Consolidated Appropriations Act, 2021

Health and Human Services Legislative Provisions Summary

Legislative Provisions

- **Provisions Relating to Child Care Centers**: Authorizes the Library of Congress, Government Accountability Office (GAO) and Senate to reimburse the Little Scholars Child Development Center, Tiny Findings Child Development Center and Senate Employee Child Care Center, respectively, for monthly expenses due to measures taken to combat COVID-19. Analogous authority for the House has already been enacted.
- **Fostering Stable Housing Opportunities**: Includes the text of HR 4300, the "Fostering Stable Housing Opportunities Act of 2019," would provide "on-demand" vouchers to foster youth who are at risk of homelessness as they transition to adulthood and would extend the voucher assistance for up to an additional two years if they participate in self-sufficiency activities.

Provisions Supporting Foster Youth and Families Through the Pandemic

- **John H. Chafee Foster Care Program for Successful Transition to Adulthood (Chafee):** Provides an additional $350 million for the John H. Chafee Foster Care Program for Successful Transition to Adulthood Chafee and an additional $50 million for the John H. Chafee Educational and Training Vouchers Program for Youths Aging out of Foster Care (Chafee ETV) without additional appropriations action. It also waives the state match requirement for these additional funds. It increases the maximum Chafee ETV award amount from $5,000 up to $12,000 per youth per year for training and postsecondary education for eligible foster youth, exempts National Youth in Transition Database penalty assessments from these additional funds and raises the maximum age through 26 for Chafee-eligible former foster youth. It also reserves funding for technical assistance, evaluation and monitoring of state child welfare programs, including $500,000 to help them set up youth driving programs. It temporarily provides the following necessary programmatic flexibilities for older youth in foster care:
    - Suspends certain training and postsecondary education requirements.
    - Clarifies that under these provisions, the Chafee ETV vouchers may be used to maintain training and postsecondary education costs, as well as to support programs to allow foster youth to drive.
    - Lifts the 30% spending cap on housing costs.
- **Temporary freeze on older youth "aging out**": Provides older foster youth who would normally "age out" with the assurance that they may continue to receive foster care supports and services during the pandemic, or, if they left, may return. It permits states to use pandemic Chafee funds to offset the cost of meeting this requirement for youth for whom federal foster care matching is not available.
- **Temporary Waiving State Matching Funds for Family First Prevention Services:** Temporarily waives the match for Family First Prevention Services until the end of the public health emergency period.

- **MaryLee Allen Promoting Safe and Stable Families Program:** Provides an additional $85 million in emergency fiscal year (FY) 2021 funding for the MaryLee Allen Promoting Safe and Stable Families program, which would be available through the end of FY 2021. It waives state matching requirements for the emergency funds and specifies that FY 2022 funding would be provided at the non-emergency level.
- **Court Improvement Program:** Reserves $10 million from the $85 million in the preceding section for the federal Court Improvement Program and waives the state matching requirement for the emergency funds.
- **Temporary waiving of state match for Prevention Services Clearinghouse:** Temporarily waives the required state match and the requirement that the specific model be in the federal Prevention Services Clearinghouse for kinship navigator programs funded with FY 2020 funds. The section maintains that programs not in the clearinghouse be under evaluation or begin an evaluation to be funded. The evaluation costs are included under federal funds.
- **Title IV- E Technical Correction:** Makes a technical correction to Title IV-E treatment of the 6.2% Federal Medical Assistance Percentage (FMAP) rate increase from the Families First Coronavirus Response Act such that it applies to the baseline based on annual average FMAP rate in the state for FY 2020 and FY 2021, to ensure access to Funding Certainty Grants, which are grants created out of the Family First Transition Act.
- **Maternal, Infant, and Early Childhood Home Visiting Program Flexibilities:** Provides needed flexibilities to home visiting programs funded by the Maternal, Infant, and Early Childhood Home Visiting program, to allow them to serve at-risk pregnant women and families during the pandemic for the duration of the public health emergency period.
- **Technical Correction:** Provides the District of Columbia with the same adjustment as states to its matching rate for services provided under Title IV-E of the Social Security Act as states.

Private Health Insurance and Public Health Provisions

No Surprises Act

- **Health insurance requirements for surprise medical billing:** Requires health plans to hold patients harmless from surprise medical bills. Patients will only be required to pay the in-network cost-sharing (i.e., co-payment, coinsurance and deductibles) amount for out-of-network emergency care, for certain ancillary services provided by out-of-network providers at in-network facilities, and for out-of-network care provided at in-network facilities without the patient's informed consent. It also requires that patients' in-network cost-sharing payments for out-of-network surprise bills are attributed to a patient's in-network deductible.
- **Out-of-network rates and independent dispute resolution process:** Provides for a 30-day open negotiation period for providers and payers to settle out-of-network claims. It also states that if the parties are unable to reach a negotiated agreement, they may access a binding arbitration process—referred to as independent dispute resolution (IDR)—in which one offer prevails. Providers may batch similar services in one proceeding when claims are from the same payer. The IDR process will be administered by independent, unbiased entities with no affiliation to providers or payers. The IDR entity is required to consider:
    - The market-based median in-network rate alongside relevant information brought by either party.

- Information requested by the reviewer.
- The provider's training and experience.
- Patient acuity and the complexity of furnishing the item or service.

In case a provider is a facility:

- Provide the teaching status, case mix and scope of services of such facility.
- Demonstrations of good faith efforts (or lack of good faith efforts) to enter into a network agreement.
- Prior contracted rates during the previous four plan years.
- Other items.

Billed charges and public payer rates are excluded from consideration. Following the IDR, the party that initiated the IDR may not take the same party to the IDR for the same item or service for 90 days following a determination by the IDR entity, to encourage settlement of similar claims. All claims that occur during that 90-day period may still be eligible for the IDR upon completion of the 90-day period.

- **Health care provider requirements regarding surprise medical billing:** Prohibits out-of-network facilities and providers from sending patients surprise bills for more than the in-network cost-sharing amount, in the surprise billing circumstances defined in Sec. 102. It also prohibits certain out-of-network providers from surprise billing patients unless the provider gives the patient notice of their network status and an estimate of charges 72 hours prior to receiving out-of-network services and the patient provides consent to receive out-of-network care. In the case of appointments made within 72 hours of receiving services, the patient must receive the notice the day the appointment is made and consent to receive out-of-network care.
- **Ending surprise air ambulance bills:** States that patients are held harmless from surprise air ambulance medical bills. Patients are only required to pay the in-network cost-sharing amount for out-of-network air ambulances, and that cost-sharing amount is applied to their in-network deductible. Air ambulances are barred from sending patients surprise bills for more than the in-network cost-sharing amount. It also provides for a 30-day open negotiation period for air ambulance providers and payers to settle out-of-network claims. If the parties are unable to reach a negotiated agreement, they may access the binding arbitration, with additional factors to account for the cost of providing air ambulance service in rural and frontier areas.
- **Reporting requirements regarding air ambulance services:** Requires air ambulance providers to submit two years of cost data to the secretaries of Health and Human Services (HHS) and the Department of Transportation. Insurers are required to submit two years of claims data related to air ambulance services to the secretary of HHS. The section requires the secretaries to publish a comprehensive report on the cost and claims data submitted, and it also establishes an advisory committee on air ambulance quality and patient safety.
- **Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations:** States that a group or individual health plan shall include on their plan or issued insurance identification card, the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitations.

- **Implementing protections against provider discrimination:** Requires the secretaries of HHS, the Department of Labor (DOL), and Department of Treasury to promulgate a rule, no later than Jan. 1, 2022, implementing protections against provider discrimination.
- **Surprise Billing Reports:** Requires the secretary of HHS, in consultation with the Federal Trade Commission and U.S. attorney general to conduct a study no later than Jan. 1, 2023 and annually, thereafter for the following four years on the effects of the provisions in the Act. It also requires the GAO to submit to Congress a report on the impact of surprise billing provisions and a report on adequacy of provider networks.
- **Consumer protections through application of health plan external review in cases of certain surprise medical bills:** Allows for an external review to determine whether surprise billing protections are applicable when there is an adverse determination by a health plan beginning no later than Jan. 1, 2022.
- **Consumer protections through health plan requirement for fair and honest advance cost estimate:** Requires health plans to provide an advance Explanation of Benefits for scheduled services at least three days in advance to give patients transparency into which providers are expected to provide treatment, the expected cost and the network status of the providers.
- **Patient protections through transparency and patient-provider dispute resolution:** Health care providers and facilities must verify, three days in advance of service and no later than one day after scheduling of service, what type of coverage the patient is enrolled in and provide notification of a good faith estimate to the payer or patient whether the patient has coverage. It also requires the secretary of HHS to establish a patient-provider dispute resolution process for uninsured individuals no later than Jan. 1, 2022.
- **Ensuring continuity of care:** If a provider changes network status, patients with complex care needs have up to a 90-day period of continued coverage at in-network cost-sharing to allow for a transition of care to an in-network provider.
- **Maintenance of price comparison tool**: Requires health plans to offer a price comparison tool for consumers.
- **State all-payer claims databases (APCDs):** Establishes a grant program to create and improve state APCDs. It also requires recipients of the grants from this program to make data available to authorized users, including researchers, employers, health insurance issuers, third-party administrators, and health care providers for quality improvement and cost-containment purposes. The secretary of HHS may waive these requirements if a state APCDs is substantially in compliance. It also requires the secretary of DOL to convene an advisory committee and develop a standardized format for voluntary reporting by group health plans to state APCD.
- **Protecting patients and improving the accuracy of provider directory information:** Requires health plans to have up-to-date directories of their in-network providers, which shall be available to patients online, or within one business day of an inquiry. If a patient provides documentation that they received incorrect information from a plan about a provider's network status prior to a visit, the patient will only be responsible for the in-network cost-sharing amount.
- **Advisory committee on ground ambulance and patient billing:** Requires the secretaries of HHS, the DOL and Treasury to establish an advisory committee for reviewing options to improve disclosure of charges and fees for ground ambulance services, inform consumers of insurance

options for such services and protect consumers from surprise billing. It also requires a report on recommendations from the committee not later than 180 days after the first meeting.

- **Implementation funding:** Provides funding to the secretaries of HHS, the DOL and Treasury for purposes of carrying out the amendments made by the "No Surprises Act," including:
    - Preparing, drafting and issuing proposed and final regulations or interim regulations.
    - Preparing, drafting and issuing guidance and public information.
    - Preparing and holding public meetings.
    - Preparing, drafting and publishing reports and enforcement of such provisions.
    - Reporting, collecting and analyzing the data.
    - Establishment and implementation of processes for independent dispute resolution and implementation of patient-provider dispute resolution.
    - Conducting audits, and other administrative duties necessary for implementation.

  Secretaries of HHS shall report annually to Congress on the funds expended under this section.

Preventing Online Sales of E-Cigarettes to Children

- **Amendments to the Jenkins Act:** Amends current law to curb online sales of e-cigarettes to minors by bringing such sales under the federal regulations applying to the sale of tobacco products by extending the current definition of a "cigarette" to include any "electronic nicotine delivery system," such as an e-cigarette. It also includes a rule of construction to ensure that the changes made do not interfere with the regulations implemented by the Food and Drug Administration (FDA) concerning tobacco products.
- **Non-mailability of electronic nicotine delivery systems (ENDS):** Requires the U.S. Postal Service, not later than 120 days after the date of enactment, to promulgate regulations to clarify that the prohibition on mailing cigarettes includes ENDS.

Health Care Transparency

- **Increasing transparency by removing gag clauses on price and quality information:** Bans gag clauses in contracts between providers and health plans that prevent enrollees, plan sponsors, or referring providers from seeing cost and quality data on providers. It also bans gag clauses in contracts between providers and health insurance plans that prevent plan sponsors from accessing de-identified claims data that could be shared, under Health Insurance Portability and Accountability Act business associate agreements, with third parties for plan administration and quality improvement purposes.
- **Disclosure of direct and indirect compensation for brokers and consultants to employer sponsored health plans and enrollees in plans on the individual market:** Requires health benefit brokers and consultants to disclose to plan sponsors any direct or indirect compensation the brokers and consultants may receive for referral of services. The section requires health benefit brokers to disclose to enrollees in the individual market or enrollees purchasing short-term limited duration insurance any direct or indirect compensation the brokers may receive for referral of coverage. It also establishes a disclosure requirement for compensation that is not known at the time a contract is signed.
- **Strengthening parity in mental health and substance use disorder benefits:** Requires group health plans and health insurance issuers offering coverage in the individual or group markets to

conduct comparative analyses of the nonquantitative treatment limitations used for medical and surgical benefits as compared to mental health and substance use disorder benefits. It requires secretaries of the HHS, DOL and Treasury to request comparative analyses of at least 20 health insurance plans per year that involve potential violations of mental health parity, complaints regarding noncompliance with mental health parity, and any other instances in which the secretaries determine appropriate. If, after review of the analysis, secretaries of the HHS, DOL and Treasury find a plan or coverage offered by an issuer is out of compliance with mental health parity law, the secretary must specify corrective actions for the plan or coverage to come into compliance. The secretaries will have 45 days to implement corrective action. If the plan is still not in compliance after those 45 days, the plan shall notify all individuals enrolled in noncompliance plans within seven days. Finally, Section 203 requires secretaries of the HHS, DOL and Treasury to publish an annual report with a summary of the comparative analyses.

- **Reporting on pharmacy benefits and drug cost**: Requires health plans to report information on plan medical costs and prescription drug spending to secretaries of the HHS, DOL and Treasury. It also states that the assistant secretary of planning and evaluation, in coordination with the Office of the Inspector General, shall publish a report on the HHS website on prescription drug pricing trends and the contribution to health insurance premiums 18 months after the date of enactment, and every two years thereafter.

Public Health and Extenders Programs

- **Extension for community health centers, the National Health Service Corps, and teaching health centers that operate GME programs:** Extends mandatory funding for community health centers, the National Health Service Corps and the Teaching Health Center Graduate Medical Education (GME) Program at current levels for each fiscal year, FY 2021 through FY 2023.
- **Diabetes programs:** Extends mandatory funding for the Special Statutory Funding Program for Type I Diabetes and the Special Diabetes Program for Indians at current levels for each fiscal year, FY 2021 through FY2023.
- **Improving awareness of disease prevention:** Authorizes a national campaign to increase awareness and knowledge of the safety and effectiveness of vaccines for the prevention and control of diseases, to combat misinformation, and to disseminate scientific and evidence-based vaccine-related information. It also directs the HHS to expand and enhance, and as appropriate, establish and improve programs and activities to collect, monitor and analyze vaccination coverage data (the percentage of people who have had certain vaccines). The section also requires the National Vaccine Advisory Committee to update, as appropriate, the report entitled, “Assessing the State of Vaccine Confidence in the United States: Recommendations from the National Vaccine Advisory Committee.” Finally, it authorizes grants for the purpose of planning, implementation, and evaluation of activities to address vaccine-preventable diseases, and for research on improving awareness of scientific and evidence-based vaccine-related information.
- **Guide on evidence-based strategies for public health department obesity prevention programs:** Authorizes the HHS to develop and disseminate guides on evidence-based obesity prevention and control strategies for state, territorial and local health departments, and Indian tribes and tribal organizations.

- **Expanding capacity for health outcomes:** Authorizes the provision of technical assistance and grants to evaluate, develop and expand the use of technology-enabled collaborative learning and capacity building models to increase access to specialized health care services in medically underserved areas and for medically underserved populations.
- **Public health data system modernization:** Requires the HHS to expand, enhance and improve public health data systems used by the Centers for Disease Control and Prevention. It also requires the HHS to award grants to state, local tribal, or territorial public health departments for the following:
    - The modernization of public health data systems to assist public health departments in assessing current data infrastructure capabilities and gaps.
    - Provide improve secure public health data collection, transmission, exchange, maintenance and analysis.
    - Provide enhance the interoperability of public health data systems.
    - Provide support and train related personnel.
    - Provide support for earlier disease and health condition detection.
    - Develop and disseminate related information and improved electronic case reporting.

  It also requires the secretary of the HHS to develop and submit to Congress a coordinated strategy and accompanying implementation plan that identifies and demonstrates measures used to carry out such activities. It requires the HHS to consult with state, local, tribal and territorial health departments and other appropriate public or private entities regarding the plan and grant program to modernize public health data systems pursuant to this section.

- **Native American suicide prevention:** Ensures states consult with Indian tribes, tribal organizations, urban Indian organizations and use Native Hawaiian Health Care Systems in developing youth suicide early intervention and prevention strategies.
- **Reauthorization of the Young Women's Breast Health Education and Awareness Requires Learning Young Act of 2009:** Reauthorizes the young women's breast health awareness and education program at $9 million for each fiscal year, FY 2022 through FY 2026.
- **Reauthorization of school-based health centers:** Reauthorizes the School-Based Adolescent Health Center Program for FY 2022 through FY 2026.

Food and Drug Administration

- **Rare pediatric disease priority review voucher extension:** Allows the FDA to continue to award priority review vouchers for drugs that treat rare pediatric diseases and are designated no later than Sept. 30, 2024 and approved no later than Sept. 30, 2026.
- **Conditions of use for biosimilar biological products:** Clarifies that biosimilar applicants can include information in biosimilar submissions to show that the proposed conditions of use for the biosimilar product have been previously approved for the reference product.
- **Orphan drug clarification:** Clarifies that the clinical superiority standard applies to all drugs with an orphan drug designation for which an application is approved after the enactment of the FDA Reauthorization Act of 2017, regardless of the date of the orphan drug designation.
- **Modernizing the labeling of certain generic drugs:** Allows the FDA to identify and select certain covered generic drugs for which labeling updates would provide a public health benefit and require sponsors of such drug applications to update labeling. It also requires the FDA to report

on the number of covered drugs and a description of the types of drugs selected for labeling changes, and the rationale for such recommended changes, and to provide recommendations for modifying the program under this section.

- **Biological product patent transparency:** Increases transparency of patent information for biological products by requiring patent information to be submitted to the FDA and published in the "Purple Book." It also codifies the publication of the "Purple Book" as a single, searchable list of information about each licensed biological product, including marketing and licensure status, patent information, and relevant exclusivity periods.

Medicare and Medicaid

- **Extension of the work geographic index floor:** Increases payments for the work component of physician fees in areas where labor cost is determined to be lower than the national average through Dec. 31, 2023.
- **Extension of funding for quality measure endorsement, input and selection:** Provides $66 million to the Centers for Medicare and Medicaid Services (CMS) for quality measure selection and to contract with a consensus-based entity to carry out duties related to quality measurement and performance improvement through Sept. 30, 2023. It also includes additional reporting requirements, facilitates measure removal, and prioritizes maternal morbidity and mortality measure endorsement.
- **Extension of funding outreach and assistance for low-income programs:** Extends funding for low-income Medicare beneficiary outreach, enrollment and education activities provided through the State Health Insurance Assistance Program, Area Agencies on Aging, Aging and Disability Resource Centers, and the National Center for Benefits and Outreach and Enrollment through Sept. 30, 2023. It provides $50 million in funding for each fiscal year, FY 2021 through 2023.
- **Extension of Medicare patient IVIG access demonstration project:** Extends the Intravenous Immunoglobulin (IVIG) treatment demonstration that is administered in the home through Dec. 31, 2023, allowing up to 2,500 additional Medicare patients with primary immunodeficiency diseases to enroll, and requiring an updated evaluation of the demonstration.
- **Extending the Independence at Home Demonstration medical practice program under the Medicare program:** Extends the Independence at Home Demonstration program for three additional years (through Dec. 31, 2023) and expands the size of the demonstration from 15,000 beneficiaries to 20,000 beneficiaries.
- **Improving measurements under the Skilled Nursing Facility Value-Based Purchasing** (SNF VBP) **Program:** Allows the HHS secretary to add up to 10 quality measures—including measures of functional status, patient safety, care coordination, or patient experience—to the SNF VBP for facilities with more than the required minimum number of cases.
- **Providing the Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission with access to certain drug payment information, including certain rebate information:** Ensures the respective executive directors of the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission to have access to certain drug pricing data for purposes of monitoring, analysis, and making program recommendations.

- **Moratorium on payment under the Medicare physician fee schedule of the add-on code for inherently complex evaluation and management visits:** Prohibits the HHS secretary from making payments under the Physician Fee Schedule for services described by Healthcare Common Procedure Coding System code G2211 (or any successor or substantially similar code) prior to Jan. 1, 2024.
- **Temporary freeze of APM payment incentive thresholds:** Freezes the current payment and patient count thresholds for physicians and other eligible clinicians participating in Advanced Alternative Payment Models (APMs) to receive a 5% incentive payment in payment years 2023 and 2024 (performance years 2021 and 2022). It also freezes the Partial Qualifying APM participant payment and patient count thresholds at current levels for payment years 2023 and 2024 (performance years 2021 and 2022).
- **Permitting occupational therapists to conduct initial assessment visit and complete a comprehensive assessment with respect to certain rehabilitation services for home health agencies:** Requires the secretary of HHS, no later than Jan. 1, 2022, to allow occupational therapists to conduct initial assessment visits and complete comprehensive assessments for certain home health services if the referral order by the physician does not include skilled nursing care but includes occupational therapy and physical therapy or speech language pathology.
- **CMS provider outreach and reporting on cognitive assessment and care plan services:** Requires the secretary of HHS to conduct outreach to Medicare physicians and practitioners regarding Medicare payment for cognitive assessment and care plan services furnished to individuals with cognitive impairment, such as Alzheimer's disease and related dementias.
- **Continued coverage of certain temporary transitional home infusion therapy services:** Ensures continued coverage of home infusion therapy services for beneficiaries taking self-administered and biological drugs that are currently included under the temporary transitional home infusion therapy benefit when the permanent home infusion therapy benefit takes effect Jan. 1, 2021.
- **Transitional coverage and retroactive Medicare Part D coverage for certain low-income beneficiaries**: Starting Jan. 1, 2024, permanently authorizes the Limited Income Newly Eligible Transition demonstration to provide immediate temporary Part D coverage for certain individuals with low-income subsidies while their eligibility is processed and increasing the use of real-time benefit tools to lower beneficiary costs. Requires Part D plan sponsors to implement real-time benefit tools that can integrate with provider electronic prescribing (e-prescribing) and electronic health record systems.
- **Beneficiary enrollment simplification:** Eliminates coverage gaps in Medicare by requiring that Part B insurance coverage begin the first of the month following an individual's enrollment and provides for a Part A and Part B Special Enrollment Period for "exceptional circumstances" to mirror authority in Medicare Advantage and Medicare Part D.
- **Waiving budget neutrality for oxygen:** Specifies that the budget neutrality requirement for establishing new payment classes of oxygen and oxygen equipment no longer applies, thereby increasing payment for certain oxygen equipment.
- **Waiving Medicare coinsurance for certain colorectal cancer screening tests:** Gradually eliminates cost-sharing for Medicare beneficiaries with respect to colorectal cancer screening tests where a polyp is detected and removed for any services provided by or after Jan. 1, 2022.

- **Expanding access to mental health services furnished through telehealth:** Expands access to telehealth services in Medicare to allow beneficiaries to receive mental health services via telehealth, including from the beneficiary's home. To be eligible to receive telehealth services, the beneficiary must have been seen in person at least once by the physician or non-physician practitioner during the six-month period prior to the first telehealth service, with additional face-to-face requirements determined by the HHS secretary.
- **Public-private partnership for health care waste, fraud and abuse detection:** Codifies an existing mechanism used within the CMS as part of the agency's ongoing responsibility to combat fraud, waste and abuse.
- **Medicare Payment for Rural Emergency Hospital Services**: Creates a new voluntary Medicare payment designation that allows either a Critical Access Hospital (CAH) or a small rural hospital with less than 50 beds to convert to a Rural Emergency Hospital (REH) to preserve beneficiary access to emergency medical care in rural areas that can no longer support a fully operational inpatient hospital. The REHs can also furnish additional medical services needed in their community, such as observation care, outpatient hospital services, telehealth services, ambulance services, and skilled nursing facility services. The REHs will be reimbursed under all applicable Medicare prospective payment systems, plus an additional monthly facility payment and an add-on payment for hospital outpatient services.
- **Distribution of additional residency position:** Supports physician workforce development by providing for the distribution of additional Medicare-funded GME residency positions. Rural hospitals, hospitals that are already above their Medicare cap for residency positions, hospitals in states with new medical schools, and hospitals that serve Health Professional Shortage Areas will be eligible for these new positions.
- **Promoting rural hospital GME funding opportunity:** Makes changes to Medicare GME Rural Training Tracks (RTT) to provide greater flexibility for rural and urban hospitals that participate in RTT programs.
- **Five-year extension of the Rural Community Hospital Demonstration:** Extends the Rural Community Hospital Demonstration by five years. The demonstration tests the feasibility and advisability of establishing "rural community hospitals" to furnish covered inpatient hospital services to Medicare beneficiaries in states with low population densities. Participating hospitals are mostly paid using reasonable cost-based methodology instead of the inpatient prospective payment system.
- **Extension of the Frontier Community Health Integration Project demonstration:** Extends the Frontier Community Health Integration Project (FCHIP) demonstration by five years. The FCHIP demonstration tests new models of health care delivery for rural CAHs.
- **Improving Rural Health Clinic payments:** Implements a comprehensive Rural Health Clinic (RHC) payment reform plan. It phases in a steady increase in the RHC statutory cap over an eight-year period, subjects all new RHCs to a uniform per-visit cap and controls the annual rate of growth for uncapped RHCs whose payments are above the upper limit. It ensures that no RHC would see a reduction in reimbursement. The RHCs with an all-inclusive rate above the upper limit will continue to experience annual growth, but the payment amount will be constrained to the facility's prior year reimbursement rate plus the Medicare Economic Index (MEI). Specifically, the policy raises the statutory RHC cap to $100 starting on April 1, 2021, and gradually increases the upper limit each year through 2028 until the cap reaches $190. This brings the RHC upper

limit roughly in line with the Federally Qualified Health Centers (FQHC) Medicare base rate. In each subsequent calendar year, starting in 2029, the new statutorily set RHC cap reverts back to an annual MEI inflationary adjustment.

- **Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations:** Allows hospitals to host a limited number of residents for short-term rotations without being negatively affected by a set permanent full-time equivalent resident cap or a per resident amount.
- **Medicare payment for certain Federally Qualified Health Center and Rural Health Clinic services furnished to hospice patients:** Allows RHCs and FQHCs to furnish and bill for hospice attending physician services when the RHC and FQHC patients become terminally ill and elect the hospice benefit, beginning Jan. 1, 2022.
- **Delay to the implementation of the radiation oncology model under the Medicare program:** Provides for a statutory six-month additional delay, in addition to the delay announced by the CMS of the Medicare radiation oncology model to Jan. 1, 2022.
- **Improving access to skilled nursing facility services for hemophilia patients:** Adds blood clotting factors and items and services related to their furnishing to the categories of high-cost, low probability services that are excluded from the SNF per-diem prospective payment system and are separately payable. This change will allow SNF care to be an option instead of continued inpatient care for this limited population.
- **Eliminating DSH reductions for FY 2021:** Amends the current schedule of Medicaid Disproportionate Share Hospital (DSH) payment reductions to eliminate the reductions in effect for FY 2021. Eliminates the reductions for FY 2022 and FY2023 and add reductions to FY 2026 and FY 2027.
- **Supplemental payment reporting requirements:** Establishes a system for supplemental payment reporting to the CMS by states, including data on the amount of supplemental payments made to each eligible provider, to better understand how state Medicaid programs use such payments. It requires supplemental payment reports be made publicly available.
- **Medicaid shortfall and third-party payments:** Includes a definition of Medicaid shortfall for purposes of third-party payments, which does not currently exist in Medicaid statute.
- **Extension of Money Follows the Person rebalancing demonstration:** Extends funding for the Medicaid Money Follows the Person rebalancing demonstration program at $450 million per fiscal year through FY 2023. It also makes a number of changes to the program. It changes the institutional residency period from 90 days to 60 days, updates state application requirements to provide additional information on use of rebalancing funds and requires the HHS secretary to issue a report on best practices, among other improvements.
- **Extension of spousal impoverishment protections:** Extends the protections against spousal impoverishment for partners of Medicaid beneficiaries who receive home and community-based services through FY 2023.
- **Extension of community mental health services demonstration program:** Extends the community mental health services demonstration program through FY 2023.
- **Clarifying authority of state Medicaid fraud and abuse control units:** Allows state Medicaid fraud control units to investigate complaints of patient abuse or neglect in non-institutional or other settings.

- **Medicaid coverage for citizens of freely associated states (FAS):** Restores Medicaid eligibility for citizens of the FAS (the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau) lawfully residing in the United States under the Compacts of Free Association.
- **Medicaid coverage of certain medical transportation:** Ensures that state Medicaid programs cover nonemergency medical transportation to necessary services. The section also requires states to comply with certain program integrity standards. It also requires the CMS to convene stakeholder meetings to address certain challenges regarding Medicaid program integrity and coverage of such services.
- **Promoting access to life-saving therapies for Medicaid enrollees by ensuring coverage of routine patient costs for items and services furnished in connection with participation in qualifying clinical trials:** Requires state Medicaid programs to cover routine patient costs for items and services that are provided in connection with a qualifying clinical trial regarding serious or other life-threatening conditions starting Jan. 1, 2022.
- **Supporting Physicians and Other Professionals In Adjusting to Medicare Payment Changes During 2021:** Provides for a one-time, one-year increase in the Medicare physician fee schedule of 3.75% to support physicians and other professionals in adjusting to changes in the Medicare physician fee schedule during 2021, and to provide relief during the COVID-19 public health emergency.
- **Extension of Temporary Suspension of Medicare Sequestration:** Provides for a three-month delay of the Medicare sequester payment reductions through March 31, 2021.

Human Services

- **Extension of TANF, Child Care Entitlement to States and related programs:** Extends current funding and policy for the Temporary Assistance for Needy Families (TANF), the Child Care Entitlement to States, and other related programs, including the Healthy Marriage and Responsible Fatherhood grants through the end of FY 2021.
- **Personal Responsibility Education Program (PREP):** Extends the program through FY 2023.
- **Title V State Sexual Risk Avoidance Education (SRAE):** Extends the program through FY 2023.
- **Extension of support for current health professions opportunity grants:** Provides $3.6 million to cover the cost of ongoing technical assistance and other HHS administrative costs related to currently operating Health Profession Opportunity Grants through the end of FY 2021, and for costs related to evaluation and reporting through the end of FY 2022.
- **Extension of MaryLee Allen Promoting Safe and Stable Families Program and state court support:** Extends current funding, authorization and reservations within the MaryLee Allen Promoting Safe and Stable Families program, including the Court Improvement Program (CIP), through the end of FY 2022, and make changes to and clarifies the CIP that take effect Oct. 1, 2021.

Health Offsets

- **Requiring certain manufacturers to report drug pricing information with respect to drugs under the Medicare program:** Requires all manufacturers of drugs covered under Medicare Part B to report average sales price (ASP) information to the secretary of HHS beginning on Jan. 1,

2022. Specifically, it adds a new requirement for manufacturers that do not have a rebate agreement through the Medicaid Drug Rebate Program to report ASP information.

- **Extended months of coverage of immunosuppressive drugs for kidney transplant patients and other renal dialysis provisions:** Establishes eligibility for immunosuppressive drug coverage through Medicare to post-kidney transplant individuals whose entitlement to benefits under Part A ends (whether before, on, or after Jan. 1, 2023) and who do not receive coverage of immunosuppressive drugs through other insurance.
- **Permitting direct payment to physician assistants under Medicare:** Allows direct payment under the Medicare program to physician assistants for services furnished to beneficiaries on or after Jan. 1, 2022.
- **Adjusting calculation of hospice cap amount under Medicare:** Extends the change to the annual updates to the hospice aggregate cap made in the "Improving Medicare Post-Acute Care Transformation Act of 2014" and applies the hospice payment update percentage rather than the Consumer Price Index for All Urban Consumers (CPI–U) to the hospice aggregate cap for FY 2026 through FY 2030.
- **Special rule for determination of ASP in cases of certain self-administered versions of drugs:** Authorizes the CMS, when determining payment for products covered under Medicare Part B, to review and exclude payments made for the self-administered versions of products that are not covered under Part B.
- **Establishing hospice program survey and enforcement procedures under the Medicare program:** Makes changes to the Medicare hospice survey and certification process to improve consistency and oversight, allowing the HHS secretary to use intermediate remedies to enforce compliance with hospice requirements and extending the requirement that hospices be surveyed no less frequently than once every 36 months. It also creates a new Special Focus Facility Program for poor-performing hospice providers, who will be surveyed not less frequently than once every six months. It increases the penalty for hospices not reporting quality data to the HHS secretary from two to four percentage points, beginning in FY 2024.

Nutrition Provisions

- **Supplemental Nutrition Assistance Program (SNAP):** Increases the monthly SNAP benefit level by 15% based on the June 2020 Thrifty Food Plan through June 30, 2021. Simplifies the state administrative process for SNAP benefit level increases and provides $100 million for state administrative costs through FY 2021 and requires these funds to be made available to states within 60 days of enactment. Excludes federal pandemic unemployment compensation from being counted toward household income for SNAP and extends SNAP eligibility to college students who are eligible for a federal or state work study program or has an expected family contribution of zero. Directs the secretary of the Department of Agriculture (USDA) to submit a report on the redemption rate and account balances for each month from January 2021 to June 2021. Shortens the statutory waivers for certain SNAP quality control requirements from Sept. 30, 2021 to June 30, 2021.
- **Additional Assistance for SNAP online purchasing and technology improvements:** Provides $5 million for technical support to the USDA in expanding the SNAP online purchasing program, including for farmers markets and direct marketing farmers, and for supporting mobile payment technologies and the electronic benefit transfer system.

- **Nutrition Assistance Programs:** Provides $614 million to Puerto Rico and American Samoa for nutrition assistance, of which $14 million shall be available to the Commonwealth of the Northern Mariana Islands.
- **Emergency Food Assistance Program:** Invests $400 million in the Emergency Food Assistance Program through Sept. 30, 2021. Allows up to 20% of these funds to be used for commodity distribution.
- **Commodity Supplemental Food Program:** Provides $13 million to the Commodity Supplemental Food Program, 20% of which may be used for administrative costs through Sept. 30, 2021.
- **Emergency costs for child nutrition programs during COVID-19 pandemic:** Provides emergency relief to help school meal and child and adult care food programs, which are in dire need of financial assistance, to continue serving children and families. Provides as much funding as necessary to carry out these payments.
- **Task force on supplemental food deliver in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC):** Requires the USDA to establish a task force on food delivery models in the WIC program so that participants have access to curbside pickup and other safe food purchasing methods during the pandemic.
- **Nutrition services under "Older Americans Act":** Provides needed flexibility to area agencies on aging and state units on aging to ensure that older adults' nutritional needs can continue to be met safely during the pandemic.
- **Assistance for children in child care:** Ensures that millions of young children can access needed nutrition benefits by clarifying that states may issue Pandemic Electronic Benefit Transfer (P-EBT) benefits to children under the age of 6 who live in households receiving SNAP benefits and residing in an area in which schools or child care facilities are closed or operating with reduced hours or attendance without the need to verify childcare enrollment at the individual household level. Additionally, makes P-EBT implementation easier for states and clarifies simplifying assumptions that may be used.
- **Aging and disability services program:** Provides $175 million in emergency funding for Older Americans Act nutrition programs, including $7 million for tribal nutrition programs.

Additional Provisions Related to HHS

- **Federal Communications Commission (FCC) COVID-19 Telehealth Program:** Appropriates an additional $250 million to the FCC for its COVID-19 Telehealth Program authorized under the CARES Act. It also puts in place new transparency obligations for the program surrounding the FCC's review of applications, and directs the FCC to ensure, to the extent feasible, that all states benefit from the program.

Resources

NCSL's COVID-19 Economic Relief Bill Summary
NCSL's Omnibus Appropriations Bill Summary
House Democrats' Division-by-Division Summary of Appropriations Provisions
House Democrats' Division-by-Division Summary of COVID-19 Relief
House Democrats' Division-by-Division Summary of Authorizing Matters

Senate Republicans Summary of Omnibus and COVID-19 Package