

Title I – Medicare Provisions

Subtitle A – 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.

Subtitle B – Other Medicare Provisions

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 low-income 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.

Title II – 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.

Title III – 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.

Title IV – 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.

Title V – Miscellaneous

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.