

## New or Noteworthy CMS Medicaid FAQs (as of June 30, 2020)

The following document highlights various [new FAQs](#) as well as some older FAQs listed in CMS' "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies," that may be of interest to PCAs and health centers.

- The complete FAQ document can be found here: <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>.
- The new FAQs can be found here: <https://www.medicaid.gov/state-resource-center/downloads/covid-19-new-faqs.pdf>.
- **Should states consider adjustments to their managed care contract quality measurement requirements to account for the changes in clinical practice resulting from the COVID-19 public health emergency? (Pages 82-83)**

CMS recognizes that the current COVID-19 pandemic is likely to affect clinical practices, and the timely and accurate reporting of quality data such that states may need or want to revise their contractual quality measurement requirements. Below are some of the common ways states implement and incentivize quality measurement in their managed care programs and issues to consider during this public health emergency.

- **Withholds:** Under 42 C.F.R. § 438.6(b)(3), states can implement a withhold, where a portion of a capitation rate is withheld from a managed care plan (MCO, PIHP, or PAHP) and a portion of or all of the withheld amount will be paid to the managed care plan for meeting targets specified in the contract. Withhold arrangements are frequently linked to quality performance measures or quality-based outcomes. CMS **strongly advises** states to work with their actuaries and their quality measurement staff to determine if any changes are needed to the data, assumptions and methodologies used to assess the ability to accurately trend the quality measurement data and to determine the portion of the withhold that is reasonably achievable. Should states believe a change or elimination of a contractual withhold arrangement is warranted due to the COVID-19 emergency, the state must submit a contract amendment and, depending on the nature of the change, a rate certification amendment.
- **Incentives:** Under 42 C.F.R. § 438.6(b)(2), states can implement an incentive arrangement, as long as total payment under the contract is not in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement. An incentive arrangement is an amount over and above the capitation rates the managed care plan was paid for meeting targets specified in the contract. Incentive payments are **in addition** to the actuarially sound capitation rates, so while changes in clinical protocols or access are likely to affect a plan's ability to earn the incentive payment, they do not affect the actuarial soundness of the underlying rates. States may elect to reexamine the specified targets for plans to earn the incentive payment; if a state chooses to do this, the state must submit a contract amendment and depending on the nature of the change, a rate certification amendment.
- **State-Directed Payments:** Under 42 C.F.R. § 438.6(c), states are prohibited from directing how a managed care plan pays its providers except for those payment methodologies that have been

approved and reviewed by CMS to be in compliance with 42 C.F.R. § 438.6(c). For states that have approved directed payment proposals for this rating period that condition payment to providers upon performance on specific quality measures, states may want to reexamine these payment arrangements to determine if changes are necessary or desired in light of the COVID-19 emergency. If a state determines changes are necessary, states will need to submit an amended directed payment preprint and, depending on the nature of the change(s), contract and rate certification amendments.

- **General Contract Requirements and Penalties:** In addition to the examples provided above, states may have several other contract requirements related to plan performance or quality measures, such as quality assessment and performance improvement (QAPI) requirements. Some of these requirements may result in penalties imposed on the plan(s) for failing to meet a certain performance level. It is within state discretion to revise their contracts to remove or lessen such penalties; however, states will need to submit contract amendments to reflect any revisions. Depending on the nature of the change, a rate certification amendment may be needed if such changes are expected to have a material impact on the actuarially certified rates.

CMS is working to prioritize and expedite reviews of COVID-19 related managed care actions. All managed care actions (contract amendments, rate amendments, state-directed preprints) needed to respond to COVID-19 should be submitted as soon as possible to [CMCSManagedCareCOVID19@cms.hhs.gov](mailto:CMCSManagedCareCOVID19@cms.hhs.gov).

- **What is the coverage period for the uninsured COVID-19 testing eligibility group, the new optional group authorized by sections 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Social Security Act? (Pages 6-7)**

Coverage for this optional Medicaid eligibility group begins no earlier than March 18, 2020 and terminates at the end of the PHE. States that want to take advantage of the 6.2% increase in the Federal Medical Assistance Percentage (FMAP) under section 6008 of the Families First Coronavirus Response Act (FFCRA), Pub L. No. 116-127 (2020) may need to keep this group enrolled until the end of the month in which the PHE period ends in order to comply with the conditions in section 6008(b)(3) of that legislation. However, the limited coverage for which this group is eligible also terminates at the end of the PHE (per statute), so states do not need to provide this group with any coverage after the PHE ends, even if they keep members of this group enrolled in order to comply with section 6008(b)(3) of the FFCRA. States may elect the COVID-19 testing eligibility group by completing the appropriate section of the Medicaid disaster relief SPA template, which can be found [here](#). The SPA is submitted to the relevant CMS SPA Mailbox for the state.

- **Will the receipt of testing or treatment for COVID-19 paid for by Medicaid or CHIP be considered a negative factor in a public charge determination? (Pages 18-19)**

No. U.S. Citizenship and Immigration Services (USCIS) has stated that it will not consider testing, treatment, or preventative care services (including vaccines, if a vaccine becomes available) related to COVID-19 as part of a public charge inadmissibility determination, even if such services are provided or paid for by public benefits as defined in DHS regulations at 8 C.F.R. §212.21(b), including Medicaid. See USCIS's website for more detail [here](#).

CHIP is not considered a public benefit for purposes of a public charge inadmissibility determination. Thus, testing or treatment for COVID-19 provided for or paid for by CHIP will also not be considered in a public charge determination.

States are encouraged to provide the information above to noncitizen applicants and beneficiaries so they have the information necessary to make decisions regarding testing and treatment for COVID-19. For additional information, about the Public Charge Final Rule issued on August 14, 2019, including policy related to COVID-19 testing, treatment or preventative services, states may refer individuals to [USCIS's website](#).

- **How do the Medicaid flexibilities around use of telehealth as a service delivery mode interact with Medicare and commercial third party liability (TPL) requirements, which may be less flexible around telehealth? For example, a Medicare or commercial payer may require a face-to-face physician visit to order care or supplies. (Page 36)**

Please note that Medicare has recently increased flexibilities related to telehealth due to the public health emergency, as summarized in this [fact sheet](#). While Medicare and commercial payers have increased flexibilities for telehealth, there may still be instances where coordination of benefits is necessary.

Medicaid payment allows for state plan flexibilities in the event Medicare or a commercial insurer denies payment. If the third party denied the claim for a substantive reason (e.g., service not covered) and the service is covered under the Medicaid state plan, Medicaid would review for payment accordingly. If at a later time, the state is made aware of a third party's coverage for these specific services, the state, as it currently does, would chase recovery of payment accordingly. Therefore, in the example above, once Medicare or a commercial payer reviews a claim and denies for a substantive reason, such as face-to-face physician visit requirement, Medicaid would review and pay according to the state plan. If telehealth is permitted under the Medicaid state plan, Medicaid would pay accordingly.

- **What is the difference between the funds available to reimburse providers for COVID-19 testing and treatment services furnished to uninsured individuals through the Health Resources and Services Administration (HRSA) and the funds available through the Families First Coronavirus Response Act (FFCRA) to provide Medicaid coverage of COVID-19 testing services for uninsured individuals? (Pages 58-59)**

The new optional COVID-19 testing eligibility group, added by section 6004(a)(3) of the FFCRA at section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act, is similar to other optional eligibility groups under which states can elect to furnish a targeted set of benefits to eligible individuals. To reimburse providers for the covered services, a state must elect to adopt this group under its state plan. States that do so can then reimburse providers enrolled in their Medicaid program for in vitro diagnostic testing and other COVID-19 testing-related services furnished to individuals whom the agency has determined are eligible under the new group. For more information on the eligibility requirements for the optional COVID-19 testing eligibility group, covered benefits, the availability of hospital presumptive eligibility for the new group, and the availability of 100 percent FMAP for the testing services provided to individuals eligible under the optional COVID-19 testing eligibility group, see [here](#).

The Health Resources and Services Administration (HRSA) is administering a separate program, referred to as the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program (COVID-19 Claims Reimbursement for Testing and Treatment of the Uninsured). This program provides reimbursement directly to eligible providers for uninsured individuals and has two components:

1. Reimbursement for COVID-19 testing services: This component, authorized via the FFCRA and the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139) (PPPHCA), reimburses providers for conducting COVID-19 testing for uninsured individuals. The FFCRA and the PPPHCA each appropriated funding for this purpose.
2. Reimbursement for COVID-19 treatment services: This component is authorized via the CARES Act and PPPHCA, which provide funds for hospitals and other health care providers, including those on the front lines of the COVID-19 response. A portion of this funding is being used to support healthcare-related expenses attributable to the treatment of uninsured individuals with COVID-19.

To access these funds, health care providers must enroll in the program as a provider participant. Once they have done so, they can submit claims for direct reimbursement for COVID-19 testing and treatment services furnished to uninsured individuals on or after February 4, 2020. Additional information on the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program can be found on [HRSA's website](#).

Note that individuals who are enrolled in a state's Medicaid program, including otherwise uninsured individuals enrolled in the new optional COVID-19 testing eligibility group, are not considered uninsured for purposes of provider reimbursement of COVID-19 testing services through the HRSA-administered program. However, providers can submit claims through the HRSA-administered program for COVID-19 treatment services provided to individuals who are enrolled in the new optional COVID-19 testing eligibility group but who do not have any health care coverage for treatment services.

- **What steps should a provider take to ensure its claims for COVID-19 testing are paid using the appropriate federal funding source, Medicaid or HRSA's COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program? (Page 59)**

In most cases, providers can utilize the Medicaid Eligibility Verification System (MEVS) to verify if an individual is enrolled under Medicaid. This may include the new optional COVID-19 testing eligibility group in states that have adopted this new group. If an individual is not enrolled in the Medicaid COVID-19 testing eligibility group and is otherwise uninsured at the time of services, a participating provider may file a claim with the HRSA-administered program for COVID-19 testing services furnished to the individual as long as the services provided meet the [coverage](#) and [billing](#) requirements established as part of the program.

- **How will HRSA operationalize coordination of benefits with Medicaid for the new optional COVID-19 testing group? (Pages 59-60)**

Individuals with Medicaid coverage of COVID-19 testing and testing-related services are not eligible for coverage of testing and testing-related services through the COVID-19 Claims Reimbursement

Program. To ensure appropriate billing, HRSA will coordinate benefits between the COVID-19 Claims Reimbursement Program and Medicaid, via HRSA's claims contractor, UnitedHealth Group (UHG). UHG will perform third party clearances at the initial receipt of a claim and conduct retrospective reviews periodically. If UHG has paid a claim for COVID-19 testing or testing-related services but determines that the individual to whom the services were furnished is eligible for and enrolled in Medicaid (including in the new optional COVID-19 testing group) with coverage effective dates that include the relevant date(s) of service, UHG will recover HRSA's claims payment(s) from the provider and will advise the provider to bill Medicaid, as primary payer. Providers may submit claims through the HRSA-administered program for COVID-19 treatment services provided to otherwise uninsured individuals who are enrolled in the new optional COVID-19 testing eligibility group but who do not have coverage for treatment services.

- **If the State Medicaid agency later determines the existence of a liable third party for an individual enrolled in the new optional COVID-19 testing group who received testing services, will States need to follow coordination of benefits requirements? (Page 60)**

Yes, once an individual becomes Medicaid eligible, including Medicaid coverage received under the new optional COVID-19 testing group, the state must take steps to coordinate benefits with all identified liable third parties that pay primary to Medicaid, pursuant to generally applicable requirements for coordination of benefits/third party liability (COB/TPL). Examples of benefits/third parties subject to COB/TPL for health coverage include employer sponsored health plans, Medicare, and commercial/private insurers. If after Medicaid has paid, a liable third party is identified, the state must seek recovery of Medicaid payment(s). Pursuing payment of claims ensures Medicaid remains payer of last resort (see 42 C.F.R. § 433.139). Because Medicaid pays primary to the HRSA-administered COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured Program (COVID-19 Claims Reimbursement Program), states are not responsible for initiating COB/TPL processes to identify payment from that HRSA-administered program. See Question 3 regarding COB between Medicaid and the COVID-19 Claims Reimbursement Program.

- **Can CMS provide further guidance on the type of interim payment arrangements that are permissible under the state plan? (Pages 66-67)**

As discussed in Section IV. Financing, Question B.1, under state plan authority, states can submit a SPA to add an interim payment methodology that says, under certain specified conditions, states will make interim payments on a periodic, lump sum basis to qualifying providers during the public health emergency period. Such periodic, lump sum interim payments to providers would be in lieu of payments based on individual claims, with a reconciliation to actual services furnished to occur at the end of a defined interim payment period. During the interim payment period, the provider would continue to submit claims for the services it provides, and the state would adjudicate the claims to determine eligibility and coverage; however, no actual payments would be remitted to the providers based on those claims, which would be subtracted from the interim payment amounts to determine the balance due from (or to) the provider upon reconciliation.

Interim payment amounts could be set using the current state plan rate and anticipated utilization during the interim payment period. Regardless of whether prior period utilization is used as a reasonable proxy for current utilization during the interim payment period, we expect that providers (identified by the state in their SPA) receiving interim payments would continue to furnish services to Medicaid beneficiaries during the interim payment period and would not limit access to care. Interim

payments are not a prepayment for services, meaning interim payments in a payment period do not represent payments for services in future payment periods. At the end of the defined interim payment period, for each provider, the state reconciles the interim payments to the amounts that would have been received for the billed claims for services provided to Medicaid beneficiaries. Any interim payments in excess of what the claims payments would have been are treated as provider overpayments, and the federal share of such overpayments are returned to CMS in accordance with 42 C.F.R. Part 433, Subpart F. Furthermore, the reconciliation of the interim payments to claims payment amounts are reported on the CMS-64 as prior period adjustments. The interim payment methodology does not waive applicable federal requirements, including those governing provider submissions of claims and state processing of claims in 42 C.F.R. § 447.45, or state claiming of expenditures for federal financial participation in 45 C.F.R. Part 95, Subpart A.

- **What information does a state need to include in a Medicaid disaster relief SPA to effectuate a new interim payment arrangement during the PHE? (Page 67)**

State proposals on periodic, lump sum interim payments should comprehensively specify within the SPA:

- Qualifications that providers must meet to receive interim payments in lieu of routine claims payments.
- The methodology for computing the interim payment for a qualifying provider.
- The service period interval each interim payment would represent (weekly, monthly, quarterly).
- The duration of the interim payments (e.g. the entire duration of the PHE).
- The timeframe the state will use to reconcile interim payments to actual claims data.
- An assurance that FFP related to interim payments in excess of actual claims will be returned to CMS in accordance with 42 C.F.R. Part 433, Subpart F.

CMS is available to provide technical assistance as states develop their SPAs related to interim payments.

- **Can states continue to make payments on a provider's claims for Medicaid services at the same time as the provider is receiving interim payments? (Page 68)**

No. Under the interim payment methodology, described in Section IV Financing, Question B.1, the interim payment becomes the state plan payment for services until the reconciliation occurs. To make an interim payment and a payment on a routine claim for services would result in a duplicate payment. Similarly, we note that “retainer payments” and “interim payments” are two separate payment concepts and are not to be interpreted as serving the same purpose. While retainer payments are made in the absence of care to a beneficiary, interim payments are made in advance for expected care and reconciled to payments for actual services delivered to beneficiaries.

- **How long do states have to reconcile the interim payments made during the PHE with the state plan payment rate for services? (Page 68)**

Within the SPA, the state should establish a reasonable timeframe for the reconciliation to occur. Under the interim payment methodology, described in Section IV. Financing, Question B.1, the interim payment becomes the state plan payment for services, and the reconciliation would be considered a prior period adjustment for which the time limits under 45 C.F.R. §95.7 would apply. Any

claims payments in excess of the interim payments would result in increasing prior period adjustments that are also subject to the time limits under 45 C.F.R. §95.7. If a state plan methodology pays providers via a reconciled cost methodology, payments under that methodology could continue to qualify for an exception under 45 C.F.R. §95.19(a), consistent with current CMS policy.

- **Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Services: (Pages 68 – 69)**

- a. **Are “telephonic services” provided by federally qualified health centers (FQHCs) or rural health clinics (RHCs) eligible for FFP during and immediately following a declared state of emergency?**

Yes, FFP is available for telephonic services. If a state’s approved state plan excludes FQHC/RHC services from being provided telephonically, CMS can work with the state to expedite processing of a state plan amendment to lift this restriction.

- b. **Do states need to submit a SPA if they pay the same PPS rate for telephonic services provided by FQHCs or RHCs as they pay for services delivered in-person?**

No state plan amendment is needed if the state plan does not specifically define a visit for the purpose of reimbursing FQHC services as a “face to face encounter” with an eligible provider type. If it does, and states would like to reimburse telephonically delivered services at the PPS rate, they would need to submit a SPA amending the definition of a visit.

- c. **Can states pay FQHCs and RHCs an amount less than the PPS rate on a FFS basis with an approved SPA or waiver? Additionally, if a service is provided telephonically, can the state pay the provider an amount lower than PPS for the telephonic service delivered via telehealth?**

If a service is covered within the scope of the FQHC/RHC benefit, section 1902(bb) of the Act requires a state to pay a provider using the state plan prospective payment system (PPS) rate or an alternative payment methodology (APM) that pays at least the PPS rate. For services that are not covered as part of the FQHC/RHC benefit, a state may pay providers using the state plan fee- for-service payment methodology established for that service. Rates for those services may be lower than the PPS or an APM paid for FQHC/RHC services, provided the rate is consistent with all other applicable requirements, including section 1902(a)(30)(A) of the Act. This policy applies whether a service is delivered face-to-face or telephonically.

- d. **Do states need a SPA or waiver to authorize payment for FQHC or RHC services provided off the clinic premises, including at a temporary shelter, a beneficiary’s home, or any location other than the clinic but within the boundaries of the state of emergency proclamation?**

FQHCs and RHCs generally may provide services outside the four walls of the clinic. If a state is concerned that something in its existing state plan might prevent that, CMS can work with the state to determine whether a state plan amendment might be necessary. If a state plan amendment is necessary, CMS can work with the state to expedite

processing it. We encourage states to maximize this flexibility during the emergency response to ensure necessary care is delivered within communities.

- e. **Healthcare Common Procedure Coding System (HCPCS) code G0071 is reimbursable to FQHC and RHCs for virtual communication activities, including telephone calls. Do states need to submit a SPA to activate that code?**

States do not need to submit a state plan amendment to activate HCPCS code G0071 unless the state decides to pay a rate for that code that is different from the face-to-face encounter rate approved in the Medicaid state plan.

- f. **During the PHE, how can a state temporarily increase payments to FQHCs to recognize additional costs incurred or higher cost per encounter?**

Using the Medicaid disaster template SPA, a state may propose to temporarily increase FQHC rates above the statutory PPS rates by proposing to implement a temporary alternative payment methodology (APM) under section 1902(bb)(6) of the Act. Each FQHC must individually agree to receive such an APM. The APM can be set in the form of a higher encounter rate or as an encounter rate add-on.

- **In what ways might states use the Medicaid disaster relief SPA template to increase payments to providers during the PHE? (Page 70)**

States can use the Medicaid disaster relief SPA template to increase payments to providers during the emergency period. This includes, but is not limited to: increasing payments to providers that are seeing an influx in Medicaid patients as a result of the PHE; recognizing additional costs incurred through the provision of Medicaid services to COVID-19 patients; increasing payments to recognize additional cost incurred in delivering Medicaid services, including additional staff costs and/or personal protective equipment; adjusting payments to providers to account for decreases in service utilization but an increase in cost per unit due to allocation of fixed costs or an increase in patient acuity as a result of the PHE; or increasing payments for Medicaid services delivered via telehealth to ensure that Medicaid services are delivered in a safe and economical manner. The payment increases can take the form of dollar or percentage increases to base payment rates or fee schedule amounts, rate add-ons, or supplemental payments, depending on the applicability to the state's payment methodology for the provider and service categories. Payments must comport with all applicable requirements, including those under section 1902(a)(30)(A) of the Act. SPA approvals and other COVID-19 related waiver documents may be found [here](#).

- **During the public health emergency, some providers are experiencing significant cost increases. Without knowing how much costs will increase right now, how should states approach making adjustments to Medicaid payment rates and methodologies to ensure that Medicaid costs are paid during the public health emergency period? (Page 70)**

States have flexibility to make reasonable adjustments to Medicaid payments to better align Medicaid payments with the increased cost of providing services to Medicaid beneficiaries during the PHE under the Medicaid state plan through base and supplemental payments. Such adjustments could include, but are not limited to, an increase resource utilization to account for the need for more personal protective equipment or other increased safety measures, but we would consider state's justification



for increases in payment rates during the PHE. We recognize the uncertainty and challenges states and providers are facing and will work with them on their proposals to increase Medicaid payments to help assure Medicaid patients have access to services. Payments must comport with all applicable requirements, including those under section 1902(a)(30)(A) of the Act.

- **If states have made supplemental payments to hospitals and nursing facilities in the past, can they make those payments to other provider types, including providers that are not subject to aggregate payment limits? How might those payments be structured? (Pages 70 – 71)**

States have considerable flexibility in establishing payment rates and methodologies for providers under the Medicaid state plan. Payments under the state plan must be consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area, as required under section 1902(a)(30)(A) of the Act. Unless there are limitations on provider payments otherwise specified in statute or regulation, states may make supplemental payments to providers under the Medicaid state plan. States have considerable flexibility in how these payments may be structured, but they must be consistent with section 1902(a)(30)(A) of the Act.

- **We are experiencing an outbreak in some areas of our state but not others. Can we target Medicaid payment increases to certain geographic regions? Similarly, we would like to target additional payment to certain provider types, such as safety-net providers or rural providers. Can we target Medicaid payment increases to certain providers? (Pages 71 – 72)**

Yes. Section 1902(a)(30)(A) of the Act requires that payments under the state plan must be consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. If a state determines that it is necessary to target payment increases to certain geographic regions within the state, certain safety net providers, or rural providers in order to assure access to Medicaid services, then the state may do so under the Medicaid state plan.

- **Are states permitted to time limit payment increases? If so, is it permissible to revert back to the rates in effect prior to the PHE? (Page 71)**

Yes. Authority for payment increases under the Medicaid disaster relief SPA template are time limited to the duration of the PHE. States can also choose a date prior to the end of the PHE to sunset the changes but may not choose a date after the end of the PHE using the authority granted via a section 1135 waiver. When the PHE ends, the authority for increased payments under the Medicaid disaster relief SPA will terminate and authority will revert back to the regular Medicaid state plan authority. This is the case for both disaster relief template SPAs and non-template Medicaid COVID-related SPAs submitted during the PHE under the authority granted through the section 1135 waiver. If a state wants these changes to be permanent, it would be advisable to simply make these changes through the regular SPA submission process.

- **My state had planned to increase Medicaid payments to providers prior to the public health emergency. These changes would help providers during the emergency period. Can states use the Medicaid SPA disaster relief template to implement the changes? (Pages 71 – 72)**

Yes, however, the authority for payment increases under the Medicaid disaster relief SPA template are time limited to the duration of the PHE. When the PHE ends, the authority for increased payments under the Medicaid disaster relief SPA will terminate and authority will revert back to the regular Medicaid state plan authority. If a state wants these changes to be permanent, it would be advisable to simply make these changes through the regular SPA submission process. If the state is concerned that there is not enough time to conduct public notice and other administrative procedures for the SPA in order to maintain the desired effective date, states may use the disaster relief SPA template to implement rate increases during the PHE, and submit a regular SPA prior to the end of the quarter in which the PHE ends to extend authority for the payment increase after the end of the PHE. In this way, states will have the authority to increase provider payments back to the beginning of the PHE and after the public health emergency ends.

- **If my state temporarily increases payment rates during this PHE and those increases expire at the end of the PHE are we required to conduct an access to care analysis to ensure compliance with section 1902(a)(30)(A) of the Act? (Page 72)**

No, state rate actions resulting from expiration of the Medicaid disaster relief SPA template would not require an extraordinary analysis of access to care when the PHE ends, however, states must still ensure that existing rates are sufficient to ensure beneficiary access as required under section 1902(a)(30)(A) of the Act.

- **My state is unsure of the level of resources that will be needed as this PHE continues. Would a state have authority under the state plan to increase payment rates to providers without submitting a state plan amendment, or would CMS approve general payment language in the Medicaid disaster relief SPA template? (Page 72)**

No. If a state has determined that increased payments are necessary under the Medicaid state plan during the PHE, the state must submit a SPA to modify the approved payment or payment methodology. However, states are encouraged to use the Medicaid disaster relief SPA template to submit proposed rate increases. The state should still provide sufficient information in the SPA to allow CMS and stakeholders to understand the proposed payment changes, and to verify that all applicable legal requirements are met.

- **Can a state increase provider payment to recognize higher costs of delivering care due to personal protective equipment? (Page 75)**

Yes. States may increase Medicaid and CHIP service payment rates to recognize increases in costs associated with personal protective equipment (PPE) and we encourage states to review their payment structures to determine whether such increases are warranted and would increase access to care during the public health emergency. Consistent with section 1902(a)(30)(A) of the Act, States may set Medicaid payment rates consistent with efficiency and economy and have the option of increasing service rates to incorporate PPE costs or paying an add-on to a service rate for PPE costs in instances when such equipment is necessary to deliver care to a beneficiary. PPE is not a distinct benefit under the Medicaid or CHIP programs and, therefore, payments to providers are only available when PPE is used in the delivery of a Medicaid or CHIP service. We note that regulations at 42 C.F.R. 447.15 require the Medicaid agency to limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency plus any deductible, coinsurance or

copayment required by the plan to be paid by the individual. Based on this requirement, providers are prohibited from charging beneficiaries for the cost of PPE when delivering Medicaid services.