Memorandum

January 6, 2023

WHG Summary of the Fiscal Year 2023 Omnibus

On December 29, 2022, President Biden signed into law the $1.7 trillion fiscal year Consolidated Appropriations Act 2023, also known as the Omnibus (press release). The culmination of months of bipartisan negotiations, the package includes all 12 of the fiscal year 2023 appropriations bills, totaling $772.5 billion for non-defense discretionary programs and $858 billion in defense funding. In addition to the appropriations bills, the 4,000 plus page omnibus also includes a number of critical health care provisions.

Summary of Appropriations Items of Interest:

- **National Institutes of Health (NIH)**: $47.5 billion, an increase of $2.5 billion for the NIH, including $150 million to help address the low rate of success of grant applications to the National Cancer Institute and $88 million to address health disparities

- **ARPA-H**: The Advanced Research Projects Agency for Health was authorized and placed within the NIH, contrary to the House bill that established it as an independent Agency. It was funded at $1.5 billion.

- **Centers for Disease Control and Prevention (CDC)**: $9.2 billion was provided for the CDC, an increase of $760 million, including $350 million in flexible funding for public health infrastructure and capacity and to rebuild the workforce at the state and local level to strengthen our capacity to be ready to respond to emerging public health threats. $10 million was also included for Climate and Health programs.

- **Nutrition Programs**: The bill includes a $13.4 billion increase for the Supplemental Nutrition Assistance Program, $28.5 billion for Child Nutrition Programs, and $6 billion for the Special Supplemental Nutrition Program for Women, Infants and Children.

- **Maternal Health Programs:** $1 billion was included for maternal and child health programs.

- **Mental Health Programs:** $2.8 billion was included for mental health programs.

- **Housing Assistance**: The bill includes $3.6 billion for Homeless Assistance Grants, $2 billion for the Rural Housing Service, $1.5 billion for the HOME Investment Partnerships Program, $1.435 billion for the Housing for the Elderly and Housing for Persons with Disabilities program, and new incremental Section 8 Housing Choice Vouchers to support over 11,700 additional low-income households.

- **Firearm Injury and Mortality Prevention**: This bill includes $25 million to support research at the CDC and NIH to identify the most effective ways to prevent firearm related injuries and deaths, and to broaden firearm injury data collection.

- **Food and Drug Administration (FDA):** The bill includes $3.5 billion for the FDA, an increase of $226 million above FY 2022. The funding includes a $41 million increase to better avoid or more quickly respond to foodborne outbreaks, improve the animal food inspection system, and address heavy metals in baby food.

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- **Climate Health:** The bill includes $10 million to the CDC's National Center for Environmental Health for Climate and Health programs. The funding is intended to support States and territories in identifying the potential health effects associated with climate change and to implement health adaptation plans.

Summary of Key Health Care Policy Items of Interest: The package further included a number of critical health care policy provisions. This includes several reauthorizations of federal programs and extensions of certain policies, which are now slated to create cliffs for legislation action leading up to their respective end dates. A detailed summary follows in this memo, but the top-line provisions include:

- **Provider Cuts**: The bill eliminated the 4.5 percent physician fee payment cuts scheduled for January 1, but only by 2.5 percent. As such, a 2 percent cut will occur in January. Congress also left a 3.5 percent cut in place for January 2024, setting up another fight next year. However, the deal did prevent the upcoming 4 percent PAYGO cuts – tied to the cost of the American Rescue Plan – from going into effect for two years.

- **Telehealth:** Telehealth flexibilities have been extended for two years, through December 2024. This is in-line with the bill that passed the House earlier in the year.

- **Graduate Medical Education:** The package includes an additional 200 Medicare funded GME slots for FY 2026. One hundred of these are required to be slots for psychiatry.

- **Mental Health:** The omnibus reauthorizes more than 30 critical programs that collectively support mental health care and substance use disorder prevention, care, treatment, peer support, and recovery support services, generally through fiscal year 2027. The bill also includes grant funding to support the maternal mental programs, establishes a maternal mental health hotline and a related task force. It extends mental health parity to state and local government workers and bolsters the mental health and substance use disorder workforce through increased capacity and training. It also provides Medicare Part B coverage of mental health counselor and therapist services.

- **Maternal and Child Health**: The omnibus extends funding for CHIP for two years through fiscal year 2029, requiring children be provided with 12 months of continuous coverage in Medicaid and CHIP effective January 1, 2024, and makes permanent a state option to allow states to continue to provide 12 months of continuous coverage during the postpartum period in Medicaid or CHIP. It also permanently extends a policy from the American Rescue Plan allowing states to provide 12 months of postpartum coverage to pregnant individuals in Medicaid and CHIP and provides a five-year investment with historic funding levels for the Maternal, Infant and Early Childhood Home Visiting Program.

- **Medicare Extenders:** The Medicare low-volume hospital payment adjustment was extended for two years through September 30, 2024 and the Dependent Hospital (MDH) program was extended for two years through September 30, 2024.

A full summary of the major health-related policy provisions is included below.

Restoring Hope for Mental Health and Well-Being (p. 3001)

The spending package incorporated the bipartisan mental health bill advanced by the House, the *Restoring Hope for Mental Health and Well-Being Act of 2022* (details), though with some slight modifications throughout. As noted above, the legislation reauthorizes more than 30 federal programs – generally through fiscal year 2027 – focused on providing mental health services and supports. Specific funding for mental health programs includes the following:

- $1.01 billion for the Mental Health Block Grant to provide mental health treatment services and support community mental health services.
- $501.6 million, a nearly $400 million increase, for the Suicide Prevention Lifeline to successfully transition to 988.
- $385 million for Certified Community Behavioral Health Clinics, a $70 million increase.
- $140 million, a $20 million increase, for Project Aware, which will expand efforts to identify and help children and youth in need of mental health care.
- $130 million for Children's Mental Health Services, a $5 million increase.
- $111 million for Department of Education programs designed to increase the availability of mental health services in schools, including by expanding training programs to prepare new school counselors, social workers and psychologists.

In addition, the legislation authorizes a Behavioral Health Crisis Coordinating Committee within the Substance Abuse and Mental Health Services Administration (SAMHSA). It also establishes a maternal mental health hotline and task force, and eliminates the option for nonfederal governmental health plans to elect out of mental health parity compliance.

Preparing For and Responding to Existing Viruses, Emerging New Threats, and Pandemics (p. 3195)

The legislation includes the Prepare for and Respond to Existing Viruses, Emerging New Threat, and Pandemics Act (PREVENT Pandemics Act) – a bipartisan bill led by Sens. Patty Murray (D-WA) and Richard Burr (R-NC) to strengthen and modernize federal public health and medical preparedness and response systems and programs. Highlights of the bill include:

- Strengthening federal and state preparedness by increasing accountability on federal leadership (e.g., requiring Senate confirmation for the CDC director, requiring CDC Strategic Plan) and increasing federal, state and local readiness (e.g., establishing an Office of Preparedness and Response Policy, creating new requirements for Public Health Emergency Preparedness cooperative agreement recipients to support enhanced inter-agency coordination during a public health emergency).
- Improving public health preparedness and response capacity by improving public health data infrastructure, growing the public health workforce, and supporting coordination on vaccine distribution, laboratory capacity, and other components of preparedness and response.
- Accelerating research and countermeasure discovery through various initiatives, including the establishment of Advanced Research Projects Agency-Health (ARPA-H) within NIH. ARPA-H seeks to foster the development of breakthrough technologies in biomedical sciences and medicine.

- Modernizing and strengthening the supply chain for vital medical products through several measures to ensure the Strategic National Stockpile is ready for public health emergencies.
- Enhancing development and combating shortages of medical products through changes in the development and review of countermeasures (e.g., permitting expedited review of countermeasures during a public health emergency) and various efforts to mitigate shortages.

Food and Drug Administration (p. 3468)

- **Subtitle A – Reauthorizations** – The bill provides reauthorizes of the following programs through FY 2027:

    - The Critical Path Public-Private Partnership
    - The Best Pharmaceuticals for Children Program
    - The Humanitarian Device Exemption Incentive
    - The Pediatric Device Consortia Program
    - Certain Device Inspections
    - Orphan Drug Grants
    - Reporting Requirements Related to Pending Generic Drug Applications and Priority Review Applications
    - Third-Party Review Program

- **Subtitle B – Drugs and Biologics**

    - **Chapter 1: Research, Development, and Competition Improvements:** This chapter requires approved biologics license holders to submit a one-time report to the FDA, within 180 days of enactment of the law, to confirm that their products listed in the Purple Book are still on the market and the FDA in turn would be required to make any corresponding updates to the Purple Book. Additionally, the FDA is required to submit a report to Congress no later than September 30, 2026, on activities related to the Orphan Drug Program, establish a rare disease endpoint advancement pilot program, and conduct a study on the European Union's review of drugs for rare disease and conditions. The chapter also requires the establishment of a National Centers of Excellence in Advanced and Continuous Manufacturing and a convening of a public workshop on cell therapies.

      The law also requires the FDA to determine whether generic drugs are therapeutically equivalent to the reference product either when the generic is approved or within 180 days of approval. Additionally, the FDA is authorized to approve a generic drug with proposed labeling that differs from the brand name drug.

      Finally, the chapter includes provisions to modernize the Accelerated Approval Program by: 1) requiring sponsors to start post-approval studies prior to receiving accelerated approval; 2) authorizes the FDA to establish post-approval study design requirements and deadlines; and 3) allows the FDA to withdraw drugs from the market.

- **Chapter 2: Transparency, Program Integrity, and Regulatory Improvements:** The chapter requires the safe disposal of opioids and requires the FDA to establish a public docket to solicit comments on factors that should be considered by the Secretary when reviewing request from sponsors of drugs that are subject to risk evaluation and mitigation strategies to change third-party vendors engaged by sponsors to aid in the implementation and management of the strategies. Finally, the chapter allows generic drugs to be labeled differently from the brand name drug and to not be considered misbranded.

- **Subtitle C – Medical Devices** – The subtitle requires medical device sponsors whose device meets the definition of a cyber device to provide information to the Secretary that ensures that the device meets the specified cybersecurity requirements found on p. 3528. The law also authorizes the FDA to approve a predetermine change control plan submitted in an application and to ban devices for one or more intended uses that are intended for human use that presents substantial deception or an unreasonable risk of injury.

- **Subtitle D – Infant Formula** – The subtitle amends the definition of critical food to include infant formula and requires the Secretary to Establish an Office of Critical Foods that responsible for the oversight, coordination, and facilitation of activities related to critical foods. Additionally, to address shortages, the subtitle authorizes the Secretary to waive the 90-day premarket submission requires for any person who intends on introducing or delivering any new infant formular into interstate commerce. The Secretary is also required to public a list on the HHS website that provides information on how to identify appropriate substitutes for infant formula products in shortage. Finally, the Secretary is required to participate in meeting with representatives of other countries to discuss methods and approaches to harmonize regulatory requirements for infant formula. The law also contains requirements related to manufacturing and the reporting of adverse events.

- **Subtitle E – Cosmetics** – The subtitle authorizes the FDA to recall cosmetic products that have been misbranded or that are unsafe, to require manufacturers of cosmetics to register their facilities and list their products with the agency, allow the FDA to access safety records of cosmetics.

- **Subtitle F – Cross-Cutting Provisions**

  - **Chapter 1: Clinical Trial Diversity and Modernization:** The chapter requires drug and device sponsors to submit a clinical trial diversity action plan as part of their trial enrollment goals and explain how they intend on meeting those goals. The FDA is also required to issue guidance on trial diversity plans, as well as well as guidance on decentralized clinical trials and the use of digital health technology to improve recruitment, retention, and participation of diverse populations. Additionally, the FDA must host a public workshop on how to enhance clinical trial diversity and submit an annual report on progress towards increasing diversity in clinical trials. The agency is also required to host a public meeting to discuss recommendations to mitigate disruption of clinical trials during the COVID-19 pandemic, 180 days after the PHE ends.

- **Chapter 2: Inspections:** The chapter authorizes FDA record inspections for non-restricted devices and clarifies the agency's authority to conduct bioresearch monitoring inspections. The law also provides that the Secretary may rely on any records or other information that the Secretary may inspect to satisfy requirements that pertain to a preapproval or risk-based surveillance inspection. Additionally, the GAO is required to submit a report on inspections conducted by the Secretary of Foreign Establishments, or a foreign government. Finally, the FDA is authorized to conduct a pilot program that increases the conduct of announced surveillance inspections of foreign huma drug establishments.

- **Chapter 3: Miscellaneous:** The chapter establishes that any contrast agent, radioactive drug, or over-the-counter OTC monograph is to be deemed a drug and not a device. This includes diagnostic radiopharmaceuticals and diagnostic agents that improve visualization of structures within the body. Additionally, the FDA is required to establish Women's Health Research Roadmap and a Strategic Workforce Plan and report. The chapter also establishes reporting requirements on the number of applications reviewed using user fees and the FDA is required to issue guidance on the use of real-world data and evidence to support regulatory decision making. Finally, the law allows drug and device makers to proactively share product information prior to approval to payors to facilitate coverage decisions.

Medicare (p. 3707)

- **Subtitle A – Medicare Extenders** – The bill extends both the Medicare low-volume hospital payment adjustment and the Medicare-Dependent Hospital program for two years through September 30, 2024. It also extends a number of add-on payments for ground ambulance services through the end of 2024.

- **Subtitle B – Other Expiring Medicare Provisions** –

  - **Provider Payment:** Related to Medicare payment for physicians and other health care professionals, the bill increases the conversion factor of the Medicare Physician Fee Schedule by 2.5 percent for 2023 and 1.25 percent for 2024, leaving providers with a 2 percent cut beginning in January 2023. A more than 3 percent cut, relative to the calendar year 2022 fee schedule, remains in place for January 2024. The legislation also prevents the 4 percent PAYGO cuts (tied to the cost of the American Rescue Plan) from going into effect for two years. Further, the omnibus extends the incentive payment for clinicians participating in advanced alternative payment models (AAPMs) by one year, however, it reduces the bonus amount from 5 percent to 3.5 percent for 2023 (paid in 2025 due to a two-year lag between performance and payment years). The bill also extends, for an additional year, the current freeze on AAPM participation thresholds to qualify for the bonus.

  - **Telehealth:** The legislation extends the pandemic-driven Medicare telehealth flexibilities – which were previously extended by the Consolidated Appropriations Act of 2022 for 151 days following the end of the PHE – until December 31, 2024. In brief, these flexibilities consist of the following:

- Removing the geographic and originating site requirements for telehealth coverage, allowing beneficiaries to receive care in all geographies and at all sites of care (including their homes) for all Medicare telehealth services;
- Expanding the range of practitioners eligible to furnish telehealth services;
- Extending telehealth services for federally qualified health centers and rural health clinics;
- Delaying the in-person requirement under Medicare for mental health services furnished through telehealth;
- Allowing for the furnishing of audio-only services; and
- Using telehealth to conduct face-to-face encounters prior to recertification of eligibility for hospice care during the emergency period.

The Centers for Medicare & Medicaid Services (CMS) will likely propose how it will implement these provisions in the forthcoming calendar year 2024 Medicare Physician Fee Schedule proposed rule. Topics for consideration will include, for example, whether CMS will continue coverage for all temporarily added telehealth services through the end of 2024.

- **Clinical Labs:** The omnibus delays by one year pending payment reductions and data reporting periods for the Clinical Laboratory Fee Schedule under the Protecting Access to Medicare Act (PAMA).

- **Subtitle C – Medicare Mental Health Care Provisions** –

  - **Coverage and Reimbursement:** The legislation establishes Medicare coverage for services provided by marriage and family therapists and licensed professional counselors beginning on January 1, 2024. It also establishes a 50 percent payment increase in Medicare Physician Fee Schedule payment rates for crisis psychotherapy services when furnished by a mobile unit, as well as additional settings other than a facility or physician office, beginning January 1, 2024. Further, CMS is required to conduct outreach and education to providers on Medicare coverage and payment for crisis psychotherapy services. The legislation also revises Medicare's partial hospitalization benefit to provide coverage of intensive outpatient services.

    The legislation also directs HHS to begin collection of data and other information necessary to revise the existing Medicare prospective payment system (PPS) for inpatient psychiatric hospitals and psychiatric units (IPFs). The HHS Secretary is instructed to use this data to update the methodology for determining payment rates under the IPF PPS beginning in rate year 2025.

  - **Workforce:** The legislation supports physician workforce development by creating 200 additional Medicare-funded graduate medical education (GME) residency positions for fiscal year 2026. The bill requires at least 100 of these positions be distributed for a psychiatry or psychiatry subspecialty residency. Additional details include:
    - Hospitals shall be notified of the number of positions distributed to the hospital by January 31 of the fiscal year of the increase;

- In determining which qualifying hospitals will see an increase in GME positions, the Secretary shall take into account the demonstrated likelihood of the hospital filling the positions made available within the first 5 training years;
- At least 10 percent of the positions must be distributed to each of the following categories of hospitals:
    1. Hospitals that are located in a rural area;
    2. Hospitals in which the reference resident level of the hospital is greater than the otherwise applicable resident limit;
    3. Hospitals in states with new medical schools that have achieved or continue to progress toward 'Full Accreditation', and in additional locations and branch campuses established on or after January 1, 2000 by medical schools with 'Full Accreditation' or 'Accreditation' status; and
    4. Hospitals that serve areas designated as health professional shortage areas.
- A hospital may not receive more than 10 additional full-time equivalent residency positions;
- A hospital has to agree to increase the total number of residency positions before an increase in the residency limit is made; and
- A hospital must ensure that any positions made available are used to expand an existing program of the hospital, and not for participation in a new medical residency training program.

- **Physician Wellness:** The legislation adds a new exception to the Stark Law to allow hospitals and other entities to provide evidence-based programs to improve mental health, increase resiliency, and prevent suicide among physicians.

- **Outreach and Reporting:** The legislation requires the HHS Inspector General to conduct a review and issue a report to Congress on whether to establish a safe harbor for evidence-based contingency management incentives, which can be used to treat substance use disorders (SUDs). The bill also requires HHS to conduct outreach to providers on the availability of behavioral health integration services as a covered benefit under the Medicare program. The omnibus directs HHS to conduct outreach to Medicare beneficiaries on the availability of OUD treatment services as well. A subsequent report to Congress is required on the methods used for provider outreach and the number of Medicare beneficiaries who were furnished behavioral health integration services and OUD treatment services.

  Additionally, the legislation directs the Comptroller of the United States to conduct a study to compare the mental health and SUD benefits offered by Medicare Advantage plans to traditional Medicare and to other benefits offered by Medicare Advantage plans. A subsequent report to Congress is due within 30 months of enactment of the bill.

- **Subtitle D – Other Medicare Provisions** –

    - **Medical equipment and supplies:** The legislation includes coverage of lymphedema compression treatment items and directs the Secretary to establish an appropriate payment basis and frequency limits.

The bill also adds permanent coverage of in-home intravenous immune globulin (IVIG) services beginning January 1, 2024 with a separate bundled payment for all items and services related to such administration (unless it is received through a home health benefit). Additionally, $4.3 million is appropriated for the Medicare IVIG Demonstration Project.

Finally, the transition rule for payment adjustment for durable medical equipment for areas other than rural or noncontiguous areas will apply through the duration of the PHE and the full adjustment for all areas cannot be implemented before either the end of the PHE or January 1, 2024, whichever comes first.

- **Payment adjustments:** The legislation adds temporary additional payments for non-opioid treatments for pain relief in the Hospital Outpatient Prospective Payment System (HOPPS) and Ambulatory Surgical Center Payment System furnished between January 1, 2025 and January 1, 2028. Payment for non-opioid treatment for pain will not be packaged into a payment for a covered OPD service. The amount of the additional payment is the amount for such drug or biologic under Medicare's average sales price (ASP) methodology that exceeds the otherwise applicable HOPPS fee schedule associated with that drug or biologic. For a medical device, the additional payment under this section would be equal to the amount of the hospital's charges for the device, adjusted to cost, that exceeds the otherwise applicable HOPPS fee schedule associated with the device. The additional payment cannot exceed the estimated average of 18 percent of the HOPPS fee schedule amount for the service. This section applies to drugs, biologics, and medical devices that are approved to reduce pain without acting on opioid receptors or can replace opioids, do not receive transitional pass-through payments, and have payment packaged into a payment for a covered outpatient service.

  The Secretary of HHS will be required to deliver a report to Congress by January 1, 2028 identifying limitations in Medicare coverage or reimbursement for restorative therapies and complementary and integrative health services that can replace or reduce opioid consumption and assessing the impact of the additional payments.

  The bill also extends the 1 percent home health rural add-on payment to home health agencies that furnish services in counties with low population density through 2023.

- **COVID-19:** The legislation includes the COVID-19 vaccine as an "excepted medical treatment" for the purposed of coverage of religious nonmedical health care institutional services. Medicare pass-through funding is extended until January 1, 2024 for medical devices whose pass-through status was set to end December 31, 2022. The bill also includes coverage of oral antiviral drugs with emergency authorization in Medicare Part D until December 31, 2024.

- **Acute care at home:** The legislation extends the Acute Hospital Care at Home initiative waivers and flexibilities for admissions occurring between the end of the PHE and December 31, 2024. These waivers and flexibilities include:

- Waiver of the requirement to provide 24-hour nursing services on premises;
- Waivers of the physical environment and Life Safety Code requirements;
- Flexibility to allow a hospital to furnish inpatient services outside the hospital under certain arrangements; and
- Waiver of the telehealth originating site requirements.

The Secretary of HHS is directed to conduct a study to analyze the criteria established by hospitals under the initiative to determine which individuals may receive such services and compare the quality of care and patient characteristics to the regular inpatient setting. The bill appropriates $5 million for this section.

- **Transparency:** The legislation includes new transparency requirements for home health payments. Within 90 days of enactment, the Secretary must hold a public forum for feedback on Medicare home health payment rate development. The information required by this section must be published 60 days in advance of the forum. CMS is required to publish the following:
  - Electronic data files showing CMS simulation of 60-day episodes under the home health prospective payment system prior to the Patient Driven Groupings Model;
  - A description of actual behavior changes, including changes that occurred between 2020 and 2026.

  Additionally, Medicare Part D payment data – including rebate and direct and indirect remuneration data – will be made available to the Congressional Budget Office.

- **Health education:** The bill appropriates $3 million and establishes an exception to the annual limitation on additional payments for nursing and allied health education for hospitals operating a school of nursing and/or school of allied health for 2010 through 2019. This change will not be taken into account for graduate medical education proportional reduction for nursing and allied health education.

- **Subtitle E – Health Care Tax Provisions** – This subtitle extends the safe harbor for plans to be treated as a high deductible health plan if they fail to have a deductible for telehealth between plan years beginning on or before December 31, 2021 and before January 1, 2025.

- **Subtitle F – Offsets** – To offset additional spending, the bill reduces the amount in the Medicare Improvement Fund from nearly $7.3 billion to $180 million. The bill also extends, by one year, the change to the hospice aggregate cap annual updates made in the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) of 2014, applying the hospice payment update percentage rather than the Consumer Price Index for Urban Consumers (CPI–U) to the aggregate cap through 2032. Finally, the bill keeps Medicare sequestration at 2 percent for FY 2030 and FY 2031 and extends the cost-cutting policy through the first six months of FY 2032 (i.e., March 2032).

Medicaid and CHIP (p. 3808)

- **Subtitle A – Territories (p. 3808)** – The legislation extends Puerto Rico's higher federal Medicaid match of 76 percent through FY 2027 and establishes a new framework for Puerto Rico's enhanced allotment payments for FY 2023 and subsequent fiscal years. Additionally, it extends a higher federal Medicaid match of 83 percent for America Samoa, the Commonwealth of the Northern Mariana Islands, Guam, and the U.S. Virgin Islands. The legislation also makes programmatic improvements – e.g., increases provider payment rates for Puerto Rico by setting a reimbursement floor for physician services at 75 percent of Medicare Part B payments.

- **Subtitle B – Medicaid and CHIP Coverage (p. 3824)** – The legislation makes two key changes to improve continuity of coverage. First, state Medicaid and CHIP programs will be required to provide 12 months of continuous coverage for children, effective January 1, 2024. Second, the state option to allow states to provide 12 months of postpartum coverage under Medicaid or CHIP is now permanent (it was previously set to expire in 2027). Additionally, the legislation includes the follow extensions: funding for CHIP through FY 2029, funding for Medicaid Money Follows the Person Rebalancing demonstration through FY 2027, and Medicaid protections against spousal impoverishment for recipients of home and community-based services through FY 2027.

- **Subtitle C – Medicaid and CHIP Mental Health Care (p. 3834)** – The legislation makes two key changes to improve access to health care, including mental health and case management services, for justice-involved youth in public institutions, effective January 1, 2025. First, state Medicaid and CHIP programs will be required to provide justice-involved youth who are eligible for Medicaid or CHIP with screening, diagnostic, and case management services in the 30-day period prior to their release. Second, the legislation allows states to receive federal matching funds through Medicaid and CHIP for health care services provided to justice-involved youth in public institutions while their cases are pending. Additionally, the legislation requires state Medicaid fee-for-service programs, Medicaid managed care organizations, and other health plans providing Medicaid services to publish and maintain searchable provider directories, including providers of mental health and substance use disorder services, effective July 1, 2025. The legislation also requires CMS and SAMHSA to issue joint guidance by July 1, 2025 to states providing recommendations and best practices to states regarding the development of an effective continuum of crisis of care through Medicaid and CHIP.

- **Subtitle D – Transitioning from Medicaid FMAP Increase Requirements (p. 3854)** – The legislation establishes a transition period to phase down the 6.2 percentage point FMAP increase and Medicaid continuous coverage requirements currently tied to the COVID-19 Public Health Emergency. States will continue to receive a 6.2 percentage point FMAP increase through March 31, 2023. Federal funds will be phased down as follows:

    - April 1 to June 30, 2023: States will receive a 5 percentage point FMAP increase;
    - July 1 to September 30, 2023: States will receive a 2.5 percentage point FMAP increase; and
    - October 1 to December 31, 2013: States will receive a 1.5 percentage point FMAP increase.

  As a condition of receiving the FMAP increase during the transition period, states will be required to meet certain conditions, such as updating beneficiaries' contact information and using more than one modality

to contact beneficiaries in the event of returned mail. States will also be required to submit monthly reports to HHS (that will be made publicly available) on their activities relating to eligibility determinations. The legislation also provides HHS with additional enforcement authorities. States that do not comply with these requirements will be subject to an automatic reduction of 0.25 percentage points for each quarter if they are not in compliance (but not to exceed 1 percentage point). HHS may also require states to submit and implement a corrective action plan. CMS recently released an Information Bulletin with guidance on implementation of the new transition period, including updated due dates for certain state deliverables. Renewal distribution plans are due February 1, 2023 for states that intend to begin renewals in February.

- **Subtitle E – Medicaid Improvement Fund (p. 3866)** – The legislation provides $7 million to the Medicaid Improvement Fund, which supports CMS manage the Medicaid program. Activities include oversight of contracts and contractors and evaluation of demonstration projects.

Human Services (p. 3867)

- **Home Visitation (MIECHV)** – The omnibus includes the *Jackie Walorski Maternal and Child Home Visiting Reauthorization Act of 2022* which reauthorizes the Maternal, Infant and Early Childhood **Home Visiting** (**MIECHV**) Program for **5 years** through September 30, 2027. Describes how funding for Federal base grants and Federal matching grants is allocated. Designates 6% of grants for Indian tribes. Funding includes $500M yearly for base grants in FYs 2023-2027 and $50M to $300M yearly for matching grants. Includes the option for virtual home visits so long as a client has had at least one in-person visit each year.

- **Temporary Assistance for Needy Families (TANF)** – Extends funding for TANF through September 30, 2023 without policy changes.

- **Child and Family Services / Child Welfare / Foster Care** – Extends funding for mandatory and discretionary child welfare programs authorized under Title IV-B for one year without policy change.

Child Care (p. 1028)

The ombibus includes a 30 percent increase in funding for the **Child Care and Development Block Grant** ($8 billion total) which provides financial assistance to low-income families thus helping them afford child care. It also provided an 8.6 percent increase in funding for **Head Start** ($11.996 B total).

Nutrition

The bill includes a $13.4 billion increase for the Supplemental Nutrition Assistance Program (SNAP), $28.5 billion for Child Nutrition Programs including $40 million for the Summer Electronic Benefit program and $30 million for school equipment grants, and $6 billion for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

Education

The bill increases funding for education including raising the maximum **Pell Grants** awards for postsecondary education from **$500 to $7,395** for the 2023-2024 school year. It also includes a 5 percent increase for both **Title I-A** grants and **TRIO**. The former supports half of the nation's public schools particularly high-poverty schools where they fund efforts to help students meet college and career-ready standards and also support preschool programs for eligible children. The latter (TRIO) helps 800,000 low-income students attend college. Special Education Grant programs that support 9 million children with disabilities received a 6 percent increase.

Housing

The bill funds a range of programs to help make housing more affordable and address homelessness. This includes the following:

- $3.6 billion for Homeless Assistance Grants, 13 percent ($420 million) increase, to serve at least 1 million people experiencing homelessness;
- $2 billion for the Rural Housing Service, a $183 million increase;
- $1.5 billion for the HOME Investment Partnerships Program to help build 10,000 new rental and homebuyer units;
- $1.435 billion for the Housing for the Elderly and Housing for Persons with Disabilities program, including $258 million to support new awards to serve an estimated 2,910 additional households;
- A $1.55 billion increase for the Community Development Block Grant program ($6.39 billion total);
- $130 million for a new incremental Section 8 Housing Choice Vouchers to support over 11,700 additional low-income households, including families and individuals experiencing or at-risk of homelessness, survivors of domestic violence, veterans at risk of or experiencing homelessness, and youth aging out of foster care; and
- $5 billion for the Low Income Home Energy Assistance Program (LIHEAP).

Gun Violence Prevention

The omnibus includes $25 million to support research at the CDC and NIH to identify the most effective ways to prevent firearm related injuries and deaths, and to broaden firearm injury data collection.