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***CMCS Informational Bulletin***

**DATE:** June 3, 2021

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Center for Medicaid & CHIP Services

**SUBJECT: Medicaid, Children’s Health Insurance Program (CHIP), and Basic Health Program (BHP) Related Provisions in the American Rescue Plan Act of 2021**

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2). This action represents the largest expansion of health coverage for the American people since the Affordable Care Act in 2010, and has a significant and immediate impact on state Medicaid and CHIP programs and beneficiaries.

This Center for Medicaid & CHIP Services (CMCS) Informational Bulletin (CIB) provides general information to states on the Medicaid, CHIP, and BHP provisions in the ARP. CMCS intends to issue additional guidance in the coming months on certain provisions, and is available to provide states with technical assistance as they begin to implement these changes. As of the publication of this guidance, CMS has released guidance related to section 9817 in a State Medicaid Director Letter, *Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency*.<sup>1</sup> CMS has also released updates to our *Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost-Sharing under Medicaid, the Children’s Health Insurance Program, and Basic Health Program*<sup>2</sup> toolkit to reflect sections 9811 and 9821 of the ARP.

**Provisions that Apply Upon (or Shortly After) Enactment of the ARP**

***Section 9811 and Section 9821 Mandatory Coverage of COVID-19 Vaccines, Vaccine Administration, Testing, and Treatment in Medicaid and CHIP***

Under the changes made to the Social Security Act (Act) by sections 9811 and 9821 of the ARP, beginning March 11, 2021, state Medicaid and separate CHIP programs<sup>3</sup> must cover COVID-19 vaccines and their administration, testing for COVID-19, and treatments for COVID-19, including specialized equipment and therapies (including preventive therapies). Additionally,

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<sup>1</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>

<sup>2</sup> <https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf>

<sup>3</sup> Applicable to child health assistance and pregnancy-related assistance under CHIP. Medicaid includes individuals whose coverage is funded by title XXI (Medicaid expansion CHIP).

beginning March 11, 2021, state Medicaid and separate CHIP programs must cover the treatment of a condition that may seriously complicate the treatment of COVID-19, if otherwise covered under the state plan (or a waiver of such plan), for individuals who are diagnosed with or presumed to have COVID-19, during the period such an individual has (or is presumed to have) COVID-19.<sup>4</sup> The ARP extended this coverage of COVID-19 vaccinations, testing, and treatment (including treatment of a condition that may seriously complicate the treatment of COVID-19) to the optional COVID-19 Medicaid eligibility group that is described at section 1902(a)(10)(A)(ii)(XXIII) of the Act (the group CMS to date has often referred to as the “optional COVID-19 testing group”).<sup>5</sup> Additionally, states are prohibited from applying cost-sharing for this coverage. These coverage requirements and mandatory cost-sharing exemptions generally end on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act.<sup>6</sup>

The ARP also closes COVID-19 vaccine and vaccine administration coverage gaps for various eligibility groups, ensuring that nearly all Medicaid and CHIP beneficiaries can receive a COVID-19 vaccine and its administration without cost-sharing throughout the entire period the ARP coverage requirement applies. States are now required to provide COVID-19 vaccination coverage to individuals covered in nearly all Medicaid populations, including most Medicaid limited-benefit groups (including the optional COVID-19 group (previously referred to as the optional COVID-19 testing group) and individuals covered for limited benefits under section 1115 demonstration authority, for example) and pregnant women covered through a separate CHIP.

The ARP also amends section 1905 of the Act to authorize a 100 percent Federal Medical Assistance Percentage (FMAP) for state expenditures for medical assistance for COVID-19 vaccines and their administration. This increased FMAP is available beginning April 1, 2021,<sup>7</sup> and ending on the last day of the first quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act. For example, if the emergency period ends on December 31, 2021, the increased FMAP would be available until March 31, 2023. A 100 percent federal matching percentage for expenditures on COVID-19 vaccines and their administration is also applicable to child health assistance under CHIP during that same period, with an adjustment to CHIP allotments.

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<sup>4</sup> Under section 1905(a)(4)(F) of the Act, as added by the ARP, this coverage of treatment for complicating conditions in Medicaid should be provided without regard to the Medicaid comparability requirements of section 1902(a)(10)(B) of the Act.

<sup>5</sup> Medical assistance and administrative expenditures for this optional group continue to be 100 percent federally matched. However, coverage for this group is available only through the end of the COVID-19 PHE, even after the ARP’s amendments.

<sup>6</sup> Under section 1902(a)(10)(A)(ii)(XXIII) of the Act and the matter following section 1902(a)(10)(G) of the Act (as amended by the ARP), states can provide coverage to the optional COVID-19 group (previously the optional COVID-19 testing group) only through the last day of the COVID-19 PHE. No federal financial participation is available for any state expenditures on benefits for this group, including coverage of COVID-19 testing, treatment, or vaccinations, after the PHE ends.

<sup>7</sup> Section 1905(hh) of the Act, as added by the ARP, provides that this 100 percent FMAP will be available beginning the first day of the first quarter beginning after the enactment of the ARP, which is April 1, 2021.

To reflect these provisions, on May 5, 2021, CMS made updates to the *Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program* toolkit. CMS plans to release additional guidance in the near future.

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

Since well before the COVID-19 PHE, home and community-based services (HCBS) have been critically important to many Medicaid beneficiaries by providing alternatives to institutional placement. The ARP will support states in enhancing these services for individuals eligible for long-term services and supports as part of PHE recovery efforts. During the period from April 1, 2021 through March 31, 2022, the ARP provides states with a 10 percentage point FMAP increase for certain state Medicaid expenditures for a broad array of services under the Act. The additional funding associated with the increased FMAP must be used by states to supplement, not supplant the level of state HCBS spending as of April 1, 2021. As a condition for this FMAP increase, states must enhance, expand, or strengthen HCBS under the state Medicaid program. Additionally, the 10 percentage point increase cannot result in a matching rate that exceeds 95 percent. On May 13, 2021 CMS released State Medicaid Director Letter #21-003 providing guidance to state on the implementation of section 9817. This letter can be found [here](#).

***Section 9819 Special Rule for the Period of Declared Public Health Emergency Related to DSH Allotment***

The ARP requires the Secretary to recalculate a state's annual disproportionate share hospital (DSH) allotment for any fiscal year during which the state receives the 6.2 percentage point FMAP increase under section 6008(a) of the FFCRA. The state's annual DSH allotment shall be recalculated to ensure that the total DSH payments (including both the Federal and state share) a state may make for a fiscal year is the same as the total DSH payments the state could have made but for the 6.2 percentage point FMAP increase under the FFCRA. The provision also specifies how DSH allotments are to be calculated for future fiscal years after the end of the public health emergency. CMS expects to provide additional guidance on future DSH allotment calculations to states in the coming months.

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

Section 9814 of the ARP generally provides a temporary, 5 percentage point increase in a qualifying state or territory's FMAP under section 1905(b) of the Act if that state or territory begins to cover the entire adult group authorized under section 1902(a)(10)(A)(i)(VIII) of the Act ("Adult group"). A qualifying state or territory is a state or territory that has not expended amounts for all individuals in the Adult group before the March 11, 2021 enactment of the ARP. Effective beginning with the first calendar quarter during which a qualifying state or territory expends amounts for all individuals in the Adult group, the 5 percentage point FMAP increase is available to a qualifying state for each quarter occurring during an 8-quarter period, except for any quarter (and each subsequent quarter) during the 8-quarter period in which a state ceases its

Adult group expansion (or limits the expansion to less than the entire Adult group). This increased FMAP applies to certain Medicaid expenditures covered under the state plan or waiver of the plan. The 5-percentage point increase can apply to applicable expenditure categories and applicable periods in addition to the temporary 6.2 percentage point FMAP increase available under section 6008 of the FFCRA, where both increases apply. CMS expects to provide additional guidance on this provision in the near future.

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

This section amends section 1905(b) of the Act to provide, for the 8 fiscal quarters beginning April 1, 2021 and ending March 31, 2023, 100 percent FMAP for medical assistance expenditures for services received through an Urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act) that has a grant or contract with the Indian Health Service under title V of the Indian Health Care Improvement Act, and for medical assistance expenditures for services received through a Native Hawaiian Health Center (as defined in section 12(4) of the Native Hawaiian Health Care Improvement Act) or a qualified entity (as defined in section 6(b) of such Act) that has a grant or contract with the Papa Ola Lokahi under section 8 of such Act. CMS expects to provide additional guidance on this provision in the coming months.

**Basic Health Program Provisions**

***Section 9661 Improving Affordability by Expanding Premium Assistance for Consumers, Section 9662 Temporary Modification of Limitations on Reconciliation of Tax Credits for Coverage under a Qualified Health Plan with Advance Payments of Such Credits, and Section 9663 Application of Premium Tax Credit in Case of Individuals Receiving Unemployment Compensation during 2021***

Sections 9661 and 9663 of the ARP effectively increase the amount of advance payments of the premium tax credit (APTC) available to some applicable taxpayers for enrollment in a Qualified Health Plan (QHP) purchased through the Exchange for coverage in 2021 and 2022. Section 9662 suspends the requirement that taxpayers increase their 2020 tax liability by all or a portion of the amount by which their 2020 APTC exceeds the amount of the PTC they may claim on their tax return for 2020. These provisions do not impact eligibility for Medicaid, CHIP or the Basic Health Program (BHP). However, they will impact the calculation of federal payments for the BHP in states that operate a BHP. CMS intends to release additional information about the impact of these sections on the calculation of federal payments for BHP in the coming months.

Section 9661 of the ARP, which applies to taxable years 2021 and 2022, modifies the applicable percentages of household income used to calculate the amount of APTC taxpayers are eligible to have paid on their behalf for coverage purchased through an Exchange. Specifically, applicable taxpayers with household income below 150 percent of the federal poverty level (FPL) will not need to contribute any portion of their household income towards purchasing the second-lowest cost Silver plan in their area. Section 1331(a)(2)(A)(i) of the Affordable Care Act requires that the amount of the monthly premium an eligible individual is required to pay for coverage under a

BHP through a standard health plan cannot exceed the amount of the monthly premium the individual would have been required to pay had the individual instead enrolled in the second-lowest cost silver plan through the Exchange. Because of this requirement, section 9661 of the ARP has the effect of also exempting individuals with household income below 150 percent of the FPL from an obligation to pay premiums for enrolling in a BHP standard health plan for taxable years 2021 and 2022. For BHP enrollees with household income between 150 percent of the FPL and 200 percent of the FPL, section 9661 of the ARP effectively limits the amount an individual must pay for coverage under a BHP standard health plan to up to 2.0% of household income for taxable years 2021 and 2022.

### **Eligibility Related Provisions**

The ARP provides significant financial and other support to individuals. For each of the following provisions, CMS describes its impact on calculating income for purposes of determining Medicaid, CHIP, or BHP eligibility. CMS plans to release additional guidance on certain provisions, as noted below, and is available to provide technical assistance.

#### ***Section 9011 Extension of Pandemic Unemployment Assistance, Section 9013 Extension of Federal Pandemic Unemployment Compensation, and Section 9016 Extension of Pandemic Emergency Unemployment Compensation***

Effective March 14, 2021, the ARP extends Pandemic Unemployment Assistance (PUA), Federal Pandemic Unemployment Compensation (FPUC) and Pandemic Emergency Unemployment Compensation (PEUC) enacted in the CARES Act (Pub. L. 116-136), as amended.

Section 9011 extends PUA under section 2102 of the CARES Act, and section 9016 extends PEUC under section 2107 of the CARES Act. Consistent with earlier guidance, these payments remain countable income under both Modified Adjusted Gross Income (MAGI) and non-MAGI financial methodologies. States may, however, through a state plan amendment (SPA), disregard these payments as income and resources under the authority of section 1902(r)(2) of the Act for applicants and beneficiaries whose financial eligibility is based on non-MAGI methodologies.

Section 9013 extends FPUC under section 2104 of the CARES Act. As with previous payments of FPUC, section 2104(h) of the CARES Act provides that FPUC payments are “disregarded when determining income for any purpose under the programs established under titles XIX [the Medicaid program] and title XXI [the CHIP program] of the Social Security Act.” Therefore, states must continue to disregard FPUC payments in determining financial eligibility using MAGI and non-MAGI income methodologies, as well as the scope of assistance for Medicaid and CHIP. We note that these payments are not disregarded for calculating financial eligibility for BHP.

As noted in previous guidance, for applicants and beneficiaries whose financial eligibility is based on non-MAGI methodologies and who are subject to a resource test, any portion of FPUC payments not spent in the month of receipt is a countable resource in subsequent months. States

have the option to disregard the amount of a FPUC payment that otherwise would be counted as a resource under section 1902(r)(2) of the Act. This would require the state to submit a SPA.

### ***Section 9042 Suspension of Tax on Portion of Unemployment Compensation***

This section of the ARP provides a special rule only for 2020 under which an individual may exclude from gross income up to \$10,200 of unemployment compensation received in 2020 (in the case of a joint return, up to \$10,200 for each spouse); section 9042 provides this amount of unemployment compensation income will not be included in an eligible individual's adjusted gross income for 2020.

Section 9042 of the ARP does not retroactively apply to MAGI-based Medicaid or CHIP eligibility determinations processed in 2020 (or thereafter), as section 1902(e)(14)(H) of the Act requires that state Medicaid agencies determine eligibility using the MAGI-based rules that are actually in effect at the time an application (or renewal) is processed. This provision does not impact the treatment of unemployment compensation for purposes of non-MAGI income eligibility determinations, under which unemployment compensation is generally countable income unless otherwise disregarded by states under section 1902(r)(2) of the Act.

### ***Section 9601 2021 Recovery Rebates to Individuals***

This section authorizes advance payments of a refundable tax credit of \$1,400 to eligible individuals in 2021. As with previous rounds of Recovery Rebates, these payments are not included in gross income for income tax purposes, and are therefore not countable in MAGI-based eligibility determinations. Separately, 26 U.S.C. § 6409 prohibits the counting of federal tax rebates or advance payments with respect to refundable tax credits as income, and, for 12 months following receipt, resources, in the eligibility determination of any federal needs-based program (such as Medicaid). Thus, these Recovery Rebates are not counted as income or, for 12 months, as resources, in non-MAGI eligibility determinations.

### ***Sections 9611 and 9612 Child Tax Credit Improvements for 2021, Sections 9621 through 9626 Strengthening the Earned Income Tax Credit, and Section 9631 Refundability and Enhancement of Child and Dependent Care Tax Credit***

The ARP provides various expansions of existing tax credits for individuals, specifically the child tax credit, the earned income tax credit, and the child and dependent care tax credit.

Consistent with the treatment of these tax credits as they previously existed, neither the credits nor any advance payment of the credits are includible in gross income (even if refundable – that is, in excess of tax liability), and are therefore not countable in MAGI-based eligibility determinations. Separately, 26 U.S.C. § 6409 prohibits the counting of federal tax rebates or advance payments with respect to refundable tax credits as income, and, for 12 months following receipt, resources, in the eligibility determination of any federal needs-based program (such as

Medicaid). Thus, these payments are not counted in MAGI or, for 12 months, as resources, in non-MAGI eligibility determinations.

***Section 9632 Increase in Exclusion for Employer-Provided Dependent Care Assistance, Section 9675 Modification of Treatment of Student Loan Forgiveness, Section 3201 Emergency Rental Assistance, Section 3206 Homeowner Assistance Fund, and Section 4006 Funeral Assistance***

The ARP provides for additional supports to individuals that are either excluded from taxable income or are excluded entirely from countable income in Medicaid, CHIP, and BHP. These provisions include:

- Section 9632: Employer-provided dependent care benefit. For 2021, the amount of employer-provided dependent care that is excluded from an individual’s gross income is increased from \$5,000 to \$10,500. This amount is also excluded in determining MAGI. It does not affect non-MAGI financial methodologies.
- Section 9675: Student loan forgiveness. For tax years 2021 through 2025, certain student loans that are discharged, or forgiven, will not be counted in the individual’s gross income. These student loan discharges are also not counted in determining MAGI, but do not affect non-MAGI financial methodologies.
- Sections 3201, 3206 and 4006: Rental assistance, homeowner assistance and funeral assistance. These sections appropriate funds to provide grants to individuals for rent or mortgage payments, utilities and related housing needs, and for COVID-19 related funeral expenses during the public health emergency. All of these types of assistance are not countable income for Medicaid, CHIP, and BHP eligibility for MAGI financial methodologies. CMS is continuing to evaluate the impact of rental and homeowners assistance under sections of section 3201 and 3206 of the ARP on non-MAGI financial methodologies. We are coordinating with our federal partners to complete this analysis.

The foregoing summary is not exhaustive, and additional ARP provisions may affect Medicaid, CHIP, and BHP financial eligibility. CMS continues to analyze the law and may issue further guidance on relevant provisions, as needed.

**Provisions with Future Applicability Dates**

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

This provision adds a new section 1947 to the Social Security Act and provides states the option to provide for certain “qualifying community-based mobile crisis intervention services” to be covered under the Medicaid state plan or a waiver of such plan during a 5-year period beginning

on April 1, 2022. States will also be eligible for a federal matching rate of 85 percent for qualifying community-based mobile crisis intervention services during each of the first 12 fiscal quarters occurring during the period of April 1, 2022 through March 31, 2027 in which a state meets the requirements in the statute. This provision also provides funding for the Secretary to issue planning grants to states to develop state plan amendments or waiver requests to provide such qualifying community-based mobile crisis intervention services.

“Qualifying community-based mobile crisis intervention services” are defined as items and services for which medical assistance is available under the state plan or a waiver of such plan that are:

- Furnished to an individual otherwise eligible for medical assistance under the state plan (or waiver) who is outside of a hospital or other facility setting and experiencing a mental health or substance use disorder crisis; and
- Furnished by a multidisciplinary mobile crisis team (as defined by this provision); and
- As appropriate, screening and assessment, stabilization and de-escalation, coordination with and referrals to, health, social and other services and supports as needed, and health services as needed.

In order to receive the 85 percent federal match rate for these services, a state must demonstrate to the Secretary’s satisfaction that it will be able to support the provision of qualifying community-based mobile crisis intervention services that meet the statutory definition. The state must also provide assurances that any additional federal funds received by the state for such services that are attributable to the increased FMAP for such services will be used to supplement and not supplant the level of state funds expended for such services for the fiscal year preceding the first fiscal quarter occurring during the 5-year period described above.

CMS intends to release more guidance on the Medicaid state plan amendment or waiver request option and the planning grants on a rolling basis over the coming months.

### ***Sections 9812 and 9822 Modifications to Certain Coverage under Medicaid and CHIP for Pregnant and Postpartum Women***

Medicaid is the largest payer for maternity care in the United States, and the program has an important role in improving maternal health outcomes. Beginning April 1, 2022, this provision gives states the option to extend Medicaid state plan coverage for pregnant women beyond the required 60-day postpartum period through the end of the month in which a 12-month postpartum period ends. The option provides for continuous eligibility during the postpartum extension. States electing this option must provide full state plan benefits during the pregnancy and postpartum period; they may not limit coverage to pregnancy-related services as otherwise permitted at 42 CFR §435.116(d)(3). If adopted for Medicaid, the extended postpartum coverage election applies automatically to a separate CHIP in the state, for targeted low-income children who are pregnant and targeted low-income pregnant women, as applicable. This option is time-limited to a 5-year period beginning on the effective date of the provision, April 1, 2022. Section 9822 of the ARP also makes continuous eligibility mandatory for targeted low-income pregnant women covered in a separate CHIP. CMS expects to provide additional guidance on these provisions in the coming months.



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

Under current law, the base and inflationary rebates manufacturers owe states for single source (S), innovator multiple source (I), and non-innovator multiple source (N) drugs under the Medicaid Drug Rebate Program are capped at 100 percent of the drug's average manufacturer price (AMP). While this maximum rebate amount specified in section 1927(c)(2)(D) of the Act facially applies only to S and I drugs, it also applies to N drugs by virtue of the provisions for an additional rebate for drugs other than S or I drugs in section 1927(c)(3)(C) of the Act. AMP is currently defined at section 1927(k)(1) of the Act as the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to retail community pharmacies and by retail community pharmacies that purchase drugs directly from the manufacturer. While a drug is likely to reach the rebate cap only if the price increases substantially over time, the cap limits the inflationary rebate owed by manufacturers to states. As a result, manufacturers can continue to increase drug prices once the cap is hit without impacting the amount of rebates they pay to a state for such drug. This provision would remove this 100 percent cap for such drugs beginning January 1, 2024. CMS plans to release additional guidance as we work towards implementation of this requirement.