EXHIBIT H

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: DMS COVID-19 Response Manual

DESCRIPTION:

Statement of Necessity

The rule is needed to render maximum assistance to the citizens of Arkansas so that the Division of Medical Services (DMS) may continue to provide services to its clients between the expiration of the state public health emergency through the end of the year. The temporary provisions amend certain rules and provide guidance, safeguarding DHS with adequate time to close out temporary measures that will no longer be needed in coming months without creating a financial risk for the state.

DMS identifies certain rules needing temporary revision and the necessity of continuing guidance to providers and clients so that services provided by the agency are available for the remainder of the year or through the national health emergency. The rule continues certain rule suspensions and issued guidance that began in March 2020. The provisions in the rule are temporary, expiring on December 31, 2021.

Rule Summary

DMS issues revisions, suspensions, and guidance in relation to certain rules. The affected areas and rules manuals are contained in the following chart.

DMS COVID-19 Response Manual Section Number & Title	Regular Manual
260.101 – Provider Enrollment fingerprint submission requirements	Medicaid Provider Manual Section I
261.100 – Ambulatory Surgical Center Provider Manual – Temporary Enrollment as Hospitals	Ambulatory Surgical Center – Medicaid Provider Manual
262.000 – Arkansas Independent Assessment Provider Manual – Temporary Use of Phone Assessments and Suspension of Timelines for Reassessments	Arkansas Independent Assessment (ARIA) – Medicaid Provider Manual
263.000 – Critical Access Hospital Provider Manual, End Stage Renal Disease Manual, Hospital Provider Manual – Use of Swing Beds	Critical Access Hospital – Medicaid Provider Manual
264.000 – Hospital Provider Manuals – Medicaid Utilization Management Program (MUMP) Review	Hospital – Medicaid Provider Manual

266.000 – Personal Care Manual – Annual Review and Renewal of Personal Care Service Plans	Personal Care – Medicaid Provider Manual
267.100 – Administration of Monoclonal Antibodies	Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manuals
267.200 – Limitations on Outpatient Laboratory Services Related to a COVID-19 Diagnosis	Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manuals
267.300 – Limitations on Outpatient Laboratory Services for COVID-19 Antigen Laboratory Testing with Procedure Code 87426	Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manuals
267.400 – Limitations on Outpatient Laboratory Services for COVID-19 Laboratory Testing with Procedure Codes U0001, U0002, U0003, and U0004	Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manuals
268.100 – Annual Limitations for Physician and Outpatient Hospital Visits (1) Treatment of COVID-19 by COVID-19 Diagnosis Codes (2) Physician and Nurse Practitioner Visits to Patients in Skilled Nursing Facilities	Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manuals; Hospital Medicaid Provider Manual; Nurse Practitioner Medicaid Provider Manual
268.200 – Places for Delivery of Services by Physicians, Advanced Practice Registered Nurses, and Hospitals for Billing for a COVID-19 Screening and Diagnostic Testing at a Mobile (Drive-Thru) Clinic (Place of Service 15)	Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manuals; Hospital Medicaid Provider Manual; Nurse Practitioner Medicaid Provider Manual; Rural Health Clinic Medicaid Provider Manual
269.000 – Transportation Provider Manual – Pick-up and Delivery Locations and Physician Certification Prior to Transport by Non-emergency Ground Ambulance	Transportation Medicaid Provider Manual

PUBLIC COMMENT: No public hearing was held on this proposed rule. The public comment period expired on May 10, 2021. The agency provided the following summary of the public comments it received and its responses to those comments.

Commenter's Name: Jaqueline Pendleton, on behalf of Summit Community Care

1: 264.000 Hospital Provider Manuals: Medicaid Utilization Management Program (MUMP): Section 212.500 through 212.550 concerning PA requirements related to MUMP review for hospital stays greater than 4 days are suspended through date of

service 12/31/2021; all hospital stays through date of service 12/31/2021 are subject only to retrospective review. This includes transfers between hospitals.

Are we mandated to abide by this entire rule? If a PASSE has no capacity or process in place to request retrospective reviews, this could lead to increased abrasion and possible recoupment if medical necessity denials are issued retrospectively. Suggest this be amended to include only COVID-diagnosis hospitalizations.

RESPONSE: This suspension is in regard to section 212.500 through 212.55 which is in reference to the DHS Quality Improvement Organization, Arkansas Foundation for Medical Care (AFMC), to determine covered lengths of stay in acute care/general and rehabilitative hospitals. This is in regard to AFMCs reviews in the FFS program.

2: 266.00 Personal Care Manual: Annual Review and Renewal of Personal Care Service Plans: Section 214.200 concerning annual review and renewal of PCSPs is suspended through 12/31/2021.

Is this a mandate or suggestion? Is this PASSE specific?

RESPONSE: 266.000 Personal Care Manual is suspending section 214.200 Service Plan Review and Renewal. This section is specific to state plan personal care services and the work done with EQ Health. This is not a PASSE suspension of PCSPs.

This rule was filed on an emergency basis and was reviewed and approved by the Executive Subcommittee on March 22, 2021. The proposed effective date for permanent promulgation is July 1, 2021.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the estimated cost to implement this rule is $0 for the current fiscal year and $584,549 for the next fiscal year ($166,655 in general revenue and $417,894 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $0 for the current fiscal year and $166,655 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

In response to the COVID-19 pandemic, the Department of Human Services identified programs and services that required additional flexibility or changes to adapt to ensuring the health and safety of our clients.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

This is an extension of a current emergency rule expiring 7/29/21 and will extend the provisions until 12/31/21.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule, and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

Due to the COVID-19 pandemic, additional flexibility or changes are needed to adapt to ensuring the health and safety of our clients.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

Not applicable.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

Not applicable.

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response;

The existing rules prior to the emergency extension would not have allowed the agency to adequately address the PHE.

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

The agency continually monitors all rules to ensure we are achieving statutory and programmatic objectives.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically

authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12); *see also* Ark. Code Ann § 20-10-203(b). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Medical Services

DIVISION DIRECTOR Janet Mann

CONTACT PERSON Mac Golden

ADDRESS P. O. Box 1437, Slot S295 Little Rock, AR 72203-1437

PHONE NO. 501-563-7634 **FAX NO.** 501-404-4619 **E-MAIL** Mac.E.Golden @dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Janet Mann

PRESENTER E-MAIL Janet.Mann@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Jessica C. Sutton
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? DMS COVID-19 Response Manual

2. What is the subject of the proposed rule? See Attached.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒
   If yes, please provide the federal rule, regulation, and/or statute citation. _____

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act?
   Yes ☒ No ☐
   If yes. what is the effective date of the emergency rule? April 1, 2021
   When does the emergency rule expire? July 29, 2021
   Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?
   Yes ☒ No ☐

5. Is this a new rule? Yes ☐ No ☒
If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

See attached. Please note, this rule contains temporary provisions of existing rules to meet the needs of the pandemic and will end no later than December 31, 2021. There will be no mark-up of existing rules.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Code Annotated §§ 20-76-201, 20 77-107, and 25-10-129.

7. What is the purpose of this proposed rule? Why is it necessary? See Attached.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/

9. Will a public hearing be held on this proposed rule? Yes ☐ No ☒
If yes, please complete the following:

Date: _____
Time: _____
Place: _____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
May 10, 2021

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
July 1, 2021

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. See Attached.

13. Please provide proof of filing the rule with the Secretary of State as required pursuant to Ark. Code Ann. § 25-15-204(e). See Attached.

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules?

Please provide their position (for or against) if known. Unknown

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rules under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20 77-107, and 25-10-129.

Effective July 1, 2021:

The Director of the Division of Medical Services (DMS) is establishing temporary rules and suspending current rules due to the continuing declaration of a National Public Health Emergency. The suspension of current rules implements one or more portions of the Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127, including the enhanced Federal Medical Assistance Percentage (FMAP), the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136, and the waiver to section 1135 of the Social Security Act that was approved by the Centers for Medicare and Medicaid Services on April 2, 2020.

Suspending these rules allow providers to render maximum assistance to the citizens of Arkansas and provide uninterrupted services. These suspensions shall automatically end December 31, 2021. DMS suspends certain non-enrolled provider screening requirements to temporarily enroll providers. DMS allows Ambulatory Surgical Centers (ACS) to temporarily enroll as hospitals to provide acute care. DMS also provides procedural information to ACSs for Medicaid billing. The in-person periodic assessments for behavioral health or individuals with developmental disability PASSE members are suspended to allow phone assessments by request. 365-day re-assessments are also suspended to allow members to stay in PASSE. For specific providers, swing bed prohibitions are suspended, and billing requirements are added. Prior authorization requirements related to Medicaid Utilization Management Program review for hospital stays greater than four days are suspended and only subject to retrospective review. Annual review and renewal of personal care service plans is suspended with requirements during the extension period. DMS is suspending certain outpatient and other treatment limitations for COVID-19 screening, diagnostic testing, and diagnoses as well as covering administration of monoclonal antibodies under the specific terms. Certain transportation rules are suspended.

The proposed rules are available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rules at https://humanservices.arkansas.gov/do-business-with-dhs/proposed -rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than **May 10, 2021**. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-396-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4501960528

Janet Mann, Director
Division of Medical Services

Jack Tiner

From: legalads@arkansasonline.com
Sent: Thursday, April 8, 2021 12:23 PM
To: Jack Tiner
Subject: Re: FULL RUN AD

[EXTERNAL SENDER]
Thanks. Will run Sun 4/11, Mon 4/12, and Tues 4/13.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Jack Tiner" <jack.tiner@dhs.arkansas.gov>
To: legalads@arkansasonline.com
Cc: "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Stephen Giese" <Stephen.Giese@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>, "Debbie Lee" <Debbie.Lee.DO@dhs.arkansas.gov>
Sent: Thursday, April 8, 2021 10:51:22 AM
Subject: FULL RUN AD

Please run the attached Notice of Public Rulemaking in the *Arkansas Democrat-Gazette* on the following days:

- Sunday, April 11, 2021
- Monday, April 12, 2021
- Tuesday, April 13, 2021

I am aware that the print version will only be provided to all counties on Sundays.

Invoice to: **AR Dept of Human Services**
P.O. Box 1437
Slot S535
Little Rock, AR 72203
ATTN: Elaine Stafford

Or email invoices to: dms.invoices@arkansas.gov

Use purchase order # 4501960528

Thank you.

DHS

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE (501) 320-6540 **FAX** _____ **EMAIL:** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE DMS COVID-19 Response Manual

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$	General Revenue	$
Federal Funds	$	Federal Funds	$
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total $ _____ Total $ _____

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	$166,655
Federal Funds		Federal Funds	$417,894
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	$ 584,549

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0	$ 0

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$	$ $166,655

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;
In response to the COVID 19 pandemic, the Department of Human Services identified programs and services that required additional flexibility or changes to adapt to ensuring the health and safety of our clients.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
This is an extension of a current emergency rule expiring 7/29/21 and will extend the provisions until 12/31/2021.

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(a) justifies the agency's need for the proposed rule; and

Due to the COVID 19 pandemic.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

Additional flexibility or changes to adapt to ensuring the health and safety of our clients.

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Not Applicable

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

Not Applicable

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

The existing rules prior to the emergency extension would not have allowed the agency to adequately address the PHE.

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(a) the rule is achieving the statutory objectives;

(b) the benefits of the rule continue to justify its costs; and

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The Agency continually monitors all rules to ensure we are achieving statutory and programmatic objectives.

Statement of Necessity and Rule Summary
DMS COVID-19 Response Manual

Statement of Necessity

The rule is needed to render maximum assistance to the citizens of Arkansas so that the Division of Medical Services (DMS) may continue to provide services to its clients between the expiration of the state public health emergency through the end of the year. The temporary provisions amend certain rules and provide guidance, safeguarding DHS with adequate time to close out temporary measures that will no longer be needed in coming months without creating a financial risk for the state.

DMS identifies certain rules needing temporary revision and the necessity of continuing guidance to providers and clients so that services provided by the agency are available for the remainder of the year or through the national health emergency. The rule continues certain rule suspensions and issued guidance that began in March 2020. The provisions in the rule are temporary, expiring on December 31, 2021.

Summary

DMS issues revisions, suspensions, and guidance in relation to certain rules. The affected areas and rules manuals affected are contained in the following chart.

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DMS	262.000—Arkansas Independent Assessment Provider Manual--Temporary Use of Phone Assessments and Suspension of Timelines for Reassessments	Arkansas Independent Assessment (ARIA) – Medicaid Provider Manual
DMS	263.000—Critical Access Hospital Provider Manual, End Stage Renal Disease Manual, Hospital Provider Manual--Use of Swing Beds	Critical Access Hospital – Medicaid Provider Manual
DMS	264.000—Hospital Provider Manuals--Medicaid Utilization Management Program (MUMP) review	Hospital – Medicaid Provider Manual
DMS	266.000—Personal Care Manual--Annual Review and Renewal of Personal Care Service Plans	Personal Care – Medicaid Provider Manual
DMS	267.100—Administration of Monoclonal Antibodies	Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manuals
DMS	267.200—Limitations on Outpatient Laboratory Services, Related to a COVID-19 Diagnosis	Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manuals

DMS	267.300—Limitations on Outpatient Laboratory services, for COVID-19 Antigen Laboratory Testing with Procedure Code 87426	Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manuals
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DMS	269.000—Transportation Provider Manual--Pick-up and Delivery Locations and Physician Certification Prior to Transport by Non-emergency Ground Ambulance	Transportation Medicaid Provider Manual

Division of Medical Services (DMS)

COVID-19 Response Manual

July 1, 2021

DMS COVID-19 RESPONSE CONTENTS

200.000 OVERVIEW

201.000 Authority

The following rules are duly adopted and promulgated by the Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) under the authority of Arkansas Code Annotated §§ 20-76-201 20-77-107, and 25-10-129.

202.000 Purpose

In response to the COVID 19 pandemic, DHS identified programs and services that required additional flexibility or changes to adapt to ensuring the health and safety of our clients. This manual details them so that DHS may render uninterrupted assistance and services to our clients.

203.000 Appeals

Appeal requests for the COVID-19 response policies must adhere to the policy set forth in the Medicaid Provider Manual Section 160.000 Administrative Reconsideration and Appeals which can be accessed at **https://medicaid.mmis.arkansas.gov/Provider/Docs/all.aspx.**

203.000 Severability

Each section of this manual is severable from all others. If any section of this manual is held to be invalid, illegal, or unenforceable, such determination shall not affect the validity of other sections in this manual and all such other sections shall remain in full force and effect. In such an event, all other sections shall be construed and enforced as if this section had not been included therein.

260.000 MEDICAL SERVICES

260.100 Medicaid Provider Manual Section I

260.101 Provider Enrollment Fingerprint Submission Requirements

Section 141.103 concerning fingerprint submission requirements for high risk providers related to background screening is suspended through date of service December 31, 2021.

With respect to providers not already enrolled with another State Medicaid Agency or Medicare, DMS will waive the following screening requirements so the state may temporarily enroll the providers for the duration of the public health emergency:

A. Payment of the application fee - 42 C.F.R. §455.460

B. Criminal background checks associated with Fingerprint-based Criminal Background Checks - 42 C.F.R. §455.434

C. Site visits - 42 C.F.R. §455.432

D. In-state/territory licensure requirements - 42 C.F.R. §455.412

The Centers for Medicare and Medicaid Services (CMS) is granting 1135 waiver authority to allow Arkansas to enroll providers who are not currently enrolled with another SMA or Medicare so long as the state meets the following minimum requirements:

A. Must collect minimum data requirements to file and process claims, including, but not limited to NPI.

B. Must collect Social Security Number, Employer Identification Number, and Taxpayer Identification Number (SSN/EIN/TIN), as applicable, to perform the following screening requirements:

   1. OIG exclusion list

   2. State licensure – provider must be licensed, and legally authorized to practice or deliver the services for which they file claims, in at least one state/territory

C. Arkansas must also:

   1. Issue no new temporary provisional enrollments after the date that the emergency designation is lifted,

   2. Cease payment to providers who are temporarily enrolled within six months from the termination of the public health emergency, including any extensions, unless a provider has submitted an application that meets all requirements for Medicaid participation and that application was subsequently reviewed and approved by Arkansas before the end of the six month period after the termination of the public health emergency, including any extensions, and

3. Allow a retroactive effective date for provisional temporary enrollments that is no earlier than March 1, 2020.

261.000 Section II of Medicaid Provider Manuals through 269.000

261.100 Ambulatory Surgical Center Provider Manual—Temporary Enrollment as Hospitals

Sections 210.200(A) and 212.000, regarding the definition of an Ambulatory Surgical Center (ASC) as exclusively furnishing outpatient surgical services to patients not requiring hospitalization, are suspended through date of service December 31, 2021.

The Division of Medical Services (DMS) is allowing Ambulatory Surgical Centers (ASCs) to temporarily enroll as hospitals under certain circumstances to provide acute hospital services to patients as needed during the COVID-19 pandemic.

ASCs that wish to enroll as temporary hospitals must submit a waiver request to CMS. Once that waiver is approved, the ASC must seek a temporary hospital license from the Arkansas Department of Health.

To bill Medicaid as hospital, the ASC must provide that temporary hospital license to Arkansas Medicaid Provider Enrollment. The ASC will receive a temporary Medicaid Provider Number as a hospital and will be able to bill for hospital services. Once the temporary hospital provider number is issued and active, the ASC provider number will be suspended temporarily. All services provided will need to be billed under the hospital provider number.

For guidance on billing services, please contact the DMS Utilization Review Unit at (501) 682-8340.

262.000 Arkansas Independent Assessment Provider Manual—Temporary Use of Phone Assessments and Suspension of Timelines for Reassessments

Section 201.000, concerning periodic assessments for behavioral health and individuals with developmental disabilities PASSE members is suspended to allow phone assessments by request only, and to extend initial assessment dates for behavioral health PASSE members. The suspension lasts through date of service December 31, 2021.

Independent Assessments are generally performed by Qualified Assessors in a face-to-face setting with behavioral health and developmentally disabled PASSE members. Due to the COVID-19 public health emergency, this rule is suspended to allow members to request phone assessments instead for periodic assessments.

Families First Corona Virus Response Act requires states to maintain an individual eligibility for amount, duration, and scope of benefits during the public health emergency BH AND IDD PASSE Members who do not receive a BH or IDD Independent re-assessment within 365 days of their existing BH AND IDD IA would be transitioned to traditional Medicaid and lose access to care coordination, home and community based and psychiatric residential services.

This rule is suspended to allow members who do not receive a timely reassessment to remain in PASSE.

263.000 Critical Access Hospital Provider Manual, End Stage Renal Disease Manual, Hospital Provider Manual—Use of Swing Beds

Section 212.419, regarding the prohibition of coverage of swing bed services by the Arkansas Medicaid Program is suspended through date of service December 31, 2021.

Arkansas Medicaid will cover Swing Beds (Revenue code 194) at a rate of $400 per diem for the following providers:

- Provider Type 05 - Hospital/Provider Specialty CH - Critical Access Hospital

Provider billing instructions for Swing Beds:

- Claims can be submitted electronically or by paper with required attachments
- Attach a cover sheet requesting coverage of Swing Bed in a critical access hospital.
- Revenue Code 194 should be billed for Swing Bed days.
- Bill all dates of service for each month on one claim (there will be separate claims filed for dates of service in different months)
- Bill at the amount of $400 per day.

264.000 Hospital Provider Manuals—Medicaid Utilization Management Program (MUMP) Review

Sections 212.500 through 212.550 concerning prior authorization requirements related to Medicaid Utilization Management Program (MUMP) review for hospital stays greater than four (4) days are suspended through date of service December 31, 2021.

All hospital stays through date of service December 31, 2021 are subject only to retrospective review. This includes transfers between hospitals.

266.000 Personal Care Manual—Annual Review and Renewal of Personal Care Service Plans

Section 214.200 concerning annual review and renewal of personal care service plans (PCSPs) is suspended through date of service, December 31, 2021.

DHS nurses may extend PCSPs and authorizations based on review of current medical/functional needs. Division of Aging and Adult Service and Behavioral Health Services (DAABHS) nurses will complete an assessment of the beneficiary's current needs and will extend the end dates for qualifying beneficiaries, ensuring continued eligibility for services. PCSP's are living documents and are to be updated as goals and needs are met. During the extension period, the PCSP will continue to be updated to the level of current service needs based on continued phone contact with beneficiary.

267.000 Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manual

267.100 Administration of Monoclonal Antibodies

Division of Medical Services (DMS) is covering administration of monoclonal antibodies through date of service December 31, 2021.

DMS will cover the administration of the following monoclonal antibodies in accordance with the terms set out in this memorandum.

CPT Code	Short Description	Rate	Effective Date
Q0239	BAMLANIVIMAB-XXXX	$0.01	November 9, 2020
M0239	BAMLANIVIMAB-XXXX INFUSION	$309.60	November 9, 2020
Q0243	CASIRIVIMAB AND IMDEVIMAB	$0.01	November 21, 2020
M0243	CASIRI AND IMBDEVI INFUSION	$309.60	November 21, 2020

The patient must have a COVID-19 diagnosis and be considered at high risk for progressing to severe COVID-19 and/or hospitalization. The Arkansas Department of Health (ADH) issued an updated Health Alert through the Health Alert Network (HAN) on November 25, 2020, that outlines the criteria and limitations on use of these monoclonal antibodies. DMS will follow the criteria and limitations outlined in that ADH alert and by the FDA in their Emergency Use Authorizations (EUAs) for the above listed drugs, which can be found here:

EUA for Bamlanivimab - https://www.fda.gov/media/143603/download

Patient Fact Sheet - https://www.fda.gov/media/143604/download

FDA Frequently Asked Questions -https://www.fda.gov/media/143605/download

EUA for Casirivimab and Imdevimab - https://www.fda.gov/media/143892/download

Patient Fact Sheet - https://www.fda.gov/media/143893/download

FDA Frequently Asked Questions - https://www.fda.gov/media/143894/download

267.200 Limitations on Outpatient Laboratory Services, Related to a COVID-19 Diagnosis

Section 225.100(A), regarding limitations on outpatient laboratory services, is suspended as to claims for any lab or x-ray services related to a COVID-19 diagnosis through date of service December 31, 2021.

DMS is exempting claims where a patient is diagnosed with COVID-19 from the lab and x-ray benefit limit outlined in Section 225.100 of the Medicaid Provider Manual for physician/Independent Lab/CRNA/Radiation Therapy Centers. If one of the following COVID-19 diagnoses is listed on any diagnosis field/position on the claim, the procedure will not count against the annual $500.00 benefit limit for lab and x-ray for adults over the age of 21:

- A41.89—Other specified sepsis

- O98.511—Other viral diseases complicating pregnancy, first trimester
- O98.512—other viral diseases complicating pregnancy, second trimester
- O98.513—other viral diseases complicating pregnancy, third trimester
- O98.519—other viral diseases complicating pregnancy, unspecified trimester
- O98.52—Other viral disease complicating childbirth
- O98.53—other viral disease complicating the puerperium
- U07.1—COVID-19
- Z03.818—Encounter for observation for suspected exposure to other biological agents ruled out
- Z09—Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
- Z11.59—Encounter for screening for other viral diseases
- Z20.828—Contact with and (suspected) exposure to other viral communicable disease

267.300 Limitations on Outpatient Laboratory services, for COVID-19 Antigen Laboratory Testing with Procedure Code 87426

Section 225.100(A), regarding limitations on outpatient laboratory services, is suspended as to claims for COVID-19 antigen laboratory testing using procedure code 87426 through date of service December 31, 2021.

The following procedures codes are available for billing COVID-19 antigen detection testing.

Code	Short Description	Fee
87426	Coronavirus AG IA Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19])	$45.23

The following provider types may bill for these services:

- Physicians (PT 01, 03 & 69) • Nurse Practitioners (PT 58)
- Rural Health Clinics (PT 29) • Hospitals (PT 05)
- Arkansas Department of Health (PT 30)
- Rehabilitation Centers (PT 26)

Medicaid is exempting these COVID-19 screens from the $500.00 limit on laboratory and x-ray services for beneficiaries over 21 years of age and from requiring a PCP referral.

267.400 Limitations on Outpatient Laboratory Services, for COVID-19 Laboratory Testing with procedure Codes U0001, U0002, U0003, and U0004

Section 225.100(A), regarding limitations on outpatient laboratory services, is suspended for claims for COVID-19 laboratory testing using procedure codes U0001, U0002, U0003, and U0004 through date of service December 31, 2021.

DMS is covering the following laboratory services:

Code	Short Description	Fee
U0001	CDC developed 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel	$35.92
U0002	Non-CDC developed 2019-nCoV Coronavirus, SARS-CoV2/2019-nCoV (COVID-19)	$51.33

The following procedure codes are available for billing "high-through put" COVID-19 diagnostic testing:

Code	Short Description	Fee
U0003	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies	$100.00
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies	$100.00

The following provider types may bill for these services:

- Physicians (PT 01 & 03)
- Nurse Practitioners (PT 58)
- Rural Health Clinics (PT 29)
- Hospitals (PT 05)
- Arkansas Department of Health (PT 30)
- Rehabilitation Centers (PT 26)

These codes are appropriate to be billed when at least one (1) of the following symptoms is present and documented on the claim:

- R05: Cough
- R06/02: Shortness of breath
- R50.9: Fever, unspecified

Medicaid is exempting these COVID-19 screens from the $500.00 limit on laboratory and x-ray services for beneficiaries over 21 years of age.

The following diagnosis codes may also be used to bill for a COVID-19 test:

- A41.89—Other specified sepsis
- O98.511—Other viral diseases complicating pregnancy, first trimester
- O98.512—Other viral diseases complicating pregnancy, second trimester
- O98.513—Other viral diseases complicating pregnancy, third trimester
- O98.519—Other viral diseases complicating pregnancy, unspecified trimester
- O98.52—Other viral disease complicating childbirth
- O98.53—Other viral disease complicating the puerperium
- U07.1—COVID-19
- Z03.818—Encounter for observation for suspected exposure to other biological agents ruled out
- Z09—Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
- Z11.59—Encounter for screening for other viral diseases
- Z20.828—Contact with and (suspected) exposure to other viral communicable disease

268.000 Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manual; Nurse Practitioner; Hospital

268.100 Annual Limitations for Physician and Outpatient Hospital Visits
(1) Treatment of COVID-19 by COVID-19 Diagnosis Codes
(2) Physician and Nurse Practitioner Visits to Patients in Skilled Nursing Facilities

Sections 225.000 and 226.000 concerning annual limitations for physician and outpatient hospital visits are suspended to allow for additional visits for (1) treatment of COVID-19 as documented by COVID-19 diagnosis codes, and (2) physician and nurse practitioner visits to patients in skilled nursing facilities through date of service December 31, 2021.

DMS is suspending Section 225.000 and 226.000 of the Medicaid Provider Manual for Physician/Independent Lab/CRNA/Radiation Therapy Center. Specifically, physician and hospital visits related to the treatment of COVID-19 will not count in the twelve (12) visit annual limit. To exempt these visits from the limit, the provider must document one of the COVID-19 related diagnosis codes, which can be found at:

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice- coronavirusfeb-20-2020.pdf.

Physician and Nurse Practitioner (APRN) visits to patients in skilled nursing facilities will not count against the twelve-visit limit for those beneficiaries.

268.200 Places for Delivery of Services by Physicians, Advanced Practice Registered Nurses, and Hospitals for Billing for COVID-19 Screening and Diagnostic Testing at a Mobile (Drive Thru) Clinic

Section 292.210 concerning places for delivery of services provided by physicians, advanced practice registered nurses, and hospitals is suspended to allow for billing for COVID-19 screening and diagnostic testing at a mobile (drive thru) clinic (Place of Service 15) through date of service December 31, 2021.

DMS is allowing certain providers to set up Mobile ("Pop-up") clinics to screen and test for COVID-19.

Specifically, physicians' clinics, rural health clinics, federally qualified health centers and hospitals may set up Pop-up or drive-thru clinics in remote locations to provide the following services only:

- Screening for COVID-19 (99499, described below)
- Diagnostic Testing for COVID-19 (U0001, U0002, 87426)

These services will be billed using the provider's Medicaid Provider Number and Place of Service Code 15 (Mobile Clinic).

To accommodate screening for COVID-19, DMS is loading the following code:

99499—Unlisted E&M Service to be billed for COVID-19 Screening. The code will be available to the following provider types:

- Physicians (PT 01 & 03)
- APRNs (PT 58)
- Rural Health Clinics (PT 29)
- Federally Qualified Health Centers (PT 49)
- Hospitals (PT 05)

This code is not to be used in conjunction with any other E&M or encounter code that may be billed by the provider but only be used to reflect a screening for COVID-19 (i.e., completing a questionnaire and taking temperature). **The rate is $25.00 for each screening.**

269.000 Transportation Provider Manual--Pick-up and Delivery Locations and Physician Certification Prior to Transport by Non-emergency Ground Ambulance

Sections 213.000, 204.000, and 205.000(A)(2) concerning pick-up and delivery locations and physician certification prior to transport by non-emergency ground ambulance are suspended through date of service December 31, 2021.

DMS is suspending the following policies:

A. Section 213.000 of the Medicaid Provider Manual for Transportation:

1. Ground transportation trips by Ambulance providers may be made to any destination that is able to provide treatment to the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols in use where the services are being furnished. These destinations may include, but are not limited to:

   a. Any location that is an alternative site determined to be part of a hospital, Critical Access Hospitals (CAH) or Skilled Nursing Facilities (SNF), community mental health centers federally qualified health centers (FQHCs), physician's offices, urgent care facilities, ambulatory surgery centers (ASCs), and any other location furnishing dialysis services outside of the ESRD facility.

B. Sections 204.000 and 205.000(A)(2) of the Medicaid Provider Manual for Transportation:

1. Physician certification does not have to be obtained to transport a beneficiary via non-emergency ground ambulance transport.