UnityPoint Health

H.R. 1319 American Rescue Plan Act of 2021

Key Health Care Provisions in the Final Bill

On March 10, 2021, Congress finalized and passed the American Rescue Plan of 2021 (ARP)—the latest and sixth COVID-19 relief package that largely tracks President Biden's initial $1.9 trillion proposal. The ARP extends unemployment insurance benefits and provides direct $1,400 stimulus payments to qualifying Americans, but it also makes a number of important health policy-related changes, including providing funding for vaccine distribution and testing to combat the COVID-19 pandemic, making policy changes to the Medicaid program, facilitating health insurance coverage and providing more money for healthcare providers. The final bill also makes two narrowly-focused technical Medicare payment changes.

This summary highlights notable health policy provisions of the final bill.

COVID-19 RELIEF

PUBLIC HEALTH FUNDING

Background: Like previous COVID-19 relief packages, this bill includes funding for COVID-19 vaccine distribution, testing and contact tracing, and support for healthcare workforce expansion and public health initiatives.

Provisions: The ARP provides funding to support vaccination and treatment, including $7.5 billion directed to the Centers for Disease Control and Prevention to plan, prepare for, promote, distribute, administer, monitor and track COVID-19 vaccines.

The bill also provides support for workforce initiatives, including $7.66 billion to state, local and territorial public health departments to hire staff and procure equipment, technology and other supplies to support public health efforts. The legislation includes $100 million for the Medical Reserve Corps, $800 million for the National Health Service Corps, $200 million for the Nurse Corps and $330 million for teaching health centers that operate graduate medical education.

The bill allocates $47.8 billion to continue implementation of an evidence-based national COVID-19 testing strategy, and directs $1.75 billion to support genomic sequencing and surveillance initiatives.

PROVIDER RELIEF LOOK-A-LIKE FUND FOR RURAL PROVIDERS

Background: The CARES Act established the Provider Relief Fund (PRF) to reimburse providers for COVID-19-related expenses and lost revenues. To date, $178 billion has been appropriated to the fund. Approximately $153 billion has been allocated to providers, and about $25 billion remains to be allocated. This $25 billion does not account for PRF distributions that have been or may yet be returned to the US Department of Health and Human Services (HHS) by recipients rejected the financial support, so the actual amount remaining could be larger. The remaining funds are subject to spending limitations for providers for the second half of 2020 and the first quarter of 2021 due to provisions in the appropriations bill passed at the end of 2020.

Provision: The ARP provides $8.5 billion through a look-a-like PRF specifically for rural entities serving Medicare and Medicaid beneficiaries. This funding is for HHS to allocate to eligible rural providers for health care-related expenses and lost revenues attributable to COVID-19 not reimbursed (or obligated to be reimbursed) by other sources. Although these funds are not directed to the existing PRF, the ARP's language largely aligns with previous PRF appropriations language. For example, the ARP definitions of lost revenues and health care-related expenses attributable to coronavirus are similar to those used in the Consolidated Appropriations Act 2021 appropriating additional funds to the PRF, and are similar to HHS's PRF guidance

documents defining those terms. Although it appears that Congress intends for these funds to be consistent with the PRF, it is unclear whether HHS will treat the $8.5 billion in a completely consistent manner.

Notably, the ARP funds are only available to rural providers or suppliers, which the bill defines as those that: (1) are located in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (SSA));
(2) are treated as being located in a rural area under SSA section 1886(d)(8)(E); (3) are located in "another area" (as defined by the HHS Secretary) that serves rural patients; (4) are a Rural Health Clinic (as defined by SSA section 1861(aa)(2)); or (5) furnish home health, hospice, or long-term services or supports in an individual's home located in a rural area (as defined in SSA section 1886(d)(2)(D)). The HHS Secretary also has authority to include other rural providers or suppliers as eligible. Unlike the PRF's targeted rural distributions, which were distributed directly to select providers by HHS, rural providers and suppliers seeking the ARP funds must submit an application to HHS. This definition of "rural" captures traditionally rural providers and suppliers, but also is broad enough to potentially render eligible a number of urban providers and suppliers that have undergone redesignation to be considered rural, or that may be in urban areas, but treat rural patient populations. And that is before accounting for the Secretary's additional broad authority to define rural for eligibility purposes.

FUNDING FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Background: Mental health remains a serious concern during the COVID-19 pandemic. Studies have shown increases in suicide, opioid addiction and other mental health crises.

Provision: The bill allocates $3 billion for block grants to state and local government entities to address mental health and substance use disorders, as well as additional funding for behavioral health workforce education and community-based behavioral health services.

FUNDING FOR STATE, LOCAL AND TRIBAL GOVERNMENTS

Background: The Coronavirus Aid, Relief, and Economic Security (CARES) Act, passed in March 2020, established a $150 billion Coronavirus Relief Fund for state, local and tribal governments. The federal relief funds are restricted and can be used only on expenses that directly relate to COVID-19. Under CARES, recipients had to use this money by December 31, 2020. The Consolidated Appropriations Act, 2021 (CAA), enacted in December 2020, extended the time period during which states, tribal governments and localities could use the original CARES Act funding to December 31, 2021.

Provision: The ARP provides an additional $350 billion to states, localities and tribes. Of those funds, State, Territory, and Tribal governments would receive $220 billion. Local governments would receive approximately $130 billion. It also extends the time period for use until December 31, 2024. The funding can be used for public health efforts to respond to the COVID-19 pandemic, the COVID-19 pandemic's economic impact, including assistance to households, small businesses, and nonprofits, or aid to impacted industries such as tourism, travel, and hospitality. It can also be used to make investments in public health infrastructure, and respond to decreases in revenue due to the COVID-19 pandemic.

RURAL HEALTHCARE GRANTS

Background: The COVID-19 pandemic has financially affected rural providers in particular. While a portion of the Provider Relief Fund was allocated specifically to providers in rural areas, many believe more support is needed.

Provision: This ARP provides $500 million through the US Department of Agriculture to award grants to eligible entities, including public municipalities and counties, non-for-profit organizations, and Tribes in rural areas. These grants could be used to cover COVID-19 related expenses and increase capacity and telehealth capabilities.

MEDICAID AND CHIP

MANDATORY COVERAGE OF COVID-19 VACCINATION WITHOUT COST SHARING

Background: The Families First Coronavirus Response Act, the first COVID-19 relief package enacted in 2020, allows states

to receive an enhanced Medicaid federal medical assistance percentage (FMAP) if they meet certain conditions. These conditions include covering COVID-19 testing services and treatment, such as vaccines and their administration, for Medicaid enrollees without cost sharing. The Trump Administration interim final rule with comment period, "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," excluded from this requirement individuals enrolled in special limited coverage groups and individuals enrolled through Section 1115 demonstration waivers that cover a narrow set of benefits.

Provision: The ARP requires state Medicaid programs and the Children's Health Insurance Program (CHIP) to provide coverage, without cost sharing, for treatment or prevention of COVID-19 for one year after the end of the public health emergency (PHE), while raising the FMAP to 100% for payments to states for administering vaccines for the same period. If a state chooses to implement an option under Medicaid to provide COVID-19 testing for uninsured individuals, the law also would extend the requirement to provide treatment and prevention to those individuals without requiring cost sharing for one year after the end of the PHE.

COVERAGE OF PREGNANT AND POSTPARTUM WOMEN

Background: For 60 days after the birth of a child, states must provide Medicaid coverage to women whose income does not exceed 138% of the federal poverty level (FPL), and states have the option extend this 60 days coverage for individuals with higher income levels. According to Kaiser Family Foundation, 48 states and the District of Columbia exercise that option under current law to provide Medicaid coverage to pregnant women whose income is above 138% of FPL, 15 states extend coverage to women between 139% - 199% FPL, 30 states extend coverage to women between 200% - 299% of FPL, and 5 states extend coverage to women between 300% - 380% of FPL. States also can provide pregnancy-related services to women under CHIP, but they may only provide postpartum services to women who, if not for their income, would otherwise be eligible for coverage under Medicaid.

States can provide CHIP coverage to eligible women during pregnancy and for 60 days after the birth of a child. CHIP cannot be used to replace existing Medicaid coverage for pregnant women. To cover pregnant women under CHIP, states must provide, at a minimum, Medicaid coverage to women whose income is up to 185% of the FPL.

Provision: The ARP gives states the option to go beyond the current 60 days to extend health coverage for women enrolled in Medicaid or CHIP for up to 12 months after the birth of a child. This option would be available for five years beginning on the first day of the first fiscal year quarter after the enactment of ARP.

INCREASED FMAP TO INCENTIVIZE STATES TO EXPAND MEDICAID

Background: The Affordable Care Act (ACA) required the federal government to pay 100% of state Medicaid costs for the expansion population through 2016, after which time the matching rate began phasing down to 90% in 2020 and thereafter. Currently, 38 states and the District of Columbia have adopted Medicaid expansion consistent with the Affordable Care Act (ACA).

Provision: The ARP provides incentive for non-expansion states to expand Medicaid eligibility for all adults with income up to 138% of the FPL by providing a five-percentage-point increase in the Medicaid FMAP for eight calendar quarters. This FMAP increase is only available to states that have not yet expanded coverage and have not yet started paying for the expansion population prior the enactment of the law. The FMAP bump applies to services provided to traditional eligibility groups and excludes certain payments such as DSH payments and Medicaid allotments to territories. This increase in FMAP likely will not be enough of an incentive for non-expansion states to expand Medicaid. However, ballot initiatives, a change in the Governor's mansion or control of the state legislature could lead additional states to Medicaid expansion.

SUNSET OF LIMIT ON MAXIMUM REBATE AMOUNT FOR SINGLE SOURCE DRUGS, INNOVATOR MULTIPLE SOURCE DRUG

Background: Drug manufacturers are required to pay Medicaid a rebate on all covered outpatient drugs. The rebate amount is determined by statute using two formulas that include a basic rebate with separate calculations for brand and generic drugs. There is also an additional inflationary rebate that reflects differences in growth between the average manufacturer prices and the consumer price index. The total rebate amount is capped at 100% of the average manufacturer price.

Provision: The ARP eliminates the cap on the total rebate amount starting January 1, 2024.

TEMPORARY ENHANCED FMAP FOR HOME AND COMMUNITY-BASED SERVICES

Background: Home and community-based services (HCBS) are long-term care services and supports that meet the needs of people who prefer to receive such services in their home or community, rather than in an institutional setting. In Medicaid, HCBS are optional services that many states offer through HCBS section 1915(c) waivers or the Medicaid state plan. HCBS include, but are not limited to, day services, supported employment and home-delivered meals.

Provision: The ARP increases the FMAP by 10 percentage points for state HCBS expenditures for four fiscal quarters (from April 1, 2021 through March 30, 2022). This funding would be a supplement to current HCBS funding. States would not be permitted to use the funding for services not related to HCBS. The 10 percentage points FMAP bump for HCBS is an increase from the FMAP bump that was included in the original House passed version, which was 7.35 percentage points.

DISPROPORTIONATE SHARE HOSPITAL ALLOTMENT TECHNICAL FIX

Background: Section 6008 of the Families First Coronavirus Response Act gave states a temporary 6.2 percentage point increase to each qualifying Medicaid program's FMAP from January 1, 2020, through the last calendar quarter of the public health emergency.

Provision: The ARP makes a technical fix to state disproportionate share hospital (DSH) allotment calculations to address an unintended consequence related to this temporary FMAP increase.
Specifically, the ARP allows the Secretary of Health and Human Services 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 would be 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.

COVERAGE

COBRA PREMIUM ASSISTANCE

Background: Under long-standing federal law, individuals who lose their job or experience another qualifying event that results in termination of their employment-based health insurance are eligible to continue health insurance coverage through the Consolidated Omnibus Budget Reconciliation Act
(COBRA). COBRA is often cost prohibitive for affected individuals, however, as they may be required to pay up to 102% of the total premium.

Provision: The ARP makes COBRA coverage more affordable by subsidizing on the individual's behalf 100% of the COBRA premiums during the period beginning the first month after enactment until September 30, 2021.

MARKETPLACE ADVANCED PREMIUM TAX CREDIT

Background: The ACA established tax subsidies for health insurance purchased through insurance exchange marketplaces, known as advanced premium tax credits (APTCs). APTCs are available to individuals earning between 100% and 400% of the FPL.

Provision: For two years (2021 and 2022), the ARP expands availability of marketplace APTCs to eligible individuals whose income is above 400% of the FPL, based on a sliding scale. On one end of the sliding scale, individuals whose income is between 100% and 150% of the FPL would be eligible for full coverage of their premiums. On the other end of the scale, individuals with incomes above 400% of the FPL would have their premiums capped at 8.5% of their income.

MEDICARE

FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN ALL-URBAN STATES

Background: Generally, Medicare payments to providers are adjusted using a wage index to account for geographic

variation in labor costs. CMS calculates one wage index for each urban area and one for each rural area within each state. The Medicare statute provides that the wage index used to adjust hospital inpatient and outpatient payments for hospitals in an urban area cannot be less than the wage index applicable to hospitals in rural areas within that same state. This rule leaves a gap for three states that have no rural areas: New Jersey, Delaware and Rhode Island. Congress has periodically provided a patch for these three states, and CMSon its own volition perpetuated this patch through fiscal year 2018.

Provision: Effective October 1, 2021, the ARP restores the wage index "rural floor" protection for the all- urban states of New Jersey, Delaware, Rhode Island and any other state that might be so designated in the future. Wage index changes are often controversial because historically they have been implemented in a budget-neutral fashion, which means the benefit given to some hospitals comes at the expense of others. The bill spends new money to implement this change, so the benefit to hospitals in all-urban states would not come at the expense of others.

TEMPORARY WAIVER OF CERTAIN REQUIREMENTS FOR AMBULANCE SERVICES

Background: Medicare will only cover ambulance services to the nearest appropriate medical facility that is available. This requirement has posed an issue for ambulance providers and Medicare beneficiaries during the COVID-19 pandemic, because many hospitals have been at capacity and therefore an individual may not be transferred to the closest facility.

Provision: The ARP allows CMS to waive restrictions on payment for ambulance services where the individual was not transported to the closest appropriate facility during PHE declarations.

For more detailed information on specific provisions, please reach out to:

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