



**AMA Summary of Select Provisions in the Consolidated Appropriations Act, 2021 (H.R. 133)**  
1/5/21 (subject to revisions)

**1. Medicare payment—E/M changes and physician payment adjustments. (Division N)**

- **Mitigates budget neutrality cuts to physician payment and extends sequestration suspension:**
  - The legislation represents a significant win for physicians regarding Medicare physician payment. For Calendar Year 2021, the Medicare physician payment final rule indicated that there would be a 10.2% across-the-board reduction due to budget neutrality requirements. The new legislation dramatically reduces this budget neutrality adjustment in two ways:
    - (1) There will be an **increase in the payment schedule of 3.75 percent**. (This is applied across the board and without distinction to all payments under the Medicare physician payment schedule). This update is not subject to administrative or judicial review and shall not factor into future calculations of the fee schedule. (Sec. 101)
      - To pay for this 3.75 percent increase, funds are to be drawn from the General Fund of the US Treasury (to the Federal Supplementary Medical Insurance Trust, or FSMIT) in the amount of \$3 billion. Amounts needed in excess of the allocated \$3 billion are to come from the FSMIT.
      - A report to Congress (Senate Finance + House W&M and E&M) is due on these payment increases by April 1, 2022. CMS is to assess the effects of any changes on access to services and workforce incentives.
    - (2) **Suspension of payments for HCPCS code G2211 for three years** (through December 2023). (Sec. 113)
      - This code was finalized as an add-on code by CMS to account for visit complexity inherent to E/M visits. As calculated by the Medicare Physician Fee Schedule Final Rule, the G2211 code accounted for approximately \$3 billion, or 3 percent of the reduction in the fee schedule. This suspension or delay in implementing the G2211 add-on code will further reduce the budget neutrality adjustment for 2021.
  - Taken together, these provisions related to Medicare physician payment mean the budget neutrality adjustment is significantly reduced. Based on the specialty impact table in the final rule, the [AMA estimates](#) that most specialties will now see either a neutral or positive change in total Medicare payments in 2021. Impacts for particular medical practices will depend on both physician specialty and their particular mix of services, as well as whether or not they would have billed G2211 if this add-on code was not delayed.
    - Generally speaking, all physician specialties are in a better position in 2021 than if nothing were enacted. This is due to relentless advocacy on the impact of the reductions to physicians, especially during the COVID-19 pandemic.
  - Additionally, **the suspension of the Medicare Sequestration cut of two percent is continued**. Originally set to end on December 31, 2020, the Medicare sequestration cut is

pushed out and is now scheduled to end on March 31, 2021. This means the two percent cut to Medicare payments is avoided for three months, which will provide a temporary but additional reprieve from the across-the-board Medicare cut. (Sec. 102)

- **Temporary freeze of APM payment incentive thresholds.** (Sec. 114)
  - The legislation also freezes the thresholds to qualify for the incentive payments for participating in Alternative Payment Models (APM) at their current levels for two years.
  - By preventing an increase in the statutory thresholds, more physicians will be able to qualify for the five percent APM lump sum incentive payment for 2023 and 2024 and avoid disqualification from failing to meet the standard.

## 2. Provisions that benefit physicians and physician practices.

- **Provider Relief Fund** (Division H, Title III):
  - \$3 billion and new distribution requirements for the Public Health and Social Services Emergency Fund (commonly referred to as “Provider Relief Fund.”)
  - The Medicare Accelerated and Advance Payments Program is continued. A report will be submitted on the Medicare Accelerated and Advance Payments Program every 60 days until funds are expended (to House/Senate Appropriations, W&M, E&C, and Senate Finance), providing a full accounting of the federal loans provided in FY 2020 and 2021.
- **Continuing the Paycheck Protection Program (PPP) and other Small Business Support (Title III)**  
PPP Provisions
  - **Emergency Rulemaking.** Requires the SBA Administrator to establish regulations to carry out this title no later than 10 days after enactment. (Sec. 303)
  - **Additional Eligible Expenses.** Expands the allowable and forgivable uses of PPP loan proceeds to include: covered operations expenditures (payment for any software, cloud computing, and other human resources and accounting needs); covered property damage costs (costs related to property damage due to public disturbances that occurred during 2020 that are not covered by insurance); covered supplier costs (expenditures to a supplier pursuant to a contract, purchase order, or order for goods in effect prior to taking out the loan that are essential to the recipient’s operations at the time at which the expenditure was made); and covered worker protection expenditures (personal protective equipment and adaptive investments to help a loan recipient comply with federal health and safety guidelines or any equivalent State and local guidance related to COVID-19 during the period between March 1, 2020, and the end of the national emergency declaration. Allows loans made under PPP before, on, or after the enactment of this act to be eligible to utilize the expanded forgivable expenses except for borrowers who have already had their loans forgiven. (Sec. 304)
  - **Selection of Covered Period for Forgiveness.** Allows the borrower to elect a covered period ending at the point of the borrower’s choosing between 8 and 24 weeks after origination. (Sec. 306)
  - **Simplified Application.** Creates a simplified application process for loans under \$150,000; requires the SBA to create this form within 24 days of enactment. Requires the SBA to submit to the Senate and House Small Business Committees a report 45 days after enactment detailing their review and forgiveness audit plan to mitigate risk of fraud and provide monthly reviews and audit updates thereafter. (Sec. 307)

- **Expansion of Expenses Counted as Payroll Costs.** Clarifies that employer-provided group life, disability, vision, or dental insurance benefits are included in payroll costs. Applies to loans made before, on, or after the date of enactment, including the forgiveness of the loan. (Sec. 308)
- **Demographic Information.** Requires the SBA to include a voluntary demographic information section on the loan origination application for initial PPP loans and second draw PPP loans. All PPP loan applications after enactment must include this section. (Sec. 309)
- **Clarification of and Additional Limitations on Eligibility.** Clarifies that a business or organization that was not in operation on February 15, 2020 shall not be eligible for an initial PPP loan and a second draw PPP loan. (Sec. 310)

#### Second Draw Loans

- **Creates a second loan from the Paycheck Protection Program, called a “PPP second draw” loan for smaller and harder-hit businesses, with a maximum amount of \$2 million. (Sec. 311)**
  - **Eligibility.** In order to receive a Second Draw PPP loan eligible entities must: employ not more than 300 employees; have used or will use the full amount of their first PPP; and demonstrate at least a 25 percent reduction in gross receipts in the first, second, or third quarter of 2020 relative to the same 2019 quarter. Provides applicable timelines for businesses that were not in operation in Q1, Q2, and Q3, and Q4 of 2019. Applications submitted on or after January 1, 2021 are eligible to utilize the gross receipts from the fourth quarter of 2020.
  - **Eligible entities** must be businesses, certain non-profit organizations, housing cooperatives, veterans’ organizations, tribal businesses, self-employed individuals, sole proprietors, independent contractors, and small agricultural cooperatives.
  - **Ineligible entities** include entities listed in 13 C.F.R. 120.110 and subsequent regulations except for entities from that regulation which have otherwise been made eligible by statute or guidance, and except for nonprofits and religious organizations; entities involved in political and lobbying activities including engaging in advocacy in areas such as public policy or political strategy or otherwise describing itself as a think tank in any public document.
  - **Loan terms.** In general, borrowers may receive a loan amount of up to 2.5X the average monthly payroll costs in the one year prior to the loan or the calendar year. No loan can be greater than \$2 million. Businesses with multiple locations that are eligible entities under the initial PPP requirements may employ not more than 300 employees per physical location. Waiver of affiliation rules that applied during initial PPP loans apply to a second loan. An eligible entity may only receive one PPP second draw loan.
  - **Loan forgiveness.** Borrowers of a PPP second draw loan would be eligible for loan forgiveness equal to the sum of their payroll costs, as well as covered mortgage, rent, and utility payments, covered operations expenditures, covered property damage costs, covered supplier costs, and covered worker protection expenditures incurred during the covered period. The 60/40 cost allocation between payroll and non-payroll costs in order to receive full forgiveness will continue to apply.

- Guidance to prioritize underserved communities. Directs the Administrator to issue guidance addressing barriers to access to capital for underserved communities no later than 10 days after enactment.
- Application of Exemption Based on Employee. Extends existing safe harbors on restoring full-time employees and salaries and wages. Specifically, applies the rule of reducing loan forgiveness for the borrower reducing the number of employees retained and reducing employees' salaries in excess of 25 percent. Allows the SBA and Treasury Department to jointly modify any date in section 7A(d) consistent with the purposes of the PPP.

#### Miscellaneous Small Business Provisions

- **Increased Ability for PPP Borrowers to Request an Increase in Loan Amount Due to Updated Regulations.** Requires the Administrator to release guidance to lenders within 17 days of enactment that allows borrowers who returned all or part of their PPP loan to reapply for the maximum amount applicable so long as they have not received forgiveness. Additionally, this section allows borrowers whose loan calculations have increased due to changes in interim final rules to work with lenders to modify their loan value regardless of whether the loan has been fully disbursed, or if Form 1502 has already been submitted. (Sec. 312)
- **Eligibility of 501(c)(6) Organizations for Loan Under the PPP.** Expands PPP eligibility to 501(c)(6) organizations if: the organization does not receive more than 15 percent of receipts from lobbying; the lobbying activities do not comprise more than 15 percent of activities; the cost of lobbying activities of the organization did not exceed \$1 million during the most recent tax year that ended prior to February 15, 2020; and the organization has 300 or fewer employees. (Sec. 318)
- **Prohibition on Use of Loan Proceeds for Lobbying Activities.** Prohibits any eligible entity from using proceeds of the covered loan for lobbying activities, as defined by the Lobbying Disclosure Act, lobbying expenditures related to state or local campaigns, and expenditures to influence the enactment of legislation, appropriations, or regulations. (Sec. 319)
- **Oversight.** Requires the SBA to comply with GAO requests no later than 15 days, and requires the SBA to submit a detailed justification to Senate and House Small Business Committees if they are unable to comply with the request. Also requires the Secretary of the Treasury and SBA Administrator to testify within 120 days of enactment of this Act and not less than twice per year for the next two years to the Senate and House Small Business Committees. (Sec. 321)
- **Conflicts of Interest.** Requires the President, Vice President, the head of an Executive department, or a Member of Congress as well as their spouse that has received a PPP loan to disclose this status at forgiveness or 30 days thereafter. It would also prohibit the covered individuals from receiving a loan in the future. (Sec. 322)
- **Commitment Authority and Appropriations.** (Sec. 323)
  - Extends the program to March 31, 2021 and sets the authorization level for PPP at \$806.5 billion.
  - Direct appropriations as follows:
    - \$284.45 billion for PPP, including \$15 billion set aside for PPP loans (initial and second draw) issued by community financial institutions, including community development financial institutions (CDFIs) and

- minority depository institutions (MDIs), and \$15 billion for PPP loans (initial and second draw) issued by certain small depository institutions.
- \$35 billion for first-time borrowers, including \$15 billion set aside for smaller, first-time borrowers with 10 or fewer employees, or loans less than \$250,000 in low-income areas; and \$25 billion for second draw PPP loans for smaller borrowers with 10 or fewer employees, or loans less than \$250,000 in low-income areas.
    - \$25 million for the Minority Business Development Centers program under the Minority Business Development Agency (MBDA); \$50 million for PPP auditing and fraud mitigation purposes; and \$20 billion for the Targeted EIDL Advance program, of which \$20 million is for the Inspector General.
  - **Clarification of tax treatment of PPP loans.** Clarifies that gross income does not include any amount that would otherwise arise from the forgiveness of a PPP loan. Also clarifies that deductions are allowed for otherwise deductible expenses paid with the proceeds of a PPP loan that is forgiven, and that the tax basis and other attributes of the borrower's assets will not be reduced as a result of the loan forgiveness. Effective as of the date of enactment of the CARES Act. Provides similar treatment for Second Draw PPP loans, effective for tax years ending after the date of enactment of the provision. (Sec. 276)
  - **Emergency Economic Injury Disaster Loan (EIDL) Grants.** Extends covered period for Emergency EIDL grants through December 31, 2021. Allows more flexibility for the SBA to verify that Emergency EIDL grant applicants have submitted accurate information and extends time for SBA to approve and disburse Emergency EIDL grants from 3 to 21 days. (Sec. 332)
  - **Repeal of EIDL Advance Deduction.** Repeals section 1110(e)(6) of the CARES Act, which requires PPP borrowers to deduct the amount of their EIDL advance from their PPP forgiveness amount. Establishes the Sense of Congress that EIDL Advance borrowers should be made whole without regard to whether those borrowers are eligible for PPP forgiveness. Requires that the Administrator shall issue rules that ensure borrowers are made whole if they received forgiveness and their EIDL was deducted from that amount. (Sec. 333)
  - **Duplication Requirements for Economic Injury Disaster Loan Recipients.** Permits certain EIDL borrowers to also apply for a PPP loan (Sec. 341)
  - **Covered Period for New PPP Loans.** Extends the covered period for all PPP loans through March 31, 2021 and applies to loans made before, on, or after the date of enactment, including the forgiveness of such loan. (Sec. 343)
  - **Employee retention tax credit modifications: Extends and Expands the CARES Act employee retention tax credit (ERTC). (Title II, Secs. 206 and 207)**
    - Beginning on January 1, 2021 and through June 30, 2021, the provision:
      - Increases the credit rate from 50 percent to 70 percent of qualified wages
      - Expands eligibility for the credit by reducing the required year-over-year gross receipts decline from 50 percent to 20 percent and provides a safe harbor allowing employers to use prior quarter gross receipts to determine eligibility.
      - Increases the limit on per-employee creditable wages from \$10,000 for the year to \$10,000 for each quarter.
      - Increases the 100-employee delineation for determining the relevant qualified wage base to employers with 500 or fewer employees.

- Allows certain public instrumentalities to claim the credit.
  - Provides rules to allow new employers who were not in existence for all or part of 2019 to be able to claim the credit.
- Retroactive to date noted in section of 2301 of the CARES Act, the provision:
  - Provides that employers who receive Paycheck Protection Program (PPP) loans may still qualify for the ERTC with respect to wages that are not paid for with forgiven PPP proceeds.
  - Clarifies the determination of gross receipts for certain tax-exempt organizations.
  - Clarifies that group health plan expenses can be considered qualified wages even when no other wages are paid to the employee, consistent with IRS guidance.
- **Office of personnel management salaries and expenses.** Funds will be provided for services including medical examinations performed for veterans by private physicians on a fee basis. (Title V)
- **Administrative Provisions.** The aggregate charges assessed during fiscal year 2021 shall not be less than 100 percent of the amounts anticipated by the Department of Homeland Security to be necessary for its Radiological Emergency Preparedness Program for the next fiscal year. (Sec. 308)
- **Delaying Implementation of the Radiation Oncology Model under Medicare.** The bill provisions provide 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. (Sec. 133)
- **Veterans' Health Administration Medical Services.** Funding will be provided for necessary expenses including patient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans including care and treatment in facilities not under the jurisdiction of the Department, and including medical supplies and equipment bioengineering services, food services, and salaries and expenses of healthcare employees. Additionally, the Secretary of Veterans Affairs may authorize the dispensing of prescription drugs from Veterans Health Administration facilities to enrolled veterans with privately written prescriptions. (Title II)
- **Medical Facilities.** Funding will be provided for necessary expenses for the maintenance and operation of hospitals, nursing homes, domiciliary facilities, and other necessary facilities of the Veterans Health Administration, for administrative expenses in support of planning, design, project management, real property acquisition and disposition, construction, and renovation of any facility under the jurisdiction or for the use of the Department. (Title II)

### 3. Provisions that will benefit medical students.

- **Extension for community health centers, the National Health Service Corps, and teaching health centers that operate GME programs.** Includes \$4 billion in funding from 2019-2023 for community health centers and the National Health Service Corps. Also provides \$310 million in additional funding from 2021-2023 for the National Health Service Corps. Also provides additional funding, until 2023, for teaching health centers that operate graduate medical education programs. (Sec. 301)
- **Promoting Rural Hospital GME Funding Opportunity.** This section makes changes to Medicare graduate medical education (GME) Rural Training Tracks (RTT) program in order to provide greater flexibility for hospitals not located in a rural area that established or establishes a medical residency training program (or rural tracks) in a rural area or establishes an accredited

program where greater than 50 percent of the program occurs in a rural area to partner with rural hospitals and address the physician workforce needs of rural areas. (Sec. 127)

- **Medicare GME treatment of hospitals establishing new medical residency training programs after hosting medical resident rotators for short durations.** This section 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). A hospital must report full-time equivalent residents on its cost report for a cost reporting period if the hospital trains at least 1.0 full-time-equivalent residents in an approved medical residency training program or programs in such period. (Sec. 131)
- **Student Financial Assistance.** \$24,545,352,000 shall be provided for carrying out Title IV of HEA and the maximum Pell Grant that a student can be eligible for during 2021-2022 will be \$5,4325. (Title III)
- **Student Aid Administration.** \$1,853,943,000 will remain available through September 30, 2022 to carry out HEA and the Public Health Service Act provided that students can pick from multiple servicers for their student loans and provides more support for borrowers and transparency. (Title III)
- **Strategy to prioritize and expand educational and professional exchange programs with Mexico.** Assess the feasibility of fostering partnerships between universities in the United States and medical school and nursing programs in Mexico to ensure that medical school and nursing programs in Mexico have comparable accreditation standards as medical school and nursing programs in the United States by the Accreditation and Standards in Foreign Medical Education, in addition to the Accreditation Commission For Education in Nursing, so that medical students can pass medical licensing board exams, and nursing students can pass nursing licensing exams, in the United States. (Sec. 1904)
- **General Provisions.** \$50,000,000 for public service loan forgiveness under the normal terms. (Sec. 311)
- **Health Workforce.** \$50,000,000 will be available for grants to public institutions of higher education to expand or support graduate education for physicians provided by such institutions. Priority will be given to public institutions located in states with a projected primary care provider shortage in 2025 and are limited to public institutions in states in the top quintile of states with a projected primary care provider shortage in 2025. (Title II)
- **Distribution of additional residency positions.** This section supports Medicare physician workforce development by providing for the distribution of 1,000 additional Medicare-funded graduate medical education (GME) residency positions. Not less than 10 percent of the aggregate number of these new positions will be given to each of the following categories: rural hospitals, hospitals that are already above their Medicare cap for residency positions, hospitals in states with new medical schools or new locations and branch campuses, and hospitals that serve Health Professional Shortage Areas. However, a hospital may not receive more than 25 additional full-time equivalent residency positions. (Sec. 126)
- **Higher Education Emergency Relief Fund.** Funding will be provided to defray expenses associated with COVID-19, to carry out student support activities authorized by the HEA that address needs related to COVID-19, and to provide financial aid grants to students which may be used for any component of the student's cost of attendance or for emergency costs that arise due to COVID-19 including tuition, food, housing, health care, or childcare. Additional funding will be provided for Historically Black Colleges and Universities, Tribal Colleges and Universities, Hispanic Serving Institutions, and certain other institutions. (Sec. 314)

- **FAFSA Simplification.** This provision makes it easier to apply for federal aid and makes that aid predictable. This provision provides a formula for determining the amount of need that a student has including tuition, room and board, dependents, book stipends, transportation, and personal expenses. It also considers parents and spouses potential financial contributions or lack thereof. (Title VII)
- **Emergency Financial Aid Grants.** Students receiving qualified emergency financial aid grants after March 26, 2020 will not have those grants included in their gross income for purposes of the Internal Revenue Code. (Sec. 277)

#### 4. Provisions on surprise billing. (See Division BB, Title I)

##### **General structure: patient protections against surprise medical bills and determining out-of-network provider payments:**

- For services provided by a nonparticipating provider (e.g., physician) at a participating facility or at a nonparticipating emergency facility:
  - Providers may not bill beyond allowed cost-sharing amount (this amount is based on the recognized amount).
  - There must be an initial payment (determined by the plan) directly from the plan to the provider, or a notice of a denial, within 30 days from when the provider transmits the bill to the plan.
  - If the provider is not satisfied with the payment from the plan, they may begin a 30-day open negotiation period.
  - If an agreement cannot be reached in the open negotiation period, the plan or provider has 4 days to notify other party and Secretary of HHS that they are initiating the Independent Dispute Resolution (IDR) process.
- IDR Structure:
  - The provider or plan have a 30-day window from the day the provider “receives an initial payment or notice of denial of payment” from the plan to initiate the open negotiation period.
  - If the provider and plan cannot reach an agreement by the end of the 30-day open negotiation period, the plan or provider may initiate IDR during the 4-day period after the open negotiation period ends.
  - IDR is initiated when the provider or plan submits a notification to the other party and Secretary of HHS.
  - Within three-business days following the date the IDR was initiated, the provider and plan jointly select a certified IDR entity.
  - The parties may continue negotiating during the 30-day IDR process, and may agree on an amount of payment before the end of the IDR process (in such case both parties will share the cost to compensate the IDR entity).
  - Within 10 days of IDR entity being selected, the parties must submit final offers, information requested by IDR entity, and any information (except and noted below) the parties would like related to their offers.
  - Within 30 days, the IDR entity selects one of the offers submitted and must consider:
    - Offers by both parties.
    - Qualifying payment amount (for the same service in the same geographic region)
    - Circumstances:
      - Training, experience, quality, and outcomes measurements.



- Market shares of parties.
  - Acuity of patients/complexity of cases.
  - Teaching status, case mix, scope of services of facility.
  - Good faith efforts by parties to contract and contracting rate history from last four years.
- The provider and plan may also submit other information relating to such an offer submitted by either party.
  - The IDR entity cannot consider usual and customary rates or billed charges.
  - The IDR entity also cannot consider the payment rates by public payors, including Medicare, Medicaid, CHIP, and Tricare rates.
- The party whose offer was not chosen by the IDR entity, pays the costs of IDR.
- Payment must be made to the provider within 30 days of the IDR entity's determination.
- Batching is allowed for claims submitted within a 30-day period that meet the following:
  - Services furnished by same provider or facility.
  - Services provided to patients under the same plan.
  - Services are for treatment of similar conditions.
  - The Secretary to specify criteria and may allow exceptions to 30-day period.
- The party that initiated IDR cannot initiate it again with the same party and for same services for 90 days. However, once the 90-day period is up, the party may submit (appropriately batched) claims from that 90-day period to IDR.
- HHS to publicly report on IDR use and outcomes, including the identity of health plans, providers, and facilities that use the process. The Secretary must ensure that there is no release of confidential or privileged information.
- Parties that use the IDR process will be required to pay an administrative fee to the Secretary each year. (The amount to be established by Secretary)
- Definitions:
  - Recognized amount:
    - Amount under specified state law (as applied to plans regulated by state law);
    - Qualifying payment amount; or
    - If the state has an All-payer model agreement, then the amount the state approves.
  - Qualifying payment amount:
    - For 2022, the median of the contracted (i.e., in-network) rates as determined by all plans of a plan sponsor, or all coverage offered by the health insurance issuer, in the same "insurance market" on 1/31/19, increased by the consumer price index for all urban consumers (CPIU).
    - In 2023, based on previous year + CPIU.
    - For new plans: Secretary determines methodology.
    - Insufficient info to determine: Plan to use database allowed by Secretary.
  - Out of network rate:
    - If specified in state law, then the state determines rate.
    - If no state law, then either agreed upon amount between the provider and plan or the IDR-determined amount.
    - If state law has All-payer model agreement, then that amount.
  - Emergency services definition includes services provided after patient is stabilized if certain conditions are met.

- Specified state law: a state law that provides for method to pay providers in these situations for service provided.
- Insurance market is one of the following:
  - The individual market;
  - The large group market;
  - The small group market; or
  - A self-insured group health plan, other self-insured group health plans.

**Notice and consent provisions for balance billing of non-emergency services by non-participating providers at participating facilities):**

- Non-participating providers at participating facilities may not bill a patient more than the cost-sharing requirements or balance bill the patient unless the notice and consent requirements are met.
- Notice and consent requirements are met if:
  - The patient is provided written notice and consent 72 hours in advance of appointment.
  - Documents provided to patients must include a good faith estimate of the costs of the services (the language specifies this advanced notice does not constitute a contract).
  - Must also provide a list of in-network providers at the facility and information regarding medical care management, such as prior authorization.
- At participating facilities, the notice and consent exception does not apply to out-of-network providers of radiology, pathology, emergency, anesthesiology, diagnostic, and neonatal services; assistant surgeons, hospitalists, intensivists, and providers offering services when no other in-network provider is available.
- The Secretary may apply civil monetary penalties of up to \$10,000 but may provide a hardship exemption or waive the penalties if the provider did not knowingly violate law and corrects with interest.

**Provider Directories**

- By 2022, plans must:
  - At least every 90 days, verify and update directories.
  - Establish procedure for removing providers unable to verify.
  - Update provider information within 2 business days of receiving it from a provider.
  - Respond to request regarding network status of provider within 1 business day and retain communication for 2 years.
  - Retain website directory with contracted providers and directory information (name, address, specialty, number, digital contact information).
  - Post information on balance billing protections including, if provided under state law, the amount providers/facilities may charge, and appropriate federal and state agency contacts to report violations.
- By 2022, providers and facilities must:
  - Have a practice in place to ensure timely provision of directory information to a plan.
  - At minimum, the provider must submit to the plan:
- When the provider begins a network agreement with a plan with respect to certain coverage.
- When the provider terminates an agreement.
- Any material changes to the content of provider directory information.
- Any other time determined appropriate by Secretary.

- If a patient relies on erroneous directory information, the plan cannot impose a cost-sharing amount greater than in-network rates and it must count toward the patient’s in-network out-of-pocket-maximum and in-network deductible.
  - It is expected that the provider will be paid the previously contracted rate (assuming a contract was previously in place).
  - If a provider submits a bill to an enrollee in excess of in-network cost sharing and enrollee pays, provider must refund with interest.

#### **All payer claims databases (APCDs)**

- Authorizes HHS to make one-time grants to states to establish an APCD or improve an existing one. The grants will be offered for a period of three years for total of \$2.5 million.
- States receiving grants will allow access for researchers and entities (including health care providers and plans) for purposes of quality improvement or cost-containment (pending application and approval).
  - HHS may prioritize applicants that will work with other states APCDS to establish a single application for access to data across multiple states.
  - HHS may prioritize applications submitted by states that will implement format for self-insured group health plans (Sec. 735 of ERISA).
- The Secretary will create an advisory committee to establish a standardized reporting format for reporting by self-insured plans to submit claims to APCDs. Format to be established 1 year after enactment.

#### **Reports**

- HHS report with the Federal Trade Commission and U.S Attorney General on effects of act on integration, costs, and access.
- Government Accountability Office (GAO) report on impact of surprise billing changes on networks, access, premiums, out-of-pocket costs.
- GAO report on network adequacy.
- GAO report on IDR and potential financial relationships.

#### **Other provisions**

- Legislation addresses surprise bills for air ambulances.
- Dispute resolution for uninsured:
  - HHS Secretary will establish a dispute resolution process by July 21, 2021 for when an uninsured patient’s bill is “substantially in excess” of good faith estimate.
  - “Uninsured” means that a patient does not have “benefits” for the item or service.
- Continuity of care:
  - If provider contract is terminated, a “continuing patient” can continue for either 90 days or the date when no longer a continuing patient, whichever is earlier.
  - The provider must continue under same terms and conditions.
    - This provision does not apply to for-cause terminations (provider fails to meet quality standards or commits fraud).
- Price comparison tool: A plan must offer price comparison guidance by phone and make tool available on internet that allows patients to compare cost-sharing amounts for specific service/item.
- HHS must issue a proposed rule implementing section 2706(a) of the Public Health Service Act regarding protections against provider discrimination within six months of implementation, and a final rule six months after the 60-day comment period of the proposed rule.

- Insurance cards to include deductible, out-of-pocket maximum, phone number, and website for assistance.
- A plan must provide an advanced explanation of benefits in advance of the service containing the following information:
  - Whether the provider or facility is participating and, if so, the contracted rate.
  - If the provider or facility is out-of-network:
    - Information on how patient can find info on contracted physicians at facility;
    - The good faith estimate from the provider, if applicable;
    - A good faith estimate of the amount the plan is responsible for paying;
    - A good faith estimate of cost-sharing based on provider's estimate and the amount to be applied to the patient's out-of-pocket maximum and deductible;
    - A disclaimer that coverage is subject to medical management requirements, if applicable;
    - A disclaimer that the information is only an estimate and may be subject to change;
    - A statement that the patient may seek care from a participating provider or at facility.
- **Prior Authorization.** If a group health plan, or a health insurance issuer offering group health insurance coverage, provides or covers any emergency services the plan or issuer shall cover emergency services without the need for any prior authorization, regardless of whether the health care provider furnishing the services is a participating provider or a participating emergency facility. (Sec. 102)
- **Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations.** A group health plan or a health insurance issuer offering group health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants or beneficiaries in the plan or coverage the following: any applicable deductible, any out-of-pocket maximum limitation, a phone number and website through which consumer assistance may be sought. (Sec. 107)
- **Consumer protections through health plan requirements for fair and honest advance cost estimate.** An advanced explanation of benefits must be provided, not later than 1 business day after the date on which the plan or coverage receives such notification, (or in the case such item or service was so scheduled at least 10 business days before such item or service is to be furnished or in the case of a request made to such plan or coverage by such participant or beneficiary 3 business days) notification including whether or not the provider is a participating provider and the contracted rate under the plan for their item or service, information regarding covered providers, good faith estimates for the amount the health plan is responsible for, a good faith estimate of the amount of any cost sharing that the participant is responsible for, a good faith estimate of the amount that the beneficiary has incurred toward meeting the limit of their financial responsibility, a disclaimer, and other appropriate information. (Sec. 111)
- **Protecting patients and improving the accuracy of provider directory information.** Additional provider directory information must be added to improve accuracy and protect patients including establishing a verification process, response protocol, and a more detailed database. (Sec. 116)

## 5. Provisions that expand access to telehealth.

- **Rural Health—Veterans.** \$1,000,000 will be provided for grants for the purchase and implementation of telehealth services, including pilots and demonstrations on the use of electronic health records to coordinate rural veterans care between rural providers and the Department of Veterans Affairs electronic health record system. (Title II).
- **Connecting Minority Communities.** Establishes an Office of Minority Broadband Initiatives at the Telecommunications and Information Administration (NTIA) to focus on broadband access and adoption at Historically Black colleges or universities, Tribal colleges and universities, and other Minority-serving institutions, including the students, faculty, and staff of such institutions and their surrounding communities. (Sec. 902).
- **Federal Communications Commission (FCC) COVID-19 Telehealth Program.** Additional \$250,000,000 in appropriations for FCC Telehealth program established under CARES which provides grants for improved telehealth access. (Sec. 903).
- **Broadband Benefit.** Provides subsidy to qualifying low-income families (under Lifeline Program) of \$50 per month for their internet service and for families on Tribal lands it would be up to \$75 in an effort to ensure access to internet service and decrease the digital divide. This discount will be available until 6 months following the date on which the public emergency ends. (Sec. 904).
- **Grants for Broadband Connectivity.** \$1.3 billion for two grants to improve broadband connectivity and access, including improving broadband infrastructure and telehealth access. \$1 billion, is directed to tribal governments to be used not only for broadband deployment on tribal lands, but also telehealth, distance learning, broadband affordability, and digital inclusion. The second is a \$300 million broadband deployment program to support broadband infrastructure deployment to areas lacking broadband, especially rural areas. (Sec. 905).
- **FCC Activities.** \$65 million to the FCC to create broadband data maps required under the Broadband DATA Act. \$1.9 billion for the FCC’s Secure and Trusted Reimbursement Program. (Sec. 906).
- **Mental health telehealth services.** Provides for access to mental health telehealth services for Medicare beneficiaries regardless of geographic or originating location, provided the physician has seen the patient in the previous six months. (Sec 123 of Division CC).
- **AI Provisions**
  - AI in Government Act of 2020 (Division U, Title I)
    - Codifies the AI Center of Excellence within the General Services Administration to advise and promote the efforts of the federal government in developing innovative uses of artificial intelligence (AI) and competency in the use of AI in the federal government.
  - Other AI Provisions
    - Requires the Secretary of Energy to carry out a research program in artificial intelligence and high-performance computing focused on developing tools to solve big data challenges associated with veterans’ health care. (Sec. 9008)
    - Seedling investment in next-generation microelectronics in support of artificial intelligence. (Sec. 502)
    - Assessment of critical technology trends relating to artificial intelligence, microchips, and semiconductors and related matters. (Sec. 604)

## 6. Other noteworthy provisions.

- **Medicaid:**
  - Eliminates disproportionate share hospital reductions for fiscal years 2021 through 2023.
  - Provides coverage for certain non-emergency medical transportation to and from providers.
  - Promotes 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.
  - Extends community mental health services demonstration program until FY 2024.
- **Medicare Extenders (Division CC):**
  - Medicare work geographic index floor extended to January 1, 2024. (Sec. 101)
  - Funding for quality measure endorsement, input, and selection extended. (Sec. 102)
    - Additional \$66 million to CMS for quality measure selection to October 1, 2023
  - Funding outreach and assistance for low-income programs extended to October 1, 2023. (Sec. 103)
    - Additional \$50 million in funding for each fiscal year 2021-2023.
  - Medicare patient IVIG access demonstration project extended to January 1, 2024. (Sec. 104)
    - Allowing up to 2500 additional Medicare patients to enroll.
  - Independence at Home medical practice demonstration program extended to January 1, 2024.
    - Expands size to 20,000 beneficiaries.
- **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. (Sec. 302)
- **Provisions Impacting Rural Health Services**
  - The bill 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. (Sec.125)
  - Extension of the Rural Community Hospital Demonstration (RCHD) by five years. (Sec 128)
  - Provision 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. (Sec. 130).
  - Allows rural health clinics and federally qualified health centers 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. (Sec. 132)

- **Improving awareness of vaccines and 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 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. (Sec. 311)
- **Additional Vaccine Funding.** Additional \$8.75 billion to CDC for activities to plan, prepare 16 for, promote, distribute, administer, monitor, and track 17 coronavirus vaccines to ensure broad-based distribution, 18 access, and vaccine coverage (Title III)
- **Additional Public Health Emergency Fund Funding.** Additional \$23 billion to prevent, prepare for, and respond to coronavirus, domestically or internationally, including the development of necessary countermeasures and vaccines, prioritizing platform-based technologies with U.S.-based manufacturing capabilities, the purchase of vaccines, therapeutics, diagnostics, necessary medical supplies, as well as medical surge capacity, and other preparedness and response activities.
- **Provisions Surrounding Health Care Price Transparency (Title II)**
  - Increases transparency by removing gag clauses on price and quality information. (Sec. 201)
    - 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.
  - Disclosure of direct and indirect compensation for brokers and consultants to employer-sponsored health plans and enrollees in plans on the individual market. (Sec. 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.
  - Includes new provisions designated to strengthen parity in mental health and substance use disorder benefits. (Sec 203)
    - 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.
    - Requires the Secretaries of HHS, Labor, and 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. HHS to issue corrective action for plans not in compliance.
  - Adds provisions regarding reporting on pharmacy benefits and drug costs. (Sec. 204)

- **Expanding Capacity for Health Outcomes.** Grants will be awarded to eligible entities in order to evaluate, develop, and, as appropriate, expand the use of technology-enabled collaborative learning and capacity building models. (Sec. 313)
- **Chronic Disease Prevention and Health Promotion.** Includes \$1,021,714 million.
- **Evidence-Based Strategies for Obesity Prevention Programs.** 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. (Sec. 312)
- **Public Health Data System Modernization.** 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. (Sec 314)
- **Native American Suicide Prevention.** 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. (Sec. 315)
- **Reauthorization of the Young Women’s Breast Health Education and Awareness Requires Learning Young Act of 2009.** Provides \$9,000,000 for each fiscal year from 2022 through 2026 for the Young Women’s Breast Health Education and Awareness Requires Learning Young Act of 2009. (Sec. 316)
- **Reauthorization of school-based health centers.** School-based health centers have been granted funding through 2026. (Sec. 317)
- **Child Nutrition Services.** Provides \$25.1 billion in required mandatory funding for child nutrition programs, which is \$1.5 billion above the FY 2020 enacted level, to provide free or reduced-price school lunches and snacks for children who qualify for the program. Also provides approximately \$552 million for the Summer Food Service Program to ensure low-income children continue to receive nutritious meals when school is not in session and provides \$42 million for the Summer EBT program, \$30 million for school kitchen equipment grants, and \$21 million for the WIC farmers market nutrition program. (Division A, Title IV)
- **WIC Program.** Provides \$6 billion in discretionary funding for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), which fully funds participation this year; includes \$90 million for the breastfeeding counselor program. (Division A, Title IV)
- **Supplemental Nutrition Assistance Program.** Provides for \$114 billion in required mandatory spending for SNAP, which fully funds participation as well as the SNAP enhanced allotments authorized by the Families First Act and includes \$998,000 that may be used to provide nutrition education services to State agencies and Federally Recognized Tribes participating in the Food Distribution Program on Indian Reservations. Increases the monthly SNAP benefit level by 15% based on the June 2020 Thrifty Food Plan through June 30, 2021. Excludes 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 have an expected family contribution of zero. (Division A, Title IV)
- **Emergency Rental Assistance (Title V, Subsection A)**
  - Appropriations for Emergency Rental Assistance (Sec. 501)
    - Appropriates \$25 billion through Treasury to provide to state and local government entities, including \$400 million for U.S. territories and \$800 million for Native Americans, Alaska Natives, and Native Hawaiians (with the District of Columbia treated as a state). Funds would be required to be allocated to state and local governments (“grantees”) within 30 days of enactment.



- Eviction Moratorium Extension (Sec. 502)
  - Extension of the CDC eviction moratorium until January 31, 2021.
- **Skilled Nursing Facilities.** Improves measurements under the skilled nursing facility value-based purchasing program. Allows Secretary to add up to 10 quality measures for facilities with more than the required minimum number of cases. (Sec 111)
- **Permitting direct payment to physician assistants under Medicare.** This section allows direct payment under the Medicare program to physician assistants for services furnished to beneficiaries before January 1, 2022. (Sec. 403.)
- **Maternal and Child Health.** \$975,284,000 has been provided to carry out the PHS Act with respect to maternal and child health. (Title II)
- **Family Planning.** \$286,479,000 to carry out title X of the PHS Act to provide voluntary family planning projects provided that the funding is not provided for abortions and that pregnancy counseling is nondirective. (Title II)
- **Centers for Disease Control and Prevention Immunization and Respiratory Diseases.** \$448,805,000 for carrying out the Immigration and Nationality Act and Refugee Education Assistance Act, with respect to immunization and respiratory diseases. (Title II)
- **Extension of support for current health professions opportunity grants.** Provides \$3,600,000 to HHS for administrative funding to carry out grants made under section 2008(a) of the Social Security Act and for research, evaluation, and reporting, and for necessary administrative expenses to carry out these activities. (Sec. 304)
- **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.** The provision permits an occupations therapist to conduct the initial assessment visit and to complete the comprehensive assessment for home health services for an individual under title XVIII of the Social Security Act. (Sec. 115)
- **Determination of out-of-network rates to be paid by health plans; independent dispute resolution process.** During the 30-day period beginning on the day the provider or facility receives an initial payment or a notice of denial of payment from the plan or coverage regarding a claim for payment they may initiate open negotiations between the provider and the plan for purposes of determining an amount for payment for such item or service. If the negotiations fail, the parties may access an independent dispute resolution process. (Sec. 103)
- **FDA Related Provisions (Title III, Subtitle C)**
  - Extending Rare Pediatric Disease Priority Review (Sec. 321)
    - Allows 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.
  - Conditions for Use of Biosimilars (Sec. 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.
  - Orphan Drug Clarification (Sec. 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.
  - Labeling of Certain Generic Drugs (Sec. 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.
  - Biological Product Patent Transparency (Sec. 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.
- **Administrative Provisions.** The funding appropriated to the Department of Veterans Affairs for medical services may be used to provide fertility counseling and treatment using assisted reproductive technology to a covered veteran or the spouse of a covered veteran, or adoption reimbursement to a covered veteran. (Sec. 234)
- **Administrative Provisions.** \$660,691,000 shall be made available for the Department of Veterans Affairs for fiscal year 2021, in this or any other designated Act will be used for gender specific care for women. (Sec. 252)
- **Administrative Provisions.** Of the unobligated balances available to the Department of Veterans Affairs from the Coronavirus Aid, Relief, and Economic Security Act for “Veterans Health Administration, Medical Services”, up to \$100,000,000 may be transferred to “Veterans Health Administration, Medical Community Care” provided, that funds transferred pursuant to this section shall be used to provide a onetime emergency payment to existing State Extended Care Facilities for Veterans to prevent, prepare for, and respond to COVID-19. (Sec. 517)
- **Veterans Electronic Health Record System.** \$2,627,000,000 for activities related to the implementation, preparation, development, interface, management, rollout, and maintenance of the Veterans Electronic Health Record System. (Title II)
- **Preventing Online Sales of E-Cigarettes to Children.** Amends current law—the Jenkins Act—to curb online sales of e-cigarettes to minors by bringing such sales under the federal regulations applying to the sale and state taxation of tobacco products, by extending the current definition of a “cigarette” to include any “electronic nicotine delivery system,” such as an e-cigarette. 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 electronic nicotine delivery systems. (Division FF, Title VI, Sec. 601-603)
- **Firearm Injury and Mortality Prevention Research.** Provides \$12.5 million to the CDC, the same amount as the 2020 enacted level, to specifically support firearm injury and mortality prevention research, and another \$12.5 million to the NIH for such research.
- **Mental Health.** Provides \$1.76 billion to provide increased mental health services and support for programs under SAMHSA, including funding for the Community Mental Health Services Block Grant; Certified Community Behavioral Health Clinics; evidence-based crisis systems; early interventions for persons not more than 25 years old at clinical high risk of developing a first episode of psychosis; evidence-based programs to address the needs of individuals with early serious mental illness.
- **Substance Use Treatment and Prevention.** Provides \$3.78 billion for substance use treatment and prevention to SAMHSA, including \$1.5 billion for the State Opioid Response Grants Program, which includes \$50 million for Indian Tribes or tribal organizations; sets aside 15% of the remaining amount for the states with the highest mortality rate related to opioid use disorders; no more than 2% for federal administrative expenses, training, technical assistance, and evaluation. Of the remaining amount, funds are to be allocated to states, territories, and the

District of Columbia according to a formula using national survey results that the Secretary determines are the most objective and reliable measure of drug use and drug-related deaths. Such formula shall be submitted to the Committees on Appropriations of the House and Senate not less than 15 days prior to publishing a funding opportunity announcement. Each state, including the District of Columbia, shall receive not less than \$4 million. Provides an additional \$208.2 million to SAMHSA for substance abuse prevention; \$128 million for health surveillance and program support; \$31.4 million to supplement funds available to carry out national surveys on drug abuse and mental health, to collect and analyze program data, and to conduct public awareness and technical assistance activities.

- **Supplemental Mental Health and Substance Use Treatment and Prevention.** Provides \$4.25 billion to SAMHSA as part of emergency coronavirus funding, as follows (Division M, Coronavirus Response and Relief Supplemental Appropriations Act):
  - \$1.65 billion for the Substance Abuse and Prevention Treatment Block Grant;
  - \$1.65 billion for the Mental Health Services Block Grant;
  - \$600 million for Certified Community Behavioral Health Clinics;
  - \$50 million for suicide prevention programs;
  - \$50 million for Project AWARE to support school-based mental health for children;
  - \$240 million for emergency grants to States; and
  - \$10 million for the National Child Traumatic Stress Network;
  - Not less than \$125 million of funds provided to SAMHSA must be allocated to tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes across a variety of programs.
- **COVID–19 Consumer Protection Act.** Protects consumers during the COVID-19 public health emergency against deceptive acts or practice related to the treatment, cure, prevention, mitigation, or diagnosis of COVID–19 or a government benefit related to COVID–19. (Division FF, Title XIV)
  - Provides that not less than \$125 million of funds provided to SAMHSA must be allocated to tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes across a variety of programs.
- **Opioid Abuse Reduction Grants (DOJ).** Provides \$394 million for comprehensive opioid abuse reduction activities, including as authorized under CARA and for the following programs, to address opioid, stimulant, and substance abuse reduction: Drug courts; mental health courts and adult and juvenile collaboration program grants; residential substance abuse treatment for state prisoners; a veteran's treatment courts program; prescription drug monitoring program; and a comprehensive opioid, stimulant, and substance abuse program. (Division B, Title II)
- **Competitive Grants for Law Enforcement Drug Investigations (DOJ).** Provides \$15 million for competitive grants to state law enforcement agencies in states with high seizures of precursor chemicals, finished methamphetamine, laboratories, and laboratory dump seizures, to be used for investigative purposes to locate or investigate illicit activities. Also provides \$35 million for competitive grants to state law enforcement agencies in states with high rates of primary treatment admissions for heroin and other opioids; such funds are to be used for investigative purposes to locate or investigate illicit activities. (Division B, Title II)
- **Office of National Drug Control Policy (ONDCP).** Rejects Administration's proposed transfer or elimination of ONDCP grant programs and includes \$290 million for the High Intensity Drug Trafficking Areas Program, an increase of \$5 million above FY 2020 and \$102 million for the Drug-Free Communities Program, an increase of \$750,000 above FY 2020. (Division E, Title II)

- **Law Enforcement Oversight and Reform.** Directs the Attorney General to establish a Task Force on Law Enforcement Oversight, with up to \$5 million to be provided across DOJ accounts. The Task Force is to be comprised of representatives from multiple Justice Department components, in consultation with law enforcement, labor, and community-based organizations to coordinate the detection and referral of complaints regarding incidents of alleged law enforcement misconduct. Also includes \$5,000,000 for the development and deployment of databases to track excessive use of force and officer misconduct, to be developed in consultation with State and local law enforcement agencies, community organizations, and advocacy groups, including those that advocate for the preservation of civil liberties and civil rights. (Division B, Title II)
- **Firearms Background Check System.** Provides \$85 million for grants to states to upgrade criminal and mental health records for the National Instant Criminal Background System (NICS). (Division B, Title II)
- **Public Health Data System Modernization.** Requires the Secretary, acting through the CDC, to: (1) conduct activities to expand, modernize, improve, and sustain public health data systems used by CDC, including with respect to interoperability and improvement of such systems as it relates to preparedness for a public health emergency; and (2) award grants or cooperative agreements for the expansion and modernization of public health data systems. In carrying out this section, the Secretary shall, as appropriate and in consultation with the Office of the National Coordinator for Health Information Technology (ONC), designate data and technology standards for public health data systems. The Secretary may develop and utilize public-private partnerships for technical assistance, training, and related implementation support on the expansion and modernization of electronic case reporting and public health data systems. The bill authorizes to be appropriated \$100 million each year, from FY 2021 through FY 2025. (Sec. 2823)
- **Public-Private Partnership for Health Care Waste, Fraud, and Abuse Detection.** The bill codifies the public-private partnership that includes health plans, federal and state agencies, law enforcement agencies, health care anti-fraud organizations, and allows inclusion of any other entity determined appropriate by the Secretary of HHS for purposes of detecting and preventing health care waste, fraud, and abuse. The bill directs the Secretary of HHS to award a contract for use of a trusted third party to carry out the duties of the partnership. (Sec. 124)
- **Continuation of Certain Transitional Home Infusion Therapy Services.** The bill continues 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. (Sec. 117)
- **Waiving Budget Neutrality for Oxygen under Medicare.** 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. (Sec. 121)
- **Waiving Coinsurance of Certain Colorectal Cancer Screening Tests under Medicare.** The bill gradually eliminates cost-sharing for Medicare beneficiaries with respect to colorectal cancer screening tests. (Sec. 122)