American Rescue Plan Act of 2021:
Key Healthcare Provisions

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On March 10, 2021, Congress finalized and passed the American Rescue Plan of 2021 (ARP), the latest 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 several important health-policy-related changes. These include providing funding for vaccine distribution and testing to combat the COVID-19 pandemic, making policy adjustments 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.

In developing and finalizing the bill, Democrats used the budget reconciliation process to pass the bill with only Democratic support. This process limited what could be included. The version that was signed into law ultimately removed a provision to increase the federal minimum wage to $15 per hour because it failed to meet reconciliation rules.

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

Timeline of Major COVID-19 Relief Legislation

March 6, 2020: Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020
- P.L. 116-123

March 18, 2020: Families First Coronavirus Response Act
- P.L. 116-127
- McDermottPlus +Insight

March 27, 2020: Coronavirus Aid, Relief, and Economic Security (CARES) Act
- P.L. 116-136
- McDermottPlus +Insight

April 24, 2020: Paycheck Protection Program and Health Care Enhancement Act
- P.L. 116-139
- McDermottPlus +Insight

December 27, 2020: Consolidated Appropriations Act, 2021
- H.R. 133

Passed Congress March 10, 2021: American Rescue Plan Act of 2021
- H.R. 1319

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 Coronavirus Aid, Relief, and Economic Security (CARES) Act, passed in March 2020, 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 that 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: Despite stakeholder requests to add as much as $35 billion to the general PRF, the ARP provides only $8.5 billion, and does so through a look-a-like PRF specifically for rural entities serving Medicare and Medicaid beneficiaries. Congress took this unconventional approach to overcome limitations imposed by the reconciliation process. HHS will allocate this funding to eligible rural providers for healthcare-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 healthcare-related expenses attributable to COVID-19 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.

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 CARES Act 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 the CARES Act, recipients had to use this money by December 31, 2020. The Consolidated Appropriations Act, 2021, 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 will receive $220 billion. Local governments will receive approximately $130 billion. The ARP also extends the time period for use until December 31, 2024. The funding can be used for public health efforts responding to the COVID-19 pandemic, and for efforts to address the 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 to 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 PRF was allocated specifically to providers in rural areas, many believe more support is needed.

Provision: The ARP provides $500 million through the US Department of Agriculture to award grants to eligible entities, including public municipalities and counties, nonprofit organizations and tribes in rural areas. These grants can be used to cover COVID-19-related expenses and to 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 extends 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 to 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. Of these, 15 states extend coverage to women between 139% and 199% the FPL, 30 states extend coverage to women between 200% and 299% of the FPL, and five states extend coverage to women between 300% and 380% of the 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 extend health coverage for women enrolled in Medicaid or CHIP for up to 12 months after the birth of a child. This option will 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 ACA.

Provision: The ARP incentivizes 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 disproportionate share hospital (DSH) payments and Medicaid allotments to territories. This increase in FMAP likely will not be sufficient incentive for non-expansion states to expand Medicaid. However, ballot initiatives, a change in the governor's mansion or change in 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 is a supplement to current HCBS funding. States will not be permitted to use the funding for services not related to HCBS. The 10 percentage point FMAP bump for HCBS is an increase from the 7.35 percentage point FMAP bump included in the original version of the bill passed in the US House of Representatives.

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 PHE.

Provision: The ARP makes a technical fix to state 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 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.

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 ARP 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 are eligible for full coverage of their premiums. On the other end of the scale, individuals with incomes above 400% of the FPL will 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. The Centers for Medicare and Medicaid Services (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 CMS on 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 ARP spends new money to implement this change, so the benefit to hospitals in all-urban states will 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.

WHERE CONGRESS COULD GO NEXT

Congressional Democrats were limited in what they could include in the ARP because they relied on reconciliation to advance the bill without Republican support. Ordinarily, senators can block legislation through a filibuster, and it requires 60 votes to end a filibuster. Knowing that some Republicans might have thwarted progress on the bill using the filibuster, Democrats triggered the budget reconciliation process, which is immune from the filibuster and allowed Democrats to advance the bill relying on their 51-vote majority. However, reconciliation rules limit what can be advanced through this process, forcing Democrats to discard many priorities. Items included in the House version of the bill, or generally desired by Democrats but left out of the final bill, could re-appear in future legislation. Additionally, provisions sought by stakeholders but not embraced here, are likely to still be pushed.

MINIMUM WAGE AND 14(C) CERTIFICATES

Many Democrats have pushed for legislation to increase the federal minimum wage from the current $7.25 per hour to $15 per hour. Some states, localities and businesses have instituted a $15 minimum wage.

Section 14(c) of the Fair Labor Standards Act authorizes employers that obtain a certificate from the US Department of Labor Wage and Hour Division to pay special minimum wages (*i.e.*, wages less than the federal minimum wage) to workers who have disabilities. Some states have phased out the 14(c) program, and there have been calls to phase out the program at the federal level.

The House version of the bill included a provision to phase in increases to the federal minimum wage to $15 per hour by 2025. The House bill would have discontinued the issuance of new 14(c) certificates, while allowing existing 14(c) certificate holders to continue using their subminimum wage certificates for five years after enactment. It also would have set the hourly wage paid to 14(c) covered employees to at least $5 in 2021 (or, if greater, the wage that was paid to the employee before the ARP's enactment). Each subsequent year, the 14(c) subminimum wage would have increased by $2.50. In 2025, the subminimum wage paid to 14(c) covered employees would have been $15 per hour, and remaining 14(c) certificates would have had no legal effect.

The Senate substitute version of the bill removed these changes to the federal minimum wage and the 14(c) program following the Senate parliamentarian's ruling that they did not meet Senate reconciliation rules. As a result, changes to the federal minimum are not included in the final version of the ARP.

MEDICAID COVERAGE OF JUSTICE-INVOLVED INDIVIDUALS DURING 30-DAY PERIOD PRECEDING RELEASE

State Medicaid programs are prohibited from financing the care of anyone committed to a jail, prison, detention center or other penal facility (otherwise known as a "justice-involved individual") unless an inmate is treated in a medical institution outside the prison or jail for 24 hours or longer. States have been seeking avenues to cover transition services and care coordination for individuals exiting the justice system. At least six states (California, Illinois, Kentucky, New York, South Carolina and Utah) have explored using Section 1115 waivers (including COVID-19 1115 waivers) to expand Medicaid coverage to justice-involved individuals. To date, no 1115 waivers have been approved to expand Medicaid coverage to justice-involved individuals.

The House version of the ARP initially included a provision to permit Medicaid payments for services to justice-involved individuals enrolled in Medicaid during the last 30 days of their incarceration. This

provision was removed from the bill prior to passage in the House, however. Ultimately, this provision was not included in the final bill.

MEDICARE ACCELERATED AND ADVANCED PAYMENTS TO PROVIDERS

On March 28, 2020, CMS expanded the existing Accelerated and Advance Payments Program, which allows pre-payment of Medicare claims in emergencies, to a broader group of Medicare providers. On April 26, 2020, CMS announced suspension of these payments.

The Continuing Appropriations Act, 2021 and Other Extensions Act, enacted on October 1, 2020, changed the repayment schedule, allowing providers up to one year from receiving the accelerated or advance payment to reimburse CMS. After that point, Medicare payments owed by providers and suppliers will be recouped at a rate of 25% for 11 months. After that time period, the payments will be recouped at a rate of 50% for another six months. After the final six months, the remaining balance will be due, and interest will attach at a rate of 4%.

Although many providers have pushed for more favorable terms for loan repayment and forgiveness, the ARP does not address accelerated and advance payments. Expect an additional uptick in concern about these programs in April 2021 when recoupment begins for some providers.

TELEHEALTH

HHS and Congress provided waivers and flexibilities related to telehealth services during the PHE. These have allowed a significant expansion of telehealth use, increasing access for patients and giving providers additional means to ensure continuity of care while the pandemic limits in-person visits. These flexibilities have also allowed providers to use new, innovative ways to treat patients with mental and behavioral health issues, as well as chronic conditions such as diabetes and hypertension.

Stakeholders have emphasized the importance of maintaining these flexibilities beyond the pandemic. The waivers are tied to the authority provided through the PHE, however. In order to stay effective, the PHE must be renewed by HHS every 90 days. While the current PHE declaration runs through April 20, 2021, the Biden Administration has indicated that it likely will extend the PHE through the end of 2021. Stakeholders are hopeful that Congress will make permanent some of the telehealth waivers before the end of the year.

MEDICARE SEQUESTER RELIEF

The Budget Control Act of 2011, as amended, established that Medicare payments are subject to reductions of up to 2% across the board from 2013 through 2029. The CARES Act suspended Medicare sequestration payment reductions from May 1, 2020, through December 31, 2020. To make up for the budget savings lost during this temporary suspension, the application of the 2% sequestration was extended through 2030.

The Consolidated Appropriations Act, 2021, extended the Medicare suspension through the first quarter of 2021. Absent congressional action, the 2% sequester is scheduled to go into effect on April 1, 2021.

The passage of the ARP will likely trigger a statutory provision created in the Statutory Pay-As-You-Go Act of 2010. The law requires that automatic payment cuts be put into place if a statutory action creates a net increase in the deficit. The Congressional Budget Office has estimated that it would require reductions in Medicare spending of four percentage points (or an estimated $36 billion) for fiscal year 2022 if congressional action is not taken to waive the requirement.

Providers participating in the Medicare program should be aware that payment cuts could be implemented absent congressional action, and that advocacy to waive the payment cuts is likely to begin immediately.

PAYMENT FOR PHYSICIAN SERVICES

The Consolidated Appropriations Act, 2021, directed Medicare to make a 3.75% positive adjustment to calendar year 2021 physician payments, which was applied to the Medicare physician conversion factor. This provision helped mitigate (but did not eliminate) scheduled payment cuts to Medicare physician services for calendar year 2021. The Medicare physician fee schedule is a budget-neutral payment system, and these payment cuts were largely driven by increased spending for office/outpatient evaluation and management services, typically delivered by primary care providers and certain specialty physicians.

The 3.75% payment boost was authorized for only one year, which means that physicians will again face reductions in 2022 unless Congress acts. The ARP does not include a fix for this impending payment cut, but stakeholders are urging Congress to act before the end of 2021.

CONCLUSION

The ARP will be touted as a major accomplishment in the new administration's first 100 days. It makes clear that a Democrat-led Washington will be focused heavily on coverage expansion, particularly through incentives to expand Medicaid that look almost identical to those used when the ACA was first passed during the Obama Administration.

While the ARP is robust in federal action, it also maintains a high degree of flexibility for state and local governments to respond to COVID-19-related needs, both for general economic recovery and healthcare support.

Democrats are highly likely to use reconciliation again in 2021, and Congress will be considering must-pass legislation relating to the debt limit and fiscal funding later this year. There will be many opportunities for the provisions that were not included in the ARP to be considered this year. However, Democrats are likely to face mounting scrutiny on high spending, particularly as the Medicare Hospital Insurance Trust Fund hurtles toward insolvency, the debt limit demands attention and Medicare sequestration looms on the horizon.

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