

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 rule 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 December 1, 2020:

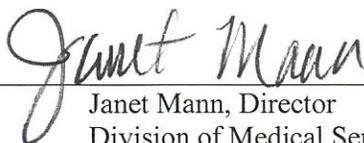
The Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) intends to implement an Electronic Visit Verification (EVV) system for in-home personal care services, attendant care, and respite services paid by Medicaid pursuant to section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(1)). An EVV system electronically verifies the type of service performed, the individual receiving service, date of the service, location of service delivery, the individual providing the service, and the time the service begins and ends. This proposed rule establishes utilization standards for provider agencies to electronically verify home visits, and verify clients receive the services authorized for which Medicaid is billed. DHS contracted a vendor to implement an EVV system that uses a smartphone application or landline phone-based system (IVR) for in-home caregivers to check-in and check-out when providing service at a client's home. The caregiver's GPS coordinates at the home are recorded and verified.

The proposed rule amends sections of the Arkansas Medicaid Provider Manual. Section 131.000 states that a provider cannot bill a beneficiary for a claim or portion thereof if the claim was denied or rejected because the provider failed to meet EVV requirements. Section 145.100 outlines the legal basis and scope of the EVV requirement. Section 145.200 establishes steps a provider must take to become eligible to use EVV. EVV will be required for submitting to Medicaid claims for reimbursement for in-home personal care services. Providers must obtain a unique identification number for each caregiver employed or contracted to serve beneficiaries and ensure that each caregiver uses the EVV system. Section 145.300 establishes that any claim for reimbursement filed with Medicaid for in-home personal care services must be verified by EVV and outlines the specific procedure codes that are subject to the EVV requirement. Section 145.400 establishes a process for providers to use their own EVV system if certified by the DHS EVV vendor.

The proposed rule is 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 rule on the Medicaid website at <https://medicaid.mmis.arkansas.gov/General/Comment/Comment.aspx>. 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 October 4, 2020. 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 501-320-6266.

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

TOC Required**131.000 Charges that Are Not the Responsibility of the Beneficiary****9-1-0812-1-
20**

Except for cost sharing responsibilities outlined in Sections 133.000 – 135.000, a beneficiary is not liable for the following charges:

- A. A claim or portion of a claim denied for lack of medical necessity.
- B. Charges in excess of the Medicaid maximum allowable rate.
- C. A claim or portion of a claim denied due to provider error.
- D. A claim or portion of a claim denied because of errors made by DMS or the Arkansas Medicaid fiscal agent.
- E. A claim or portion of a claim denied due to changes made in state or federal mandates after services were performed.
- F. A claim or portion of a claim denied because a provider failed to obtain prior, concurrent, or retroactive authorization for a service.
- G. A claim or portion of a claim denied because the claim did not meet Electronic Visit Verification (EVV) requirements (see 145.000).
- GH. The difference between the beneficiary Medicaid cost sharing responsibility, if any, and the Medicare or Medicare Advantage co-payments.
- HJ. Medicaid pays the difference, if any, between the Medicaid maximum allowable fee and the total of all payments previously received by the provider for the same service. Medicaid beneficiaries are not responsible for deductibles, co-payments, or coinsurance amounts to the extent that such payments, when added to the amounts paid by third parties, equal or exceed the Medicaid maximum for that service, even if the Medicaid payment is zero. -The beneficiary is responsible for paying applicable Medicaid cost share amounts.
- IJ. The beneficiary is not responsible for insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the beneficiary as a Medicaid patient. Arkansas Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. -Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate.

If an individual who makes payment at the time of service is later found to be Medicaid eligible and Medicaid is billed, the individual must be refunded the full amount of his or her payment for the covered service(s). -If it is agreeable with the individual, these funds may be credited against unpaid non-covered services and Medicaid cost-sharing amounts that are the responsibility of the beneficiary.

The beneficiary may not be billed for the completion and submission of a Medicaid claim form.

Exception: Medicaid does not cover the deductible, co-payments, or other cost share amounts levied to Medicare Part D drugs.

145.000 Electronic Visit Verification (EVV) for In-Home Personal Care, Attendant Care, and Respite-Services

145.100 Legal Basis and Scope of EVV Requirement**12-1-20**

In accordance with section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(l)), the Arkansas Department of Human Services (DHS) is implementing an electronic visit verification (EVV) system for in-home personal care services (PCS), attendant care, and respite services paid by Medicaid.

An EVV system is a telephone-, computer-, or other technology-based system under which visits conducted as part of personal care services or home health care services are electronically verified with respect to:

1. The type of service(s) performed;
2. The individual receiving the service(s);
3. The date of the service(s);
4. The location of service delivery;
5. The individual providing the service(s); and
6. The time the service(s) begins and ends.

The EVV requirement establishes utilization standards for provider agencies to electronically verify home visits and verify that clients receive the services authorized for their support and for which Medicaid is being billed.

The EVV requirement applies to Medicaid PCS, attendant care, or respite care provided during an in-home visit under the Medicaid State Plan, the Provider-Led Arkansas Shared Savings Entity (PASSE), the ARChoices Medicaid §1915(c) Home and Community-Based Services Waiver, or under any self-direction plan.

PCS, attendant care, and respite services provided to more than one person throughout a shift in 24-hour residential settings are not subject to the EVV requirement because they do not involve an “in home” visit. This includes without limitation PCS, attendant care, and respite services provided in a group home, assisted living facility, hospital, nursing facility, or other congregate setting.

PCS, attendant care or respite services provided to a student in a public school is not subject to the EVV requirement because it does not involve an “in-home” visit.

Additional information regarding EVV is available from the DHS EVV Vendor. **View or print the DHS EVV Vendor contact information.**

145.200 EVV Participation Requirements**12-1-20**

To submit a claim for any service that is subject to the EVV requirement or pay based upon a self-directed plan of care subject to the EVV requirement, a provider must:

1. Submit and maintain on file with both DHS Provider Enrollment and the DHS EVV Vendor a contact e-mail address for the provider. The e-mail address must be one that is active and is controlled and regularly checked by the provider. The e-mail address must be a business address that is unique to the provider and must not be an employee’s personal e-mail address or other shared address. The e-mail address submitted by a provider to DHS Provider Enrollment will be the e-mail address used by the DHS EVV Vendor to create the provider’s account to access the EVV system;
2. Obtain from DHS a Medicaid Practitioner Identification Number (PIN) for each and every caregiver employed or contracted by the provider to furnish care for which Medicaid PCS, attendant care, or respite care claims may be submitted;

3. Submit, with every claim for a service subject to the EVV requirement, the PIN for the caregiver providing the service to the beneficiary. The PIN shall be listed in the field for the Rendering Provider ID#;
4. Use an EVV system that documents and verifies every in-home visit resulting in a claim for reimbursement. A provider must use the EVV system furnished by the DHS EVV Vendor or a third-party EVV system that has been certified by the DHS EVV Vendor;
5. Require caregivers employed or contracted by the provider to use EVV for all in-home Medicaid-paid PCS, attendant care, or respite care, and train the caregivers on the use of the provider's chosen EVV system;
6. If the provider uses the DHS EVV system, register the provider's caregivers with the EVV system. By registering a caregiver with the DHS EVV system, the provider is attesting that all applicable requirements, including without limitation training requirements, have been satisfied for that caregiver. A caregiver who is excluded or debarred from participation in Medicaid under any state or federal law is not eligible to register with the DHS EVV system;
7. Create and maintain documentation to justify any manual modifications, adjustments, or exceptions made by the provider in the EVV system after a caregiver has entered or failed to enter any required information;
8. Comply with EVV requirements established by the Centers for Medicare & Medicaid Services (CMS);
9. Comply with applicable federal and state laws regarding confidentiality of information about clients receiving services; and
10. Ensure that DHS may review documentation generated by an EVV system or obtain a copy of that documentation at no charge.

145.300 EVV Claims Requirements**12-1-20**

EVV is required for the following procedure codes and modifiers when the Place of Service is coded as the beneficiary's home (POS code 12):

<u>Procedure Code</u>	<u>Modifier</u>	<u>Service Description</u>
<u>T1019</u>		<u>Personal Care for a (non-RCF) Beneficiary Under 21</u>
<u>T1019</u>	<u>U3</u>	<u>Personal Care for a non-RCF Beneficiary Aged 21 or Older</u>
<u>S5125</u>		<u>Attendant Care Services</u>
<u>S5125</u>	<u>U2</u>	<u>Agency Attendant Care Traditional</u>
<u>S5150</u>		<u>Respite Care – In-Home</u>

A claim for any of these procedure codes and modifiers may be rejected or denied, or subject to recoupment, if delivery of the service was not verified by EVV or if there is any inconsistency among or between:

1. The data submitted in the claim;
2. The data recorded by EVV for the claimed service;
3. The data in the approved prior authorization or plan of care applicable to the claimed service; or
4. Address or other eligibility data maintained in the Medicaid Management Information System (MMIS) or other eligibility system maintained by DHS.

A claim for any of these procedure codes and modifiers is subject to the EVV requirement regardless of how the claim is submitted, including third-party EVV vendors, through a PASSE claims system, or through a self-direction plan.

For PCS delivered in a beneficiary's home, it is a fraudulent billing practice to list any Place of Service (POS) code other than POS code 12, unless the Provider Manual or other Rule explicitly permits the use of a different POS code.

The EVV Requirement also applies to any equivalent services provided to a beneficiary through the IndependentChoices program, or any other self-direction program made available under the state plan or ARChoices. Such equivalent services may be rejected or denied if delivery of the service was not verified by EVV or if there is any inconsistency among or between:

1. The data submitted in the claim;
2. The data recorded by EVV for the claimed service;
3. The data in the approved prior authorization or plan of care applicable to the claimed service; or
4. Address or other eligibility data maintained in the Medicaid Management Information System (MMIS) or other eligibility system maintained by DHS.

145.400 Third Party EVV System Requirements

12-1-20

A third-party EVV system procured and chosen by a provider or Managed Care Organization (MCO) or self-directed services vendor must be certified by the DHS EVV Vendor as meeting the following requirements:

1. The provider must submit a written attestation that the third-party EVV system meets or exceeds all applicable CMS and DHS requirements. Certification of a third-party EVV system is valid only so long as the system continues to meet or exceed all applicable CMS and DHS requirements;
2. The DHS EVV Vendor must certify that the third-party EVV system has the technical capabilities to receive and transmit all EVV data in a way that is compatible with the DHS EVV system; and
3. The third-party EVV system must timely collect and submit to the DHS EVV Vendor all data required for EVV verification of a claim, including without limitation:
 - a. The procedure code and modifier for the service(s) delivered, and the specific ADL/IADL task(s) performed by the caregiver during the visit;
 - b. Identifying information for the beneficiary, including without limitation the beneficiary's Medicaid identification number;
 - c. The date of the service(s);
 - d. The location where the service(s) were delivered;
 - e. Identifying information for the agency and the individual caregiver providing the service(s), including without limitation a Practitioner Identification Number (PIN) as assigned by DHS for the individual caregiver who is listed as the rendering provider;
 - f. Universal Time Code (UTC) for the time the service(s) begins and ends; and
 - g. EVV capture method (including without limitation telephony, GPS, or fixed visit) and corresponding validation data (including without limitation phone number, coordinates, or encryption key); and
4. By including a caregiver in any EVV data submitted to the DHS EVV Vendor, the provider is attesting that all applicable requirements, including without limitation training requirements and background checks, have been satisfied for that caregiver. Claims made for services performed by a caregiver who is excluded or debarred

from participation in Medicaid may be denied or rejected and are subject to recoupment.

MARKY UP

TOC Required**131.000 Charges that Are Not the Responsibility of the Beneficiary**

12-1-20

Except for cost sharing responsibilities outlined in Sections 133.000 – 135.000, a beneficiary is not liable for the following charges:

- A. A claim or portion of a claim denied for lack of medical necessity.
- B. Charges in excess of the Medicaid maximum allowable rate.
- C. A claim or portion of a claim denied due to provider error.
- D. A claim or portion of a claim denied because of errors made by DMS or the Arkansas Medicaid fiscal agent.
- E. A claim or portion of a claim denied due to changes made in state or federal mandates after services were performed.
- F. A claim or portion of a claim denied because a provider failed to obtain prior, concurrent, or retroactive authorization for a service.
- G. A claim or portion of a claim denied because the claim did not meet Electronic Visit Verification (EVV) requirements (see 145.000).
- H. The difference between the beneficiary Medicaid cost sharing responsibility, if any, and the Medicare or Medicare Advantage co-payments.
- I. Medicaid pays the difference, if any, between the Medicaid maximum allowable fee and the total of all payments previously received by the provider for the same service. Medicaid beneficiaries are not responsible for deductibles, co-payments, or coinsurance amounts to the extent that such payments, when added to the amounts paid by third parties, equal or exceed the Medicaid maximum for that service, even if the Medicaid payment is zero. The beneficiary is responsible for paying applicable Medicaid cost share amounts.
- J. The beneficiary is not responsible for insurance cost share amounts if the claim is for a Medicaid-covered service by a Medicaid-enrolled provider who accepted the beneficiary as a Medicaid patient. Arkansas Medicaid pays the difference between the amount paid by private insurance and the Medicaid maximum allowed amount. Medicaid will not make any payment if the amount received from the third party insurance is equal to or greater than the Medicaid allowable rate.

If an individual who makes payment at the time of service is later found to be Medicaid eligible and Medicaid is billed, the individual must be refunded the full amount of his or her payment for the covered service(s). If it is agreeable with the individual, these funds may be credited against unpaid non-covered services and Medicaid cost-sharing amounts that are the responsibility of the beneficiary.

The beneficiary may not be billed for the completion and submission of a Medicaid claim form.

Exception: Medicaid does not cover the deductible, co-payments, or other cost share amounts levied to Medicare Part D drugs.

145.000 Electronic Visit Verification (EVV) for In-Home Personal Care, Attendant Care, and Respite-Services

145.100 Legal Basis and Scope of EVV Requirement

12-1-20

In accordance with section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(l)), the Arkansas Department of Human Services (DHS) is implementing an electronic visit verification (EVV) system for in-home personal care services (PCS), attendant care, and respite services paid by Medicaid.

An EVV system is a telephone-, computer-, or other technology-based system under which visits conducted as part of personal care services or home health care services are electronically verified with respect to:

1. The type of service(s) performed;
2. The individual receiving the service(s);
3. The date of the service(s);
4. The location of service delivery;
5. The individual providing the service(s); and
6. The time the service(s) begins and ends.

The EVV requirement establishes utilization standards for provider agencies to electronically verify home visits and verify that clients receive the services authorized for their support and for which Medicaid is being billed.

The EVV requirement applies to Medicaid PCS, attendant care, or respite care provided during an in-home visit under the Medicaid State Plan, the Provider-Led Arkansas Shared Savings Entity (PASSE), the ARChoices Medicaid §1915(c) Home and Community-Based Services Waiver, or under any self-direction plan.

PCS, attendant care, and respite services provided to more than one person throughout a shift in 24-hour residential settings are not subject to the EVV requirement because they do not involve an “in home” visit. This includes without limitation PCS, attendant care, and respite services provided in a group home, assisted living facility, hospital, nursing facility, or other congregate setting.

PCS, attendant care or respite services provided to a student in a public school is not subject to the EVV requirement because it does not involve an “in-home” visit.

Additional information regarding EVV is available from the DHS EVV Vendor. [View or print the DHS EVV Vendor contact information.](#)

145.200 EVV Participation Requirements

12-1-20

To submit a claim for any service that is subject to the EVV requirement or pay based upon a self-directed plan of care subject to the EVV requirement, a provider must:

1. Submit and maintain on file with both DHS Provider Enrollment and the DHS EVV Vendor a contact e-mail address for the provider. The e-mail address must be one that is active and is controlled and regularly checked by the provider. The e-mail address must be a business address that is unique to the provider and must not be an employee’s personal e-mail address or other shared address. The e-mail address submitted by a provider to DHS Provider Enrollment will be the e-mail address used by the DHS EVV Vendor to create the provider’s account to access the EVV system;
2. Obtain from DHS a Medicaid Practitioner Identification Number (PIN) for each and every caregiver employed or contracted by the provider to furnish care for which Medicaid PCS, attendant care, or respite care claims may be submitted;

3. Submit, with every claim for a service subject to the EVV requirement, the PIN for the caregiver providing the service to the beneficiary. The PIN shall be listed in the field for the Rendering Provider ID#;
4. Use an EVV system that documents and verifies every in-home visit resulting in a claim for reimbursement. A provider must use the EVV system furnished by the DHS EVV Vendor or a third-party EVV system that has been certified by the DHS EVV Vendor;
5. Require caregivers employed or contracted by the provider to use EVV for all in-home Medicaid-paid PCS, attendant care, or respite care, and train the caregivers on the use of the provider's chosen EVV system;
6. If the provider uses the DHS EVV system, register the provider's caregivers with the EVV system. By registering a caregiver with the DHS EVV system, the provider is attesting that all applicable requirements, including without limitation training requirements, have been satisfied for that caregiver. A caregiver who is excluded or debarred from participation in Medicaid under any state or federal law is not eligible to register with the DHS EVV system;
7. Create and maintain documentation to justify any manual modifications, adjustments, or exceptions made by the provider in the EVV system after a caregiver has entered or failed to enter any required information;
8. Comply with EVV requirements established by the Centers for Medicare & Medicaid Services (CMS);
9. Comply with applicable federal and state laws regarding confidentiality of information about clients receiving services; and
10. Ensure that DHS may review documentation generated by an EVV system or obtain a copy of that documentation at no charge.

145.300 EVV Claims Requirements

12-1-20

EVV is required for the following procedure codes and modifiers when the Place of Service is coded as the beneficiary's home (POS code 12):

Procedure Code	Modifier	Service Description
T1019		Personal Care for a (non-RCF) Beneficiary Under 21
T1019	U3	Personal Care for a non-RCF Beneficiary Aged 21 or Older
S5125		Attendant Care Services
S5125	U2	Agency Attendant Care Traditional
S5150		Respite Care – In-Home

A claim for any of these procedure codes and modifiers may be rejected or denied, or subject to recoupment, if delivery of the service was not verified by EVV or if there is any inconsistency among or between:

1. The data submitted in the claim;
2. The data recorded by EVV for the claimed service;
3. The data in the approved prior authorization or plan of care applicable to the claimed service; or
4. Address or other eligibility data maintained in the Medicaid Management Information System (MMIS) or other eligibility system maintained by DHS.

A claim for any of these procedure codes and modifiers is subject to the EVV requirement regardless of how the claim is submitted, including third-party EVV vendors, through a PASSE claims system, or through a self-direction plan.

For PCS delivered in a beneficiary's home, it is a fraudulent billing practice to list any Place of Service (POS) code other than POS code 12, unless the Provider Manual or other Rule explicitly permits the use of a different POS code.

The EVV Requirement also applies to any equivalent services provided to a beneficiary through the IndependentChoices program, or any other self-direction program made available under the state plan or ARChoices. Such equivalent services may be rejected or denied if delivery of the service was not verified by EVV or if there is any inconsistency among or between:

1. The data submitted in the claim;
2. The data recorded by EVV for the claimed service;
3. The data in the approved prior authorization or plan of care applicable to the claimed service; or
4. Address or other eligibility data maintained in the Medicaid Management Information System (MMIS) or other eligibility system maintained by DHS.

145.400 Third Party EVV System Requirements

12-1-20

A third-party EVV system procured and chosen by a provider or Managed Care Organization (MCO) or self-directed services vendor must be certified by the DHS EVV Vendor as meeting the following requirements:

1. The provider must submit a written attestation that the third-party EVV system meets or exceeds all applicable CMS and DHS requirements. Certification of a third-party EVV system is valid only so long as the system continues to meet or exceed all applicable CMS and DHS requirements;
2. The DHS EVV Vendor must certify that the third-party EVV system has the technical capabilities to receive and transmit all EVV data in a way that is compatible with the DHS EVV system; and
3. The third-party EVV system must timely collect and submit to the DHS EVV Vendor all data required for EVV verification of a claim, including without limitation:
 - a. The procedure code and modifier for the service(s) delivered, and the specific ADL/IADL task(s) performed by the caregiver during the visit;
 - b. Identifying information for the beneficiary, including without limitation the beneficiary's Medicaid identification number;
 - c. The date of the service(s);
 - d. The location where the service(s) were delivered;
 - e. Identifying information for the agency and the individual caregiver providing the service(s), including without limitation a Practitioner Identification Number (PIN) as assigned by DHS for the individual caregiver who is listed as the rendering provider;
 - f. Universal Time Code (UTC) for the time the service(s) begins and ends; and
 - g. EVV capture method (including without limitation telephony, GPS, or fixed visit) and corresponding validation data (including without limitation phone number, coordinates, or encryption key); and
4. By including a caregiver in any EVV data submitted to the DHS EVV Vendor, the provider is attesting that all applicable requirements, including without limitation training requirements and background checks, have been satisfied for that caregiver. Claims made for services performed by a caregiver who is excluded or debarred from participation in Medicaid may be denied or rejected and are subject to recoupment.

[42 USCS § 1396b](#)

Current through PL 116-19, approved May 31, 2019

United States Code Service - Titles 1 through 54 > TITLE 42. THE PUBLIC HEALTH AND WELFARE > CHAPTER 7. SOCIAL SECURITY ACT > TITLE XIX. GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§ 1396b. Payment to States

(a) Computation of amount. From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this [title \[42 USCS §§ 1396 et seq.\]](#) for each quarter, beginning with the quarter commencing January 1, 1966--

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b) [[42 USCS § 1396d\(b\)](#)]), subject to subsections (g) and (j) of this section and section 1923(f) [[42 USCS § 1396r-4\(f\)](#)] of the total amount expended during such quarter as medical assistance under the State plan; plus

(2)

(A) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus

(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) [[42 USCS § 1396r\(e\)\(1\)](#)] (including the costs for nurse aides to complete such competency evaluation programs), regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent (or, for calendar quarters beginning on or after July 1, 1988, and before October 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus

(C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1919(e)(7) [[42 USCS § 1396r\(e\)\(7\)](#)]; plus

(D) for each calendar quarter during--

(i) fiscal year 1991, an amount equal to 90 percent,

(ii) fiscal year 1992, an amount equal to 85 percent,

(iii) fiscal year 1993, an amount equal to 80 percent, and

(iv) fiscal year 1994 and thereafter, an amount equal to 75 percent,

of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under section 1919(g) [[42 USCS § 1396r\(g\)](#)]; plus

42 USCS § 1396b

(26)with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) [[42 USCS § 1396u-7\(b\)\(1\)](#)] or benchmark equivalent coverage described in section 1937(b)(2) [[42 USCS § 1396u-7\(b\)\(1\)](#)]; or

(27)with respect to any amounts expended by the State on the basis of a fee schedule for items described in section 1861(n) [[42 USCS § 1395x\(n\)](#)] and furnished on or after January 1, 2018, as determined in the aggregate with respect to each class of such items as defined by the Secretary, in excess of the aggregate amount, if any, that would be paid for such items within such class on a fee-for-service basis under the program under part B of title XVIII [[42 USCS §§ 1395j](#) et seq.], including, as applicable, under a competitive acquisition program under section 1847 [[42 USCS § 1395w-3](#)] in an area of the State.

Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this [title \[42 USCS §§ 1396](#) et seq.] that are not reasonable in amount, duration, and scope to achieve their purpose. Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1932(a)(1)(B) [[42 USCS § 1396u-2\(a\)\(1\)\(B\)](#)]) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.

(j)Adjustment of amount. Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1914 [[42 USCS § 1396m](#)].

(k)Technical assistance to States. The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any medicaid managed care organization which meets the requirements of subsection (m) of this section for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this title .

(l)Electronic visit verification system.

(1)Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this [title \[42 USCS §§ 1396](#) et seq.] (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2020 (or, in the case of home health care services, on or after January 1, 2023), unless a State requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced--

(A)in the case of personal care services--

(i)for calendar quarters in 2020, by .25 percentage points;

(ii)for calendar quarters in 2021, by .5 percentage points;

(iii)for calendar quarters in 2022, by .75 percentage points; and

(iv)for calendar quarters in 2023 and each year thereafter, by 1 percentage point; and

(B)in the case of home health care services--

(i)for calendar quarters in 2023 and 2024, by .25 percentage points;

(ii)for calendar quarters in 2025, by .5 percentage points;

(iii)for calendar quarters in 2026, by .75 percentage points; and

(iv)for calendar quarters in 2027 and each year thereafter, by 1 percentage point.

(2)Subject to paragraphs (3) and (4), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a State shall--

42 USCS § 1396b

(A)consult with agencies and entities that provide personal care services, home health care services, or both under the State plan (or under a waiver of the plan) to ensure that such system--

(i)is minimally burdensome;

(ii)takes into account existing best practices and electronic visit verification systems in use in the State; and

(iii)is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act [42 USCS § 300j-19]);

(B)take into account a stakeholder process that includes input from beneficiaries, family caregivers, individuals who furnish personal care services or home health care services, and other stakeholders, as determined by the State in accordance with guidance from the Secretary; and

(C)ensure that individuals who furnish personal care services, home health care services, or both under the State plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.

(3)Paragraphs (1) and (2) shall not apply in the case of a State that, as of the date of the enactment of this subsection, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services, so long as the State continues to require the use of such system with respect to the electronic verification of such visits.

(4)

(A)In the case of a State described in subparagraph (B), the reduction under paragraph (1) shall not apply--

(i)in the case of personal care services, for calendar quarters in 2020; and

(ii)in the case of home health care services, for calendar quarters in 2023.

(B)For purposes of subparagraph (A), a State described in this subparagraph is a State that demonstrates to the Secretary that the State--

(i)has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); and

(ii)in implementing such a system, has encountered unavoidable system delays.

(5)In this subsection:

(A)The term "electronic visit verification system" means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to--

(i)the type of service performed;

(ii)the individual receiving the service;

(iii)the date of the service;

(iv)the location of service delivery;

(v)the individual providing the service; and

(vi)the time the service begins and ends.

(B)The term "home health care services" means services described in section 1905(a)(7) provided under a State plan under this title (or under a waiver of the plan).

(C)The term "personal care services" means personal care services provided under a State plan under this title (or under a waiver of the plan), including services provided under section

42 USCS § 1396b

1905(a)(24), 1915(c), 1915(i), 1915(j), or 1915(k) [42 USCS § 1396d(a)(24), 1396n(c), (i), (j), or (k)] or under a wavier under section 1115 [42 USCS § 1315].

(6)

(A)In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

(B)Subparagraph (A) shall not apply in the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system that is not operated by the State or a contractor on behalf of the State.

(m)"Health maintenance organization" defined; duties and functions of Secretary; payments to States; provisional determination of status by State.

(1)

(A)The term "health maintenance organization" means a health maintenance organization, an eligible organization with a contract under section 1876 [42 USCS § 1395mm] or a Medicare + Choice organization with a contract under part C of title XVIII [42 USCS §§ 1395w-21 et seq.], a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1902(w) [42 USCS § 1396a(w)] and--

(i)makes services it provides to individuals eligible for benefits under this title [42 USCS §§ 1396 et seq.] accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

(ii)has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, meets the requirements of subparagraph (C)(i) (if applicable), and which assures that individuals eligible for benefits under this title [42 USCS §§ 1396 et seq.] are in no case held liable for debts of the organization in case of the organization's insolvency.

An organization that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) is deemed to meet the requirements of clauses (i) and (ii).

(B)The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a medicaid managed care organization within the meaning of subparagraph (A), shall be integrated with the administration of section 1312(a) and (b) of the Public Health Service Act [42 USCS § 300e-11(a) and (b)].

(C)

(i)Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk-bearing entity.

(ii)Clause (i) shall not apply to an organization if--

(I)the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians' services;

(II)the organization is a public entity;

(III)the solvency of the organization is guaranteed by the State; or



Division of Medical Services

P.O. Box 1437, Slot S401, Little Rock, AR 72203-1437

P: 501.682.8292 F: 501.682.1197

MEMORANDUM

TO: Interested Persons and Providers

FROM: Janet Mann, Director, Division of Medical Services

DATE: September 4, 2020

SUBJ: Electronic Visit Verification (EVV) Implementation

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov 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 have any comments, please submit those comments in writing, no later than October 4, 2020.