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American Rescue Plan Act Strengthens Medicaid, Better Equips States to Combat the Pandemic

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The American Rescue Plan Act gives states an additional financial incentive to expand Medicaid, strengthens coverage for current enrollees, and helps states weather the COVID-19 public health and economic crises. States can leverage the new funding and options to chart a course for a stronger and more equitable recovery.

In addition to giving the 14 states that haven't yet implemented the Medicaid expansion a significant financial incentive to do so,¹ the Act:

- Increases federal Medicaid funding for home- and community-based services (HCBS) to help seniors and people with disabilities receive services safely in the community rather than in nursing homes and other congregate care settings;
- Increases federal funding for COVID-19 vaccines and gives states the option to provide vaccines and treatment to uninsured people in addition to testing, which was already allowed;
- Gives states a new option to provide coverage for postpartum people for 12 months after the end of their pregnancy, up from 60 days in current law;
- Creates a state option to encourage states to cover mobile crisis intervention services that can help people avoid hospitalization and incarceration; and
- Removes the cap on the amount of prescription drug rebates that states and the federal government can receive from prescription drug manufacturers, saving states and the federal government billions.

¹ For more information on the incentives for Medicaid expansion in the Act, see Tara Straw *et al.*, "Health Provisions in American Rescue Plan Act Would Improve Access to Health Coverage During COVID Crisis," CBPP, March 11, 2021, <https://www.cbpp.org/research/health/health-provisions-in-american-rescue-plan-act-improve-access-to-health-coverage>.

Additionally, the Act includes two years of full federal funding for Medicaid services provided by urban Indian and Native Hawaiian Health Centers to enable equal treatment to services provided by the Indian Health Service or tribal facilities.

Increased Federal Funds for Home- and Community-Based Services Will Let More People Live Safely at Home

The Act increases Medicaid’s federal matching rate (FMAP) for HCBS by 10 percentage points for one year starting in April, to bolster state efforts to help seniors and people with disabilities live safely in their homes and communities rather than in nursing homes or other congregate settings. The FMAP increase could provide over \$11 billion in additional federal Medicaid dollars, the Kaiser Family Foundation estimates.² States must use the increased federal funds to supplement their current spending on HCBS and to enhance, expand, or strengthen their HCBS programs. For instance, states could cover additional HCBS in their state plans or increase provider reimbursement rates, among other strategies.

Medicaid is the primary source of coverage for HCBS, providing services such as home health and assistance with self-care and household activities to nearly 5 million seniors and people with disabilities.³ Long-term care facilities account for 5 percent of total reported COVID-19 cases and nearly 40 percent of deaths, the most recent available data indicate.⁴ With the virus hitting nursing home and other congregate care residents and staff so hard, maintaining and expanding access to home-based care is essential to help people transition out of institutional settings at risk of virus outbreaks and keep them safe in their homes.

Many state Medicaid programs have made policy changes during the pandemic to make it easier for seniors and people with disabilities to receive HCBS, to expand services, and to increase payment rates and take other steps to help providers continue delivering home-based care.⁵ But some of these strategies are expensive for states to implement, and many states and localities are facing large revenue shortfalls.⁶ HCBS providers have also encountered new challenges and costs during the crisis, with workers needing protective equipment, training, and other help to keep themselves, their clients, and their families safe.

² Priya Chidambaram and MaryBeth Musumeci, “Potential Impact of Additional Federal Funds for Medicaid HCBS for Seniors and People with Disabilities,” Kaiser Family Foundation, March 15, 2021, <https://www.kff.org/report-section/potential-impact-of-additional-federal-funds-for-medicaid-hcbs-for-seniors-and-people-with-disabilities-table/>.

³ Molly O’Malley Watts, MaryBeth Musumeci, and Priya Chidambaram, “Medicaid Home and Community-Based Services Enrollment and Spending,” Kaiser Family Foundation, February 4, 2020, <https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/>.

⁴ Kaiser Family Foundation, “State COVID-19 Data and Policy Actions,” February 3, 2021, <https://www.kff.org/coronavirus-covid-19/issue-brief/state-covid-19-data-and-policy-actions/#long-term-care-cases-deaths>.

⁵ Jessica Schubel, “States Are Leveraging Medicaid to Respond to COVID-19,” CBPP, September 2, 2020, <https://www.cbpp.org/research/health/states-are-leveraging-medicaid-to-respond-to-covid-19>.

⁶ Michael Leachman and Elizabeth McNichol, “Despite Improved State Fiscal Conditions, Serious Challenges Remain, Including for Localities, Tribal Nations, and Territories,” Center on Budget and Policy Priorities, February 26, 2021, <https://www.cbpp.org/research/state-budget-and-tax/despite-improved-state-fiscal-conditions-serious-challenges-remain>.

Before the pandemic, there was already a severe shortage of HCBS — which are “optional” services that states don’t have to cover — with over three-quarters of states reporting wait lists for some HCBS delivered through waivers and wait times averaging more than three years.⁷ Without additional federal funds, states are unlikely to fully address the increased needs for HCBS and may even cut provider rates to address their budget shortfalls. Provider rate cuts would make it even harder for HCBS providers to keep their doors open. Increasing Medicaid’s federal match and requiring that states use the increased funds to strengthen their HCBS programs will shore up HCBS and prevent an erosion of services that could undermine future efforts to expand HCBS — including behavioral health services — to all people who need them.

Indeed, the HCBS FMAP increase also applies to many community-based behavioral health services, such as mental health or substance use disorder counseling and peer support services. Like other HCBS providers, community-based behavioral health providers have been hit hard by heavy financial losses and new expenses during the pandemic.⁸ This has added to the strain of already low public and private coverage behavioral health reimbursement rates.⁹ The situation has forced many behavioral health providers to lay off staff, delay care, and even turn away patients or close programs.

Act Strengthens Coverage of COVID-19 Testing, Vaccines, and Treatment

Building on provisions in the Families First Coronavirus Response Act, the Act fills gaps in Medicaid coverage of COVID-19 testing, vaccines, and treatment, and potentially makes testing, vaccines, and treatments available to all Medicaid enrollees and many uninsured people for over a year after the public health emergency ends. The Act:

- **Makes coverage of COVID-19 vaccines and treatment a mandatory Medicaid and Children’s Health Insurance Program (CHIP) benefit.** The Act guarantees coverage of testing, vaccines, and treatment without cost sharing for all full-benefit Medicaid enrollees.

⁷ MaryBeth Musumeci, Molly O’Malley Watts, and Priya Chidambaram, “Key State Policy Choices About Medicaid Home and Community-Based Services,” Kaiser Family Foundation, February 4, 2020, <https://www.kff.org/medicaid/issue-brief/key-state-policy-choices-about-medicaid-home-and-community-based-services/>.

⁸ National Council for Behavioral Health, “Demand for Mental Health and Addiction Services Increasing as COVID-19 Pandemic Continues to Threaten Availability of Treatment Options,” September 9, 2020, <https://www.thenationalcouncil.org/press-releases/demand-for-mental-health-and-addiction-services-increasing-as-covid-19-pandemic-continues-to-threaten-availability-of-treatment-options/>.

⁹ See, for example, Katherine Hayes *et al.*, “Integrating Clinical and Mental Health: Challenges and Opportunities,” Bipartisan Policy Center, January 2019, <https://bipartisanpolicy.org/wp-content/uploads/2019/03/Integrating-Clinical-and-Mental-Health-Challenges-and-Opportunities.pdf>; Dana Foney and Shannon Mace, “Factors that Influence Access to Medication-Assisted Treatment,” University of Michigan Behavioral Health Workforce Research Center and the National Council for Behavioral Health, August 2019, <http://www.behavioralhealthworkforce.org/wp-content/uploads/2019/10/Factors-that-Influence-MAT-Full-Report.pdf>; Steve Melek, Stoddard Davenport, and T.J. Gray, “Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement,” Milliman, November 19, 2019, http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf; and Lisa Clemans-Cope *et al.*, “Leveraging Medicaid to Address Opioid and Substance Use Disorders in Maine: Ten State Policy Options from an Expedited Review,” Urban Institute, June 2019, https://www.urban.org/sites/default/files/publication/100443/2019.06.20_mainecare_report_final_7.pdf.

- **Plugs holes in coverage of vaccines for people enrolled in limited-benefit Medicaid coverage groups.** The Trump Administration issued an interim final rule in December saying that states could exclude coverage of COVID-19 vaccines for millions of people enrolled in coverage for family planning, breast and cervical cancer, and tuberculosis, and other limited-coverage groups. The Act requires coverage for COVID-19 vaccines for all these enrollees.
- **Expands the state option to cover testing for uninsured and underinsured people to also cover vaccines and treatment.** Families First included an option for states to cover COVID-19 testing for uninsured people regardless of their income. The Coronavirus Aid, Relief, and Economic Security Act extended the option to cover underinsured people, who don't have minimum essential coverage, including those enrolled in limited-benefit Medicaid groups. Even though states receive 100 percent federal match for both health care services and administrative costs under the option, only 16 states have taken up this option to date. Expanding the option to cover vaccines and treatment should provide an incentive for more states to take up the option and give uninsured and underinsured people access to the COVID-19-related care they need now and even after the end of the public health emergency.
- **Provide 100 percent federal match to states for the cost of the vaccines and the costs to administer them.**

Extending Medicaid Coverage for Postpartum People Will Help Families and Reduce Racial Disparities

The Act gives states a new option to extend comprehensive Medicaid or CHIP coverage to postpartum people for 12 months after the end of their pregnancy, up from 60 days under current law. The option takes effect one year after the bill's enactment and lasts for five years.¹⁰

State Medicaid programs must provide coverage to pregnant people with incomes up to 138 percent of the federal poverty line (about \$33,000 for a family of three in 2021), and most offer coverage above that level.¹¹ Medicaid plays a key role in financing prenatal and postpartum care, financing 43 percent of all births nationwide in 2018.¹² Medicaid coverage significantly improves pregnancy-related health outcomes by increasing access to care — particularly during the postpartum period, research shows.¹³ But Medicaid coverage lasts only 60 days after pregnancy ends, so many people lose coverage unless they remain eligible through a different pathway.

¹⁰ The Families First Coronavirus Response Act enacted last March prevents states from ending Medicaid coverage for the duration of the public health emergency, which will last at least until the end of 2021, so postpartum people are currently receiving more than 60 days of postpartum coverage.

¹¹ Kaiser Family Foundation, "Medicaid and CHIP Income Eligibility Limits for Pregnant Women as a Percent of the Federal Poverty Level, January 1, 2020, <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

¹² Medicaid and CHIP Payment and Access Commission, "Medicaid's Role in Maternal Health," June 2020, <https://www.macpac.gov/wp-content/uploads/2020/06/Chapter-5-Medicaid%E2%80%99s-Role-in-Maternal-Health.pdf>;

¹³ Usha Ranji, Ivette Gomez, and Alina Salganicoff, "Expanding Postpartum Medicaid Coverage," Kaiser Family Foundation, December 21, 2020, <https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicicaid-coverage/~:text= Pregnancy-related%20coverage%20for%20the.is%20up%20to%20the%20states.>

In states that have expanded Medicaid under the Affordable Care Act, postpartum people with incomes up to 138 percent of the federal poverty line remain eligible for Medicaid after their postpartum period ends. However, people with incomes above that threshold often lose their Medicaid eligibility. And in states that have not expanded Medicaid, postpartum people with much lower incomes lose Medicaid coverage 60 days after giving birth, and those with incomes below the poverty line aren't eligible for subsidized coverage in the ACA marketplaces. For example, in Alabama, the income eligibility limit for parents is just 18 percent of poverty — less than \$4,000 *per year* for a family of three.

Postpartum health coverage is particularly important because life-threatening conditions during and after pregnancy are distressingly common in the United States. People with low incomes and people of color — especially Black people and American Indians and Alaska Natives — are disproportionately likely to face these conditions.¹⁴ Low-income people and people of color are also more likely to fall into the coverage gap in states that have not expanded Medicaid.¹⁵

Enhanced Funding for Mobile Crisis Services Will Reduce Unnecessary Hospitalizations for People With Behavioral Health Needs

The Act provides an 85 percent enhanced federal matching rate for three years to states that opt to cover mobile crisis intervention services to encourage more states to expand access to mobile crisis teams. It also provides the Department of Health and Human Services with \$15 million in funding for state planning grants and other implementation efforts.

Many communities have implemented mobile crisis teams led by behavioral health professionals in recent decades, which help de-escalate behavioral health crises and connect people to community-based services, avoiding costly emergency department visits and hospitalizations.¹⁶ Mobile crisis services may also prevent the arrest and incarceration of people with mental health and substance use disorders, who are disproportionately represented in the nation's jails and prisons and among fatal police shootings.¹⁷

One model — Eugene, Oregon's Crisis Assistance Helping Out On The Streets (CAHOOTS) program — dispatches teams of mental health experts and medics to respond to mental health

¹⁴ MACPAC 2020; See also Emily E. Petersen *et al.*, “*Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017*,” Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, May 2019, <https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6818e1-H.pdf>.

¹⁵ Jesse Cross-Call, “Medicaid Expansion Has Helped Narrow Racial Disparities in Health Coverage and Access to Care,” CBPP, October 21, 2020, <https://www.cbpp.org/research/health/medicaid-expansion-has-helped-narrow-racial-disparities-in-health-coverage-and>.

¹⁶ Substance Abuse and Mental Health Services Administration, “Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies,” U.S. Department of Health and Human Services, 2014, https://www.nasmhpd.org/sites/default/files/SAMSHA%20Publication%20on%20Effectiveness%20%26%20Cost-Effectiveness%20of%2C%20and%20Funding%20Strategies%20for%2C%20Crisis%20Services%206-5-14_8.pdf.

¹⁷ Julie Tate, Jennifer Jenkins, and Steven Rich, “988 People Have Been Shot and Killed by Police in the Past Year,” *Washington Post*, updated March 17, 2021, https://www.washingtonpost.com/graphics/investigations/police-shootings-database/?itid=lk_inline_manual_3; Amam Z Saleh *et al.*, “Deaths of People with Mental Illness During Interactions with Law Enforcement,” *International Journal of Law and Psychiatry*, May-June 2018, <https://pubmed.ncbi.nlm.nih.gov/29853001/>.

crises, and it has reported a large drop in the need for law enforcement to respond to such emergencies.¹⁸ However, many mobile crisis teams rely heavily on limited grants and local funding and lack the staff capacity and resources to fully meet the need in their communities.¹⁹ The Act's enhanced matching rate should help scale up mobile crisis services and reduce reliance on law enforcement to address mental health crises.

Removing the Cap on Medicaid Prescription Drug Rebates Will Save Federal and State Funds

To pay for the longer-term costs of the Medicaid improvements, the Act removes the cap on the amount of prescription drug rebates that states and the federal government can receive from prescription drug manufacturers.

The Medicaid drug rebate program is designed to ensure that Medicaid pays the lowest price for prescription drugs of any payer. Medicaid drug rebates are calculated based on the average manufacturer price (AMP) for the drug. The rebate includes two components: base rebates that apply to most drugs, and an inflationary rebate designed to prevent prescription drug manufacturers from price gouging by applying an additional rebate if the price of a drug grows faster than inflation. However, prior to the enactment of this Act, federal law capped the total rebate (the sum of the base rebate and inflationary rebate) at 100 percent of the AMP. This cap on the inflationary rebate limited the savings that this provision achieved for states and the federal government.

The Act removes the cap on the Medicaid drug rebate program's inflationary rebate, beginning January 1, 2024. In addition to allowing states and the federal government to receive a larger rebate when a drug's price increases dramatically, removing the cap will also create a disincentive for manufacturers to significantly increase prices from year to year.

¹⁸ White Bird Clinic, "What is CAHOOTS?" October 2020, <https://whitebirdclinic.org/what-is-cahoots/>; Jackson Beck, Melissa Reuland, and Leah Pope, "Behavioral Health Crisis Alternatives—Case Study: Cahoots, Eugene, Oregon," Vera Institute of Justice, November 2020, <https://www.vera.org/behavioral-health-crisis-alternatives/cahoots>.

¹⁹ Amy Watson, Michael Compton, and Leah Pope, "Crisis Response Services for People with Mental Illnesses or Intellectual and Developmental Disabilities: A Review of the Literature on Police-based and Other First Response Models," Vera Institute of Justice, October 2019, <https://www.vera.org/downloads/publications/crisis-response-services-for-people-with-mental-illnesses-or-intellectual-and-developmental-disabilities.pdf>.