Mercer

Medicaid and CHIP Provisions in the American Rescue Plan Act

The American Rescue Plan Act of 2021 (ARPA) was signed into law (P.L. 117-2) on March 11, 2021. ARPA contains several provisions affecting Medicaid and the Children's Health Insurance Program (CHIP), which are described below. Substantive guidance and/or regulations from federal agencies has yet to be released, but should provide greater detail as to how states should implement these Medicaid and CHIP provisions in practice.

Vaccines and Treatment

The following pertain to vaccine and treatment provisions in the ARPA:

- Mandatory coverage for COVID-19 vaccines and treatment in Medicaid and CHIP with no cost-sharing to beneficiaries. This is currently a condition of receiving the COVID relief 6.2% enhanced federal medical assistance percentage (FMAP). ARPA makes the coverage mandatory and extends the requirement through the last day of the quarter beginning one year after the end of the Public Health Emergency (PHE).

- Coverage for COVID-19 vaccines provided to certain limited-benefit populations, such as family planning expansion groups, effective March 11, 2021. CMS previously interpreted the Families First Coronavirus Response Act (FFCRA) vaccine coverage requirement to exclude certain enrollees receiving limited benefit packages. The coverage provision applies to all enrollees, except those eligible only for Medicare cost-sharing assistance (partial duals) or COBRA premium assistance.

- Coverage of COVID-19 treatment services, without cost-sharing, for enrollees in the COVID-19 uninsured testing group and enrollees who receive alternative benefit plans. This coverage includes specialized equipment and preventive therapies and treatment (if otherwise covered under Medicaid) of a condition that may seriously complicate treatment of COVID-19 for those presumed to have or have been diagnosed with COVID-19. The COVID-19 uninsured testing group was created by the FFCRA and is available at state option, with 100% federal matching funds, during the PHE. The benefit package for this group previously was limited to COVID-19 testing and testing-related services.

- 100% federal matching funds for COVID-19 vaccines and vaccine administration effective April 1, 2021, through the last day of the quarter beginning one year after the PHE ends. This provides a fiscal assurance to states that the federal government will continue to pay for the vaccine ingredient cost.

- Inclusion of COVID-19 vaccines and treatment drugs in the Medicaid Drug Rebate Program.

State Option to Provide Medicaid Eligibility for Postpartum Women for 12 months

Medicaid and CHIP programs can opt to extend Medicaid and CHIP eligibility to women for the 12-month postpartum period, extended beyond the current 60-day period. States must maintain the same covered benefits during the extended eligibility period. This option is available to states for five years and coverage is effective April 1, 2022.

Enhanced FMAP Provisions

Below is a summary of provisions that include increased FMAP for states. Note: Vaccine and vaccination administration 100% match is described above.

Improvements to Medicaid HCBS

States that "enhance, expand, or strengthen" home- and community-based services (HCBS) are eligible to receive an FMAP increase of 10% for a one-year period (April 1, 2021 through March 31, 2022) on expenditures for HCBS services, including state plan HCBS services and the Program of All-Inclusive Care for the Elderly (PACE). The early versions of the legislation defined the activities that would qualify as enhancing, expanding or strengthening HCBS, the final language did not include qualifying examples and appears to give discretion to states on those strategies though states must supplement, not supplant, current levels of state funding. It is expected that CMS will release guidance to states to help them understand how to qualify and claim the enhanced funding.

Mobile Crisis Units

Beginning April 1, 2022, states can receive an enhanced FMAP (85%) for 12 quarters for Medicaid programs that cover mobile crisis intervention services for individuals experiencing a mental health or substance use disorder crisis. The additional funds must supplement, not supplant, the level of state spending for these services in the fiscal year before the first quarter that a state elects this option.

Services must be otherwise covered by Medicaid and provided by a multidisciplinary team to enrollees experiencing a mental health or substance use disorder crisis outside a hospital or other facility setting. These services generally do not have to be offered statewide, do not have to be comparable for all enrollees, and can restrict enrollees' free choice of provider. The new option is available to states for five years, beginning April 1, 2022. States can implement this option through a state plan amendment or waiver authorities. ARPA also provides $15 million to the Department of Health and Human Services to support states through planning grants to prepare for these services. "Qualifying community-based mobile crisis intervention services" are defined as those:

- Furnished to an individual otherwise eligible for Medicaid who is not in a hospital or other facility setting and experiencing a mental health or substance use disorder crisis
- Furnished by a multidisciplinary mobile crisis team that meets certain criteria (e.g., at least one behavioral health care professional who is capable of conducting an assessment of the individual, available 24/7/365, etc.)

Urban Indian Organizations and Native Hawaiian Health Centers

States can receive 100% FMAP for two years for services provided to Medicaid beneficiaries receiving care through Urban Indian Organizations and Native Hawaiian Health Centers. These providers are not formally part of the Indian Health Service (IHS) and, as a result, do not receive the 100% FMAP available for IHS providers. The enhanced FMAP is effective April 1, 2021.

Cap on Medicaid Drug Rebates

The cap on Medicaid drug rebates is lifted beginning January 1, 2024. Under current law, in addition to the basic rebate amount, manufacturers pay an additional inflationary rebate if the manufacturer increases the price of its drug in excess of the CPI-U. However, those inflationary rebates for brand or authorized generic drugs are capped at 100% of a drug's average manufacturer price. That cap will cease to exist as of January 1, 2024.

MACPAC suggested lifting this cap in its June 2019 report. The report described that in the fourth quarter of 2015 alone, approximately 18.5% of brand drugs hit the rebate cap, and as a result, Medicaid lost $690 million in rebates. At that time, the Congressional Budget Office estimated that lifting this cap would decrease federal spending by $15 billion to $20 billion over 10 years.

Funding for Nursing Facility "Strike Teams"

The law appropriated $250 million to be distributed by the US Department of Health and Human Services for states to establish "strike teams" to be deployed to nursing facilities with diagnosed or suspected COVID-19 cases among residents. The legislation does not detail timing or method of distribution.

Special Rule for DSH Payments

During the PHE, when the Families First enhanced FMAP is in effect, states' disproportionate share hospital (DSH) allotments will be recalculated to ensure that total DSH payments remain at the same levels that would have been paid in the absence of the FMAP increase.

Mercer Government will continue to provide updates as guidance and regulations from federal agencies are released.

Email us at mercer.government@mercer.com with any questions or to be added to our contact list to ensure you receive the latest details.