

The consortium that is formed here is the type of partnership that will be useful in kick-starting this technology and then turning it over to let industry take the reins.

I thank my partners on this bill—Mr. FLORES, Mr. UPTON, Mr. WALDEN, and Mr. Pallone—for their leadership on this issue, and I thank our staffs for their work on this critical legislation.

Mr. Speaker, finally, I thank my friend and colleague Mr. GREEN, again, who is retiring this year. He has been a champion for bipartisanship and compromise, and an advocate for sound policy in this Chamber. He will be missed. I will also miss the Speaker who is sitting in the Chair right now.

Mr. Speaker, I urge my colleagues to support H.R. 6140.

Mr. GENE GREEN of Texas. Mr. Speaker, I have no other speakers, and I yield back the balance of my time.

Mr. FLORES. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, it is simple. H.R. 6140 will set the stage for powering electricity in the future in a green manner by allowing for the development of those new-generation reactors, but we have to have the fuel to do it. This bill, by working with my good friend Mr. McNERNEY from California, does that.

This bill passed the subcommittee in the Committee on Energy and Commerce by a unanimous voice vote. It also passed the full committee by a voice vote. It is a bipartisan solution to address a real need to generate electricity, always-on, baseload electricity, in a zero-emissions manner.

Mr. Speaker, I urge all of my colleagues to vote for this important piece of legislation, and I yield back the balance of my time.

Mr. UPTON. Mr. Speaker, H.R. 6140, the “Advanced Nuclear Fuel Availability Act,” is a bipartisan bill sponsored by my Energy and Commerce colleagues, BILL FLORES of Texas, along with JERRY McNERNEY of California.

We considered this bill through regular order in Committee and the Full Committee reported the bill favorably, as amended, by a voice vote.

Imagine designing a new car that is safer, less expensive, and gets triple the mileage than anything we see on the road today. But when the vehicle is ready to hit the road, there is no gas to fill up the tank.

Nuclear innovators face a similar—and very critical—challenge as they work to bring several promising advanced nuclear technologies to the market. These new designs require fuels that have different attributes than what is used in today’s fleet of nuclear reactors, but the fuels are not commercially available.

H.R. 6140 addresses this challenge by ensuring nuclear innovators will have the advanced fuels needed to develop and demonstrate their products commercially.

The bill provides a direct path to align advanced nuclear fuel supply with initial demand for the deployment of next generation nuclear technologies. It provides for the development of the technical information necessary to assist the creation of the regulatory and licensing framework for these fuels.

The bill directs the Secretary of Energy to establish a temporary program, operating to

support a public-private partnership, that will make what is known as high-assay low-enriched uranium available for use in the first-of-a-kind advanced nuclear reactor designs. It provides for the surveys and information necessary to inform the new market development and cost recovery for initial federal investments.

In short, the Advanced Nuclear Fuel Availability Act takes practical, targeted steps to ensure the infrastructure will be in place in time to enable the development and deployment of a new generation of nuclear technologies in the United States.

This is an important bill for ensuring the nation’s international leadership on nuclear technology, for ensuring our energy security, and achieving our clean energy goals.

I urge all of my colleagues to support H.R. 6140.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. FLORES) that the House suspend the rules and pass the bill, H.R. 6140, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

#### IMPROVING MEDICAID PROGRAMS AND OPPORTUNITIES FOR ELIGIBLE BENEFICIARIES ACT

Mr. BARTON. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 7217) to amend title XIX of the Social Security Act to provide States with the option of providing coordinated care for children with complex medical conditions through a health home, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 7217

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

#### SECTION 1. SHORT TITLE.

This Act may be cited as the “Improving Medicaid Programs and Opportunities for Eligible Beneficiaries Act” or the “IMPROVE Act”.

#### TITLE I—ACE KIDS

##### SEC. 101. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR CHILDREN WITH MEDICALLY COMPLEX CONDITIONS.

Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1945 the following new section:

##### “SEC. 1945A. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR CHILDREN WITH MEDICALLY COMPLEX CONDITIONS.

“(a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability), beginning October 1, 2022, a State, at its option as a State plan amendment, may provide for medical assistance under this title to children with medically complex conditions who choose to enroll in a health home under this section by selecting a designated provider, a team of health care professionals operating with such a provider, or a health team as the child’s health home

for purposes of providing the child with health home services.

“(b) HEALTH HOME QUALIFICATION STANDARDS.—The Secretary shall establish standards for qualification as a health home for purposes of this section. Such standards shall include requiring designated providers, teams of health care professionals operating with such providers, and health teams to demonstrate to the State the ability to do the following:

“(1) Coordinate prompt care for children with medically complex conditions, including access to pediatric emergency services at all times.

“(2) Develop an individualized comprehensive pediatric family-centered care plan for children with medically complex conditions that accommodates patient preferences.

“(3) Work in a culturally and linguistically appropriate manner with the family of a child with medically complex conditions to develop and incorporate into such child’s care plan, in a manner consistent with the needs of the child and the choices of the child’s family, ongoing home care, community-based pediatric primary care, pediatric inpatient care, social support services, and local hospital pediatric emergency care.

“(4) Coordinate access to—

“(A) subspecialized pediatric services and programs for children with medically complex conditions, including the most intensive diagnostic, treatment, and critical care levels as medically necessary; and

“(B) palliative services if the State provides such services under the State plan (or a waiver of such plan).

“(5) Coordinate care for children with medically complex conditions with out-of-State providers furnishing care to such children to the maximum extent practicable for the families of such children and where medically necessary, in accordance with guidance issued under subsection (e)(1) and section 431.52 of title 42, Code of Federal Regulations.

“(6) Collect and report information under subsection (g)(1).

“(c) PAYMENTS.—

“(1) IN GENERAL.—A State shall provide a designated provider, a team of health care professionals operating with such a provider, or a health team with payments for the provision of health home services to each child with medically complex conditions that selects such provider, team of health care professionals, or health team as the child’s health home. Payments made to a designated provider, a team of health care professionals operating with such a provider, or a health team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 2 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be increased by 15 percentage points, but in no case may exceed 90 percent.

“(2) METHODOLOGY.—

“(A) IN GENERAL.—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

“(i) may be tiered to reflect, with respect to each child with medically complex conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, the severity or number of each such child’s chronic conditions, life-threatening illnesses, disabilities, or rare diseases, or the specific capabilities of the provider, team of health care professionals, or health team; and

“(i) shall be established consistent with section 1902(a)(30)(A).

“(B) ALTERNATE MODELS OF PAYMENT.—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

“(3) PLANNING GRANTS.—

“(A) IN GENERAL.—Beginning October 1, 2022, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

“(B) STATE CONTRIBUTION.—A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded.

“(C) LIMITATION.—The total amount of payments made to States under this paragraph shall not exceed \$5,000,000.

“(d) COORDINATING CARE.—

“(1) HOSPITAL NOTIFICATION.—A State with a State plan amendment approved under this section shall require each hospital that is a participating provider under the State plan (or a waiver of such plan) to establish procedures for, in the case of a child with medically complex conditions who is enrolled in a health home pursuant to this section and seeks treatment in the emergency department of such hospital, notifying the health home of such child of such treatment.

“(2) EDUCATION WITH RESPECT TO AVAILABILITY OF HEALTH HOME SERVICES.—In order for a State plan amendment to be approved under this section, a State shall include in the State plan amendment a description of the State’s process for educating providers participating in the State plan (or a waiver of such plan) on the availability of health home services for children with medically complex conditions, including the process by which such providers can refer such children to a designated provider, team of health care professionals operating such a provider, or health team for the purpose of establishing a health home through which such children may receive such services.

“(3) FAMILY EDUCATION.—In order for a State plan amendment to be approved under this section, a State shall include in the State plan amendment a description of the State’s process for educating families with children eligible to receive health home services pursuant to this section of the availability of such services. Such process shall include the participation of family-to-family entities or other public or private organizations or entities who provide outreach and information on the availability of health care items and services to families of individuals eligible to receive medical assistance under the State plan (or a waiver of such plan).

“(4) MENTAL HEALTH COORDINATION.—A State with a State plan amendment approved under this section shall consult and coordinate, as appropriate, with the Secretary in addressing issues regarding the prevention and treatment of mental illness and substance use among children with medically complex conditions receiving health home services under this section.

“(e) GUIDANCE ON COORDINATING CARE FROM OUT-OF-STATE PROVIDERS.—

“(1) IN GENERAL.—Not later than October 1, 2020, the Secretary shall issue (and update as the Secretary determines necessary) guidance to State Medicaid directors on—

“(A) best practices for using out-of-State providers to provide care to children with medically complex conditions;

“(B) coordinating care for such children provided by such out-of-State providers (including when provided in emergency and non-emergency situations);

“(C) reducing barriers for such children receiving care from such providers in a timely fashion; and

“(D) processes for screening and enrolling such providers in the respective State plan (or a waiver of such plan), including efforts to streamline such processes or reduce the burden of such processes on such providers.

“(2) STAKEHOLDER INPUT.—In carrying out paragraph (1), the Secretary shall issue a request for information to seek input from children with medically complex conditions and their families, States, providers (including children’s hospitals, hospitals, pediatricians, and other providers), managed care plans, children’s health groups, family and beneficiary advocates, and other stakeholders with respect to coordinating the care for such children provided by out-of-State providers.

“(f) MONITORING.—A State shall include in the State plan amendment—

“(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved care coordination and management under this section;

“(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider); and

“(3) a methodology for tracking prompt and timely access to medically necessary care for children with medically complex conditions from out-of-State providers.

“(g) DATA COLLECTION.—

“(1) PROVIDER REPORTING REQUIREMENTS.—In order to receive payments from a State under subsection (c), a designated provider, a team of health care professionals operating with such a provider, or a health team shall report to the State, at such time and in such form and manner as may be required by the State, the following information:

“(A) With respect to each such provider, team of health care professionals, or health team, the name, National Provider Identification number, address, and specific health care services offered to be provided to children with medically complex conditions who have selected such provider, team of health care professionals, or health team as the health home of such children.

“(B) Information on all applicable measures for determining the quality of health home services provided by such provider, team of health care professionals, or health team, including, to the extent applicable, child health quality measures and measures for centers of excellence for children with complex needs developed under this title, title XXI, and section 1139A.

“(C) Such other information as the Secretary shall specify in guidance.

When appropriate and feasible, such provider, team of health care professionals, or health team, as the case may be, shall use health information technology in providing the State with such information.

“(2) STATE REPORTING REQUIREMENTS.—

“(A) COMPREHENSIVE REPORT.—A State with a State plan amendment approved under this section shall report to the Secretary (and, upon request, to the Medicaid and CHIP Payment and Access Commission), at such time and in such form and manner

determined by the Secretary to be reasonable and minimally burdensome, the following information:

“(i) Information reported under paragraph (1).

“(ii) The number of children with medically complex conditions who have selected a health home pursuant to this section.

“(iii) The nature, number, and prevalence of chronic conditions, life-threatening illnesses, disabilities, or rare diseases that such children have.

“(iv) The type of delivery systems and payment models used to provide services to such children under this section.

“(v) The number and characteristics of designated providers, teams of health care professionals operating with such providers, and health teams selected as health homes pursuant to this section, including the number and characteristics of out-of-State providers, teams of health care professionals operating with such providers, and health teams who have provided health care items and services to such children.

“(vi) The extent to which such children receive health care items and services under the State plan.

“(vii) Quality measures developed specifically with respect to health care items and services provided to children with medically complex conditions.

“(B) REPORT ON BEST PRACTICES.—Not later than 90 days after a State has a State plan amendment approved under this section, such State shall submit to the Secretary, and make publicly available on the appropriate State website, a report on how the State is implementing guidance issued under subsection (e)(1), including through any best practices adopted by the State.

“(h) RULE OF CONSTRUCTION.—Nothing in this section may be construed—

“(1) to require a child with medically complex conditions to enroll in a health home under this section;

“(2) to limit the choice of a child with medically complex conditions in selecting a designated provider, team of health care professionals operating with such a provider, or health team that meets the health home qualification standards established under subsection (b) as the child’s health home; or

“(3) to reduce or otherwise modify—

“(A) the entitlement of children with medically complex conditions to early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r)); or

“(B) the informing, providing, arranging, and reporting requirements of a State under section 1902(a)(43).

“(i) DEFINITIONS.—In this section:

“(1) CHILD WITH MEDICALLY COMPLEX CONDITIONS.—

“(A) IN GENERAL.—Subject to subparagraph (B), the term ‘child with medically complex conditions’ means an individual under 21 years of age who—

“(i) is eligible for medical assistance under the State plan (or under a waiver of such plan); and

“(ii) has at least—

“(I) one or more chronic conditions that cumulatively affect three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; or

“(II) one life-limiting illness or rare pediatric disease (as defined in section 529(a)(3) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360ff(a)(3))).

“(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the

number or severity of chronic, life threatening illnesses, disabilities, rare diseases or mental health conditions for purposes of determining eligibility for receipt of health home services under this section.

“(2) **CHRONIC CONDITION.**—The term ‘chronic condition’ means a serious, long-term physical, mental, or developmental disability or disease, including the following:

- “(A) Cerebral palsy.
- “(B) Cystic fibrosis.
- “(C) HIV/AIDS.
- “(D) Blood diseases, such as anemia or sickle cell disease.
- “(E) Muscular dystrophy.
- “(F) Spina bifida.
- “(G) Epilepsy.
- “(H) Severe autism spectrum disorder.
- “(I) Serious emotional disturbance or serious mental health illness.

“(3) **HEALTH HOME.**—The term ‘health home’ means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by a child with medically complex conditions (or the family of such child) to provide health home services.

“(4) **HEALTH HOME SERVICES.**—

“(A) **IN GENERAL.**—The term ‘health home services’ means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider, a team of health care professionals operating with such a provider, or a health team.

“(B) **SERVICES DESCRIBED.**—The services described in this subparagraph shall include—

- “(i) comprehensive care management;
- “(ii) care coordination, health promotion, and providing access to the full range of pediatric specialty and subspecialty medical services, including services from out-of-State providers, as medically necessary;
- “(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;
- “(iv) patient and family support (including authorized representatives);
- “(v) referrals to community and social support services, if relevant; and
- “(vi) use of health information technology to link services, as feasible and appropriate.

“(5) **DESIGNATED PROVIDER.**—The term ‘designated provider’ means a physician (including a pediatrician or a pediatric specialty or subspecialty provider), children’s hospital, clinical practice or clinical group practice, prepaid inpatient health plan or prepaid ambulatory health plan (as defined by the Secretary), rural clinic, community health center, community mental health center, home health agency, or any other entity or provider that is determined by the State and approved by the Secretary to be qualified to be a health home for children with medically complex conditions on the basis of documentation evidencing that the entity has the systems, expertise, and infrastructure in place to provide health home services. Such term may include providers who are employed by, or affiliated with, a children’s hospital.

“(6) **TEAM OF HEALTH CARE PROFESSIONALS.**—The term ‘team of health care professionals’ means a team of health care professionals (as described in the State plan amendment under this section) that may—

- “(A) include—
- “(i) physicians and other professionals, such as pediatricians or pediatric specialty or subspecialty providers, nurse care coordinators, dietitians, nutritionists, social workers, behavioral health professionals, physical therapists, occupational therapists, speech pathologists, nurses, individuals with experience in medical supportive technologies, or any professionals determined to be appro-

priate by the State and approved by the Secretary;

“(ii) an entity or individual who is designated to coordinate such a team; and

“(iii) community health workers, translators, and other individuals with culturally-appropriate expertise; and

“(B) be freestanding, virtual, or based at a children’s hospital, hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity determined to be appropriate by the State and approved by the Secretary.

“(7) **HEALTH TEAM.**—The term ‘health team’ has the meaning given such term for purposes of section 3502 of Public Law 111-148.”

## TITLE II—OTHER MEDICAID

### SEC. 201. EXTENSION OF MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) **GENERAL FUNDING.**—Section 6071(h) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(1) in paragraph (1)—

(A) in subparagraph (D), by striking “and” after the semicolon;

(B) in subparagraph (E), by striking the period at the end and inserting “; and”; and

(C) by adding at the end the following:

“(F) subject to paragraph (3), \$112,000,000 for fiscal year 2019.”

(2) in paragraph (2)—

(A) by striking “Amounts made” and inserting “Subject to paragraph (3), amounts made”; and

(B) by striking “September 30, 2016” and inserting “September 30, 2021”; and

(3) by adding at the end the following new paragraph:

“(3) **SPECIAL RULE FOR FY 2019.**—Funds appropriated under paragraph (1)(F) shall be made available for grants to States only if such States have an approved MFP demonstration project under this section as of December 31, 2018.”

(b) **FUNDING FOR QUALITY ASSURANCE AND IMPROVEMENT; TECHNICAL ASSISTANCE; OVERSIGHT.**—Section 6071(f) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended by striking paragraph (2) and inserting the following:

“(2) **FUNDING.**—From the amounts appropriated under subsection (h)(1)(F) for fiscal year 2019, \$500,000 shall be available to the Secretary for such fiscal year to carry out this subsection.”

(c) **TECHNICAL AMENDMENT.**—Section 6071(b) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended by adding at the end the following:

“(10) **SECRETARY.**—The term ‘Secretary’ means the Secretary of Health and Human Services.”

### SEC. 202. EXTENSION OF PROTECTION FOR MEDICAID RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.

(a) **IN GENERAL.**—Section 2404 of Public Law 111-148 (42 U.S.C. 1396r-5 note) is amended by striking “the 5-year period that begins on January 1, 2014,” and inserting “the period beginning on January 1, 2014, and ending on March 31, 2019.”

(b) **RULE OF CONSTRUCTION.**—

(1) **PROTECTING STATE SPOUSAL INCOME AND ASSET DISREGARD FLEXIBILITY UNDER WAIVERS AND PLAN AMENDMENTS.**—Nothing in section 2404 of Public Law 111-148 (42 U.S.C. 1396r-5 note) or section 1924 of the Social Security Act (42 U.S.C. 1396r-5) shall be construed as prohibiting a State from disregarding an individual’s spousal income and assets under a State waiver or plan amendment described in paragraph (2) for purposes of making determinations of eligibility for home and

community-based services or home and community-based attendant services and supports under such waiver or plan amendment.

(2) **STATE WAIVER OR PLAN AMENDMENT DESCRIBED.**—A State waiver or plan amendment described in this paragraph is any of the following:

(A) A waiver or plan amendment to provide medical assistance for home and community-based services under a waiver or plan amendment under subsection (c), (d), or (i) of section 1915 of the Social Security Act (42 U.S.C. 1396n) or under section 1115 of such Act (42 U.S.C. 1315).

(B) A plan amendment to provide medical assistance for home and community-based services for individuals by reason of being determined eligible under section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(10)(C)) or by reason of section 1902(f) of such Act (42 U.S.C. 1396a(f)) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care under which the State disregarded the income and assets of the individual’s spouse in determining the initial and ongoing financial eligibility of an individual for such services in place of the spousal impoverishment provisions applied under section 1924 of such Act (42 U.S.C. 1396r-5).

(C) A plan amendment to provide medical assistance for home and community-based attendant services and supports under section 1915(k) of such Act (42 U.S.C. 1396n(k)).

### SEC. 203. REDUCTION IN FMAP AFTER 2020 FOR STATES WITHOUT ASSET VERIFICATION PROGRAM.

Section 1940 of the Social Security Act (42 U.S.C. 1396w) is amended by adding at the end the following new subsection:

“(k) **REDUCTION IN FMAP AFTER 2020 FOR NON-COMPLIANT STATES.**—

“(1) **IN GENERAL.**—With respect to a calendar quarter beginning on or after January 1, 2021, the Federal medical assistance percentage otherwise determined under section 1905(b) for a non-compliant State shall be reduced—

“(A) for calendar quarters in 2021 and 2022, by 0.12 percentage points;

“(B) for calendar quarters in 2023, by 0.25 percentage points;

“(C) for calendar quarters in 2024, by 0.35 percentage points; and

“(D) for calendar quarters in 2025 and each year thereafter, by 0.5 percentage points.

“(2) **NON-COMPLIANT STATE DEFINED.**—For purposes of this subsection, the term ‘non-compliant State’ means a State—

“(A) that is one of the 50 States or the District of Columbia;

“(B) with respect to which the Secretary has not approved a State plan amendment submitted under subsection (a)(2); and

“(C) that is not operating, on an ongoing basis, an asset verification program in accordance with this section.”

### SEC. 204. DENIAL OF FFP FOR CERTAIN EXPENDITURES RELATING TO VACUUM ERECTION SYSTEMS AND PENILE PROSTHETIC IMPLANTS.

(a) **IN GENERAL.**—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended by inserting after paragraph (11) the following:

“(12) with respect to any amounts expended for—

“(A) a vacuum erection system that is not medically necessary; or

“(B) the insertion, repair, or removal and replacement of a penile prosthetic implant (unless such insertion, repair, or removal and replacement is medically necessary); or”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply with respect to items and services furnished on or after January 1, 2019.

**SEC. 205. MEDICAID IMPROVEMENT FUND.**

Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w-1(b)(1)) is amended by striking “\$31,000,000” and inserting “\$9,000,000”.

**SEC. 206. PREVENTING THE MISCLASSIFICATION OF DRUGS UNDER THE MEDICAID DRUG REBATE PROGRAM.**

(a) APPLICATION OF CIVIL MONEY PENALTY FOR MISCLASSIFICATION OF COVERED OUTPATIENT DRUGS.—

(1) IN GENERAL.—Section 1927(b)(3) of the Social Security Act (42 U.S.C. 1396r-8(b)(3)) is amended—

(A) in the paragraph heading, by inserting “AND DRUG PRODUCT” after “PRICE”;

(B) in subparagraph (A)—

(i) in clause (ii), by striking “; and” at the end and inserting a semicolon;

(ii) in clause (iii), by striking the period at the end and inserting a semicolon;

(iii) in clause (iv), by striking the semicolon at the end and inserting “; and”; and

(iv) by inserting after clause (iv) the following new clause:

“(v) not later than 30 days after the last day of each month of a rebate period under the agreement, such drug product information as the Secretary shall require for each of the manufacturer’s covered outpatient drugs.”; and

(C) in subparagraph (C)—

(i) in clause (ii), by inserting “, including information related to drug pricing, drug product information, and data related to drug pricing or drug product information,” after “provides false information”; and

(ii) by adding at the end the following new clauses:

“(iii) MISCLASSIFIED OR MISREPORTED INFORMATION.—

“(I) IN GENERAL.—Any manufacturer with an agreement under this section that knowingly (as defined in section 1003.110 of title 42, Code of Federal Regulations (or any successor regulation)) misclassifies a covered outpatient drug, such as by knowingly submitting incorrect drug category information, is subject to a civil money penalty for each covered outpatient drug that is misclassified in an amount not to exceed 2 times the amount of the difference, as determined by the Secretary, between—

“(aa) the total amount of rebates that the manufacturer paid with respect to the drug to all States for all rebate periods during which the drug was misclassified; and

“(bb) the total amount of rebates that the manufacturer would have been required to pay, as determined by the Secretary, with respect to the drug to all States for all rebate periods during which the drug was misclassified if the drug had been correctly classified.

“(II) OTHER PENALTIES AND RECOVERY OF UNDERPAID REBATES.—The civil money penalties described in subclause (I) are in addition to other penalties as may be prescribed by law and any other recovery of the underlying underpayment for rebates due under this section or the terms of the rebate agreement as determined by the Secretary.

“(iv) INCREASING OVERSIGHT AND ENFORCEMENT.—Each year the Secretary shall retain, in addition to any amount retained by the Secretary to recoup investigation and litigation costs related to the enforcement of the civil money penalties under this subparagraph and subsection (c)(4)(B)(ii)(III), an amount equal to 25 percent of the total amount of civil money penalties collected under this subparagraph and subsection (c)(4)(B)(ii)(III) for the year, and such retained amount shall be available to the Secretary, without further appropriation and until expended, for activities related to the oversight and enforcement of this section

and agreements under this section, including—

“(I) improving drug data reporting systems;

“(II) evaluating and ensuring manufacturer compliance with rebate obligations; and

“(III) oversight and enforcement related to ensuring that manufacturers accurately and fully report drug information, including data related to drug classification.”; and

(iii) in subparagraph (D)—

(I) in clause (iv), by striking “, and” and inserting a comma;

(II) in clause (v), by striking “subsection (f).” and inserting “subsection (f), and”; and

(III) by inserting after clause (v) the following new clause:

“(vi) in the case of categories of drug product or classification information that were not considered confidential by the Secretary on the day before the date of the enactment of the IMPROVE Act.”.

(2) TECHNICAL AMENDMENTS.—

(A) Section 1903(i)(10) of the Social Security Act (42 U.S.C. 1396b(i)(10)) is amended—

(i) in subparagraph (C)—

(I) by adjusting the left margin so as to align with the left margin of subparagraph (B); and

(II) by striking “, and” and inserting a semicolon;

(ii) in subparagraph (D), by striking “; or” and inserting “; and”; and

(iii) by adding at the end the following new subparagraph:

“(E) with respect to any amount expended for a covered outpatient drug for which a suspension under section 1927(c)(4)(B)(ii)(II) is in effect; or”.

(B) Section 1927(b)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r-8(b)(3)(C)(ii)) is amended by striking “subsections (a) and (b)” and inserting “subsections (a), (b), (f)(3), and (f)(4)”.

(b) RECOVERY OF UNPAID REBATE AMOUNTS DUE TO MISCLASSIFICATION OF COVERED OUTPATIENT DRUGS.—

(1) IN GENERAL.—Section 1927(c) of the Social Security Act (42 U.S.C. 1396r-8(c)) is amended by adding at the end the following new paragraph:

“(4) RECOVERY OF UNPAID REBATE AMOUNTS DUE TO MISCLASSIFICATION OF COVERED OUTPATIENT DRUGS.—

“(A) IN GENERAL.—If the Secretary determines that a manufacturer with an agreement under this section paid a lower per-unit rebate amount to a State for a rebate period as a result of the misclassification by the manufacturer of a covered outpatient drug (without regard to whether the manufacturer knowingly made the misclassification or should have known that the misclassification would be made) than the per-unit rebate amount that the manufacturer would have paid to the State if the drug had been correctly classified, the manufacturer shall pay to the State an amount equal to the product of—

“(i) the difference between—

“(I) the per-unit rebate amount paid to the State for the period; and

“(II) the per-unit rebate amount that the manufacturer would have paid to the State for the period, as determined by the Secretary, if the drug had been correctly classified; and

“(ii) the total units of the drug paid for under the State plan in the period.

“(B) AUTHORITY TO CORRECT MISCLASSIFICATIONS.—

“(i) IN GENERAL.—If the Secretary determines that a manufacturer with an agreement under this section has misclassified a covered outpatient drug (without regard to whether the manufacturer knowingly made the misclassification or should have known

that the misclassification would be made), the Secretary shall notify the manufacturer of the misclassification and require the manufacturer to correct the misclassification in a timely manner.

“(ii) ENFORCEMENT.—If, after receiving notice of a misclassification from the Secretary under clause (i), a manufacturer fails to correct the misclassification by such time as the Secretary shall require, until the manufacturer makes such correction, the Secretary may—

“(I) correct the misclassification on behalf of the manufacturer;

“(II) suspend the misclassified drug and the drug’s status as a covered outpatient drug under the manufacturer’s national rebate agreement; or

“(III) impose a civil money penalty (which shall be in addition to any other recovery or penalty which may be available under this section or any other provision of law) for each rebate period during which the drug is misclassified not to exceed an amount equal to the product of—

“(aa) the total number of units of each dosage form and strength of such misclassified drug paid for under any State plan during such a rebate period; and

“(bb) 23.1 percent of the average manufacturer price for the dosage form and strength of such misclassified drug.

“(C) REPORTING AND TRANSPARENCY.—

“(i) IN GENERAL.—The Secretary shall submit a report to Congress on at least an annual basis that includes information on the covered outpatient drugs that have been identified as misclassified, the steps taken to reclassify such drugs, the actions the Secretary has taken to ensure the payment of any rebate amounts which were unpaid as a result of such misclassification, and a disclosure of expenditures from the fund created in subsection (b)(3)(C)(iv), including an accounting of how such funds have been allocated and spent in accordance with such subsection.

“(ii) PUBLIC ACCESS.—The Secretary shall make the information contained in the report required under clause (i) available to the public on a timely basis.

“(D) OTHER PENALTIES AND ACTIONS.—Actions taken and penalties imposed under this paragraph shall be in addition to other remedies available to the Secretary including terminating the manufacturer’s rebate agreement for noncompliance with the terms of such agreement and shall not exempt a manufacturer from, or preclude the Secretary from pursuing, any civil money penalty under this title or title XI, or any other penalty or action as may be prescribed by law.”.

(2) OFFSET OF RECOVERED AMOUNTS AGAINST MEDICAL ASSISTANCE.—Section 1927(b)(1)(B) of the Social Security Act (42 U.S.C. 1396r-8(b)(1)(B)) is amended by inserting “, including amounts received by a State under subsection (c)(4),” after “in any quarter”.

(c) CLARIFYING DEFINITIONS.—Section 1927(k)(7)(A) of the Social Security Act (42 U.S.C. 1396r-8(k)(7)(A)) is amended—

(1) by striking “an original new drug application” and inserting “a new drug application” each place it appears;

(2) in clause (i), by inserting “but including a drug product approved for marketing as a non-prescription drug that is regarded as a covered outpatient drug under paragraph (4)” after “drug described in paragraph (5)”;

(3) in clause (ii), by striking “was originally marketed” and inserting “is marketed”; and

(4) in clause (iv)—

(A) by inserting “, including a drug product approved for marketing as a non-prescription drug that is regarded as a covered

outpatient drug under paragraph (4),” after “covered outpatient drug”; and

(B) by adding at the end the following new sentence: “Such term also includes a covered outpatient drug that is a biological product licensed, produced, or distributed under a biologics license application approved by the Food and Drug Administration.”.

(d) EXCLUSION OF MANUFACTURERS FOR KNOWING MISCLASSIFICATION OF COVERED OUTPATIENT DRUGS.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

“(17) KNOWINGLY MISCLASSIFYING COVERED OUTPATIENT DRUGS.—Any manufacturer or officer, director, agent, or managing employee of such manufacturer that knowingly misclassifies a covered outpatient drug under an agreement under section 1927, knowingly fails to correct such misclassification, or knowingly provides false information related to drug pricing, drug product information, or data related to drug pricing or drug product information.”.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act, and shall apply to covered outpatient drugs supplied by manufacturers under agreements under section 1927 of the Social Security Act (42 U.S.C. 1396r–8) on or after such date.

### TITLE III—MEDICARE

#### SEC. 301. EXCLUSION OF COMPLEX REHABILITATIVE MANUAL WHEELCHAIRS FROM MEDICARE COMPETITIVE ACQUISITION PROGRAM; NON-APPLICATION OF MEDICARE FEE-SCHEDULE ADJUSTMENTS FOR CERTAIN WHEELCHAIR ACCESSORIES AND CUSHIONS.

(a) EXCLUSION OF COMPLEX REHABILITATIVE MANUAL WHEELCHAIRS FROM COMPETITIVE ACQUISITION PROGRAM.—Section 1847(a)(2)(A) of the Social Security Act (42 U.S.C. 1395w–3(a)(2)(A)) is amended—

(1) by inserting “, complex rehabilitative manual wheelchairs (as determined by the Secretary), and certain manual wheelchairs (identified, as of October 1, 2018, by HCPCS codes E1235, E1236, E1237, E1238, and K0008 or any successor to such codes)” after “group 3 or higher”; and

(2) by striking “such wheelchairs” and inserting “such complex rehabilitative power wheelchairs, complex rehabilitative manual wheelchairs, and certain manual wheelchairs”.

(b) NON-APPLICATION OF MEDICARE FEE SCHEDULE ADJUSTMENTS FOR WHEELCHAIR ACCESSORIES AND SEAT AND BACK CUSHIONS WHEN FURNISHED IN CONNECTION WITH COMPLEX REHABILITATIVE MANUAL WHEELCHAIRS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, during the period beginning on January 1, 2019, and ending on June 30, 2020, use information on the payment determined under the competitive acquisition programs under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) to adjust the payment amount that would otherwise be recognized under section 1834(a)(1)(B)(ii) of such Act (42 U.S.C. 1395m(a)(1)(B)(ii)) for wheelchair accessories (including seating systems) and seat and back cushions when furnished in connection with complex rehabilitative manual wheelchairs (as determined by the Secretary), and certain manual wheelchairs (identified, as of October 1, 2018, by HCPCS codes E1235, E1236, E1237, E1238, and K0008 or any successor to such codes).

(2) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this subsection by program instruction or otherwise.

The SPEAKER pro tempore (Mr. SIMPSON). Pursuant to the rule, the gentleman from Texas (Mr. BARTON) and the gentleman from Texas (Mr. GENE GREEN) each will control 20 minutes.

The Chair recognizes the gentleman from Texas (Mr. BARTON).

#### GENERAL LEAVE

Mr. BARTON. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous materials in the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BARTON. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, we are here today, the culmination of a 6-year journey. The IMPROVE Act is a combination of three bills. One bill is a bill that allows Medicare to follow the patient; another bill is a bill for spousal impoverishment, to prevent that; and the third bill, and the primary bill in this package, is a bill that we call the ACE Kids Act.

Mr. Speaker, there are, luckily, not a large number, about 2 million children in this country, who have multiple complex medical conditions that are life-threatening. These are the sickest of the sick of our young population. About 500,000 of these children are Medicaid eligible. In other words, their families qualify for low-income health insurance called Medicaid.

Mr. Speaker, under current law, the parents of these children have to create the healthcare network on a case-by-case basis for their child. They also cannot seek healthcare across State lines that is covered by Medicaid. So current law makes it very difficult on these sickest-of-the-sick children.

The ACE Kids Act changes that, Mr. Speaker. It allows the creation of a medical home that can cross State lines, that can coordinate care.

It is optional. The States do not have to participate in this program. The parents of the child do not have to participate in this program. But if they do wish to participate, you create a health home for the child wherein everything is coordinated.

In the pilot programs that have been run using this model, you get better quality healthcare at lower cost. We think the pilot programs show that, over time, if we adopt this model and if the States adopt it and the families adopt it, we get a lot better healthcare at a lower cost. So this is a win-win, Mr. Speaker.

As I said, we have worked on this for 6 years. It is a bipartisan bill. In the last Congress, we had a majority of the Congress that sponsored the bill. In this Congress, we have more than 130 cosponsors on a bipartisan basis.

We have had a hearing in the committee of jurisdiction, the Committee on Energy and Commerce. We have had

a markup in subcommittee. We have had a markup in full committee. Now, Mr. Speaker, we are bringing it to the floor.

We hope the House, later today, will vote affirmatively to pass this on suspension and send it to the Senate. We have preconference it with the Senate, and we have every reason to believe, if the House passes it today, the Senate will take it up expeditiously and pass it, and this is a bill that will become law.

Mr. Speaker, I reserve the balance of my time.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 7217, the IMPROVE Act. This legislation contains several important policies related to Medicaid and Medicare.

First, I am a proud original cosponsor of the ACE Kids Act, and I am happy to see it included in H.R. 7217. The ACE Kids Act aims to improve care coordination for children with complex medical conditions served by Medicaid.

The legislation creates a Medicaid health home, State optional, specifically targeted for this population of children. It also requires the Secretary to issue best practices on coordinating out-of-State care for children with complex medical conditions.

Mr. Speaker, I thank the sponsors of the ACE Kids Act, Representative CASTOR and Congressman BARTON, both members of the Energy and Commerce Committee, for championing this issue for so many years.

The IMPROVE Act also provides new funding for the Money Follows the Person, the MFP, program. The MFP program helps individuals transition from institutional care to care in their community, where they can live more independent lives.

MFP also helps support States' home and community-based services infrastructure. Without this extension funding, we would start to see many of these MFP programs end in short order.

Mr. Speaker, I urge support for the program, which provides thousands of Americans with the choice to receive services in their home or community rather than in an institution.

□ 1245

The committee will continue to work on providing long-term funding to the MFP program in the next Congress.

I also voice my support for the extension of spousal impoverishment protections until April 2019. These protections will help ensure that a person can maintain enough income and assets to meet their basic living expenses while still allowing for their spouse to receive long-term care in their home or community under Medicaid.

The expiration of this policy would lead to people losing their long-term care services and the unnecessary institutionalization of people currently

receiving services in their homes or communities. The committee will continue to work on a long-term solution in the next Congress.

Mr. Speaker, I urge my colleagues to support passage of H.R. 7217, the IMPROVE Act, and I reserve the balance of my time.

Mr. BARTON. Mr. Speaker, I yield 3 minutes to the gentleman from Oregon (Mr. WALDEN), who is the current chairman of the Energy and Commerce Committee.

Mr. WALDEN. Mr. Speaker, I thank Mr. BARTON for his great leadership on the ACE Kids Act. I know this has been something he has been dedicated to for many years, and I am glad we could get this worked out and to the floor today. In fact, Mr. Speaker, these bills add to the 129 that the Energy and Commerce Committee has passed across this House floor.

Mr. Speaker, 92 percent of those bills have been bipartisan. I don't think the American people know that, because when we get along and do things, it doesn't get much coverage. But most of our work, 92 percent of our bills have been bipartisan, plus these today. 28 of those measures have become law.

I rise in strong support of this bipartisan H.R. 7217, which includes a number of different policies to improve and bolster the Medicaid and Medicare programs for vulnerable patients across our country, Mr. Speaker.

I recognize JOE BARTON and our colleague, KATHY CASTOR from Florida, who I know is going to speak in a moment. They have just worked relentlessly on the ACE Kids Act. This is an important bill, and it is included in this package and one I am proud the House will advance forward today.

They both should be commended for their work because, you see, Mr. Speaker, the ACE Kids Act is bipartisan. It is cost-effective legislation. It provides children and their families the treatment and coordinated care they so desperately need and deserve.

Representative BARTON, former chairman of the committee, has long been a champion on this issue, and, again, I thank him for his tireless efforts to advocate for improving care for our Nation's sickest children.

This bill also extends two key Medicaid programs: the Money Follows the Person Demonstration Program and the spousal impoverishment rules in Medicaid, both of which were due to expire or be out of money by the end of the year.

I am disappointed we weren't able to secure a longer term extension of these programs. I know many of my colleagues share that disappointment. Both sides negotiated in good faith, though, on how to pay for an extension, and I hope that the bipartisan work on the long-term bill will continue early in the new Congress. Today, we are moving forward with a 3-month extension to prevent these programs from expiring.

Finally, this package includes a small but critically important Medi-

care fix to ensure disabled seniors have access to necessary mobility devices, and that is fully offset and paid for.

Further boosting our efforts to advance public health, we have four other bills before us today. Collectively, these bills reauthorize several important programs, promote safe motherhood, and improve patient care.

Lastly, we will consider H.R. 6140. That is the Advanced Nuclear Fuel Availability Act. This bill, as you already know, Mr. Speaker, directs the Secretary of Energy to establish a program to make high-assay, low-enriched uranium available for use in the first-of-a-kind advanced nuclear reactor designs. This fuel will enable the development and deployment of a new generation of innovative nuclear technologies.

Nuclear energy is the largest source of emissions-free electricity in the United States, so a strong U.S. nuclear energy policy can ensure a reliable, clean U.S. energy sector for years to come and provide American families and businesses with affordable energy.

In closing, Mr. Speaker, I thank Ranking Member PALLONE, Mr. GREEN, and the other members of the Energy and Commerce Committee. I urge my colleagues to support passage of all of these bills, especially H.R. 7217, on behalf of patients in Oregon and all across our country.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 5 minutes to the gentlewoman from Florida (Ms. CASTOR), a cosponsor of the ACE Kids Act and a great member of our Energy and Commerce Committee.

Ms. CASTOR of Florida. Mr. Speaker, I thank Congressman GREEN for being an outspoken advocate for his constituents, but especially for affordable healthcare for all Americans, especially children. It has been a privilege serving with him.

Mr. Speaker, on behalf of the families with children with complex medical needs all across America, I rise to urge approval of the IMPROVE Act, which includes a bill that I have been working on for a number of years with Representative JOE BARTON called the ACE Kids Act.

We drafted the Advancing Care for Exceptional Kids Act a few years ago with the simple but important goal of putting families and children first. The bill authorizes the creation of cost-saving and time-saving health homes where specialized care is coordinated in a high-quality setting.

Mr. Speaker, the children with complex medical conditions and their families are heroic.

Caroline West in Tampa, Florida, has a rare genetic condition, also cerebral palsy and a seizure disorder. She can't walk. It is very difficult for her to speak, but she is able to attend school part-time and enjoys the life of a typical teenager, in many respects.

Lucy Ferlita is the only living person in the United States with early onset myopathy with areflexia, respiratory

distress, and dysphagia. Very little is known about this disease, but what we know is that it is very difficult for her to eat. She has to have a feeding tube, a ventilator to breathe, and nursing care 24 hours a day, and yet she is a bright and social 6-year-old.

Jaden Velasquez has a congenital heart defect. He was born with it. The left side of his heart is severely underdeveloped. He has undergone numerous surgeries, yet he is a loving and happy 10-year-old, loves swimming, and is enjoying life.

Lakota Lockhart, with congenital central hypoventilation syndrome, a central nervous system disorder, causes him to not be able to breathe every time he tries to sleep.

I met these children in Tampa, Florida, at St. Joseph's Children's Hospital. They have the world-renowned Chronic-Complex Clinic that was started 16 years ago by a passionate pediatric doctor named Dr. Daniel Plasencia. The ACE Kids Act is modeled after the work being done at St. Joe's by the professionals at the Chronic-Complex Clinic and the 700 kids and families they currently serve and other children's hospitals all across the country.

The families have shared with us how difficult it is to get quality healthcare. It is oftentimes so fragmented and uncoordinated that they have to go from one office to another, and maybe the specialist is in another State. That is why we put together the ACE Kids Act, to help coordinate care in a single setting to help give these kids a better quality of life, and the ACE Kids Act will do just that.

The bill provides an incentive to States to establish health homes to better coordinate care for kids with medical complexities. It also directs HHS to provide guidance to States on best practices relating to providing care across State lines.

As so many of these families know all too well, coordinating care across State lines can be burdensome, so that is the aim of the ACE Kids Act: to lift that burden.

In addition to Congressman JOE BARTON, who has worked diligently for so many years to get this over the finish line, I thank all of the families with children with complex medical challenges. They deserve credit for moving this bill forward, coming to Congress, and helping to explain the importance of coordinating care.

I also thank Chairman WALDEN, Ranking Member PALLONE, Chairman BURGESS, and Ranking Member GREEN for their support, and our stalwart partners: Representatives HERRERA BEUTLER, ESHOO, and REICHERT.

Thank you to America's children's hospitals, the March of Dimes, the American Academy of Pediatrics, and thanks to the professional staff at the committee for your dedication to these families, especially Rachel Pryor, Samantha Satchell, Tiffany Guarascio, and Josh Trent and Caleb Graff on the Republican side.



Additionally, this bill would not be where it is without the stellar work of Representative BARTON's staffers: Krista Rosenthal, Gable Brady, Sophie Trainor, and Jeannine Bender, and my LD, Elizabeth Brown.

Passage of this bill will be a gift to so many families during this holiday season and beyond, so I urge my colleagues here in the House and then over in the Senate to pass the ACE Kids Act contained within the IMPROVE Act.

Mr. BARTON. Mr. Speaker, before I yield to Dr. BURGESS, I echo what Congresswoman CASTOR just said about the staffs that have worked so hard. We couldn't have done this bill without all the individuals she just named.

I also thank her. When she said I have been tireless, she makes me look like a snail, and she is the rabbit working every day to make this possible.

Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. BURGESS), the distinguished subcommittee chairman of the Health Subcommittee, my good friend.

Mr. BURGESS. Mr. Speaker, I rise in support of H.R. 7217. This is a bipartisan Medicaid package that moves forward House priorities with responsible offsets. The Energy and Commerce Committee has been working to draft and perfect the legislation before us, and it is encouraging to see this reach the House floor.

Not only does this package include a new program to improve access to care, it reauthorizes important and effective programs from which Americans benefit each and every day. Title I of this package is based upon Representative JOE BARTON and Representative KATHY CASTOR's ACE Kids Act.

But I do want to assure families that have children with chronic illnesses that this legislation is intended to help them, if they want help, to obtain care coordination services. However, I also want to clarify that this legislation is not intended to limit families or their physicians from selecting their provider of medical services.

There is nothing in this legislation that restricts the child's family and their physician from deciding who is the best provider amongst those accepting Medicaid and qualified to offer the medical services. The Center for Medicare and Medicaid Services has provided assurances that current freedom-of-choice rules will apply to new care coordination activity.

As a doctor, I know that many children with chronic illnesses have a strong relationship with their doctors and with other members of their healthcare team. I want to make certain that this new law will help families coordinate their care without affecting the relationship that families have with their current medical care providers or with other providers in their communities from whom they may wish to receive their care.

This package also extends funding for the Money Follows the Person Dem-

onstration, an effort that was led by my Energy and Commerce Subcommittee on Health Vice Chair BRETT GUTHRIE and Representative DEBBIE DINGELL from Michigan.

This Medicaid demonstration was established in 2005 for individuals in States across our Nation, including Texas, to receive long-term care services in their homes or other community settings rather than institutions such as nursing homes. The funding for this program has already expired, and a funding extension is already overdue. While it would have been nice to extend this for longer, it was essential to get this extension across the floor.

A 3-month extension for the protection for Medicaid recipients of home and community-based services against spousal impoverishment was also included. This effort was championed by Representatives FRED UPTON and DEBBIE DINGELL.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. BARTON. Mr. Speaker, I yield an additional 30 seconds to the gentleman from Texas.

Mr. BURGESS. Mr. Speaker, in an effort to be fiscally responsible, this legislation includes several offsets to make this package, on net, a saver.

While it is largely a Medicaid package, there is one small but important Medicare provision. This provision excludes complex medical rehabilitative wheelchairs from Medicare's Competitive Acquisition Program. Currently, these chairs are not included, but because the statute did not provide the same clear exemption that power wheelchairs received, there is fear that this unintended omission can lead to them being included.

Mr. Speaker, I thank the gentleman for the additional time, and I include my full statement in the RECORD.

Mr. Speaker, I rise today in support of H.R. 7217, a bipartisan Medicaid package that propels forward House priorities with responsible offsets. The Energy and Commerce Committee has been working diligently to draft and perfect the legislation before us, and it is encouraging to see this package reach the House floor. Not only does this package include an exciting new program to improve access to care, it reauthorizes important and effective programs from which Americans benefit each and every day.

Title I of this package is based upon Rep. JOE BARTON and Rep. KATHY CASTOR's ACE Kids Act. I want to ensure families who have children with chronic illnesses that this legislation is intended to help them, if they want help, to obtain care coordination services. However, I want to clarify that this legislation is not intended to limit families and their physicians from selecting the provider of medical services. There is nothing in this legislation that restricts the child's family, and their physician, from deciding who is the best provider among those accepting Medicaid and qualified to offer the medical services. CMS has provided assurances that current "freedom of choice" rules will apply to new care coordination activity. As a physician, I know that many children with chronic illnesses have a strong

relationship with their physician and with other providers. I want to make sure that this new law will help families coordinate their care without affecting the relationship that families have with their current medical care providers or with other providers in their communities from whom they may want to receive such care from."

This package also extends funding for the Money Follows the Person demonstration, an effort led by my E&C Subcommittee on Health Vice Chair, BRETT GUTHRIE, and Rep. DEBBIE DINGELL. This Medicaid demonstration, which was established in 2005, has enabled eligible individuals in states across our nation, including Texas, to receive long-term care services in their homes or other community settings, rather than in institutions such as nursing homes. The funding for this program has already expired, and a funding extension is already long overdue. While we would have like to extend the funding for longer, it was essential that we get an extension across the floor, even if a small one.

A 3-month extension for the Protection for Medicaid Recipients of Home and Community-Based Services Against Spousal Impoverishment program is also included. This effort was championed by Representatives FRED UPTON and DEBBIE DINGELL. Our seniors are among our most vulnerable citizens, and it is programs like this one that help to protect them from financial ruin.

In an effort to be fiscally responsible, this legislation includes several offsets that make this package on net a saver, which is something that Energy & Commerce insists upon and is critically important.

While this is largely a Medicaid Package, there is one small but important Medicare provision. This provision excludes manual Complex Rehabilitative wheelchairs from Medicare's Competitive Acquisition Program. Currently, these chairs are not included but because statute did not provide the same clear exemption that power wheelchairs received, there is fear this unintended omission could lead them to being included. This provision also delays the application of competitive bid pricing with CRT accessories used with a CRT manual chair for 18 months. This mirrors a similar protection last provided by Congress for power wheelchairs in the 21st Century Cures Act.

This package contains must-pass provisions that the Energy and Commerce Committee have long fought to pass. The provisions included in this legislation will improve access to care for Medicaid and Medicare beneficiaries, which is a laudable and important goal. Not only are these provisions imperative, but they are responsibly offset. I would particularly like to thank Energy and Commerce Committee staffer Caleb Graff, who has spent countless hours negotiating to get this package to the floor. I support this legislation, and I urge my fellow members and our friends in the Senate to do so as well.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 3 minutes to the gentlewoman from Michigan (Mrs. DINGELL), another member of the Energy and Commerce Committee.

□ 1300

Mrs. DINGELL. Mr. Speaker, I thank my colleague, Ranking Member GENE GREEN, for yielding me the time.

I rise in support of H.R. 7217, the IMPROVE Act, and I thank Chairman WALDEN, Ranking Member FALLONE, and Representatives UPTON and GUTHRIE for their leadership in negotiating this important bill and for bringing it to the floor today.

I also thank and acknowledge my dear friend JOE BARTON for all of his leadership on the ACE Kids Act and congratulate him on his retirement. JOE has been a great friend to John and me over the years, and he will be dearly missed in the next Congress. Getting the IMPROVE Act signed into the law by the end of the year will be a fitting tribute to his decades of service in the Congress.

Ranking Member GREEN has also been critical to so many measures. Texas has had two valuable public servants.

Improving long-term care has been one of my top priorities since coming to Congress, and our system is completely broken. We need a broader overhaul of long-term care financing, and we also need to build off existing programs to make sure we are doing everything we can to ensure that we are enhancing the opportunities for independent living and supporting aging with dignity.

I am proud to have authored two important provisions in the IMPROVE Act that extend critical programs that are about to expire.

The first is a 3-month extension of the Money Follows the Person program. This very successful program provides grants to States to cover transitional services for individuals who voluntarily wish to leave a nursing home or other institution and transition to a community care setting. Money Follows the Person is a win for both beneficiaries and taxpayers, because the program has demonstrated significant savings over the years while bringing a real benefit to people's lives.

I am also pleased that legislation I authored with the gentleman from Michigan (Mr. UPTON), my good friend, the Protecting Married Seniors from Impoverishment Act, is also included in this bill. Extending spousal impoverishment protections for seniors in Medicaid is just common sense. Nobody should be forced to spend down all of their resources and have to go bankrupt just to get the care they need.

But these are only partial victories. Both programs are extended for 3 months. This is enough to keep these important programs alive for now, but all of us have a lot of work to do when we come back in the new year.

Let me be clear: I will continue to fight for long-term extensions of both programs in the next Congress, and I am confident that we can get that done with the Democratic majority. These programs clearly have bipartisan support, and they do so much good for so many people.

Once again, congratulations to my two dear friends from Texas for their leadership. I urge my colleagues to join me in support of this bill.

Mr. BARTON. Mr. Speaker, I thank the gentlewoman from Michigan for her kind words. I appreciate the nice gift I got yesterday from her and her husband, his new book, "The Dean." I look forward to reading it over Christmas.

Mr. Speaker, I yield 1 minute to the distinguished gentleman from Kentucky (Mr. GUTHRIE).

Mr. GUTHRIE. Mr. Speaker, I rise in support of my legislation, the EMPOWER Care Act, which is included in H.R. 7217. It will ensure that Medicaid beneficiaries can receive the best long-term care possible in their communities or in their own homes.

The EMPOWER Care Act will extend the Medicaid Money Follows the Person program, which allows certain Medicaid beneficiaries, such as the elderly or individuals with disabilities, to transition from a healthcare facility to receiving care in their own homes. It does not force patients to leave a facility if they don't want to.

My home State of Kentucky is currently working to transition 50 individuals from healthcare facilities back into their own communities, empowering these individuals who have chosen to receive care in their community.

I thank my friend, Congresswoman DEBBIE DINGELL, for working with me on this bipartisan bill. I look forward to working with her to make the Money Follows the Person program permanent in the future.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 3 minutes to the gentleman from Vermont (Mr. WELCH), another good member of our Energy and Commerce Committee.

Mr. WELCH. Mr. Speaker, I extend my congratulations as well to Mr. BARTON. It has been a pleasure working with you, sir. Thank you. Also, to Mr. GREEN, thank you very much for all your service. What an incredible career both of you have had.

My colleagues have talked about the underlying bill, and I am in agreement with what everyone has said.

I wanted to focus attention on an aspect of the bill that was sponsored by my colleague KURT SCHRADER and me, and that is a provision that addresses abusive practices of drug manufacturers who intentionally misrepresent their brand drugs as a generic in order to avoid providing a larger discount to the Medicaid program.

My colleagues, whatever our position on the best way to deliver healthcare, one thing we know is the case: It is too expensive. Whether it is taxpayers footing the bill, consumers, or employer-sponsored healthcare plans, it is too expensive. And one of the reasons is rip-off pharma practices.

This is a situation where, oftentimes, brand-name drugs try to keep generics off the market. But this is a case where a brand name tried to pretend they were a generic in order to get a lower price.

I will give an example. In 2016, Mylan misclassified the EpiPen as a generic

drug instead of a brand drug, and that allowed them to charge Medicaid a higher price for the drug. Mylan ended up paying \$465 million in a settlement to Health and Human Services, but the estimated malfeasance cost Medicaid—which is to say, taxpayers—more than \$1 billion.

Simultaneously, Mylan was raising its list price on EpiPen, which parents have to have for their kids who have an allergic reaction, from \$103 to \$608 over 7 years, a 500 percent increase.

Mylan is not alone. This practice of unrelenting drug price hikes is tried and true for manufacturers.

So I am very pleased that we have included in this bill an end to this abusive practice. We have to make healthcare affordable.

Representative SCHRADER and I, with this provision, are taking a small step. With the help of our Congress and the passage of this very good bill, we will be taking one more step in dealing with the cost crisis in our healthcare system.

Mr. BARTON. Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. UPTON), the former full committee chairman and the current subcommittee chairman of the Energy Subcommittee.

Mr. UPTON. Mr. Speaker, I stand in support of this legislation today.

I thank my colleague DEBBIE DINGELL. The two of us helped cosponsor the spousal impoverishment bill, which is part of this bill. There was no objection to that, and I am delighted that we are getting it done.

But I want to particularly take this time and just thank JOE BARTON for his leadership on the ACE Kids Act.

All of us come here to this House for particular causes that really grab our interest and attention. JOE BARTON has been so good—some would say like a dog to a Frisbee—in getting the ACE Kids Act to the House floor. This bill is going to save lives.

It was bipartisan. Frankly, I wanted to move it as part of the 21st Century Cures Act, but we didn't have a CBO score. We couldn't get it done.

We had plenty of meetings over the last couple of years on this, and here it is. We are going to get it done. Hopefully, the Senate is going to get it done, and we are going to get it to the President's desk.

This is probably the last time that JOE BARTON is actually managing a bill on the House floor, and it is appropriate that this is his bill, that it is his engine that is moving this train that really is going to make a difference for families across the country. So I say thank you, JOE BARTON.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield 3 minutes to the gentleman from Oregon (Mr. SCHRADER), a colleague from our committee.

Mr. SCHRADER. Mr. Speaker, I rise today in support of H.R. 7217, the IMPROVE Act.

I appreciate all the work that has been done on this bill over the years.



From improving care for kids with complex medical conditions to strengthening community-based, long-term care services for the disabled community, there is a lot to support in this bill.

I want to highlight one portion of the bill that my colleague and good friend PETER WELCH alluded to a few moments ago. A few years ago, families were shocked when the drug company Mylan raised the price on EpiPen, a common generic drug used to treat allergies in emergency situations, by more than 400 percent.

While patients were facing this sticker shock for a drug necessary to keep them alive, investigators in the Department of Health and Human Services and in our own House and Senate committees were doing some digging of our own.

In the course of their investigation, they found that not only was the manufacturer of EpiPen ripping off patients and their families, they were ripping off the American taxpayer, too. By misclassifying their drug as a generic when it was actually a brand drug, Medicaid was being overcharged for years.

Further investigations by HHS found that hundreds of other drugs were also misclassified, and Medicaid was overcharged by more than \$1 billion in the 4 years between 2012 and 2016. By passing this bill today, we can put an end to this waste and abuse in our Medicaid system.

Under this bill, if a drug company knowingly misclassifies their brand drug as a generic, CMS will have the power to fine that drug company double the normal rebate they would have had to pay the government. The bill strengthens CMS and congressional oversight of the program to prevent this from ever happening again.

I thank Mr. WELCH, and Senators WYDEN and GRASSLEY, for their active work on this one, as well as Mr. BARTON, Mr. GREEN, Chairman WALDEN, and Mr. PALLONE for including it in this great reform package.

Mr. Speaker, I urge all Members to support the bill.

Mr. BARTON. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. BILIRAKIS).

Mr. BILIRAKIS. Mr. Speaker, I rise in support of H.R. 7217, the IMPROVE Act, which includes several important Medicaid provisions, including the ACE Kids Act. I have been a cosponsor of the ACE Kids Act since its first introduction.

Mr. Speaker, in the Tampa area, we have St. Joseph's Children's Hospital. They run a Chronic-Complex Clinic for children. This medical home is a great model that the ACE Kids Act is trying to build on.

This integrated care model, where the care is built around the needs of the patient, has made a huge difference in the lives of so many children. I am excited that, finally, we have reached the finish line on the ACE Kids Act.

I thank former full committee chairman and also, I guess—well, I am not sure, but he is a great guy. Yes, he is vice chairman of the committee. I thank him for all of his hard work on the ACE Kids and the IMPROVE Acts. I also thank my colleague KATHY CASTOR for being relentless. The two of them are relentless on behalf of our children.

I thank all the children that came up and advocated for this bill as well.

So, in any case, we are going to get this done. We couldn't do it without these two, so thank you very much.

Mr. GENE GREEN of Texas. Mr. Speaker, how much time do I have left?

The SPEAKER pro tempore. The gentleman from Texas (Mr. GREEN) has 4½ minutes remaining. The gentleman from Texas (Mr. BARTON) has 6½ minutes remaining.

Mr. GENE GREEN of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I think this is how we need to work together, and this is a good example of not only inter-State but also inter-party, to be able to solve these three problems that this bill corrects. I hope the next Congress will continue that effort of Republicans and Democrats talking to each other, Texans talking to Oklahomans, which is sometimes tough, to work together for the people we represent.

Mr. Speaker, I yield back the balance of my time.

Mr. BARTON. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Georgia (Mr. CARTER), a strong supporter.

Mr. CARTER of Georgia. Mr. Speaker, I rise today in support of the IMPROVE Act. My colleagues on the Energy and Commerce Committee and I have been working to address a number of the issues that culminated under this legislation.

For instance, the ACE Kids Act, an effort championed by Representative BARTON, would make strides in addressing the challenges of children with medically complex conditions.

It sets standards for health home qualifications, so as to ensure better coordinated care for children in need.

It updates and streamlines the coordinated care provisions for health homes for children, so that they will have the system and framework in place to properly respond and work with health systems and professionals.

Additionally, it overhauls the data collection requirements for providers and updates the State reporting requirements, so as to maintain a more comprehensive network of care for children with complex medical conditions.

Mr. Speaker, this legislation is a culmination of a lot of hard work by my colleagues, particularly Representative BARTON and the staff of the Energy and Commerce Committee, and represents a commonsense step forward in assisting needy children. I urge my colleagues to support this legislation.

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Mr. BARTON. Mr. Speaker, I yield 2 minutes to the gentlewoman from Washington (Ms. HERRERA BEUTLER), one of the tireless supporters of this bill from day one, who herself has a medically complex special needs child, who went through the nightmare of having to create her own network for her child, and who has been a cosponsor since day one.

Ms. HERRERA BEUTLER. Mr. Speaker, I thank Chairman BARTON for his leadership on this.

I am so excited that we are here today to celebrate this. I have spent months of my life in a NICU for my own medically complex child, and I have stood bedside-to-bedside with many a family as they have faced the reality of having a sick kid and they have hit hard economic times. I can put too many faces and names to the reality that little kiddos often can't get the care they need, and today we are taking a step to fix it. I am so excited about this.

One in 25 children in the U.S. is medically complex. That means they have diagnoses like cancer or end-stage renal disease or congenital heart disease or other diagnoses that require consistent critical medical care. They need the expertise.

Out of those 3 million medically complex kiddos, 2 million of them rely on Medicaid, which means what we do with Medicaid significantly impacts them.

They are also less expensive than the other folks on Medicaid, so we can go a long way to make sure of getting them care.

So in order to enhance the critical care for these 2 million kiddos, the ACE Kids Act would create networks, anchored by children's hospitals, to help coordinate care, allowing families to seamlessly pursue the best doctors and facilities, even if it takes them out of State, and that is the key.

Right now under Medicaid, you can get stuck in your ZIP Code. So maybe there is a specialist for your child's rare disease in another State. Well, if you are on Medicaid, you are limited.

We are breaking open that limitation today to allow those kiddos to cross State lines and pursue the best doctors regardless of where they are. This just makes sense.

Here is the great thing: the efficiency and the better coordination is going to improve outcomes, number one, that is the best thing. But the next best thing is this is even going to save money, because we are not going to build that expertise in every single community, we are going to get those kids where they need to go.

It is really going to cut down on duplication and it is going to increase efficiency and it is going to be the right thing. So this is a win-win proposition. I am so excited about this.

Mr. Speaker, I urge my colleagues to vote "yes."

And, again, Mr. Speaker, I thank the chairman and Ms. CASTOR for their leadership here.

Mr. BARTON. Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. ZELDIN).

Mr. ZELDIN. Mr. Speaker, I thank Mr. BARTON for yielding the time.

Mr. Speaker, today I rise to speak in support of language that was added to the IMPROVE Act that would protect access to critical equipment for individuals with disabilities.

In November of 2014, the Centers for Medicare and Medicaid Services issued a rule stating that accessories used on complex rehabilitative wheelchairs would no longer be part of the fixed fee schedule and would be subject to competitive bidding pricing, decreasing access to customized wheelchairs and accessories relied on by adults and children with disabilities.

My language included in this legislation will include a commonsense clarification to ensure those in the Medicare Program do not have to go through the difficulty of adjusting to the new rules and pricing arbitrarily set by CMS. This will ensure that they have reliable and consistent access to the equipment they need.

Mr. Speaker, I urge my colleagues to protect those with disabilities and their access to the resources they rely on.

Mr. BARTON. Mr. Speaker, may I inquire how much time I have remaining?

The SPEAKER pro tempore. The gentleman from Texas has 2½ minutes remaining.

Mr. BARTON. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, before I close, I want to set the record straight on one thing. There has been a report that this bill, the ACE Kids Act, expands Medicaid. That is factually incorrect.

The children that qualify for the ACE Kids Act are already covered by Medicaid.

There is no expansion. We do not create a new program. We do not expand an existing program. We do not change the definitions.

We simply make it possible, if this bill becomes law, for parents of children that qualify and that are already covered under Medicaid, they can choose a healthcare home for their child, and that healthcare home can cross State lines. But as Dr. BURGESS pointed out, it is not coercive. The States don't have to participate in the program, the families don't have to participate in the program. It is all voluntary. But the pilot programs that have been done on this model, they save money and they give better care. It has been proven.

CBO has scored this over time that it saves money, but we put pay-fors in the bill. If it did cost some extra money, it would be paid for. There is a 2-quarter, 6-month increase in the FMAP, the Federal matching that the Federal Government gives to States

that choose to participate. I think it is about 15 percent extra money for 6 months. That is the only cost.

Now, to close, I am going to read a list, and Congresswoman CASTOR read a lot of these, but these are the national groups that support our bill: the Adult Congenital Heart Association, America's Essential Hospitals, American Academy of Pediatrics, American Association of Child & Adolescent Psychiatry, American Board of Pediatrics, American College of Cardiology, American College of Surgeons, American Heart Association, American Psychological Association, American Society of Echocardiography, American Thoracic Society, Amicus Therapeutics, Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, Autism Society, Autism Speaks, ChildServe, Children's Cause for Cancer Advocacy, Children's Hospital Association, Epilepsy Foundation, Family Voices, Foundation to Eradicate Duchenne, International Pediatric Rehabilitation Collaborative, March of Dimes, Mended Little Hearts, MomsRising, National Association for Children's Behavioral Health. There are about seven or ten more.

Mr. Speaker, I want to thank the staff, especially Krista Rosenthal, Jeannine Bender, committee staff Caleb Graff, Josh Trent, and Ryan Long. And, again, I thank KATHY CASTOR and GENE GREEN.

Mr. Speaker, this has been a bipartisan effort. I ask for a strong "yea" vote.

Mr. Speaker, I yield back the balance of my time.

Mr. SMITH of Texas. Mr. Speaker, I believe it is important to make very clear with this legislation that CMS should not waive any Medicaid state plan requirements that would limit the freedom to choose qualified Medicaid providers who can provide medical services to children with chronic conditions. Nothing in this bill modifies section 1902(a)(23) of the Social Security Act—related to freedom of choice requirements. Children and their families or guardians retain the right to elect care from a provider or supplier who is qualified and eligible to receive Medicaid payment for the services. It is the intent of this legislation to permit and guarantee the family, in consultation with their physician, in all instances, to be permitted to select the best provider/supplier who can meet the patient's needs. While I support this legislation to provide care coordination for these children, the ultimate choice of the who will provide direct medical services must remain with the family.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. BARTON) that the House suspend the rules and pass the bill, H.R. 7217.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the yeas have it.

Mr. BARTON. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further pro-

ceedings on this motion will be postponed.

# SICKLE CELL DISEASE AND OTHER HERITABLE BLOOD DISORDERS RESEARCH, SURVEILLANCE, PREVENTION, AND TREATMENT ACT OF 2018

Mr. BURGESS. Mr. Speaker, I move to suspend the rules and pass the bill (S. 2465) to amend the Public Health Service Act to reauthorize a sickle cell disease prevention and treatment demonstration program and to provide for sickle cell disease research, surveillance, prevention, and treatment.

The Clerk read the title of the bill.

The text of the bill is as follows:

S. 2465

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

## SECTION 1. SHORT TITLE.

This Act may be cited as the "Sickle Cell Disease and Other Heritable Blood Disorders Research, Surveillance, Prevention, and Treatment Act of 2018".

## SEC. 2. DATA COLLECTION ON CERTAIN BLOOD DISORDERS.

Part A of title XI of the Public Health Service Act is amended by inserting after section 1105 (42 U.S.C. 300b-4) the following:

"SEC. 1106. SICKLE CELL DISEASE AND OTHER HERITABLE BLOOD DISORDERS RESEARCH, SURVEILLANCE, PREVENTION, AND TREATMENT.

"(a) GRANTS.—

"(1) IN GENERAL.—The Secretary may award grants related to heritable blood disorders, including sickle cell disease, for one or more of the following purposes:

"(A) To collect and maintain data on such diseases and conditions, including subtypes as applicable, and their associated health outcomes and complications, including for the purpose of—

"(i) improving national incidence and prevalence data;

"(ii) identifying health disparities, including the geographic distribution, related to such diseases and conditions;

"(iii) assessing the utilization of therapies and strategies to prevent complications; and

"(iv) evaluating the effects of genetic, environmental, behavioral, and other risk factors that may affect such individuals.

"(B) To conduct public health activities with respect to such conditions, which may include—

"(i) developing strategies to improve health outcomes and access to quality health care for the screening for, and treatment and management of, such diseases and conditions, including through public-private partnerships;

"(ii) providing support to community-based organizations and State and local health departments in conducting education and training activities for patients, communities, and health care providers concerning such diseases and conditions;

"(iii) supporting State health departments and regional laboratories, including through training, in testing to identify such diseases and conditions, including specific forms of sickle cell disease, in individuals of all ages; and

"(iv) the identification and evaluation of best practices for treatment of such diseases and conditions, and prevention and management of their related complications.

"(2) POPULATION INCLUDED.—The Secretary shall, to the extent practicable, award grants