

December 22, 2020

Detailed Summary of Health Provisions in Consolidated Appropriations Act, 2021

Legislation includes helpful changes to Provider Relief Fund, elimination of some Medicaid DSH cuts and Medicare sequester cuts, and provisions to address surprise medical bills, among other issues

The House and Senate last night approved the [Consolidated Appropriations Act, 2021](#). The legislation includes roughly \$900 billion in COVID-19 relief, including a number of provisions beneficial to hospitals and health systems, and \$1.4 trillion in spending that will fund the federal government for fiscal year 2021. President Trump is expected to sign the legislation.

AHA Take: In a statement, AHA President and CEO Rick Pollack said, “America’s hospitals and health systems, and our heroic front-line caregivers, appreciate the continued support from Congress as our ongoing battle with the COVID-19 pandemic enters its second year. While this legislation is welcome news for patients and their families, and the hospitals that provide them and their communities with essential services, there is no question that additional relief will be necessary as we continue to battle the pandemic.” [View AHA’s full statement that was shared with the media yesterday detailing its comments on specific provisions included in the legislation.](#)

A detailed summary of provisions important to hospitals and health systems included in the 5,500-page legislative package follows.

Key Takeaways

Among other health care-related provisions, the package:

- Provides helpful flexibility in Provider Relief Fund (PRF) reporting, including allowing the use of “budgeted-to-actual” lost revenue calculation and transfer of “targeted distributions” within a health system.
- Adds \$3 billion to the PRF.
- Eliminates \$4 billion in Medicaid DSH cuts that were scheduled to go into effect in FY 2021 and further eliminates the DSH cuts in the two subsequent years.
- Eliminates the 2% Medicare sequester cuts through March of 2021.
- Protects patients from receiving surprise medical bills.
- Lifts the cap on Medicare-funded physician residency positions in teaching hospitals by 1,000, effective in FY 2023.
- Provides billions in funding for COVID-19 vaccines, testing and contact tracing.
- Establishes a new Rural Emergency Hospital Medicare designation.
- Provides approximately \$3 billion in increased payments for physician services under the Medicare Physician Fee Schedule for 2021.
- Extends the availability of funds provided to states and localities by the Coronavirus Relief Fund through December 2021.

Notably, the legislation does not contain harmful provisions related to the Occupational Safety and Health Administration.

HIGHLIGHTS OF PROVISIONS IMPORTANT TO HOSPITALS AND HEALTH SYSTEMS

The legislation includes a number of provisions important to hospitals and health systems. We have organized the major provisions in the following sections:

- [COVID-19 Provisions](#)
- [Surprise Medical Billing and Transparency Provisions](#)
- [Medicare Provisions](#)
- [Medicaid Provisions](#)
- [Rural Health Provisions](#)
- [Prescription Drugs](#)
- [Additional Public Health Provisions](#)
- [Parity in Behavioral Health and Substance Use Disorder Benefits](#)
- [Extenders](#)
- [Appropriations Provisions](#)
- [Other Provisions](#)

COVID-19 PROVISIONS

Provider Relief Fund (PRF). The legislation includes helpful changes to the PRF reporting guidelines. Specifically, as requested by the AHA, it would allow providers to calculate lost revenues using the Frequently Asked Questions guidance released by the Department of Health and Human Services (HHS) in [June 2020](#), which specified that providers could use “any reasonable method” for the calculation. The legislation clarifies that such methods include the difference between budgeted and actual revenue if such budget had been established and approved prior to March 27, 2020.

In addition, the legislation clarifies that health systems may move all PRF distributions within their system. Specifically, a parent organization may allocate any or all of its subsidiary organizations’ PRF payments, including “targeted distributions,” among subsidiary eligible health care providers of the parent organization.

Finally, the legislation also includes \$3 billion in new dollars for the PRF.

Medicare Physician Fee Schedule Payments. The legislation provides a 3.75% increase in payments under the Physician Fee Schedule for 2021, or about \$3 billion in increased payments for physician services.

Medicare Sequester Cuts. The legislation eliminates the Medicare sequester cuts through the first three months of 2021. The 2% cut to all Medicare payments was supposed to resume Jan. 1, 2021.

Vaccines and Therapeutics. The legislation includes approximately \$30 billion for the federal government to assist with the purchase and administration of COVID-19 vaccines and COVID-19-related therapeutics. This includes:

- \$8.75 billion to the Centers for Disease Control and Prevention (CDC) to plan, prepare for, administer, monitor and track coronavirus vaccines and ensure broad

distribution and access. Of this amount, \$4.5 billion must be allocated to states, localities and territories, with \$1 made available within 21 days of enactment. In addition, \$300 million must be allocated to high risk and underserved populations, including racial and ethnic minorities and rural communities.

- \$19.7 billion to the Biomedical Advanced Research and Development Authority (BARDA) for the manufacturing and procurement of vaccines, therapeutics and diagnostics, as well as the ancillary supplies needed to support them.
- \$3.25 billion to support procurement of vaccines, therapeutics, diagnostics and related supplies to the Strategic National Stockpile.

COVID-19 Testing and Tracing. The legislation includes \$22 billion that will be sent directly to states for testing, tracing and COVID-19 mitigation programs. This includes \$2.5 billion for a targeted effort to improve testing and contract tracing in underserved populations.

National Institutes of Health (NIH). The legislation provides NIH with \$1.25 billion to support research and clinical trials related to the long-term effects of COVID-19, as well as the NIH's Rapid Acceleration of Diagnostics program.

Coronavirus Relief Fund. The legislation extends the availability of funds provided to states and localities by the Coronavirus Relief Fund through December 2021.

Child Care. The legislation provides an additional \$10 billion for child care providers through the Child Care and Developmental Block Grant program with the intent of both helping the child care providers remain open, as well as providing care for dependents of essential workers.

SURPRISE MEDICAL BILLING AND TRANSPARENCY PROVISIONS

Surprise Medical Billing Patient Protections. Beginning Jan. 1, 2022, patients will be protected from surprise medical bills that could arise from out-of-network emergency care, 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. Patients will be required to pay only the in-network cost-sharing amount, which will be determined through a formula established by the HHS Secretary and will count toward the patient's health plan deductible and out-of-pocket cost-sharing limits. Providers will not be permitted to balance bill patients beyond this cost-sharing amount. Both providers and health plans will be required to inform patients about these protections. Violations could result in state enforcement action or federal civil monetary penalties of up to \$10,000.

In certain instances, an out-of-network provider still may be permitted to bill a patient more than the in-network cost-sharing amount for care. However, the provider would need to give the patient notice of their network status and an estimate of charges, as well as obtain the patient's written consent, prior to the delivery of care.

Provider Reimbursement and Independent Dispute Resolution (IDR) Process.

Health plans will be required to reimburse out-of-network providers for the services subject to surprise medical billing protections (or issue a denial notice) within 30 days, and patients will be shielded from any payment disputes that may arise between plans and providers.

The amount an insurer pays the provider may be subject to state law or policy, such as in states with an all-payer rate model or in states with laws regulating how certain out-of-network claims or surprise medical bills are handled. In states where such laws are in effect, state laws will continue to apply to state-regulated products, and the reimbursement and IDR provisions of this legislation will apply only to health plans regulated by the federal government, such as those regulated under the Employee Retirement Income Security Act of 1974 (ERISA).

If a provider is dissatisfied with a payment made by a health plan, it will be able to initiate a structured process to resolve the dispute. First, the health plan and provider will have 30 days to attempt to resolve the dispute through negotiation. If a settlement cannot be reached during that period, the involved parties will be able to access an IDR process conducted by an unbiased entity approved by the federal government. This process must be triggered within four days of the end of the negotiation period. Each party would submit a final offer for consideration by the arbiter (also known as “baseball-style arbitration”), along with supporting information.

The arbiter will be directed to consider a wide range of relevant information, including: the median contracted in-network rate; the provider’s training and experience; the patient’s acuity and the complexity of care provided; the facility’s teaching status, case mix and scope of services; any demonstration of good faith effort or lack thereof to resolve the dispute; prior year contracted rates; and other information brought forward by the involved parties. The arbiter will not be able to consider provider charges or the rates paid by public programs such as Medicare or Medicaid.

There will be no minimum disputed payment threshold to enter the IDR process, and similar claims within a certain timeframe could be batched together to ease administrative burden. The arbitration process will need to be concluded within 30 days, and the losing entity will be required to pay the fees to participate in the process. However, if the dispute is resolved by the parties before the arbiter makes a decision, the parties share in the cost. Following the determination by the IDR arbiter, the parties involved could not initiate another IDR process for the same item or service for a 90-day period.

Many of the provisions will require rulemaking over the next 6-12 months by the departments of HHS, Treasury and Labor to implement. For example, the departments will need to establish via rulemaking the operational details for the IDR process, how cost-sharing will be calculated, and the notice and consent process, among other provisions.

Application of Protections to Ambulance Services. Patients using air (but not ground) ambulance services will be accorded similar protections against surprise

medical billing as previously described, and providers of air ambulance services and health plans will be accorded a similar process for resolving disputed claims as outlined above. Air ambulance providers also will be subject to new cost- and claims-reporting requirements to both HHS and the Department of Transportation. An advisory committee will be established to review and make recommendations on policy related to air ambulance quality and patient safety. In addition, a separate advisory committee will be established to review ground ambulance billing practices and recommend consumer protections regarding balance billing.

Provider Price Transparency. Health care providers (both individual practitioners and facilities) will be required to share “good faith estimates” of the total expected charges for scheduled items or services, including any expected ancillary services, with a health plan (if the patient is insured) or individual (if the patient is uninsured). The language is unclear whether these estimates must be provided upon patient request or for every scheduled service. The estimate will need to include the expected billing and diagnostic codes for all items and services included in the estimate. The provider would need to determine the patient’s health coverage status and develop the good faith estimate at least three business days before the service is furnished and no later than one business day after scheduling, unless the service is scheduled for more than 10 business days later. In those instances, the provider will need to furnish the information within three business days of a patient requesting a service or scheduling a service. This requirement will go into effect Jan. 1, 2022.

In addition, the HHS Secretary is required to establish a “patient-provider dispute resolution process” to adjudicate any disputes over pricing for uninsured patients that receive a substantially higher bill than the good faith estimate provided prior to service.

The legislation does not include a provision from earlier drafts that would have established new timeframes for patient billing and required facilities to bill on behalf of independent providers.

Health Plan Price Transparency. Health plans will be required to send patients an “Advanced Explanations of Benefits” (EOB) prior to scheduled care or upon request by patients looking for more information prior to scheduling. The Advanced EOB requirement is triggered by the provider sending the “good faith estimate” required in Section 112 to the plan. The Advanced EOB will need to include:

- Whether the provider and facility are in-network and either the contracted rate for the item or service (if in-network) or information on finding in-network providers for the item or service (if out-of-network);
- The “good faith estimate” provided by the provider (see above), with a delineation by the health plan of the portion the patient should expect to pay and the portion the health plan is expected to pay;
- An estimate of the amount the patient has incurred toward their deductible and cost-sharing limits;
- Information on any medical management (i.e., prior authorization) required for the item or service; and

- A disclaimer that all information included in the notice is an estimate and subject to change.

Health plans will need to share this information within three business days of receiving a request or notice that a service had been scheduled, as long as the service was scheduled for at least 10 business days after the notice. If scheduled for less than 10 days after the notice, the health plan will need to provide this information within one business day. The HHS Secretary will have the authority to modify the timing requirements for services deemed to have low utilization or significant variations in costs. This requirement will go into effect for plan years beginning on or after Jan. 1, 2022.

In addition, health plans would need to maintain online price comparison tools that would allow patients to compare expected out-of-pocket costs for particular items and services across multiple providers. Health plans also would need to provide price comparisons over the phone. Health plans would need to offer such price comparisons for plan years beginning on or after Jan. 1, 2022.

Other Provisions to Help Patients Access Care. The legislation includes certain other provisions to help patients access care, including requirements around access to obstetrical or gynecological care, as well as the ability of a patient to select a pediatrician as the child's primary care provider. In addition, the legislation protects continuity of care for patients when health plans change provider networks, particularly for individuals with complex care needs.

Provider Directories. Health plans will be required to ensure their in-network providers are up-to-date. This requirement entails a verification process that patients can access online or within one business day of an inquiry. A patient that relies on a health plan's inaccurate provider directory will be responsible only for the in-network cost-sharing amount if the patient provides documentation they received incorrect information.

Disclosure of Cost-sharing. The legislation requires that health plans include on any physical or electronic health plan or insurance identification card issued to an 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. Plans also will be required to include information on how consumers can seek further assistance.

All-payer Claims Databases (APCDs). The legislation provides grants to states to build or improve APCDs and direct the federal government to develop a standard for voluntary self-insured plan reporting to state APCDs. States that receive grants would be required to provide access to data for researchers, employers, health insurance issuer, health care provider, or other stakeholder for the purpose of quality improvement or cost containment, although states could apply for waivers of those requirements.

Reporting and Audits. The legislation includes a number of instances where the government is directed to audit health plans and providers for compliance, conduct evaluations of the impact of certain provisions, and publicly release data. For example, the legislation directs an evaluation of network adequacy and whether plans have a history of routine denials, low payment, down-coding or other abuses. Other evaluations

focus on the impact of these provisions on health care costs and consolidation, among other areas of focus.

Health Plan and Provider Contract Requirements: Sharing of Price and Quality Data. The legislation disallows contract terms between health insurers and providers that would directly or indirectly restrict the insurer from providing provider-specific cost or quality data through a consumer engagement tool or other means to referring providers, the plan sponsor (e.g., an employer), enrollees or individuals eligible to become enrollees. In addition, insurer and provider contracts could not include provisions that would bar access to de-identified claims and encounter data on a per-enrollee basis. The legislation does not include a provision from earlier drafts that would have disallowed certain contracting terms related to tiered networks and patient steering.

MEDICARE PROVISIONS

Additional Graduate Medical Education (GME) Residency Slots. The legislation lifts the cap on Medicare-funded physician residency positions in teaching hospitals by 1,000, effective in FY 2023. It lifts the cap by 200 positions per year until the slots are filled. This provision is based on an AHA-supported bill, the Resident Physician Shortage Reduction Act of 2019 (S. 348/H.R.1763).

GME Funding Opportunity. The legislation amends the Medicare GME Rural Training Tracks (RTT) program to provide greater flexibility for rural and urban hospitals that participate in RTT programs.

GME Rotator Fix. The legislation eliminates the Centers for Medicare & Medicaid Services' (CMS) penalty imposed on certain community hospitals that have hosted "rotator" residents for brief periods, and allows those hospitals to establish new residency programs without limitations on the number of residency slots.

Moratorium on Payment under the Medicare Physician Fee Schedule (PFS) of the Add on Code for Inherently Complex Evaluation and Management Visits. The legislation freezes payment until 2024 for G2211, the visit complexity add-on code that CMS finalized in the calendar year (CY) 2020 PFS final rule and modified in the CY 2021 PFS final rule.

Temporary Freeze of Alternative Payment Model (APM) Payment Incentive Thresholds. The legislation freezes the current payment and patient count thresholds for physicians and other eligible clinicians to qualify for the 5% advanced APM bonus payment in payment years 2023 and 2024. It also freezes the partial qualifying APM participant payment threshold and the patient count threshold at current levels for performance years 2021 and 2022 (and payment years 2022 and 2023).

Expanding Access to Mental Health Services Furnished through Telehealth. The legislation waives the geographic and originating site requirements for mental health services delivered via telehealth, allowing beneficiaries to receive tele-mental health services in their homes and in any area of the country. To take advantage of this flexibility, beneficiaries will be required to receive at least one in-person mental health

service during the six months prior to the first telehealth service; Congress authorizes the HHS Secretary to develop additional in-person requirements.

Delay to the Implementation of the Radiation Oncology Model under the Medicare Program. This provision delays the implementation of the Radiation Oncology Model until Jan. 1, 2022.

MEDICAID PROVISIONS

Eliminating Medicaid DSH Reductions for Fiscal Years 2021 through 2023. The legislation eliminates the \$4 billion in Medicaid disproportionate share hospital (DSH) cuts that were scheduled to go into effect in fiscal year (FY) 2021 and further eliminates the DSH cuts in the two subsequent years. Additional cuts are added in FY 2026 and FY 2027.

Non-DSH Supplemental Payment Reporting Requirements. By Oct. 1, 2021, the legislation requires that the HHS Secretary establish a reporting system for states regarding their non-DSH supplemental payment programs. This new reporting requirement will be a condition of the state plan amendment. State reports must provide the criteria used to determine provider eligibility, a detailed description of the methodology used to establish the payment, an explanation of how the state is ensuring such payments adhere to the statutory “equal access” standard, and an attestation that hospital non-DSH supplemental payments do not exceed the Upper Payment Limit. The provision includes a definition of supplemental payment as any such payment that is in addition to the Medicaid base payment including payments made under 1115 waiver demonstrations. Lastly, the non-DSH supplemental payment information reported by the state will be publicly available through CMS’ website.

Medicaid Shortfall and Third Party Payments. For purposes of the calculations used to establish Medicaid DSH hospital-specific limits, the legislation defines how third party payments are to be treated. In general, all payments (including third party payments) received by the hospital would be subtracted from its costs in determining the hospital’s uncompensated care. The uncompensated care value would be factored in the methodology used to set the hospital’s Medicaid DSH payment limit. Indigent care payments received by a hospital from state and local governments would not count toward the hospital’s third party payment exclusion. In addition, hospitals treating very specific patient populations would have some of their third party payments exempted from this exclusion. This provision becomes effective date as of Oct.1, 2021.

Medicaid Coverage of Certain Medical Transportation. The legislation codifies current regulation that requires states to provide non-emergency transportation as a Medicaid benefit. The legislation also calls on the Government Accountability Office (GAO) to report to Congress on state oversight and program integrity measures.

Other Medicaid Provisions. In other Medicaid-related provisions, the legislation would restore Medicaid coverage for citizens living in Freely Associated States (the Federated

States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau). See “Extenders” below for other Medicaid-related programs extended by the legislation.

RURAL HEALTH PROVISIONS

New Rural Emergency Hospital (REH) Designation. The legislation establishes a REH designation under the Medicare program that will allow existing facilities to meet a community’s need for emergency and outpatient services without having to provide inpatient care. Emergency services would be provided 24 hours a day, 365 days a year, and communities would have the flexibility to align additional outpatient and post-acute services with community needs. REH’s will receive a fixed monthly payment plus a 5% add-on to the Outpatient Prospective Payment System (PPS) rate for outpatient services. The fixed monthly payment will be 1/12th of the average annual payment critical access hospitals received in excess of the PPS (for all services – inpatient, outpatient, skilled nursing facility) in 2019. The fixed amount will be adjusted each year by the hospital market-basket update.

Work Geographic Practice Cost Index (GPCI) Floor through 2023. The legislation extends the work GPCI floor increases payments for the work component of physician fees in areas where labor cost is determined to be lower than the national average.

Conrad State 30 Program through FY 2021. The legislation extends the Conrad State 30 J-1 visa waiver program, which waives the requirement to return home for a period of time if physicians holding J-1 visas agree to stay in the U.S. for three years to practice in a federally designated underserved area.

RHC and FQHC Hospice Services. The legislation allows Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) physicians to provide hospice attending physician services for their patients if they elect the hospice benefit.

Direct Billing of Medicare by Physician Assistants. The legislation allows direct payment under the Medicare program to physician assistants for services furnished to beneficiaries on or after Jan. 1, 2022.

Rural Community Hospital (RCH) Demonstration Program. The legislation extends the RCH program for five years. This program allows hospitals with 25-50 beds to test the feasibility of cost-based Medicare reimbursement for inpatient services.

Frontier Community Health Integration Project (FCHIP). The legislation extends for five years the FHIP demonstration project, which tests several care delivery innovations, including cost-based reimbursement for telehealth services.

RHC Payment Changes. The legislation phases in an increase in the RHC statutory cap over an eight-year period, subjects all new RHCs to a uniform per-visit cap, and limits the annual rate of growth for uncapped RHCs whose payments are above the upper limit. RHCs with an all-inclusive rate above the upper limit 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 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.

PRESCRIPTION DRUGS

The legislation includes a series of provisions focused on prescription drugs. Specifically, it requires health plans to submit information pertaining to the most frequently dispensed brand prescription drugs, as well as the most costly drugs and drugs that had the largest expenditure increases. Plans also will need to provide information around the impact of any remuneration received from drug manufacturers for specific prescription drugs. The legislation also revises and clarifies several provisions related to the Food and Drug Administration. Specifically, it includes an extension of priority voucher review for rare pediatric diseases and clarification regarding the applicability of the Orphan Drug Act. Further, the legislation makes changes to drug labeling provisions with a focus on increasing access to biosimilar products, making product label updates in the interest of benefitting public health and codifying the purple book for more transparency around biological product patents.

ADDITIONAL PUBLIC HEALTH PROVISIONS

The legislation includes provisions that support public health initiatives. Specifically, it:

- Supports efforts to address vaccine-preventable illnesses by authorizing a national educational campaign to increase the awareness of vaccines to prevent and control the spread of diseases and disseminate evidence-based vaccine-related information. It also funds planning, implementation and evaluation grants to address vaccine preventable diseases.
- Strengthens and modernizes public health data systems by requiring HHS to award grants to state and local health departments to improve data collection, simplify provider reporting, create data standards in collaboration with the Office of the National Coordinator for Health Information Technology, and enhance interoperability of public health systems with health information technology. It also authorizes CDC to update and improve the agency's public health data systems.
- Promotes research, education and tools aimed at reducing obesity.
- Creates a program to award grants to evaluate, develop and expand the use of technology-enabled collaborative learning and capacity building models that will help to retain health care providers and increase access to health care services. The grants can be awarded for up to five years.

PARITY IN BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits are prohibited by federal law from imposing less favorable benefit limitations (i.e. stricter quantitative limits, like fewer covered visits, or

non-quantitative treatment limitations — NQTLs — like use of prior authorization) on those benefits than on medical/surgical benefits. This legislation would strengthen the family of laws imposing this prohibition by requiring plans sold on the individual marketplace, ERISA plans, and group plans to perform and document comparative analyses of their plan designs and applications of NQTLs.

Upon request of the applicable state authority, Secretary of Labor or HHS Secretary, these plans must supply a report documenting the specific terms regarding NQTLs and a description of the benefits to which the terms apply within 45 days. In this report, the plan would have to include the factors used to apply NQTLs to benefits (either medical/surgical or MH/SUD), as well as the evidentiary standards upon which those factors are based and the process used in the comparative analysis proving compliance with federal parity laws. The legislation stipulates that the relevant Secretary shall request these analyses for plans that involve potential violations or complaints regarding non-compliance and any other instances the HHS Secretary deems appropriate; the HHS Secretary would be required to request no fewer than 20 of these comparative analyses per year.

If the HHS Secretary finds the plan non-compliant, the plan must specify the actions it will take to come into compliance and provide a new comparative analysis demonstrating compliance within 45 days of the HHS Secretary's initial determination of non-compliance. If the plan is still found to be non-compliant, the HHS Secretary will notify all enrollees of the non-compliance within seven days. The HHS Secretary would have to submit a report to Congress with a summary of the comparative analyses received within a year of the bill's enactment and then no later than October 1 of each year thereafter.

The bill also directs the HHS Secretary to finalize guidance and regulations to implement the law within 18 months of the bill's enactment. These documents would have to include instances of non-compliance, fully explained real-life (but de-identified) illustrative examples, and clarification on the process and timeline to file complaints. The compliance guidance document must be updated every two years, and the HHS Secretary shall issue additional guidance to help plans satisfy compliance requirements.

EXTENDERS

Quality Measure Endorsement, Input and Selection. The legislation authorizes three additional years of funding (\$66 million total) for CMS' contract with a consensus-based entity to carry out quality measure endorsement, and provide pre-rulemaking input on measures CMS is considering for future quality measurement and value programs. That entity currently is the National Quality Forum.

Other Extenders. In addition to the ones mentioned above, the legislation extends a number of other health care programs, including funding for outreach and assistance for low-income Medicare beneficiaries; Medicaid spousal impoverishment protections; the Money Follows the Person Demonstration program; and the community mental health services demonstration. It also expands the authority of Medicaid Fraud and Abuse Control units to all health care settings.

APPROPRIATIONS PROVISIONS

The omnibus legislation includes all 12 appropriations bills that fund the government for FY 2021. The Labor, Health and Human Services, and Education appropriations bill for includes \$197 billion in funding for those departments.

Labor/HHS Funding. The bill provides \$97 billion for HHS, \$2.1 billion more than the FY 2020 enacted level and \$9.9 billion more than the president's budget. Specific increases include: \$1.25 billion more for the National Institutes of Health to focus on research and clinical trials related to long-term studies of COVID-19 as well as Rapid Acceleration of Diagnostics; \$110 million more for the Public Health and Social Services Emergency Fund; \$133 million more for the Substance Abuse and Mental Health Services Administration (SAMHSA); \$125 million more for the CDC; \$151 million more for the Health Resources and Services Administration (HRSA). Rural health programs would receive \$330 million, including increases for telehealth and rural hospitals.

Funding for Addiction and Mental Health. The bill appropriates funds to various agencies to address addiction and mental health issues, including \$554 million to the National Institute on Alcohol Abuse and Alcoholism, \$1.5 billion to the National Institute on Drug Abuse, \$2 billion to the National Institute of Mental Health, and \$1.8 billion to SAMHSA.

The SAMHSA appropriations are further delineated; in addition to several hundred million dollars for technical assistance and data collection, the bill provides:

- \$250 million for the Certified Community Behavioral Health Center initiative, extending the AHA-supported demonstration program through 2023.
- \$1.5 billion for State Opioid Response grants; \$50 million of this would go to Indian Tribes and tribal organizations, and 15% of the remaining funds would go to states with the highest opioid mortality rates. Otherwise, all 50 states and the District of Columbia would receive \$4 million.
- \$72 million for the National Child Traumatic Stress initiative.

Children's Hospitals Graduate Medical Education (CHGME). The legislation provides \$350 million, a \$10 million increase, for the CHGME program, which protects children's access to high quality medical care by providing freestanding children's hospitals with funding to support the training of pediatric providers.

Health Equity. The legislation appropriates \$62 million to the HHS Office of Minority Health and \$55 million for the Minority HIV/AIDS Initiative. In addition, it allocates \$80 million for the Research Centers in Minority Institutions (RCMI) program at the National Institute on Minority Health and Health Disparities (NIMHD).

Social Determinants of Health. The legislation provides \$3 million in funding to establish a Social Determinants of Health Pilot Program to create Social Determinants of Health Accelerator Plans, key provisions of which were taken from the AHA-supported

Social Determinants Accelerator Act (H.R. 4004/S.2986). The funding will help state and local governments develop plans to address the health and social needs of targeted populations.

Maternal and Child Health. The legislation provides \$44 million, an increase of \$5 million, for the NIH Office of Research on Women's Health, \$10 million for NIH research on premature births, \$63 million, an increase of \$5 million, for CDC efforts on safe motherhood, and \$975 million, an increase of \$32 million, for HRSA programs to improve maternal and child health.

OTHER PROVISIONS

Paycheck Protection Program (PPP). The legislation commits an additional \$284 billion for the PPP and extends the program, with changes, through March 31, 2021. The legislation expands eligibility for the program to new types of entities, allows for certain smaller borrowers (300 or fewer employees) that have sustained a minimum threshold of financial losses to apply to receive a second PPP loan, and expands the types of expenses that may be eligible for forgiveness, including costs associated with securing personal protective equipment.

Extension of Paid Leave Credits. The legislation extends through March 31, 2021, the refundable payroll tax credits for paid sick and family leave that were established in the Families First Coronavirus Response Act.

Flexible Spending Arrangements (FSA). The legislation allows individuals to carry over any unused health and dependent care FSA benefits from 2020 into the 2021 plan year, along with other FSA plan flexibilities.

FURTHER QUESTIONS

If you have questions, please contact AHA at 800-424-4301.