report the bill within 7 days, after which the bill will be discharged. The Joint Committee will be required to hold at least five public meetings or hearings, and at least three public hearings including possible field hearings outside of D.C. The Joint Committee terminates on the earlier of December 31, 2018 or 30 days after submission of the report.

DIVISION D: Revenue Measures

TITLE I – EXTENSION OF EXPIRING PROVISIONS

Subtitle A – Tax Relief for Families and Individuals

Section 40201. Extension and modification of exclusion from gross income of discharge of qualified principal residence indebtedness. The provision extends through 2017 the exclusion from gross income of a discharge of qualified principal residence indebtedness. The provision also modifies the exclusion to apply to qualified principal residence indebtedness that is discharged pursuant to a binding written agreement entered into in 2017. *This provision is estimated to cost \$2.4 billion over the 10-year budget window.*

Section 40202. Extension of mortgage insurance premiums treated as qualified residence interest. The provision extends through 2017 the treatment of qualified mortgage insurance premiums as interest for purposes of the mortgage interest deduction. This deduction phases out ratably for taxpayers with adjusted gross income of \$100,000 to \$110,000. *This provision is estimated to cost \$1.079 billion over the 10-year budget window.*

Section 40203. Extension of above-the-line deduction for qualified tuition and related expenses. The provision extends through 2017 the above-the-line deduction for qualified tuition and related expenses for higher education. The deduction is capped at \$4,000 for an individual whose adjusted gross income (AGI) does not exceed \$65,000 (\$130,000 for joint filers) or \$2,000 for an individual whose AGI does not exceed \$80,000 (\$160,000 for joint filers). *This provision is estimated to cost \$357 million over the 10-year budget window.*

Subtitle B – Incentives for Growth, Jobs, Investment, and Innovation

Section 40301. Extension of Indian employment tax credit. The provision extends through 2017 the Indian employment tax credit. The Indian employment credit provides a credit on the first \$20,000 of qualified wages paid to each qualified employee who works on an Indian reservation. *This provision is estimated to cost \$57 million over the 10-year budget window.*

Section 40302. Extension and modification of railroad track maintenance credit. The provision extends through 2017 the railroad track maintenance tax credit. The provision includes a “safe harbor” to provide that assignments of the credit shall be effective if made pursuant to a written agreement entered into no later than 90 days following date of enactment. *This provision is estimated to cost \$215 million over the 10-year budget window.*

Section 40303. Extension of mine rescue team training credit. The provision extends through 2017 the mine rescue team training tax credit. Employers may take a credit equal to the lesser of 20 percent of the training program costs incurred, or \$10,000. *This provision is estimated to cost \$2 million over the 10-year budget window.*

Section 40304. Extension of classification of certain race horses as 3-year property. The provision extends the 3-year recovery period for race horses to property placed in service during 2017. This provision is estimated to cost \$2 million over the 10-year budget window.

Section 40305. Extension of 7-year recovery period for motorsports entertainment complexes. The provision extends the 7-year recovery period for motorsport entertainment complexes to property placed in service during 2017. *This provision is estimated to cost \$40 million over the 10-year budget window.*

Section 40306. Extension and modification of accelerated depreciation for business property on an Indian reservation. The provision extends accelerated depreciation for qualified Indian reservation to property placed in service during 2017. *This provision is estimated to cost \$112 million over the 10-year budget window.*

Section 40307. Extension of election to expense mine safety equipment. The provision extends the election to expense mine safety equipment to property placed in service during 2017. *This provision is estimated to have no revenue impact over the 10-year budget window.*

Section 40308. Extension of special expensing rules for certain film, television, and theatrical productions. The provision extends through 2017 the special expensing provision for qualified film, television, and theatrical productions. In general, only the first \$15 million of costs may be expensed. *This provision is estimated to cost \$37 million over the 10-year budget window.*

Section 40309. Extension of deduction allowable with respect to income attributable to domestic production activities in Puerto Rico. The provision extends through 2017 the eligibility of domestic gross receipts from Puerto Rico for the domestic production deduction. *This provision is estimated to cost \$67 million over the 10-year budget window.*

Section 40310. Extension of Treatment of timber gains. The provision provides that C corporation timber gains are subject to a tax rate of 23.8 percent. The provision is effective for tax year 2017. *This provision is estimated to cost \$32 million over the 10-year budget window.*

Section 40311. Extension of empowerment zone tax incentives. The provision extends through 2017 the tax benefits for certain businesses and employers operating in empowerment zones. Empowerment zones are economically distressed areas, and the tax benefits available include tax-exempt bonds, employment credits, increased expensing, and gain exclusion from the sale of certain small-business stock. *This provision is estimated to cost \$252 million over the 10-year budget window.*

Section 40312. Extension of American Samoa economic development credit. The provision extends through 2017 the existing credit for taxpayers currently operating in American Samoa. *This provision is estimated to cost \$11 million over the 10-year budget window.*

Subtitle C – Incentives for Energy Production and Conservation

Section 40401. Extension of credit for nonbusiness energy property. The provision extends through 2017 the credit for purchases of nonbusiness energy property. The provision allows a credit of 10 percent of the amount paid or incurred by the taxpayer for qualified energy improvements, up to \$500. *This provision is estimated to cost \$542 million over the 10-year budget window.*

Section 40402. Extension and Modification of Credit for Residential Energy Property.

The provision extends the credit for residential energy efficient property for all qualified property placed in service prior to 2022, subject to a reduced rate of 26 percent for property placed in service during 2020 and 22 percent for property placed in service during 2021. The provision would be effective for property placed in service after 2016. *This provision is estimated to cost \$3.174 billion over the 10-year budget window.*

Section 40403. Extension of credit for new qualified fuel cell motor vehicles. The provision extends through 2017 the credit for purchases of new qualified fuel cell motor vehicles. The provision allows a credit of between \$4,000 and \$40,000, depending on the weight of the vehicle, for the purchase of such vehicles. *This provision is estimated to cost \$4 million over the 10-year budget window.*

Section 40404. Extension of credit for alternative fuel vehicle refueling property. The provision extends through 2017 the credit for the installation of non-hydrogen alternative fuel vehicle refueling property. (Under current law, hydrogen-related property already is eligible for the credit.) Taxpayers are allowed a credit of up to 30 percent of the cost of the installation of the qualified alternative fuel vehicle refueling property. *This provision is estimated to cost \$67 million over the 10-year budget window.*

Section 40405. Extension of credit for 2-wheeled plug-in electric vehicles. The provision extends through 2017 the 10-percent credit for two-wheeled plug-in electric vehicles (capped at \$2,500). *This provision is estimated to cost \$1 million over the 10-year budget window.*

Section 40406. Extension of second generation biofuel producer credit. The provision extends through 2017 the credit for production of cellulosic biofuels. *This provision is estimated to cost \$11 million over the 10-year budget window.*

Section 40407. Extension of biodiesel and renewable diesel incentives. The provision extends through 2017 the existing \$1.00 per gallon tax credit for biodiesel and biodiesel mixtures, and the small agri-biodiesel producer credit of 10 cents per gallon. The provision also extends through 2017 the \$1.00 per gallon production tax credit for diesel fuel created from biomass. The provision extends through 2017 the fuel excise tax credit for biodiesel mixtures. *This provision is estimated to cost \$3.25 billion over the 10-year budget window.*

Section 40408. Extension of production credit for Indian coal facilities. The provision extends through 2017 the \$2 per ton production tax credit for coal produced on land owned by an Indian tribe. *This provision is estimated to cost \$38 million over the 10-year budget window.*

Section 40409. Extension and of credits with respect to facilities producing energy from certain renewable resources. The provision extends the production tax credit (PTC) for certain renewable sources of electricity to facilities for which construction has commenced by the end of 2017. *This provision is estimated to cost \$330 million over the 10-year budget window.*

Section 40410. Extension of credit for energy-efficient new homes. The provision extends through 2017 the tax credit for manufacturers of energy-efficient residential homes. An eligible contractor may claim a tax credit of \$1,000 or \$2,000 for the construction or manufacture of a

new energy efficient home that meets qualifying criteria. *This provision is estimated to cost \$299 million over the 10-year budget window.*

Section 40411. Extension and phaseout of energy credit. The provision generally harmonizes the expiration dates and phaseout schedules for different properties. The 30 percent Investment Tax Credit (ITC) for solar energy, fiber optic solar energy, qualified fuel cell, and qualified small wind energy property is available for property the construction of which begins before 2020 and is then phased out for property the construction of which begins before 2022. Additionally, the 10 percent ITC for qualified microturbine, combined heat and power system, and thermal energy property is made available for property the construction of which begins before 2022. *This provision is estimated to cost \$1.433 billion over the 10-year budget window.*

Section 40412. Extension of special allowance for second generation biofuel plant property. The provision extends through 2017 50-percent bonus depreciation for cellulosic biofuel facilities. This provision is estimated to cost less than \$500,000 over the 10-year budget window.

Section 40413. Extension of energy efficient commercial buildings deduction. The provision extends through 2017 the deduction for energy efficiency improvements to lighting, heating, cooling, ventilation, and hot water systems of commercial buildings. *This provision is estimated to cost \$69 million over the 10-year budget window.*

Section 40414. Extension of special rule for sales or dispositions to implement FERC or State electric restructuring policy for qualified electric utilities. The provision extends through 2017 a rule that permits taxpayers to elect to recognize gain from qualifying electric transmission transactions ratably over an eight-year period beginning in the year of sale (rather than entirely in the year of sale) if the amount realized from such sale is used to purchase exempt utility property within the applicable period. *This provision is estimated to have no revenue impact over the 10-year budget window.*

Section 40415. Extension of excise tax credits relating to alternative fuels. The provision extends through 2017 the \$0.50 per gallon alternative fuel tax credit and alternative fuel mixture tax credit. *This provision is estimated to cost \$555 million over the 10-year budget window.*

Section 40416. Extension of Oil Spill Liability Trust Fund financing rate. An excise tax of \$0.09 per barrel is imposed on crude oil received at a refinery and petroleum products entered into the U.S. and deposited into the Oil Spill Liability Trust Fund. Having expired at the end of 2017, the excise tax is reinstated beginning on the first day of the first calendar month beginning after the date of enactment. *This provision is estimated to have no revenue effect over the 10-year budget window*

Subtitle D – Modifications of Energy Incentives

Section 40501. Credit for Production from Advanced Nuclear Power Facilities. The provision allows the Secretary of the Treasury, after January 1, 2021, to re-allocate any of the national 6,000 megawatt capacity that is unused, first to qualifying facilities to the extent such facilities did not receive an allocation equal to their full capacity, and then to facilities placed in service after such date. Additionally, certain public entities would be eligible for an election to transfer tax credits to specified project partners. *This provision is estimated to cost \$637 million over the 10-year budget window.*

TITLE II – MISCELLANEOUS PROVISIONS

Section 41102. Modifications to Rum Cover Over. The provision extends the rum cover over through the end of 2021. Additionally, the provision maintains the cover-amount as being based on \$13.25 per proof gallon of rum imported into the U.S. regardless of actual tax collected. *This provision is estimated to cost \$676 million over the 10-year budget window.*

Section 41103. Extension of Waiver of Limitations With Respect to Excluding From Gross Income Amounts Received by Wrongfully Incarcerated Individuals. As of December 18, 2015, current law provides that, with respect to any wrongfully incarcerated individual, gross income does not include any civil damages, restitution, or other monetary award (including compensatory or statutory damages and restitution imposed in a criminal matter) relating to the incarceration of that individual for the covered offense for which that individual was convicted. Current law contains a special rule allowing individuals to make a claim for credit or refund of any overpayment of tax resulting from the exclusion, even if such claim would be disallowed, if the claim for credit or refund is filed before the close of the one-year period beginning on December 18, 2015 (i.e., before December 18, 2016). This provision in the bill would extend the waiver on the statute of limitations with respect to filing a claim for a credit or refund of an overpayment of tax resulting from the exclusion described above for an additional two years – that is, until December 18, 2018. *The provision is effective on the date of enactment. This provision is estimated to cost less than \$500,000 over the 10-year budget window.*

Section 41104. Individuals Held Harmless on Improper Levy On Retirement Plans. Under present law, if the IRS improperly levies on an individual retirement arrangement (“IRA”) or certain employer-sponsored retirement plans (“employer-sponsored plans”), an individual may not be made whole even if the IRS returns the amount levied with interest because the individual may lose the opportunity to have those funds accumulate on a tax-favored basis until retirement. The provision allows amounts, including interest, returned to an individual from the IRS pursuant to a levy to be contributed to the IRA or employer-sponsored plan without regard to normal contribution limits. In general, any tax attributable to the amount distributed from the IRA or employer-sponsored plan by reason of a levy is not to be assessed, if assessed is to be abated, and if collected is to be credited or refunded as an overpayment. In addition, the IRS is required to pay interest on an amount returned to the individual in the case of a levy that is determined to be premature or otherwise not in accordance with administrative procedures, as well as in the case of a wrongful levy under present law. The provision is effective for levied amounts, and interest thereon, returned to individuals in taxable years beginning after December 31, 2017. *This provision is estimated to have negligible revenue effect over the 10-year budget window.*

Section 41105. Modification of User Fee Requirements For Installment Agreements. An installment agreement with the IRS allows taxpayers who cannot afford to fully pay their tax liability the option to pay through monthly installments. The provision prohibits increases in the amount of user fees charged by the IRS for installment agreements. In addition, the IRS is required to waive the fees imposed for installment agreements for taxpayers whose income falls below 250 percent of the poverty line and has agreed to make the payments by electronic means through a debit account. Further, for those taxpayers whose income falls below 250 percent of the poverty line, are unbanked, and successfully complete an installment agreement, the fee would be reimbursed at the end of the installment agreement period. The provision applies to

agreements entered into on or after the date that is 60 days after the date of enactment. *This provision is estimated to raise \$47 million over the 10-year budget window.*

Section 41106. Form 1040SR for Seniors. Current law provides that persons required to file tax returns do so in the form prescribed by the Secretary of the Treasury in regulations. The standard form available for individuals subject to income tax are in the series of form known as Form 1040, and include two simplified versions, the Form 1040A and the Form 1040EZ. The provision requires that the IRS publish a simplified income tax return form designated a Form 1040SR, for use by persons who are age 65 or older by the close of the taxable year. The form is to be as similar as possible to the Form 1040EZ. The use of Form 1040SR is not to be restricted based on the amount of taxable income to be shown on the return, or the fact that the income to be reported for the taxable year includes social security benefits, distributions from qualified retirement plans, annuities or other such deferred payment arrangements, interest and dividends, or capital gains and losses taken into account in determining adjusted net capital gain. This provision is effective for taxable years beginning after date of enactment. *This provision is estimated to have no revenue effect over the 10-year budget window.*

Section 41107. Attorney Fees Relating to Awards to Whistleblowers. This provision would allow an above-the-line deduction for attorney fees and courts costs paid by, or on behalf of, a taxpayer in connection with any action involving a claim under State False Claims Acts, the SEC whistleblower program, and the Commodity Futures Trading Commission whistleblower program. The provision would be applicable in to taxable years beginning after December 31, 2017. *This provision is estimated to cost \$135 million over the 10-year budget window.*

Section 41108. Clarification of Whistleblower Awards. This provision modifies the definition of collected proceeds eligible for awards to include: (1) penalties, interest, additions to tax, and additional amounts, and (2) any proceeds under enforcement programs that the Treasury has delegated to the IRS the authority to administer, enforce, or investigate, including criminal fines and civil forfeitures, and violations of reporting requirements. This definition would also be used to determine eligibility for the enhanced reward program under which proceeds and additional amounts in dispute exceed \$2,000,000. Collected proceeds amounts would be determined without regard to whether such proceeds are available to the IRS. The provision would apply to information provided before, on, or after the date of enactment with respect to which a final determination for an award has not been made before the date of enactment. *This provision is estimated to cost \$52 million over the 10-year budget window.*

Section 41109. Clarification Regarding Excise Tax Based on Investment Income of Private Colleges and Universities. The provision narrows the scope of educational institutions that are subject to the excise tax on investment income of private colleges and universities, by modifying the definition of “student” to “tuition-paying student.” *This provision is estimated to cost \$22 million over the 10-year budget window.*

Section 41110. Exception from Private Foundation Excess Business Holding Tax for Independently-Operated Philanthropic Business Holdings. The provision creates an exception to the excess business holdings rules for certain philanthropic business holdings. Specifically, the tax on excess business holdings does not apply with respect to the holdings of a private foundation in any business enterprise that, for the taxable year, satisfies the following requirements: (1) the ownership requirements; (2) the "all profits to charity" distribution

requirement; and (3) the independent operation requirements. The ownership requirements are satisfied if: (1) all ownership interests in the business enterprise are held by the private foundation at all times during the taxable year; and (2) all the private foundation's ownership interests in the business enterprise were acquired under the terms by a means other than purchase of the testator or settlor, as the case may be. *This provision is estimated to raise less than \$500,000 over the 10-year budget window.*

Section 41111. Rule of Construction for Craft Beverage Modernization and Tax Reform.

The provision states that the provisions contained within the Craft Beverage Modernization and Tax Reform Section of the Tax Cuts and Jobs Act, shall be not construed to preempt, supersede, or otherwise limit or restrict any State, local, or tribal law that prohibits or regulates the production or sale of distilled spirits, wine, or malt beverages. *This provision is estimated to have no revenue effect over the 10-year budget window.*

Section 41112. Simplification of Rules Regarding Records, Statements, and Returns.

Under current law, brewers are subject to certain inventory rules for both tax paid and non-tax paid beer, which are in some cases unclear. This section would require Treasury to clarify these regulations to allow a unified accounting system for beer on which excise tax has already been paid, including in cases where such beer is intended to be consumed on the brewery premises. *This provision is estimated to have a negligible revenue effect over the 10-year budget window.*

Section 41113. Modification of Rules Governing Hardship Distribution.

Elective deferrals under a section 401(k) plan or a section 403(b) plan may not be distributed before the occurrence of one or more specified events, including financial hardship of the employee. Applicable Treasury regulations provide that a distribution is made on account of hardship only if the distribution is made on account of an immediate and heavy financial need of the employee and is necessary to satisfy the heavy need. The Treasury regulations provide a safe harbor under which a distribution may be deemed necessary to satisfy an immediate and heavy financial need. One requirement of this safe harbor is that the employee be prohibited from making elective deferrals and employee contributions to the plan and all other plans maintained by the employer for at least six months after receipt of the hardship distribution. The provision directs the Secretary of the Treasury is directed to modify the applicable regulations within one year of the date of enactment to (1) delete the requirement that an employee be prohibited from making elective deferrals and employee contributions for six months after the receipt of a hardship distribution in order for the distribution to be deemed necessary to satisfy an immediate and heavy financial need, and (2) make any other modifications necessary to carry out the purposes of the rule allowing elective deferrals to be distributed in the case of hardship. Thus, under the modified regulations, an employee would not be prevented for any period after the receipt of a hardship distribution from continuing to make elective deferrals and employee contributions. The regulations as revised by the provision shall apply to plan years beginning after December 31, 2018. *This provision, along with the provision below, are estimated to raise \$546 million over the 10-year budget window.*

Section 41114. Modification of Rules Relating to Hardship Withdrawals from Cash or Deferred Arrangements. Under current law, defined contribution plans are generally not permitted to allow in-service distributions (distributions while an employee is still working for the employer) attributable to elective deferrals if the employee is less than 59½ years old. One exception is for hardship distributions, which plans have the option of offering to participants.

Hardship distributions may be allowed only for amounts actually contributed by the employee and may not include account earnings or amounts contributed by the employer. Under the provision, employers may choose to allow hardship distributions to also include account earnings and employer contributions. *The provision would be effective for plan years beginning after 2018.*

Section 41115. Opportunity Zones Rule for Puerto Rico. The Tax Cuts and Jobs Act created certain Opportunity Zones in the mainland United States. This provision would expand the areas that could qualify for Opportunity Zone designation to include all census tracts within Puerto Rico. *This provision is estimated to cost \$137 million over the 10-year budget window.*

Section 41116. Tax Home of Certain Citizens or Residents of the United States Living Abroad. At the election of the individual, section 911 excludes from gross income certain foreign earned income of the individual. Generally, to receive such exclusion, the individual must have a “tax home” outside the United States. Under the provision, if an individual is serving in area designated by the President as a combat zone, then such individual has a tax home outside the United States. *This provision is estimated to cost \$779 million over the 10-year budget window.*

Section 41117. Treatment of Foreign Persons for Returns Relating to Payments Made In Settlement of Payment Card and Third Party Network Transactions. The provision modifies section 6050W(d)(1)(B) reporting requirements with respect to participating payees with only a foreign address. This provision is estimated to cost \$10 million over the 10-year budget window.

Section 41118. Repeal of Shift in Time of Payment of Corporate Estimated Taxes. In the case of a corporation with assets of at least \$1 billion (determined as of the end of the preceding taxable year), the amount of the required installment of estimated tax otherwise due in July, August, or September of 2020 is increased by 8 percent of that amount (determined without regard to any increase in such amount not contained in the Internal Revenue Code) (i.e., the installment due in July, August or September of 2020, is increased to 108 percent of the payment otherwise due). The next required installment is reduced accordingly (i.e., the payment due in October, November, or December of 2020). The provision repeals this increased corporate estimated tax installment rate in section 803 of the Trade Preferences Extension Act of 2015. *This provision is estimated to have no revenue effect over the 10-year budget window.*

Section 41119. Enhancement of Carbon Dioxide Sequestration Credit. Section 45Q provides a credit for carbon dioxide (CO₂) sequestration and is available to taxpayers that capture qualified CO₂ at a qualified facility – such as a coal power plant or manufacturing facility – and dispose of the CO₂ in secure geological storage or use it as an injectant in an enhanced oil or natural gas recovery project. The provision amends Section 45Q by: allowing facilities that have commenced construction within 7 years of enactment to qualify; allowing qualified taxpayers to claim the credit for 12 years; expanding the credit to include CO₂ disposed of through utilization in another end product; and increasing the credit amounts for geologic storage and enhanced oil recovery. *This provision is estimated to cost \$1.907 billion over the 10-year budget window.*