STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

March 27, 2020

Calder Lynch, Deputy Administrator & Director
Judith Cash, Director of the State Demonstrations Group
Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Lynch and Ms. Cash:

Thank you for our recent meeting and for your partnership as we grapple with the many challenges related to the COVID-19 pandemic. To move our discussions forward, in my capacity as the Secretary of the North Carolina Department of Health and Human Services, I submit this urgent request for the Centers for Medicare and Medicaid Services (CMS) to approve an emergency demonstration project under Section 1115 of the Social Security Act (the Act).

As you know, North Carolina is preparing for rapid spread of the Novel Coronavirus Disease (COVID-19) pandemic. As of March 26, 2020, there have been 636 confirmed cases of COVID-19 in North Carolina.[1] COVID-19 now threatens the lives of thousands and risks placing extraordinary strain on North Carolina's healthcare system by increasing treatment needs for the uninsured and insured alike; shifting demand for healthcare services dramatically, with sharp increases for some providers and steep declines for others; risking overwhelming our physical capacity to treat patients; stretching thin our healthcare workforce, given increased likelihood of illness and caregiving needs at home; and exceeding our supply of critical equipment. Medicaid has a key role to play in alleviating many of these challenges as the source of coverage for one in five North Carolinians.

The State is using various emergency authorities that have been invoked under federal and State law, including the waivers approved by CMS under Section 1135 of the Act on March 23, 2020. Based on what we are learning in other states about what lies ahead, it is clear that the State requires additional federal flexibility and support that is available only through waivers under Section 1115. In light of the rapidly evolving and unprecedented crisis presented by COVID-19, we urge CMS to review and approve

[1] *COVID-19 Case Count in North Carolina*, North Carolina Department of Health and Human Services, https://www.ncdhhs.gov/covid-19-case-count-nc.

expeditiously the attached application. We ask for this flexibility while we continue to work closely with the Legislature to secure necessary state approvals.

We have modeled this request on both the CMS 1115 disaster waiver template, released on March 22, as well as prior actions CMS has taken using Medicaid 1115 waivers when our country faced earlier unprecedented threats to health and safety, including in the aftermath of the September 11th terrorist attacks, Hurricane Katrina, and the discovery of high levels of lead in the water of Flint, Michigan. In the wake of Hurricane Katrina, for example, CMS acted quickly to approve uncompensated care pools to address disaster-related costs (with no requirement for budget neutrality offsets). Among other flexibilities, North Carolina needs a similarly flexible funding vehicle to address the COVID-19 pandemic.[2]

Specifically, North Carolina seeks CMS approval under Section 1115 for the following:

- **Expanding coverage for uninsured individuals related to COVID-19.** Section 6004 of the Families First Coronavirus Response Act ("Families First") provides limited coverage for the cost of testing uninsured individuals for COVID-19. However, North Carolina also requires the ability to provide treatment to those with a positive diagnosis and to provide necessary medical services and prevent further spread of the disease. As such, we request the ability to implement a targeted coverage expansion for limited services for individuals with incomes up to 200% of the federal poverty level (FPL), subject to legislative approval.

- **Establishing a COVID-19 Disaster Relief Fund.** North Carolina Medicaid providers require support as they rapidly implement new, expanded care delivery sites, modalities and access needed equipment; confront unprecedented disruption in their workforce and patient revenue; act quickly to ensure access to testing and care for all residents; and mitigate the surge in demand for healthcare. Congress is poised to approve a Coronavirus Relief Fund that would allocate funding to the states to address many of these challenges. Medicaid, however, still has a role to play in providing targeted relief to individuals and providers beyond. Accordingly, the State requests a limited COVID-19 Disaster Relief Fund to provide targeted Medicaid-funded support in the following ways not addressed in the Relief Fund:
    - ***Covering uncompensated care costs*.** The State would use the COVID-19 Disaster Relief Fund to cover uncompensated care costs of Medicaid providers preventing, identifying, and treating COVID-19 in uninsured patients. Even if North Carolina adopts a further expansion of eligibility, there still will be a significant number of uninsured individuals who otherwise will not be able to secure coverage for treatment.
    - ***Adapting healthcare delivery to reflect the realities of COVID-19.*** Medicaid providers will need to make significant unanticipated investments in, among other things, telemedicine platforms, bed reconfiguration, off-site screening venues, and quarantine/post-acute care sites, as they adjust to a new reality. Providers will also need to purchase additional respirators, ventilators, and personal protective equipment to treat patients. Providers will be required to apply directly to the U.S. Department of Health and Human Services first to seek reimbursement for many of these expenditures. It is unclear whether the award process will meet the specific needs of Medicaid beneficiaries and

[2] Congress appropriated funds relating to the Katrina waivers, but that appropriation provided retroactive relief to states for the nonfederal share of those waivers. The appropriation was enacted on February 6, 2006, months after CMS approved the waivers**.** See, https://www.govinfo.gov/content/pkg/PLAW-109publ171/pdf/PLAW-109publ171.pdf**.** CMS approved the initial Katrina waiver on September 15, 2005 and it released a model template for other states impacted by Katrina on September 16, 2005. North Carolina is seeking similarly quick action from CMS on a disaster relief section 1115 waiver to address the COVID-19 public health emergency.

providers. The State's COVID-19 Disaster Relief Fund would be available to cover eligible expenses not reimbursed through other mechanisms.

   - ***Preserving access to care in light of dramatic shifts in utilization.*** With extensive social distancing in place for weeks or months, patient utilization patterns are likely to shift dramatically—especially in light of the mandatory cancellation of elective cases and other non-essential services for a not-yet-known period of time. Providers will vary in their abilities to weather sharp declines in utilization, but many essential Medicaid providers, like rural hospitals, school-based providers, and home and community-based care agencies, already operate on slim margins and will require financial assistance to remain open. The costs associated with declines in utilization are not eligible for relief under Congress's stimulus package.

Medicaid would cover the cost of a portion of expenses eligible for support from the COVID-19 Disaster Relief Fund appropriately allocated to Medicaid. Additionally, the State would require that entities receiving funds seek support from other available sources of federal and state funding, to ensure that Medicaid is the payer of last resort. Finally, all payments would be subject to audit.

- **Providing temporary shelter for homeless people with a COVID-19 diagnosis, known COVID-19 exposure, or who live in hotspots to reduce the need for hospital beds**. Homeless individuals are at increased risk of contracting COVID-19, potentially leading to hospitalization. Further, as demand for hospital beds begins to outstrip supply, North Carolina requires tools to help hospitals free up beds whenever medically appropriate. By providing housing support to individuals with a COVID-19 diagnosis, known COVID-19 exposure, or who live in a COVID-19 hotspot, the State would reduce the spread of the virus in hotspots and ensure that homeless individuals are not taking up hospital beds when they could safely recover in the community. The State requests authority to include housing supports as a time-limited benefit available to beneficiaries covered under the State Plan or through the temporary eligibility group established under this demonstration.
- **Offering nutrition support to allow vulnerable Medicaid beneficiaries to comply with social distancing and home orders.** Social distancing is essential as the State tries to "flatten the curve" and mitigate a surge in the need for critical care. North Carolina requests authority to strategically provide nutrition supports to targeted individuals and families when it is critical to support shelter at home orders. The State requests authority to include nutritional supports as a time-limited benefit available to beneficiaries covered under the State Plan or through the temporary eligibility group established under this demonstration.
- **Providing more flexibility for beneficiaries receiving home care.** Individuals receiving home care services are particularly vulnerable during the pandemic both to COVID-19 itself and from the exacerbation of their chronic conditions as the homecare workforce frays under a combination of illness and childcare needs. North Carolina requests additional flexibility to keep these beneficiaries safe in their homes, rather than filling much-needed hospital beds.
- **Ensuring appropriate behavioral health care.** Many Medicaid beneficiaries have ongoing behavioral health needs, and the State must ensure that those needs are still met as the COVID-19 crisis unfolds. Many behavioral health providers have seen dramatic declines in volume since social distancing began, and certain types of group treatment options are not feasible, threatening to destabilize providers and jeopardize access to services. The State requests flexibility to make directed payments to behavioral health providers through the State's behavioral health managed care plans (known as LME/MCOs), without needing prior approval of a directed payment preprint. Relatedly, the State requests flexibility to allow LME/MCOs to cover as an "in lieu of" service

treatment in IMDs that extends beyond 15 days in a month, since many partial hospitalization or other post-discharge treatment options are not currently available to patients in light of COVID-19.

- **Streamlining Eligibility and Enrollment.** In the days and weeks ahead, many North Carolinians will be arriving at overwhelmed hospitals and clinics without coverage, or they may be sent to alternative holding facilities until beds open up. Others will be quarantined at home and need simplified telephone or video options for enrolling rapidly in coverage. Even if they are not directly affected by the virus, vast numbers of North Carolinians are expected to lose their jobs, placing an enormous burden on our already-taxed eligibility and enrollment system. It is critical that North Carolina has the ability to quickly enroll beneficiaries into coverage. As such, we request flexibility to implement the following changes to eligibility and enrollment processes:
    - ***Expedited enrollment.*** For the duration of the emergency, North Carolina requests the ability to establish an expedited eligibility process that allows individuals to attest to all elements of a streamlined Medicaid application with the State permitted to delegate authority to make a determination for a limited period in anticipation of a final determination made by the State. To ensure appropriate coverage of services, the State also requests flexibility to allow providers to bill to a temporary ID number for individuals determined eligible through the streamlined process.
    - ***Other eligibility and enrollment simplifications to mitigate the surge in enrollment.*** Some of the workforces of the Medicaid agency and the local social services districts will be directed to address urgent issues related to COVID-19. At the same time, North Carolina is expecting a major surge in enrollment as unemployment spikes while the Medicaid agency and local social service agencies are working to address other urgent issues related to COVID-19. As the pandemic continues, North Carolina will need the ability to identify other eligibility and enrollment flexibilities, such as automatically renewing for 12 months for all individuals whose eligibility is up for renewal during the period of the national emergency.

Thank you for your prompt attention to this urgent matter. Please contact us immediately if you require any additional information.

Sincerely,

Mandy K. Cohen, MD, MPH
Secretary

cc: Dave Richard, Deputy Secretary for Medicaid
Jay Ludlam, Assistant Secretary for Medicaid

COVID-19 Section 1115(a) Demonstration Application Template

The State of North Carolina, Department of Health and Human Services 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.

I. DEMONSTRATION GOAL AND OBJECTIVES

Effective retroactively to March 1, 2020, the State of North Carolina, 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

A. Eligible Individuals: The following populations will be eligible under this demonstration. To the extent coverage of a particular service is available for a particular beneficiary under the State plan, such coverage will be provided under the State plan and not under demonstration authority.

Check to Apply	Population
✓	Current title XIX State plan beneficiaries
✓	Current section 1115(a)(2) expenditure population(s) eligible for/enrolled in the following existing section 1115 demonstrations: • Temporary eligibility group created under this demonstration for all individuals with incomes up to 200% FPL

B. Benefits: The state will provide the following benefits and services to individuals eligible under this demonstration. To the extent coverage of a particular service is available for a particular beneficiary under the State plan, such coverage will be provided under the State plan and not under demonstration authority.

Check to Apply	Services
✓	Current title XIX State plan benefits

Check to Apply	Services
✓	Others as described here: • For the new temporary eligibility group created under this demonstration, benefits would be limited to those necessary for the prevention, testing,[3] and treatment related to COVID-19. Benefits would include outpatient services, inpatient services, emergency services, prescription drugs, rehabilitative services, laboratory services, vaccinations, targeted nutritional supports, housing supports for homeless individuals with a COVID-19 diagnosis, known exposure to COVID-19, or who live in a COVID-19 hotspot, as designated by the State.

C. Cost-sharing

Check to Apply	Cost-Sharing Description
✓	There will be no premium, enrollment fee, or similar charge, or cost-sharing (including copayments and deductibles) required of individuals who will be enrolled in this demonstration that varies from the state's current state plan.
	Other as described here:

D. Delivery System:

Check to Apply	Delivery System Description
✓	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.
	Other as described here:

III. EXPENDITURE AND ENROLLMENT PROJECTIONS

A. Enrollment and Enrollment Impact.

[3] Testing for COVID-19 would be covered at 100% FMAP, as provided for under Families First. All other services would be eligible for match at the State's medical match rate.

i. State projects that approximately 3.2 M[4] individuals as described in section II will be eligible for the period of the demonstration. The overall impact of this section 1115 demonstration is that these individuals, for the period of the demonstration, will continue to receive HCBS or coverage through this demonstration to address the COVID-19 public health emergency.

B. Expenditure Projection.

The state projects that the total aggregate expenditures under this section 1115 demonstration is $900 M, assuming a six month duration of the emergency.

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 consistent with section 1135 of the Act, and the time-limited nature of demonstrations that would be approved under this opportunity, 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.

Check to Apply	Program
✓	Medicaid state plan
✓	Section 1915(c) of the Social Security Act ("HCBS waiver"). Provide applicable waiver numbers below: • 0132.R07.00 • 4141.R06.00 • 0662.R01.00 • 0423.R03.00 • 0663.R01.00 • 1326.R00.00
✓	Section 1115(a) of the Social Security Act (i.e., existing, approved state demonstration projects). Provide applicable demonstration name/population name below: • North Carolina Medicaid Reform Demonstration (11-W00313/4)

[4] This includes the currently eligible population plus the temporary eligibility category.

Check to Apply	Program
✓	Other: The eligibility group established under this demonstration

V. WAIVERS AND EXPENDITURE AUTHORITIES

A non-exhaustive list of waiver and expenditure authorities available under this section 1115 demonstration opportunity has been provided below. States have the flexibility to request additional waivers and expenditure authorities as necessary to operate their programs to address COVID-19. If additional waivers or expenditure authorities are desired, please identify the authority needed where indicated below and include a justification for how the authority is needed to assist the state in meeting its goals and objectives for this demonstration. States may include attachments as necessary. Note: while we will endeavor to review all state requests for demonstrations to combat COVID-19 on an expedited timeframe, dispositions will be made on a state-by-state basis, and requests for waivers or expenditure authorities in addition to those identified on this template may delay our consideration of the state's request.

A. Section 1115(a)(1) Waivers and Provisions Not Otherwise Applicable under 1115(a)(2)

The state is requesting the below waivers pursuant to section 1115(a)(1) of the Act, applicable for beneficiaries under the demonstration who derive their coverage from the relevant State plan. With respect to beneficiaries under the demonstration who derive their coverage from an expenditure authority under section 1115(a)(2) of the Act, the below requirements are identified as not applicable. Please check all that apply.

Check to Waive	Provision(s) to be Waived	Description/Purpose of Waiver
✓	Section 1902(a)(1)	To permit the state to target services on a geographic basis that is less than statewide.
✓	Section 1902(a)(8), (a)(10)(B), and/or (a)(17)	To permit the state to vary the amount, duration, and scope of services based on population needs; to provide different services to different beneficiaries in the same eligibility group, or different services to beneficiaries in the categorically needy and medically needy groups; and to allow states to triage access to long-term services and supports based on highest need.

B. Expenditure Authority

Pursuant to section 1115(a)(2) of the Act, the state is requesting that the expenditures listed below be regarded as expenditures under the state plan.

Note: Checking the appropriate box(es) will allow the state to claim federal financial participation for expenditures that otherwise would be ineligible for federal match.

Check to Request Expenditure	Description/Purpose of Expenditure Authority
✓	Allow for self-attestation or alternative verification of individuals' eligibility (income/assets) and level of care to qualify for long-term care services and supports.
✓	Long-term care services and supports for impacted individuals even if services are not timely updated in the plan of care, or are delivered in alternative settings.
✓	Ability to pay higher rates for HCBS providers in order to maintain capacity.
✓	The ability to make retainer payments to certain habilitation and personal care providers to maintain capacity during the emergency. For example, adult day sites have closed in many states due to isolation orders, and may go out of business and not be available to provide necessary services and supports post-pandemic
✓	Allow states to modify eligibility criteria for long-term services and supports.
✓	The ability to reduce or delay the need for states to conduct functional assessments to determine level of care for beneficiaries needing LTSS.
✓	Allow for self-attestation or alternative verification of all elements needed to determine an individual's eligibility
✓	Allow for fast-track eligibility process that extends from thirty days prior to the date of determination through the duration of the national public health emergency without the need for additional paperwork
✓	Allow for eligibility simplifications, including allowing billing linked to temporary ID numbers and automatically renewing for 12 months all individuals whose eligibility is up for renewal during the period of the national public health emergency

Check to Request Expenditure	Description/Purpose of Expenditure Authority
✓	Establish a COVID-19 Disaster Relief Fund that: • Covers uncompensated care costs of providers related to COVID-19; • Funds investments by providers necessary to adapt healthcare delivery to reflect the realities of COVID-19, including investments in telemedicine platforms, bed reconfiguration, off-site screening venues, and quarantine/post-acute care sites, and the purchase of additional respirators, ventilators, and personal protective equipment; and • Provides payments to providers, including rural hospitals and behavioral health providers, necessary to preserve access to care in light of dramatic shifts in utilization. The COVID-19 Disaster Relief Fund would be retroactive to the date of the national public health emergency. All expenditures would be subject to appropriate cost allocation to Medicaid or other limits consistent with economy, efficiency, and access to care. Payments from the Fund would not count as patient service revenue. See attachment for additional detail.
✓	Ability to provide temporary shelter for homeless people who have a diagnosis of COVID-19, have a known exposure to COVID-19, or live in COVID-19 hotspots to ensure access to critically needed beds
✓	Ability to offer nutrition support to allow vulnerable Medicaid beneficiaries, including seniors, individuals with disabilities, and children, to comply with social distancing and home orders
✓	Ability to require managed care plans to make directed payments to certain behavioral health providers, without prior approval from CMS as required under 42 C.F.R. § 438.6.
✓	Ability to permit managed care plans to cover as an "in lieu of" service inpatient treatment in an IMD lasting more than 15 days in a month

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.

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

State Medicaid Director Name: Dave Richard
Telephone Number: (919)855-4101
E-mail Address: dave.richard@dhhs.nc.gov

State Lead Contact for Demonstration Application: Jay Ludlam
Telephone Number: (919)527-7033
E-mail Address: jay.ludlam@dhhs.nc.gov

Authorizing Official (Typed): Mandy Cohen, MD

Authorizing Official (Signature): Mandy K Cohen ____________________
Date: March 27, 2020

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 1115 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 Judith Cash at 410-786-9686.

Additional Specifications for COVID-19 Disaster Relief Fund

North Carolina is requesting expenditure authority to establish a COVID-19 Disaster Relief Fund (the "Fund") that can be used to sustain providers through the pandemic and mitigate the impact of the virus. The Fund would have three different permissible uses, as outlined in the 1115 waiver template and described in more detail below. The State shares CMS's interest in ensuring that dollars from the Fund are deployed efficiently and responsibly, and that recipients do not divert dollars to non-COVID-19 uses. This attachment includes additional details related to how the State would distribute dollars from the Fund and how it would monitor appropriate use.

The guardrails below apply to all expenditures:

- **Medicaid pays only for its share.** As a general matter, all expenditures would be subject to appropriate cost allocation to Medicaid. Medicaid has an important role in sustaining providers and supporting communities throughout this crisis, but these funds are to be used to protect Medicaid beneficiaries and providers that serve significant numbers of Medicaid beneficiaries.
- **Medicaid is the payer of last resort.** Providers would be required to rely on financial support from other sources to the extent available. Congress is moving quickly to address the pandemic; if Congress creates new funding streams that overlap with some of the intended uses of the Fund, the State would require providers and communities to first exhaust what other funds are available.
- **Expenditures must be consistent with economy, efficiency, and access to care.** Like all Medicaid payments, payments from the Fund would be consistent with economy, efficiency, and access to care. The State would achieve this by capping funding at cost and, for some uses, require pre-approval of budgets or limit expenditures used to sustain providers to no more than historical levels.
- **All records would be subject to audit.** The State will require that any entity receiving payments from the Fund maintain accurate records, and the State will conduct random audits to ensure appropriate use.

Additional details on how the State would make payments for each of the three different uses of the Fund are described below:

- **Cover uncompensated care costs of providers related to COVID-19.**
    - Providers delivering COVID-19-related services would be eligible to receive uncompensated care payments, including hospitals, sub-acute care, and primary care.
    - The State may create a bifurcated system to structure payments in a way that acknowledges the differences between hospital and non-hospital providers:
        - *Hospital providers*. Drawing from DSH methodologies, uncompensated care payments would be capped at a hospital's uncompensated care costs. Total uncompensated care costs would be calculated using DSH rules and then would be allocated to COVID-19 based on each hospital's percentage of patients with a diagnosis of COVID-19. (For example, if 35% of a hospital's patient days are for COVID-19 patients, then up to 35% of the hospital's uncompensated care costs would be eligible for payment from the Fund.)
        - *Non-hospital providers.* The State would establish a per diem (for sub-acute care) or encounter rate (for non-hospital ambulatory care), based on Medicaid rates. Providers would be eligible for a per diem or encounter payment for their uninsured COVID-19 patients.

- **Assist providers in making necessary investments to adapt healthcare delivery to reflect the realities of COVID-19**
  - The State would create a list of approved COVID-19-related items for purchase that could be eligible for partial reimbursement from the Fund. Approved items would include telemedicine software and hardware, personal protective equipment, and ventilators. All expenditures above a certain dollar threshold would require prior approval.
  - For other investments, like to reconfigure non-clinical space, convert units to ICUs, establish alternative screening sites, or create quarantine/sub-acute care spaces, providers would need approval prior to payment.
  - Expenses would be cost allocated to Medicaid based on the providers Medicaid share, in terms of patient days or encounters, as appropriate.
  - Providers would first be required to apply for funding from the Department of Health and Human Services.
- **Support vulnerable providers as necessary to preserve access to care in light of dramatic shifts in utilization**
  - The State would target dollars to vulnerable high Medicaid and rural providers based on size, cash reserves, and eligibility for other special payments.
  - At the provider level, aggregate payments to maintain access—meaning claims payments plus any additional payments from the Fund—to providers for the year would be capped at the prior year's Medicaid payments.