Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Items with shorter effective periods are listed below:

1) Section E. The Direct Care Workers Payments will be effective on April 5, 2020 and will end on May 31, 2020. However, DHS requests the ability to extend the Direct Care Worker Payments for additional thirty (30) day increments with fifteen (15) day notice to CMS.

2) Section D. Management & Evaluation will be effective on April 13, 2020, through the end of the national emergency.

3) Section D. COVID-19 screening services and use of mobile clinics will be effective on March 31, 2020, through the end of the national emergency.

4) Section D. Parental Consult Services will be effective on March 20, 2020, through the end of the national emergency.

5) Section D. Virtual Check-in Service will be effective on March 18, 2020, through the end of the national emergency.

6) Section D. Well Check services will be effective on April 5, 2020, through and will end on May 31, 2020. However, DHS requests the ability to extend the well check service for additional thirty (30) day increments with 15-day notice to CMS.

7) Section E. Day Habilitation Enhanced Payments for EIDTs and ADDTs will be effective on April 5, 2020 and will end on May 31, 2020. However, DHS requests the ability to extend the Enhanced Payments for additional thirty (30) day increments with 15-day notice to CMS.

8) Section G. Prior Approval relaxations will be effective April 15, 2020.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

xxx The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. XXX SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. xxx Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. _____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

b. _____ The agency uses a simplified online application.

c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. XXXX The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

For all Medicaid eligibility groups, deductibles, cost sharing, copayments and coinsurance are waived for any services associated with the diagnosis or treatment of COVID-19.

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

   a. _____ All beneficiaries

   b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. XXXX The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. XXX The agency makes the following adjustments to benefits currently covered in the state plan:

Management and Evaluation service for adults with serious mental illness who have received an independent assessment and are eligible to receive services under the 1915(i) Adult Behavioral Health Services for Community Integration (ABSCI). Providers of Management and Evaluation

services are Outpatient Behavioral Health Agencies. Beneficiaries are eligible to receive one evaluation and management contact per day, up to five contacts per week. The contacts may be provided in the home or using telemedicine. Each contact is reimbursed at $15.00.

Well Check service for children and adults with developmental disabilities and delays who are receiving services in a day treatment facility and are unable to attend. The beneficiaries are eligible to receive one (2) well checks per week, one by telemedicine (including telephone) and one face-to-face. The well check may be provided in the home or using telemedicine. Each face-to-face contact is reimbursed at $15.00. Each telemedicine contact is reimbursed at $7.50.

COVID-19 Screening service for all eligible Medicaid beneficiaries. This service may be billed by physicians, APRNs, Rural Health Clinics, Federally Qualified Health Centers, and Hospitals, and is paid at $25.00 per screening.

Parental Consultation telemedicine service for beneficiaries receiving habilitative physical therapy, speech therapy or occupational therapy. This service must be provided with a parent or caregiver present. Providers include physical therapists and physical therapy assistants, occupational therapists and certified occupational therapy assistant, speech therapists or speech therapist assistants. The service limit is up to 15 minutes per session, one session per day. There is a maximum of 8 sessions per month. The service will pay $1.15 per minute if provided by a therapist or $1.05 per minute if provided by a therapy assistant.

Virtual Check-in service provided by telephone for any patients who are being treated for a chronic health condition or opioid or substance use disorder. This service may be provided by physicians, advanced practice registered nurses, rural health clinics, or federally qualified health clinics. The service is billed in events and cannot be provided in relation to an office visit or encounter. The service is paid at $13.33 per event.

Expand the **behavioral assistance** services provided by Outpatient Behavioral Health Agencies (OBHA) to include beneficiaries who are in the PASSE and over the age of 21.

Allow physicians, nurse practitioners, rural health clinics, federally qualified health centers, and hospitals to provide COVID-19 screening and diagnostic services in a mobile clinic setting.

Exempt physician visits, outpatient hospital visits, rural health clinic visits, and federally qualified health center visits from the twelve visit per year limit when the visit is associated with the diagnosis or treatment of COVID-19.

Exempt physician visits to a nursing home from the twelve visit her year limit.

3. XXXX The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. XXXX Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

a. XXX The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. ____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Drug Benefit:

6. XXXX The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Allow for 90-day supplies of medication at retail and mail-order pharmacies where clinically appropriate, as well as waiver of early refill requirements during public health emergencies.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. XXX The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. XXX Newly added benefits described in Section D are paid using the following methodology:

    a. XXX Published fee schedules –

    Effective date (enter date of change): March 18, 2020

    Location (list published location):
    https://humanservices.arkansas.gov/resources/response-covid-19/response-covid-19-providers

    b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. XXXX The agency increases payment rates for the following services:

Direct care services provided to beneficiaries of long-term services and supports. **Early Intervention Day Treatment and Adult Developmental Day Treatment--Day Habilitation Services**.

    a. XXXX Payment increases are targeted based on the following criteria:

Direct Care Services: The payments are dedicated to direct care workers employed or contracted by the following provider types: 1) Intermediate Care Facilities, including private and public 2) Nursing Facilities, including public and private 3) Home Health Agencies 4) Personal Care Agencies 5) Hospice 6) Assisted Living Facilities 7) Residential Care Facilities 8) Psychiatric Residential Treatment Facility

    b. Payments are increased through:

        i. XXX A supplemental payment or add-on within applicable upper payment limits:

Direct Care Services: The enhanced payments, described below, are dedicated amounts that must go directly to the direct support staff of the provider types listed who are providing direct care services to beneficiaries. The base supplemental payments will be paid per direct care worker, as follows:
a) work 20-39 hours per week---$125.00/week
b) work 40+ hours per week---$250.00/week
c) work a regularly planned split shift schedule that overlap weeks that equal or exceed 150 hours per month, not including overtime---$250.00/week

Tiered payments based on acuity of beneficiaries who have tested positive for COVID-19 and are receiving treatment will be made as follows:
a) work 0-19 hours per week--$125.00/week
b) work 20-39 hours per week--$250.00/week
c) work 40+ hours per week--$500.00/week
d) work a regularly planned split shift schedule that overlap weeks that equal or exceed 150 hours per month, not including overtime---$500.00/week

Day Habilitation Services: An additional $15.00 per day will be added for each beneficiary who is eligible to receive day habilitation services and attends, in person, an Early Intervention Day Treatment (EIDT) or Adult Developmental Day Treatment (ADDT) facility that day.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

____ Through a modification to published fee schedules –

Effective date (enter date of change): April 5, 2020—May 31, 2020

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

____ By the following factors:

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. ____ Are not otherwise paid under the Medicaid state plan;

   b. ____ Differ from payments for the same services when provided face to face;

c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

a. _____ The individual's total income

b. _____ 300 percent of the SSI federal benefit rate

c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

For the individuals receiving services under the 1915(i), the requirement for an independent assessment of need every twelve months, as found in 42 CFR 441.720, is waived for the duration of the public health emergency, and the existing service plan may be extended during that time, unless new needs are identified by the beneficiary.

Remove prior authorization requirements on the following services:
1) Certain durable medical equipment
2) Hospital Stays (MUMP reviews)
3) viscosupplementation
4) hyperalimentation services

Suspend certain licensure requirements for Early Intervention Day Treatment and Adult Developmental Day Treatment providers.

PRA Disclosure Statement

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