

ARKANSAS COVID-19 CARE CONTINUITY
SECTION 1115 DEMONSTRATION WAIVER

In response to the COVID-19 Pandemic, the State of Arkansas, Department of Human Services (DHS) proposes emergency relief as an affected state through the use of Section 1115(a) demonstration authority as outlined in the Social Security Act (the Act) to address the multi-faceted effects of the novel coronavirus (COVID-19) on the state's Medicaid Program. Arkansas is requesting flexibility in administration of the Medicaid program, utilizing waiver authority pursuant to Section 1115 of the Social Security Act. If approved, it will be referenced as the **Arkansas COVID-19 Care Continuity Initiative**.

I. DEMONSTRATION GOAL AND OBJECTIVES

Effective upon approval, the State of Arkansas seeks section 1115(a) demonstration authority to operate its Medicaid program without regard to the specific statutory or regulatory provisions (or related policy guidance) described below, in order to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.

II. DEMONSTRATION PROJECT FEATURES

Arkansas COVID 19 Care Continuity Overview

Arkansas, like other states, along with our city, county, and federal partners, has been on the front line of the COVID-19 response for our citizens. As we accumulate and analyze actionable data and best practices from other heavily impacted areas, both external and internal to the United States, one thing is clear—the existing healthcare infrastructure is not prepared to provide an adequate level of service in the event the infection rate grows substantially, and in light of increasing public health prevention measures. In addition, we recognize that it is vital to support the frontline healthcare providers by ensuring adequate and sustained capacity, even as the providers deal with staffing shortages due to illness and family caregiving, as well as financial strains on their practices due to the slowing, or even shutting down, of some service delivery methods.

Arkansas has undertaken a broad-based approach for our emergency response to COVID-19. We have implemented a variety of preventive measures in line with CDC guidance and public health best practices, such as the closing of schools and other businesses, including health care practices such as dental clinics, and restrictions on large gatherings to increase social distancing practices across the state. We also have started preparing our healthcare facilities to provide much needed capacity in anticipation of a potential influx of COVID-19 patients, and of frontline workers due to the virus. Such steps include funding for personal protective equipment, relaxed requirements to encourage the use of telemedicine, suspension of elective surgical procedures, and other measures being recommended by the CDC.

To date, Arkansas has not been hit as hard as some other states, but as of noon on the date of this submission, we have 310 confirmed infections and 2 COVID-19 related fatalities. Unfortunately, these numbers will continue to grow by the day. In addition, while numerous steps have been taken to limit unnecessary face-to face-contact, as well as provide additional capacity in our healthcare facilities, these necessary public health actions are having a devastating financial impact on those same providers we are depending on to respond to this outbreak, threatening their ability to maintain necessary service levels.

The State of Arkansas, working with providers and other stakeholders, is quickly mobilizing a plan to rapidly reconfigure our healthcare service delivery system to ensure continuation of critical medical services to those in need in the face of this new COVID-19 reality. This includes efforts to update physical facilities to meet new operational needs, add technology and logistical capabilities, and protect and maintain a provider workforce capable of delivering services.

Arkansas hopes to utilize authority granted pursuant to this application to make emergency payments to providers that will enable increased access to and safe delivery of needed health care services. In order to protect Arkansas' health care safety net, providers who serve the highest proportion of Medicaid beneficiaries will be eligible to receive more support. The intent of this request is to maintain continuity of health care services for the most vulnerable Medicaid beneficiaries and support continued economic stability for Medicaid health care providers during the COVID-19 incident.

These planned investments will not only meet the short term goal of responding to the COVID-19 crisis; but the investments proposed in this program are also smart, innovative, and forward-looking policies that, in the long term, will allow for increased access, improved service delivery, and a more robust and better trained provider workforce no matter what emergencies or disasters the future may hold. Following the end of the current COVID-19 public health emergency, it is anticipated that positive outcomes will continue to be realized from investments made in health care infrastructure, workforce training and supports, care continuity retention payments, and community connections resulting in long-term system sustainability and improved quality for Medicaid beneficiaries, health care providers, and communities.

Program Summary

The COVID-19 Care Continuity Initiative is a multifaceted program intended to empower and enable Arkansas healthcare providers to improve access, capacity, treatment modalities, and quality of care they provide to Arkansans, particularly as our citizens need it most. First and most immediately, it will equip Arkansas providers with flexibility, tools, and financial support necessary to more adequately respond to the COVID-19 pandemic--critical measures that will save lives. But this initiative is about more than just responding to the immediate need. It is also about updating restructuring the process flow of patient engagement to allow for a more modern, flexible, and efficient delivery of services, the result of which will prepare Arkansas to handle other rapid increases in healthcare treatment needs, whether it is another season of COVID, a different health emergency, or a natural disaster. In addition, the infrastructure improvements requested in this demonstration are long-term investments that will allow our providers to

improve access to treatment, services and quality of care for beneficiaries in their communities during non-emergent situations.

The COVID-19 pandemic has required Arkansas state leaders and providers to take a fresh assessment of its provider network, health care facilities, telemedicine capabilities, and social service support system. Many gaps in our continuum of care were identified. Some are gaps that we have been aware of, while others became more visible as we assessed the system in light of COVID-19.

Currently, our provider network, especially Critical Access Hospitals (CAH) and other safety net providers, are in danger of heading quickly toward a crisis point that could preclude their ability to continue operations. On one hand, we are asking them to invest financially to respond to COVID—purchasing necessary supplies and equipment, increasing isolation space in facilities, providing COVID training to their workforce, maintaining staffing levels, and enhancing sanitation and decontamination efforts. At the same time, it is a necessity that these already financially struggling safety net providers must eliminate key revenue sources, such as elective surgical procedures. Anecdotally, these providers report losing about 25% of their revenue streams weekly, jeopardizing their ability to remain operational at a time when we need them most.

In order for Arkansas to modify its service delivery system and stabilize the fragile provider network rapidly enough to address the immediate issues presented by COVID-19, the state is proposing a series of expenditure authorities under 1115 waiver authority. The public health benefits of this proposal exceed the costs.

Furthermore, it is also important to note that these immediate changes and investments also are intended to result in long-term improvements focused on (1) improving patient care, (2) reducing healthcare costs, (3) improving population health, especially in rural Arkansas.

In order to address these issues and improve Arkansas' healthcare delivery system in support of the goals outlined above, this proposed demonstration includes the following major components. (Further details about each of these payment types are provided in the subsequent sections below.)

- **Care Continuity Payments.** These include an Environmental Modification Payment, a Workforce Support and Training Payment, Care Continuity Payments for LTSS direct care workers, and a COVID-Specific In-Home Caregiver Payment Benefit for Children in Foster Care.
 - **Environmental Modification Payment.** A fixed, time-limited payment for environmental modification (the “Environmental Modification Payment”) which will be available to hospitals having 65 beds or less, and which specifically includes critical access hospitals and hospitals participating in the Small Hospital Improvement Program (“Eligible Hospitals”) and qualified independent physician practices and health care clinics (“Eligible HCCs”).

- **Workforce Support and Training Payment.** A fixed rate, time-limited payment for workforce support, safety, and training. The payment is flexible to meet the priority needs of the provider. This payment may be repeated if needed due to the continuation of the emergency.
 - **Care Continuity Payments.** A per-employee additional monthly payment for LTSS direct care workers in institutional and noninstitutional residential settings (made directly to non-physician direct care staff through providers). Payments will include direct care workers in public facilities including those in the Arkansas State Hospital, an Institution for Mental Diseases (IMD). Payment parity is important to reduce churn in the workforce.
 - **COVID-Specific In-Home Caregiver Payment Benefit for Children in Foster Care.** An additional monthly payment made to all foster caregivers (licensed foster parents, relative caregivers, and fictive kin) for providing at-home care needed to help prevent negative impacts to physical and mental health during emergency period.
 - **COVID-19 Cluster Payment for Nursing Facilities.** The Arkansas Department of Human Services (DHS) will offer a time-limited, one-time payment for emergency and ongoing expenditures for Nursing Facilities (“NFs”) that experience a cluster incident of COVID-19 infection (the “COVID-19 Cluster Payment”).
- **Screening and testing all-inclusive payment for COVID-19 for individuals who are uninsured as well as Qualified Medicare Beneficiaries (QMBs),** which supports President Trump’s commitment to provide testing at no cost to the individual. We believe this is a faster and more appropriately targeted approach than to enroll everyone into the Medicaid program. Arkansas is utilizing this waiver to elect to cover the uninsured in accordance with Section 6004(a)(3) of Public Law 111-127/ H.R.6201 - Families First Coronavirus Response Act.
 - **Community Connection Payments,** which includes **expansion of telemedicine** for licensed professionals and a **Home Delivery Benefit** that contemplates the expansion and flexibility of non-emergency transportation (NEMT) services. The intent of Community Connection Payments is to keep patients connected to their providers and community resources, keeping them healthy in their homes at a time when congregate settings must be avoided.
 - **Temporary Housing Assistance for High-Risk Homeless Population.** Allow for federal financial participation for Medicaid expenditures related to temporary housing for the homeless, which are required due to health concerns as a result of the emergency. This provision will be administered through a unit of local government.

Arkansas is requesting that to the extent the above proposals include expenditures, which may otherwise not be matchable, that they be regarded as authorized expenses under the State’s Medicaid Title XIX State plan.

Care Continuity Payments

Through this waiver, Arkansas intends to make strategic investments to ensure completion of physical facility changes to build both the short- and long-term capacity and capability of healthcare providers to safely, efficiently and effectively treat those who contract COVID-19 or similar illnesses in the future. In addition, these investments will allow providers to invest in technology infrastructure, training, and other improvements to ensure continuity of quality care for those who continue to need treatment for acute or chronic conditions.

Care Continuity Payment 1: COVID-19 Environmental Modification Payment

The Arkansas Department of Human Services (DHS) will offer a time-limited, one-time payment for environmental modifications (the “Environmental Modification Payment”) to hospitals having 65 beds or less, which specifically includes critical access hospitals (CAHs) and hospitals participating in the Small Hospital Improvement Program (the “Eligible Hospitals”), as well as qualifying independent physician clinics and primary care and certain specialty health care clinics, including federally qualified health centers (“FQHCs”) and rural health clinics (the “Eligible Clinics”). The Environmental Modification Payment shall be made available to Eligible Hospitals and Eligible Clinics to make qualifying physical changes to their facilities per the list set forth below in order to better meet the challenges presented by COVID-19.

The amount of the Environmental Modification Payment available to Eligible Hospitals and Eligible Clinics will be determined by the state, and made available for provider types as listed below:

Type of Health Care Provider
Eligible Hospital <ol style="list-style-type: none"> 1. Critical Access Hospitals 2. Small Hospital Improvement Program (SHIP) Hospitals 3. Hospitals having 65 beds or less
Eligible Clinics <ol style="list-style-type: none"> 1. Independent Physician Practices 2. Independent Rural Health Care Clinics (may not be affiliated with a hospital) 3. Behavioral Health Agencies including Community Mental Health Centers 4. Federally Qualified Health Centers (restricted to parent clinic for distribution, not each individual site)

An Eligible Hospital or an Eligible Clinic must accept Medicaid patients, and either be a state-determined safety net provider type or have a certain level of Medicaid discharges, in order to qualify for an Environmental Modification Payment. In addition, an Eligible Clinic must meet applicable licensing requirements in order to qualify for an Environmental Modification Payment. Furthermore, clinics providing primarily speech therapy, occupational therapy or

physical therapy services do not qualify for an Environmental Modification Payment. Any provider-based clinics or practices which are included in the cost reports of a hospital shall not separately qualify for an Environmental Modification Payment (in this case, only the related hospital may qualify, presuming they also meet other state requirements). DHS shall retain the authority to determine whether the health care providers described in this Application meet the requirements necessary to qualify for an Environmental Modification Payment.

The Eligible Hospitals and Eligible Clinics which are entitled to receive an Environmental Modification Payment may use the funds for any of the following suggested purposes or may propose additional improvements, not included below, for state consideration and approval prior to payment:

1. Establishing drive-through screening and testing for COVID-19;
2. Re-configuring patient intake areas to maintain social distancing and reduce the risk of COVID-19 transmission;
3. Enhancing cleaning and sanitation services beyond what would be required under normal infection control policy, and in compliance with CDC recommendations;
4. Emergency operations facility improvements;
5. Shifting to or enhancing available telemedicine services through equipment, technology, and facility upgrades; and
6. Purchase or lease of specialized equipment.

To be eligible to receive the Environmental Modification Payment, an Eligible Hospital or an Eligible Clinic shall submit to DHS a description of the infrastructure improvement(s) proposed or made to its facilities to better meet the challenge of COVID-19. The submission shall be on a form provided by DHS and shall include copies of the invoices or other documentation reflecting the proposed or actual costs incurred in making the infrastructure improvement(s). Eligible expenses must be incurred between March 1, 2020, the retroactive date of the national emergency declaration per the SMDL #20-002, and no later than 60 days after the end of the public health emergency (the "COVID-19 Demonstration Period"), and invoices or other records of the expenses incurred must be collected and retained by the Eligible Hospital or Eligible Clinic. Eligible Hospitals and Eligible Clinics will have up to 90 days following the end of the COVID-19 Demonstration Period in which to submit their Environmental Modification Payment requests.

The total amount of the Environmental Modification Payment available to Eligible Hospitals and Eligible Clinics may not exceed the maximum Environmental Modification Payment as determined by the state, even if the particular provider incurs costs in making the particular infrastructure improvement(s) in excess of the maximum amount of the Environmental Modification Payment. Eligible Hospital or Eligible Clinic may receive an Environmental Modification Payment for costs incurred in making qualifying infrastructure improvements to its facilities after the expiration of the COVID-19 Demonstration Period.

Care Continuity Payment 2: COVID-19 Workforce Support and Training Payment

The COVID-19 Workforce Support and Training Payment will be used to maintain continuity of care during and as a result of the COVID-19 pandemic. This will be a payment for maintaining

or expanding treatment capacity, changing practice patterns to increase health and safety, maintaining additional staffing, increasing cleaning, etc. Permissible uses of the Support and Training Payment include:

1. Maintaining operations by adding extended hours or additional days, or shifting scheduled hours to accommodate well vs. sick visits
2. Changing business models to expand services available (e.g. ambulatory surgical centers, CHMCs, CSUs currently cannot bill for overnight stays, but have limited beds used for longer observation. Could shift to provide overnight care - all subject to state approval).
3. Expanding in-home services (payment would be used to establish ability to change method of providing services, e.g. for equipment, connectivity, etc.)
4. Additional workforce support or training purposes suggested by providers and approved by DHS.

The Workforce Support and Training Payment is available to both types of eligible providers referenced in the Environmental Modification Payment above, as identified in Care Continuity Payment 1.

To be eligible to receive the Workforce Support and Training Payment, an Eligible Provider must submit a claim to DHS for approval of reimbursement at the state-established flat rate for the qualifying Workforce Support and Training activity. Eligible Providers must collect and retain invoices or other appropriate records of the activities conducted under this section. The provider will be required to certify the accuracy of the claim and a sample of these claims can be checked retroactively against employer licensure training or certification records filed with the state to ensure program integrity.

No Eligible Provider may receive a Workforce Support and Training Payment for costs incurred after the expiration of the COVID-19 demonstration period.

Care Continuity Payment 3: Care Continuity LTSS Direct Care Worker Payments

Care Continuity Payments will be made to providers that employ LTSS direct care workers in institutional and noninstitutional settings. This will be for all non-physician direct care workers taking care of patients directly. This payment is available to all providers who employ LTSS direct care workers, with the exception that eligible providers referenced in the Environmental Modification Payment above, as identified in Care Continuity Payment 1, are not eligible for this payment type.

The payment mechanism will be a pass-through payment, and the provider must distribute the entire amount of the payment made to the direct care workers as described in this section and must not retain any portion of the payment at the provider level. Payment will be made to help support those individuals who remain employed with the provider, including those employees who have been ordered home due to exposure or quarantine. Those employees not ordered to remain at home due to exposure or quarantine must continue to work their assigned schedule, in

order to qualify for the payments. The duration of both levels of payments will be eight (8) weeks. DHS requests the ability to extend the Direct Care Worker Payments for additional thirty (30) day increments with fifteen (15) day notice to CMS.

Because of the fluidity of the labor market for direct care workers, employees in public LTSS facilities will be eligible for payments. Payment parity is important to mitigate churn in the labor force which can unnecessarily increase costs.

Full payments will be made to employers to compensate full time employees (40 hours per week). Part time employees will receive an amount equal to 50 percent of the full-time payment. Workers providing direct care to patients being treated for COVID-19 infection will receive additional payments.

Care Continuity Payment 4: COVID-Specific In-Home Caregiver Benefit for Children in Foster Care

Children in foster care are among our most vulnerable citizens. That it is why Congress specifically included them as a mandatory Medicaid population in 42 CFR § 435.145. Children in out-of-home care have higher incidences of physical health issues and medical frailty, as well as higher levels of trauma and behavioral health challenges than their peers. Many children in out-of-home care have suffered numerous adverse childhood experience making them especially vulnerable both mentally and physically in times of high stress. It is critically important that we take extraordinary preventive measures to ensure their physical and mental health are protected.

In order to ensure that children in foster-care can be supported by their out-of-home caregivers (i.e. foster parents, relative caregivers, fictive kin) to prevent the risk of children being left unattended for long periods or left with an unknown caregiver, and to ensure as much normalcy as possible during the COVID-19 public health emergency, Arkansas is proposing that a temporary, in-home caregiver benefit for Children in Foster Care be established. This rate could be used for any current caregiver who is enrolled as a Medicaid provider. In addition, given the potential lack of available caregivers, and to ensure that foster children can be safely in their homes with someone they trust, we will establish a process to allow the child's foster parent, relative caregiver, or other approved foster home type to be compensated as an in-home caregiver for the duration of the COVID-19 Public Health Emergency.

Providing this flexibility will ensure that those foster parents and other caregivers can continue to support the health, safety and welfare of these vulnerable children while they are out of school during this high stress time.

Care Continuity Payment 5: COVID-19 Cluster Payment for Nursing Facilities

The Arkansas Department of Human Services (DHS) will offer a time-limited, one-time payment for emergency and ongoing expenditures for Nursing Facilities (“NFs”) that experience a cluster of COVID-19 infection (the “COVID-19 Cluster Payment”). The Cluster Payment shall be made

available to Eligible NFs to make qualifying expenditures for their facilities in order to better meet the challenge of COVID-19.

To be eligible to receive the COVID-19 Cluster Payment, an Eligible NF shall submit to DHS a description of the expenditures proposed or made in support of residents and staff to better meet the challenge of COVID-19. The submission shall be on a form provided by DHS and shall include copies of the invoices or other documentation reflecting the proposed or actual costs incurred in making the infrastructure improvement(s). Eligible expenses must be incurred between March 1, 2020, the retroactive date of the national emergency declaration per the SMDL #20-002, and no later than 60 days after the end of the public health emergency (“the COVID-19 Demonstration Period”), and invoices or other records of the expenses incurred must be collected and retained by the Eligible NF. Eligible NFs will have up to 90 days following the end of the COVID-19 Demonstration Period in which to submit their COVID-19 Cluster Payment requests. DHS requests the ability to extend the Direct Care Worker Payments for additional thirty (30) day increments with fifteen (15) day notice to CMS.

The total amount of the COVID-19 Cluster Payment available to Eligible NFs may not exceed the maximum COVID-19 Cluster Payment as determined by the state, even if the particular provider incurs costs in making the particular infrastructure improvement(s) in excess of the maximum amount of the COVID-19 Cluster Payment. The Eligible NF may not receive a COVID-19 Cluster Payment for costs incurred in making qualifying infrastructure improvements to its facilities after the expiration of the COVID-19 Demonstration Period.

Community Connection Payments

We are including a community connection benefit under this waiver to support the expansion of access to telemedicine, non-emergency transportation, home delivery services, community services. This is critical at a time when congregate settings must be avoided to ensure continuity of care.

There are two temporary supports being established to support delivery of services to Medicaid beneficiaries who must now receive remote or at-home services due to the COVID-19 emergency, through the following Community Connection Payments:

1. A telemedicine enhancement focused on helping small independent providers previously unequipped to offer telemedicine services obtain access to the technology and training needed to initiate serving Medicaid beneficiaries through a new modality.
2. Expanded authority to allow brokers and non-emergency transportation (NEMT) providers additional flexibility to expand the scope of reasons for which nonemergency transportation may be provided, especially in conjunction with the home delivery assistance.

Community Connection Payment 1—Telemedicine Enhancement

The Telemedicine Enhancement payment is focused on assisting small independent providers who are currently serving Medicaid beneficiaries in local communities’ transition to offering telemedicine services during the COVID-19 outbreak and continue offering these services long-

term. This will allow more people to receive quality health services via technology when such services can be effectively delivered, in lieu of visits in the traditional office setting. This reduces the number of face-to-face interactions in a congregate setting and opens access to needed services for people living in rural and super rural areas of the state. Payments can also be made for creating safe spaces in residential settings to allow for electronic visitation between residents and family members.

The Telemedicine Enhancement will allow the State to make grants to smaller community providers so that they can expand or initiate services to local communities through telemedicine. This Community Connection Payment will only be available for those providers not eligible for the Environmental Infrastructure Payment.

Community Connection Payment 2— Home Delivery Assistance

While Arkansans are trying to follow CDC and public health guidance by social distancing or self-isolating as much as possible, it is imperative that Arkansas Medicaid beneficiaries continue to have access to the treatment, services, and supports needed to maintain health and wellness. As part of our COVID response, Arkansas proposes enhancing the capability of its existing Medicaid NEMT network by allowing these providers to deliver prescription drugs, groceries, personal hygiene supplies, and hot meals. Arkansas will provide additional funding in partnership with its NEMT network to build on its existing meal and pharmacy delivery programs.

Arkansas will develop parameters for other possible qualifying payments under the Home Delivery Benefit, which may include payments to specialist providers for making home visits, payments to other Medicaid providers for providing off-site and community-accessible services, and payments to incentivize community partnerships that facilitate expanded home delivery of prescriptions, groceries, and personal hygiene supplies.

COVID-19 Screening and Testing All-inclusive payment for uninsured individuals

COVID-19 is highly contagious and can spread rapidly. The ability to quickly screen, test, and get results of those who test positive for the virus is a critical strategy for slowing the spread of the virus. With time being of the essence, Arkansas is requesting that CMS authorize a one-time payment for both COVID-19 screening and testing for uninsured individuals. In addition, this benefit will also be provided to the Qualified Medicare Beneficiaries (QMBs). This mirrors the services we are offering to current Medicaid beneficiaries, as is required by the Families First Act.

This approach is consistent with President Trump's commitment to provide testing at no cost to the individual, while providing a common infrastructure by which providers can receive reimbursement. It also allows DHS to track claims and payments for services, as well as results. We believe this approach is faster, presents fewer barriers, and is a more appropriately targeted approach than enrolling everyone into the Medicaid program for purposes of screening and testing. The state will establish a COVID-19 screening and testing code that can be used for claims not tied to a Medicaid beneficiary number.

Arkansas is utilizing this waiver to elect to cover the screening and testing of the uninsured in accordance with Section 6004(a)(3) of Public Law 111-127/ H.R.6201 - Families First Coronavirus Response Act.

The reimbursement amount for these screening and testing services will be consistent with the Arkansas Medicaid fee-for service fee schedule.

Temporary Housing Assistance for High-Risk Homeless Population

The homeless population is at very high risk for contraction of infectious disease such as COVID-19. Additionally, many homeless shelters are shutting down or finding alternative settings to prevent the spread of COVID-19 in congregate settings, leaving the homeless who rely on such shelters with no safe place to go. Given that people experiencing homelessness often utilize emergency rooms at high rates, this could also have negative consequences for our hospital capacity at a time when every hospital resource is needed to combat the public health crisis. In order to mitigate the risk and spread of infection within this population, Arkansas is requesting expenditure authority to allow federal financial participation for Medicaid expenditures related to temporary housing for the homeless due to health concerns as a result of the emergency. Eligibility will be limited to those who are Medicaid beneficiaries and meet the definition of “Homeless” as defined in 24 CFR § 578.3 and who have tested positive for COVID-19, or who indicate they may have been exposed and possibly be in the infection incubation period.

A qualifying temporary residence could include apartments, hotels, and other facilities that are suitable for use as places of temporary residence, as determined by DHS, as well as temporary designation of medical facilities for quarantining, isolating or treating individuals who test positive for COVID-19 or who are considered high-risk for exposure and possibly in the incubation period.

This provision would be administered through a Memorandum of Understanding (MOU) with a local unit of government.

A. Eligibility

Eligible populations include for this initiative include

- 1) All current eligible Medicaid populations (including those enrolled in QHPs under AR Works) included under the State’s Medicaid title XIX state plan;
- 2) All current eligible beneficiaries who receive coverage under the Arkansas Children’s Health Insurance Program (CHIP);
- 3) Individuals who are uninsured and in need COVID-19 screening/testing, provided that such screenings are completed by a qualified and appropriately licensed Medicaid provider as required by state regulation, for Screening and Testing benefit only (Arkansas

is utilizing this waiver to elect to cover the uninsured in accordance with Section 6004(a)(3) of Public Law 111-127/ H.R.6201 - Families First Coronavirus Response Act.); and

- 4) Qualified Medicare Beneficiaries (QMBs), as defined in 42 CFR 400.200 are included as an eligible population for the Community Connection Benefit as well as the COVID-19 Screening and Testing benefit only.

B. Temporary Enhanced Benefits

Screening and Testing for COVID-19

While Screening and Testing for COVID-19 is an existing Medicaid benefit, Arkansas seeks, through this 1115 waiver, to allow qualified providers to be reimbursed for conducting the screening and testing for individuals who are uninsured and for QMBs.

Community Connection Benefits

- a. Care Continuity Payment 4 - COVID-Specific In-Home Caregiver Benefit for Children in Foster Care
- b. Community Connection Payment 3 - Home Delivery Benefit
- c. COVID-19 Screening and testing for individuals who are uninsured and QMBs (Arkansas is utilizing this waiver to elect to cover the uninsured in accordance with Section 6004(a)(3) of Public Law 111-127/ H.R.6201 - Families First Coronavirus Response Act.)

Temporary Housing Assistance for High-Risk Homeless Population

As described in the section above.

C. Cost Sharing

This proposal does not seek to change any premium, enrollment fee, or similar charge, or cost sharing (including copayments and deductibles) required of individuals who will be enrolled in this demonstration that would vary from the state's current state plan or previously approved waivers currently in effect.

However, as required under the Families First Act, Arkansas will not apply copays or other cost sharing related to screening or testing for COVID-19.

D. Delivery System and Payment Rates for Services

The health care delivery system for the provision of services under this demonstration will be implemented in the same manner as under the state's current state plan, with the exception of the PASSE program (1915(b)) and the AR Works program (1115(a)), where any enhanced covered benefits will be provided as a wrap-around benefit utilizing the fee-for-service payment system.

III. EXPENDITURE AND ENROLLMENT PROJECTIONS

A. Enrollment Impact

The state projects that approximately 15,000 individuals who are currently uninsured or a QMB recipient would receive the limited benefit of COVID-19 Screening and Testing.

The state does not propose any expansion of Medicaid eligibility categories or loosening of Medicaid eligibility criteria as a result of this waiver, and therefore would not project an increase in overall enrollment related specifically to this waiver.

B. Expenditure projection

The state projects that the total aggregate expenditures under this section 1115 demonstration is estimated to be \$110 million state and federal. This is a projection, not a cap on expenditures. The federal and state governments will proportionately share the actual costs of the Demonstration.

In light of the unprecedented emergency circumstances associated with the COVID-19 pandemic and consistent with the President's proclamation that the COVID-19 outbreak constitutes a national emergency, and the time-limited nature of demonstrations that would be approved under this opportunity, we understand that the Department will not require States to submit budget neutrality calculations for Section 1115 demonstration projects designed to combat and respond to the spread of COVID-19. In general, CMS has determined that the costs to the Federal Government are likely to have otherwise been incurred and allowable. States will still be required to track expenditures and should evaluate the connection between and cost effectiveness of those expenditures and the state's response to the public health emergency in their evaluations of demonstrations approved under this opportunity.

IV. APPLICABLE TITLE XIX AUTHORITIES

The state is proposing to apply the flexibilities granted under this demonstration opportunity to the populations identified in section II.A above.

Program Title	Waiver Type	Waiver Number (Most Recent Amendment)
AR Medicaid State Plan	NA	NA
Autism Waiver	1915(c)	AR.0936.R01.00
ARChoices in Homecare	1915(c)	AR.0195.R05.01
Community and Employment Support Waiver	1915(c)	AR.0188.R05.03
Living Choices Assisted Living Waiver	1915(c)	AR.0400.R03.01
Arkansas TEFRA-like Section 1115 Demonstration	1115	11-W-00163/6
Arkansas Works Section 1115 Demonstration	1115	11-W-00287/6

Provider-Led Arkansas Shared Savings Entity (PASSE) Model	1915(b)	AR.0007.R00.01
Arkansas Dental Managed Care	1915(b)	AR.0008.R00.00
Arkansas Non-Emergency Transportation	1915(b)	AR.0003

V. PROPOSED WAIVERS AND EXPENDITURES AUTHORITIES

Expenditures:

Cost Not Otherwise Matchable (CNOM): Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items described within this application, which would not otherwise be included as matchable expenditures under section 1903, shall, for the periods of this demonstration, be regarded as matchable expenditures under the State's Medicaid title XIX state plan. These expenditures include

- a. Care Continuity Payment 1 — Environmental Modification Payments
- b. Care Continuity Payment 2 — Workforce Support and Training Payments
- c. Care Continuity Payment 3 — Care Continuity Payments
- d. Care Continuity Payment 4 — COVID-Specific In-Home Caregiver Benefit for Children in Foster Care
- e. Care Continuity Payment 5: COVID-19 Cluster Payment for Skilled Nursing Facilities
- f. Community Connection Payment 1—Telemedicine Enhancement
- g. Community Connection Payment 2— Home Delivery Benefit
- h. COVID-19 Screening and testing for individuals who are uninsured and QMBs
- i. Temporary Housing Assistance for High-Risk Homeless Population
- j. Expenditures made for beneficiaries who have had coverage extended beyond the 12-month recertification period.

DHS has the discretion to cease expenditures prior to the end of the Demonstration Period, if such efforts are no longer needed to combat the COVID-19 pandemic. However, all expenditures under this 1115 Demonstration Waiver will cease no later than ninety (90) days after the end of the Demonstration Period (unless otherwise noted).

Waivers:

Extension of Renewal/Redetermination Period: Waiver of the requirements of 42 CFR § 435.916 - Periodic renewal of Medicaid eligibility, and 42 CFR § 457.343 - Periodic renewal of CHIP eligibility insofar as it requires redeterminations to be completed once every 12 months. This request is consistent with Section 6008(b)(3) of Public Law 111-127/ H.R.6201 - Families First Coronavirus Response Act.

Reports and Reimbursement Calculations: Arkansas is requesting that any and all payments made through the Arkansas COVID-19 Care Continuity 1115 Demonstration Waiver are exempt from calculations into costs, cost reports, allowable costs or other provider reimbursement calculations. A separate set of forms will be utilized by DMS to document any expenditures and payments made through the 1115 Demonstration Project.

VI. PUBLIC NOTICE

Pursuant to 42 CFR 431.416(g), the state is exempt from conducting a state public notice and input process as set forth in 42 CFR 431.408 to expedite a decision on this section 1115 demonstration that addresses the COVID-19 public health emergency. For the information of our citizens, we will make available information regarding this waiver on a public-facing website.

VII. EVALUATION INDICATORS and ADDITIONAL APPLICATION REQUIREMENTS

- A. Evaluation Hypothesis.** The demonstration will test whether and how the waivers and expenditure authorities affected the state's response to the public health emergency, and how they affected coverage and expenditures.
- B. Final Report. This report will consolidate demonstration monitoring and evaluation requirements.** No later than one year after the end of this demonstration addressing the COVID-19 public health emergency, the state will be required to submit a consolidated monitoring and evaluation report to CMS to describe the effectiveness of this program in addressing the COVID-19 public health emergency. States will be required to track expenditures and should evaluate the connection between and cost effectiveness of those expenditures and the state's response to the public health emergency in their evaluations of demonstrations approved under this opportunity. Furthermore, states will be required to comply with reporting requirements set forth in 42 CFR 431.420 and 431.428, such as information on demonstration implementation, progress made, lessons learned, and best practices for similar situations. States will be required to track separately all expenditures associated with this demonstration, including but not limited to administrative costs and program expenditures, in accordance with instructions provided by CMS. CMS will provide additional guidance on the evaluation design, as well as on the requirements, content, structure, and submittal of the report.

VIII. STATE CONTACT AND SIGNATURE

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Authorizing Official (Signature): *Dawn Stehle*

Date: March 26, 2020