

## **Table of Contents State**

**Territory Name: Arkansas**

**State Plan Amendment (SPA) #: 20-0014**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

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



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April 15, 2020

Dawn Stehle  
Deputy Director for Health and Medicaid Director  
Arkansas Department of Human Services  
112 West 8th Street, Slot S401  
Little Rock, AR 72201-4608

Re: Arkansas State Plan Amendment (SPA) 20-0014

Dear Ms. Stehle:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) 20-0014. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

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 of the 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 this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

The State of Arkansas requested a waiver of public notice requirements applicable to the state plan amendment (SPA) submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to ABPs. These requirements help to ensure that the affected public has reasonable opportunity to comment on these SPAs. CMS recognizes that during this public health emergency, Arkansas must act expeditiously to protect and serve the general public. Therefore, under section 1135(b)(1)(C) as applicable of the Act, CMS is approving the state's request to waive these notice requirements applicable to this SPA.

These approvals under section 1135 only apply with respect to SPAs that provide or increase beneficiary access to items and services related to COVID-19 (such as cost sharing waivers, payment rate increases, or amendments to ABPs to add services or providers) and that would not restrict or limit payment or services or otherwise burden beneficiaries and providers, and that are temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 emergency (or any extension thereof). Even though CMS is approving this waiver, we encourage the state to make all relevant information available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that Arkansas' Medicaid SPA Transmittal Number 20-0014 is approved effective April 5, 2020. Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Michala Walker at 816-426-6503 or by email at [michala.walker@cms.hhs.gov](mailto:michala.walker@cms.hhs.gov) if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Arkansas and the health care community.


Sincerely,

Anne M.  
Costello -S

Digitally signed by Anne  
M. Costello -S  
Date: 2020.04.15  
10:42:31 -04'00'

Anne Marie Costello  
Deputy Director  
Center for Medicaid & CHIP Services

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER  2 0 — 0 0 1 4	2. STATE  <b>Arkansas</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE  April 5, 2020 *	
		5. TYPE OF PLAN MATERIAL ( <i>Check One</i> )  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION  1902		7. FEDERAL BUDGET IMPACT a. FFY <u>20</u> \$ <u>\$55.00</u> million b. FFY _____ \$ _____	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  7.5 (new page)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> )	
10. SUBJECT OF AMENDMENT  Disaster SPA for COVID-19: Direct Care Worker Payments for Long Term Services and Supports Providers			
11. GOVERNOR'S REVIEW ( <i>Check One</i> )  <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF REGIONAL OFFICIAL  		16. RETURN TO Office of Rules Promulgation PO Box 1437, Slot S295 Little Rock, AR 72203-1437  Attn: Alexandra Rouse	
13. TYPED NAME Janet Mann		17. DATE RECEIVED  April 8, 2020	
14. TITLE Director, Division of Medical Services			
15. DATE SUBMITTED		18. DATE APPROVED  April 15, 2020	
<b>FOR REGIONAL OFFICE USE ONLY</b>			
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL  April 5, 2020		20. SIGNATURE OF REGIONAL OFFICIAL  Anne M. Costello -S	
21. TYPED NAME  Anne Marie Costello		22. TITLE  Deputy Director, CMCS	
23. REMARKS  * Pen & Ink Change Authorized per state email dated 4.15.20.			

Digitally signed by Anne M. Costello -S  
Date: 2020.04.15 10:42:55 -04'00'

**Section 7 – General Provisions**  
**7.5. 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:

The Direct Care Workers Payments will be effective on April 5, 2020 and will end on May 31, 2020. However, if the number of active COVID-19 cases is at least 1000 on May 31, 2020, the payments are authorized for an additional 30-day period. However, no extension shall authorize payments past the end date of the national public health emergency.

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. \_\_\_\_\_ 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. xxxx 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),

State/Territory: Arkansas

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 inconsistencies 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.*



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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.

<i>Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.</i>
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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. \_\_\_\_ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

<i>Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).</i>
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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. \_\_\_\_ 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. \_\_\_\_ The agency makes the following adjustments to benefits currently covered in the state plan:

3. \_\_\_\_ 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. \_\_\_\_ 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. \_\_\_\_ 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.*

State/Territory: Arkansas

*Telehealth:*

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

*Please describe.*

*Drug Benefit:*

6. \_\_\_\_ 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.

*Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.*

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. \_\_\_\_ 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. \_\_\_\_ Newly added benefits described in Section D are paid using the following methodology:

- a. \_\_\_\_ Published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

TN: AR-20-0014  
Supersedes TN: NEW

Approval Date: 4/15/20  
Effective Date: 4/5/20

State/Territory: Arkansas

Location (list published location): \_\_\_\_\_

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.

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

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:

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. Direct Support staff of the provider types listed will receive either the base supplemental payments or the acuity-based tiered payments if they are providing care to beneficiaries who have tested positive for COVID-19 and are receiving treatment or are working in a facility in which there are COVID-19 positive beneficiaries receiving treatment. The base supplemental payments will be paid per direct care worker if the direct care workers are not treating beneficiaries with COVID-19 or do not work in a facility treating beneficiaries with COVID-19. If the direct care workers are treating beneficiaries with COVID-19 or working in a facility in which there are COVID-19 positive beneficiaries receiving treatment, those workers will receive the acuity-based tiered payment.

The base supplemental payments will be paid per direct care worker, as follows:

TN: AR-20-0014  
Supersedes TN: NEW

Approval Date: 4/15/20  
Effective Date: 4/5/20

- 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

- 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

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*CMS Disclosure\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.