Oregon

Tina Kotek, Governor

Department of Human Services
Office of Developmental Disabilities Services
Office of the Director
500 Summer St. NE, E-15
Salem, OR 97301

Date: February 9, 2023

TO: The Honorable Sara Gelser Blouin, Chair
Senate Committee on Human Services

FROM: Acacia McGuire Anderson, Interim Deputy Director
Office of Developmental Disabilities Services
Oregon Department of Human Services

SUBJECT: Senate Bill 576

Dear Senator Gelser Blouin, and Members of the Committee,

The Oregon Department of Human Services is neutral on Senate Bill 576, but we have carefully analyzed it and determined that, if passed, it would allow income and resources to be disregarded for people with disabilities who are working as well as allow these individuals who are medically improved to continue to receive Medicaid. It is important to note that this is not a new program, but rather an adjustment to the current Employed People with Disabilities program already allowing people with disabilities access to slightly enhanced asset and resource limits.

I am specifically submitting testimony in response to a question you posed at the end of the February 8, 2023, hearing on the bill. Your question pertained to recent interpretation of federal legislation by the Center for Medicaid/Medicare Services (CMS). The CMS interpretation provided states guidance in targeting and tailoring income and resource disregards for individuals seeking home and community-based services (HCBS).

In 2019, Congress passed the Sustaining Excellence in Medicaid Act, Pub. L. No. 116-39, and as part of that statute Congress included a "rule of construction," or guidance in interpreting the statute. This rule provided that states were not

prohibited from “applying an income or resource disregard under a methodology authorized” by a particular provision of federal statute.

This rule was subsequently interpreted by CMS as “permit[ting] states to adopt higher effective income and resource eligibility standards for people who need HCBS, either for all such individuals or for a particular cohort of such individuals.” (See SMD# 21-004, attached as Appendix A). In other words, CMS has provided that states have the option to target and tailor income and resource disregards for individuals with disabilities who need Home and Community-Based Services (HCBS); making it federally allowable for states to have higher income and resource limits.

This is substantially different from previous interpretations, as it was generally assumed that income and asset limits had to be more broadly applied to all Medicaid recipients, not just those with disabilities or on a specific waiver. In these scenarios, the cost of raising income or asset limits would be prohibitive.

With the current federal rules as interpreted by CMS, if this bill were to pass, individuals would still “buy in” or contribute to their services at a level that is manageable with earned income but would be able to earn a living wage and save for necessary items they currently cannot afford. In short, working people with disabilities would be able to earn and save money while remaining eligible for their health care and long-term support services, such as attendant care or residential supports.

This is important, as multiple studies indicate that income and resource limits of public health benefits, such as Medicaid, perpetuate poverty and keep people from becoming more financially independent. (See, e.g., Chen and Lerman, “Do Asset Limits in Social Programs Affect the Accumulation of Wealth?”, 2005).

An earlier version of this bill was analyzed as potentially incurring a significant cost for the department to implement across the two programs whose service populations it would impact: the Office of Developmental Disabilities Services and the Office of Aging and People with Disabilities. ODHS has since evaluated this bill and revised this original fiscal analysis estimating that roughly 900 new users may access EPD over the biennium and roughly 30% of those would access higher levels of care, including long term services and supports, rather than 100% as used in the previous fiscal analysis. For these reasons it is predicted that the current fiscal will be substantially less than in previous years.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SMD# 21-004

RE: State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services

December 7, 2021

Dear State Medicaid Director:

This letter provides guidance to states on a "rule of construction" of the Medicaid Act under section 3(b) of the Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39, which has been included in several subsequent federal laws (hereafter the "construction rule").[1] The construction rule provides that states have the option to target and tailor income and resource disregards at individuals who are eligible for, or seeking coverage of, home and community-based services (HCBS) authorized under section 1915(c), (i), (k) and 1115 authorities.[2]

This new option permits states to adopt higher effective income and resource eligibility standards for people who need HCBS, either for all such individuals or for a particular cohort of such individuals. The option affords states with broad discretion in selecting the cohorts of individuals needing HCBS for whom the state will apply higher effective income or resource standards. States could, for example, effectively raise the resource standard for all individuals eligible for HCBS, or for individuals eligible for a particular 1915(i) or 1915(k) benefit approved under a state's plan, or for individuals eligible for one or more of the eligibility groups covered under a state's section 1915(c) waiver. This option presents states with a critical tool to use in their efforts to "rebalance" their Medicaid coverage of long-term services and supports (LTSS)

[1] *See* The Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Division N, Title I, Section 204(b); Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, Division A, Title III, Subtitle E, Part II, Section 3812(b); Continuing Appropriations Act, 2021, Pub. L. No. 116-159, Division C, Title III, Section 2302(b); Further Continuing Appropriations Act, 2021, and Other Extensions Act, Pub. L. No. 116-215, Division B, Title I, Section 1105(b); Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Division H, Title II, Section 205(b). CMS does not interpret the construction rule in these provisions or the Sustaining Excellence in Medicaid Act rule of construction provision to be time-limited, notwithstanding its inclusion in multiple federal laws.

[2] The construction rule in the Sustaining Excellence in Medicaid Act provision and in the provisions described in footnote 1 reads: "Nothing in section 2404 of Public Law 111-148, section 1902(a)(17) or 1924 of the Social Security Act shall be construed as prohibiting a State from applying an income or resource disregard under a methodology authorized under section 1902(r)(2) of such Act (1) to the income or resources of an individual described in section 1902(a)(10)(A)(ii)(VI) of such Act (including a disregard of the income or resources of such individual's spouse); or (2) on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act or under section 1115 of such Act."

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from institutional to community-based care. The purpose of this letter is to provide information on how states can utilize the construction rule to expand coverage of HCBS under their Medicaid programs.

Background

In order to understand the new flexibility under the construction rule to expand eligibility for individuals seeking HCBS, it is helpful to review certain requirements and state options regarding the financial methodologies applied in determining eligibility for individuals seeking Medicaid based on their need for long term services and supports, eligibility groups for individuals seeking coverage of HCBS, and spousal impoverishment protections for married individuals receiving institutional care or HCBS.

Section 1902(r)(2)-based disregard authority

Section 1902 of the Social Security Act (the Act) contains two broad mandates for state Medicaid agencies in their determinations of financial eligibility for individuals who are excepted from the use of modified adjusted gross income (MAGI) methodologies.[3] First, section 1902(a)(17) of the Act requires that states use comparable financial methodologies in determining eligibility for categorical populations (e.g., individuals who are 65 years old and older, 21 years old or younger, or who have disabilities).[4] Second, section 1902(r)(2)(A) of the Act requires that states use financial methodologies in Medicaid that are no more restrictive than those applied in the most closely related cash assistance program.[5] However, section 1902(r)(2)(A) of the Act allows states to adopt income and/or resource methodologies which are less restrictive than the applicable cash assistance program. Typically, less restrictive methodologies adopted by states involve disregarding a certain amount or type of income or resources in determining applicants' and beneficiaries' countable income or resources.

CMS regulations implementing the states' authority to apply less restrictive methodologies than the corresponding cash assistance program's methodologies under section 1902(r)(2)(A) of the

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[3] Section 1902(e)(14)(A) of the Act requires that states use MAGI-based methodologies in determining financial eligibility for Medicaid, subject to the exceptions described in subparagraph (D) of the same provision. Populations excepted from MAGI-based methodologies generally include, but are not limited to, individuals who seek Medicaid on the basis of being 65 years old or older, or having blindness or a disability, individuals who seek coverage for long-term services and supports, and individuals who seek Medicaid on the basis of being "medically needy." *See* 42 C.F.R. §435.603(j).

[4] *See* section 1905(a).

[5] Certain states have elected the authority provided under section 1902(f) of the Act to apply financial methodologies more restrictive than the SSI program in determining eligibility for individuals 65 years old or older or who have blindness or a disability, subject to certain conditions. *See* 42 C.F.R. §435.121. These states are referred to as "209(b)" states, after the provision of the Social Security Act Amendments of 1972, Pub. L. No. 92-603, section 209(b), which enacted what became codified at 1902(f) of the Act.

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Act require that such less restrictive methodologies be comparable for all individuals in an eligibility group, consistent with section 1902(a)(17) of the Act.[6] In other words, targeting disregards at selected individuals in the same group is not permitted. For example, if a state elects to disregard $100 in income for individuals seeking coverage under an eligibility group for individuals 65 years old and older, $100 must be disregarded in determining the income eligibility of all 65 and older individuals applying for the group.[7]

Individuals eligible for the "217" group

In operating HCBS programs authorized under section 1915(c) of the Act, states commonly extend eligibility to individuals described in section 1902(a)(10)(A)(ii)(VI) of the Act. This section authorizes Medicaid coverage for individuals who: would be eligible for Medicaid if they were in a medical institution; would require an institutional level of care in the absence of the provision of HCBS; and will receive 1915(c) services. This eligibility group is further described in 42 C.F.R. §435.217 and is commonly referred to as the "217 group."

Determining whether the 217 group applicants satisfy the requirement in section 1902(a)(10)(A)(ii)(VI) of the Act that they "would be eligible . . . if they were in a medical institution" involves the hypothetical assumption that the applicant *is* in an institution and the concomitant identification of an eligibility group under which the individual would be eligible under the state's plan assuming such institutional status.[8] Treating a 217 group applicant as institutionalized can facilitate eligibility because: (1) the income standards of eligibility groups for institutionalized individuals covered under a state's plan may be higher than those serving noninstitutionalized individuals; and (2) the income and resources of other individuals (i.e., a spouse or parent) are not included in an institutionalized individual's eligibility determination.[9]

In order to adopt a 217 group, the state selects a group that is already covered under the state plan. We refer to this group as the "principal group." The principal group is identified in the state's section 1915(c) waiver. [10] In evaluating an applicant's financial eligibility for the 217 group, his or her income and resources are determined based on the hypothetical assumption that the applicant is institutionalized and then compared to the income and resource standards of the principal group.

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[6] *See* 42 C.F.R. § 435.601(d)(4).
[7] Id.
[8] *See* 50 F.R. 10013, 10016-17 (March 13, 1985).
[9] Id., at 10020-21.
[10] "CMS Application for a §1915(c) Home and Community-Based Waiver [Version 3.5, Includes Changes Implemented through November 2014], Instructions, Technical Guide, and Review Criteria," pages 81-83 (Release Date: January 2015).

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For example, many states that cover the 217 group also cover the "special income level group" (the SIL group) for institutionalized individuals, described in section 1902(a)(10)(A)(ii)(V) of the Act and 42 C.F.R. § 435.236. States establish the income eligibility for the SIL group, which may be up to 300 percent of the supplemental security income federal benefit rate (SSI FBR) ($2,382 a month in 2021).[11] This means that, for an individual seeking Medicaid through the 217 group in a state that: (1) has selected the SIL group as the principal group in its section 1915(c) waiver, and (2) has elected an income standard of 300 percent of the SSI FBR for the SIL group, the individual can have income up to 300 percent of the SSI FBR and be income-eligible for the 217 group (as the individual would be income-eligible under the principal SIL group if institutionalized). If the individual meets the other eligibility requirements for coverage under the 217 group (e.g., meets the level of care defined by the state and resource standard), then the individual can receive HCBS covered under the state's 1915(c) waiver.

Historically, CMS has required that states use not only the same income and resource standards of the principal group to determine eligibility for a 217 group applicant, but the same financial methodologies as well.[12] In practice, this has meant that states have applied section 1902(r)(2)-authorized disregards to the 217 group only to the extent that the same disregards are applied in determining eligibility for the principal group.

The spousal impoverishment rules

Section 1924 of the Act, commonly referred to as the "spousal impoverishment statute," requires that financial eligibility determinations for "institutionalized" spouses be determined consistent with the spousal impoverishment statute's methodology. Section 1924(h)(1) of the Act defines an "institutionalized spouse" as a married individual who is in a medical institution or, at state option, is eligible for the 217 group, and is married to an individual who is not in a medical institution or nursing facility. However, section 2404 of the Affordable Care Act (ACA), as amended by the Consolidated Appropriations Act, 2021, P.L. 116-260,[13] requires that section 1924(h)(1)'s definition of an "institutionalized spouse" include, through September 30, 2023, married individuals who are in need of HCBS authorized under section 1915(c), (i), or (k) of the Act, or a comparable package of HCBS available under section 1115 authority.

The spousal impoverishment statute generally ensures that the "community spouse" of an institutionalized beneficiary is permitted to keep a share of the couple's combined income and resources to meet the individual's own community needs, up to certain maximum standards established under section 1924(c) of the Act. In determining the amount of the couple's combined resources to set aside for a community spouse (referred to as the "community spouse resource allowance," or CSRA), the spousal impoverishment statute requires that all resources

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[11] Sections 1902(a)(10)(A)(ii)(V) and 1903(f)(4)(B) of the Act.
[12] *See* 50 F.R., at 10021.
[13] *See* Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Division H, Title II, Section 205(a) ("Extension of the spousal impoverishment protections").

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owned by either spouse, jointly or solely, be pooled. The CSRA is then subtracted from this amount and the remainder is deemed to be available to the institutionalized spouse and counted in determining whether the value of his or her resources is at or below the resource standard for eligibility.

Targeting disregards on the basis of need for certain HCBS

The construction rule directs that nothing in certain statutory provisions, including section 1902(a)(17) of the Act, "shall be construed as prohibiting a state from applying an income or resource disregard" under the authority of section 1902(r)(2)(A) of the Act "on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act or under section 1115 of such Act."

As described above, CMS's regulation implementing section 1902(r)(2)(A) of the Act requires that income and resource disregards adopted by a state must be comparable for (i.e., applied to all) individuals seeking coverage under a given eligibility group. CMS interprets the construction rule to create a narrow exception to that rule, such that states may target income and resource disregards at individuals within an eligibility group based on their need for certain HCBS described in sections 1915(c), (d), (i) and (k) or authorized under a section 1115 demonstration.

For example, if a state covers the optional categorically needy eligibility group authorized in section 1902(a)(10)(A)(ii)(X) of the Act, which serves individuals who have incomes up to the federal poverty level (FPL) and who are either 65 years old or older or have disabilities ("FPL group for individuals age 65 and older or who have a disability"), a state could apply an income and/or resource disregard in determining financial eligibility for the group exclusively to those individuals 65 or older who have a need for 1915(c), (i), or (k) services, or HCBS authorized under a section 1115 demonstration. Similarly, in a state that covers the medically needy, as authorized in section 1902(a)(10)(C) of the Act, the state could target an income or resource disregard at all prospective medically needy individuals who need the HCBS described in the construction rule, or even more narrowly at medically needy individuals who need HCBS and who are, for example, 65 years old and older, or under the age of 21.

CMS also interprets the construction rule to permit states to target a disregard based on an individual's need for a particular HCBS. For example, in a state that operates a 1915(c) waiver and also offers coverage for both 1915(i) and (k) services, the state could limit application of the disregard to individuals who need 1915(i) services. Furthermore, if a state operates multiple 1915(i) benefits, it could choose to apply a disregard exclusively for individuals who need one of the 1915(i) benefits. We also note that CMS has long permitted states to disregard types of income or resources, income or resources used or set aside for a particular purpose, or the

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income and resources of a spouse. Per the construction rule, such disregards also may be targeted to individuals receiving HCBS or particular HCBS.[14]

We note that the construction rule refers to an individual's "need" for HCBS available under various authorities. Generally, CMS would consider it reasonable for a state to define "need" in terms of satisfying the eligibility requirements for these services; i.e., based on an individual meeting the level-of-care and coverage criteria applicable to the relevant HCBS. In the context of 1915(c) services, however, an individual's eligibility to receive such services is contingent not only on the individual meeting the level of care and coverage eligibility criteria, but also on the availability of a slot in the relevant 1915(c) waiver. It would be permissible for states to target a disregard at individuals who need 1915(c) services; i.e., individuals who meet the level-of-care and coverage criteria for a 1915(c) waiver, but may not be enrolled in and receiving those services because of a waiting list for available waiver slots.

For example, in a state that covers the 217 group in a 1915(c) waiver and uses the SIL group as the principal group (and has selected 300 percent of the SSI FBR as the income standard), an individual who meets the financial eligibility requirements for the 217 group and the clinical and coverage requirements for the waiver is ineligible for Medicaid so long as the individual is on a waiting list for the waiver and is not eligible under a separate group. This is because, as noted above, an eligibility requirement for the 217 group is that the individual will receive 1915(c) services; i.e., that there is a slot in a 1915(c) waiver in which the individual will be placed and through which the individual will receive coverage for 1915(c) services that have been included in an individual's approved plan of care.

However, an individual could still qualify for Medicaid coverage under certain circumstances. Specifically, if a state separately covers under its state plan the FPL group for individuals age 65 and older or who have a disability and elect to apply to this group, under the authority of the construction rule, an income disregard above the FPL and below 300 percent of the SSI FBR for all individuals who meet the level-of-care criteria for the relevant 1915(c) waiver. In this instance, individuals who meet such criteria but are on the waiting list for the 1915(c) waiver and who otherwise would be eligible under the 217 group can alternatively qualify for Medicaid in the FPL group for individuals age 65 and older or who have a disability and will receive coverage for other state plan services, possibly including home health care services, personal care services, and 1915(i) services (if otherwise available under the state plan) while the individual is on the waiting list for the 1915(c) waiver.

Targeting less restrictive income and resource disregards at the 217 group

[14] *See* "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources Questions and Answers," May 11, 2001, at page 6, 7.

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As noted above, CMS has historically required states to apply section 1902(r)(2)-authorized disregards to the 217 group to the same extent they are applied in determining eligibility for the principal group.[15] However, the construction rule directs that nothing in sections 1902(a)(17) or 1924 of the Act or section 2404 of the ACA shall be construed to prohibit a state from applying income or resource disregards to an individual "described in section 1902(a)(10)(A)(ii)(VI) of the Act" (i.e., the 217 group) or such individual's spouse.

Section 1902(r)(2) of the Act authorizes states to apply income or resource disregards to, among others, individuals described in section 1902(a)(10)(A)(ii) of the Act, of which the 217 group is a part. Furthermore, the implementing regulation at 42 CFR 435.601(d)(1)(ii) authorizes the use of less restrictive income and resource methodologies to "[o]ptional categorically needy individuals under groups established under . . . section 1902(a)(10)(A)(ii) of the Act." Neither the statute nor regulation limit application of income or resource disregards in determining eligibility for the 217 group.[16] While it has been the historical CMS policy to limit less restrictive methodologies for the 217 group to the extent of their application to the principal group, this policy was not mandated by the plain language of section 1902(r)(2) of the Act.

While neither sections 1902(a)(17) nor 1924 of the Act have imposed a barrier on a state's targeting of income or resource disregards at the 217 group, we interpret the specific reference in the construction rule regarding the use of section 1902(r)(2)-based disregards and the 217 group to confirm the states' authority to do so. Accordingly, states may now apply less restrictive methodologies, including income and resource disregards, exclusively to individuals seeking eligibility for a 217 group, even if such less restrictive methodologies are not applied to the principal group for which the individual would be eligible if living in an institution.[17]

As noted above, the language in the construction rule relating to the 217 group specifically references the "disregard of the income or resources of [the 217 group enrollee's] spouse." Generally, the income and resources of other third parties are not deemed available to (and therefore would have no need under the authority of section 1902(r)(2) of the Act to be disregarded for) 217 group applicants and enrollees. However, where a married individual who is a 217 group applicant or enrollee is considered an "institutionalized spouse,"[18] as defined under section 1924(h)(1), states must include the community spouse's resources in the married 217 group applicant's financial eligibility determination, consistent with the resource eligibility

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[15] *See* "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources Questions and Answers," May 11, 2001, at page 22.
[16] 42 C.F.R. § 435.601(d)(1)(ii).
[17] Disregards that apply to a principal group will continue to apply to the 217 group. As noted further in this letter, states will need to submit state plan amendments to exercise the authority provided by the rule of construction provision. However, as it relates to the 217 group, such amendments will only be necessary for disregards that states wish to target exclusively at the 217 group.
[18] *See* footnote 10, above.

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formula mandated by section 1924(c) of the Act.[19] In determining resource eligibility under the spousal impoverishment statute, however, for a married 217 group enrollee, CMS interprets the construction rule to permit the disregard of a community spouse's resources. In other words, in pooling the spouses' resources for a 217 group applicant or beneficiary under the spousal impoverishment rules, states can elect to disregard all or a portion of the resources of the community spouse under section 1902(r)(2)(A) of the Act.

The same outcome may now be achieved for married medically needy individuals. Prior to the ACA's mandatory application of the spousal impoverishment rules for married 1915(c) waiver participants, states could permit the spouses of medically needy 1915(c) waiver participants to keep more resources than otherwise permitted under section 1924(c) of the Act. Section 1915(c)(3) permits a waiver of section 1902(a)(10)(C)(i)(III) of the Act, which governs the income and resource methodology rules for the medically needy, and therefore permits states to apply institutional deeming rules to married individuals (i.e., not count the community spouse's income or resources) who seek to participate in 1915(c) waivers as medically needy.[20]

Thus, before the ACA's enactment, if a married individual seeking section 1915(c) services as a medically needy individual in a 1915(c) waiver in which section 1902(a)(10)(C)(iii) of the Act had been waived, only the resources (and income) in the name of the married applicant would be included in his or her financial eligibility determination; resources exclusively in the other spouse's name, even if in total exceeding the CSRA, would not be deemed available to the married applicant.

However, by mandatory application of the spousal impoverishment rules, the resource eligibility determination requires that all of the resources owned by either spouse, separately or jointly, be pooled, and the amount exceeding the CSRA deemed available to the "institutionalized" spouse. CMS is aware that a few states preferred the pre-ACA method of effectively permitting a couple to keep all resources when one spouse needs 1915(c) waiver services, but that options for accomplishing this have generally been unavailable, with both the ACA's spousal impoverishment provision being in effect and there being no exceptions to the comparability mandate in a state's use of 1902(r)(2)-based disregards. Now, however, the construction rule permits the targeting of resource (and income) disregards at married medically needy individuals who are eligible for 1915(c) (or other HCBS) services, such that states may ultimately permit such couples to keep all resources.

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[19] Section 1924(a)(1) of the Act mandates that its provisions supersede other provisions of the Medicaid statute that are inconsistent with the former. While not relevant here, CMS has opined that section 1924 of the Act does not supersede section 1902(e)(14)(A) of the Act, which mandates the use of MAGI income methodologies for certain Medicaid eligibility populations. *See* SMDL #15-001, "Affordable Care Act's Amendments to the Spousal Impoverishment Statute," pages 5-6.
[20] *See* 50 F.R. at 10021.

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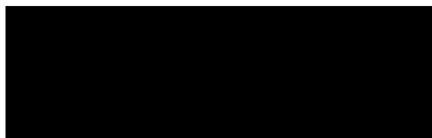
Other related provisions of federal law

As noted, the construction rule that is the subject of this letter is contained in several recently-enacted federal laws.[21] Also included as a component of this construction rule in some of these federal laws, and independently in others, is additional language referring to home and community-based services and spousal-related income and asset disregards for individuals who qualify for Medicaid by reducing their income based on their incurred medical or remedial care expenses.[22] This letter does not address those provisions, and CMS continues to review their impact on program policies.

Conclusion

States that are interested in electing the new flexibility authorized by the construction rule must submit a state plan amendment in order to effectuate a new income or resource disregard. CMS is prepared to offer technical assistance to states that are interested. Questions about this letter may be directed to Gene Coffey, Technical Director, Division of Medicaid Eligibility Policy, CMCS, at Gene.Coffey@cms.hhs.gov.

Sincerely,



Daniel Tsai
Deputy Administrator and Director

[21] *See* Footnote 1, above.

[22] *See* Medicaid Extenders Act of 2019, Pub. L. No. 116-3, Section 3(b)(1); Medicaid Services Investment and Accountability Act of 2019, Pub. L. No. 116-16, Section 2(b)(1); Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Division N, Title I, Section 204(b)(2); Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, Division A, Title III, Subtitle E, Part II, Section 3812(b)(2); Continuing Appropriations Act, 2021, Pub. L. No. 116-159, Division C, Title III, Section 2302(b)(2); Further Continuing Appropriations Act, 2021, and Other Extensions Act, Pub. L. No. 116-215, Division B, Title I, Section 1105(b)(2); Consolidated Appropriations Act, 2021 Pub. L. No. 116-260, Division H, Title II, Section 205(b)(2).

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