American Hospital Association™
Advancing Health in America

Legislative Advisory

March 17, 2021

Summary of American Rescue Plan Act of 2021 and Provisions Affecting Hospitals and Health Systems

President Biden March 11 signed into law the American Rescue Plan Act of 2021, a $1.9 trillion COVID-19 relief package, which includes a number of provisions that affect hospitals and health systems.

The legislation includes additional new funding for rural hospitals and health care providers for COVID-19 relief; increased federal subsidies for COBRA coverage; and changes to the Medicare wage index.

The legislation also includes provisions to bolster the nation's COVID-19 health care response with additional resources for vaccines, treatment, personal protective equipment (PPE), testing, contact tracing and workforce development. Other health care-related provisions provide funding to the Department of Labor for worker protection activities.

In addition, non-health care specific provisions provide financial support for families and small businesses, as well as extend and expand support for housing, child care, food and the education system.

AHA Take: The legislation includes many provisions to help hospitals and health systems provide care to their patients and communities. These include measures to increase access to health coverage for those who lose insurance or are uninsured. It also makes critical investments to bolster the nation's COVID-19 response, with resources for vaccines, treatment, testing, contact tracing, personal protective equipment and workforce development. Additionally, the legislation expands eligibility and provides more resources for the Paycheck Protection Program, which has helped save jobs in the hospital field. Importantly, the bill will help provide much-needed relief for rural hospitals, many of which came into the pandemic on the brink of closure but play an indispensable role in providing care to their communities.

We were disappointed that the legislation does not deliver more overall funding for the Provider Relief Fund, which has been crucial in supplying hospitals, health systems and other providers with resources during the pandemic. We are also concerned that law does not include an extension of relief from Medicare sequester cuts, which will go back into effect at the beginning of next month, and also fails to provide loan forgiveness for Medicare accelerated payments for hospitals.

We look forward to continuing to work with Congress and the Administration on ensuring hospitals and health systems have the support, resources and tools they need to continue to provide essential services to their patients and communities during the pandemic and beyond.

A summary of provisions affecting hospitals and health systems follows.

SUMMARY OF PROVISIONS IMPORTANT TO HOSPITALS AND HEALTH SYSTEMS

Additional Financial Relief for Rural Providers. The law provides $8.5 billion to reimburse rural health care providers for health care-related expenses and lost revenues attributable to COVID–19. Its definition of rural provider is broad and includes those that:

- are located outside a metropolitan statistical area (MSA); or
- are located in a rural census tract of an MSA; or
- are located in an area designated by the state as rural; or
- are a sole community hospital or rural referral center; or
- are located in area that serves rural patients, such as a small MSA; or
- are a rural health clinic; or
- provide home health, hospice, or long-term services and supports in patients' homes that are located in rural areas; or
- otherwise qualify as a rural provider, as defined by the Health and Human Services (HHS) Secretary.

This fund is separate from, although similar to, the Provider Relief Fund. The key distinction is that this legislation specifies that HHS must create a process by which eligible providers will apply for funds. Applications must include a statement justifying the need for the payment, the tax identification number of the provider, and assurances that the provider will maintain and submit reports to ensure compliance with any requirements HHS sets forth, as well as any other information required by HHS.

Vaccines and Testing. The law includes a number of provisions to improve the nation’s vaccine and testing capacity. It allocates $10 billion for the purposes of carrying out activities under the Defense Production Act. Specifically, the funding can be used for the manufacturing and procurement of medical supplies and equipment related to combatting the COVID-19 pandemic, including diagnostic products, PPE, drugs, medical devices and biological products.

It also allocates more than $70 billion for COVID-19 vaccine, testing and workforce efforts. Specifically, more than $15 billion is geared toward enhancing, expanding and improving the nationwide distribution and administration of vaccines by supporting efforts such as increasing access, especially in underserved communities, increasing vaccine confidence and funding the research, development, manufacturing and procurement of vaccines, therapeutics and other ancillary supplies. The law further assigns $6 billion for the research, development, manufacturing, production and purchasing of vaccines, therapeutics and other ancillary products, as well as $1 billion for efforts to boost vaccine confidence.

With respect to testing, the law allocates $47.8 billion to continue implementation of an evidence-based national testing strategy with a focus on components such as detection, diagnosis, tracing and monitoring. Further, $1.75 billion is directed to support genomic sequencing and surveillance initiatives.

Health Care Coverage. The law makes changes to a number of health care coverage programs to expand eligibility and increase federal financial support for coverage.

- **Medicaid**. The law makes several changes to Medicaid financing and eligibility rules in order to increase access to coverage.

    - *Postpartum Coverage*. The law now gives states, for five years, the option to extend Medicaid and Children's Health Insurance Program (CHIP) eligibility to pregnant individuals for 12 months postpartum. States choosing this option must provide the full Medicaid benefit for pregnant and postpartum individuals during the 12-month postpartum period.

    - *Expansion Incentive*. The law provides an incentive for states that have not already done so to expand Medicaid by temporarily increasing the state's Federal Medical Assistance Percentage (FMAP) for their base program by 5 percentage points for two years. The FMAP increase is immediately available to states and would begin in the first calendar quarter when a new expansion state incurs spending for people in the Medicaid adult expansion groups. If a state expands during the public health emergency (PHE), that state will receive both the COVID-19-related 6.2 percentage point FMAP and the new 5-percentage-point increase. The increased match does not apply to the already-enhanced matching rate for expansion populations, to federal matching rates for Medicaid Disproportionate Share Hospital (DSH) payments or CHIP. States choosing to expand will be required to maintain coverage levels to access the FMAP increase, including the newly established requirement to cover COVID-19 vaccine and treatment.

- **Temporary Expansion of Health Insurance Marketplace Subsidies**. The law further reduces the cost of Marketplace coverage for all subsidy-eligible individuals and families by increasing the dollar value of the premium tax credit subsidies. For example, individuals making between 100% and 150% of the federal poverty level (FPL) will not pay anything in Marketplace premiums. In addition, the law expands eligibility for the tax credit subsidies to more individuals. Specifically, more households above 400% FPL, the current maximum eligibility threshold, are newly eligible for subsidies. These changes are temporary and in effect for tax years 2021 and 2022.

In a separate section, the law newly makes eligible for marketplace coverage individuals who receive unemployment compensation during 2021.

- **Employer-sponsored Coverage through COBRA**. The law provides federal subsidies valued at 100% of the health insurance premium for eligible individuals

and families to remain on their employer-based coverage. This provision is temporary and in effect until Sept. 30, 2021.

Maintaining Medicaid DSH During PHE. The law addresses an unintended consequence of the temporary increase in the FMAP and state DSH spending. The enacted temporary COVID-19-related FMAP increase did not make a corresponding adjustment to Medicaid DSH allotments to reflect the increased federal share. As a result, fewer state funds were needed to draw down the entire federal allotment. To address this, the law now requires that the Centers for Medicare & Medicaid Services recalculate the annual DSH allotments for any year the temporary COVID-19-related FMAP increase applies to ensure that the total DSH payments a state makes (including federal and state shares) is equal to the DSH payment amount the state would have made in the absence of the temporary FMAP increase. This DSH allotment recalculation is retroactive to coincide with the temporary FMAP increase that was initiated last year and ends at the beginning of the fiscal year after the PHE has ended.

Coverage of Vaccines for Medicaid and CHIP Beneficiaries. The law requires Medicaid and CHIP coverage of COVID-19 vaccines and treatment without beneficiary cost sharing. Vaccines and vaccine administration costs will be matched at a 100% FMAP until one year after the end of the PHE. States also have the option to provide coverage to the uninsured for COVID-19 vaccines and treatment without cost sharing at 100% FMAP.

Other FMAP, Coverage or Funding Improvements. The law provides a temporary one-year FMAP increase to improve home-and-community-based-services, as well as FMAP increases for services provided through the Urban Indian Organizations and Native Hawaiian Health Care Systems. The law also provides funding to states for the creation of nursing home strike teams to assist in managing COVID-19 outbreaks when they occur.

Mental Health and Substance Use Disorders. The law allocates $3.5 billion for block grants addressing behavioral health disorders and several million more for other behavioral health programs and workforce issues. Specifically, the law allocates:

- $1.5 billion for mental health block grants;
- $1.5 billion for substance use disorder block grants;
- $420 million in grants to clinics participating in the Certified Community Behavioral Health Clinic program;
- $100 million in behavioral health workforce education and training grants;
- $80 million for grants to health professional schools, academic medical centers, local government and other nonprofits for training in evidence-based strategies to decrease behavioral health disorders among health care personnel;
- $40 million in grants to health care providers for programs promoting good behavioral health among their personnel;
- $30 million in grants for local governments, nonprofits, and health organizations for overdose prevention and harm reduction programs, including needle exchanges and naloxone distribution;

- $20 million for an education campaign directed at health care personnel and first responders to encourage identification and prevention of behavioral health disorders; and
- Over $100 million to programs addressing community-based and child and adolescent mental health.

In addition, the law creates a new optional Medicaid covered service. For the five years following enactment, states can cover mobile crisis intervention services for individuals experiencing a mental health or substance use disorder crisis. The law provides $15 million for planning grant funds for states to develop a mobile crisis service program, and provide enhanced FMAP for states that implement such a program. The law also directs $80 million to pediatric mental health services.

Elimination of Medicaid Drug Rebate Cap and Inclusion of COVID-19-Related Drugs in Medicaid Rebate. The law eliminates the Medicaid drug rebate cap (previously, this was set at 100% of the average manufacturer price), with an effective date of Jan. 1, 2024. The law also allows outpatient drugs used for COVID-19 prevention or treatment to be included in the Medicaid Drug Rebate Program.

Public Health Workforce. The law provides HHS with nearly $9.1 billion in public health workforce-related support. This includes $7.66 billion for establishing, expanding and sustaining the public health workforce by making awards to state, local and territorial public health departments. Public health departments may use awarded funds to recruit, hire and train staff to fulfill a wide variety of functions, such as case investigators, contact tracers, laboratory personnel and community health workers. The staff hired using the funds can be employed by health departments directly, or by non-profit entities "with demonstrated expertise in public health programs and established relationships with [health] departments, particularly in medically underserved areas." In theory, this provision makes it possible that health departments could award support to a few hospitals working closely with them to fulfill public health-related functions in their communities; however, the decision to do so will be up to the health departments. Health departments also may use the funding appropriated in this section to procure needed equipment and resources to support the workforce, including PPE, technology, and other supplies.

The law also includes $100 million for the Medical Reserve Corps, a national volunteer network of health professionals and others that assist in response to natural and public health disasters. It also provides additional funds for loan forgiveness and scholarship programs for health professionals. This includes $800 million for the National Health Service Corps, which provides loan forgiveness and scholarships to primary care health clinicians serving in health professional shortage areas. The law also includes $200 million for the Nurse Corps, which repays up to 85% of unpaid nursing education debt for eligible nurses working in critical shortage facilities or as nurse faculty in an eligible nursing school. The law also provides $330 million for teaching health centers that operate graduate medical education.

Public health workforce also is one of the permitted uses of funds in several other sections (for example, the section on COVID-19 testing, contact tracing and mitigation).

Skilled Nursing Facilities (SNFs). The law provides $450 million to support SNFs in protecting against COVID-19; $200 million for the development and dissemination of COVID-19 prevention protocols in conjunction with quality improvement organizations; and $250 million to states and territories to deploy strike teams that can assist SNFs experiencing COVID-19 outbreaks.

Occupational Safety and Health Administration (OSHA). The law allocates not less than $100 million for OSHA, of which $10 million is for Susan Harwood training grants and not less than $5 million is for enforcement activities related to COVID-19 at high-risk workplaces, including health care, meat and poultry processing facilities, agricultural work places and correctional facilities.

Federal Emergency Management Agency (FEMA). The law provides $50 billion, available until Sept 30, 2025, to carry out the purposes of the Disaster Relief Fund for costs associated with major disaster declarations.

Medicare Wage Index. The law establishes a minimum wage index for hospitals in all-urban states for purposes of Medicare hospital payments, beginning Oct. 1, 2021. From fiscal years 2003-2018, CMS had established a methodology known as the “imputed floor” for determining a floor on the wage index for hospitals in all urban states (New Jersey, Delaware and Rhode Island), with the methodology subject to budget neutrality. The law reestablishes the imputed rural floor and waives budget neutrality under the inpatient PPS only.

Rural Health Care Grants. The law provides $500 million to the Department of Agriculture to award grants to eligible entities, including certain rural hospitals, based on needs related to the COVID-19 pandemic. Awardees may use the grant to cover COVID-19-related expenses and lost revenue to maintain capacity, such as increasing capacity for vaccine distribution or telehealth capabilities.

Child Care Provisions. The law includes a number of provisions to increase access to child care, including an additional $15 billion through Sept. 30, 2021 for the Child Care and Development Block Grant that could be used specifically for health care and other front-line workers, regardless of income.

Paid Family and Medical Leave. The law reinstates until Sept. 30, 2021 tax credits for employers who voluntarily cover the paid family and medical leave provisions that were established by the Families First Coronavirus Response Act but that had expired on Dec. 31, 2020.

Funding for State, Local, Territorial and Tribal Governments. The law provides an additional $350 billion for states, territories, and Tribal governments to mitigate the fiscal effects stemming from the PHE. In addition, it creates a “Coronavirus Capital Projects Fund” to provide $10 billion for states, territories, and Tribal governments to carry out

critical capital projects directly enabling work, education, and health monitoring, including remote options, in response to the COVID-19 PHE.

Paycheck Protection Program (PPP). The law modifies the PPP to clarify that the Small Business Administration affiliation rules will not apply to certain applicants. Specifically, 501(c)(3) organizations that employ not more than 500 employees per physical location of the organization are eligible for the program. The law also provides an additional $7.25 billion for the program.

Single-Employer Pension Plan Provisions. The law stabilizes interest rates at historical norms and allow for a more reasonable amortization timetable.

FURTHER QUESTIONS

If you have questions, please contact AHA at 800-424-4301.