American Rescue Plan Act of 2021 (P.L. 117-2): Private Health Insurance, Medicaid, CHIP, and Medicare Provisions

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SUMMARY

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American Rescue Plan Act of 2021 (P.L. 117-2): Private Health Insurance, Medicaid, CHIP, and Medicare Provisions

The American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) addresses a number of issues that were before Congress related to Coronavirus Disease 2019 (COVID-19) relief and economic stimulus. The ARPA was enacted through the budget reconciliation process. On February 5, 2021, the House and the Senate adopted S.Con.Res. 5, a budget resolution for fiscal year (FY) 2021 that included reconciliation directives to 23 House and Senate committees. On February 22, 2021, the House Budget Committee voted to report the American Rescue Plan Act of 2021 (ARPA; H.R. 1319). On February 27, the House passed H.R. 1319 by a vote of 219-212, and the bill was received in the Senate on March 2, 2021. On March 6, 2021, the Senate voted to pass H.R. 1319, as amended, by a vote of 50-49. On March 10, 2021, the House voted to concur in the Senate amendment, 220-211, sending the bill to the President for his signature. The following day, the President signed the bill and it became P.L. 117-2.

The ARPA includes provisions addressing a number of issues, such as tax credits, unemployment benefits, state fiscal relief, health, housing, education, and food assistance, among others. This report provides information about the provisions in the ARPA related to private health insurance, Medicaid, the State Children's Health Insurance Program (CHIP), and Medicare.

Private Health Insurance. For private health insurance, the ARPA includes provisions relevant to workers who lose their employment-based health benefits and to the individual exchanges and the coverage sold through them. The ARPA temporarily subsidizes Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage for certain individuals who lost employer-based health insurance due to an involuntary termination or reduction in hours. The ARPA also temporarily expands eligibility for and the amount of the premium tax credits (PTCs) and cost-sharing reductions applicable to certain exchange plans and specified individuals, including those who receive unemployment compensation in 2021. In addition, the ARPA suspends the requirement, for tax year 2020, that individuals pay back PTC amounts that were provided in excess. The ARPA also provides grant funding for state-administered health insurance exchanges to modernize or update their systems, programs, or technology.

Medicaid and CHIP. The ARPA includes a number of Medicaid and CHIP provisions. The ARPA adds a new temporary Medicaid and CHIP requirement for states to provide fully federally funded coverage of COVID-19 vaccines and treatment without enrollee cost sharing. The law eliminates the cap on total Medicaid drug rebates and recalculates Medicaid disproportionate share hospital allotments to account for the FFCRA federal medical assistance percentage increase. The ARPA provides temporary enhanced federal reimbursement rates for certain Medicaid expenditures, including non-expansion states that implement the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion, home and community-based services for states that meet certain requirements, and Medicaid services at Urban Indian Organizations and Native Hawaiian Health Centers. The ARPA includes some new temporary optional Medicaid activities for states, such as Medicaid and CHIP postpartum coverage for 12 months, coverage of qualifying community-based mobile crisis intervention services, and Medicaid and CHIP coverage of COVID-19 vaccines and treatment without cost sharing for the COVID-19 testing population.

Medicare. The Medicare provisions in the ARPA impact nursing homes, hospitals located in states with no rural areas, and ambulance services. The ARPA provides funding for quality improvement organizations to carry out infection control and vaccination uptake support in Medicare-certified nursing homes. Other provisions affecting Medicare (1) establish a floor on the Medicare area wage index for hospitals located in states with no rural areas and (2) allow payment for ground ambulance services furnished when no actual transport was provided due to community restrictions imposed during the COVID-19 public health emergency.

Medicare, Medicaid, and CHIP. A couple of ARPA provisions impact both Medicare and Medicaid. The ARPA provides funding to establish and implement strike teams to help respond to COVID-19 in Medicare-certified and Medicaid-certified nursing homes. The ARPA also provides $8.5 billion to make payments to rural Medicare and Medicaid providers for health care-related expenses and lost revenue attributable to COVID-19.

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Introduction

The American Rescue Plan Act of 2021 (ARPA; P.L. 117-2), enacted on March 11, 2021, is the latest in a series of Coronavirus Disease 2019 (COVID-19)-related relief and economic stimulus legislation, that includes the Families First Coronavirus Response Act (FFCRA; P.L. 116-127); the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136); and the Consolidated Appropriations Act, 2021 (P.L. 116-260). The ARPA was enacted through the budget reconciliation process.

The ARPA includes provisions addressing a number of issues, such as tax credits, unemployment benefits, state fiscal relief, health, housing, education, and food assistance, among others. This report provides information about the ARPA provisions related to private health insurance, Medicaid, the State Children's Health Insurance Program (CHIP), and Medicare.

The report begins with a summary of the reconciliation process for the ARPA. Then, the report provides high-level summaries of the provisions in the ARPA under the following headings: private health insurance, Medicaid and CHIP, Medicare, and Medicare and Medicaid. The high-level summaries are followed by a table with abbreviated summaries of each provision. The sections following the table provide more detailed summaries of these provisions. The **Appendix** includes a table with a list of the abbreviations used in this report.

Budget Reconciliation Process

On February 5, 2021, the House and the Senate adopted S.Con.Res. 5, a budget resolution for fiscal year (FY) 2021.[1] A budget resolution generally represents an agreement between the House and the Senate on a budgetary plan for the upcoming fiscal year. The House Budget Committee, however, stated that this budget resolution was adopted solely to allow Congress to employ the special procedures available under the budget reconciliation process to facilitate the enactment of President Joe Biden's proposed American Rescue Plan.[2]

S.Con.Res. 5 included reconciliation directives to 23 House and Senate committees, instructing each committee to develop legislation within its jurisdiction that would increase the deficit by a specified amount.[3] Committees were directed to transmit such legislation to their respective Budget Committees by February 16, 2021. Under reconciliation procedures, once "instructed" committees transmit such legislation to their respective Budget Committees, the Budget

[1] For more information on S.Con.Res. 5, see CRS Report R46675, *S.Con.Res. 5: The Budget Resolution for FY2021*.

[2] The House Budget Committee stated, "The 2021 budget resolution is not a comprehensive fiscal blueprint for the next 10 years. It is designed solely to provide the option of using reconciliation to deliver critical relief and achieve the goals of the American Rescue Plan." U.S. Congress, House Committee on the Budget, *The Budget Resolution and Reconciliation: An Alternative Path for the American Rescue Plan*, 117th Cong., 1st sess., February 1, 2021, at https://budget.house.gov/publications/report/budget-resolution-and-reconciliation-alternative-path-american-rescue-plan. See also CRS Report R46675, *S.Con.Res. 5: The Budget Resolution for FY2021*. For more information on the American Rescue Plan, see White House, "President Biden Announces American Rescue Plan," January 20, 2021, at https://www.whitehouse.gov/briefing-room/legislation/2021/01/20/president-biden-announces-american-rescue-plan/.

[3] The directives to the 12 House committees totaled approximately $2.1 trillion in deficit increases, and the directives to the 11 Senate committees totaled $1.9 trillion. The House Budget Committee indicated that this difference was due to "overlapping committee jurisdictions in the House" and that the budget resolution assumed the net effect of a reconciliation bill would not exceed $1.9 trillion. See U.S. Congress, House Committee on the Budget, *Section-by-Section Analysis: 2021 Budget Resolution*, February 1, 2021, at https://budget.house.gov/publications/report/section-section-analysis-2021-budget-resolution.

Committee must package the responses together into an omnibus budget reconciliation bill and report the bill without "any substantive revision."[4] The reconciliation bill is then eligible to be considered under special expedited procedures. These procedures are especially important in the Senate, as they exempt the reconciliation bill from the general requirement that legislation garner the support of at least three-fifths of Senators to bring debate to a close.[5]

In responding to reconciliation directives, three House committees developed legislation affecting private health insurance, Medicaid, CHIP, and Medicare, as described in later sections of this report:

- In response to a reconciliation directive to increase the deficit by no more than $358 billion over the period FY2021-FY2030, the House Committee on Education and Labor held a markup on February 9-10, 2021, and voted to transmit legislation to the House Budget Committee by a vote of 27-21. The legislation was formally submitted to the House Budget Committee on February 16, 2021.[6]
- In response to a reconciliation directive to increase the deficit by no more than $188.5 billion over the period FY2021-FY2030, the House Committee on Energy and Commerce held a markup on February 11-12, 2021, and voted to transmit legislation to the House Budget Committee by a vote of 31-25. The legislation was formally submitted to the House Budget Committee on February 16, 2021.[7]
- In response to a reconciliation directive to increase the deficit by no more than $940.7 billion over the period FY2021-FY2030, the House Committee on Ways and Means held a markup on February 10, 2021, and voted to transmit the legislation to the House Budget Committee by a vote of 24-18. The legislation was formally submitted to the House Budget Committee on February 16, 2021.[8]

On February 22, 2021, the House Budget Committee voted to report the American Rescue Plan Act of 2021 (H.R. 1319) by a vote of 19-16; the bill was formally reported on February 24, 2021.[9] H.R. 1319 comprised legislation from the nine instructed House committees that submitted legislation to the House Budget Committee in response to their reconciliation directives.[10]

On February 26, 2021, the House adopted H.Res. 166, a special rule reported from the House Committee on Rules, by a vote of 219-210. H.Res. 166 brought H.R. 1319 to the House floor and provided for its consideration, including automatically amending H.R. 1319 to add legislative

[4] Pursuant to §310(b)(2) of the Congressional Budget Act of 1974, as amended (P.L. 93-344). In fulfilling this requirement, the Budget Committee typically will hold a business meeting before voting to report to the chamber. Although amendments are not in order during the markup, members of the Budget Committee still may communicate support or concern related to the underlying legislation.

[5] For more information on the reconciliation process, see CRS Report R44058, *The Budget Reconciliation Process: Stages of Consideration*.

[6] U.S. Congress, House Committee on the Budget, *American Rescue Plan of 2021*, 117th Cong., 1st sess., H.Rept. 117-7 (Washington, DC: GPO, 2021), pp. 47, 49 (hereinafter, H.Rept. 117-7).

[7] H.Rept. 117-7, pp. 130, 139.

[8] H.Rept. 117-7, pp. 561, 565.

[9] H.Rept. 117-7, p. 915.

[10] The nine committees are the Committee on Agriculture, the Committee on Education and Labor, the Committee on Energy and Commerce, the Committee on Financial Services, the Committee on Oversight and Reform, the Committee on Small Business, the Committee on Transportation and Infrastructure, the Committee on Veterans' Affairs, and the Committee on Ways and Means.

language within the jurisdiction of the three instructed House committees that did not submit legislation to the House Budget Committee in response to their reconciliation directives.[11]

On February 27, the House passed H.R. 1319 by a vote of 219-212. The bill was received in the Senate on March 2, 2021; on March 4, the Senate voted to proceed to its consideration by a vote of 51-50. None of the Senate committees that were instructed to submit reconciliation legislation to the Senate Budget Committee responded formally to their instruction. The Senate Majority Leader, however, offered Senate Amendment 891, which replaced the text of the House bill with 11 separate titles, reflecting text within the jurisdiction of each of the 11 instructed Senate committees.[12] Over the course of several days, the Senate debated the bill, as well as dozens of amendments and motions to commit. The Senate ultimately agreed to eight amendments offered to Senate Amendment 891, before agreeing to Senate Amendment 891 on March 6, 2021, by voice vote. The Senate then voted to pass H.R. 1319, as amended, by a vote of 50-49.

On March 9, the House adopted H.Res. 198, a special rule reported from the House Committee on Rules, by a vote of 219-210. H.Res. 198 made in order a vote in the House on a motion to concur in the Senate amendment. The following day, March 10, 2021, the House voted to concur in the Senate amendment, 220-211, sending the bill to the President for his signature. The following day, the President signed the bill and it became P.L. 117-2.

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation issued a cost estimate for H.R. 1319.[13] According to the estimate, the bill will increase federal deficits by approximately $1.856 trillion over the period FY2021-FY2030.

High-Level Summary

The following is a high-level summary of the ARPA provisions impacting private health insurance, Medicaid and CHIP, Medicare, and both Medicare and Medicaid.

Private Health Insurance

The ARPA includes provisions relevant to workers who lose their employment-based health benefits, and provisions relevant to the individual exchanges and the coverage sold through them.

The ARPA subsidizes Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage from April 1, 2021, through September 30, 2021, for certain individuals who lost employer-based health insurance as a result of an involuntary termination or reduction in hours. It also provides employers (or, in some instances, multiemployer plans or insurers) with a refundable payroll tax credit to reimburse the employers for the unpaid premium amounts.

The ARPA expands eligibility for and the amounts of the premium tax credit (PTC) and cost-sharing reductions (CSRs) applicable to certain exchange plans for individuals who receive unemployment compensation (UC) during calendar year (CY) 2021. The ARPA expands eligibility for and the amount of the PTC applicable to certain exchange plans for tax years 2021

[11] U.S. Congress, House Committee on Rules, *Providing for Consideration of the Bill (H.R. 1319) to Provide for Reconciliation Pursuant to Title II of S.Con.Res.5*, 117th Cong., 1st sess., H.Rept. 117-8 (Washington, DC: GPO, 2021). The committees were the Committees on Foreign Affairs; the Committee on Natural Resources; and the Committee on Science, Space, and Technology.

[12] This amendment struck all of the text of the House bill after the first word and so was not technically an amendment in the nature of a substitute.

[13] U.S. Congressional Budget Office, *Estimated Budgetary Effects of H.R. 1319, American Rescue Plan Act of 2021, as Passed by the Senate on March 6, 2021*, March 10, 2021, at https://www.cbo.gov/publication/57056.

and 2022, and the ARPA suspends the requirement, for tax year 2020, that individuals pay back PTC amounts that were provided in excess.

The ARPA also provides for new grants to be available to state-administered (as opposed to federally administered) health insurance exchanges for purposes of modernizing or updating their systems, programs, or technology.

Medicaid and CHIP Provisions

The ARPA includes a number of Medicaid and CHIP provisions that add new Medicaid requirements for states, provide enhanced federal reimbursement for certain Medicaid expenditures, and include new optional Medicaid activities for states.

The ARPA requires states to provide temporary coverage of COVID-19 vaccines and treatment under Medicaid and CHIP without enrollee cost sharing. The law also eliminates the cap on total Medicaid drug rebates and recalculates Medicaid disproportionate share hospital (DSH) allotments to take into account the FFCRA federal medical assistance percentage (FMAP) increase.

The ARPA provides states the following new temporary options: Medicaid and CHIP postpartum coverage for 12 months, coverage of qualifying community-based mobile crisis intervention services, and temporary coverage of COVID-19 vaccines and treatment under Medicaid and CHIP without enrollee cost sharing to the COVID-19 testing population, among other groups.

The ARPA includes a number of temporary FMAP exceptions: (1) a 10-percentage-point increase to the FMAP rate for home and community-based services (HCBS) for states that meet the requirements, (2) 100% federal reimbursement (i.e., fully federally funded) for Medicaid coverage and administration of the COVID-19 vaccines, (3) a 5-percentage-point increase to the regular FMAP rate for states that implement the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion, (4) 100% federal Medicaid reimbursement for Urban Indian Organizations (UIOs) and Native Hawaiian Health Centers, and (5) 85% federal reimbursement for qualifying community-based mobile crisis intervention services.[14]

Medicare Provisions[15]

The Medicare provisions in the ARPA impact nursing homes, certain hospitals, and ambulance services. The ARPA provides funding to the Secretary of the Department of Health and Human Services (HHS) for quality improvement organizations (QIOs) to carry out infection control and vaccination uptake support to Medicare-certified nursing homes. Other provisions impacting the Medicare program (1) establish a floor on the Medicare area wage index for hospitals located in states with no rural areas and (2) allow payment for ground ambulance services furnished when

[14] The federal government's share for most Medicaid expenditures is called the *federal medical assistance percentage* (FMAP) rate. There are exceptions to the regular FMAP rate for certain states, situations, populations, providers, and services. For more information about the FMAP rate, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

[15] The American Rescue Plan Act (ARPA; P.L. 117-2) §9833 is listed under "Subtitle L-Medicare." This report does not include §9833, because the provision is not specific to Medicare. The provision provides $5 million for the inspector general of the Department of Health and Human Services (HHS) to provide oversight of activities supported with funds appropriated to HHS to prevent, prepare for, and respond to Coronavirus Disease 2019 (COVID–19), domestically or internationally.

no actual transport was provided due to community restrictions imposed during the COVID-19 public health emergency.

Medicare and Medicaid Provisions

Some ARPA provisions impact both Medicare and Medicaid. The ARPA provides funding to establish and implement "strike" teams to help respond to COVID-19 in Medicare-certified and Medicaid-certified nursing homes. The ARPA also provides $8.5 billion to make payments to rural Medicare and Medicaid providers for health care-related expenses and lost revenue attributable to COVID-19. This provision creates a new fund that is similar to the Provider Relief Fund (PRF), which was created in the CARES Act, with a few differences.[16]

Definition of COVID-19 Public Health Emergency Period

Several provisions in this report refer to the *COVID-19 public health emergency period*. For the provisions in this report, the *COVID-19 public health emergency period* refers to the emergency period described in Section 1135(g)(1)(B) of the Social Security Act (SSA) or comparable construction. Section 1135 allows the Secretary of the Department of Health and Human Services, under certain conditions, to waive specified requirements and regulations to ensure health care items and services are available to enrollees in Medicare, Medicaid, and CHIP during emergencies. Paragraph (1)(B) of SSA Section 1135(g) refers specifically to "the public health emergency declared with respect to the COVID-19 outbreak by the Secretary on January 31, 2020, pursuant to section 319 of the [Public Health Service Act]" and any renewal of such declaration. Hence, these references to SSA Section 1135(g)(1)(B) simply mean the period during which the Section 319 public health emergency declaration for COVID-19—whether initial or renewed—is in effect.

Note: For information about public health emergency declarations, see Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, "Public Health Emergency Declarations," at https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx.

Abbreviated Summary of Provisions

Table 1 provides abbreviated summaries for each of the provisions in the ARPA impacting private health insurance, Medicaid, CHIP, Medicare, and both Medicare and Medicaid. For each provision, the table provides the section of the ARPA, the title of the provision, a summary of the provision, the CBO estimates, and a CRS point of contact.

[16] For more information on the Provider Relief Fund (PRF), see CRS Insight IN11438, *The COVID-19 Health Care Provider Relief Fund*.

Table 1. Abbreviated Summaries of Selected Provisions in the American Rescue Plan Act of 2021 (P.L. 117-2)

Section Number	Section Title	Description of Section	CBO Estimated Direct Spending Outlays and Revenue Changes: FY2021-FY2030 (in $ millions)	CRS Contact
Private Health Insurance Provisions				
2305	Reduced Cost Sharing	Expands eligibility for and the amount of cost-sharing reductions applicable to certain exchange plans for individuals who receive unemployment compensation during CY2021. (See Section 9663 for a related PTC provision.)	Outlays: $0 Revenue: $0	Bernadette Fernandez
2801	Establishing a Grant Program for Exchange Modernization	Provides for new grants to be available to state-administered (as opposed to federally administered) health insurance exchanges for purposes of modernizing or updating their systems, programs, or technology. Appropriates $20 million for FY2021, to remain available until the end of FY2022.	Outlays: $20 Revenue: $0	Vanessa C. Forsberg
9501	Preserving Health Benefits for Workers	Subsidizes COBRA continuation coverage from April 1, 2021, through September 30, 2021, for certain individuals who lost employer-based health insurance as a result of an involuntary termination or reduction in hours. Provides employers (or, in some instances, multiemployer plans or insurers) with a refundable payroll tax credit to reimburse the employer for the unpaid premium amounts.	Outlays: -$14,369 Revenue: -$32,172	Ryan J. Rosso
9661	Improving Affordability by Expanding Premium Assistance for Consumers	Expands eligibility for and the amount of the PTC applicable to certain exchange plans for tax years 2021 and 2022. Expands income eligibility to households with annual incomes above 400% of the FPL and reduces amounts eligible individuals would be required to pay to enroll in certain exchange plans; eligible individuals with incomes at or below 150% of the FPL receiving full premium subsidies.	Outlays: $22,022 Revenue: -$12,165	Bernadette Fernandez

Section Number	Section Title	Description of Section	CBO Estimated Direct Spending Outlays and Revenue Changes: FY2021-FY2030 (in $ millions)	CRS Contact
9662	Temporary Modification of Limitations on Reconciliation of Tax Credits for Coverage Under a Qualified Health Plan with Advance Payments of Such Credit	Suspends the requirement, for tax year 2020, that individuals pay back PTC amounts that were provided in excess due to higher-than-estimated income during the year.	Outlays: $0 Revenue: -$6,261	Bernadette Fernandez
9663	Application of PTC in Case of Individuals Receiving Unemployment Compensation During 2021	Expands eligibility for and the amount of the PTC in tax year 2021 for individuals who receive unemployment compensation during CY2021. Such individuals may receive full premium subsidies for certain exchange plans. (See Section 2305 for a related cost-sharing-reduction provision.)	Outlays: $2,426 Revenue: -$2,089	Bernadette Fernandez
Medicaid Provisions				
9811	Mandatory Coverage of COVID-19 Vaccines and Administration and Treatment Under Medicaid	Adds the COVID-19 vaccines (and the administration of COVID-19 vaccines) and treatment services to the list of Medicaid mandatory services without enrollee cost sharing. Gives states the option to provide coverage of these services for the optional COVID-19 testing group, among other changes. Medicaid coverage and administration of the COVID-19 vaccines receive 100% federal reimbursement (i.e., fully federally funded) during the specified period. Provisions are in effect for the period that begins on the date of enactment (i.e., March 11, 2021) and ends the last day of the first calendar quarter that begins one year after the last day of the COVID-19 public health emergency period.	Outlays: $1,131 Revenue: $0	Evelyne P. Baumrucker

Section Number	Section Title	Description of Section	CBO Estimated Direct Spending Outlays and Revenue Changes: FY2021-FY2030 (in $ millions)		CRS Contact
9812	Modifications to Certain Coverage Under Medicaid for Pregnant and Postpartum Women	Establishes a state plan option to extend full Medicaid benefit coverage during pregnancy and throughout the 12-month postpartum period to any women who received Medicaid coverage while pregnant, effective during the five-year period beginning April 1, 2022, and ending March 31, 2027. (See related CHIP requirements under Section 9822.)	Outlays:[a] Revenue:	$6,051 $832	Evelyne P. Baumrucker
9813	State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services	Adds a state option for states to provide qualifying community-based mobile crisis intervention services during the five-year period beginning April 1, 2022, and ending March 31, 2027. For the first 12 fiscal quarters, states receive an increased federal Medicaid reimbursement rate of 85%.	Outlays: Revenue:	$1,137 $0	Julia A. Keyser
9814	Temporary Increase in FMAP for Medical Assistance Under State Medicaid Plans Which Begin to Expend Amounts for Certain Mandatory Individuals	Provides a five-percentage-point increase to the regular FMAP rate for eight quarters to qualifying states that implement the ACA Medicaid expansion after the date of enactment (i.e., March 11, 2021).	Outlays: Revenue:	$16,149 $658	Alison Mitchell
9815	Extension of 100% FMAP to UIOs and Native Hawaiian Health Care Systems	Provides eight fiscal quarters of 100% federal reimbursement (i.e., fully federally funded) for Medicaid services received through (1) UIOs and (2) Native Hawaiian Health Centers for the period April 1, 2021, through March 31, 2023.	Outlays: Revenue:	$162 $0	Alison Mitchell
9816	Sunset of Limit on Maximum Rebate Amount for Single-Source Drugs and Innovator Multiple-Source Drugs	Eliminates the cap limiting the maximum rebate amount drug manufacturers participating in Medicaid can owe on brand-name drugs per quarter to 100% of the drug's average manufacturer price, effective January 1, 2024.	Outlays: Revenue:	-$14,504 $0	Cliff Binder

Section Number	Section Title	Description of Section	CBO Estimated Direct Spending Outlays and Revenue Changes: FY2021-FY2030 (in $ millions)	CRS Contact
9817	Additional Support for Medicaid HCBS During the COVID-19 Emergency	Increases the FMAP rate of Medicaid expenditures for states that meet the HCBS program requirements by 10 percentage points for certain HCBS during the program-improvement period (i.e., April 1, 2021, through March 31, 2022).	Outlays: $12,667 Revenue: $0	Kirsten J. Colello
9819	Special Rule for the Period of a Declared Public Health Emergency Related to Coronavirus	Directs the HHS Secretary to recalculate the Medicaid DSH allotments to take into account the higher federal share of Medicaid DSH expenditures under the FFCRA FMAP increase during the COVID-19 public health emergency period.	Outlays: $1,673 Revenue: $0	Alison Mitchell
State Children's Health Insurance Program (CHIP) Provisions				
9821	Mandatory Coverage of COVID-19 Vaccines and Administration and Treatment Under CHIP	Adds fully federally funded COVID-19 vaccines (and administration of COVID-19 vaccines) and treatment services to the list of CHIP mandatory services without enrollee cost sharing for the period that begins on the date of enactment (i.e., March 11, 2021) and ends the last day of the first calendar quarter that begins one year after the last day of the COVID-19 public health emergency period.	Outlays: $68 Revenue: $0	Evelyne P. Baumrucker
9822	Modifications to Certain Coverage Under CHIP for Pregnant and Postpartum Women	Requires states that elect to provide full Medicaid coverage during pregnancy and throughout the 12-month postpartum period under Medicaid (as specified under Section 9812) to also provide all items or services available to a targeted low-income child or a targeted low-income pregnant woman under the CHIP state plan (or waiver) during pregnancy and throughout the 12-month postpartum period under CHIP. Effective for state elections of extended pregnancy coverage under Medicaid and CHIP during the five-year period beginning April 1, 2022, and ending March 27, 2027.	See Section 9812[a]	Evelyne P. Baumrucker

Section Number	Section Title	Description of Section	CBO Estimated Direct Spending Outlays and Revenue Changes: FY2021-FY2030 (in $ millions)		CRS Contact
Medicare Provisions					
9401	Providing for Infection Control Support to Skilled Nursing Facilities Through Contracts with QIOs	Appropriates $200 million to the HHS Secretary for QIOs to carry out infection control and vaccination uptake support to Medicare-certified nursing homes. Such amounts are to remain available until expended.	Outlays: Revenue:	$200 $0	Phoenix Voorhies
9831	Floor on the Medicare Area Wage Index for Hospitals in All-Urban States	Establishes in statute a "floor" wage index for purposes of Medicare IPPS payments to hospitals located in states with no rural areas and waives the budget-neutrality requirement, effective FY2022 (i.e., October 1, 2021).	Outlays: Revenue:	$625 $0	Marco A. Villagrana
9832	Secretarial Authority to Temporarily Waive or Modify Application of Certain Medicare Requirements with Respect to Ambulance Services Furnished During Certain Emergency Periods	Gives the HHS Secretary authority to waive the requirement that a ground ambulance transport occur for purposes of Medicare AFS payments during the COVID-19 public health emergency.	Outlays: Revenue:	$160 $0	Marco A. Villagrana
Medicare, Medicaid, and CHIP Provisions					
9402	Funding for Strike Teams for Resident and Employee Safety in Skilled Nursing Facilities	Appropriates $250 million to the HHS Secretary to establish and implement state strike teams to assist Medicare-certified nursing homes with clinical care, infection control, or staffing during the COVID-19 emergency period and for one year following the emergency period; such amounts are to remain available until expended.	Outlays: Revenue:	$250 $0	Phoenix Voorhies

Section Number	Section Title	Description of Section	CBO Estimated Direct Spending Outlays and Revenue Changes: FY2021-FY2030 (in $ millions)	CRS Contact
9818	Funding for State Strike Teams for Resident and Employee Safety in Nursing Facilities	Appropriates $250 million to the HHS Secretary to establish and implement state strike teams to assist Medicaid-certified nursing homes with clinical care, infection control, or staffing during the COVID-19 emergency period and for one year following the emergency period; such amounts are to remain available until expended.	Outlays: $250 Revenue: $0	Phoenix Voorhies
9911	Funding for Providers Relating to COVID-19	Appropriates $8.5 billion for FY2021, to remain available until expended, to make payments to rural health care providers, as defined, for health care-related expenses and lost revenue attributable to COVID-19.	Outlays: $8,500 Revenue: $0	Elayne J. Heisler

Source: CRS analysis of the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) and CBO, "Detailed Tables," in *Estimated Budgetary Effects of H.R. 1319, American Rescue Plan Act of 2021*, March 10, 2021, at https://www.cbo.gov/publication/57056.

Notes: The *public health emergency period* is defined in paragraph (1)(B) of SSA §1135(g) as a public health emergency declared by the HHS Secretary pursuant to §319 of the Public Health Service Act. This table refers to the public health emergency declared by the HHS Secretary on January 31, 2020, with respect to the COVID-19 outbreak. The determination was made retroactive to January 27, 2020.

ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); AFS = Ambulance Fee Schedule; CBO = Congressional Budget Office; CHIP = State Children's Health Insurance Program; COBRA = Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272); COVID-19 = Coronavirus Disease 2019; CY = Calendar Year; DSH = Disproportionate Share Hospital; FFCRA = Families First Coronavirus Response Act (P.L. 116-127); FMAP = Federal Medical Assistance Percentage; FPL = Federal Poverty Level; FY = Fiscal Year; HCBS = Home and Community-Based Services; HHS = Department of Health and Human Services; IPPS = Inpatient Prospective Payment System; PTC = Premium Tax Credit; QIO = Quality Improvement Organization; SSA = Social Security Act; UIO = Urban Indian Organization.

a. The outlays and revenues for §9812 include the budgetary effects of §9822

Detailed Summaries of Provisions

Private Health Insurance Provisions

Section 2305: Reduced Cost Sharing

Background

Certain individuals (and families) who are enrolled in health plans through health insurance exchanges and are eligible for the PTC also may receive federal assistance that reduces their cost-sharing requirements; such requirements may include deductibles, coinsurance, co-payments, and an annual cost-sharing limit, as applicable. To receive CSRs, individuals must meet income and other eligibility criteria. There are two types of CSRs, both of which provide larger subsidies to individuals with lower incomes. UC generally counts toward the calculation of income; therefore, receipt of UC would affect the amount of income used for CSR purposes.[17]

Provision

Section 2305 amends 42 *U.S. Code* (U.S.C.) 18071 to expand eligibility for and the amount of CSRs for eligible individuals who receive UC during CY2021. It temporarily deems individuals who receive UC for any week in CY2021 to have met the CSR income eligibility criteria for plan year 2021. It also temporarily disregards any household income above 133% of the federal poverty level (FPL) for purposes of determining the level of CSRs, which effectively increases the amount of cost-sharing assistance that eligible individuals receive and provides the greatest available level of cost-sharing assistance. (See Section 9663 under "Sections 9661-9663: Premium Tax Credit" for a related PTC provision.)

Section 2801: Establishing a Grant Program for Exchange Modernization

Background

The health insurance exchanges are virtual marketplaces in which consumers can shop for and purchase private health insurance coverage and, where applicable, be connected to public health insurance programs (e.g., Medicaid).[18] Each state's exchange may be established either by the state itself as a state-based exchange (SBE) or by the HHS Secretary as a federally facilitated exchange (FFE). Some states have state-based exchanges on the federal platform (SBE-FPs): they have SBEs but use the federal information technology platform (FP), including the federal exchange website www.HealthCare.gov. For plan year 2021, 30 states have FFEs, 15 states have SBEs, and 6 states have SBE-FPs.

Whether state-based or federally facilitated, exchanges are required by law to fulfill certain minimum functions. At a high level, this includes (1) facilitating consumers' purchase of coverage (by operating a web portal, making determinations of eligibility for coverage and any

[17] For additional background on the cost-sharing reductions, see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

[18] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) required the health insurance exchanges to be established in every state. For more information about the exchanges, see CRS Report R44065, *Overview of Health Insurance Exchanges*.

financial assistance, and offering different forms of enrollment assistance) and (2) certifying, recertifying, and otherwise monitoring the plans offered through the exchange.

In general, ongoing federal spending on the exchanges is specific to FFEs, while states with SBEs finance their own exchange administration. States with SBE-FPs finance some of their exchange functions, and the federal government finances other functions for them (e.g., as related to Healthcare.gov).

Provision

Subsection (a) of Section 2801 provides for new grants to be awarded to health insurance exchanges "for purposes of enabling such Exchange to modernize or update any system, program, or technology utilized by such Exchange to ensure such Exchange is compliant with all applicable requirements." The HHS Secretary is authorized to determine specified aspects of the application process. Eligibility for these grants is limited to SBEs and SBE-FPs. The legislation specifies that FFEs are not eligible through its reference to exchanges established under 42 U.S.C. 18041(c).

For this grant program, subsection (b) of Section 2801 appropriates $20 million for FY2021. The funds are appropriated out of Treasury funds not otherwise appropriated and are to remain available until the end of FY2022.

Section 9501: Preserving Health Benefits for Workers

Background

COBRA Continuation Coverage Private-sector employers that have at least 20 employees and offer health insurance benefits to their employees are required to provide qualified individuals and their families who experience specified qualifying events with the option of enrolling in COBRA continuation coverage (i.e., continuing their coverage under the employer's group health insurance plan).[19] Specified *qualifying events* include both voluntary and involuntary termination of employment, a reduction in hours, and other statutorily defined events, and they must result in an individual losing health insurance coverage. State and local government workers are covered by similar federal COBRA requirements. In addition, many states have enacted "mini-COBRA" laws, which require that continuation coverage be offered to employees of smaller firms.

Under federal COBRA rules, eligible individuals who experience qualifying events must be notified of their right to elect COBRA coverage. In accordance with such notification, eligible individuals have the right to elect COBRA coverage within an election period, defined as (at least) 60 days from the later of two dates: (1) the date coverage would be lost due to the qualifying event or (2) the date the beneficiary is sent notice of his or her right to elect COBRA coverage. An individual electing COBRA coverage ordinarily will receive the same coverage he or she was receiving immediately before the qualifying event. In general, the COBRA coverage for the employee and the employee's spouse and dependent children must be allowed to continue for 18 months from the date of the qualifying event. In certain circumstances, an employer may cut short COBRA coverage or may be required to extend such coverage according to statutory limits.

When offering COBRA coverage to a qualified individual, employers are permitted to charge the covered beneficiary a premium for COBRA continuation coverage that is 102% of the employer-

[19] For more information on Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*.

sponsored insurance premium. In other words, the COBRA premium can equal the sum of (1) the portion of employer-sponsored insurance premium normally paid by the employee, (2) the portion of the premium that would be paid by the employer (if any), and (3) an additional 2% administrative fee. For disabled individuals who qualify for an additional 11 months of COBRA coverage (i.e., qualify for 29 total months of COBRA coverage), the employer may charge up to 150% of the premium for these additional months.

Temporary COBRA Premium Subsidies Under the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5)

In 2009, Congress enacted ARRA, which, as amended, provided up to 15 months of COBRA premium subsidies to certain individuals who enrolled in COBRA coverage after experiencing an involuntary termination on or after September 1, 2008, and through May 31, 2010.

Individuals who received the subsidy were required to pay no more than 35% of their COBRA premiums. As such, these individuals received a 65% COBRA premium subsidy. Generally, the employer providing the subsidized COBRA coverage was reimbursed the remaining 65% of the premium for the COBRA coverage through a credit against its payroll taxes (or, if the premium subsidy exceeded their tax liability, a refund). In some instances, a multiemployer plan or the insurer was allowed the credit. For the individual, the subsidy was not considered income or other financial resources for determining eligibility for any other public benefit and was not counted as gross income for tax purposes.

The premium subsidy applied to continuation coverage provided under the federal COBRA requirements (including state and local government continuation coverage), continuation coverage made available to federal employees, and continuation coverage provided under state "mini-COBRA" laws that were comparable to COBRA coverage.

Provisions

Section 9501(a) Premium Assistance for COBRA Continuation Coverage for Individuals and Their Families

Section 9501(a)(1) provides eligible individuals with a 100% premium subsidy of COBRA coverage during the period beginning April 1, 2021, and ending September 30, 2021. As such, eligible individuals are not required to pay any premium amounts for COBRA coverage during this time frame. The premium subsidy applies to continuation coverage provided under the federal COBRA requirements (including state and local government continuation coverage) and to continuation coverage provided under state "mini-COBRA" laws that is comparable to COBRA coverage.

Individuals are eligible for the subsidy if they became eligible for COBRA coverage as a result of an involuntary termination or reduction in hours and they elect COBRA coverage. In addition, any individual who otherwise would be eligible for COBRA premium assistance except for the fact that the individual (1) did not elect COBRA coverage before April 1, 2021, or (2) initially elected COBRA coverage and discontinued such coverage before April 1 also would be allowed to receive COBRA premium assistance if he or she subsequently enrolled (or reenrolled) in COBRA coverage.[20]

[20] These two groups of individuals are to be provided with an extended election period of, at most, 120 days after April 1 to elect COBRA continuation coverage. Under such election, the COBRA continuation coverage would begin with the first coverage period that begins on or after April 1 and could not extend beyond the period of COBRA continuation coverage for which the individual is eligible.

Premium assistance-eligible individuals may be allowed to enroll in COBRA coverage that is different than the plan the individuals were enrolled in at the time of a qualifying event if all of the following occur: (1) the employer allows such change; (2) the premium for the new coverage does not exceed that of the old coverage; (3) the new coverage also is offered to similarly situated active employees at the time of the change; and (4) the new coverage is not a qualified small employer health reimbursement arrangement (QSEHRA), a flexible spending arrangement (FSA), or coverage that provides only excepted benefits.[21] An individual is required to make such election within 90 days of being notified of his or her ability to do so.

In some instances, the COBRA premium assistance may end earlier than September 30, 2021. Specifically, COBRA premium assistance ends if an individual (1) reaches the end of the maximum COBRA coverage period, (2) becomes eligible for coverage under another employer-sponsored plan (other than coverage consisting only of excepted benefits, an FSA, or a QSEHRA), or (3) becomes eligible for benefits under Medicare.[22]

Section 9501(a) specifies that notices provided after April 1, 2021, and before September 30, 2021, to individuals regarding their right to elect COBRA continuation coverage must include an additional written notification with information specified by the legislation. This additional written notification must inform the individual of the availability of COBRA premium assistance and the ability to enroll in different coverage, if the employer allows. Notices without this additional written notification would not be considered to have satisfied the corresponding federal COBRA requirements. For continuation coverage that is not subject to the federal COBRA notice requirements, the Secretary of Labor, in consultation with the Secretary of the Treasury, the HHS Secretary, and administrators of the employer-sponsored plans that provide or administer such continuation coverage, is required to provide rules requiring the provision of such notice.

Within 60 days after April 1, 2021, administrators of the applicable employer-sponsored plans are required to provide the additional notice to (1) premium assistance-eligible individuals who became entitled to elect COBRA coverage before April 1; (2) individuals who would be eligible for COBRA premium assistance, except that the individual did not elect COBRA coverage before April 1; and (3) individuals who elected COBRA continuation coverage and discontinued such coverage before April 1. Failure to provide the additional written notification is treated as a failure to meet the notice requirements under the applicable COBRA continuation provision.

Not later than 30 days after the ARPA's enactment, the Secretary of Labor, in consultation with the Secretary of the Treasury and the HHS Secretary, is required to prescribe models for this additional notice.[23]

Section 9501(a)(6) requires notices regarding the expiration of COBRA premium assistance. The section specifies that, to meet COBRA requirements regarding the provision of notices to individuals in accordance with their right to elect COBRA coverage, plan administrators must provide a written notice to the premium assistance-eligible individual informing the individual that the premium assistance will expire soon and conveying other specified information. Plan

[21] For more information about excepted benefits, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

[22] Under ARPA §9501(a)(2), eligible individuals are required to notify the COBRA coverage plan sponsor in the event that they become eligible for coverage under any other employer-sponsored plan (other than coverage consisting only of excepted benefits, a flexible spending arrangement, or a qualified small employer health reimbursement arrangement) or become eligible for benefits under Medicare.

[23] The Department of Labor released model notices for the COBRA premium assistance. Department of Labor, Employee Benefits Security Administration, "COBRA Premium Subsidy," at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra/premium-subsidy.

administrators must provide this notice between the 45th day and the 15th day before the premium assistance expires. Employer-sponsored plan administrators do not need to provide this written notice if an individual loses eligibility for premium assistance because the individual becomes eligible for coverage under any other employer-sponsored plan (other than coverage consisting only of excepted benefits, an FSA, or a QSEHRA) or for benefits under Medicare. Not later than 45 days after the ARPA's enactment, the Secretary of Labor, in consultation with the Secretary of the Treasury and the HHS Secretary, is required to prescribe models for this notification.

Section 9501(a)(8) requires the Secretary of Labor, in consultation with the Secretary of the Treasury and the HHS Secretary, to provide outreach consisting of public education and enrollment assistance relating to the COBRA premium assistance. The outreach is to target specified entities and must include an initial focus on those individuals electing continuation coverage who became entitled to elect COBRA continuation coverage before April 1, 2021. Information on the COBRA premium assistance also must be made available on the websites of the Departments of Labor, the Treasury, and HHS.

In addition, Section 9501(a)(8) requires the HHS Secretary to provide public education outreach that targets individuals who lose health insurance coverage. The HHS Secretary is required to include in this outreach information regarding Medicare enrollment in order to prevent mistaken delays of enrollment, including lifetime penalties for failure of timely enrollment.

Section 9501(a)(10) allows the Secretaries of the Treasury and Labor to jointly prescribe regulations or other guidance as may be necessary or appropriate to carry out the provisions of the subsection, including the prevention of fraud and abuse. However, the section specifies that the Secretary of Labor and the HHS Secretary are allowed to prescribe regulations or other guidance as may be necessary or appropriate to carry out the provisions relating to notices to individuals regarding premium assistance, notices to individuals regarding the expiration of premium assistance, and outreach.

Section 9501(a) appropriates $10 million to the Department of Labor Employee Benefits Security Administration to carry out the provisions of this subtitle. Such amounts are appropriated for FY2021 and are to remain available until expended.

Section 9501(b) COBRA Premium Assistance

Section 9501(b) adds three sections to the Internal Revenue Code (IRC): Sections 6432, 6720C, and 139I (as described below). In addition, this subsection modifies the Health Care Tax Credit (HCTC) so that individuals who receive COBRA premium assistance during any month would not be eligible for the HCTC for that month.[24] This HCTC amendment applies to taxable years ending after the date of the ARPA's enactment. The three new IRC sections are described in detail below.

- **IRC Section 6432.** The new IRC Section 6432 allows the *person to whom premiums are payable* (i.e., an eligible individual's employer or other entity, as specified below) to receive a refundable payroll tax credit for the amount of premiums not paid by COBRA premium assistance-eligible individuals.[25]

[24] For more information about the Health Care Tax Credit, see CRS Report R44392, *The Health Coverage Tax Credit (HCTC): In Brief*.

[25] ARPA §9501(b) requires the *person to whom premiums are payable* to reimburse excess premium payments that are collected from individuals who paid excess COBRA premium amounts as a result of not considering the premium assistance. The employer or other entity is required to issue the reimbursement payment to the individual not later than 60 days after the individual made the premium payment. The entity reimbursing the individual is allowed a credit, in

(Premium assistance is available from April 1, 2021, through September 30, 2021.) The credit, including any refundable portion, may be advanced up to the amount calculated through the end of the most recent payroll period in the quarter.

The *person to whom premiums are payable* is considered as being, except as otherwise provided by the Secretary of the Treasury, the multiemployer plan (if the group health plan is a multiemployer plan), the employer maintaining the plan (if the group health plan is not a multiemployer plan, and the group health plan is subject to federal COBRA requirements or if some or all of the coverage is not provided by insurance), or the insurer providing the group health plan (in all other instances). State governments (or any political subdivision thereof), any Indian tribal government (as defined in IRC §39E(c)(1)), any agency or instrumentality of any of the foregoing, and any agency or instrumentality of the U.S. government (as described in IRC §501(c)(1) and exempt from taxation under IRC Section 501(a)) are eligible for the payroll tax credit.

The Secretary of the Treasury is required to waive any penalty for any failure to make a deposit of the payroll taxes if the Secretary determines that such failure was due to anticipation of the credit. Any payroll tax credit amounts are treated in the same manner as a refund due from a credit provision under 31 U.S.C. 1324(b)(2).

Any payroll tax credit amounts excessively claimed and received by an entity are treated as an underpayment of payroll taxes and may be assessed and collected by the Secretary of the Treasury in the same manner as other payroll taxes. Entities receiving the payroll tax credit must increase their gross income by the amount of the credit allowed for the taxable year that includes the last day of the calendar quarter associated with the credit. Furthermore, credits are not allowed for amounts taken into account as qualified wages for the purposes of the employee retention credit or as qualified health plan expenses under the payroll tax credits for paid sick or paid family leave.

Although an amount of tax due normally must be assessed within three years after the relevant return has been filed, amounts attributable to the payroll tax credit provided under this section may be assessed up to five years after the later of (1) the date on which the original return that includes such quarter is filed or (2) April 15 of the calendar year succeeding the year that includes such quarter. The Secretary of the Treasury is required to issue regulations or other guidance, forms, instructions, and publications as may be necessary or appropriate to carry out this section. This includes requirements to report information or the establishment of other methods for verifying the correct amounts of reimbursements; the application of this section to group health plans that are multiemployer plans; the allowance of the advance payment of the payroll tax credit, subject to the specified limitations, based on the information required by the Secretary; the reconciliation of the advance payment of the payroll tax credit

accordance with new Internal Revenue Code (IRC) §6432, as added by this subsection, for any reimbursement. In this context, *payroll tax* refers to the tax imposed by IRC §3111(b) or the amount of taxes imposed under IRC §3221(a) attributable to IRC §3111(b).

at the time of filing the appropriate tax return (quarter or taxable year); and the allowance of the credit to third-party payers.

This section applies to COBRA continuation coverage premiums during the premium assistance period (April 1, 2021, through September 30, 2021) and wages paid on or after April 1, 2021.

- **IRC Section 6720C.** The new IRC Section 6720C penalizes individuals receiving COBRA premium assistance if they fail to notify the employer-sponsored plan that they are no longer eligible for the COBRA premium assistance due to eligibility under another employer-sponsored plan (other than coverage consisting only of excepted benefits, an FSA, or a QSEHRA) or eligibility for benefits under Medicare. If an individual fails to notify his or her employer-sponsored plan, the individual will be liable for a penalty of $250 for each failure. If there is a fraudulent failure by the individual, the individual will be responsible for a penalty that is the greater of $250 or 110% of the COBRA premium assistance. If the individual's failure to notify were due to reasonable cause and not willful neglect, the individual would not be liable for a penalty.
- **IRC Section 139I.** The new IRC Section 139I excludes COBRA premium assistance from the gross income of eligible individuals. This section applies to taxable years ending after the date of the ARPA's enactment.

Sections 9661-9663: Premium Tax Credit

Background

Individuals (and families) who meet income and other eligibility criteria receive federal financial assistance in the form of a PTC, which reduces the cost of purchasing health insurance offered through exchanges. As originally authorized, the PTC is available to individuals whose annual household income is at or above 100% of the FPL but no more than 400% of the FPL. The credit amount is calculated according to a formula that generally provides larger amounts to individuals with lower incomes. Specifically, a percentage of income is used in the formula; that percentage limits the amount a given eligible individual would pay to enroll in certain exchange plans. Under regulations promulgated prior to enactment of the ARPA, the percentage varied from 2.07% to 9.83% for incomes within the original range of 100%-400% of the FPL.

Eligible individuals may wait to claim the credit on their income tax returns after completion of the plan year, or receive advance payments of the credit (APTC) during the plan year to automatically receive reduced monthly premiums. Individuals who receive advance payments may be required to pay back some or all of the APTC if their income increased during the year; this is conducted under the existing tax reconciliation process.[26]

Provisions[27]

Section 9661: Improving Affordability by Expanding Premium Assistance for Consumers

[26] For additional background on the premium tax credit (PTC), see CRS Report R44425, *Health Insurance Premium Tax Credit and Cost-Sharing Reductions*.

[27] The Internal Revenue Service (IRS) currently is reviewing the tax provisions in the ARPA. Information concerning the law's PTC provisions will be posted at IRS, "The Premium Tax Credit - The Basics," at https://www.irs.gov/affordable-care-act/individuals-and-families/the-premium-tax-credit-the-basics.

Section 9661 amends 26 U.S.C. 36B to expand eligibility for and the amount of the PTC, for tax years 2021 and 2022, by modifying the income eligibility criteria and the credit formula. Regarding income, the provision temporarily expands eligibility by eliminating the phaseout for households with annual incomes above 400% of the FPL. In addition, it temporarily reduces the percentage of annual income used in the credit formula. The temporary percentage ranges from 0.0% to 8.5% of annual household income, effectively reducing the amount eligible individuals would pay to enroll in certain exchange plans. The temporary percentages faced by lower-income individuals are smaller than the temporary percentages applied to higher-income individuals. The benefit is most significant for those with incomes at or below 150% of the FPL; such individuals may receive full subsidies to cover standard plan premiums.

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

Section 9662 amends 26 U.S.C. 36B to provide tax relief, for tax year 2020, to individuals who would be required to pay back excess APTC under the tax reconciliation process. It temporarily suspends the recapture of excess credit payments.

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

Section 9663 amends 26 U.S.C. 36B to expand eligibility for and the amount of the PTC for individuals who receive UC in 2021.[28] It temporarily deems individuals who receive UC for any week in CY2021 to have met the PTC income eligibility criteria for tax year 2021. It also temporarily disregards any household income above 133% of the FPL for purposes of determining the credit amount; this effectively increases the amount of premium assistance that eligible individuals would otherwise receive. Such individuals may receive full subsidies to cover standard plan premiums. (See "Section 2305: Reduced Cost Sharing" for a related CSR provision.)

Medicaid Provisions

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

Background

In general, testing, diagnostic, and laboratory services are commonly covered services under Medicaid. However, testing and diagnostic services are an optional benefit category under traditional Medicaid, and coverage can vary by state. The FFCRA, as amended by the CARES Act, requires state Medicaid programs to cover testing and testing-related services under traditional Medicaid,[29] beginning on or after March 18, 2020, through the public health

[28] With respect to this provision, *unemployment compensation* (UC) references a long-standing definition in the federal tax code: "any amount received under a law of the United States or of a State which is in the nature of unemployment compensation" (26 U.S.C. §85(b)). For a discussion of various UC benefits, see CRS Report R46687, *Current Status of Unemployment Insurance (UI) Benefits: Permanent-Law Programs and COVID-19 Pandemic Response*.

[29] The Families First Coronavirus Response Act (FFCRA; P.L. 116-127) provision is silent about the addition of this benefit under Medicaid alternative benefit plans (ABPs). For more information about ABPs, see CRS Report R45212, *Water Resources Development Act of 2018 (H.R. 8) and America's Water Infrastructure Act of 2018 (Amendment to H.R. 8): An Overview*.

emergency period, as defined. States and territories are prohibited from charging beneficiary cost sharing for such testing or for testing-related state plan services furnished during this period.[30]

In general, states cover a range of medically necessary inpatient and outpatient hospital services, including preventive, diagnostic and testing, therapeutic, rehabilitative, and palliative care, for most Medicaid enrollees. For some benefits, states have flexibility to determine whether they will offer the coverage for certain populations (e.g., states have flexibility to determine whether they will provide vaccines to adults who receive coverage under traditional Medicaid). Regardless of the benefit under consideration, coverage may vary by benefit and by state. As a condition of receiving the FFCRA 6.2-percentage-point FMAP rate increase during the public health emergency period, states are required to provide coverage of COVID-19 treatments—including vaccines and their administration, specialized equipment, and therapies—without enrollee cost sharing.

Pharmaceutical manufacturers that voluntarily agree to participate in Medicaid are required to rebate a portion of drug payments to states and to comply with other federal requirements. Although state Medicaid programs must make available most outpatient drugs and biological products offered by participating manufacturers to Medicaid beneficiaries, some drugs and biological products (e.g., vaccines) are not considered covered outpatient drugs.[31] As a result, these drugs and biologicals are not subject to Medicaid rebates and other federal Medicaid requirements. Generally, drugs and biologicals paid as part of other services are not considered covered outpatient drugs, such as drugs paid as part of inpatient hospital services, hospice services, or nursing facility services.

The FFCRA, as amended by the CARES Act, provides states an option during the COVID-19 public health emergency period to use Medicaid to pay participating providers for COVID-19 testing, testing-related state plan services, testing-related visits, and the administration of testing without cost sharing to certain specified uninsured individuals covered under selected Medicaid eligibility groups that are available at state option (e.g., individuals who would be eligible for the ACA Medicaid expansion in non-ACA Medicaid expansion states and certain Medicaid enrollees who, by virtue of their Medicaid eligibility pathway, are entitled to limited Medicaid benefits). For states that adopt this "COVID-19 testing" eligibility group, the medical assistance and administrative costs associated with these uninsured individuals receive 100% Medicaid federal reimbursement. Benefits under the COVID-19 testing group are limited and terminate with the sunset of the COVID-19 public health emergency period.

The federal government's share for most Medicaid expenditures is called the FMAP rate. States are receiving the FFCRA 6.2-percentage-point increase to the regular FMAP rates during the COVID-19 public health emergency period. In FY2021, FMAP rates range from 50% (13 states) to 77.76% (Mississippi). There are exceptions to the FMAP rate for certain states, situations, populations, providers, and services.

Provision

Section 9811 amends Social Security Act (SSA) Sections 1905(a)(4) (42 U.S.C. §1396d(a)(4)) and 1937(b) (42 U.S.C. §1396u-7(b)) to add (1) COVID-19 vaccines and administration of

[30] The provision applies to traditional cost-sharing state plan authority, as well as to the state option for alternative cost sharing that permits states to charge higher cost-sharing amounts (subject to a specified cap) for individuals with higher annual income.

[31] Social Security Act (SSA) §1927(k)(2)(B).

COVID-19 vaccines and (2) testing and treatments for COVID-19,[32] including specialized equipment and therapies (e.g., preventive therapies), to the list of Medicaid mandatory services under traditional Medicaid benefits and alternative benefit plan (ABP) coverage for the period that begins on the date of the ARPA's enactment (i.e., March 11, 2021) and ends the last day of the first calendar quarter that begins one year after the last day of the COVID-19 public health emergency period. For enrollees who are diagnosed with (or presumed to have) COVID-19 during such period, states also are required to cover treatment services available under the state plan (or waiver) for any conditions that may seriously complicate the treatment of COVID-19 while that enrollee has (or is presumed to have) COVID-19. The provision amends SSA Section 1927 (42 U.S.C. §1396d(a)(4)) to apply the requirements of the Medicaid drug rebate program to drugs and biologic products used in COVID-19 prevention and treatment.

Section 9811 also provides coverage of COVID-19 vaccines and administration of COVID-19 vaccines during the specified period for the following eligibility groups by amending SSA Section 1902(a)(10) (42 U.S.C. §1396a(a)(10)) in the matter following subparagraph (G): (1) low-income tuberculosis-infected enrollees; (2) ACA Medicaid expansion enrollees; (3) enrollees eligible only for family planning services and supplies; and (4) enrollees entitled to limited Medicaid benefits, with the exception of specified enrollees whose Medicaid benefits consist only of payment for premiums (e.g., qualified Medicare beneficiaries, qualifying individuals).

For the optional COVID-19 testing group, the provision provides coverage of COVID-19 vaccines and their administration during the specified period. It also provides coverage of treatment, including prescription drugs and treatment for conditions that complicate COVID-19 treatment during the specified period.

For certain low-income pregnant woman who are entitled to pregnancy-related services during a specified pregnancy coverage period, the provision adds coverage of COVID-19 vaccines and their administration, as well as medical assistance for services related to other conditions that may complicate pregnancy during the specified period.

Finally, the provision prohibits states and territories from charging beneficiary cost sharing for all such services furnished during the period that begins on the date of the ARPA's enactment (i.e., March 11, 2021) and ends the last day of the first calendar quarter that begins one year after the last day of the COVID-19 public health emergency period.[33]

Section 9811 adds a subsection to SSA Section 1905 (42 U.S.C. §1396d) that provides 100% federal reimbursement (i.e., fully federally funded) for Medicaid coverage and administration of COVID-19 vaccines. This increased federal reimbursement begins the first day of the first fiscal quarter after the date of the ARPA's enactment (i.e., April 1, 2021), and the increase ends the last day of the first fiscal quarter that begins one year after the last day of the COVID-19 public health emergency period.

[32] Where there is overlap between FFCRA and ARPA §9811 in terms of coverage requirements for COVID-19 testing and related services under traditional Medicaid, ARPA §9811 overrides the FFCRA provision to extend the period of time that such coverage is available.

[33] The provision applies to traditional cost-sharing state plan authority, as well as to the state option for alternative cost sharing that permits states to charge higher cost-sharing amounts (subject to a specified cap) for individuals with higher annual income.

For the territories, any Medicaid payments for the coverage of the COVID-19 vaccines that are subject to this FMAP increase are disregarded for purposes of the territories' annual federal capped funding for Medicaid.[34]

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

Background

In general, Medicaid benefits for pregnant women can differ by eligibility pathway both across and within states. Depending on the individual's eligibility pathway, coverage may include full Medicaid benefit coverage or states may limit services to those related to pregnancy. States use the targeted pregnancy benefit coverage to provide enhanced pregnancy-related benefits (e.g., prenatal vitamins, genetic counseling, smoking cessation services, postpartum home visits). States also rely on various Medicaid waiver authorities to undertake demonstration projects that, in the HHS Secretary's judgement, further the goals of the Medicaid program as a way to provide targeted benefits to pregnant women (e.g., Substance Use Disorder Section 1115 demonstrations that target pregnant and postpartum women, among other populations, or waivers that extend the duration of postpartum care).[35]

For program enrollees who are eligible through one of Medicaid's poverty-related pregnant women pathways, coverage generally begins at the time of application and ends after 60 days postpartum. Women who are otherwise eligible for Medicaid (e.g., meet the financial eligibility criteria of the state's old Aid to Families with Dependent Children program, are eligible under the ACA Medicaid expansion pathway, or are eligible through a family coverage pathway) and who become pregnant generally are permitted to retain their existing full Medicaid state plan coverage (whether provided under traditional Medicaid or ABP coverage) until that individual's next eligibility redetermination (up to 12 months).

Provision

Section 9812 adds a new paragraph to Section 1902(e) (42 U.S.C. §1396(a)(e)) to establish a state plan option to extend full Medicaid benefit coverage during pregnancy and throughout the 12-month postpartum period to any women who received Medicaid coverage while pregnant.

In addition to any available pregnancy-related services and 60-day postpartum care that an individual might be entitled to under the Medicaid state plan (or waiver), pregnancy and postpartum coverage under this state plan option will include the full Medicaid benefit coverage that is available to other mandatory eligibility groups (or substantially equivalent benefit coverage, as determined by the HHS Secretary), and this coverage will be available during the pregnancy through the last day of the month of the 12-month period that begins on the last day of the individual's pregnancy. States that make this election for pregnant and postpartum women under Medicaid are required to take up the parallel state plan option to extend child health assistance through the 12-month postpartum period for targeted-low income children who are pregnant or targeted low-income pregnant women under CHIP. (See "Section 9822: Modifications to Certain Coverage Under CHIP for Pregnant and Postpartum Women.")

[34] For more information about the annual federal capped Medicaid funding for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*.

[35] For more information about waivers, see CRS Report R43357, *Medicaid: An Overview*.

Section 9812 is effective during the five-year period beginning April 1, 2022, and ending March 31, 2027.

Section 9813: State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services

Background

States cover a variety of behavioral health services under Medicaid. Some services (e.g., physician care) are mandatory for states to cover, whereas other services (e.g., rehabilitation services) are optional for states. States provide coverage for behavioral health services under their Medicaid state plans or via waivers (e.g., Sections 1115, 1915(b), 1915(c) waivers), which allow states to disregard certain federal requirements and operate their programs outside of federal Medicaid rules, such as by varying services by geographic areas or by Medicaid population, subject to the approval of the Centers for Medicare & Medicaid Services (CMS).

States define specific Medicaid coverage features of Medicaid-covered services within four broad federal guidelines:

1. Each service must be *sufficient in amount, duration*, and *scope* to reasonably achieve its purpose. States may place appropriate limits on a service based on such criteria as medical necessity.
2. Within a state, services available to the various population groups must be equal in amount, duration, and scope. This requirement is the *comparability* rule.
3. With certain exceptions, the amount, duration, and scope of benefits must be the same statewide, referred to as the *statewideness* rule.
4. With certain exceptions, enrollees must have *freedom of choice* among health care providers.

In addition, providers that meet the specified federal and state requirements may enter into *provider agreements* with state Medicaid agencies to provide Medicaid-coverable services to individuals enrolled in the Medicaid program.

Some states choose to offer mobile crisis intervention services as an optional Medicaid benefit through Medicaid state plans, Section 1115 waivers, and Section 1915(b) waivers. In general, *mobile crisis intervention services* are mental health crisis stabilization and psychiatric assessments and treatment provided in the community, with the goal of avoiding unnecessary stays in emergency departments and inpatient facilities as well as criminal justice involvement.

The federal government's share for most Medicaid expenditures is called the FMAP. In FY2021, FMAP rates range from 50% (13 states) to 77.76% (Mississippi). There are exceptions to the FMAP rate for certain states, situations, populations, providers, and services.

Provision

Section 9813 adds SSA Section 1947, which is a state plan option to provide Medicaid coverage of qualifying community-based mobile crisis intervention services during the five-year period beginning April 1, 2022, and ending March 27, 2027. The state option allows states to offer qualifying community-based mobile crisis intervention services without regard to the Medicaid statutory requirements related to comparability, statewideness, freedom of choice of providers, and provider agreements.

Qualifying community-based mobile crisis intervention services are defined as services provided by a multidisciplinary mobile crisis team to a Medicaid-eligible individual experiencing a mental health or substance use disorder crisis outside of a hospital or other facility setting. The multidisciplinary team must include at least one behavioral health care professional who meets specified qualifications. The team members are to be trained in trauma-informed care, de-escalation strategies, and harm reduction. The team must be able to respond in a timely manner and provide screening and assessment; stabilization and de-escalation; and coordination with (and referrals to) health, social, and other services and supports as needed. The multidisciplinary team must maintain (1) relationships with relevant community partners, including medical and behavioral providers, and (2) the privacy and confidentiality of patient information consistent with federal and state requirements. The team must be available 24 hours a day, every day of the year.

Under the state option, states receive an increased federal Medicaid reimbursement rate of 85% for qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters a state meets the requirements for the state option. The 85% federal Medicaid reimbursement should not result in a state receiving a lower FMAP rate than the state otherwise would have received. The provision specifies that the 85% federal Medicaid reimbursement does not apply to the ACA Medicaid expansion population, which receives a 90% federal Medicaid reimbursement rate.

For the state option, states must demonstrate to the HHS Secretary that the state will be able to support the provision of qualifying community-based mobile crisis intervention services as specified. Further, states must provide assurance to the HHS Secretary that any additional federal funds received via the increased federal reimbursement for qualifying community-based mobile crisis intervention services will be used to supplement, not supplant, the level of state funds expended for such services for the fiscal year preceding the first quarter occurring during the period of the state option. States also must provide assurance to the HHS Secretary that if a state makes available qualifying community-based mobile crisis intervention services in a region of the state in such fiscal year, the state will continue to make available the services in that region during each month in which the 85% federal reimbursement is available (i.e., the first 12 fiscal quarters of the state option).

Section 9813 appropriates $15 million for implementation, administration, and planning grants to states to develop state plan amendments or Sections 1115, 1915(b), or 1915(c) waiver requests or amendments to provide qualifying community-based mobile crisis intervention services. The funds are available until expended.

Section 9814: Temporary Increase in FMAP for Medical Assistance Under State Medicaid Plans Which Begin to Expend Amounts for Certain Mandatory Individuals

Background

Eligibility for Medicaid is determined by federal and state law. States set individual eligibility criteria within federal standards. Individuals must meet both categorical (e.g., elderly, individuals with disabilities, children, pregnant women, parents, certain non-elderly childless adults) and financial (i.e., income and sometimes asset limits) criteria. In addition, individuals must meet federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship. Some eligibility groups are mandatory, meaning all states with a Medicaid program must cover them; others are optional. States are permitted to apply to CMS for a waiver

of federal law to expand health coverage beyond the mandatory and optional groups listed in federal statute.

The ACA established 133% of the FPL as the mandatory minimum Medicaid income-eligibility level for most non-elderly adults beginning January 1, 2014. On June 28, 2012, the U.S. Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, finding that the enforcement mechanism for the ACA Medicaid expansion violated the Constitution, which effectively made the ACA Medicaid expansion optional for states. On January 1, 2014, 24 states and the District of Columbia (DC) implemented the ACA Medicaid expansion. Since then, 12 additional states have implemented the expansion.[36] Oklahoma and Missouri approved ballot initiatives to implement the expansion in June 2020 and August 2020, respectively, and both states are expected to implement the ACA Medicaid expansion on July 1, 2021.

The federal government's share for most Medicaid expenditures is called the FMAP rate. In FY2021, FMAP rates range from 50% (13 states) to 77.76% (Mississippi). States are receiving the FFCRA 6.2-percentage-point increase to the regular FMAP rates during the COVID-19 public health emergency period. There are exceptions to the regular FMAP rate for certain states, situations, populations, providers, and services. For instance, expenditures for the ACA Medicaid expansion receive a 90% federal reimbursement rate instead of the regular FMAP rate.

Provision

Section 9814 adds subsection (ii) to SSA Section 1905 (42 U.S.C. §1396d), which provides a five-percentage-point increase to the regular FMAP rate, after the application of the FFCRA FMAP increase (if applicable), for qualifying states that implement the ACA Medicaid expansion after the date of the ARPA's enactment (i.e., March 11, 2021). *Qualifying states* are states that have not expended amounts under Medicaid for all individuals in the expansion population prior to the date of enactment.

The five-percentage-point increase begins the first calendar quarter the qualifying state has expenditures for the ACA Medicaid expansion. The increase continues for eight quarters, as long as the state continues to have expansion expenditures. The five-percentage-point increase ends if the state ceases to provide coverage of the ACA Medicaid expansion population in a quarter during the eight-quarter period.

The five-percentage-point FMAP increase does not apply to expenditures for Medicaid DSH payments. The FMAP increase also does not apply to expenditures that use the FMAP rate under SSA Title IV-A (Block Grants to States for Temporary Assistance for Needy Families), SSA Title IV-D (Child Support and Establishment of Paternity), and SSA Title IV-E (Federal Payments for Foster Care, Prevention, and Permanency). The increase is not used to calculate the enhanced FMAP (or E-FMAP rate) that is used for CHIP. For the territories, any Medicaid payments subject to this FMAP increase are disregarded for purposes of the territories' annual federal capped funding for Medicaid.[37]

[36] For more information about the ACA Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

[37] For more information about the annual federal capped Medicaid funding for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*.

Section 9815: Extension of 100% Federal Medical Assistance Percentage to Urban Indian Health Organizations and Native Hawaiian Health Care Systems

Background

The federal government's share for most Medicaid expenditures is called the FMAP rate. In FY2021, FMAP rates range from 50% (13 states) to 77.76% (Mississippi). There are exceptions to the FMAP rate for certain states, situations, populations, providers, and services. One of these FMAP exceptions provides 100% federal reimbursement (i.e., fully federally funded) for Medicaid services provided through an Indian Health Service (IHS) facility, because of the federal responsibility to provide care to American Indians and Alaska Natives. This exception applies to two of the three types of IHS-funded facilities: (1) IHS-operated facilities and (2) facilities operated by Indian tribes or tribal organizations. This exception does not apply to the third component of the IHS system, facilities operated by UIOs, which receive grants or contracts from IHS to provide health services to American Indians and Alaska Natives in urban areas. Separate from IHS, HHS awards grants to Native Hawaiian organizations to provide health services to the Native Hawaiian population. These Native Hawaiian Health Centers are exclusively located in Hawaii. The regular FMAP rate applies to services provided through UIOs, and Native Hawaiian Health Centers receive the state's regular FMAP rate.

Provision

Section 9815 amends SSA Section 1905(b) (42 U.S.C. §1396d(b)) to provide eight fiscal quarters beginning April 1, 2021, through March 31, 2023, of 100% federal reimbursement (i.e., fully federally funded) for Medicaid services received through (1) UIOs that have a grant or contract with IHS and (2) Native Hawaiian Health Centers or qualified entities that have a grant or contract with the Papa Ola Lokahi.

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

Background

Under Medicaid law, for drug manufacturers to sell their products to state Medicaid programs, they must agree to the Medicaid Drug Rebate Program (MDRP) conditions. Among other MDRP requirements, drug manufacturers must pay rebates on covered outpatient drugs to state Medicaid programs. Covered outpatient drugs include drugs made from chemicals as well as biologic products, which are derived from living sources such as plants, animals, and bacteria. Statutory Medicaid rebates have two components: a base rebate and an inflation rebate, which is owed when a drug manufacturer increases prices more than the rate of inflation since the drug was first introduced. Medicaid rebates paid by manufacturers to state Medicaid programs are calculated quarterly as a percentage of each drug's average manufacturer price (AMP). Generally, the base rebate percentage varies depending on whether a drug or biological is covered by a patent (brand name) or is available from multiple sources (generic). The inflation rebate is the amount the drug or biological AMP has increased above an inflation-adjusted AMP.

Section 2501(e) of the ACA limited the maximum rebate amount owed by drug manufacturers for each covered drug to 100% of the drug's AMP for the applicable calendar quarter. Some drug manufacturers have increased drug and biological prices faster than the rate of inflation, thus increasing the amount owed under the inflation component of the Medicaid rebate. As a result,

the total Medicaid rebate for some drugs could reach the maximum amount allowed by law—100% of the drug's quarterly AMP. Future price increases for drugs and biologicals that have reached the maximum rebate would not increase the total rebate owed to state Medicaid programs for those drugs but could increase state and federal expenditures for those drugs, as well as costs to other health care purchasers, including insurance companies and consumers.

Provision

Section 9816 amends SSA Section 1927(c)(2)(D) (42 U.S.C. §1396r–8(c)(2)(D)) to eliminate the maximum Medicaid rebate amount drug manufacturers can owe in statutory rebates for each covered drug. This provision is effective for drugs dispensed to Medicaid beneficiaries beginning January 1, 2024.

Section 9817: Additional Support for Medicaid Home and Community-Based Services During the COVID-19 Emergency

Background

Medicaid long-term services and supports include coverage of HCBS, such as case management, personal care, homemaker, respite care, and adult day health care, among other services.[38] Medicaid HCBS are authorized under the Medicaid state plan, which is the contract a state makes with the federal government to administer its Medicaid program, subject to CMS approval. These HCBS state plan authorities include optional packages of services, referred to as *service categories*, that states may choose to provide under the SSA Section 1915(i) HCBS state plan option, the SSA Section 1915(k) Community First Choice (CFC) state plan option, and the SSA Section 1915(j) Self-Directed Personal Care Assistance Services, among others.

As an alternative to states providing all of the mandatory and selected optional state plan services under traditional Medicaid, states may offer ABPs under SSA Section 1937. In general, these benefit packages look more like coverage available in the private market and may cover fewer services than traditional Medicaid. However, in designing a Medicaid ABP, states also may choose to offer HCBS.

In addition, states may offer Medicaid HCBS through waiver program authorities that permit states to disregard certain Medicaid requirements under the state plan in the provision of waiver services, also subject to CMS approval. Medicaid HCBS waiver authorities include SSA Section 1915(c) HCBS waivers and SSA Section 1115 research and demonstration waivers. SSA Section 1915(b) waivers provide states with authority to implement managed care delivery systems and typically are authorized concurrently with other HCBS state plan or waiver authorities.

The federal government's share for most Medicaid expenditures (including HCBS) is called the FMAP. In FY2021, FMAP rates range from 50% (13 states) to 77.76% (Mississippi). There are exceptions to the FMAP rate for certain states (e.g., the territories), situations (e.g., FFCRA's FMAP increase), populations (e.g., individuals covered by ACA's Medicaid expansion), providers, and services (e.g., CFC state plan option).

[38] For more information about Medicaid coverage of home and community-based services, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*.

Provision

Section 9817 increases the FMAP rate of Medicaid expenditures by 10 percentage points for certain HCBS for states that meet the HCBS program requirements during the program-improvement period (i.e., April 1, 2021, through March 31, 2022). This FMAP increase for certain HCBS is applied to the regular FMAP rates for states and territories, and the increase is applied to the FMAP exceptions for the ACA Medicaid expansion, the adjustment for disaster-recovery, CFC, the FFCRA FMAP increase, and the temporary increase for non-expansion states that implement the expansion (see "Section 9814: Temporary Increase in FMAP for Medical Assistance Under State Medicaid Plans Which Begin to Expend Amounts for Certain Mandatory Individuals"). The application of the FMAP increase may not result in an FMAP rate of more than 95%. For the territories, any Medicaid payments subject to this FMAP increase are disregarded for purposes of the territories' annual federal capped funding for Medicaid.[39]

The HCBS FMAP increase applies to individuals who are eligible for and enrolled in Medicaid and includes individuals who become eligible for Medicaid when removed from a waiting list. The FMAP increase applies to services and service categories offered under the Medicaid state plan, ABPs, waiver programs, and demonstrations. Specifically, the FMAP increase applies to the following Medicaid state plan services and service categories: case management, CFC, home health, the HCBS state plan option, personal care, the Program of All-Inclusive Care for the Elderly, rehabilitative services, and Self-Directed Personal Care Assistance Services. It applies to HCBS offered in ABPs under SSA Section 1937. It also applies to HCBS authorized through SSA Section 1915(c) and SSA Section 1115 waiver authorities, as well as to HCBS offered under SSA Section 1915(b) managed care waivers. In addition, the FMAP increase may apply to other services, as specified by the HHS Secretary.

To receive the HCBS FMAP increase, states must meet the following HCBS program requirements: (1) states are required use this HCBS FMAP increase to supplement, and not supplant, the level of state funding for HCBS for eligible individuals through programs in effect as of April 1, 2021, and (2) states are required to implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen HCBS under the state Medicaid program.

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

Background

SSA Section 1923 requires states to make Medicaid DSH payments to hospitals treating large numbers of low-income patients.[40] This provision is intended to recognize the disadvantaged financial situation of those hospitals, because low-income patients are more likely to be uninsured or Medicaid enrollees. Hospitals often do not receive payment for services rendered to uninsured patients, and Medicaid provider payment rates generally are lower than the rates paid by Medicare and private insurance.

Whereas most federal Medicaid funding is provided on an open-ended basis, federal Medicaid DSH funding is capped. Each state receives an annual DSH allotment, which is the maximum

[39] For more information about the annual federal capped Medicaid funding for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*.

[40] For more information about Medicaid disproportionate share hospital payments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

amount of federal matching funds that each state is permitted to claim for Medicaid DSH payments.

As with most Medicaid expenditures, the federal government reimburses states for a portion of their Medicaid DSH expenditures based on each state's FMAP rate, which is the federal government's share for most Medicaid expenditures. In FY2021, FMAP rates range from 50% (13 states) to 77.76% (Mississippi). There are exceptions to the FMAP rate for certain states, situations, populations, providers, and services. For instance, states are receiving the FFCRA 6.2-percentage-point increase to FMAP rates during the COVID-19 public health emergency period.[41]

Provision

Section 9819 amends SSA Section 1923(f)(3) (42 U.S.C. §1396r–4(f)(3)) for the Medicaid DSH allotments for states to be recalculated by the HHS Secretary to take into account the higher federal share of Medicaid DSH expenditures under the FFCRA FMAP increase. The HHS Secretary should ensure that the total Medicaid DSH payments (including federal and state expenditures) a state can make in a fiscal year are equal to the Medicaid DSH payments a state could have made without the application of the FFCRA FMAP increase.

Section 9819 takes effect and is applied as if it were included in the FFCRA. The recalculation of Medicaid DSH allotments does not apply for the first fiscal year beginning after the end of the COVID-19 public health emergency period or any succeeding fiscal year.

State Children's Health Insurance Program (CHIP) Provisions

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

Background

States may design their CHIP programs as (1) a CHIP Medicaid expansion; (2) a separate CHIP program; or (3) a combination approach, where the state concurrently operates a CHIP Medicaid expansion and one or more separate CHIP programs. CHIP benefit coverage and cost-sharing rules depend on program design.

In general, medically necessary testing, diagnostic, and laboratory services are commonly covered services under CHIP, regardless of program design. The FFCRA, as amended by the CARES Act, requires CHIP programs to cover COVID-19 testing and testing-related services for CHIP enrollees for the period beginning March 18, 2020, through the duration of the public health emergency period, as specified. States are prohibited from charging beneficiary cost sharing for such testing or for testing-related visits furnished to CHIP enrollees during this period.

In general, under CHIP Medicaid expansion programs, states are required to cover COVID-19 vaccines authorized for use in children without enrollee cost sharing, as well as any medically necessary COVID-19 specialized treatment and therapies that might be available under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment benefit, generally without cost sharing. As a condition of receiving the FFCRA 6.2-percentage-point FMAP rate increase, states also are required to provide Medicaid coverage of COVID-19 treatments, including vaccines and their administration, specialized equipment, and therapies, without enrollee cost

[41] For more information about the FFCRA FMAP increase, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*.

sharing. This requirement applies to CHIP Medicaid expansion enrollees in the same way that it applies to all other Medicaid enrollees.

Under separate CHIP programs, states are required to cover COVID-19 vaccines authorized for use in children without enrollee cost sharing, and at state option for pregnant women. Coverage of COVID-19 specialized treatment and therapies may vary by state, and cost-sharing rules may apply.

The federal government's share of CHIP expenditures (including both services and administration) is determined by the E-FMAP rate. The E-FMAP varies by state; statutorily, the E-FMAP can range from 65% to 85%. States receive CHIP allotments, which are the federal funds allocated to each state and the territories for the federal share of their CHIP expenditures.[42]

Provision

Section 9821 adds a new paragraph to SSA Section 2102(c) (42 U.S.C. §1397cc(c)) to temporarily require CHIP programs (regardless of program design and including pregnancy-related assistance available at state plan option) to cover, without enrollee cost sharing, COVID-19 vaccines, the administration of COVID-19 vaccines, and testing and treatments for COVID-19, including specialized equipment and therapies (e.g., preventive therapies).

Section 9821 amends SSA Section 2105(c) (42 U.S.C. §1397ee(c)) to provide 100% federal reimbursement (i.e., fully federally funded) rather than the E-FMAP rate for COVID-19 vaccines and administration of COVID-19 vaccines. Section 9821 also amends SSA Section 2104(m) (42 U.S.C. §1397dd(m)) to increase CHIP allotments by the projected expenditures for COVID-19 vaccines and administration of COVID-19 vaccines, and when the actual increased expenditures for COVID-19 vaccine and administration of COVID-19 vaccines are available in the subsequent fiscal year, the increased CHIP allotments will be reconciled.

For enrollees who are diagnosed with (or presumed to have) COVID-19, states are required to cover, without cost sharing, the treatment of conditions that may seriously complicate the treatment of COVID-19 for services that are available under the state plan (or waiver). These requirements apply for the period that begins on the date of the ARPA's enactment (i.e., March 11, 2021) and end the last day of the first calendar quarter that begins one year after the last day of the COVID-19 public health emergency period.

Section 9822: Modifications to Certain Coverage Under CHIP for Pregnant and Postpartum Women

Background

Under separate CHIP programs, states may extend CHIP coverage to uninsured low-income pregnant women through (1) the CHIP state plan option for pregnant women; (2) the Section 1115 waiver authority; and/or (3) the unborn child pathway. Under the state plan option, states are permitted to cover pregnant women through a state plan amendment when certain conditions are met (e.g., the Medicaid income standard for pregnant women must be at least 185% of the FPL but in no case may be lower than the percentage level in effect on July 1, 2008; no preexisting conditions or waiting periods may be imposed; CHIP cost-sharing protections apply). The period of coverage associated with the state plan option includes pregnancy through the postpartum

[42] For more information about State Children's Health Insurance Program (CHIP) financing, see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*.

period (through 60 days postpartum), and benefits include all services available to CHIP children in the state as well as prenatal, delivery, and postpartum care.

Under CHIP-funded pregnancy-related Section 1115 demonstration waivers, states define the eligibility criteria, benefit coverage (including duration of postpartum care), cost-sharing rules that apply, etc., and states may target the benefit coverage to meet particular health care needs (e.g., treatment for pregnant women with substance use disorders). CMS-approved coverage arrangements under the waiver are outlined in the waiver special terms and conditions and may vary by state.

States also are permitted to provide CHIP coverage to pregnant women (including women aged 19 and older) by extending coverage to unborn children as permitted through federal regulation. Coverage available to such women may be limited to prenatal and delivery services but still is used in a number of states, because it permits the extension of CHIP coverage to a pregnant woman regardless of her immigration status.

Provision

Section 9822 adds a new paragraph to SSA Section 2107(e)(1) (42 U.S.C. §1397gg(e)(1))—the place in the CHIP statute that identifies Medicaid provisions that also apply to CHIP. The modification requires states that elect to provide full Medicaid coverage during pregnancy and throughout the 12-month postpartum period under Medicaid to provide all items or services available to a targeted low-income child or a targeted low-income pregnant woman (SSA §2112(d)(2)(A); 42 U.S.C. §1397ll(d)(2)(A)) under the CHIP state plan (or waiver) to women during pregnancy and throughout the 12-month postpartum period under CHIP.

Section 9822 is effective for state elections for such coverage under Medicaid and CHIP during the five-year period beginning April 1, 2022, and ending March 31, 2027.

Medicare Provisions

Section 9401: Providing for Infection Control Support to Skilled Nursing Facilities Through Contracts with Quality Improvement Organizations

Background

Medicare's quality assurance activities are handled primarily by state survey agencies (SAs) and QIOs. SAs and QIOs operate in all states and DC, Puerto Rico, and the U.S. Virgin Islands. The SAs are responsible for inspecting Medicare provider facilities (e.g., nursing homes, home health agencies, and hospitals) to ensure they comply with federal safety and quality standards. QIOs are mostly private, not-for-profit organizations that monitor the quality of care delivered to Medicare beneficiaries and educate providers on the latest quality improvement techniques.

On July 10, 2020, CMS announced it would deploy QIOs "to provide immediate assistance to nursing homes in the hotspot areas as identified by the White House Coronavirus Task Force."[43] The Coronavirus Commission on Safety and Quality in Nursing Homes confirmed that QIOs had begun assisting federally certified nursing homes when it released its report in September 2020,

[43] Centers for Medicare & Medicaid Services (CMS), "CMS Directs Additional Resources to Nursing Homes in COVID-19 Hotspot Areas," July 10, 2020, at https://www.cms.gov/newsroom/press-releases/cms-directs-additional-resources-nursing-homes-covid-19-hotspot-areas.

but reported that "technical assistance and quality improvement support [had] not been sufficiently available at nursing homes during the pandemic."[44] The commission recommended that QIOs should offer "expanded, outcomes-oriented, on-the-ground technical assistance with organizational diagnosis, strategic direction, organizational resilience, resource prioritization, emergency-management assistance, data-management assistance, and workforce capability development in infection prevention and control, trauma-informed care, person-centered and person-directed care, visitation, and/or family communications and engagement."[45]

Provision

Section 9401 amends SSA subsection 1862(g) (42 U.S.C. §1395y(g)) and appropriates, out of funding otherwise not obligated, $200 million (to remain available until expended) to the HHS Secretary for the purpose of QIOs carrying out infection control and vaccination uptake support relating to the prevention or mitigation of COVID-19 within Medicare-certified nursing homes (i.e., skilled nursing facilities, or SNFs), as determined appropriate by the Secretary.

Section 9831: Floor on the Medicare Area Wage Index for Hospitals in All-Urban States

Background

Medicare pays most short-term, acute-care hospitals a predetermined, fixed payment amount for furnishing inpatient services. This payment is called the *inpatient prospective payment system* (IPPS) payment. The IPPS payment is subject to a number of adjustments, including the wage index adjustment, which adjusts the IPPS payment to reflect geographic differences in wages.

CMS recognizes geographic areas as *urban* (i.e., metropolitan statistical areas, or MSAs) and *rural* (i.e., non-MSAs) for purposes of the wage index. A wage index value is calculated and assigned to each MSAs, and a single wage index value is assigned to all of a state's non-MSA areas. A hospital's wage index value is the wage index that CMS assigns to the geographic area in which the hospital is located.[46]

Congress enacted legislation, the Balanced Budget Act of 1997 (P.L. 105-33), establishing that the wage index for any urban area in a state may not be less than the wage index of that state's rural area.[47] This is referred to as the *rural floor* policy. Although most states have both urban and rural areas and therefore may benefit from the rural floor policy, some states have no rural areas. Currently, three states—Delaware, New Jersey, and Rhode Island—have no rural areas; as such, these states are considered *all-urban*. Therefore, the rural floor policy does not apply to IPPS payments made in these states.

To address concerns that the rural floor policy disadvantaged hospitals in states without a rural wage index area, CMS implemented the *imputed floor* policy beginning in FY2005. The imputed

[44] Coronavirus Commission for Safety and Quality in Nursing Homes, *Commission Final Report*, September 2020, p. 53, at https://sites.mitre.org/nhcovidcomm/wp-content/uploads/sites/14/2020/09/FINAL-REPORT-of-NH-Commission-Public-Release-Case-20-2378.pdf (hereinafter, Coronavirus Commission for Safety and Quality in Nursing Homes, *Final Report*).

[45] Ibid, p. 54.

[46] For more details about the Medicare hospital wage index, see CRS Report R46702, *Medicare Hospital Payments: Adjusting for Variation in Geographic Area Wages*.

[47] The Balanced Budget Act of 1997 (P.L. 105-33), Title IV, §4410; 42 U.S.C. §1395ww Note.

floor policy, which applied to all-urban states, was the product of the state's highest wage index value multiplied by whichever ratio was higher: (1) the average ratio of the lowest-to-highest wage index values of all-urban states or (2) the state's ratio of the lowest-to-highest wage index values. The imputed floor policy was budget neutral—to offset the increased IPPS payments made to certain hospitals attributed to the imputed floor, CMS made a proportional reduction in IPPS payments to other hospitals. CMS discontinued the imputed floor policy, effective FY2019 (beginning October 1, 2018).[48]

Provision

Section 9831 amends SSA Section 1886(d)(3)(E) (42 U.S.C. §1395ww(d)(3)(E)) to reinstate the imputed floor policy, effective FY2022 (i.e., October 1, 2021), as the policy was in effect during FY2018—the year before CMS discontinued it. Section 9831 defines an *all-urban state* as a state (1) with no rural areas, as defined in statute, or (2) in which there are no hospitals classified as rural.[49] The section also waives budget neutrality for the imputed floor.

Section 9832: Secretarial Authority to Temporarily Waive or Modify Application of Certain Medicare Requirements with Respect to Ambulance Services Furnished During Certain Emergency Periods

Background

Medicare covers ambulance service "where the use of other methods of transportation is contraindicated by the individual's condition."[50] Medicare pays for medically necessary ground ambulance transports from an appropriate origin and destination under the ambulance fee schedule (AFS).[51] Also, except in limited circumstances, Medicare pays an ambulance supplier or provider only when a transport occurs.[52] Such transport is usually "to the nearest hospital, critical access hospital (CAH), or skilled nursing facility (SNF) that is capable of furnishing the required level and type of care for the beneficiary's illness or injury."[53] The HHS Secretary temporarily expanded ambulance transport destinations during the COVID-19 public health emergency but continued to require that a transport occur.[54]

[48] 42 C.F.R. §412.64(h)(4)(vi).

[49] Under current law, Medicare permits a qualifying hospital or group of hospitals to *reclassify* from the geographic area where they are physically located to a nearby geographic area to obtain a different wage index value. See CRS Report R46702, *Medicare Hospital Payments: Adjusting for Variation in Geographic Area Wages*, for more information about wage index reclassifications.

[50] SSA §1861(s)(7).

[51] 42 C.F.R. §410.40.

[52] For example, Medicare pays for paramedic intercept emergency medical technician/paramedic services furnished by the non-transporting entity under the ambulance fee schedule (AFS). This service is called a *Paramedic ALS (Advance Life Support) Intercept Service*. An intercept service payable under the Medicare AFS is defined at 42 U.S.C. §1395x Note; 42 C.F.R. §414.605; and 42 C.F.R. §410.40(c).

[53] 42 C.F.R. §410.40(f).

[54] CMS, "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency," 85 *Federal Register* 19230, April 6, 2020.

Provision

Section 9832 amends SSA Section 1135(b) (42 U.S.C. §1320b-5(b)) to give the HHS Secretary authority to waive the ground ambulance *transport* requirement under the Medicare AFS for a 911 or other emergency system response service. Payment would be allowed for ground ambulance services furnished in cases in which an individual would have been transported to a destination permitted under Medicare regulations but when no transport occurred due to community-wide restrictions imposed to prevent COVID-19 exposure of patients and health care personnel during the public health emergency. The Medicare payment rate for a service established by this section is the amount otherwise payable under the Medicare AFS, excluding the mileage payment, if the transport had occurred; the applicable amount otherwise payable to a CAH for furnishing an ambulance transport;[55] and the applicable amount for a telehealth service furnished during an emergency period in an emergency area, as defined.[56]

Medicare, Medicaid, and CHIP Provisions

Sections 9402 and 9818: Funding for Strike Teams for Resident and Employee Safety in Nursing Facilities

Background

CMS is required to oversee certain institutional care facilities that participate in Medicare or Medicaid, which CMS refers to as *long-term care facilities* (LTCFs). To differentiate between LTCFs participating in each program, federal law designates Medicare LTCFs as SNFs and Medicaid LTCFs as nursing facilities (NFs). The majority of federally certified LTCFs participate in both programs and thus constitute SNFs and NFs. In the United States, 15,340 LTCFs participated in Medicare and/or Medicaid as of January 2021. Of this total, 94% of LTCFs were dually certified to participate in both Medicare and Medicaid, 4% were certified as Medicare-only, and 2% were certified as Medicaid-only.[57]

On July 22, 2020, CMS announced that HHS was deploying Task Force Strike Teams, composed of public health service officials from CMS, the Centers for Disease Control and Prevention, and the Office of the Assistant Secretary for Health, "to provide onsite technical assistance and education to nursing homes experiencing outbreaks in an effort to help reduce transmission and the risk of COVID-19 spread among residents" in SNFs and NFs.[58]

After CMS announced the deployment of Task Force Strike Teams, and after other agency activities responding to the spread of COVID-19 in nursing homes, to assist the decisionmaking of these entities, CMS convened a commission of experts tasked to identify "lessons learned from the early days of the pandemic and [to develop] recommendations for future actions to improve infection prevention and control measures, safety procedures, and the quality of life of residents

[55] SSA §1834(l)(8).

[56] SSA §1135(b)(8).

[57] CRS analysis of CMS data, "Provider Info" file on "Nursing Home Compare," as of February 1, 2021, at https://data.cms.gov/provider-data/dataset/4pq5-n9py.

[58] CMS, "Trump Administration Announces New Resources to Protect Nursing Home Residents Against COVID-19," July 22, 2020, at https://www.cms.gov/newsroom/press-releases/trump-administration-announces-new-resources-protect-nursing-home-residents-against-covid-19.

within nursing homes."[59] The Coronavirus Commission on Safety and Quality in Nursing Homes provided recommendations in a September 2020 final report.

The commission found in its final report that the aforementioned strike teams, which were defined as "a set number of resources of the same kind and type that have an established minimum number of personnel, common communications, and a designated leader,"[60] had focused on verifying competency of federal requirements among nursing homes rather than providing instruction. The commission recommended that CMS develop its ability to focus on nursing home workforce support and to "deploy emergency management, infection control, and capacity-building support to nursing homes in collaboration with state-based strike teams."[61]

Provisions

Section 9402: Funding for Strike Teams for Resident and Employee Safety in Skilled Nursing Facilities

Section 9402 amends SSA Section 1819 (42 U.S.C. §1395i–3) by adding a subsection that appropriates, out of funding otherwise not obligated, $250 million (to remain available until expended) to the HHS Secretary for the purpose of allowing states and territories (including DC) to "establish and implement" strike teams to deploy to SNFs with "diagnosed or suspected cases of COVID-19 among residents or staff for the purposes of assisting with clinical care, infection control, or staffing" during the COVID-19 emergency period and for one year following the emergency period.

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

Section 9818 amends SSA Section 1919 (42 U.S.C. §1396r) by adding a subsection that appropriates, out of funding otherwise not obligated, $250 million (to remain available until expended) to the HHS Secretary for the purpose of allowing states and territories (including DC) to "establish and implement" strike teams to deploy to NFs with "diagnosed or suspected cases of COVID-19 among residents or staff for the purposes of assisting with clinical care, infection control, or staffing" during the COVID-19 emergency period and for one year following the emergency period.

Section 9911: Funding for Providers Relating to COVID-19

Background

In response to the COVID-19 pandemic, some health care providers limited in-person visits and canceled elective procedures to reduce the spread of COVID-19, prepare for COVID-19 patients, and conserve personal protective equipment. As a consequence, some providers reported forgone revenue and/or significant financial challenges, making it difficult to sustain services. To address these concerns, Congress established the PRF in the CARES Act.[62] The PRF was written with broad language, giving the Administration discretion both in how funds could be allocated and in the potential application and documentation requirements. The most recent amendment to the

[59] Coronavirus Commission for Safety and Quality in Nursing Homes, *Final Report*.

[60] Ibid.

[61] Ibid, p. G-1.

[62] For more information on the PRF, see CRS Insight IN11438, *The COVID-19 Health Care Provider Relief Fund*.

PRF created some statutory requirements for the fund and its future uses. Specifically, the Consolidated Appropriations Act, 2021 (P.L. 116-260), defined uses of the fund, defined *lost revenue* to reflect the definition in the HHS "Frequently Asked Questions" document released June 2020, and specified application processes, among other things.[63]

In total, the PRF has received $178 billion in appropriations under three of the five COVID-19 response laws.[64] Specifically, the CARES Act appropriated $100 billion; the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139) added an additional $75 billion; and the Consolidated Appropriations Act, 2021, added $3 billion, while making some modifications to the fund. The PRF has been allocated using general and targeted distributions. Among the targeted distributions was an allocation of $11.3 billion for rural facilities, although rural providers and suppliers also were eligible for general distributions. The targeted allocation provided funds to rural hospitals (including CAHs), rural health clinics, and rural community health centers.[65] Notably, rural clinician practices or suppliers did not receive funds as part of this allocation.

Provision

Section 9911 creates a new SSA Section 1150C (42 U.S.C. §§1301 et. seq.), "Funding for Providers Relating to COVID-19." The section appropriates $8.5 billion to make payments to rural health care providers for FY2021 to account for lost revenue and increased health care-related expenses due to COVID-19. These funds are available until expended. The provision also specifies application requirements for providers to receive funds and uses of funds, and it defines key terms in ways that are substantively similar to those specified in the Consolidated Appropriations Act, 2021. However, the section defines an *eligible health care provider* differently from how the term was defined in the Consolidated Appropriations Act, 2021, and in prior laws appropriating funds to the PRF. The ARPA defines *eligible health care provider* as a Medicare provider or supplier or a Medicaid or CHIP provider or supplier that provides COVID-19 diagnoses, testing, or care and is a rural provider or supplier.

The provision further defines *rural provider and supplier* as

- a provider or supplier that is a rural provider or is treated as a rural provider under the Medicare statute (as defined);[66]
- a provider or supplier that is not located in a rural area but is determined by the HHS Secretary to serve rural patients;
- a rural health clinic (as defined);[67]

[63] The current reporting requirements that use the June 2020 definition of *lost revenue* can be found at HHS, "General and Targeted Distributions Post-payment Notice of Reporting Requirements," January 15, 2021, at https://www.hhs.gov/sites/default/files/provider-post-payment-notice-of-reporting-requirements-january-2021.pdf.

[64] CRS Report R46711, *U.S. Public Health Service: COVID-19 Supplemental Appropriations in the 116th Congress* (see section on the Health Resources and Services Administration).

[65] CRS Insight IN11438, *The COVID-19 Health Care Provider Relief Fund*; and HHS, "Provider Relief Fund: CARES Act Provider Relief Fund: General Information: Targeted Distributions," at https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html#phase15.

[66] SSA §§1886(d)(2)(D) and 1886(d)(8)(E), respectively.

[67] SSA §1861(aa)(2).

- a home health, hospice, or long-term services and supports provider or supplier that provides supplies or services in an individual's home that is located in a rural area (as defined);[68] or
- any other rural provider or supplier, as defined by the HHS Secretary.

[68] SSA §1886(d)(2)(D).

Appendix. Abbreviations Used in the Report

This report uses a number of abbreviations, listed in the table below.

Acronym	Definition
ABP	Alternative Benefit Plan
ACA	Patient Protection and Affordable Care Act (P.L. 111-148, as amended)
AFS	Ambulance Fee Schedule
AMP	Average Manufacturer Price
APTC	Advance Premium Tax Credit
ARPA	American Rescue Plan Act of 2021 (P.L. 117-2)
ARRA	American Recovery and Reinvestment Act of 2009 (P.L. 111-5)
CAH	Critical Access Hospital
CARES Act	Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136)
CBO	Congressional Budget Office
CFC	Community First Choice
C.F.R.	Code of Federal Regulations
CHIP	State Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act (Continuation of Health Coverage)
COVID-19	Coronavirus Disease 2019
CSR	Cost-Sharing Reduction
CY	Calendar Year
DSH	Disproportionate Share Hospital
E-FMAP	Enhanced FMAP
FFCRA	Families First Coronavirus Response Act (P.L. 116-127)
FFE	Federally Facilitated Exchange
FMAP	Federal Medical Assistance Percentage
FP	Federal Information Technology Platform
FPL	Federal Poverty Level
FSA	Flexible Spending Arrangement
FY	Fiscal Year
HCBS	Home and Community-Based Services
HCTC	Health Care Tax Credit
HHS	Department of Health and Human Services
IHS	Indian Health Service
IPPS	Inpatient Prospective Payment System
IRC	Internal Revenue Code
IRS	Internal Revenue Service

Acronym	Definition
LTCF	Long-Term Care Facility
MDRP	Medicaid Drug Rebate Program
MSA	Metropolitan Statistical Area
NF	Nursing Facility
PRF	Provider Relief Fund
PTC	Premium Tax Credit
QIO	Quality Improvement Organization
QSEHRA	Qualified Small Employer Health Reimbursement Arrangement
SA	State Survey Agency
SBE	State-Based Exchange
SBE-FP	State-Based Exchange on the Federal Platform
SNF	Skilled Nursing Facility
SSA	Social Security Act
UC	Unemployment Compensation
UIO	Urban Indian Organization
U.S.C.	*U.S. Code*

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