Selected Health Provisions of the American Rescue Plan Act of 2021
Summary

The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) was signed into law on March 11, 2021. This summary addresses the health provisions in the Act that relate to the Medicare, Medicaid, the Children's Health Insurance Program (CHIP), programs authorized under the Public Health Service (PHS) Act, provisions related to private health insurance Exchanges, and premium subsidies for coverage under former employers' health plans.

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Title II – Committee on Health, Education, Labor and Pensions
Subtitle D – Public Health

Sec. 2301. Funding for COVID-19 Vaccine Activities at the CDC

Appropriates $7.5 billion for fiscal year (FY) 2021 to plan, prepare for, promote, distribute, administer, monitor and track COVID-19 vaccines. Funds are in addition to any amounts otherwise available, and are available until expended.

Through the Centers for Disease Control and Prevention (CDC) and in consultation with other agencies, the Secretary of Health and Human Services (HHS) is directed to use the funds for the following:

1. Activities to enhance, expand, and improve nationwide COVID-19 vaccine distribution and administration, including distribution of ancillary medical products and supplies related to vaccines.
2. Technical assistance, guidance, support and grant awards or cooperative agreements to state, local, tribal, and territorial public health departments for enhancement of COVID-19 vaccine distribution and administration capabilities. This support is to include:
    - distribution and administration of vaccines (licensed and those authorized for emergency use) as well as related ancillary medical products and supplies;
    - establishment and expansion, including staffing support, of community vaccination centers and deployment of mobile vaccination units, particularly in underserved areas;
    - information technology, standards-based data and reporting enhancements including support for data sharing on vaccine distribution and vaccinations and systems that enhance vaccine safety, effectiveness, and uptake, particularly among underserved populations;
    - enhancement of facilities;
    - communication with the public on when, where and how to receive COVID-19 vaccines; and
    - transporting individuals to obtain vaccinations, particularly for underserved populations.

From the appropriated amount, supplemental funding is also provided for CDC state vaccination grants provided through the FY 2020 Public Health Emergency Preparedness (PHEP) cooperative agreement. The additional amount available to a state, locality or territory is based on a comparison of the amount that was received (or would be received) through the allocation formula used for the FY 2020 PHEP cooperative agreement ("base amount") and an alternative allocation calculated using the state, territory, or locality's percentage of the aggregate amount of the FY 2020 PHEP cooperative agreement awards under section 319C-1 of the PHS Act. If the alternative allocation amount for a state, territory or locality is higher than the base amount, supplemental funding is provided equal to the difference between the alternative allocation

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amount and the base amount. The supplemental funds are to be provided no later than 21 days after enactment.

Sec. 2302. Funding for Vaccine Confidence Activities

Appropriates $1 billion in FY 2021 funds for CDC activities to strengthen vaccine confidence in the US and its territories, provide further information on vaccines (licensed or with emergency authorization), and improve vaccination rates. Activities include those described in section 313 of the PHS Act which provides for a national, evidence-based campaign to increase awareness and knowledge vaccine safety and effectiveness, combat misinformation about vaccines, and disseminate scientific and evidence-based vaccine-related information. Funds are in addition to any amounts otherwise available, and are available until expended.

Sec. 2303. Funding for Supply Chain for COVID-19 Vaccines, Therapeutics, and Medical Supplies

Appropriates $6.065 billion in FY 2021 funds for research, development, manufacturing, production, and the purchase of vaccines, therapeutics, and ancillary medical products and supplies to prevent, prepare, or respond to SARS-CoV-2 (or any viral variant mutating from it with pandemic potential) and COVID-19 or any disease with potential for creating a pandemic. Funds are in addition to any amounts otherwise available, and are available until expended.

Sec. 2304. Funding for COVID-19 Vaccine, Therapeutic, and Device Activities at the FDA

Appropriates $500,000,000 in FY 2021 funds to the Food and Drug Administration (FDA) for the following activities:

1. Evaluation of the continued performance, safety, and effectiveness (including with respect to emerging COVID-19 variants) of vaccines, therapeutics, and diagnostics approved, cleared, licensed, or authorized for use for the treatment, prevention, or diagnosis of COVID-19.
2. Facilitation of advanced continuous manufacturing activities for production of vaccines and related materials.
3. Inspections related to the manufacturing of vaccines, therapeutics, and devices delayed or cancelled for reasons related to COVID-19.
4. Review of devices authorized for use for the treatment, prevention, or diagnosis of COVID-19.
5. Oversight of the supply chain and mitigation of shortages of vaccines, therapeutics, and devices approved, cleared, licensed, or authorized for use by the FDA for the treatment, prevention, or diagnosis of COVID-19.

Funds are in addition to any amounts otherwise available, and are available until expended.

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Sec. 2305. Reduced Cost Sharing

Effective for plan years beginning after December 31, 2020, individuals enrolled in a qualified health plan through an Exchange who receive unemployment compensation for any week beginning during 2021 shall be treated as meeting the income eligibility requirements for cost-sharing subsidies, and will be eligible for a reduced cost sharing plan that covers 94 percent of the plan's actuarial value. For Indians who meet this condition, cost sharing will be eliminated. (Specifically, the provision prohibits income in excess of 133 percent of the poverty line for the family size involved to be taken into account when determining the amount of the cost sharing reduction.) These individuals must still be enrolled in an individual market silver-level plan to qualify for the cost sharing reduction.

Subtitle E – TESTING

Sec. 2401. Funding for COVID-19 Testing, Contact Tracing, and Mitigation Activities

Appropriates $47.8 billion in FY 2021 funds to detect, diagnose, trace, and monitor SARS-CoV-2 and COVID-19 infections and related strategies to mitigate the spread of COVID-19. Funds are in addition to any amounts otherwise available, and are available until expended. The Secretary of HHS is directed to use the funds for the following activities:

1. Implement a national, evidence-based strategy for testing, contact tracing, surveillance, and mitigation of SARS–CoV–2 and COVID-19, including through activities authorized for public health emergencies under section 319(a) of the PHS Act.
2. Provide technical assistance, guidance, support, and grants or cooperative agreements to state, local, and territorial public health departments to detect, diagnose, trace, and monitor SARS–CoV–2 and COVID-19 infections and related strategies and activities to mitigate the spread of COVID-19.
3. Support the development, manufacturing, procurement, distribution, and administration of tests to detect and diagnose SARS–CoV–2 and COVID-19, including through supplies needed to administer tests, such as personal protective equipment, and where necessary to ensure sufficient supplies through support for acquiring, altering, constructing, or renovating non-federal facilities to produce diagnostics and ancillary supplies.
4. Establish and expand federal, state, local and territorial contract tracing capabilities including with respect to quarantine and isolation of contacts and through investments in laboratory capacity, such as academic and research laboratories or others used for processing COVID-19 tests, community-based testing sites and organizations, and mobile health units, particularly in medically underserved areas.
5. Enhance information technology, data modernization, and reporting, including improvements to support sharing of data related to public health capabilities.
6. Provide for grants, cooperative agreements, or contracts with state, local, and territorial public health departments to establish, expand, and sustain a public health workforce.
7. Cover administrative and program support costs to conduct these activities.

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Sec. 2402. Funding for SARS–CoV–2 Genomic Sequencing and Surveillance

Appropriates $1.75 billion for FY 2021 to strengthen and expand activities and workforce related to genomic sequencing, analytics, and disease surveillance. Funds are in addition to any amounts otherwise available, and are available until expended.

The funds are to be used to carry out the following activities at the CDC:

1. Conduct, expand, and improve activities to sequence genomes, identify mutations, and survey the circulation and transmission of viruses and other organisms, including strains of SARS–CoV–2.
2. Award grants or cooperative agreements to state, local, tribal, or territorial public health departments or public health laboratories to increase their capacity to sequence genomes of circulating strains, identify mutations, use genomic sequencing to identify outbreaks and clusters of diseases or infections, and develop effective disease response strategies based on genomic sequencing and surveillance data.
3. Enhance and expand the informatics capabilities of the public health workforce.
4. Award grants for the construction, alteration, or renovation of facilities to improve genomic sequencing and surveillance capabilities at the state and local level.

Sec. 2403. Funding for Global Health

Appropriates $750 million for FY 2021 for the CDC to combat SARS-CoV-2, COVID-19, and other emerging infectious disease threats globally. This includes efforts related to global health security, global disease detection and response, global health protection, global immunization, and global coordination on public health. Funds are in addition to any amounts otherwise available, and are available until expended.

Sec. 2404. Funding for Data Modernization and Forecasting Center

Appropriates $500 million for FY 2021 to support public health data surveillance and analytics infrastructure modernization initiatives at the CDC and to establish, expand, and maintain efforts to modernize the US disease warning system to forecast and track hotspots for COVID-19, its variants, and emerging biological threats. This includes academic and workforce support for analytics and informatics infrastructure and data collection systems. Funds are in addition to any amounts otherwise available, and are available until expended.

Subtitle F – Public Health Workforce

Sec. 2501. Funding for Public Health Workforce

Appropriates $7.66 billion for FY 2021 for establishing, expanding, and sustaining a public health workforce, including through awards to state, local, and territorial public health departments. Funds are in addition to any amounts otherwise available, and are available until expended.

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The funds are to be used for several specified purposes. One purpose is for wages, benefits and other costs related to recruiting, hiring, and training individuals in a number of positions when employed by state, territorial or local public health departments or by public or nonprofit private organizations with expertise and relationships with public health departments. The positions specified are case investigators, contact tracers, social support specialists, community health workers, public health nurses, disease intervention specialists, epidemiologists, program managers, laboratory personnel, informaticians, communication and policy experts and other positions to prevent, prepare for, and respond to COVID-19.

Other specified uses for the funds are personal protective equipment or other necessary supplies, data management and other technology, subawards from recipients to local health departments, and administrative costs and activities.

Sec. 2502. Funding for Medical Reserve Corps

Appropriates $100 million for FY 2021 for the Volunteer Medical Reserve Corps under section 2813 of the PHS Act, which provides volunteers in the case of a federal, state, local or tribal public health emergency. Funds are in addition to any amounts otherwise available, and are available until expended.

Subtitle G – Public Health Investments

Sec. 2601. Funding for Community Health Centers and Community Care

Appropriates $7.6 billion for FY 2021 for grants and cooperative agreements for community health centers, grants to federally qualified health centers (FQHCs), and grants or contracts to Papa Ola Lokahi and qualified native Hawaiian health care systems. Funds are in addition to any amounts otherwise available, and are available until expended. Of the total, at least $20 million must be used for grants or contracts to Papa Ola Lokahi and qualified native Hawaiian health care systems.

These funds are for several specified purposes. These are:

- to carry out vaccine related activities including planning, promoting, distributing, administering, and tracking COVID-19 vaccines;
- to detect, diagnose, trace and monitor COVID-19 infections and related activities to mitigate the spread of COVID-19 including the purchase of equipment and supplies for testing, contract tracing, surveillance, mitigation, and treatment;
- COVID-19 mobile testing or vaccinations, particularly in medically underserved areas, including the purchase of vehicles, equipment, and supplies, and the hiring and training of staff;
- workforce;
- services and infrastructure; and
- community outreach and education related to COVID-19.

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Awardees may use the funds they receive to cover past expenditures for these specified activities dating back to the declaration of the COVID-19 public health emergency on January 31, 2020. Certain existing restrictions on the Secretary in providing health center funding will not apply to these new funds. Specifically, the requirement that funds for operating grants may only be used for expanding and modernizing existing buildings or constructing new buildings (including the costs of amortizing the principal of, and paying the interest on, loans) with respect to projects approved prior to October 1, 1996 does not apply. In addition, for these funds the Secretary is not bound by the requirement that grant applications for new delivery sites or expanded capacity be approved such that the ratio of medically underserved populations expected to use the applicants' services in rural areas to those in urban areas must be from two to three. The requirement that the amounts available for migratory and seasonal workers, the homeless population, and residents of public housing each be in the same the proportion of the total that was provided in FY 2001 will not apply to these funds.

Sec. 2602. Funding for National Health Service Corps

Appropriates $800 million for FY 2021 for the National Health Service Corps scholarships and loan repayment programs. Funds are in addition to any amounts otherwise available, and are available until expended.

Of the total appropriation, $100 million is designated for providing primary health services through grants to states for state loan repayment programs under section 338I of the PHS Act for health professionals providing primary care in health professional shortage areas. The existing matching fund requirement will not apply to these funds. No more than 10 percent of the funds may be used for administering the state loan repayment program.

Sec. 2603. Funding for Nurse Corps

Appropriates $200 million for FY 2021 for the Nurse Corps Loan Repayment Program under section 846 of the PHS Act. Funds are in addition to any amounts otherwise available, and are available until expended.

Sec. 2604. Funding for Teaching Health Centers that Operate Graduate Medical Education

Appropriates $330 million for teaching health centers that operate graduate medical education under section 340H of the PHS Act, and for teaching center development grants under section 749A of the PHS Act. Under section 340H, teaching health centers are defined as community based, ambulatory patient care centers that operate a primary care residency program, and include FQHCs, community mental health centers, rural health centers, family planning programs, and health centers operated by the Indian Health Service, an Indian tribe, tribal organization, or an urban Indian organization. Existing caps on total funding will not apply to these appropriations. Funds are in addition to any amounts otherwise available, and are available until September 30, 2023.

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Funds are to be used to establish new graduate medical residency training programs, increase the per-resident amount, maintain filled positions at existing medical residency programs, expand medical residency programs, establish new accredited or expanded primary care residency programs through teaching health center development grants, and cover administrative costs at qualified teaching health centers.

Sec. 2605. Funding for Family Planning

Appropriates $50 million for fiscal year 2021 for project grants and contracts for family planning services under Title X of the PHS Act. Funds are in addition to any amounts otherwise available, and are available until expended.

Subtitle H – Mental Health and Substance Use Disorder

Sec. 2701. Funding for Block Grants for Community Mental Health Services

Appropriates $1.5 billion for FY 2021 for community mental health services block grants, and for activities of the Center for Behavioral Health Statistics and Quality relating to mental health. Funds are in addition to amounts otherwise available and must be expended by states by September 30, 2025.

Sec. 2702. Funding for Block Grants for Prevention and Treatment of Substance Abuse

Appropriates $1.5 billion for FY 2021 for block grants for prevention and treatment of substance abuse, and for activities of the Center for Behavioral Health Statistics and Quality relating to substance abuse. Funds are in addition to amounts otherwise available and must be expended by states by September 30, 2025.

Sec. 2703. Funding for Mental and Behavioral Health Training for Health Care Professionals, Paraprofessionals, and Public Safety Officers

Appropriates $80 million for fiscal year 2021 for Health Resources and Services Administration (HRSA) grants and contracts to health professions schools, academic health centers, state or local governments, Indian tribes and tribal organizations, or other public or nonprofit entities, including those promoting multidisciplinary approaches. HRSA is to consider the needs of rural and medically underserved communities. The grants and contracts are to plan, develop, operate, or participate in health professions and nursing training for health care students, residents, professionals, paraprofessionals, trainees, public safety officers, and employees of these individuals on evidence-informed strategies for reducing and addressing suicide, burnout, mental health conditions and substance use disorders among health care professionals. Funds are in addition to amounts otherwise available and are available until expended.

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Sec. 2704. Funding for Education and Awareness Campaign Encouraging Healthy Work Conditions and Use of Mental and Behavioral Health Services by Health Care Professionals

Appropriates $20 million for FY 2021 through CDC and in consultation with the medical professional community for an evidence-based education and awareness campaign directed at health care professionals and first responders and their employers. The campaign is to encourage primary prevention of mental health conditions and substance use disorders and secondary and tertiary prevention by encouraging health care professionals to seek support and treatment for their own mental health and substance use concerns, and help these individuals identify and respond to risk factors in themselves and others. Funds are in addition to amounts otherwise available and are available until expended.

Sec. 2705. Funding for Grants for Health Care Providers to Promote Mental and Behavioral Health Among Their Health Professional Workforce

Appropriates $40 million for FY 2021 for HRSA to award grants and contracts to entities providing health care, including health care provider associations and FQHCs, to establish, enhance, or expand evidence-informed programs or protocols to promote mental health among their providers, other personnel, and members. In making these awards, HRSA is to consider the needs of rural and medically underserved communities. Funds are in addition to amounts otherwise available and are available until expended.

Sec. 2706. Funding for Community-based Funding for Local Substance Use Disorder Services

Appropriates $30 million for FY 2021 for the Substance Abuse and Mental Health Administration (SAMHSA), in consultation with CDC, to award grants to state, local, tribal, and territorial governments, tribal organizations, nonprofit community organizations and primary and behavioral health organizations to support community-based overdose prevention programs, syringe services programs and other harm reduction services. Funds are in addition to amounts otherwise available and are available until expended.

Grant funds are to be used for preventing and controlling the spread of infectious diseases and the consequences of such diseases for individuals with substance use disorder; distributing opioid overdose reversal medication to individuals at risk of overdose; connecting individuals at risk for or with a substance use disorder to overdose education, counseling, and health education; and encouraging such individuals to take steps to reduce the negative personal and public health impacts of substance use or misuse.

Sec. 2707. Funding for Community-based Funding for Local Behavioral Health Needs

Appropriates $50 million for FY 2021 to SAMHSA for grants to state, local, tribal, and territorial governments, tribal organizations, nonprofit community organizations and primary and behavioral health organizations to address community behavioral health needs worsened by the COVID-19

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public health emergency. Funds are in addition to amounts otherwise available and are available until expended.

Grant funds are to be used for promoting care coordination among local entities; training the mental and behavioral health workforce, relevant stakeholders, and community members; expanding evidence-based integrated models of care; addressing surge capacity for mental and behavioral health needs; providing mental and behavioral health services to individuals with mental health needs (including co-occurring substance use disorders) as delivered by behavioral and mental health professionals utilizing telehealth services; and supporting, enhancing, or expanding mental and behavioral health preventive and crisis intervention services.

Sec. 2708. Funding for the National Child Traumatic Stress Network

Appropriates $10 million for FY 2021 for grants under section 582 of the PHS Act with respect to the problem of high-risk or medically underserved persons who experience violence-related stress. Section 582 provides for the continued operation of the National Child Traumatic Stress Initiative among other activities. Funds are in addition to amounts otherwise available and are available until expended.

Sec. 2709. Funding for Project AWARE

Appropriates $30 million for FY 2021 for section 520A of the PHS Act with respect to advancing wellness and resiliency in education. Among other activities, section 520A funds the Project AWARE (Advancing Wellness and Resiliency in Education) State Education Agency Grants. Funds are in addition to amounts otherwise available and are available until expended.

Sec. 2710. Funding for Youth Suicide Prevention

Appropriates $20 million for FY 2021 for sections 520E and 520E-2 of the PHS Act, which address youth suicide early intervention and prevention strategies and mental health and substance use disorder services on campus, respectively. Funds are in addition to amounts otherwise available and are available until expended.

Sec. 2711. Funding for Behavioral Health Workforce Education and Training

Appropriates $100 million for mental and behavioral health education and training grants under section 756 of the PHS Act. Funds are in addition to amounts otherwise available and are available until expended.

Sec. 2712. Funding for Pediatric Mental Health Care Access

Appropriates $80 million for pediatric mental health care access grants under section 330M of the PHS Act. Funds are in addition to amounts otherwise available and are available until expended.

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Sec. 2713. Funding for Expansion Grants for Certified Community Behavioral Health Clinics

Appropriates $420 million to SAMHSA for grants to communities and community organizations that meet the criteria for Certified Community Behavioral Health Clinics under section 223(a) of the Protecting Access to Medicare Act of 2014 (P.L. 113-93). Funds are in addition to amounts otherwise available and are available until expended.

Subtitle I – Exchange Grant Program

Sec. 2801. Establishing a Grant Program for Exchange Modernization

The Act authorizes and appropriates $20 million in grants for the Secretary to award to state health insurance Exchanges to enable the Exchanges to modernize or update systems, programs, or technologies. States must apply for these the funds which will remain available until expended.

Title IX – Committee on Finance

Subtitle F – Preserving Health Benefits for Workers

Sec. 9501. Preserving Health Benefits for Workers

Under Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA; P.L. 99-272), an employer with 20 or more employees who provides health insurance benefits is required to provide certain employees and their families the option of continuing coverage under the employer's group health insurance plan after employment ends. Availability of COBRA coverage usually lasts for 18 months, but it can be extended up to a total of 36 months, depending on the nature of the triggering event. Those who take up their COBRA benefits are required to pay up to 100 percent of the premium, plus an additional 2 percent for the administrative costs incurred.

Section 9501 provides for a subsidy for the full cost of COBRA continuation coverage during the period beginning on enactment (March 11, 2021) and extending through September 30, 2021. Individuals who become eligible for another group health plan may no longer be eligible for the temporary COBRA assistance and are required to notify the plan sponsor in this case.

While under existing rules, a person opting for COBRA continuation coverage must remain in the plan that they were enrolled in upon leaving employment, Section 9501 adds some potential flexibility for individuals wishing to change to a different plan. If permitted by the employer, a person can elect to be covered by another plan option offered by the employer so long as the new plan is offered to all similarly situated active employees of the employer and if the premium for such coverage is below the premium for the coverage they are electing to disenroll from. The new plan may not cover only excepted benefits (such as dental-only or vision coverage), nor be a qualified small employer health reimbursement arrangement or a flexible spending arrangement.

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Those individuals who qualified but had not elected COBRA continuation coverage as of the date of the enactment the Act or who elected it but subsequently dropped it and who would have qualified for the temporary assistance if they had elected or maintained such coverage are provided with a temporary election period. Under section 9501, they may elect to enroll in continuation coverage starting on the first day of the first month after enactment through 60 days after receiving notification of their ability to do so.

The provision modifies existing notification requirements to require that employers provide notice about the premium assistance, the additional plan choice flexibilities, and the extended election period available under section 9501. In addition, notice is required to be provided in advance of the end of the temporary period of premium assistance.

The Secretary of Labor is provided with $10 million for implementation of these provisions and is required to provide, in consultation with the Secretaries of HHS and the Treasury, outreach and education regarding the premium assistance.

Subtitle G – Promoting Economic Security
Part 7 – Premium Tax Credit

Section 9661. Improving Affordability by Expanding Premium Assistance for Consumers

Section 9661 temporarily increases the premium assistance for individuals purchasing health insurance coverage through health insurance Exchanges. For all of taxable years 2021 and 2022, the amount of premium tax credit is increased for individuals with income below 400 percent of the federal poverty level (FPL). In addition, premium tax credits are made available for individuals with income in excess of 400 percent FPL. Those individuals qualify for a subsidy to the extent that their health insurance premium exceeds 8.5 percent of their income. Those with income below 150 percent of FPL qualify for subsidies that cover the full amount of the second lowest cost silver metal-level plan available in their area.

Section 9662. Temporary Modification of Limitations on Reconciliation of Tax Credits for Coverage Under a Qualified Health Plan with Advance Payments of Such Credit

The existing requirement that a person must repay all or some portion of excess advance premium tax credits is temporarily waived. Individuals who received the advance premium tax credit during the 2020 tax year in excess of the amounts that they should have received will not be required to pay those excess amounts back via the tax reconciliation process.

Section 9663. Application of Premium Tax Credit in Case of Individuals Receiving Unemployment Compensation During 2021

For individuals who receive unemployment compensation during 2021, income in excess of 133 percent of FPL (for their applicable family size) will not be counted in determining the amount of the premium tax credit for which they are eligible. During 2021, these individuals will qualify for

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a premium tax credit that will cover the full amount of the second lowest-cost silver metal level plan available in their area. This provision does not impact determinations of the affordability of an employer-sponsored plan.

Subtitle J – Medicaid

Section 9811. Mandatory Coverage of COVID-19 Vaccines and Administration and Treatment Under Medicaid

(1) Coverage of Vaccines and their Administration

Beginning upon enactment of the ARPA and extending through one year after the end of the COVID-19 public health emergency period, state Medicaid programs are required to cover a COVID-19 vaccine, administration of the vaccine, and testing and treatments for COVID-19. Such coverage includes specialized equipment and therapies including preventive therapies for individuals diagnosed or presumed to have COVID-19 as well as treatment of a condition that may seriously complicate the treatment of COVID-19 so long as it would otherwise be covered under the state plan or waiver program. The requirement extends to childless adults covered under the Affordable Care Act (ACA) Medicaid expansion, individuals qualifying for partial coverage (for example, pregnant women, individuals with tuberculosis, or individuals qualifying for family planning only services), and individuals receiving alternative benefits plans. The requirement does not apply to those qualifying only for premium assistance.

(2) Prohibition of Cost Sharing

Beginning upon enactment of the ARPA and extending through one year after the end of the COVID-19 public health emergency period, state Medicaid programs are prohibited from imposing deductibles, coinsurance, or other cost sharing for COVID-19 vaccines, administration of the vaccines, and testing and treatments for COVID-19.

(3) Drug Rebate Program

Drug rebate requirements applicable to Medicaid outpatient drugs also will apply to drugs or biologicals furnished as medical assistance for the testing or treatment of COVID-19.

(4) Federal Matching for Vaccines

Beginning upon enactment and ending on the last day of the first quarter that begins one year after the last day of the COVID-19 public health emergency period, the federal share of costs for Medicaid vaccines for COVID-19 and their administration will be 100 percent. Any federal Medicaid payments made to a U.S. territory for spending on Medicaid vaccines for COVID-19 will not count toward the territory's payment limits.

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Section 9812. Modifications to Certain Coverage Under Medicaid for Pregnant and Postpartum Women

For a limited period of time, states may opt to extend pregnancy-related Medicaid coverage for low-income women through the end of the 12-month period postpartum. Under prior law, pregnancy-related coverage ends 60 days postpartum. Under this provision, states electing to extend such coverage must provide coverage for all items and services covered under the state plan throughout the coverage period including pregnancy and during the 12 months postpartum. In addition, a state making such an election that also covers targeted low-income children who are pregnant or targeted low-income pregnant women under CHIP must also extend pregnancy related coverage for 12-months postpartum under that program. The option to extend pregnancy-related coverage to 12 months is available to states starting with the first fiscal quarter beginning one year after enactment and ending 5 years after that date.

Section 9813. State Option to Provide Qualifying Community-based Mobile Crisis Intervention Services

For a temporary period, states have the option to cover under Medicaid qualifying community-based mobile crisis intervention services. Such services are defined as those provided by a multidisciplinary mobile crisis team to an individual who is outside of a hospital or facility and who is experiencing a mental health or substance use disorder crisis. Services must be available 24 hour per day, every day of the year. The members of the team must include at least one behavioral health care professional; be trained in trauma-informed care; be able to timely provide screening and assessment, stabilization, and de-escalation; and must coordinate referrals to other health services. This state option is available for a period of 5 years beginning on the first day of the calendar quarter beginning one year after the date of enactment. Enhanced federal matching for the costs of the services is set at 85 percent unless the state qualifies for a higher matching percentage under other applicable provisions and is available for 12 fiscal quarters.

A state electing the option must assure the Secretary that the funds provided for qualifying community-based mobile crisis intervention services will be used to supplement and not supplant state funds for such services. Medicaid requirements for statewideness (benefits must be made available across an entire state), comparability (benefits must be comparable across groups of Medicaid beneficiaries), and freedom of choice of providers (Medicaid beneficiaries must be free to choose their own providers) do not apply to the temporary option to cover qualifying community-based mobile crisis intervention services.

Authorizes and appropriates $15 million to the Secretary of Health and Human Services (HHS) for implementing, administering, and making planning grants to states for developing a state plan amendment or waiver amendment to provide such services.

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Section 9814. Temporary Increase in FMAP for Medical Assistance under State Medicaid Plans which Begin to Expend Amounts for Certain Mandatory Individuals

To date, 39 states have opted to extend Medicaid coverage to childless adults as permitted under the ACA and 12 states have not chosen to do so. Section 9814 provides for a temporary increase in a state's regular federal matching percentage for those states newly expanding coverage to childless adults under the ACA provision.

The 5-percentage point enhanced matching rate applies to spending for a period of 8 calendar quarters beginning with the quarter in which the state extends coverage to ACA adults. The enhanced matching applies in addition to any federal medical assistance percentage (FMAP) increase authorized under section 6008 of the Families First Coronavirus Response Act (FFCRA, P.L. 116-127).[1] Enhanced federal matching payments provided under this section do not apply to disproportionate share hospital payments and may not be not taken into account in calculating a state's enhanced matching rate under the CHIP program, nor applied to the caps on federal payments applicable to the U.S. territories.

Section 9815. Extension of 100 Percent FMAP to Urban Indian Health Organizations and Native Hawaiian Health Care Systems

Provides for a temporary increase in the FMAP applicable for medical assistance provided by an Urban Indian organization with a grant or contract with the Indian Health Services and by a Native Hawaiian Health Center or a qualified entity that has a grant or contract with Papa Ola Lokahi. For 8 fiscal year quarters, beginning with the first fiscal year quarter after enactment, the FMAP for such medical assistance will be 100 percent.

Section 9816. Sunset of Limit on Maximum Rebate Amount for Single Source Drugs and Innovator Multiple Source Drugs

Presently, the amount that a pharmaceutical manufacturer of a single source drug or innovator multiple source drug must pay in Medicaid rebates is subject to a cap equal to 100 percent of the average manufacturer price of a drug. This provision sunsets that cap beginning with rebate periods starting after January 1, 2024.

Section 9817. Additional Support for Medicaid Home and Community-Based Services (HCBS) during the COVID-19 Emergency

Section 9817 provides for a temporary increase in the FMAP for Medicaid home and community-based services provided during the period beginning on April 1, 2021 and ending March 31, 2022.

[1] Section 6008 of FFCRA provided a temporary increase in the regular federal matching percentage applicable to most Medicaid benefits during the COVID-19 public health emergency period. The increased federal matching share applies to Medicaid spending starting on the first day of the COVID-19 public health emergency period and extending to the last day of the calendar quarter in which the COVID-19public health emergency period ends.

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The FMAP for those services is increased by 10 percentage points above the applicable FMAP subject to a ceiling of 95 percent. Subject to the ceiling, the 10 percentage points are added to an enhanced FMAP for the coverage of Medicaid ACA childless adults, an enhanced disaster recovery FMAP, an enhanced FMAP for states under the FFCRA, and enhanced matching for the Community First Choice Option.

Services that are considered to be home and community based under this provision include home health, personal care, Programs of All-Inclusive Care for the Elderly, home and community-based services authorized under certain waivers under sections 1915[2] and 1115 of the Social Security Act, case management, rehabilitative services, and other services as specified by the Secretary of HHS.

To receive the enhanced federal payments, a state must use the funds to supplement and not supplant existing spending for HCBS, and must implement (or supplement) activities to enhance, expand or strengthen HCBS under Medicaid. Federal payments for the services subject to the enhanced matching under section 9817 are excluded from the U.S. territories' caps.

Section 9818. Funding for State Strike Teams for Resident and Employee Safety in Nursing Facilities

Authorizes and appropriates $250 million for the Secretary to distribute among states (including the District of Columbia and the territories) to establish and implement a strike team to be deployed to a nursing facility in the state with diagnosed or suspected cases of COVID-19 among residents or staff. The purpose of the strike teams is to assist with clinical care, infection control or staffing during the COVID-19 public health emergency period. Funds remain available until expended and are for strike team visits during the COVID-19 public health emergency period and for one year after the end of the emergency period.

Section 9819. Special Rule for the Period of a Declared Public Health Emergency Related to Coronavirus

Section 9819 adds a special rule to provisions establishing Medicaid allotments for disproportionate share hospital payments during the COVID-19 public health emergency period. The rule ensures that during the period for which enhanced federal matching is available under section 6008 of the FFCRA, such increased federal share does not result in a reduction to total permissible DSH payments. Under the rule, DSH payments in a state during the period for which enhanced federal matching is available under section 6008 of FFCRA should be calculated to ensure that the total amount of payments equals to the total amount of payments that would have been made without the increase in the federal share. The provision is effective as of the date of enactment of the FFCRA.

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[2] Authorized under subsection (b), (c), (i), (j), and (k) of section 1915.

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Subtitle K – Children's Health Insurance Program

Section 9821. Mandatory Coverage of COVID-19 Vaccines, Administration and Treatment Under CHIP

(1) Coverage

Beginning upon enactment and extending through one year after the end of the COVID-19 public health emergency period, section 9821 requires state CHIP programs to cover a COVID-19 vaccine, administration of the vaccine, and testing and treatments for COVID-19. Such coverage includes specialized equipment and therapies including preventive therapies for individuals diagnosed or presumed to have COVID-19 as well as treatment of a condition that may seriously complicate the treatment of COVID-19 so long as it would otherwise be covered under the state plan or waiver program.

(2) Prohibition of Cost Sharing

A state CHIP program is prohibited from imposing deductibles, coinsurance, or other cost sharing for COVID-19 vaccines, administration of the vaccine, and testing and treatments for COVID-19 during the period beginning upon enactment and extending through one year after the end of the COVID-19 public health emergency period.

(3) Temporary Increase in Federal Payment for Coverage and Administration of COVID-19 Vaccines

The federal share of costs under CHIP for COVID-19 vaccines and their administration will be 100 percent during the period beginning upon enactment and ending on the last day of the first quarter that begins at least one year after the last day of the COVID-19 public health emergency period.

(4) CHIP Allotments

A state receiving 100 percent federal matching payments for the costs of vaccines and their administration during the period beginning with enactment and ending one year after the end of the COVID-19 public health emergency period will have its CHIP allotment adjusted up by the amount spent on such vaccines and administration. The allotment will be increased by the projected expenditures for that year and in the subsequent year, once actual expenditures are available, the allotment will be adjusted to reflect the difference between the projected amount and the actual amount of spending for the year.

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Sec. 9822. Modifications to Certain Coverage Under CHIP for Pregnant and Postpartum Women

If a state has chosen the Medicaid options described above to extend coverage to women for 12 months postpartum and to provide full benefits to pregnant and postpartum women under Medicaid, and the state covers targeted low-income children who are pregnant or targeted low-income pregnant women under CHIP, the state is required to extend full benefits for 12 months postpartum under CHIP as well.

Subtitle M – Medicare

Sec. 9831. Floor on the Medicare Area Wage Index for Hospitals in All Urban States

The Balanced Budget Act of 1997 established a floor on the hospital wage index such that an urban hospital could not have a lower wage index than hospitals located in the rural areas of its state. The provision is known as the "rural floor". As all urban states (New Jersey, Delaware, and Rhode Island) have no rural areas, this provision cannot apply to hospitals in these states.

From October 1, 2003 until October 1, 2018, CMS established a methodology for determining a floor on the wage index for hospitals in all urban states and states with rural areas but no hospitals located in them (there have been none). CMS' original methodology was designed such that only hospitals in New Jersey could benefit. Beginning October 1, 2012, CMS established an alternative methodology that also benefitted hospitals in Delaware and Rhode Island. These provisions, known as the imputed floor, were subject to budget neutrality.

CMS ended the imputed floor on September 30, 2018. Section 9831 reestablishes the imputed floor effective October 1, 2021 with a budget neutrality waiver. CMS adopted the imputed floor for both the inpatient prospective payment system (IPPS) and outpatient prospective payment system by regulation. Section 9831 only modifies provisions of statute that apply to the IPPS.

Sec. 9832. Authority to Waive Transport Requirement for Medicare to Pay for Ambulance Services During the COVID-19 Public Health Emergency

The Medicare statute will only pay for "ambulance service where the use of other methods of transportation is contraindicated by the individual's condition." The law requires the patient to be transported for there to be Medicare payment. Medicare will not pay for an ambulance service if its crew treats the patient without transport. Prior to enactment of section 9832, the transport requirement could not be waived during a public health emergency.

Section 9832 allows the Secretary to waive the transportation requirement only during the COVID-19 public health emergency if: 1) the ambulance is dispatched in response to a 911 call (or equivalent for areas without a 911 call system); and 2) the patient could not be transported because of community-wide protocols in place during the COVID-19 public health emergency. Absent these protocols, Medicare would have paid for a ground ambulance service. Payment will

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be at the base rate for ground ambulance services without any mileage. For critical access hospitals (CAH) or ambulance services owned and operated by CAHs, Medicare will pay 101 percent of reasonable costs.

Sec. 9833. Funding for HHS Office of Inspector General

The OIG is provided $5 million for oversight activities of funds appropriated to HHS to prevent, prepare for and respond to COVID-19 domestically or internationally. Funds are available until expended.

Subtitle N – Other Provisions

Section 9911. Funding for Providers Related to COVID-19

The Secretary is provided with FY 2021 appropriations of $8.5 billion to make payments to eligible health care providers for health care related expenses and lost revenues attributable to COVID-19. Funds are available until expended. Eligible providers must apply to receive funds. The application must include the provider's taxpayer identification number, assurances that the recipient will provide documentation and reports as the Secretary determines are needed and any other information required by the Secretary. No payments may be made for expenses or losses that are reimbursed or obligated to be reimbursed by another source.

An eligible health care provider is a rural provider or supplier that provides diagnoses, testing or care for individuals with actual or possible cases of COVID-19 that is a participating provider under Medicare, Medicaid ort CHIP. A rural provider or supplier is any of the following:

1. A Medicare provider or supplier that is geographically rural (not in a metropolitan statistical area (MSA)) under the Office of Management Budget's (OMB) statistical area delineations or is treated as rural under the IPPS;
2. A provider or supplier located in any other area that serves rural patients (as determined by the Secretary) and may include MSAs of less than 500,000;
3. A rural health clinic;
4. A Medicare provider or supplier that furnishes home health, hospice or long-term care services in an individual's home located in a geographically rural area;
5. Any other rural provider or supplier defined by the Secretary.

Health Care Related Expenses: Expenses to prevent, prepare for, and respond to COVID-19, including the building or construction of a temporary structure, the leasing of a property, the purchase of medical supplies and equipment, including personal protective equipment and testing supplies, providing for increased workforce and training (including maintaining staff, obtaining additional staff, or both), the operation of an emergency operation center, retrofitting a facility, providing for surge capacity, and other expenses determined appropriate by the Secretary.

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Lost Revenue Attributable to COVID-19: The term ‘lost revenue attributable to COVID-19 has the meaning given that term in the Frequently Asked Questions (FAQ) guidance released by the HHS in June 2020, including the difference between such provider’s budgeted and actual revenue if such budget had been established and approved prior to March 27, 2020. See footnote for the full text of the FAQ that is not currently on the HHS website.

Payment: Includes any payment determined appropriate by the Secretary including a prepayment, prospective payment, a retrospective payment or a payment through a grant or other mechanism.

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