NEW FAQs – Released January 6, 2021

COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies [1]

Emergency Preparedness and Response

For states that have received a section 1135 waiver approval, how long will they have to complete Medicaid provider enrollments once the Public Health Emergency (PHE) ends?

The section 1135 waiver approval letter received by those states that had requested waivers of the provider enrollment and the authority to perform temporary abbreviated enrollment processes specified that states have up to six months from the end of the PHE (including any extensions) to cease payment to providers not fully screened and enrolled. CMS will request an assurance from states that they have taken the necessary steps to complete enrollments. If the provider enrollments are not complete by the end of the six-month period, states must cease payment to providers that were temporarily enrolled. CMS will continue to monitor and determine whether corrective action is warranted. The corrective action may include state reporting on the number of temporary providers that have pending applications but not enrolled permanently and those that do not have pending enrollments but continue to receive reimbursement.

For states that have received a section 1135 waiver approval, how long will they have to complete Medicaid provider revalidations once the Public Health Emergency (PHE) ends?

For states that have temporarily paused revalidation work per their 1135 waiver approval, revalidation work is expected to resume with the termination of the PHE. For those revalidation due dates that occurred during the PHE, the state may delay the revalidation due date by the amount of time the PHE is in place with an additional six months lead time to allow for notification to the provider of the new revalidation due date. The following example will illustrate the timeline assuming the PHE, which began on March 1, 2020, is terminated on November 1, 2020 (PHE in place for eight months). The provider's revalidation due date was March 2, 2020. Therefore, the state will move the provider's revalidation due date to May 2, 2021. In this example, the state has 14 months following the termination of the PHE to notify and revalidate this provider. However, this amount of time will continue to increase as long as the PHE remains in place.

Do the Medicare Blanket waivers apply to Medicaid and CHIP Programs?

To the extent that Medicare regulations apply to providers and suppliers in the Medicaid and CHIP programs, Medicare blanket waivers would also apply to Medicaid and CHIP providers and suppliers as long as those providers and suppliers continued to comply with any applicable non-waived federal and state law. In certain circumstances, the Secretary of the Department of Health and Human Services (HHS), using section 1135 of the Social Security Act (the Act)), can temporarily modify or waive certain Medicare, Medicaid, CHIP, or Health Insurance Portability and Accountability Act (HIPAA) requirements; these are generally referred to as "blanket

[1] NOTE: These newly released FAQs have also been integrated into the previously released COVID-19 FAQ document, available at https://www.medicaid.gov/state-resource-center/Downloads/covid-19-faqs.pdf

waivers." There are different kinds of 1135 waivers, including Medicare blanket waivers. When there is an emergency, sections 1135 or 1812(f) of the Act allow the Secretary to issue blanket waivers to help beneficiaries access care. When a Medicare blanket waiver is issued, providers do not have to apply for an individual waiver of regulations under section 1135 of the Act. However, the federal government has no authority to waive state law, even if the state law cross-references federal law. Therefore, absent some state waiver activity, for example state laws waiving their own conditions of participation, the Medicare blanket waiver would not exempt a Medicaid facility from complying with its own state's laws, even if those laws address the same activities.

Eligibility and Enrollment

Application and Renewal Processing

What is the responsibility of a state with respect to identifying Medicaid-eligible children and pregnant women who no longer meet the criteria to receive full Medicaid coverage under the "CHIPRA 214 option" if the state is delayed in conducting eligibility renewals and acting on changes in circumstance due to the public health emergency?

In Question II.I.6 of the Frequently Asked Questions available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf, we explained that once a noncitizen is no longer eligible for full Medicaid coverage due to no longer meeting the criteria for full coverage under Section 1903(v)(4) of the Act, as added by Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIIPRA 214 option) (under which states can elect to provide full benefits to lawfully residing children and pregnant women who are not otherwise in a satisfactory immigration status), Federal Financial Participation (FFP) is only available for payment for services necessary for the treatment of an emergency medical condition.

Regulations at 42 C.F.R. § 435.916(d) require that states promptly redetermine eligibility whenever the state receives information about a change in a beneficiary's circumstance that may affect eligibility. However, 42 C.F.R. § 435.912(e) outlines certain exceptions in meeting the timeliness standards for processing applications, renewals and changes in circumstance for Medicaid eligibility during an administrative or other emergency beyond the agency's control. The current COVID-19 PHE represents such a circumstance for many state agencies.

The exception to the timeliness requirements at 42 C.F.R. § 435.912(e) applies equally in the case of noncitizen beneficiaries who are no longer eligible for full Medicaid coverage because they no longer meet the criteria under the CHIPRA 214 option (e.g., the individual has turned age 21, is no longer pregnant and is past the 60-day post-partum period, or no longer meets the definition of lawfully residing). If a state is unable to process redeterminations and fails to identify a beneficiary in this situation FFP is available for full Medicaid coverage until such time as the state is able to process redeterminations. We note that, even with the exception at 42 C.F.R. § 435.912(e), states are still required to continue processing changes in circumstances and renewals as expeditiously as possible, and to provide Medicaid coverage only for treatment of an emergency medical condition for individuals who no longer have a satisfactory immigration

status and who are otherwise eligible for assistance under the state plan. When the state does process such a change, the state must notify the beneficiaries that, while they are no longer eligible for full Medicaid coverage, they may continue to be eligible for treatment of an emergency medical condition, if the individual is otherwise eligible for Medicaid under the state plan.

During the COVID-19 PHE, can states choose not to enforce the requirement under 42 C.F.R. § 435.608 that Medicaid applicants and beneficiaries apply for certain other benefits? Alternatively, can states automatically grant a good-cause exception to individuals for not applying for other benefits?

No. During the PHE, states must continue to require that Medicaid applicants and beneficiaries take all necessary steps to obtain other benefits for which they may be entitled, unless they can show good cause for not doing so, consistent with 42 C.F.R. § 435.608.

We note that enforcement of the requirement at 42 C.F.R. § 435.608 occurs post-enrollment and should not delay an applicant's eligibility determination. Once enrolled, states need to ensure that individuals are making a good faith effort to take the necessary steps to apply for other benefits. Generally, each individual must provide information to the state agency establishing the need for a good faith exception. However, we recognize that other benefit programs are experiencing delays processing applications due to the PHE, and individuals may not be able to complete the application process as timely. Therefore, if there is a specific benefit for which the state determines the application process would represent a hardship for all beneficiaries during the PHE – e.g., the application process requires an in-person interview which are not being conducted due to the PHE –it would be permissible for states to grant a good cause exception with respect to such benefit for all applicants and beneficiaries who may be eligible for such benefit during the PHE.

During the PHE, can states choose not to enforce the requirement that Medicaid applicants and beneficiaries assist the state agency in establishing the identity of a child's parents and obtaining medical support payments, or provide information on third parties who may be liable to pay for care and services provided under the state plan?

No. A state may not choose to forego implementing the requirements in 42 C.F.R. § 435.610(a) that applicants and beneficiaries assist the state agency with identifying absent parents, obtaining medical support and payments, and providing information on third parties who may be liable for care and services provided under the state plan. However, we note that enforcement of the requirement at § 435.610(a) occurs post-enrollment, and should not delay an applicant's eligibility determination. Regulations at 42 C.F.R. § 433.148 provides that states may only require applicants to attest that they will cooperate with this requirement. Once enrolled, absent a need to comply with the continuous enrollment requirement in section 6008(b)(3) of the FFCRA, states must terminate coverage if a beneficiary refuses to do so and the individual has not established good cause for not doing so per 42 C.F.R. §§ 433.147(c) and 435.610(a)(3); however, states claiming the temporary FMAP increase cannot, consistent with section 6008(b)(3) of the FFRCA, terminate the individual's enrollment for the failure to cooperate, through the end of the month in which the emergency period ends.

Premiums and Cost Sharing

If an individual has an increase in income that would normally result in the individual becoming ineligible for his/her current eligibility group and moving to a new eligibility group that provides the same benefits but also charges a premium, can the state move forward with this change during the emergency period?

Section 6008(b)(2) of the FFCRA requires states to maintain premiums at the same or lower level as assessed on January 1, 2020, "with respect to an individual[.]" While the state could move the individual to the new eligibility group, it could not charge this individual the higher premium until the last day of the calendar quarter in which the PHE ends.

Are states permitted to adopt new eligibility groups that charge premiums during the public health emergency?

Yes. States are not precluded from adopting premiums during the emergency period if they are applied to new optional eligibility groups. While section 6008(b)(1) of the FFCRA prohibits changes in eligibility standards, methodologies or procedures under the state plan that are more restrictive than what was in effect on January 1, 2020, adopting a new eligibility group, with or without a premium, would not be more restrictive than the eligibility policies in effect on January 1, 2020 and therefore would be permissible. If the individual is a new Medicaid beneficiary, after the individual's enrollment and initial premium payment (if required for enrollment), the state (is claiming the temporary FMAP) could not, under section 6008(b)(3) of the FFRCA, *terminate* the individual's enrollment for the failure to make premium payments, through the end of the month in which the emergency period ends. However, in the case of an individual enrolled in a state's Medicaid program as of or after March 18, 2020 with no premiums who is no longer eligible in his/her current eligibility group, while the state could move the individual to the newly-adopted eligibility group, it could not charge a new premium until the last day of the calendar quarter in which the PHE ends.

In order to comply with the requirement in section 6008(b)(4) of the FFCRA to cover drugs used to treat COVID-19 without cost sharing, do states need to cover, without cost sharing, both FDA–approved drugs with a new indication authorized under an FDA Emergency Use Authorization (EUA) to treat COVID-19, and unapproved drugs authorized under an FDA EUA to treat COVID-19?

Yes. CMS interprets the reference in section 6008(b)(4) of the FFCRA to "any testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies" to mean that the treatments that states must cover and exempt from cost sharing under this provision include: 1) FDA-approved drugs and licensed biologicals with a labeled indication to treat COVID-19 and FDA-approved drugs and licensed biologicals without a labeled indication for COVID-19, but for which an FDA EUA authorizes a new indication to treat COVID-19;[2]

[2] This means FDA-approved drugs or licensed biologicals without a labeled indication to treat COVID-19 would be used for a medically accepted indication to treat COVID-19 consistent with the definition of "medically accepted

and, 2) unapproved drugs and biologicals authorized under an FDA EUA to treat COVID-19. In order to comply with FFCRA section 6008(b)(4), states must also cover the administration of the treatments for COVID-19 described in that provision without cost-sharing, such as costs related to an office visit in which a drug that must be covered under FFCRA section 6008(b)(4) is administered.

Because a given drug or biological may be prescribed for multiple conditions, states can operationalize the cost sharing exemption required under FFCRA section 6008(b)(4) in one of four ways:

(1) The state could require prior authorization for coverage of (a) any FDA approved drugs or licensed biologicals that either have a labeled indication for COVID-19 or that pursuant to an FDA EUA may be used for a medically accepted indication as defined in section 1927(k)(6) of the Act to treat COVID-19, and (b) unapproved drugs and biologicals that are authorized under an FDA EUA to treat COVID-19; this will enable the state to link the drug or biological to its use for treatment of a confirmed or suspected case of COVID-19;

(2) The state could use a two-part approach depending on whether a beneficiary has a confirmed COVID-19 diagnosis. (a) The state could presume any FDA approved drug or licensed biological that either has a labeled indication for COVID-19 or that pursuant to an FDA EUA may be used for a medically accepted indication as defined in section 1927(k)(6) of the Act to treat COVID-19 or an unapproved drug that is authorized under an FDA EUA to treat COVID-19 is being used as a treatment for COVID-19 based on the appearance of a COVID-19 diagnosis on the claim and exempt the drug or biological from cost sharing. (b) For beneficiaries who do not yet have a confirmed COVID-19 diagnosis or for claims which do not include COVID-19 diagnosis information, the state could require the prior authorization process described above;

(3) The state could exempt from cost sharing all FDA-approved drugs and licensed biologicals that either have a labeled indication for COVID-19 or that pursuant to an FDA EUA may be used for a medically accepted indication as defined in section 1927(k)(6) of the Act to treat COVID-19, or unapproved drugs and biologicals that are authorized under an FDA EUA to treat COVID-19, regardless of the purpose for which the drug or biological is used; or

(4) The state could establish another systematic methodology, which has been agreed upon by both CMS and the state, for exempting beneficiaries from cost sharing for any drug or biological that either has a labeled indication for COVID-19 or that pursuant to an FDA EUA may be used for a medically accepted indication as defined in section 1927(k)(6) of the Act to treat COVID-19 or that is authorized under an FDA EUA to treat COVID-19, and is being used as a treatment for COVID-19 following either a confirmed COVID-19 test or potential exposure to COVID-19.

indication" in section 1927(k)(6) of the Act. That is because any use which is approved under the FFDCA (including pursuant to an FDA EUA) or which is supported by one or more citations included or approved for inclusion in a drug compendium described in 1927(g)(1)(B)(i) of the Act is considered a medically accepted indication.

Can CMS explain its previous answer in section B.1 of the COVID-19 FAQs issued on June 30, 2020 concerning targeting cost sharing exemptions to individuals diagnosed with COVID-19?

In an FAQ originally issued on March 12, 2020, and republished most recently on June 30, 2020, as Question II.B.1 in the "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies," available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf, we discussed that states need to submit a SPA to stop charging cost sharing for particular items or services. We also explained that a SPA exempting individuals from cost-sharing could not be applied narrowly to only those affected by a particular diagnosis, such as COVID-19. It would be inconsistent with the comparability requirement at section 1902(a)(10)(B) of the Act for a state to apply different cost-sharing requirements to certain beneficiaries on the basis of their disease type or diagnosis. In addition, as described in CMS-2334-F (78 Fed. Reg. 42159, 42273 (July 15, 2013)), we believe that targeting cost-sharing based on disease type or diagnosis would constitute a discriminatory practice.

We are clarifying here that states are permitted (and in some cases, required) to exempt from cost-sharing drugs used to treat COVID-19, as also noted in the question above. Nothing in section 6008(b)(4) of the FFCRA alters this flexibility; indeed, that provision *requires* states to exempt such drugs from cost-sharing as a condition of claiming the temporary FMAP increase under FFCRA section 6008. To receive a drug for treatment of COVID-19, a beneficiary typically will have a COVID-19 diagnosis; this fact does not render the cost sharing exemption for drugs used to treat COVID-19 impermissible. However, the limitation on providing a blanket cost sharing exemption for a targeted group of beneficiaries based on diagnosis means that states cannot exempt from cost sharing all items or services only for beneficiaries with a COVID-19 diagnosis; in other words, the state cannot implement a cost-sharing exemption for COVID-19 treatments by exempting all persons with a COVID-19 diagnosis from cost-sharing for any covered Medicaid services, whether or not those services are used to treat COVID-19.

Eligibility

Are the $600/week Federal Pandemic Unemployment Compensation (FPUC) payments counted as a resource for Medicaid eligibility in the month following the month of receipt?

As noted in Question II.C.8 of the Frequently Asked Questions available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf, Federal Pandemic Unemployment Compensation (FPUC) authorized under section 2104 of the CARES Act is not counted as income for any purpose under Medicaid and CHIP including when determining eligibility. Any portion of an FPUC payment that is not spent in the month of receipt is countable as a resource in subsequent months for applicants and beneficiaries whose financial eligibility is based on non-MAGI methodologies and who are subject to a resource test. 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 a state plan amendment (SPA).

Are the $400 per week Lost Wages Assistance payments under the August 8, 2020 Presidential Memorandum counted as income or a resource when determining Medicaid and CHIP eligibility?

No, the Lost Wages Assistance payments are considered neither income nor resources to the recipient for the purposes of Medicaid and CHIP eligibility. Lost Wages Assistance payments made consistent with the Presidential Memorandum of August 8, 2020 ("Memorandum on Authorizing the Other Needs Assistance Program for Major Disaster Declarations Related to Coronavirus Disease 2019"[3]) are provided through the authority of section 408(e)(2) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act ("the Stafford Act"). Because assistance under the Stafford Act is "major disaster assistance provided to individuals and households," section 312(d) of the Stafford Act and implementing regulations at 44 C.F.R. § 206.110(f) require that the assistance is not counted as income or a resource in determining eligibility or benefit levels for a federally-funded means-tested benefit. Medicaid and CHIP qualify as federally-funded means-tested benefit programs. As a result, Lost Wages Assistance is excluded from countable income considered in the eligibility determinations based on both MAGI-based as well as non-MAGI-based financial methodologies. Moreover, for applicants and beneficiaries whose financial eligibility is based on non-MAGI methodologies, the assistance is not counted as a resource for those subject to a resource test, nor is it counted for determining the amount of benefits for an individual. Regular state unemployment benefits are not excluded from income in determining Medicaid and CHIP eligibility.

The Lost Wages Assistance payments are inclusive of the federal share ($300/week) and the state share ($100/week) of assistance. Under Department of Labor guidance[4], states have flexibility in making a state contribution of $100 per week or using regular unemployment benefits as state match. For states choosing to provide an additional $100 weekly benefit, the total of $400 per week in Lost Wages Assistance is excluded from Medicaid and CHIP financial eligibility methodologies, as described above. Thus, in states that are not providing an additional $100 in weekly benefits above regular state unemployment benefits, only the $300/week in Lost Wages Assistance funded through section 408(e)(2) of the Stafford Act is excluded.

In calculating the minimum monthly maintenance allowance of the spouse of an institutionalized beneficiary, should federal pandemic unemployment compensation payments the community spouse is receiving be excluded in the income determined available to the community spouse?

Yes, the requirement in section 2104(h) of the CARES Act that the monthly equivalent of any federal pandemic unemployment compensation be disregarded when determining income "for any purpose" means that such compensation is not counted when determining the income available to a community spouse in calculating the community spouse's monthly income allowance under section 1924(d)(2)(B) of the Act. A "community spouse" is defined in section 1924(h)(2) of the Act as "the spouse of an institutionalized spouse."

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[3] https://www.whitehouse.gov/presidential-actions/memorandum-authorizing-needs-assistance-program-major-disaster-declarations-related-coronavirus-disease-2019/

[4] https://wdr.doleta.gov/directives/attach/UIPL/UIPL_27-20.pdf; and https://wdr.doleta.gov/directives/attach/UIPL/UIPL_27-20_Change-1.pdf

Are supplemental payments for workers – such as "hazard pay," "hero pay," supplemental payments to long-term services and supports (LTSS) direct care workers through Appendix K of an HCBS waiver, or other additional wages paid by employers – counted as income for Medicaid and CHIP eligibility?

As described, these payment classifications are not covered by a specific income exemption or exclusion under federal income tax rules or the methodologies of the supplemental security income (SSI) program. Such payments therefore would generally be included in determining Medicaid and CHIP eligibility in both MAGI and non-MAGI financial eligibility determinations. We note, however, that states have the option to disregard types of income, such as "hazard" or "hero" pay, or supplemental pay for direct care workers, under section 1902(r)(2) of the Act in non-MAGI financial eligibility determinations. This would require a SPA.

Can a state disregard earnings received under the Pandemic Unemployment Assistance program (CARES Act section 2102) for self-employed or part-time workers when determining eligibility for Medicaid and CHIP?

In contrast to the FPUC payments described above, the CARES Act does not explicitly disregard Pandemic Unemployment Assistance benefits. Pandemic Unemployment Assistance allows individuals who otherwise are ineligible for traditional unemployment benefits to obtain such benefits, such as individuals who are self-employed. For example, self-employed individuals who are independent contractors or gig economy workers can receive Pandemic Unemployment Assistance benefits.

Under section 1902(r)(2) of the Act, a state may elect to disregard this income type (or a portion thereof) for individuals applying for, or eligible for, coverage on a non-MAGI basis. This would require a SPA. However, states cannot disregard Pandemic Unemployment Assistance benefits when using MAGI-based methodologies because such disregards are prohibited in MAGI-based methodologies by section 1902(e)(14)(B) of the Act and 42 C.F.R. § 435.603(g)(2).

How are the recovery rebates, also known as economic impact payments, treated for purposes of Medicaid and CHIP eligibility, including treatment of income and assets and post-eligibility treatment of income?

As CMS generally noted in prior FAQs (see Question II.C.11 of the Frequently Asked Questions available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf), the recovery rebates authorized under section 2201 of the CARES Act are not considered income for Medicaid and CHIP financial eligibility determinations, and, for individuals whose Medicaid financial eligibility is based on non-MAGI methodologies, as a resource for the 12 months following receipt. As CMS also noted in the prior FAQs, this exclusion is required under 26 U.S.C. § 6409, which mandates that any federal tax refunds or advanced payments of a refundable credit may not be counted as income for purposes of determining the eligibility for, or the amount or extent of benefits or assistance under, any federal needs-based program. This means that, in addition to the eligibility-related income and resource exclusions of the recovery rebates, the recovery rebates also may not be included in determining beneficiary financial

liability for institutional services or other LTSS under the post-eligibility treatment of income (PETI) rules.

If an employer obtains a loan through the Paycheck Protection Program (PPP) in order to continue meeting its payroll, do the payments received by employees count as income?

Yes. Income received from an employer that is using the PPP for its payroll is countable income under MAGI-based methodologies and non-MAGI methodologies. The compensation is countable to the same extent that it would be in the absence of the PPP.

Generally, if, after the PHE ends and during an individual's renewal, a beneficiary is determined to have accumulated resources that exceed the limit for the eligibility group for which the individual is enrolled, instead of terminating the beneficiary's coverage, could the state opt to recoup the excess resources from the individual (e.g., equal to the lesser of the amount of medical assistance paid by the state and the amount by which the individual's resources exceed the standard)?

No. States may not seek recoupment of medical assistance paid by the state on behalf of any individual whom the state determined eligible for coverage. Specifically, if a state that seeks to claim the temporary FMAP increase authorized under section 6008 of the FFCRA determines that an individual who was enrolled in coverage as of or after March 18, 2020 no longer meets eligibility requirements for any Medicaid eligibility category, the state must continue the individual's enrollment through the end of the month in which the PHE ends in order to meet the condition in section 6008(b)(3) of the FFCRA. After the PHE ends, such a state must take appropriate steps, consistent with 42 C.F.R. § 435.916 and 42 C.F.R Part 431 Subpart E, to terminate the individual's eligibility after the end of the month in which the PHE ends, unless a redetermination after the PHE ends establishes that the individual again meets Medicaid eligibility requirements. Any effort to seek recovery against such a beneficiary for the period during which he or she did not meet all eligibility requirements during the PHE would be tantamount to retroactively terminating an individual's enrollment, in violation of section 6008(b)(3) of the FFCRA, during the period when the state was required to keep the individual enrolled in order to claim the temporary FMAP increase. Further, such a retroactive termination would be in violation of the requirement to provide beneficiaries with advance notice of termination under 42 C.F.R. § 431.211.

Notices and Fair Hearings

Can a state reinstate coverage for a beneficiary who requests a fair hearing more than 10 days after the date of action in the notice?

Yes. A state can reinstate coverage for a beneficiary who requests a fair hearing more than 10 days after the date of action, provided it has been granted authority under section 1135 of the Act to do so. Regulations at 42 C.F.R. § 431.231(a) allow the state to reinstate services for beneficiaries who request a fair hearing not more than 10 days after the date of action. States that would like the flexibility to reinstate coverage for beneficiaries who request a fair hearing more than 10 days after the date of action must submit a section 1135 waiver request. This

request should specify the number of days following the effective date of an adverse action during which the state will reinstate services for beneficiaries who request a fair hearing (i.e., the specific number of days, not to exceed the time permitted for beneficiaries to request a fair hearing). For example, a state has received section 1135 authority to allow individuals up to 120 days (instead of 90 days) from the date the notice of action is mailed, to request a fair hearing. This state sends advance notice 10 days prior to the date of action (e.g. a termination of coverage). The state wants to align the reinstatement period with the timeline the individual has to request a fair hearing. In this example, the state would request section 1135 authority to allow it to reinstate benefits for individuals up to 110 days after the date of action (e.g. a termination), for a total of 120 days after the date the notice of action is mailed.

Presumptive Eligibility

How should a state evaluate disability when utilizing hospital presumptive eligibility for disabled individuals?

States using hospital presumptive eligibility for non-MAGI populations must have hospitals ask questions, for those whose prospective eligibility is based on disability, that are sufficient to determine whether the individual's condition presumptively meets the state's definition of disability, consistent with 42 C.F.R. § 435.540. For example, at least the following questions would be appropriate for a hospital to ask of an individual whom the hospital is evaluating for presumptive eligibility on the basis of a disability: 1) does the individual have a medical condition for which he or she has been treated by a doctor; 2) has the individual had the condition for more than a year, or is the individual expected to have the condition for more than a year; and 3) has the condition served as an impediment to the individual engaging in employment, or reduced the number of jobs the individual can perform. CMS is available to provide additional technical assistance in helping states develop disability-related questions for the hospitals participating in their hospital presumptive eligibility programs.

May a state that is a section 1915(k) Community First Choice (CFC) state use the CFC functional assessment to meet disability determination requirements for a hospital presumptive eligibility determination?

No. Functional needs assessments to evaluate need for institutional or home and community-based services do not provide the information needed to evaluate disability status. Therefore, states may not use a favorable level-of-care determination for the CFC benefit or other LTSS as the basis for determining an individual to have a disability.

Children's Health Insurance Program (CHIP)

Can a state that suspends CHIP enrollees' payment of premiums as part of an approved CHIP Disaster Relief SPA claim federal financial participation (FFP) for the additional capitation payments the state makes to managed care organizations as a result of the SPA?

Yes. States that have suspended premiums under an approved or activated CHIP disaster SPA may claim FFP for additional amounts included in a capitation payment to cover the premium

amount that the beneficiary otherwise would have been required to pay. Existing requirements at 42 C.F.R § 457.224(a)(1) exclude FFP for any cost sharing amounts, including premiums, that beneficiaries are expected to pay; however, for the period during which the state has suspended premium charges, no premium payments are expected from beneficiaries and therefore this FFP exclusion does not apply. If the state accepts any voluntary premium payments during the public health emergency, the state would need to reduce its request for enhanced FMAP for such expenditures by the amount of premium payments received consistent with 42 C.F.R. § 457.224(b).

Can states continue coverage for the duration of the Public Health Emergency for individuals in a separate CHIP who are aging out of eligibility or ending their postpartum period?

No. The requirement in section 6008(b)(3) of the FFCRA to maintain coverage in Medicaid in order to receive the temporary increase in the Medicaid federal medical assistance percentage does not apply to separate CHIPs. Therefore, states may not continue to provide separate CHIP coverage to young adults aging out or women ending their postpartum period. If the state determines that the individual is eligible for Medicaid, they may be transitioned to the appropriate Medicaid eligibility group. States may not transition individuals to Medicaid without first determining them eligible in accordance with 42 C.F.R § 457.350(b). States are required to transfer the accounts of individuals losing CHIP eligibility who are determined to be ineligible for Medicaid to the Exchange, in accordance with 42 C.F.R § 457.350(b)(3) and (i).

If states maintained separate CHIP eligibility for young adults who aged out or pregnant women whose postpartum period ended for some portion of the PHE when should they terminate enrollment?

As mentioned above, the requirement in section 6008(b)(3) of the FFCRA to maintain coverage in Medicaid in order to receive the temporary increase in the Medicaid federal medical assistance percentage does not apply to separate CHIPs. States are expected to take steps needed to appropriately terminate separate CHIP enrollment of individuals who have aged out of coverage or whose postpartum period ended as expeditiously as possible. CHIP regulations at 42 C.F.R. § 457.340(e) require written notice of a termination that is sufficient to enable the enrollee to take any appropriate actions that may be required to allow coverage to continue without interruption. CMS recognizes that states may need time to process these terminations.

Can states choose to maintain coverage for all individuals enrolled in their separate CHIP for the duration of the public health emergency, even though the Medicaid continuous coverage requirements in section 6008(b)(3) of the FFCRA do not apply to separate CHIP programs?

No. As noted in the Eligibility FAQs, states are required to process renewals and changes in circumstances as expeditiously as possible. Under CHIP regulations at 42 C.F.R. § 457.340(d)(1), which cross reference Medicaid regulations at 42 C.F.R. § 435.912(e)(2), states that are unable to timely process eligibility renewals and redeterminations following a change in beneficiary circumstances within the period otherwise allowed due to an administrative or other

emergency beyond the agency's control are not considered to be in violation of the timeliness standards. This exception to the timeliness standards, which applies equally to Medicaid and CHIP, could include a public health emergency, like the COVID-19 PHE, which may impact the agency's ability to complete timely renewals. In order to invoke this exception to the timeliness standards, states must submit and CMS must approve a CHIP disaster SPA.

We note that an approved CHIP disaster SPA does not grant states the authority to extend eligibility periods for separate CHIP enrollees who have been determined ineligible for coverage. If a state receives information from an enrollee, processes that information, and determines the individual ineligible for a separate CHIP, the state would need to process the termination and transfer the individual to Medicaid or the Exchange, in accordance with 42 C.F.R. § 457.350(b) and (i).

Optional COVID-19 Testing Group

Is an individual enrolled in a limited-benefit section 1115 demonstration project eligible for the optional COVID-19 testing group under 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act (the Act)?

No. Individuals receiving limited benefits through section 1115 expenditure authority are not eligible for the optional COVID-19 testing group. The optional COVID-19 testing group authorized under section 1902(a)(10)(A)(ii)(XXIII) of the Act provides eligibility for individuals who are uninsured as defined in section 1902(ss) of the Act. Individuals enrolled in a Federal health care program, as defined in section 1128B(f) of the Act, are not considered "uninsured" for purposes of the optional testing group. Coverage funded through "expenditure authority" under section 1115(a)(2) of the Act is a "Federal health care program" as defined in section 1128B(f) of the Act. While section 3716 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. No. 116-136) amended the definition of an "uninsured individual" in section 1902(ss) of the Act for the purpose of the COVID-19 testing group to include certain exceptions for limited-benefit Medicaid eligibility groups under the state plan, the CARES Act did not except limited-benefit section 1115 demonstration projects. Therefore, for example, a section 1115 demonstration that provides eligibility for limited family planning services coverage only is considered a Federal health care program and individuals enrolled for coverage under such demonstration are not considered to be "uninsured" for purposes of the Medicaid COVID-19 testing group.

Can a state enroll into the COVID-19 testing group individuals who are considered "under-insured?" Specifically, can a state enroll individuals into the COVID-19 testing group who have group health insurance coverage or individual health insurance coverage, such as a High Deductible Health Plan (HDHP), short-term, limited duration insurance, or an excepted benefits plan?

Individuals must be uninsured pursuant to the definition in section 1902(ss) of the Act to be eligible for the optional COVID-19 testing group. The definition of "uninsured individual" in section 1902(ss) of the Act specifies, in part, that the individual must not be enrolled in a group health plan, or group or individual health insurance coverage offered by a health insurance issuer

as those terms are defined in section 2791 of the Public Health Service Act (PHSA). There is no exception for individuals enrolled in a group health plan, or group or individual health insurance coverage, on the basis that such insurance does not cover COVID-19 testing services. Therefore, in the event that an individual is enrolled in a group plan or group or individual health insurance coverage within the relevant definitions of section 2791 of the PHSA that does not cover COVID-19 testing, that individual would not fall within the definition of "uninsured individual" under section 1902(ss) of the Act for purposes of eligibility for the COVID-19 testing group, and thus would not be eligible for the COVID-19 testing group. We note, however, that group health plans and health insurance issuers offering group or individual health insurance coverage, including High Deductible Health Plans (HDHPs), are required to cover COVID-19 testing without cost-sharing requirements, prior authorization, or other medical management requirements under section 6001 of the Families First Coronavirus Response Act (FFCRA) (Pub. L. No. 116-127), as amended by section 3201 of the CARES Act.

Individuals who are enrolled in short-term, limited-duration insurance are eligible for the COVID-19 testing group. This is because the definition of Individual Health Insurance Coverage under section 2971(b)(5) of the PHSA excludes short-term, limited-duration insurance. Thus, enrollment in short-term, limited-duration insurance would not be a basis for an individual to be ineligible for the COVID-19 testing group.

While we do not believe that this situation often would arise, it is possible that in limited circumstances an individual may not have coverage for COVID-19 testing if their plan provides only "excepted benefits" as defined under section 2791(c) of the PHSA, section 733(c) of ERISA, and section 9832(c) of the Internal Revenue Code. Examples of plans covering only excepted benefits include a limited benefit plan for vision or dental services or services provided through an Employee Assistance Program. These plans generally are exempt from the federal insurance market requirements, including the diagnostic testing requirements under section 6001 of the FFCRA, as amended by section 3201 of the CARES Act. However, individuals who are enrolled in excepted benefit plans would not fall within the definition of "uninsured individual" under section 1902(ss) of the Act, and thus would not be eligible for the COVID-19 testing group. Please see FAQs at https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf and https://www.cms.gov/files/document/FFCRA-Part-43-FAQs.pdf for more information about the types of group health plans and health insurance coverage subject to the requirement in section 6001 of the FFCRA, as amended by section 3201 of the CARES Act, to cover COVID-19 testing as well as details on plans or coverage of excepted benefits.

Can a state enroll individuals enrolled in the optional state plan family planning group into the optional COVID 19 testing group in order to provide coverage of the testing benefit to those individuals without requiring a new application?

Yes, once the state has verified the individual does not have any other insurance. Section 3716 of the CARES Act, which amended section 1902(ss) of the Act, established that individuals eligible for the optional state plan family planning group under section 1902(a)(10)(A)(ii)(XXI) of the Act are considered "uninsured" for purposes of eligibility under the optional COVID-19 testing group and therefore may obtain COVID-19 testing coverage under that group in addition

to coverage under the family planning group. Note that states may accept self-attestation of uninsured status.

States may enroll individuals eligible in the family planning group in the optional COVID-19 testing group and provide COVID-19-related testing and diagnostic services to them without requiring them to complete an application for the COVID-19 testing group if the state has sufficient information to determine they are eligible. Eligibility in the COVID-19 testing group requires that individuals be uninsured as defined in section 1902(ss) of the Act. Therefore, states must verify that family planning beneficiaries do not have other insurance coverage before administratively enrolling them in the COVID-19 testing group. States may verify that individuals do not have other insurance using information available to the state (for example, based on routine coordination-of-benefit processes to identify liable third parties). If there is not sufficient information available to the state to determine that the individual is uninsured, the state may not administratively enroll the individual and must request the necessary information to establish that the individual is uninsured prior to enrolling in the COVID-19 testing group.

States must provide appropriate notices to affected beneficiaries explaining that they have been enrolled in and may access services through the COVID-19 testing group while maintaining their eligibility for family planning services. For more information regarding the COVID-19 testing group, please visit: https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

Can a state administratively enroll parents of Medicaid children into the optional COVID-19 testing group without requiring them to complete an application?

No, states may not enroll parents of Medicaid children into the optional COVID-19 testing group without those parents first completing an application. Even though a state may have some of the relevant information about the parent from the child's application/case record, the state would need to obtain information to complete a determination for the COVID-19 testing group from the parents including citizenship and immigration status and whether or not the parent is uninsured. Parents must also sign their own application to indicate their intent to apply for Medicaid. If a state would like to streamline the application process, it can send a pre-populated version of the simplified application for the optional COVID-19 testing group with whatever information it has on file about the parent and ask the parents to complete the required information, sign and return to the state.

Medically Needy and Post-Eligibility Treatment of Income (PETI)/Transfer of Assets/Estate Recovery

Can a state count the amount that the MCO pays for COVID-19 related treatment and diagnosis toward the beneficiary's spenddown in the budget period, to help reduce barriers to overall care?

No. An individual's spenddown liability may not be reduced by medical bills paid by a third-party. The medically needy regulations, at 42 C.F.R. § 435.831(d), allow for deduction of incurred medical expenses only when they are not subject to payment by a third-party.

During the PHE, can states suspend the reduction of payments to Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs) and nursing facilities by the amount of a beneficiary's share of the cost of care under the PETI rules?

States are required to reduce the payment for institutional services by the amount of income a beneficiary is determined to have available based on the post-eligibility treatment of income (PETI) calculation. However, states can effectively reduce or eliminate any required reduction in payments to the facility by reducing or eliminating beneficiaries' liability under the PETI rules. This can be accomplished by temporarily increasing the personal needs allowances (PNA) for beneficiaries subject to the PETI rules. Temporarily setting the PNA at the highest income standard applied to an eligibility group under which individuals may be eligible for institutional services or other LTSS subject to PETI would effectively eliminate all beneficiary liability for LTSS and any corresponding need to reduce payment to the provider. Any PETI-related changes can be made through the Medicaid disaster SPA template, available here: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html. States may make similar changes to the PETI rules that are applied to certain recipients of home and community-based services authorized under section 1915(c) of the Act using Appendix K. CMS is available to provide technical assistance to states interested in making such changes to their PETI rules.

For individuals who were subject to PETI and whose liability for institutional services or other LTSS was unchanged from March 18, 2020, through November 1, 2020 despite income increases, due to state compliance with CMS guidance on section 6008(b)(3) of the FFCRA that was in effect before November 2, 2020, may states disregard assets that accumulated for such individuals as a result and which exceed relevant resource standards on or after November 2, 2020?

Yes, states can exercise authority provided under section 1902(r)(2) of the Act to disregard excess resources that accumulated from March 18, 2020 through November 1, 2020 due to circumstances such as that described in this question. This would require a SPA, and CMS is available to provide technical assistance to states that may be interested in exploring this option.

Would an individual who is subject to Medicaid's transfer-of-asset rules and who transfers his or her recovery rebate received under section 2201 of the CARES Act without receiving something of equal value in return be subject to a penalty under section 1917(c) of the Act?

The answer depends on when the transfer occurs relative to receipt of the recovery rebate. As mentioned above, section 2201 of the CARES Act authorizes recovery rebates that are, pursuant to 26 U.S.C. § 6409, excluded from income, and, for the 12 months following their receipt, resources, in determining eligibility and the amount or extent of medical assistance. Applied to the transfer-of-asset penalties, this means that any portion of a recovery rebate which is transferred for less than fair market value more than 12 months following receipt of the rebate would be subject to the transfer of asset rules under section 1917(c) of the Act. If such a transfer

occurs in the month in which the recovery rebate is received or within the 12 months following receipt of the rebate, no penalty under section 1917(c) of the Act would apply.

Are recovery rebate funds subject to estate recovery?

The answer depends on when the recovery rebate becomes part of the beneficiary's estate. Any portion of a recovery rebate which becomes part of a beneficiary's estate more than 12 months following receipt of the rebate would be subject to the estate recovery rules described in section 1917(b) of the Act. If the funds become part of the recipient's estate in the month the Recovery Rebate is received or within the 12 months following receipt, the recovery rebates would not be subject to Medicaid's estate recovery rules, in accordance with 26 U.S.C. § 6409. As explained above, § 6409 prohibits counting the recovery rebates as income or resources in determining eligibility or the amount or extent of medical assistance for 12 months following their receipt. As Medicaid's estate recovery rules directly relate to the amount of an individual's medical assistance, the estate recovery rules are superseded by § 6409 for the month in which an individual receives the recovery rebate and the 12 months following.

Expiration of Requirements for Claiming the Temporary FMAP Increase under Section 6008 of the FFCRA

Can CMS clarify its previous answer in the Families First Coronavirus Response Act – Increased FMAP FAQs, Question B.1 concerning the termination dates for the requirements defined in section 6008(b) of the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127)?

In the Families First Coronavirus Response Act – Increased FMAP FAQs issued on March 24, 2020, and updated on April 13, 2020, we provided guidance in Question B.1[5] that states and territories seeking the temporary FMAP increase must adhere to the requirements of section 6008(b) of the FFCRA through the end of the month when the public health emergency ends in order to qualify for the temporary FMAP increase. While the condition set forth in section 6008(b)(3) does terminate at the end of the month in which the public health emergency ends, we are correcting our guidance regarding the termination date for sections 6008(b)(1), (b)(2) and (b)(4), all of which end the last day of the calendar quarter in which the PHE ends. In the table below, we are providing updated guidance in accordance with the FFCRA on the termination dates for each of the section 6008(b) requirements.

[5] In January 2021, this set of FAQs was integrated into CMS' COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf. This FAQ is now question IV.F.1. in the integrated document.

FFCRA Authority	Provision	Termination Date
6008(b)(1)	Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020 (maintenance of effort requirement).	Expires the first day of the month following the end of the calendar quarter in which the PHE ends.
6008(b)(2)	Not charge premiums that exceed those that were in place as of January 1, 2020.[6]	Expires the first day of the month following the end of the calendar quarter in which the PHE ends.
6008(b)(3)	Ensure that individuals who were enrolled for benefits under the Medicaid state plan or waiver as of or after March 18, 2020, are treated as eligible for such benefits through the end of the month in which the PHE ends, unless the individual voluntarily terminates eligibility or is no longer a resident of the state.	Expires the first day of the month following the month in which the PHE ends.
6008(b)(4)	Cover, without imposition of any cost sharing, testing, services and treatments for COVID-19— including vaccines, specialized equipment, and therapies.	Expires the first day of the month following the end of the calendar quarter in which the PHE ends.

When the PHE period ends and the authority approved through the Medicaid disaster SPAs sunsets, will states need to continue the cost sharing exemption for COVID-19 testing and treatment services through the last day of the calendar quarter in which the PHE ends to be eligible for the 6.2 percentage point FMAP increase?

Yes. In order to be eligible for the temporary FMAP increase under the FFCRA, states must cover, without any cost sharing, testing services, testing-related services, and treatments for COVID-19, including vaccines, specialized equipment and therapies, through the last day of any calendar quarter in which they claim the FMAP increase. If a state claims the FMAP increase during the quarter in which the PHE ends, it must comply with the condition in section 6008(b)(4) of the FFCRA through the end of that quarter. States will not be required to submit a new SPA to extend the cost sharing exemption through the last day of the quarter in which the PHE ends. However, by drawing funds from the increased FMAP account in the Payment Management System (PMS), each state must attest that it is eligible for the increased FMAP, that the expenditures for which it is drawing funds are those for which the increased FMAP is applicable, and that it has met the conditions required to claim the temporary FMAP increase. Additionally, if the COVID-19 PHE ends early in a quarter, a state may want to submit a new cost-sharing SPA to document that the cost-sharing exemption continues at least through the end of that quarter.

[6] Pursuant to section 6008(d) of the FFCRA, as added by section 3720 of the Coronavirus Aid, Relief, and Economic Security Act, P.L. 116-136, a state is not ineligible for the temporary FMAP increase on the basis that it imposed a premium higher than any in effect on January 1, 2020, during the 30-day period beginning on March 18, 2020, if such premium was in effect on March 18, 2020.

If premiums were required as of January 1, 2020, and were suspended under the disaster SPA effective March 1, 2020, can a state resume charging premiums in the month after the PHE ends, or is the state required to suspend premiums until the month following the end of the quarter in which the PHE ends?

The state may resume charging premiums at the level it charged as of January 1, 2020 the month after the expiration of the PHE. Because these premiums do not exceed those in place on January 1, 2020, resumption would not violate the condition described in section 6008(b)(2) of the FFCRA. However, the state may not charge beneficiaries' premiums that are higher than those charged as of January 1, 2020, until the month after the last day of the calendar quarter in which the PHE ends, unless the exception in section 6008(d) of the FFCRA applies.

Benefits

Home and Community Based Services

Would Personal Care and Home Health Care Services rendered in a home remotely via telehealth constitute a home visit under the purview of Electronic Visit Verification (EVV) as outlined in section 12006 of the 21st Century Cures Act?

No. The remote delivery of services via telehealth does not constitute an "in home visit" as described in the 21st Century Cures Act, and EVV requirements do not apply. However, states may choose to apply EVV requirements to such services.

May providers require beneficiaries to sign waivers of liability should the beneficiary or the beneficiary's family acquire COVID-19 through the receipt of services from the provider or at the provider's physical location? What role do states play in ensuring continued provision of services if a beneficiary does not sign such a waiver?

CMS is aware that some providers of Medicaid-covered services are requiring beneficiaries or their legal representatives to sign waivers of liability relieving the provider of any responsibility should the beneficiary or the beneficiary's family be exposed to or contract COVID-19 as a result of receiving services from the provider in their own home, and/or attending a physical location of the provider. CMS takes no opinion on the permissibility of these waivers of liability, or on the language they may contain.

However, we remind states of their continued obligation during the PHE to ensure appropriate service provision to beneficiaries, including when such a waiver of liability is not signed, and beneficiaries do not receive services from their usual provider. In such circumstances, states should ensure that beneficiaries receive needed services through alternative means, which could include temporary enlargements to the pool of providers to deliver services, utilization of family members to deliver appropriate services, utilization of telehealth, or other approaches. CMS is available to provide technical assistance to states on the utilization of Medicaid coverage authorities and PHE flexibilities to enable these mechanisms to operate efficiently.

Miscellaneous

Do states have to request any kind of waiver to offer transitional case management longer than 180 consecutive days?

No. A waiver is not needed to extend the time in which case management services are provided to an individual transitioning to the community from an institutional stay. Further, there is no limit on how many times an individual can attempt to transition to the community from an institution. If the individual has not transitioned to the community by the end of the 180 consecutive days, the state should document why the transition was unsuccessful. If appropriate, the state could start a new 180 consecutive day period to assist someone with transitioning to the community. Furthermore, the state must ensure that the case management services do not duplicate the services required of the nursing home related to discharge planning, which are described at 42 C.F.R. § 483.21(c).

Managed Care

Contracts and Rates

What should states do to account for the effects of COVID-19 in Medicaid managed care rate development during rating periods impacted by the public health emergency?

CMS understands the significant level of uncertainty surrounding future COVID-19 and non-COVID-19 costs, and acknowledges that in some cases it may not be possible to prospectively project costs associated with the COVID-19 public health emergency in Medicaid managed care capitation rates with sufficient reliability or certainty until significantly more information is known about the impact of the virus on healthcare costs and utilization. Even as data for the initial periods of the public health emergency begins to emerge, CMS continues to recognize the significant level of uncertainty that exists around the future impacts of the public health emergency, including direct and indirect COVID-19 costs and savings such as new treatments and potential vaccines, deferred care, expanded coverage of telehealth, etc. CMS believes there are several strategies states can utilize to address this uncertainty in rate development, including utilization of a risk mitigation strategy (also known as a risk-sharing mechanism) and ceding COVID-19 related risk-based managed care plan costs back to the state and covering these costs in a non-risk payment outside the capitation payment. States could utilize one of these options or in combination.

Will CMS require states to implement a risk mitigation strategy with its Medicaid managed care plans to address the impact of COVID-19?

CMS requires implementation of a two-sided risk mitigation strategy when states implement new or revised state directed payments intended to mitigate the impacts of the public health emergency that are reviewed under the process outlined in the CIB published on May 14, 2020. However, while CMS will not generally require risk mitigation strategies to address the impact of COVID-19, CMS recommends that all states incorporate a two-sided risk mitigation strategy to address the uncertainty of COVID-19 related costs. States could implement a two-sided risk mitigation strategy alone, or in combination with contract modifications and revised rate

certification as appropriate that cede COVID-19 related costs back to the state for the time period, or within the applicable rating periods, impacted by the public health emergency. CMS assumes most states will implement a two-sided risk corridor as their risk mitigation strategy.

We note that CMS recently published the 2020 Medicaid managed care final rule, and this final rule included new requirements for state risk-sharing mechanisms. In accordance with our finalized rule at 42 C.F.R. § 438.6(b)(1), all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period. This final rule is effective on December 14, 2020.

What factors should states consider when implementing a two-sided risk mitigation strategy with Medicaid managed care plans to address the impact of COVID-19?

CMS believes there are many factors a state should consider when designing and implementing a two-sided risk mitigation strategy with its Medicaid managed care plans (MCPs). First, CMS believes the addition of a two-sided risk mitigation strategy across all benefit costs will mitigate risk for the MCPs while not impacting beneficiaries' continuity of care. Additionally, CMS strongly recommends that states implement an adequately narrow and symmetrical risk corridor. This strategy will provide financial protection to the MCPs, while also providing some limit on financial risk for states and the federal government in the event benefit costs are significantly different from expected. CMS also recommends the risk mitigation strategy be implemented on all benefit costs (not just COVID-19 costs) as this option would be simpler to implement and would mitigate risk if non-COVID-19 costs differ significantly from projected. However, CMS understands that a two-sided risk mitigation strategy alone may not mitigate all potential risk, therefore, a state should consider, where appropriate, combining this option with an adjustment to the risk-based capitation rates and contract provision(s) ceding COVID-19 related risk-based MCP costs back to the state and covering these costs in a non-risk payment. Additionally, states may consider performing interim risk corridor calculations and making interim reconciliation payments based on emerging data, with final calculations and payments or reimbursements taking place at a later date once complete data are available and consistent with all applicable federal requirements. Finally, states must also ensure they adhere to all applicable federal requirements, including for risk mitigation strategies at 42 C.F.R. § 438.6(b). CMS reminds states that 42 C.F.R. § 438.6(b) requires, among other things, risk mitigation strategies be developed in accordance with 42 CFR §§ 438.4 and 438.5 and generally accepted actuarial principles and practices. The actuarial rate certification and supporting documentation must also describe any risk mitigation arrangement and how it may affect the rates or the final net payments to the managed care plan(s) under the contract as part of complying with 42 C.F.R. § 438.7.

The inclusion of a two-sided risk mitigation strategy that meets the above criteria will help to facilitate an expeditious review of states' rate certifications during rating periods impacted by the public health emergency. CMS provided an example of a narrow and symmetrical two-sided

risk corridor as part of the CIB published on May 14, 2020 on managed care flexibilities in response to COVID-19.

We note that CMS recently published the 2020 Medicaid managed care final rule, and this final rule included new requirements for state risk-sharing mechanisms. In accordance with our finalized rule at 42 C.F.R. § 438.6(b)(1), all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period. This final rule is effective on December 14, 2020.

How should states incorporate risk mitigation arrangements within Medicaid managed care contracts and rate development to address the impact of COVID-19?

In accordance with 42 C.F.R. § 438.6(b)(1), states should adequately describe the risk mitigation arrangements in their contract(s), including the methodology, process, and timeline for finalizing the results. States should submit the contract actions that incorporate a risk mitigation arrangement into the states' contracts with Medicaid managed care plans to CMS for review and approval in accordance with 42 C.F.R. § 438.3(a).

Additionally, the risk mitigation arrangements must also be developed in accordance with all applicable requirements in 42 C.F.R. Part 438, including 42 C.F.R. §§ 438.4 and 438.5, and generally accepted actuarial principles and practices. The actuarial rate certification and supporting documentation must describe any risk mitigation arrangement that may affect the rates or the final net payments to the managed care plan(s) under the applicable contract as part of complying with 42 C.F.R. § 438.7.

States seeking to add or amend an existing risk mitigation arrangement, including arrangements required as a result of a new or revised state directed payment to address the impacts of the public health emergency during a rating period already in effect, must submit both a contract amendment and a revised actuarial rate certification or addendum, in accordance with federal requirements. If there are no other material impacts on the capitation rates, the revised rate certification could be limited to incorporating the necessary documentation related to the risk mitigation strategy into the rate certification. Further details on CMS' documentation expectations for risk mitigation strategies in all rate certifications are outlined in Section I, item 4.C. of the most recent Medicaid Managed Care Rate Development Guide.

We note that CMS recently published the 2020 Medicaid managed care final rule, and this final rule included new requirements for state risk-sharing mechanisms. In accordance with our finalized rule at 42 C.F.R. § 438.6(b)(1), all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period. This final rule is effective on December 14, 2020.

What factors should states consider when they seek to move COVID-19 related costs from a risk-based managed care plan to the state, using a non-risk payment outside a capitation payment?

CMS understands the significant level of uncertainty surrounding future COVID-19 costs. There may also be other non-COVID-19 related costs that may have a level of uncertainty due to utilization changes caused by COVID-19 (e.g., delays in elective care, etc.). In addition, CMS acknowledges that it is difficult to prospectively include costs associated with the COVID-19 public health emergency in the Medicaid managed care risk-based capitation rates until significantly more information is known about the impact of the virus on healthcare costs and utilization.

In light of this uncertainty, CMS recommends that states concerned about not being able to account for costs associated with COVID-19 in capitation rate development consider covering such costs on a non-risk basis. This option could be accomplished as either a separate non-risk contract with a prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP) (see the definition of "non-risk contract" at 42 C.F.R. § 438.2) or as an amendment to a state's existing risk-based managed care plan contracts to include a non-risk payment.

Under this approach, states could either cover (1) all COVID-19 service costs; or (2) all service costs for beneficiaries with a COVID-19 diagnosis on a non-risk basis. States that choose to amend their existing risk-based Medicaid managed care plan (MCP) contracts should reimburse MCPs separately for these non-risk costs outside of the risk-based capitation rates. In addition, if a state is seeking to cover such costs on a non-risk basis, the state and its actuary will also need to determine if the rate certification adequately reflects services to be covered within the risk-based contract and that it excludes the services ceded to the state (i.e., to address any services and activities or plan functions previously included in capitation rate development that now need to be removed and paid on a non-risk basis). Contracts that contain non-risk elements must be clearly drafted to identify the specific services and costs that are paid by the State on a non-risk basis and must comply with applicable requirements in federal statute and regulation, including in 42 C.F.R. Part 438.

Covering such costs on a non-risk basis addresses the challenges of accounting for these costs in capitation rate development given the uncertainty and lack of data while mitigating the impact to the continuity of care for beneficiaries. CMS would also strongly recommend combining use of a non-risk contract or non-risk payment for certain costs, populations or benefits with a two-sided risk mitigation strategy on all risk-based benefit costs to reduce the risk to the state and federal government if remaining costs are significantly lower than projected.

However, states' ability to cover such costs on a non-risk basis will depend on being able to identify relevant costs and/or beneficiaries accurately in the existing MCP contract(s) to carve them out into a new contract or new contract provision. The state would need to amend their contracts with such MCPs to clearly define the benefits the MCPs must cover on a risk basis and the benefits (or populations) that are excluded from capitation rates and will be covered on a non-risk basis. For a state that chooses to amend existing contracts to include a non-risk

payment or to enter into a non-risk contract, the state must comply with upper payment limits outlined at 42 C.F.R. § 447.362 consistent with the requirements for non-risk contracts and separately identify administrative and medical assistance costs to comply with 42 C.F.R. § 438.812 as well as ensure administrative costs and activities associated with the benefits covered on a non-risk basis are also carved out of the risk-based capitation rates.

If a state is seeking to cover such costs on a non-risk basis during a rating period already in effect and has already submitted a rate certification to CMS, the state and its actuary will also need to determine if a rate amendment is necessary (i.e., to address any services and activities or plan functions previously included in capitation rate development that now need to be removed and paid on a non-risk basis). The state will need to work with their actuary to determine if the actuarially sound capitation rates need to be changed. States currently have the authority to make de minimis rate adjustments to their managed care capitation rates under 42 C.F.R. § 438.7(c)(3) if these adjustments result in an increase or decrease to the capitation rate per rate cell of up to 1.5 percent. If the expected effect on capitation rate development would have an increase or decrease of more than 1.5 percent per rate cell, the state will need to submit a rate amendment to address this change.

When can states utilize the de minimis rate adjustments in Medicaid managed care to address the impact of COVID-19?

In accordance with 42 C.F.R. § 438.7(c)(3), states have the authority to make de minimis rate adjustments to their actuarially sound Medicaid managed care capitation rates. This approach provides states the flexibility to make small programmatic changes while minimizing state administrative burden and upholding principles of actuarial soundness.

These de minimis adjustments may increase or decrease the most recently certified actuarially sound capitation rates per rate cell up to 1.5 percent within the rating period, and do not require the state to submit a revised rate certification. States should submit a contract amendment to effectuate any rate adjustment as the final capitation rates must be specifically identified in the managed care plan contracts in accordance with 42 C.F.R. § 438.3(c)(1). CMS also expects states to provide documentation of how this de minimis rate adjustment ensures compliance with 42 C.F.R. § 438.7(c)(3), including the percentage change of the rate adjustment per rate cell in comparison to the most recently certified actuarially sound capitation rates and an assurance that the state has not previously utilized this flexibility within the applicable rating period.

To implement capitation rate adjustments that result in an increase or decrease of more than 1.5 percent from the most recently certified capitation rates for any rate cell, states must submit a revised rate certification or rate amendment and contract amendment. The revised rate certification or rate amendment must address and account for all differences from the most recently certified rates.

What should states and their actuaries consider when setting Medicaid managed care capitation rates during rating periods that overlap the public health emergency, and what should be documented in the rate certification?

CMS expects that states and their actuaries consider applicable state specific, and other applicable national or regional, data that is available when the actuary develops actuarially sound capitation rates for rating periods that overlap the public health emergency. CMS expects that states and actuaries consider this data in order to make an informed decision on whether to include any adjustments for COVID-19 specific costs, or adjustments to other projected costs to reflect the indirect impacts of COVID-19 costs or savings, in rate development.

In accordance with 42 C.F.R. §§ 438.4 and 438.5 and generally accepted actuarial principles and practices, as states develop capitation rates for rating periods impacted by the public health emergency, CMS expects that states and their actuaries evaluate if rate development assumptions should be included that account for the direct and indirect impacts of COVID-19. States and their actuaries should evaluate all state specific, and other applicable national or regional, data that is available, including COVID-19 cases, Medicaid eligibility and enrollment changes, utilization implications, deferred caseload, etc. Even as data for the initial periods of the public health emergency begins to emerge, CMS continues to recognize the significant level of uncertainty that exists around the future impact of the COVID-19 pandemic, including direct and indirect costs and savings, such as new treatments and potential vaccines, deferred care, expanded coverage of telehealth, etc.

For rates developed at the beginning of the public health emergency, it may have been appropriate to continue monitoring the situation before making any specific adjustments to the rates. However, as states develop rates for their next rating period, CMS does not believe it is reasonable for capitation rates to be developed absent any evaluation and consideration for the COVID-19 public health emergency.

CMS' expectation is that the state's actuary describes within the rate certification the evaluation the state and its actuary conducted, and the rationale for the assumptions the state and its actuary did or did not include in rate development related to the COVID-19 public health emergency. This documentation expectation is consistent with Section I, Item 1.B.i and Item 2.B.iii of the most recent Medicaid Managed Care Rate Development Guide.

How will CMS consider the effects of COVID-19 in its actuarial review of Medicaid managed care rate development during rating periods impacted by the public health emergency?

Section 1903(m) of the Act and 42 C.F.R. § 438.4 require that Medicaid managed care capitation rates be actuarially sound, meaning that the capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract. In accordance with 42 C.F.R. §§ 438.4(b) and 438.7(a), states must submit all rate certifications to CMS and CMS reviews and, as appropriate, approves the capitation rates included in these rate certifications as actuarially sound. CMS will review and

approve actuarially sound capitation rates consistent with generally accepted actuarial practices and principles while acknowledging the significant uncertainty related to the COVID-19 public health emergency.

As CMS has delayed 2019 Medicare cost reporting due dates for hospitals, how does this impact states' base amount calculation for hospital pass-through payments for 2021 in Medicaid managed care?

As outlined in the fact sheet for CMS Flexibilities to Fight COVID-19 for hospitals, CMS is delaying the filing deadline of certain cost report due dates due to the COVID-19 outbreak. CMS is currently authorizing delay for the following fiscal year end (FYE) dates. CMS will delay the filing deadline of FYE 10/31/2019 cost reports due by March 31, 2020 and FYE 11/30/2019 cost reports due by April 30, 2020. The extended cost report due dates for these October and November FYEs will be June 30, 2020. CMS will also delay the filing deadline of the FYE 12/31/2019 cost reports due by May 31, 2020. The extended cost report due date for FYE 12/31/2019 will be July 31, 2020.

Hospital pass-through payments included in Medicaid managed care capitation rates are subject to a "lesser of" requirement of either a percentage of a base amount calculation or the historical payment amount as stipulated in 42 C.F.R. § 438.6(d)(1)(i). The base amount identifies the aggregate difference of a Medicare equivalent amount and the Medicaid paid amount for inpatient and outpatient hospital services utilized by eligible populations in managed care, and is calculated using data for the 12-month period immediately two years prior to the rating period as outlined in 42 C.F.R. § 438.6(d)(2)(i)-(ii).

As states' rating periods and data sources vary, CMS encourage states to reach out to CMS via the MMCratesetting@cms.hhs.gov mailbox if they have questions or concerns regarding the impact that the delay in these 2019 Medicare cost reports will have on the state's base amount calculation for hospital pass-through payments. As a general rule, consistent with 42 C.F.R. § 438.6(d)(2)(iv), CMS aims to ensure consistency between pass-through payments in Medicaid managed care with the upper payment limit requirements in 42 C.F.R. part 447.

When a state seeks to utilize a state directed payment to address the impacts of the public health emergency in Medicaid managed care, what are the requirements for a risk mitigation strategy?

States may direct Medicaid managed care plan expenditures to providers under certain circumstances. These payments can assist states in furthering the goals and priorities of their Medicaid programs, including a state's response to the COVID-19 public health emergency. As outlined in the CIB published on May 14, 2020, and described in the response to a related question in the Managed Care Contracts and Rates section, when a state submits a new or amended state directed payment proposal to address the public health emergency under the review process outlined in the CIB, a state is required to implement a two-sided risk mitigation strategy if a two-sided risk mitigation is not already currently in place. States must also ensure they adhere to all applicable federal requirements, including for risk mitigation strategies at 42 C.F.R. § 438.6(b).

When states direct payments to providers to specifically respond to the public health emergency, states may utilize the flexibilities outlined in the framework described in Section 3 of the May 14, 2020 CIB only if states also adhere to all standards outlined in this framework. However, if states are not seeking to utilize those flexibilities, states can utilize CMS' standard review process for state directed payments. Under CMS' standard review process, the flexibilities described in the May 14, 2020 CIB are not available, and states must complete the standard state directed payment preprint and comply with all of CMS' standard review requirements for state directed payments under 42 C.F.R.§ 438.6(c).

CMS notes that risk mitigation strategies are not required when the state submits a state directed payment tied to retainer payments authorized under section 1915(c)(4)(B) of the Act. CMS does not believe a risk mitigation strategy for retainer payments is required as these payments are specifically linked to the delivery of services specified in an individual's person-centered service plan, are made only when qualifying circumstances prevent an individual from receiving those services, and the underlying services are already included in the managed care contracts and rates.

We note that CMS recently published the 2020 Medicaid managed care final rule, and this final rule included new requirements for state risk-sharing mechanisms. In accordance with our finalized rule at 42 C.F.R. § 438.6(b)(1), all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period. This final rule is effective on December 14, 2020.

Should the measurement period for a risk mitigation strategy implemented to mitigate the impact of the public health emergency in Medicaid managed care (either in the context of a state directed payment or not) align with the state's rating period or target a more specific timeframe?

CMS believes states in negotiation with their managed care plans are in the best position to determine a reasonable and appropriate measurement period for the risk mitigation strategy based on the unique circumstances of the public health emergency and its impact on the Medicaid beneficiaries enrolled in managed care in their states.

While CMS generally expects that most risk mitigation strategies would be implemented to align with the full duration of the state's 12-month rating period, it is possible that states (and their actuaries) may find it reasonable to implement a risk mitigation strategy for a period of time that does not align with the full duration of the rating period. For example, if a state implements a state directed payment to respond to COVID-19 in the last quarter of their state fiscal year, the state may find it reasonable to design the required risk mitigation strategy to align with the implementation of the state directed payment. If the state is approved under § 438.6(c) to continue that state directed payment into the next fiscal year, CMS believes it would also be reasonable for the state to maintain the risk mitigation strategy in the next contract rating period.

CMS believes that states in negotiation with their managed care plans are in the best position to determine the strategy that best provides protection to states and their plans during the public health emergency.

States must also ensure they adhere to all applicable federal requirements, including for risk mitigation strategies at 42 C.F.R. § 438.6(b). The rate certification should include documentation describing the state's risk mitigation strategy as outlined in Section I, item 4.C. of the most recent Medicaid Managed Care Rate Development Guide, and include the state's rationale for the measurement period utilized for the state's risk mitigation strategy if different from the state's 12-month rating period.

We note that CMS recently published the 2020 Medicaid managed care final rule, and this final rule included new requirements for state risk-sharing mechanisms. In accordance with our finalized rule at 42 C.F.R. § 438.6(b)(1), all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with § 438.4, the rate development standards in § 438.5, and generally accepted actuarial principles and practices. Risk-sharing mechanisms may not be added or modified after the start of the rating period. This final rule is effective on December 14, 2020.

Financing

FFCRA Temporary FMAP Increase

If a state decides it will no longer comply with the requirements of section 6008(b) of the FFCRA that are necessary to be eligible for the temporary 6.2 percentage point FMAP increase, must it forfeit the Federal Financial Participation (FFP) associated with increased FMAP retroactive to the start of the PHE or to the start of the quarter in which it no longer complied?

The state must comply with the requirements of section 6008(b) for each quarter in which FFP associated the temporary 6.2 percentage temporary point FMAP increase is claimed. If, during the PHE, a state decides to no longer comply with the 6008(b) requirements, FFP at the increased FMAP is no longer available for state expenditures effective the start of the quarter in which the state is no longer in compliance. However, states are able to receive FFP associated with the increased FMAP for expenditures incurred in prior quarters, if the state met the requirements of section 6008 (b) for that entire quarter.

Can a state claim prior period adjustments, including those relating to supplemental payments, at the FMAP temporarily increased by 6.2 percentage points under section 6008(a) of the FFCRA?

As indicated in Question IV.F.17 of the Frequently Asked Questions available at https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf, states should follow existing federal requirements regarding the applicability of a particular match rate available for a given quarter. The applicable FMAP is based on date of payment, not date of

service, for current quarter original expenditures. The FMAP applicable to expenditures for all prior period adjustments should be the FMAP at which the original expenditure was claimed.

Because supplemental payments are adjustments to base payments originally made for the underlying services, supplemental payments are claimed as prior period adjustments to the original base payments. Accordingly, expenditures for supplemental payments are claimed at the same FMAP as the underlying original base payment expenditures, and in accordance with the timely claims filing requirement at 45 C.F.R. § 95.7, must be claimed within two years of the original base payment expenditures. We recognize that some states use the date of service to approximate the date of the base payment for the underlying services, as a practical means to determine the applicable FMAP when making supplemental payments. Such states should continue to do so. For example, if the state makes a lump sum supplemental payment in the quarter ending December 31, 2020 for services provided in the quarter ending March 31, 2020, the state should claim the supplemental payment as a prior period adjustment using the FMAP for the quarter ending March 31, 2020.

If a state has specific questions based on how it has traditionally claimed state plan lump sum supplemental payments, CMS will work with the state on a case-by-case basis to advise on how the increased FMAP under section 6008(a) of the FFCRA would apply.

Miscellaneous

How should states and providers treat Provider Relief Fund revenue for purposes of Medicaid Disproportionate Share Hospital (DSH) payments?

Section 1923(g) of the Act limits DSH payments on a hospital-specific basis to each hospital's uncompensated care costs for inpatient and outpatient hospital services provided to Medicaid-eligible and uninsured individuals. Pursuant to 42 C.F.R. § 447.299(c), the hospital-specific DSH limit is calculated by reference to payments for inpatient and outpatient hospital services furnished to Medicaid beneficiaries "under the State plan" and "by Medicaid managed care organizations," 42 C.F.R. § 447.299(c)(6) through (c)(9), and payments "received by the hospital by or on behalf of individuals with no source of third party coverage," 42 C.F.R. § 447.299(c)(12).

Provider Relief Fund General and Targeted Distribution payments do not satisfy any of these regulatory provisions. Accordingly, Provider Relief Fund General and Targeted Distribution payments should not be included in the determination of total inpatient and outpatient hospital services payments for Medicaid beneficiaries.

However, when a provider receives reimbursement from either (1) the Families First Coronavirus Response Act (FFCRA) Relief Fund for COVID-19 testing and testing-related services or (2) the Uninsured Relief Fund for COVID-19 care or treatment furnished to uninsured individuals,[7] the payment made is made "on behalf of" the individual with no other

[7] Please see the terms and conditions applicable to each fund for additional relevant information. The FFCRA Relief Fund terms and conditions may be accessed at https://www.hhs.gov/sites/default/files/terms-and-conditions-ffcra-

source of third party coverage for the service. Accordingly, when such payments are for inpatient and outpatient hospital services, they must be included in the determination of inpatient and outpatient hospital services revenue for the uninsured.

For more information, including permissible uses for General and Targeted Distribution payments for providers that have received Medicaid DSH payments, see https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html.

How should states and providers treat Provider Relief Fund revenue for purposes of Medicaid fee-for-service (FFS) Upper Payment Limits (UPL)?

Provider Relief Fund payments will not impact a state's UPL demonstration, for either the calculation of Medicare payment-based ceiling or the accounting of the Medicaid payments subject to the ceiling. Specifically, states may not increase the UPL ceiling by counting all or a portion of these relief funds as Medicare FFS payments, since these payments are not made under Medicare payment principles in 42 C.F.R. Chapter IV, Subchapter B, *see* 42 C.F.R. §§ 447.272(b)(1), 447.321(b)(1). Furthermore, states will not count these relief funds as Medicaid FFS payments that are counted against the UPL, since the UPL is a limit on FFS Medicaid payments under the state plan. *See* 42 C.F.R. §§ 447.250 and 447.300.

How should states and providers treat Provider Relief Fund revenue for purposes of Medicaid cost reimbursement?

States and providers should continue to use ordinary cost reporting principles for Medicaid cost reimbursement. States and providers may modify cost reporting templates, consistent with all applicable cost reporting requirements, to allow documentation of additional health care related expenses that are attributable to coronavirus, for example, additional costs of personal protective equipment or isolation facilities. Further, when a state pays for Medicaid services using cost reimbursement, the provider is not required to offset Medicaid costs by Provider Relief Fund General and Targeted Distribution payments.

For information about the availability of Provider Relief Fund payments for Medicaid cost-reimbursed services, see https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html.

How should states and providers treat Provider Relief Fund payments for purposes of health care related taxes under 42 C.F.R. § 433.68?

Providers should refer to their state's guidance on the determination of revenues subject to an applicable health care-related tax, and to their tax counsel. To the extent the state determines that a health care-related tax is imposed on certain revenue received by a provider from the Provider Relief Fund, then the state must include such tax proceeds in applying the indirect hold harmless test at 42 C.F.R. § 433.68(f)(3)(i)(A), which establishes an indirect guarantee safe

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relief-fund.pdf and the CARES Act Uninsured Relief Fund terms and conditions may be accessed at https://www.hhs.gov/sites/default/files/terms-and-conditions-uninsured-relief-fund.pdf .

harbor for health care-related taxes that produce revenue less than or equal to 6% of net patient service revenue for each permissible class of health care items or services.