

**Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127
Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136
Frequently Asked Questions (FAQs)**

Posted 4/13/2020

A. Emergency Period

1. What is the emergency period described in sections 6004 and 6008 of the Families First Coronavirus Response Act (FFCRA)?

Sections 6004 and 6008 of the FFCRA refer to the emergency period defined in section 1135(g)(1)(B) of the Social Security Act (the Act). Section 1135(g)(1)(B) of the Act defines the emergency period as the period during which there exists a public health emergency under section 319 of the Public Health Service Act for COVID-19. The Health and Human Services (HHS) Secretary's public health emergency declaration for COVID-19 was effective on January 27, 2020, so the emergency period as defined in section 1135(g)(1)(B) began then, and continues through any renewal of the HHS Secretary's public health emergency declaration.¹ The emergency period expires after 90 days, unless further extended by the Secretary. The emergency period will terminate upon termination of the public health emergency, including any extensions. At the time the public health emergency period for COVID-19 ends, CMS will inform states.

B. New Optional Medicaid Eligibility Group

2. Does the FFCRA expand coverage under Medicaid?

Section 6004(a)(3) of the FFCRA adds a new optional Medicaid eligibility group for uninsured individuals during the COVID-19 public health emergency described in section 1135(g)(1)(B) of the Act that was declared by the HHS Secretary pursuant to section 319 of the Public Health Service Act for the COVID-19 pandemic. Coverage under this new optional eligibility group, including for covered services received during the retroactive eligibility period under section 1902(a)(34) of the Act and 42 CFR 435.915(a), may be effective no earlier than March 18, 2020. This group was added at section 1902(a)(10)(A)(ii)(XXIII) of the Act. Individuals eligible for the new group receive a limited benefit package of services related to testing and diagnosis of COVID-19 that are rendered during the emergency period. See question B.6 for more information on the covered benefits for this group. We refer to the new group as the "COVID-19 testing" optional Medicaid eligibility group.

3. What are the eligibility criteria for the COVID-19 testing eligibility group?

In order to be eligible, individuals must meet the definition of an "uninsured individual" in section 1902(ss) of the Act, as amended by section 3716 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. Specifically, an individual must:

- a. Not be eligible to receive coverage under a mandatory Medicaid eligibility group, except that in states that have not adopted the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act, individuals who would be eligible under the adult group, if the group had been adopted by the

¹ The emergency period is defined in paragraph (1)(B) of section 1135(g) of the Act, as amended by H.R. 6074—The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Pub. L. 116-123). The Secretary's determination that a public health emergency exists was issued on January 31, 2020 with an effective date of January 27, 2020. The Secretary's declaration is available at <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>.

state, are not considered to be eligible for that group and therefore may meet the definition of uninsured individual;

- b. Not be enrolled in Medicaid coverage, except that individuals who are enrolled in a limited-benefit Medicaid eligibility group will not be considered to be enrolled in health coverage as a result of such enrollment and therefore may meet the definition of uninsured individual. The limited-benefit Medicaid eligibility groups include the groups for:
 - i. Individuals infected with tuberculosis under section 1902(a)(10)(A)(ii)(XII) and 1902(z) of the Act; and 42 CFR 435.215;
 - ii. Individuals eligible for family planning and related services under section 1902(a)(10)(A)(ii)(XXI), 1902(ii) and clause (XVI) in the matter following section 1902(a)(10)(G) of the Act; and 42 CFR 435.214 and 435.603(k);
 - iii. Individuals eligible as medically needy under section 1902(a)(10)(C) of the Act; and 42 CFR 435, Subpart D (to the extent that the individual's coverage is considered not to meet the requirements of minimum essential coverage, as defined under section 5000A(f)(1) of the Internal Revenue Code of 1986); and
- c. Not be enrolled in another health care program funded by the federal government, including: the Children's Health Insurance Program (CHIP), Basic Health Program (BHP), Medicare, TRICARE and Veterans Administration, and federal employee health plans²; and
- d. Not be enrolled in a group health plan or health insurance coverage offered by a health insurance issuer (as defined in section 2791 of the Public Health Service Act), including: a qualified health plan through an Exchange, employer-sponsored health insurance, retiree health plans and COBRA continuation coverage.

* Note that, although section 3716 of the CARES Act also amended section 1902(ss)(2) of the Act to exclude pregnant women enrolled for coverage under both sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act from the definition of a Federal health care program in the definition of "uninsured individual" for purposes of eligibility under the optional COVID-19 testing eligibility group, pregnant women described in the mandatory eligibility group for pregnant women in section 1902(a)(10)(A)(i)(IV) of the Act are not eligible for the new optional COVID-19 testing eligibility group under section 1902(ss)(1) of the Act (relating to exclusion of individuals who may be enrolled for coverage under a mandatory group from the definition of uninsured). CMS is not aware that any state currently covers pregnant women under the optional eligibility group described in section 1902(a)(10)(A)(i)(IX) of the Act, which is implemented along with the mandatory eligibility group described in section 1902(a)(10)(A)(i)(IV) of the Act at 42 CFR 435.116. CMS will provide technical assistance to any state which believes that it currently covers some pregnant women under this optional eligibility group. States should contact their state lead for assistance if needed.

4. How do states elect the COVID-19 testing optional Medicaid eligibility group?

States may elect the COVID-19 testing eligibility group by completing the appropriate section of the [Medicaid Disaster Relief State Plan Amendment template](#). The State Plan Amendment (SPA) is submitted to the relevant CMS SPA Mailbox for the state.

5. Are there financial or other eligibility requirements for coverage under the COVID-19 testing group?

There is no income or resource test for coverage under the COVID-19 testing eligibility group. Individuals must meet other non-financial eligibility requirements, including being a resident of the state and furnishing a Social Security Number (SSN). Recall that the state agency must assist individuals who do not have an SSN in completing an application to obtain one in accordance with 42 CFR 435.910. For individuals who meet all eligibility criteria for the COVID-19 testing group, but are not a United States citizen or do not have a satisfactory immigration status, federal financial participation (FFP) is limited to payment for services that are necessary for treatment for an emergency medical condition as defined in section 1903(v)(3) of the Act.

6. What services are covered for this new eligibility group?

Effective no earlier than March 18, 2020, covered services for beneficiaries under the COVID-19 testing eligibility group are limited to medical assistance for:

- in vitro diagnostic testing (and administration of that testing) described in section 1905(a)(3)(B) of the Act, as added by section 6004(a)(1) of the FFCRA, and as amended by section 3717 of the CARES Act, and
- COVID-19 testing-related services described in 1916(a)(2)(G) of the Act, added by section 6004(a)(2)(A) of the FFCRA, furnished during a provider visit related to such testing during the public health emergency period.

The limitation on the benefits available to beneficiaries under this group is found in clause (XVIII) in the matter following section 1902(a)(10)(G) of the Act, as added by section 6004(a)(3)(A)(ii) of the FFCRA. See Question C.14 for information on the requirement to cover COVID-19-related testing and diagnostic services for all Medicaid beneficiaries.

7. Does Medicaid coverage for the optional COVID-19 testing eligibility group include coverage for serological tests for COVID-19?

Yes. Effective no earlier than March 18, 2020, covered services for beneficiaries under the COVID-19 testing eligibility group include the in vitro diagnostic testing benefit described in section 1905(a)(3)(B) of the Act, as added by section 6004(a)(1) of the FFCRA, and as amended by section 3717 of the CARES Act. Section 1905(a)(3)(B) of the Act defines “in vitro diagnostic products” through a cross reference to Food and Drug Administration (FDA) regulations at 21 CFR 809.3(a). FDA has advised that serological tests for COVID-19 meet the definition in 21 CFR 809.3(a) of an in vitro diagnostic product for the detection of SARS-CoV-2 or the diagnosis of COVID-19.² Serological tests for COVID-19 are used to detect antibodies against the SARS-CoV-2 virus, and are intended for use in the diagnosis of the disease or condition of having current or past COVID-19 infection, which is caused by the presence of the SARS-CoV-2 virus. Therefore, states that elect the COVID-19 testing eligibility group must provide coverage for this group of serological tests for COVID-19.³ FDA currently believes such tests should not

² 21 CFR 809.3(a) defines in vitro diagnostic products as “reagents, instruments, and systems intended for use in the diagnosis of disease or other conditions, including a determination of the state of health, in order to cure, mitigate, treat, or prevent disease or its sequelae. Such products are intended for use in the collection, preparation, and examination of specimens taken from the human body.”

³ To date, FDA has authorized one emergency use authorization for a serological test that is intended for use by clinical laboratories. See U.S. Food and Drug Administration, Letter to Cellex Inc. Regarding qSARS-CoV-2 IgG/IgM Rapid Test (Apr. 1, 2020), available at <https://www.fda.gov/media/136622/download>.

be used as the sole basis for diagnosis, as noted in its Policy for Diagnostic Tests for COVID-19 Guidance.

8. What services are considered COVID-19 testing-related services?

CMS interprets the COVID-19 testing-related services language in section 6004(a)(2)(A) of the FFCRA to include items and services for which payment is available under the state plan that are directly related to the administration of an in vitro diagnostic product described in section 1905(a)(3)(B) of the Act or to the evaluation of a beneficiary for purposes of determining the need for such product, such as an X-ray. COVID-19 testing-related services do not include services for the treatment of COVID-19.

9. Are states required to verify that an applicant is uninsured in determining eligibility for the COVID-19 testing group?

States are permitted to accept self-attestation of uninsured status in determining eligibility for this new group. States can update their verification plans to indicate whether self-attestation will be accepted. Updates may take effect immediately and do not require CMS approval. Because income is not a factor of eligibility for this new optional eligibility group, no verification of income is required. States that accept self-attestation are expected to perform customary procedures to identify liable third parties, including other insurance coverage, and to bill such third-party sources first. States are also expected to notify all individuals found eligible for this coverage that the Medicaid agency may pursue and seek recovery from such third parties.

10. Are states required to determine that applicants are not eligible for any of the mandatory groups before enrolling them in the optional COVID-19 testing group?

States may enroll individuals into the COVID-19 testing group without first assessing eligibility for all other mandatory groups. States that choose to use a simplified application for the COVID-19 testing group are not required to determine that an applicant is ineligible for all mandatory eligibility groups before furnishing assistance under the COVID-19 testing group. However, states are encouraged to inform all individuals seeking coverage in the COVID-19 testing group that they may be eligible for comprehensive benefits. This language can be included in the state's application. Individuals determined eligible for the COVID-19 testing group who subsequently apply and are determined eligible for Medicaid in another group should be transferred into that other group. Individuals who apply for coverage through the regular single, streamlined application and are determined ineligible for other full-benefit eligibility groups should be screened for potential eligibility for Marketplace coverage, CHIP and coverage in the COVID-19 testing group.

11. If an applicant applies for Medicaid on a single streamlined application or alternative application, and is found eligible only for the COVID-19 testing group, how should the state explain in its eligibility notice that the individual is only eligible for the benefits associated with the COVID-19 group?

When an applicant applies for full benefit Medicaid coverage and is determined eligible for only the COVID-19 group, the eligibility determination notice must clearly explain that the beneficiary is only eligible for coverage of in vitro diagnostic testing and testing-related services furnished during a provider visit related to that testing during the public health emergency (see B.6 for more information on the benefit package for this group). States are encouraged also to include in their notices that if the beneficiary has a change in circumstances, such as a job loss or reduction in income, the beneficiary should notify the state so that the state can determine whether the individual is eligible for full benefits. Please see 42 CFR 435.917 and 431.206 through 431.214 for additional requirements regarding notices.

12. What is the Federal Medical Assistance Percentage (FMAP) for the services provided for the COVID-19 testing group?

The FMAP for services provided to an individual enrolled in the COVID-19 testing group is 100 percent. The 100 percent match is only available for the testing and testing-related services provided to beneficiaries enrolled in the new COVID-19 testing group (and for related administrative expenditures); the 100 percent match is not provided for COVID-19-related testing and diagnostic services provided to individuals covered under other Medicaid eligibility groups. See question G.46 for additional information.

13. What changes did the FFCRA make to the rules on outstation locations processing applications?

FFCRA amends section 1902(a)(55) of the Act to add the COVID-19 testing group to the list of groups for which outstation rules apply. Please refer to the outstation regulations at 42 CFR 435.904 for more information about the out-stationing requirements.

C. Benefits and Cost Sharing for COVID-19-Related Testing and Diagnostic Services

14. Did the FFCRA require state Medicaid and CHIP programs to cover any COVID-19-related testing and diagnostic services?

Yes. Subsections 6004(a) and (b) of the FFCRA, as amended by section 3717 of the CARES Act, require Medicaid and CHIP coverage of in vitro diagnostic products, including the administration of such products, for the detection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) or diagnosis of COVID-19 during any portion of the public health emergency period defined in section 1135(g)(1)(B) of the Act beginning on or after March 18, 2020.

15. Are X-rays considered an in-vitro diagnostic product, for purposes of the required benefit for COVID-19 testing at section 1905(a)(3)(B) of the Act?

Section 1905(a)(3)(B) of the Act defines “in vitro diagnostic products” through a cross reference to Food and Drug Administration (FDA) regulations at 21 CFR 809.3(a). That regulation defines “in vitro diagnostic products (IVDs)” (in relevant part) as “those reagents, instruments, and systems intended for use in diagnosis of disease or other conditions, including a determination of the state of health, in order to cure, mitigate, treat, or prevent disease or its sequelae. Such products are intended for use in the collection, preparation, and examination of specimens taken from the human body.” X-rays are not intended to collect, prepare, or examine specimens taken from the human body, and thus are not considered an in vitro diagnostic product under this regulation or for purposes of section 1905(a)(3)(B) of the Act. However, as indicated in question 8, X-rays could be a component of “COVID-19 testing-related services.” Additionally, X-rays continue to be a mandatory service in the Medicaid program, and should be utilized when medically necessary. For more information on the FDA definition, visit <https://www.fda.gov/medical-devices/device-labeling/vitro-diagnostic-device-labeling-requirements>.

16. Does in vitro diagnostic testing described in section 1905(a)(3)(B) of the Act, as added by section 6004(a)(1) of the FFCRA, and as amended by section 3717 of the CARES Act, include serological tests for COVID-19?

Yes. Section 1905(a)(3)(B) of the Act defines “in vitro diagnostic products” through a cross reference to Food and Drug Administration (FDA) regulations at 21 CFR 809.3(a). FDA has advised that serological tests for COVID-19 meet the definition in 21 CFR 809.3(a) of an in vitro diagnostic product for the

detection of SARS-CoV-2 or the diagnosis of COVID-19⁴. Serological tests for COVID-19 are used to detect antibodies against the SARS-CoV-2 virus, and are intended for use in the diagnosis of the disease or condition of having current or past COVID-19 infection, which is caused by the presence of the SARS-CoV-2 virus. Therefore, states must provide coverage for serological tests for COVID-19.⁵ FDA [currently believes such tests should not be used as the sole basis for diagnosis, as noted in its Policy for Diagnostic Tests for COVID-19 Guidance.](#)

17. What services are considered COVID-19 testing-related services for purposes of the cost sharing exemptions under section 6004(a)(2) of the FFCRA?

Section 6004(a)(2) of the FFCRA amended sections 1916 and 1916A of the Act to prohibit Medicaid cost sharing both for the services described in section 1905(a)(3)(B) of the Act and for COVID-19 testing-related services, during the portion of the public health emergency period defined in section 1135(g)(1)(B) of the Act beginning on the date of enactment of FFCRA (March 18, 2020). CMS interprets the COVID-19 testing-related services language in section 6004(a)(2)(A) of the FFCRA as described in question 8. COVID-19 testing-related services do not include services for the treatment of COVID-19.

18. Is cost-sharing permitted for COVID-19 testing and testing-related services?

No. Section 6004 of the FFCRA amends sections 1916, 1916A, and 2103 of the Act to exempt from cost sharing in Medicaid and CHIP: (1) any in vitro diagnostic product described in section 1905(a)(3)(B) of the Act (and its administration); and (2) any other COVID-19 testing-related services for which payment may be made under the State plan, during the portion of the public health emergency period defined in section 1135(g)(1)(B) of the Act beginning on the date of enactment of FFCRA (March 18, 2020). See Question 8 above for more information on COVID-19 testing related services. States must submit a SPA if they currently charge cost sharing for services that would encompass any in vitro diagnostic product described in section 1905(a)(3)(B) of the Act (or its administration), or any COVID-19 testing related services. For Medicaid, the [Medicaid Disaster Relief State Plan Amendment template](#) can be used. For CHIP, states that impose cost sharing for the services at issue will need to submit a CHIP SPA unless the state already has an approved Disaster Relief SPA under which the required cost sharing exemption is effectuated, and the state has activated the cost sharing provisions.

If the state intends to qualify for the temporary 6.2 percentage point FMAP increase authorized under section 6008 of the FFCRA, it must also waive copays for testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies, for any quarter in which the temporary increased FMAP is claimed.

In order to comply with both the mandatory cost sharing exemption and the exemption required to receive the temporary FMAP increase, states can use the following language in the Medicaid Disaster Relief SPA template: “[Name of state] will not impose cost sharing for testing services (including in vitro diagnostic products, and including test administration), testing-related services, and treatments

⁴ 21 CFR 809.3(a) defines in vitro diagnostic products as “reagents, instruments, and systems intended for use in the diagnosis of disease or other conditions, including a determination of the state of health, in order to cure, mitigate, treat, or prevent disease or its sequelae. Such products are intended for use in the collection, preparation, and examination of specimens taken from the human body.”

⁵ To date, FDA has authorized one emergency use authorization for a serological test that is intended for use by clinical laboratories. See U.S. Food and Drug Administration, Letter to Cellex Inc. Regarding qSARS-CoV-2 IgG/IgM Rapid Test (Apr. 1, 2020), available at <https://www.fda.gov/media/136622/download>.

for COVID-19, including vaccines, specialized equipment and therapies, for any quarter in which the increased FMAP is claimed.”

D. Implications for the Children’s Health Insurance Program

19. What benefits were added for targeted low-income children and targeted low-income pregnant women covered by CHIP?

Section 6004(b) of the FFCRA requires coverage of in vitro diagnostic products for the detection of SARS-CoV-2 or diagnosis of COVID-19 in the same way that such products are covered in Medicaid. This coverage is required beginning March 18, 2020 through the duration of the public health emergency defined in section 1135(g)(1)(B) of the Act. States will not need to submit a CHIP SPA to effectuate these changes if they already indicate in their state plan that they cover laboratory and radiological services in section 6.2.8 of their CHIP state plan.

20. Are individuals covered through CHIP also exempt from cost sharing for testing related to COVID-19?

Yes. Section 6004(b)(3) of the FFCRA exempts from cost sharing: (1) any in vitro diagnostic product described in section 1905(a)(3)(B) of the Act; and (2) any other COVID-19 testing-related services. This requirement went into effect on March 18, 2020 and lasts through the duration of the public health emergency defined in section 1135(g)(1)(B) of the Act. See Question 12 above for more information on COVID-19 testing-related services. States will need to submit a CHIP SPA to effectuate the cost-sharing changes.

E. Implications for the Basic Health Program

21. Did the FFCRA make any changes to coverage through the Basic Health Program (BHP)? Must BHP standard plans cover the diagnosis and treatment of COVID-19?

BHP standard health plans must cover the diagnosis and treatment of COVID-19. The FFCRA did not make any changes to BHP coverage because section 6001 of the FFCRA requires only a group health plan or a health insurance issuer offering group or individual health insurance coverage to cover diagnostic testing related to COVID-19. Section 6001 of the FFCRA does not apply to the BHP because as we explained in the March 2014 Basic Health Program Final Rule, we determined that BHP should be excluded from the individual market. See 79 Fed. Reg. 14,111, at 14,131 (March 12, 2014).

However, 42 CFR 600.405(a) requires that BHP standard health plan coverage “must include, at a minimum, the essential health benefits as determined and specified under 45 CFR 156.110.” CMS released “FAQs on Essential Health Benefit Coverage and the Coronavirus (COVID-19)” on March 12, 2020, available at <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/EHB-Benchmark-Coverage-of-COVID-19.pdf>. Q1 of these March 12, 2020 FAQs explains that Essential Health Benefits (EHB) generally includes coverage for the diagnosis and treatment of COVID-19. However, the exact coverage details and cost-sharing amounts for individual services may vary by plan, and some plans may require prior authorization before these services are covered.

States that operate a BHP may choose to enhance coverage for COVID-19 testing related services.

F. Additional Questions on the Increased FMAP Under Section 6008 of the FFCRA

22. Can a state terminate Medicaid coverage for beneficiaries for failure to pay premiums during the COVID-19 public health emergency period and still receive the temporary 6.2 percentage point FMAP increase?

No. Until the end of the month in which the public health emergency ends, states cannot terminate Medicaid coverage for beneficiaries for failure to pay premiums and still get the temporary increase in FMAP.

23. How did the CARES Act change the requirement that states may not increase premiums above the levels in effect on January 1, 2020, in order to be eligible for the temporary 6.2 percentage point FMAP increase? What is the impact on states that implemented a new premium after January 1, 2020? What about states that have not yet implemented their authority to collect premiums?

Section 3720 of the CARES Act added a new subsection (d) to section 6008 of the FFCRA in order to provide states which have increased premiums for any Medicaid beneficiaries above the amounts in effect on January 1, 2020, with a 30-day grace period to restore premiums to amounts no greater than those in effect as of January 1 without jeopardizing the state's eligibility for the temporary 6.2 percentage point FMAP increase. A state which has increased its premium charges after January 1, 2020, and before March 18, 2020 (the date of the FFCRA enactment), has 30 days to reduce its premiums to be no higher than the amount charged as of January 1, 2020. This 30-day grace period for returning premiums to no higher than the January 1 level begins on March 18 and ends on April 17. States also must reimburse beneficiaries for higher amounts charged after January 1, 2020, in order to obtain the temporary 6.2 percentage point FMAP increase. If a state has authority to charge higher premiums and has not done so as of March 18, 2020, the state may not begin charging the higher premiums authorized and still obtain the temporary 6.2 percentage point FMAP increase.

24. For an individual subject to a premium requirement who fails to pay, but whose eligibility is not terminated for failure to pay premiums on the basis of section 6008 of the FFCRA, can the state, after the end of the emergency period, seek recovery against the individual?

No. States seeking to claim the temporary FMAP increase may not collect premiums after the end of the emergency period for an individual who owed a premium during the emergency period but whose Medicaid eligibility is maintained solely on the basis of the FFCRA's enhanced FMAP provision. Effective the month following the month in which the emergency ends, a state may resume implementation of its premium policy under 42 CFR 447.55(b)(2) or other authorized policy with respect to premium non-payment, such as under an approved section 1115 waiver.

25. If an individual is participating in a home and community-based services (HCBS) waiver program authorized under section 1915(c) of the Act, and the individual is determined to no longer meet the level-of-care (LOC) requirements (or other requirements) for the waiver, in order to claim the temporary FMAP increase, must the state maintain the individual's participation in the 1915(c) waiver and continue to provide 1915(c) services?

States seeking to claim the temporary FMAP increase are required to maintain an individual's eligibility for benefits (through the end of the month in which the public health emergency ends) for which an individual attained eligibility under the state plan or a waiver of the state plan. This means that the state should maintain an individual's participation in a 1915(c) waiver for which the individual is enrolled during the emergency period, even if the individual is determined to no longer meet the LOC or other requirements for waiver participation, such as receiving a service within the last 30 days. Moreover, if a state determined after enactment of the FFCRA that an individual had not received services within the previous 30 day time period and terminated the individual, the state should

reinstate the individual to ensure that the state can receive the 6.2 percentage point FMAP increase. However, states should continue to apply any criteria that is used in determining the services included in the individual's 1915(c) person-centered service plan. Services would only be provided if they are reflected in the person-centered service plan and based on an assessment of functional need, per regulations at 42 CFR 441.301(c)(2). An individual's person-centered care plan can be updated to reflect updated assessments of functional need during the period of the public health emergency. Services should not be provided that are not based on an assessed need.

- 26. If an individual's Medicaid eligibility is connected to his/her need for, and receipt of, section 1915(c) waiver services (i.e., the individual is enrolled in the eligibility group described at 42 CFR 435.217, or the "217" group), and the individual is determined to no longer meet the requisite level-of-care (LOC) requirement for the waiver, in order to claim the temporary FMAP increase, must a state maintain the individual in the 217 group and continue to provide coverage for 1915(c) services?**

Where an individual no longer meets the eligibility requirements for the group in which he or she is enrolled and the individual is not eligible for a separate eligibility group covered under the state plan that provides the same amount, duration and scope of benefits, a state must maintain the individual's enrollment in his or her original group in order to claim the temporary 6.2 percentage point FMAP increase. In the example of a 217 group enrollee who no longer meets the LOC requirement for the relevant 1915(c) waiver (or other eligibility requirements for the group), unless the individual is eligible for a separate eligibility group which provides the same amount, duration and scope of benefits, the state would have to maintain the individual's enrollment in the 217 group and participation in the 1915(c) waiver until the end of the month in which the public health emergency ends. Covered services would be provided subject to limitations relating to assessments of functional need, as described in the question above.

- 27. To be eligible for the temporary FMAP increase, should an individual who is enrolled in the adult group described at 42 CFR 435.119, but who turns 65 and becomes eligible for Medicare, be retained in the adult group during the emergency period, or can the state transition the individual to a Medicare Savings Program group for assistance with his or her Medicare premiums and cost sharing?**

To be eligible for the enhanced FMAP authorized by the FFCRA, states may not reduce benefits for any beneficiary enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, and still qualify for increased FMAP. This means that states must continue to provide coverage to such beneficiaries in the eligibility group in which the beneficiary is enrolled if transitioning the beneficiary to another eligibility group would result in a reduction in benefits. If there is a separate eligibility group for which the individual is eligible and which provides the same amount, duration and scope of benefits, then a state may shift the individual to that group; what is critical for ensuring eligibility for the temporary FMAP increase is that the same amount, duration and scope of medical assistance be maintained. If, in the scenario provided, an individual turns 65 while in the adult group and becomes enrolled in Medicare and eligible for assistance with Medicare premiums and/or cost sharing under one of the Medicare Savings Program (MSP) groups (which do not provide the full benefit package available to adult group beneficiaries), and the individual is ineligible for another eligibility group which confers the same amount, duration and scope of benefits, the state must continue to furnish services available to beneficiaries enrolled in the adult group until the last day of the month in which the emergency period ends, and also enroll the individual in the MSP group. In this case, Medicare would be the primary payer, with Medicaid providing secondary coverage.

- 28. In order to comply with the condition under section 6008(b)(3) of the FFCRA for receiving the temporary FMAP increase, how should a state treat beneficiaries who would no longer be eligible**

for full Medicaid coverage as a lawfully residing child under 21 or pregnant woman under 1903(v)(4) (often referred to as the “CHIPRA 214 option”), when they no longer meet the criteria the state has elected under their state plan?

Once a noncitizen is no longer eligible for full Medicaid coverage due to no longer meeting the criteria for under the CHIPRA 214 option (i.e., a lawfully residing child has reached the age of 19, 20 or 21, or the post-partum period has ended for a lawfully residing pregnant woman) and is not otherwise in satisfactory immigration status as a qualified noncitizen under 42 CFR 435.4, FFP would only be available for payment for services necessary for the treatment of an emergency medical condition, due to the limitation on FFP for beneficiaries who are not in a satisfactory immigration status. Limiting the provision of medical assistance to noncitizens whose eligibility is continued in accordance with section 6008(b)(3) of the FFCRA to treatment of an emergency medical condition would not render a state ineligible for the temporary FMAP increase.

29. Does the requirement to continue coverage through the end of the emergency period apply to noncitizens receiving coverage of services necessary to treat an emergency medical condition?

Yes. There is no exception to the condition for states to receive the temporary FMAP increase described in section 6008(b)(3) of the FFCRA based on a limitation on the benefits for which FFP is available. The scope of such continued assistance would be limited to services necessary for treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

30. Under section 6008 of the FFCRA, can states suspend or terminate coverage of incarcerated beneficiaries and still qualify for the increase in FMAP?

Incarceration does not impact a beneficiary’s eligibility for Medicaid; rather, incarceration limits the availability of FFP to inpatient services provided to the incarcerated beneficiary. (See paragraph (A) of the matter following section 1905(a)(30) of the Social Security Act, 42 CFR 435.1009–1010, and State Health Official (SHO) letter # 16-007) (<https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf>). Therefore, in order to receive the temporary FMAP increase provided under section 6008 of the FFCRA, states must provide continuous coverage through the end of the month in which the emergency period ends to Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, if they become incarcerated. However, the FFCRA does not supersede the limitation on FFP for inmates of a public institution, and states continue to be limited to claiming FFP for inmates for covered inpatient services.

We recognize that some states are able to suspend eligibility for Medicaid beneficiaries who become incarcerated, and this practice complies with the condition in section 6008(b)(3) of the FFCRA for receipt of the temporary FMAP increase. Many states, however, currently terminate eligibility upon incarceration, and re-enroll the inmate if the inmate is admitted to an inpatient facility. These states can comply with the terms of section 6008(b)(3) of the FFCRA by ensuring that inmates are re-enrolled in coverage when admitted to an inpatient facility and prior to release, if they are released before the end of the month in which the emergency period ends.

31. Does the Maintenance of Effort requirement to maintain benefits for an individual enrolled for benefits under a plan (or waiver) as of the date of enactment of the FFCRA through the last day of the month in which the emergency period ends apply to individuals who are eligible for Refugee Medical Assistance?

No. The conditions for states to be eligible to receive the temporary FMAP increase under section 6008(b) of the FFCRA apply only to medical assistance furnished under title XIX of the Social Security

Act. Refugee Medical Assistance (RMA) is not furnished under title XIX of the Act. The Office of Refugee Resettlement (ORR) will be providing states with additional information on this issue. Contact John Cusey, Director Policy of ORR, at John.Cusey@acf.hhs.gov or Dee Daniels Scriven at Dee.DanielsScriven@acf.hhs.gov with additional questions.

- 32. In order to comply with the condition under section 6008(b)(3) of the FFCRA for receiving the temporary FMAP increase, how should states treat beneficiaries who age out of an eligibility group – for example, adolescents who turn 19 and age out of the eligibility group for children under age 19 described in 42 CFR 435.118; individuals eligible under the group for former foster care children, described in 42 CFR 435.150, when they turn age 26; and individuals eligible under the adult group described in 42 CFR 435.119 when they turn age 65?**

The answer to this question depends on the coverage options under other eligibility groups under the state plan or waiver. If a beneficiary aging out of an eligibility group is eligible for another eligibility group which covers the same amount, duration and scope of benefits, the state would transition the beneficiary to that group. For example, in a state which has expanded coverage to the adult group, a child covered under section 42 CFR 435.118 whose household income is at or below 133 percent of the Federal poverty level would be transitioned to the adult group upon attaining age 19. If, however, there is no other eligibility group for which the individual is eligible under the state plan or waiver that provides the same amount, duration and scope of benefits as those available to beneficiaries in the group under which the individual has been receiving coverage (42 CFR 435.118, 435.119 or 435.150), then the state must continue to furnish the benefits available under such group in order to qualify for the temporary FMAP increase.

- 33. How should a state handle Medicaid beneficiaries who are eligible based on receipt of Supplemental Security Income (SSI) in 1634 states who become ineligible for SSI? Does the state need to continue Medicaid coverage if it receives a notification from State Data Exchange interface (SDX) that the individual was terminated from SSI?**

An individual who is eligible for Medicaid based on his or her receipt of SSI as of March 18, 2020 or is determined eligible based on receipt of SSI after that date, and who becomes ineligible for SSI, may not be terminated from Medicaid prior to the end of month in which the emergency period ends if the state claims the temporary FMAP increase. If such an individual is eligible for a different eligibility group which offers at least the same benefits available to SSI beneficiaries, the state may transfer the individual to that group.

- 34. Can a state, consistent with the requirement in section 6008(b)(3) of the FFCRA, move an individual from one Medicare Savings Program (MSP) group into another? For example, could a state move an individual from the qualified Medicare beneficiary (QMB) group to the specified low-income Medicare beneficiary (SLMB) group?**

A state must maintain, during the emergency period, an individual's eligibility for at least the same amount, duration, and scope of benefits as are covered for the group in which the individual is enrolled, including paying for Medicare Part A/B premiums through MSPs and other Medicaid categories. In the example of a QMB who is determined during the emergency period to no longer meet the QMB group eligibility requirements, the individual could not be shifted to the SLMB group, because the SLMB group offers a lesser amount of assistance with Medicare premiums and cost sharing than the QMB group. The state would have to maintain the individual's enrollment in the QMB group.

35. If an agency has not been able to verify an individual’s declared citizenship or satisfactory immigration status during a reasonable opportunity period, must the state keep the individual enrolled in Medicaid in order to qualify for the temporary FMAP increase?

When an otherwise eligible individual has made a declaration of citizenship or satisfactory immigration status in accordance with 42 CFR 435.406(a) and the agency is unable to verify citizenship or satisfactory immigration status, the agency must enroll the individual in Medicaid for a reasonable opportunity period (ROP) under 435.956(b). Because such individuals are enrolled in Medicaid during the ROP if they otherwise meet all eligibility requirements, in order to satisfy the condition for receipt of the temporary FMAP increase under section 6008(b)(3) of the FFCRA, they must remain enrolled in Medicaid until the end of the month when the emergency period ends even if their citizenship or satisfactory immigration status has not been verified. At the end of the month in which the emergency ends, the state must terminate eligibility for any individuals whose status has not been verified prior to the end of their ROP. If and when the state determines that an individual is not a U.S. citizen or in a satisfactory immigration status, coverage would be limited to services necessary for treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

36. In question A.2. of the FAQs CMS previously issued on the FFCRA, CMS indicated that Community First Choice (CFC) 1915(k) service expenditures already eligible for the 6 percentage point in Federal match rate increase are not eligible for the 6.2 percentage point FMAP increase under section 6008 of the FFCRA. Is this accurate?

No. We incorrectly stated that the 6.2 percentage point FMAP increase under the FFCRA does not apply to Community First Choice (CFC) 1915(k) service expenditures, which are already eligible for a separate 6 percentage point FMAP increase. Expenditures for these services are, in fact, eligible for both the 6 percentage point FMAP increase under section 1915(k) of the Social Security Act and the 6.2 percentage point increase under section 6004 of the FFCRA, if the expenditures otherwise qualify. These FMAP increases are additive.

37. In question A.4. of the FAQs CMS previously issued on the FFCRA, CMS indicated that although the 6.2 percentage point FMAP increase under section 6008 of the FFCRA does not apply directly to CHIP expenditures, it does have an indirect effect of increasing the “enhanced” FMAP (EFMAP) under section 2105(b) of the Act. Will there be a similar impact on the enhanced match rates for Money Follows the Person (MFP) demonstration expenditures and Certified Community Behavioral Health Clinic (CCBHC) expenditures?

Yes. Similar to CHIP expenditures, these expenditures are matched at rates that use the FMAP in the first sentence of section 1905(b) of the Act as a “base.” Match rates for MFP and CCBHC expenditures will be indirectly increased as a result of the 6.2 percentage point FMAP increase under the FFCRA. Please note that the MFP match rate has a statutory limit of 90 percent.

38. In question A.2. of the FAQs CMS previously issued on the FFCRA, CMS indicated that the 6.2 percentage point FMAP increase under section 6008 of the FFCRA does not apply to adult group expenditures matched at either the “newly eligible” FMAP specified in section 1905(y) of the Act or at the “expansion state” FMAP specified in section 1905(z) of the Act. Are other adult group expenditures that are matched at the state-specific FMAP in the first sentence of 1905(b) eligible for the 6.2 percentage point FMAP increase?

Yes. Adult group expenditures matched at the state-specific FMAP in the first sentence of 1905(b) are eligible for the 6.2 percentage point FMAP increase. For example, the 6.2 percentage point FMAP increase is available for most expenditures for services provided to “not newly” eligible individuals in a state that has expanded Medicaid, but does not qualify as an “expansion state” under section

1905(z)(3) of the Act. (Note, the FMAP increase would not apply to “not newly” expenditures already matched at rates not subject to the 6.2 percentage point FMAP increase, such as family planning services matched at 90%.)

39. Will CHIP allotments for FY 2020 increase as a result of the 6.2 percentage point increase to the FMAP provided under section 6008 of the FFCRA?

No. CHIP allotment formulas are set in statute under section 2104(m) of the Act and do not rely directly on the FMAP or enhanced FMAP (EFMAP) EFMAP in the calculation. Therefore, FY 2020 CHIP allotments will not increase as a result of the 6.2 percentage point increase FMAP. However, there is CHIP funding potentially available to states through contingency fund and/or redistribution payments should they exceed their allotments and if they meet the criteria provided in statute under sections 2104(n) and 2104(f) of the Social Security Act, respectively.

As stated in Question A.4. of the FAQs CMS previously issued on the FFCRA, the 6.2 percentage point increase to the FMAP results indirectly in an increase in the EFMAP (although not the same amount) coinciding with the duration of the increase to the FMAP. The indirect increase to the EFMAP for applicable quarters in FY 2020 will affect the amount of each state’s FY 2021 CHIP allotment, determined under a “rebasings” methodology provided in section 2104(m)(2)(b)(i) of the Act. Specifically, the FY 2021 CHIP allotments calculated under section 2104(m)(2)(b)(i) will be determined based on the previous fiscal year’s Federal payments reported and applied to allotments (including contingency fund and redistribution payments if any) multiplied by the FY 2021 allotment increase factor. Any increases in the federal share of expenditures applied to available CHIP allotment funding for FY 2020 will be accounted for in the calculation of the FY 2021 CHIP allotments.

40. Does the 6.2 percentage point increase under the FFCRA have the same indirect effect on the match rate for CHIP administrative expenditures as it does on CHIP service expenditures?

In general, yes. CHIP expenditures, including CHIP administrative expenditures, are matched at the EFMAP rate under section 2105(b) of the Social Security Act (the Act) unless otherwise provided in the statute. As a reminder, CHIP administrative expenditures are included among other certain CHIP expenditures described at section 2105(a)(1)(D) of the Act (HSI, outreach, other child health assistance, and translation and interpretation) that are limited to 10 percent of the total amount of total computable expenditures reported for the fiscal year under section 2105(a) of the Act.

States have the option to claim Medicaid expansion CHIP administrative expenditures as Medicaid administrative expenditures. If the state elects to do so, these expenditures are matched at the Medicaid administrative match rate and are not eligible for the 6.2 percentage point FMAP increase.

41. The calculation of Medicaid DSH limits for Institutions for Mental Diseases (IMD) under section 1923(h) of the Act relies, in part, on the 1905(b) FMAP to determine the “applicable percentage” at section 1923(h)(2). Will CMS use the 1905(b) FMAP increased by 6.2 percentage points for this calculation? If so, what will the impact be?

Yes, we will use the section 1905(b) FMAP increased by 6.2 percentage points for each quarter that is subject to this increase to calculate the applicable percentage for each state under section 1923(h)(2) of the Act. As a result, some states will experience an increase to their Medicaid DSH limits for IMDs for FY 2020 and any subsequent FY that includes at least one quarter in which the 6.2 percentage point increase applies. Please note that this increase to some states’ IMD limits does not affect states’ overall DSH allotment amounts.

- 42. CMS indicated that the 6.2 percentage point increase under section 6008 of the FFCRA applies to territories that meet eligibility requirements specified in that same section. If territories qualify for the increase, are these 6.2 percentage points added to the territory FMAPs specified at section 1905(ff) of the Act?**

Yes. The 6.2 percentage point increase under the FFCRA is in addition to the existing FMAP increases under section 1905(ff) of the Act. For example, the FMAP for the quarter ending March 31, 2020, is 89.20% for American Samoa, Guam, the Northern Mariana Islands, and the Virgin Islands and 82.20% for Puerto Rico, if each territory qualifies for the temporary increase under section 6008 of the FFCRA.

G. Availability of 100 Percent FMAP and Other Financial Questions

- 43. Did the FFCRA or the CARES Act increase Medicaid disproportionate share hospital (DSH) allotments for states under section 1923 of the Act?**

Not directly. However, section 3813 of the CARES Act eliminated \$4 billion in Medicaid DSH allotment reductions applicable to FY 2020 that were scheduled to take effect on May 23, 2020, reduced the FY 2021 DSH allotment reductions from \$8 billion to \$4 billion, and delayed the start of FY 2021 DSH allotment reductions until December 1, 2020.

- 44. Is there an increased federal match rate available for expenditures under section 6004 of the FFCRA for beneficiaries eligible under the new, optional group in section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act?**

Yes, but only for expenditures associated with certain services and certain administrative activities. Section 6004(a)(3)(D) of the FFCRA specifies that the FMAP is 100 percent for expenditures for covered services provided to beneficiaries under the new optional eligibility group added at section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act. See the section titled "[Benefits and Cost Sharing for COVID-19-Related Testing and Diagnostic Services](#)" in this FAQ document for more information on the covered benefits for this group. Additionally, 100 percent match is available for administrative costs related to providing for such services to such individuals under the state plan.

This 100 percent match rate does not apply to expenditures for medical services or administrative costs not described in the immediately preceding paragraph.

- 45. For which period is the 100 percent FMAP under section 6004(a)(3)(D) available for services?**

As specified in section 6004(a)(3)(D) of the FFCRA, the 100 percent FMAP is available for expenditures based on the services provided to uninsured individuals as defined in section 1902(ss) of the Act who are eligible only on the basis of section 1902(a)(10)(A)(ii)(XXIII) of the Act. To the extent a state elects to cover the population and services under its state plan, and subject to other federal requirements, the 100 percent FMAP is applicable for the specified testing and testing-related services provided to beneficiaries determined eligible under section 1902(a)(10)(A)(ii)(XXIII) of the Act beginning with effective date of the approved state plan amendment adding coverage for this eligibility group and for the duration of the public health emergency period.

- 46. Are states required to obtain approval of a state plan amendment prior to claiming FFP at the 100 percent match rate under section 6004(a)(3)(D)?**

Yes. Prior to claiming expenditures at the 100 percent match rate under section 6004(a)(3)(D) on the Form CMS-64, a state must have adopted the optional COVID-19 group in their approved Medicaid

state plan (states should use the [Medicaid Disaster SPA template](#) to do so). States may request a retroactive effective date to adopt the optional COVID-19 group, as early as the effective date of the FFCRA, or March 18, 2020.

47. Will CMS require the state to update their cost allocation plan or administrative claiming plan to identify the administrative costs eligible for the 100 percent match under section 6004(a)(3)(D)?

No. CMS will not require states to update their public assistance cost allocation plans (PACAP) or Medicaid administrative claiming plans (MAC) in order to initiate claiming for COVID-19 related administrative costs associated with section 6004(a)(3)(D) of the FFCRA. However, states should notify CMS of their intention to claim COVID-19 related administrative costs under this provision. CMS will work with states to ensure they are in compliance with federal claiming requirements associated with COVID-19-related administrative costs for the duration of the public health emergency. Due to the public health emergency posed by COVID-19 and the urgent need to make available to states the 100 percent match under the amendment to section 1905(b) of the Act made by section 6004(a)(3)(D) of the FFCRA, CMS is exercising its enforcement discretion to adopt a temporary policy of relaxed enforcement in connection with the PACAP requirements under 42 CFR 433.34 and Subpart E of 45 CFR Part 95. We therefore believe that this guidance is a statement of agency policy not subject to the notice and comment requirements of the Administrative Procedure Act (APA). 5 U.S.C. § 553(b)(A). For the same reasons, CMS additionally finds that, even if this guidance were subject to the public participation provisions of the APA, prior notice and comment for this guidance is impracticable, and there is good cause to issue this guidance without prior public comment and without a delayed effective date. 5 U.S.C. § 553(b)(B) & (d)(3). As a result, states will be permitted to postpone updating their PACAP/MAC plans to reflect the addition of COVID-19 activities until after the cessation of the public health emergency.

48. Are there special expenditure reporting requirements for the Form CMS-64 (i.e., separate lines or a separate form report for expenditures relating to section 6004 of the FFCRA)?

We are currently working to modify the MBES/CBES system to accommodate the changes from the FFCRA and the CARES Act, including reporting of budget estimates and eligible expenditures relating to section 6004 of the FFCRA. We intend to issue further guidance and offer training to states as soon as possible.

49. Will CMS be issuing separate grant awards to states associated with COVID-19 testing under Medicaid and CHIP described under section 6004 of the FFCRA? What if a state determines that the Medicaid funding currently available in its Payment Management System (PMS) account isn't sufficient to cover its estimated expenditures for the rest of a particular quarter?

CMS does not intend to issue special grant awards to all states for funding associated with COVID-19 testing under Medicaid and CHIP described under section 6004 of the FFCRA.

Consistent with existing practice, states have an opportunity at any time throughout each quarter to request additional funding from CMS as necessary to cover expenditures for allowable Medicaid administrative and service costs, including expenditures resulting from amendments made by section 6004 of the FFCRA. Should any state need additional funds before the end of a quarter, they may request them through a supplemental grant award request to the extent that the state and its expenditures are allowable and the state has a permissible source of non-Federal share. CMS will evaluate such requests and issue any appropriate additional supplemental grant awards.

50. Are there special requirements for claiming FFP at the 100 percent FMAP under section 6004 of the FFCRA when the legislatively-specified services for in vitro diagnostic products for detection of SARS-CoV-2 are delivered through managed care?

Medical assistance under the State Plan now includes the COVID-19 testing benefit described in section 1905(a)(3)(B) of the Act. States should ensure that their managed care contracts adequately address the COVID-19 testing benefit described in section 1905(a)(3)(B) of the Act so that the managed care plan covers the testing benefit for individuals covered under the managed care contract. The 100 percent FMAP is available for only the COVID-19 testing and testing-related services provided to only beneficiaries enrolled in the new COVID-19 testing group (and for related administrative expenditures); the 100 percent match is not provided for COVID-19-related testing and diagnostic services provided to individuals covered under other Medicaid eligibility groups.

In order to provide coverage for the optional COVID-19 testing group under section 1902(a)(10)(A)(ii)(XXIII) of the Act, the State must ensure that the managed care contract provides for coverage of both the population and the COVID-19 test and testing-related services (see Q&A 6 and 8 above). The State should first review its contract with its managed care plans; depending on how covered populations are specified in the contract as being covered or eligible for coverage by the managed care plan, the State will need to amend the managed care contract to add coverage of the optional COVID-19 testing group and specify the scope of covered services available to that group.

To ensure proper claiming at the 100 percent FMAP available under section 6004 of the FFCRA when the State has included coverage of the optional COVID-19 testing group (i.e., coverage of the population for this specific benefit) in the managed care contract, states will need to isolate the managed care expenditures eligible for this increased match rate. Options include:

- Creating a kick payment (consistent with actuarial soundness requirements) for managed care plans for coverage of the test for the optional COVID-19 testing group, which would require both a contract and rate certification amendment. This option will require compliance with 42 C.F.R. §§ 438.4 through 438.7 regarding rate development and amendment of capitation rates.
- Paying for the tests for the optional COVID-19 testing group outside of the managed care capitation payment as a non-risk payment, either as a separate non-risk contract with its managed care plans (see the definition of “non-risk contract” at 42 CFR 438.2) or as an amendment to its existing managed care plan contracts to include a non-risk payment. If a state chooses to amend its existing contracts to include a non-risk payment, the state would need to comply with upper payment limits outlined at 42 CFR 447.362 for the non-risk payment, consistent with the requirements for non-risk contracts.

Note: CMS will process these contract amendments as expeditiously as possible and asks states to submit any COVID-19 related rate/contract amendments to our newly established mailbox at CMCSManagedCareCOVID19@cms.hhs.gov, including **COVID-19** in the subject line of the email and identifying the type of action(s) included.

H. Coronavirus Aid, Relief, and Economic Security (CARES) Act

51. What are the changes to Unemployment Insurance (UI) Compensation in the CARES Act, and how do they affect financial eligibility for Medicaid and CHIP?

The CARES Act makes a number of changes to Unemployment Insurance (UI) in response to the COVID-19 public health emergency.

- Section 2102 creates the Pandemic Unemployment Assistance program that provides benefits for eligible individuals who are self-employed, seeking part-time employment, or who otherwise would not qualify for unemployment benefits under state or federal law. To be eligible, among other requirements, individuals must demonstrate that they are otherwise able to work and available for work within the meaning of applicable state law, except that they are unemployed, partially unemployed, or unable or unavailable to work because of COVID-19 related reasons.
- Section 2104 provides that, under the Federal Pandemic Unemployment Compensation program, eligible individuals who are collecting certain UI benefits, including regular unemployment compensation, will receive an additional \$600 in federal benefits per week for weeks of unemployment ending on or before July 31, 2020.
- Section 2107 creates the Pandemic Emergency Unemployment Compensation program that allows those who have exhausted benefits under regular unemployment compensation or other programs to receive up to 13 weeks of additional benefits. States must offer flexibility in meeting eligibility requirements related to “actively seeking work” if an applicant’s ability to do so is impacted by COVID-19.

For more information, see: <https://www.dol.gov/newsroom/releases/eta/eta20200402-0> and https://wdr.doleta.gov/directives/attach/UIPL/UIPL_14-20.pdf.

Unemployment benefits are typically countable income under both Modified Adjusted Gross Income (MAGI) and non-MAGI financial methodologies. However, section 2104(h) of the CARES Act states: “The monthly equivalent of any Federal pandemic unemployment compensation paid to an individual under this section shall be disregarded when determining *income for any purpose* under the programs established under titles XIX [the Medicaid program] and title XXI [the CHIP program] of the Social Security Act.” (Emphasis added.) Consequently, states must disregard the \$600 weekly Pandemic Unemployment Compensation (monthly equivalent of \$2,580) in determining underlying income eligibility, and the scope of assistance (e.g., cost-sharing, post-eligibility treatment-of-income), for both Medicaid and CHIP.

Note that FFP at the 90 percent federal matching rate for the design and development of improvements to Medicaid eligibility determination systems might be available in accordance with applicable requirements,⁶ and states can request such funding through the emergency process outlined at 45 CFR 95.624. Likewise, seventy-five percent enhanced federal match also might be available for ongoing maintenance and operations, in accordance with applicable requirements.⁷

The section 2104(h) disregard applies specifically to Federal pandemic unemployment benefits. It does not apply to payments received based on regular UI, the expansion of eligibility for regular UI payments under the Pandemic Unemployment Assistance program, or extensions of regular UI payments under the Pandemic Emergency Unemployment Compensation program.

⁶ 42 CFR Part 433, subpart C, 80 Fed. Reg. 75817-75843 (Dec. 4, 2015); and SMD# 16-004 RE: Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding, available at <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/SMD16004.pdf>

⁷ *Id.*

52. How do states identify the Unemployment Compensation payments that are subject to the disregard for Medicaid and CHIP?

State Medicaid/CHIP agencies may work with their state Unemployment Insurance agency to ascertain how the Unemployment agency will identify who qualifies for additional payments under the Pandemic Unemployment Compensation program. States may also be able to find ways to identify the additional payments. For example, state Unemployment Insurance agencies have flexibility to include the additional payment in the regular payment or as a separate payment, which may help identify the additional amount. If the Medicaid/CHIP agency becomes aware that all UI recipients will receive the additional payments, the agency can program its eligibility system to automatically reduce all unemployment income by \$600 per week as countable income until the Pandemic Unemployment Compensation program expires July 31, 2020.

As a more immediate solution, or if states are not able to differentiate the regular UI payments from the Pandemic Unemployment Compensation increased payments, the state can provide help text/instructions on the application and renewal forms (as well as call center scripts and other help resources) that direct individuals not to include the \$600 per week additional payments in their income for any purpose under Medicaid and CHIP. The state could also ask that individuals self-attest to whether or not their income from UI includes the non-countable \$600 per week additional payments.

53. Do states need to submit a SPA to implement section 2104 of the CARES Act which disregards additional unemployment compensation as income for Medicaid and CHIP?

No, states do not need to submit a SPA. The statutory provision affects the operation of MAGI-based and non-MAGI financial methodologies but does not present policy that is documented in the state plan.

54. Is the relief payment to individuals and families provided by section 2201 of the CARES Act countable for Medicaid and CHIP eligibility?

No. Section 2201 of the CARES Act allows a refundable tax credit for 2020 to eligible individuals. It also directs the Internal Revenue Service to provide payments in 2020 as an advance refund of the credit to eligible individuals, called "Recovery Rebates." The payments are not taxable income, and are therefore not countable in MAGI-based eligibility determinations. Separately, 26 U.S.C. § 6409 prohibits the counting of federal tax rebates or advance payments with respect to refundable tax credits as income, and, for 12 months following receipt, resources, in the eligibility determination of any federal needs-based program (such as Medicaid). Thus, the Recovery Rebates may not be counted as income, and, for 12 months, as resources, in non-MAGI financial eligibility determinations.

55. Does the CARES Act affect any income counting rules for Medicaid/CHIP applicants and beneficiaries whose financial eligibility is based on MAGI?

The CARES Act makes some changes to individual income tax rules that may affect Medicaid and CHIP MAGI-based financial eligibility for some individuals.

- Section 2204: Tax filers who do not itemize their deductions are permitted to deduct from their MAGI up to \$300 in charitable contributions made by an eligible individual in tax years beginning in 2020.
- Section 2202(a)(5): A tax filer who takes an early "Coronavirus-related distribution" from a retirement account (up to \$100,000) may elect to spread out the inclusion in income of such a

distribution over three years. Tax filers electing to spread the inclusion in income would also spread it for purposes of MAGI.

- Section 2206: Amounts that an employer pays in 2020 for an employee's student loan principal and interest are not counted in the employee's MAGI (similar to the treatment of employer-paid tuition and fees or employer-provided courses of instruction).