DIVISION-BY-DIVISION SUMMARY OF AUTHORIZING MATTERS

Division BB: Private Health Insurance and Public Health Provisions

Title I – No Surprises Act

Section 102. Health insurance requirements regarding surprise medical billing. Section 102 requires health plans to hold patients harmless from surprise medical bills. Patients are only required to pay the in-network cost-sharing (i.e., co-payment, coinsurance and deductibles) amount for out-ofnetwork 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.

Section 103. Determination of out-of-network rates to be paid by health plans; Independent dispute resolution process. Section 103 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, as well as factors such as the provider's training and experience, patient acuity and the complexity of furnishing the item or service, in the case of a provider that is a facility, 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, and other items. Billed charges and public payer rates are excluded from consideration. Following IDR, the party that initiated the IDR may not take the same party to IDR for the same item or service for 90 days following a determination by the IDR entity, in order to encourage settlement of similar claims, but all claims that occur during that 90-day period may still be eligible for IDR upon completion of the 90-day period.

Section 104. Health care provider requirements regarding surprise medical billing. Section 104 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.

Section 105. Ending surprise air ambulance bills. Section 105 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, which is the same as outlined in Section 103, with additional factors to account for the cost of providing air ambulance service in rural and frontier areas.

Section 106. Reporting requirements regarding air ambulance services. Section 106 requires air ambulance providers to submit two years of cost data to the Secretaries of Health and Human Services (HHS) and Transportation and insurers 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.

Section 107. Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations. Section 107 states that a group or individual health plan shall include on their plan or insurance identification card issued to the enrollee the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitations.

Section 108. Implementing protections against provider discrimination. Section 108 requires the Secretaries of HHS, Labor, and Treasury to promulgate a rule no later than January 1, 2022 implementing protections against provider discrimination.

Section 109. Reports. Section 109 requires the Secretary of HHS, in consultation with the Federal Trade Commission and Attorney General, to conduct a study no later than January 1, 2023 and annually thereafter for the following four years on the effects of the provisions in the Act. It also requires the Government Accountability Office (GAO) to submit to Congress a report on the impact of surprise billing provisions and a report on adequacy of provider networks.

Section 110. Consumer protections through application of health plan external review in cases of certain surprise medical bills. Section 110 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 January 1, 2022.

Section 111. Consumer protections through health plan requirement for fair and honest advance cost estimate. Section 111 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.

Section 112. Patient protections through transparency and patient-provider dispute resolution. Section 112 states that health care providers and facilities must verify, three days in advance of service and not 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 or not 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 January 1, 2022.

Section 113. Ensuring continuity of care. Section 113 states that 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.

Section 114. Maintenance of price comparison tool. Section 114 requires health plans to offer a price comparison tool for consumers.

Section 115. State All Payer Claims Databases. Section 115 establishes a grant program to create and improve State All Payer Claims Databases. 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 All Payer Claims Database is substantially in compliance. It also requires the Secretary of Labor to convene an advisory committee and develop a standardized format for voluntary reporting by group health plans to State All Payer Claims Databases.

Section 116. Protecting patients and improving the accuracy of provider directory information. Section 116 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.

Section 117. Advisory committee on ground ambulance and patient billing. Section 117 requires the Secretaries HHS, Labor, 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 first meeting.

Section 118. Implementation funding. Section 118 provides funding to the Secretaries of HHS, Labor, 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; enforcement of such provisions; reporting, collection and analysis of 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. Each of the Secretaries shall report annually to Congress on the funds expended under this section.

Section 201. Increasing transparency by removing gag clauses on price and quality information. Section 201 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 (HIPAA) business associate agreements, with third parties for plan administration and quality improvement purposes.

Section 202. Disclosure of direct and indirect compensation for brokers and consultants to employer sponsored health plans and enrollees in plans on the individual market. Section 202 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.

Section 203. Strengthening parity in mental health and substance use disorder benefits. Section 203 requires group health plans and health insurance issuers offering coverage in the individual or group markets to conduct comparative analyses of the no quantitative treatment limitations used for medical and surgical benefits as compared to mental health and substance use disorder benefits. It requires the Secretaries of HHS, Labor, and the Treasury to request comparative analyses of at least 20 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, upon review of the analysis, the Secretaries of HHS, Labor, and the Treasury find that 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, which the plan will have 45 days to implement. 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 the Secretaries of HHS, Labor, and the Treasury to publish an annual report with a summary of the comparative analyses.

Section 204. Reporting on pharmacy benefits and drug costs. Section 204 requires health plans to report information on plan medical costs and prescription drug spending to the Secretaries of HHS, Labor, and the 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.

Title III – Public Health Provisions Subtitle A – Extenders Provisions

Section 301. 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 Program at current levels for each of fiscal years 2021 through 2023.

Section 302. Diabetes programs. Extends mandatory funding for the Special Diabetes Program for Type I Diabetes and the Special Diabetes Program for Indians at current levels for each of fiscal years 2021 through 2023.

Section 311. Improving awareness of disease prevention. Section 311 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 Department of 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.

Section 312. Guide on evidence-based strategies for public health department obesity prevention programs. Section 312 authorizes 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.

Section 313. Expanding capacity for health outcomes. Section 313 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.

Section 314. Public health data system modernization. Section 314 requires HHS to expand, enhance, and improve public health data systems used by the Centers for Disease Control and Prevention (CDC). It also requires HHS to award grants to State, local, Tribal, or territorial public health departments for the modernization of public health data systems in order to assist public health departments in assessing current data infrastructure capabilities and gaps; to improve secure public health data collection, transmission, exchange, maintenance, and analysis; to enhance the interoperability of public health data systems; to support and train related personnel; to support earlier disease and health condition detection; and to develop and disseminate related information and improved electronic case reporting. Section 314 also requires the Secretary of HHS to develop and submit to Congress a coordinated strategy and accompanying implementation plan that identifies and demonstrates measures utilized to carry out such activities, and requires 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.

Section 315. Native American suicide prevention. Section 315 ensures states consult with Indian tribes, tribal organizations, urban Indian organizations, and Native Hawaiian Health Care Systems in developing youth suicide early intervention and prevention strategies.

Section 316. Reauthorization of the Young Women's Breast Health Education and Awareness Requires Learning Young Act of 2009. Section 316 reauthorizes the young women's breast health awareness and education program at $9 million for each of fiscal years 2022 through 2026.

Section 317. Reauthorization of school-based health centers. Section 317 reauthorizes the School-Based Health Center program for fiscal years 2022 through 2026.

Section 321. Rare pediatric disease priority review voucher extension. Section 321 allows the Food and Drug Administration (FDA) to continue to award priority review vouchers for drugs that treat rare pediatric diseases and are designated no later than September 30, 2024, and approved no later than September 30, 2026.

Section 322. Conditions of use for biosimilar biological products. Section 322 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.

Section 323. Orphan drug clarification. Section 323 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.

Section 324. Modernizing the labeling of certain generic drugs. Section 324 allows 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 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.

Section 325. Biological product patent transparency. Section 325 increases transparency of patent information for biological products by requiring patent information to be submitted to 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 Extenders

Section 101. Extension of the work geographic index floor under the Medicare program. Section 101 increases payments for the work component of physician fees in areas where labor cost is determined to be lower than the national average through December 31, 2023.

Section 102. Extension of funding for quality measure endorsement, input, and selection. Section 102 provides $66 million in funding to the Centers for Medicare & 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 September 30, 2023. It also includes additional reporting requirements, facilitates measure removal, and prioritizes maternal morbidity and mortality measure endorsement.

Section 103. Extension of funding outreach and assistance for low-income programs. Section 103 extends funding for low-income Medicare beneficiary outreach, enrollment, and education activities provided through State Health Insurance Assistance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the National Center for Benefits and Outreach and Enrollment through September 30, 2023. It provides $50 million in funding for each of fiscal years 2021, 2022, and 2023.

Section 104. Extension of Medicare patient IVIG access demonstration project. Section 104 extends the Intravenous Immunoglobulin (IVIG) treatment demonstration that is administered in the home through December 31, 2023, allowing up to 2,500 additional Medicare patients with primary immunodeficiency diseases (PIDD) to enroll and requiring an updated evaluation of the demonstration.

Section 105. Extending the Independence at Home medical practice demonstration program under the Medicare program. Section 105 extends the Independence at Home demonstration for three additional years (through December 31, 2023) and expands the size of the demonstration from 15,000 beneficiaries to 20,000 beneficiaries.

Section 111. Improving measurements under the skilled nursing facility value-based purchasing program under the Medicare program. Section 111 allows the Secretary to add up to 10 quality measures – including measures of functional status, patient safety, care coordination, or patient experience – to the skilled nursing facility (SNF) value-based purchasing program for facilities with more than the required minimum number of cases.

Section 112. 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. Section 112 ensures the respective executive directors of the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) have access to certain drug pricing data for purposes of monitoring, analysis, and making program recommendations.

Section 113. Moratorium on payment under the Medicare physician fee schedule of the add-on code for inherently complex evaluation and management visits. Section 113 prohibits the Secretary of the Department of Health and Human Services (HHS) from making payments under the Physician Fee Schedule for services described by Healthcare Common Procedure Coding System (HCPCS) code G2211 (or any successor or substantially similar code) prior to January 1, 2024.

Section 114. Temporary freeze of APM payment incentive thresholds. Section 114 freezes the current payment and patient count thresholds for physicians and other eligible clinicians participating in Advanced Alternative Payment Models (APMs) to receive a five percent 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).

Section 115. Permitting occupational therapists to conduct the initial assessment visit and complete the comprehensive assessment with respect to certain rehabilitation services for home health agencies under the Medicare program. Section 115 requires the Secretary of HHS, no later than January 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.

Section 116. Centers for Medicare & Medicaid Services provider outreach and reporting on cognitive assessment and care plan services. Section 116 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.

Section 117. Continued coverage of certain temporary transitional home infusion therapy services. Section 117 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 January 1, 2021.

Section 118. Transitional coverage and retroactive Medicare Part D coverage for certain low-income beneficiaries. Section 118 permanently authorizes, beginning January 1, 2024, the Limited Income Newly Eligible Transition (LI NET) demonstration to provide immediate temporary Part D coverage for certain individuals with lowincome subsidies (LIS) while their eligibility is processed.

Section 119. Increasing the use of real-time benefit tools to lower beneficiary costs. Section 119 requires Part D plan sponsors to implement real-time benefit tools (RTBT) that are capable of integrating with provider electronic prescribing (e-prescribing) and electronic health record (EHR) systems.

Section 120. Beneficiary enrollment simplification. Section 120 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.

Section 121. Waiving budget neutrality for oxygen under the Medicare program. Section 121 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.

Section 122. Waiving Medicare coinsurance for certain colorectal cancer screening tests. Section 122 gradually eliminates cost-sharing for Medicare beneficiaries with respect to colorectal cancer screening tests where a polyp is detected and removed.

Section 123. Expanding access to mental health services furnished through telehealth. Section 123 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 these services via telehealth, 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 Secretary.

Section 124. Public-private partnership for health care waste, fraud, and abuse detection. Section 124 codifies an existing mechanism used within CMS as part of the agency's ongoing responsibility to combat fraud, waste, and abuse.

Section 125. Medicare Payment for Rural Emergency Hospital Services. Section 125 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. 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. 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.

Section 126. Distribution of additional residency positions. Section 126 supports physician workforce development by providing for the distribution of additional Medicare-funded graduate medical education (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.

Section 127. Promoting rural hospital GME funding opportunity. Section 127 makes changes to Medicare GME Rural Training Tracks (RTT) to provide greater flexibility for rural and urban hospitals that participate in RTT programs.

Section 128. Five-year extension of the Rural Community Hospital Demonstration. Section 128 extends the Rural Community Hospital Demonstration (RCHD) 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.

Section 129. Extension of the Frontier Community Health Integration Project demonstration. Section 129 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.

Section 130. Improving Rural Health Clinic payments. Section 130 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. RHCs with an all-inclusive rate (AIR) 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.

Section 131. Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations. Section 131 allows hospitals to host a limited number of residents for short-term rotations without being negatively impacted by a set permanent full-time equivalent (FTE) resident cap or a Per Resident Amount (PRA).

Section 132. Medicare payment for certain Federally Qualified Health Center and Rural Health Clinic services furnished to hospice patients. Section 132 allows RHCs and FQHCs to furnish and bill for hospice attending physician services when RHC and FQHC patients become terminally ill and elect the hospice benefit, beginning January 1, 2022.

Section 133. Delay to the implementation of the radiation oncology model under the Medicare program. Section 133 provides for a statutory six-month additional delay, in addition to the delay announced by CMS of the Medicare radiation oncology model to January 1, 2022.

Section 134. Improving access to skilled nursing facility services for hemophilia patients. Section 134 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 skilled nursing facility 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.

Medicaid Extenders and Other Policies

Section 201. Eliminating DSH reductions for fiscal year 2021. Section 201 amends the current schedule of Medicaid Disproportionate Share Hospital (DSH) payment reductions to eliminate the reductions in

effect for fiscal year 2021, eliminate the reductions for fiscal years 2022 and 2023, and add reductions to fiscal years 2026 and 2027.

Section 202. Supplemental payment reporting requirements. Section 202 establishes a system for supplemental payment reporting to 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.

Section 203. Medicaid shortfall and third party payments. Section 203 includes a definition of Medicaid shortfall for purposes of third party payments, which does not currently exist in Medicaid statute.

Section 204. Extension of Money Follows the Person Rebalancing Demonstration. Section 204 extends funding for the Medicaid Money Follows the Person Rebalancing Demonstration program at $450 million per fiscal year through fiscal year 2023. It also makes a number of improvements 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 Secretary to issue a report on best practices, among other improvements.

Section 205. Extension of spousal impoverishment protections. Section 205 extends the protections against spousal impoverishment for partners of Medicaid beneficiaries who receive home and community-based services through fiscal year 2023.

Section 206. Extension of community mental health services demonstration program. Section 206 extends the community mental health services demonstration program through fiscal year 2023.

Section 207. Clarifying authority of State Medicaid fraud and abuse control units. Section 207 allows state Medicaid fraud control units to investigate complaints of patient abuse or neglect in non-institutional or other settings.

Section 208. Medicaid coverage for citizens of Freely Associated States. Section 208 restores Medicaid eligibility for citizens of the Freely Associated States (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.

Section 209. Medicaid coverage of certain medical transportation. Section 209 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 CMS to convene stakeholder meetings to address certain challenges regarding Medicaid program integrity and coverage of such services.

Section 210. 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. Section 210 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 January 1, 2022.

Human Services

Section 301. Extension of TANF, child care entitlement to States, and related programs. Section 301 extends current funding and policy for the Temporary Assistance for Needy Families, the Child Care Entitlement to States, and other related programs, including the Healthy Marriage and Responsible Fatherhood grants, through the end of fiscal year 2021.

Section 302. Personal Responsibility Education Program. Section 302 extends the Personal Responsibility Education Program (PREP) through fiscal year 2023.

Section 303. Sexual Risk Avoidance Education. Section 303 extends the Sexual Risk Avoidance Education (SRAE) program through fiscal year 2023.

Section 304. Extension of support for current health professions opportunity grants. Section 304 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 (HPOGs) through the end of fiscal year 2021, and for costs related to evaluation and reporting through the end of fiscal year 2022.

Section 305. Extension of MaryLee Allen Promoting Safe and Stable Families Program and State court support. Section 305 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 fiscal year 2022, and make changes and clarifications to CIP that take effect October 1, 2021.

Health Offsets

Section 401. Requiring certain manufacturers to report drug pricing information with respect to drugs under the Medicare program. Section 401 requires all manufacturers of drugs covered under Medicare Part B to report average sales price (ASP) information to the Secretary of HHS beginning on January 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.

Section 402. Extended months of coverage of immunosuppressive drugs for kidney transplant patients and other renal dialysis provisions. Section 402 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 January 1, 2023) and who do not receive coverage of immunosuppressive drugs through other insurance.

Section 403. Permitting direct payment to physician assistants under Medicare. Section 403 allows direct payment under the Medicare program to physician assistants for services furnished to beneficiaries on or after January 1, 2022.

Section 404. Adjusting calculation of hospice cap amount under Medicare. Section 404 extends the change to the annual updates to the hospice aggregate cap made in the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) of 2014 and applies the hospice payment update percentage rather than the Consumer Price Index for Urban Consumers (CPI–U) to the hospice aggregate cap for fiscal years 2026 through 2030.

Section 405. Special rule for determination of ASP in cases of certain self-administered versions of drugs. Section 405 authorizes 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.

Section 406. Medicaid Improvement Fund. Section 406 rescinds $3,464,000,000 from the Medicaid Improvement Fund.

Section 407. Establishing hospice program survey and enforcement procedures under the Medicare program. Section 407 makes changes to the Medicare hospice survey and certification process to improve consistency and oversight, allowing the 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 Secretary from two to four percentage points, beginning in fiscal year 2024.

Section. 408. Medicare Improvement Fund. Section 408 provides $165 million for the Medicare Improvement Fund.

Section. 501. Implementation funding. Section 501 provides $37 million to the CMS Program Management Account to support implementation of the Medicare and Medicaid related provisions of the legislation.

Tax Extenders

Sec. 101. Reduction in medical expense deduction floor. Between 2013 and 2017, individuals under 65 years old could claim an itemized deduction for unreimbursed medical expenses to the extent that such expenses exceeded 10 percent of AGI, while for individuals 65 or older, the threshold was 7.5 percent of AGI. Prior to this period, the 7.5 percent threshold generally applied regardless of age. The provision makes permanent the lower threshold of 7.5 percent for all taxpayers, originally restored for 2017 and 2018 and then extended for 2019 and 2020.

Sec. 102. Energy efficient commercial buildings deduction. The provision makes permanent the deduction for energy efficiency improvements to building envelope, lighting, heating, cooling, ventilation, and hot water systems of commercial buildings. The provision updates the ASHRAE Reference Standard 90.1 from the 2007 standard to the most recent standard as of two years before the start of construction. The most recent Reference Standard 90.1 is the most recent standard published and affirmed by the Secretary of the Treasury, after consultation with the Secretary of Energy. The provision additionally indexes to inflation the amount of the $1.80-per-square-foot limitation.

Sec. 103. Benefits provided to volunteer firefighters and emergency medical responders. The provision makes permanent the exclusions for qualified state or local tax benefits and qualified reimbursement payments provided to members of qualified volunteer emergency response organizations and increases the exclusion for qualified reimbursement payments to $50 for each month during which a volunteer performs services. This provision was originally reinstated for 2020 in the SECURE Act.

Sec. 104. Transition from deduction for qualified tuition and related expenses to increased income limitation for lifetime learning credit. The qualified tuition deduction is capped at $4,000 for an individual whose AGI does not exceed $65,000 ($130,000 for joint filers) or $2,000 for an individual

whose AGI does not exceed $80,000 ($160,000 for joint filers). After 2020, the provision repeals the qualified tuition deduction and replaces it by increasing the phase-out limits on the Lifetime Learning credit from $58,000 ($116,000 for joint filers) to $80,000 ($160,000 for joint filers). In the vast majority of circumstances, these increased phase-out limits hold harmless those taxpayers who would have otherwise benefited from this deduction.

Sec. 106. Certain provisions related to beer, wine, and distilled spirits. The provision makes permanent the reduction of certain excise taxes and simplified record-keeping requirements related to the taxation of beer, wine, and distilled spirits. The provision also modifies certain requirements for in-bond transfers of bottled distilled spirits.

Sec. 107. Refunds in lieu of reduced rates for certain alcohol produced outside the United States. The provision provides that, starting in 2023, reduced rates for imports will be administered as refunds by the Treasury Department, rather than determined upon entry by Customs and Border Protection. The refunds shall be paid at least quarterly. The provision also determines how interest will be applied to the amount of the refund.

Sec. 108. Reduced rates not allowed for smuggled or illegally produced beer, wine, and spirits. The provision clarifies that reduced rates for beer, wine, and spirits are not allowed for smuggled or illegally produced products.

Sec. 109. Minimum processing requirements for reduced distilled spirits rates. The provision modifies the definition of processing for purposes of determining the volume limitations on reduced rates. The provision disregards mere bottling of distilled spirits in determining whose controlled group is relevant for purposes of the limitations.

Sec. 110. Modification of single taxpayer rules. The provision makes certain modifications to single taxpayer rules for beer, wine, and distilled spirits.

Sec. 119. Employer tax credit for paid family and medical leave. The provision extends, through 2025, the employer credit for paid family and medical leave, which permits eligible employers to claim an elective general business credit based on eligible wages paid to qualifying employees with respect to family and medical leave. The credit is equal to 12.5 percent of eligible wages if the rate of payment is 50 percent of such wages, and is increased by 0.25 percentage points (but not above 25 percent) for each percentage point that the rate of payment exceeds 50 percent. The maximum amount of family and medical leave that may be taken into account with respect to any qualifying employee is 12 weeks per taxable year.

Sec. 120. Exclusion for certain employer payments of student loans. The provision extends, through 2025, the allowance for employers to provide a student loan repayment benefit to employees on a tax-free basis. Under the provision, an employer may contribute up to $5,250 annually toward an employee's student loans, and such payment would be excluded from the employee's income. The $5,250 cap applies to both the student loan repayment benefit as well as other educational assistance (e.g., tuition, fees, books) provided by the employer under current law. The provision applies to any student loan payments made by an employer on behalf of an employee through 2025.

Sec. 149. Black lung disability trust fund excise tax. The provision extends, through 2021, the rates of 1.10 per ton for coal from underground mines and 55 cents per ton for coal from surface mines for the

excise tax that funds the Black Lung Disability Trust Fund. Both rates are limited to a maximum of 4.4 percent of the coal's selling price. Under the provision, the coal excise tax rates are scheduled to decline to 50 cents per ton for underground mines and 25 cents per ton for surface mines (both limited to two percent of the coal's selling price) on the earlier of January 1, 2022 or the first January 1 after which there is no balance of repayable advances from the General Fund that have been made to the Trust Fund and no unpaid interest on previous such advances.