MEMORANDUM

To: Governors' Offices
From: NGA Government Relations and NGA Center for Best Practices
Re: Health Care Provisions in the American Rescue Plan Act

On March 11, 2021, President Biden signed the $1.9 trillion pandemic relief package, the American Rescue Plan Act (ARPA) into law (P.L. 117-2), which includes several key provisions that increase health care access and affordability. Specifically, the ARPA expands subsidies, broadens eligibility and offers more opportunities for individuals to obtain health care coverage. In addition, the ARPA provides funding and resources to health care providers and facilities who have been critical in response to the COVID-19 pandemic.

Some of the provisions included below are subject to the public health emergency (PHE) designation. In February 2021, then-acting Health and Human Services Secretary Norris Cochran signaled that the COVID-19 PHE “will likely remain in place for the entirety of 2021” and when a determination is made to terminate the PHE or let it expire, HHS will provide states with 60 days’ notice.

Please note that much of the funding and changes included in the ARPA that affect states and territories are temporary. Therefore, states and territories should carefully plan for the most effective use of these funds and changes to policy. Below is an overview of the critical provisions in the American Rescue Plan that increase health care access and affordability, as well as other health provisions.


Funding for Manufacturing and Purchasing of COVID-19 Vaccines, Therapeutics, and Related Medical Supplies
Provides $6 billion to the U.S. Department of Health and Human Services (HHS) to support research, development, manufacturing, production and purchase of vaccines, therapeutics, and medical products and supplies for purposes of responding to COVID-19, including emerging viral variant mutations “or any disease with potential for creating a pandemic.”

In addition, the ARPA allocates $10 billion under the Defense Production Act, to be available until Sept. 30, 2025, to increase domestic production of COVID-related medical supplies and equipment, including diagnostic tests, personal protective equipment and vaccines.

Funding to the Food and Drug Administration (FDA) for Evaluation and Manufacturing of COVID-19 Vaccines, Devices and Therapeutics, Managing the Supply Chain and Resuming Inspections
Provides $500 million to the FDA to (1) review the performance, safety and effectiveness of COVID-19 vaccines, therapeutics and diagnostics, including for emerging variants; (2) facilitate advanced continuous manufacturing activities for vaccines and related materials; (3) conduct inspections related to the manufacturing of vaccines, therapeutics and devices that have been delayed or cancelled for reasons related to COVID-19; (4) review devices authorized for the treatment, prevention or diagnosis of COVID-19; and (5) conduct oversight of the supply chain and address shortages of COVID-19 vaccines, therapeutics and devices.
**Funding for COVID-19 Testing, Contact Tracing and Mitigation Activities**

Provides $48 billion to HHS to advance its work to detect, diagnose and trace COVID-19 infections. This includes funding for state, local and territorial public health departments for research, community-based testing sites, mobile health units, data modernization and the public health workforce. HHS must implement a national testing and contact tracing strategy and support the development, manufacturing, purchasing and distribution of diagnostic tests.

**Medicaid Provisions**

**Expanded Medicaid and Children’s Health Insurance Program (CHIP) Coverage for COVID-19 Services**

The Families First Coronavirus Response Act (FFCRA, P.L. 116-127) requires Medicaid and CHIP coverage of COVID-19 testing without cost sharing. The ARPA builds on this provision by explicitly requiring Medicaid and CHIP coverage of COVID-19 vaccines, treatment (including prescription drugs), and treatment of conditions that complicate COVID-19 treatment, without the imposition of cost-sharing charges for all individuals enrolled in full-benefit Medicaid and CHIP coverage. The FFCRA indirectly requires states to cover COVID-19 testing and treatment without cost-sharing in Medicaid as part of its maintenance-of-effort requirement, but that provision did not apply to separate state CHIP programs.

These requirements apply through the end of the first calendar year quarter that starts one year after the end of the COVID-19 PHE. In addition, the federal matching rate for COVID-19 vaccines and its administration is also increased to 100 percent. The 100 percent matching rate increase would be exempt from the territorial funding caps and in the case of CHIP, states’ CHIP allotments would be adjusted to reflect this 100 percent matching rate. Finally, the package clarifies that any drugs used for COVID-19 treatment are subject to the Medicaid Drug Rebate Program, which would lower their cost for state Medicaid programs. The law also expands the state option to cover uninsured individuals for not only testing but also vaccines and treatment of COVID-19 as well as any condition that could seriously complicate treatment.

**Changes to the Medicaid Drug Rebate Program (MDRP)**

The ARPA eliminates the statutory cap on MDRP rebates, which the Affordable Care Act (ACA) added. Under this provision of the ARPA, which is characterized as a “sunset” provision in the law, MDRP rebates on covered outpatient drugs would no longer be capped at 100 percent of Average Manufacturer Price, and drug manufacturers’ MDRP rebate liability on certain covered outpatient drugs may rise. This change is scheduled to take effect Jan. 1, 2024 and will require drug manufacturers to pay more in Medicaid rebates for drugs with large price increases. The Congressional Budget Office estimates that eliminating this statutory cap would save the federal government approximately $15.9 billion over the 10-year period and will yield state savings.

**Incentives for Medicaid Expansion**

The federal government covers 90 percent of coverage costs for eligible Medicaid expansion populations, for states that have not expanded Medicaid pursuant to the ACA, the ARPA offers a 5-percentage point increase on their base Federal Medical Assistance Percentage (FMAP) rate for most non-expansion populations under Medicaid for two years if they expand coverage.

The additional incentive applies whenever a state newly expands Medicaid and does not expire. The new incentive is available to the 12 states that have not yet adopted the expansion as well as Missouri and Oklahoma, which are expected to implement expansion by July 2021. The increase in the regular matching rate is estimated to more than offset the increased state costs of expansion in these states for the first two years. If a state expands during the PHE, that state will receive both the COVID-19-related 6.2 percentage point FMAP and the new 5–percentage point increase.

**Medicaid Coverage for Post-Partum Women**

Provides states with a new option to extend Medicaid coverage for post-partum women from the current 60 days to a full year. States that elect this option must provide full state plan benefits throughout the enrollee’s
pregnancy and post-partum period and cannot limit benefits to only those that are “pregnancy related.” The new option is available to states for five years, beginning April 1, 2022.

States should begin to plan on the necessary steps to pull down the federal match and begin extended postpartum Medicaid coverage, so they will be ready once it is available.

**Home and Community-Based Services (HCBS)**
Includes an increase to the FMAP for spending on Medicaid HCBS by 10 percentage points from April 1, 2021 through March 31, 2022 provided states maintain state spending levels as of April 1, 2021. The new funds must supplement, not supplant, the level of state HCBS spending as of April 1, 2021, and states must implement or expand one or more activities to enhance HCBS. HCBS help seniors and people with disabilities live independently in the community by assisting with daily self-care and household activities.

While ARPA does not detail specific activities, examples of initiatives that states might fund include bolstering the workforce by supporting direct care workers, family caregivers and/or HCBS providers adversely affected by the pandemic; offering services to address the pandemic’s impact on seniors and people with disabilities; and/or increasing the number of people receiving HCBS. Additionally, spending in some states may not be eligible for the full increase, should the state hit the 95 percent federal match cap, after accounting for the 10-percentage point increase in the bill as well as other enhanced matching rates available to states, such as the enhanced match for the ACA Medicaid expansion group.

**State Option for Mobile Crisis Service Programs**
Provides $15 million for planning grant funds for states to develop a mobile crisis service program, with an 85 percent FMAP for the first three years. During the five-year period beginning on the first day of the first fiscal year quarter that begins on or after one year following enactment, states can cover mobile crisis intervention services for individuals experiencing a mental health or substance use disorder crisis. The additional funds must supplement, not supplant, the level of state spending for these services in the fiscal year before the first quarter that a state elects this option. Services must be otherwise covered by Medicaid and provided by a multidisciplinary team to enrollees experiencing a mental health or substance use disorder crisis outside a hospital or other facility setting. These services generally do not have to be offered statewide, do not have to be comparable for all enrollees, and can restrict enrollees’ free choice of provider.

To be eligible, mobile crisis teams need to include at least one behavioral health professional capable of assessing the individual, in accordance with the professional’s permitted scope of practice under state law. The teams can also include other professionals or paraprofessionals with appropriate expertise in behavioral health or mental health crisis response, including nurses, social workers and peer support specialists, and others as designated by a state’s Medicaid program.

**Technical Fix to the Disproportionate Share Hospital Allotment (DSH)**
Makes a technical fix to state DSH allotment calculations to address an unintended consequence related to the FFCRA temporary 6.2 percentage point FMAP increase. Specifically, the ARPA allows HHS to recalculate DSH allotments when the state received the 6.2 percentage point increase in FMAP. This change ensures that the total DSH payments that a state makes are equal to the total DSH payments that the state could have made for the fiscal year without the 6.2 percentage point increase in FMAP.

**Marketplace and COBRA Provisions**

**Marketplace Advanced Premium Tax Credits (APTCs)**
Includes several provisions related to APTCs that assist consumers who purchase health insurance on the ACA marketplaces. For two years, 2021 and 2022, the ARPA expands availability of marketplace APTCs to eligible individuals whose income is above 400 percent of the federal poverty level (FPL), based on a sliding scale. On one end of the sliding scale, individuals whose income is between 100 percent and 150 percent of the FPL are eligible for full coverage of their premiums. On the other end of the scale, individuals with incomes above 400 percent of the FPL will have their premiums capped at 8.5 percent of their income.
The ARPA also provides a temporary modification (limited to tax year 2020) that forgives certain payments that otherwise would be owed by those whose 2020 advanced premium tax credits did not match their income level for the year. Additionally, the law permits individuals who receive (or have been approved to receive) unemployment compensation during any week that begins during 2021 to receive premium tax credits for ACA marketplace coverage at a level equivalent to that of a person earning up to 133 percent of FPL.

According to HHS, current enrollees on the federally facilitated marketplace should review their application, make any changes needed to their current information, submit their application and select a plan, or reselect their current plan, to receive the increased advance payments of premium tax credits for 2021 Marketplace coverage. Consumers who act in April and confirm updated savings on the plan of their choice will begin receiving the savings and lower costs starting with their May 1 premiums. To view CMS guidance please click here and to view CMS fact sheet please click here.

**Marketplace Modernization**
Allocates $20 million in funding to state-based marketplaces to update or modernize any program, system or technology. Such funding for “marketplace modernization” is available through September 2022.

**Consolidated Omnibus Budget Reconciliation Act (COBRA) Subsidies**
Requires employers who are subject to COBRA, as well as small employers who are not subject to COBRA but are subject to a state continuation law to offer 100 percent subsidized COBRA continuation coverage to “assistance eligible individuals” between April 1, 2021 and Sept. 30, 2021. This additional premium COBRA support applies to certain individuals who have experienced unemployment or work-hour reductions during the COVID-19 PHE. COBRA premiums will be paid by former employers during this period, who will then be reimbursed by the Internal Revenue Service (IRS) through a refundable payroll tax credit for the premiums. Eligible individuals will also have an extended time period from their qualifying event to elect COBRA, however, ARPA does not extend the maximum COBRA coverage period (generally 18 months).

While the Internal Revenue Service has yet to release guidance on claiming reimbursements, on April 7, 2021, the Department of Labor’s Employee Benefits Security Administration issued frequently asked questions.

**Medicare Provisions**

**Change in Hospital Wage Index for All-Urban States**
The Centers for Medicare & Medicaid Services (CMS) adjusts Medicare payments using a wage index that reflects variations in labor costs in different areas of the country. The ARPA directs HHS to establish a minimum wage index for hospitals in each of the all-urban states for purposes of Medicare hospital payments (i.e., Delaware, New Jersey and Rhode Island), beginning Oct. 1, 2021. This would increase certain urban state hospital reimbursements because under the “rural floor” rule, a hospital in an urban area of a state cannot have a Medicare wage index value that is lower than that of a hospital in a rural area of that same state, and this would provide such a floor in these all-urban states.

**Waiver of Certain Requirements for Medicare Reimbursement for Ambulance Services**
Allows CMS to waive restrictions on Medicare payment for ground ambulance services where the individual was not transported to the closest appropriate facility during PHE declarations. Specifically, this waiver would allow CMS to pay for ground ambulance services furnished in response to a 9-1-1 call (or equivalent in areas without 9-1-1) in cases where a patient was not transported but was instead treated in place in accordance with communitywide EMS protocols. This waiver was made because these restrictions posed an issue for ambulance providers and Medicare beneficiaries during the COVID-19 pandemic, due to many hospitals having been at capacity and therefore an individual may not be transferred to the closest facility.

**Additional Health Care Funding Provisions**

**Supplemental Funding for Rural Providers**
Provides $9 billion for rural providers broken out into two sections:
• $500 million to the Department of Agriculture for the creation of an emergency grant program for rural development no later than 150 days after the date of enactment of this act. The program will award grants to nonprofit health care providers in rural areas with lower than median incomes.
  o Grantees will be able to use the funds to pay for a variety of activities including: vaccine distribution, medical supplies, lost revenue, telehealth costs, and capital projects.
• $8.5 billion to reimburse Medicare, Medicaid or CHIP “rural providers or suppliers” for health care-related expenses and lost revenues attributable to COVID-19.
  o Rural health providers will have to justify their need for additional funding in an application to the secretary of Health and Human Services (HHS) before they receive any money.
    ▪ Applications must include a statement justifying the need for the payment, the tax identification number of the provider, and assurances that the provider will maintain and submit reports to ensure compliance with HHS requirements.
  o Rural providers seeking this funding will need to demonstrate that they are only using this funding for expenses that are not otherwise reimbursed.
  o The law does not specify a minimum or a maximum amount that rural health providers may seek from this fund.

Support for Community Health Centers
Provides $7.6 billion to support COVID-19 response at Community Health Centers for prevention, mitigation and response to COVID-19 and to enhance health care services and infrastructure. Funds can be used for past expenditures, dating back to Jan. 31, 2020. For more information, please click here.

Support for Skilled Nursing Facilities (SNFs)
Provides $450 million to support SNFs in protecting against COVID-19. The funding is broken out by:
• $200 million to quality improvement organizations to provide infection control and vaccination uptake support to SNFs.
• $250 million for state and territory strike teams to be deployed to nursing facilities with diagnosed or suspected cases of COVID-19 among residents or staff. The strike teams will assist with clinical care, infection control or staffing during the public health emergency (PHE) and one year after the end of the PHE.

Substance Use Disorder and Mental Health Funding Includes $3.5 billion in emergency funding for substance use and mental health programs, including:
• $1.5 billion for block grants for prevention and treatment of substance use;
• $1.5 billion for block grants for community mental health services;
• $420 million for expansion grants for certified community behavioral health clinics;
• $100 million for behavioral health workforce education and training;
• $80 million for mental health and substance use disorder training for health care professionals, paraprofessionals and public safety officers;
• $80 million for pediatric mental health care access;
• $50 million for community-based funding for local behavioral health needs;
• $40 million for grants for health care providers to promote mental health among their health professional workforce;
• $30 million for project AWARE;
• $30 million for community-based funding for local substance use disorder services;
• $20 million for education and awareness campaign encouraging healthy work conditions and use of mental health and substance use disorder services by health care professionals;
• $20 million for youth suicide prevention; and
• $10 million for the national child traumatic stress network.

Increase Federal Support for Certain Indian Health and Native Hawaiian Health Providers
For two years the 100 percent FMAP available to Indian Health Service (IHS) providers for furnishing care to Medicaid beneficiaries to services furnished by Urban Indian Health Programs. Such providers are grantees of the IHS and serve IHS-eligible patients on Medicaid, but they are not formally part of the IHS and as a result,
payments to these providers do not otherwise receive the 100 percent FMAP that other IHS providers do. The provision would also provide for two years a 100 percent FMAP for services furnished by Native Hawaiian Health centers. The funding is available commencing April 1, 2021.

**Public Health Workforce**
Provides $7.7 billion to HHS to establish, expand and sustain a public health workforce to help respond to the current pandemic, including through awards to state and local public health departments. Specifically, HHS must use the funds to increase the number of contact tracers, social support specialists, community health workers, public health nurses, epidemiologists, lab personnel, disease intervention specialists and communications personnel. Funds could also be spent on technology and supplies needed and used by the public health workforce, such as PPE.

The ARPA also provides a separate $100 million to support the Medical Reserve Corps, which is a network of volunteers (including medical and public health professionals) who support emergency response efforts and community health activities.

In addition, the ARPA provides $800 million for the National Health Service Corps.

**Title X Family Planning Program**
The ARPA provides an additional $50 million to the Title X family planning program.

**Home Visiting Programs**
An additional $150 million, to remain available through Sept. 30, 2022, for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. To receive funding, entities must be operating an MIECHV home visiting program and meet other eligibility requirements, including agreeing not to reduce staffing levels during the pandemic. Eligible uses of the funding include serving families with home visits (in person or virtual), staff costs including hazard pay, training, helping families acquire necessary technology to conduct virtual visits, providing emergency supplies to families (e.g., formula, food, water, hand soap and sanitizer, and diapering supplies).
REFERENCES


