

ARKANSAS REGISTER

Proposed Rule Cover Sheet



Secretary of State
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Name of Department _____

Agency or Division Name _____

Other Subdivision or Department, If Applicable _____

Previous Agency Name, If Applicable _____

Contact Person _____

Contact E-mail _____

Contact Phone _____

Name of Rule _____

Newspaper Name _____

Date of Publishing _____

Final Date for Public Comment _____

Location and Time of Public Meeting _____

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:

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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

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MARK UP

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 - 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.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Brian Jones

TELEPHONE 501-537-2064 **FAX** _____ **EMAIL:** brian.jones@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 Electronic Visit Verification (EVV) Implementation

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

General Revenue	<u>\$365,729</u>
Federal Funds	<u>\$1,840,758</u>
Cash Funds	_____
Special Revenue	_____
Other (Identify)	_____

Next Fiscal Year

General Revenue	<u>\$241,800</u>
Federal Funds	<u>\$725,400</u>
Cash Funds	_____
Special Revenue	_____
Other (Identify)	_____

Total	<u>\$2,206,487</u>	Total	<u>\$967,200</u>
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(b) What is the additional cost of the state rule?

Current Fiscal Year

General Revenue	\$	
Federal Funds	\$	
Cash Funds		
Special Revenue		
Other (Identify)		
Total	\$	

Next Fiscal Year

General Revenue	\$	
Federal Funds	\$	
Cash Funds		
Special Revenue		
Other (Identify)		
Total	\$	

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

\$ 63,158

Next Fiscal Year

\$ 31,579

Some providers may purchase Smartphones or tablets for direct care workers to easily access the EVV system in client's homes

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

\$ 365,729

Next Fiscal Year

\$ 241,800

This represents the state share of expenditures for EVV implementation and ongoing maintenance and operations.

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;

The basis and purpose of this rule is to implement an electronic visit verification (EVV) system for in-home personal care services, attendant care, and respite services paid by Medicaid, as required by section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(l)).

- (2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute; Section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(l))

compels the Arkansas Medicaid program to require all personal care providers to use EVV for in-home services on and after December 1, 2020. DHS has no way to implement this requirement except through promulgation of a rule.

(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; Section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(1)) compels the Arkansas Medicaid program to require all personal care providers to use EVV for in-home services on and after December 1, 2020. The proposed rule reflects the implementation costs as determined through a competitive procurement process, and an estimate of the cost to providers. The costs estimated above are the minimum cost of the state coming into compliance with the EVV mandate.

(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; The agency is unaware of any less costly alternatives.

(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; No alternatives have been identified or suggested through public comment to date.

(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
No existing state rules have created or contributed to the problem the agency seeks to address. The need for this rule is entirely a creation of federal statute.

(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 monitors State and Federal rules and policies for opportunities to reduce and control cost.

Statement of Necessity and Rule Summary Electronic Visit Verification (EVV) Implementation

Statement of Necessity

Section 12006 of the 21st Century Cures Act (42 U.S.C. § 1396b(l)) requires states to implement Electronic Visit Verification (EVV) for in-home personal care services, attendant care, and respite services paid by Medicaid no later than December 1, 2020.

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);
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4. The location of service delivery;
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This proposed rule 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 Department of Human Services (DHS) has contracted with a vendor to implement an EVV system that uses a smartphone app for an in-home caregiver to check in and out when they go to a client's home to provide services. The smartphone app records the caregiver's GPS coordinates to verify that the caregiver is actually at the client's home.

Rule Summary

The proposed rule is an addition to an amendment of Section I of the Arkansas Medicaid Provider Manual.

- Section 131.000 is amended to clarify that a provider cannot bill a beneficiary for a claim or portion of a claim that was denied or rejected because the provider failed to meet the EVV requirements.
- Section 145.100 outlines the legal basis and scope of the EVV requirement.
- Section 145.200 establishes the steps that a Medicaid provider must take to become eligible to use EVV, which will be a requirement for submitting any claims for reimbursement to Medicaid for in-home personal care services. Providers will be required to obtain a unique identification number for each caregiver employed or contracted by the provider to serve Medicaid beneficiaries, and then ensure that each caregiver uses the EVV app.
- 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.
- Providers will have the ability to use their own EVV system instead of the state system, so long as that system is certified by the DHS EVV Vendor. The certification process is set out in section 145.400.