

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: Electronic Visit Verification (EVV) for In-Home Personal Care, Attendant Care, Respite Care, and Home Health (20 CAR pt. 600)

DESCRIPTION:

Statement of Necessity

The Division of Medical Services (DMS) updates Electronic Visit Verification (EVV) rules to align with requirements in the 21st Century Cures Act. EVV is provided for in-home personal care, attendant care, respite care, and home health services. The updates clarify expectations for the use of EVV, remove ambiguous language, and provide specific EVV provider requirements.

As part of the updates, DMS removes the provider application requirement to submit a copy of a W-9 tax form. Instead, DMS adds the requirement to submit a National Provider Identifier (if applicable) for health care providers as defined in 45 CFR § 160.103. New forms will capture information necessary to attest to EVV requirements.

Summary

DMS updates Section I of the Arkansas Medicaid Provider Manual. Sections 140.00 through 145.400 are revised to state the new EVV rules in compliance with the federal act and the new provider enrollment application process.

PUBLIC COMMENT: A public hearing was held on this rule on April 29, 2026. The public comment period expired on May 18, 2026. The agency indicated that it received no public comments.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The agency indicated that this rule has no financial impact.

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



ARKANSAS
DEPARTMENT OF
**HUMAN
SERVICES**

Office of Policy and Rules

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

P: 501.320.6383 F: 501.404.4619

April 17, 2026

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: Electronic Visit Verification (EVV) for In-home Personal Care, Attendant Care, Respite Care, and Home Health

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact me at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

Mac Golden

Mac Golden
Attorney III
Office of Policy and Rules

Attachments

**QUESTIONNAIRE FOR FILING PROPOSED RULES WITH
THE ARKANSAS LEGISLATIVE COUNCIL**

DEPARTMENT _____
 BOARD/COMMISSION _____
 BOARD/COMMISSION DIRECTOR _____
 CONTACT PERSON _____
 ADDRESS _____
 PHONE NO. _____ EMAIL _____
 NAME OF PRESENTER(S) AT SUBCOMMITTEE MEETING _____
 PRESENTER EMAIL(S) _____

INSTRUCTIONS

In order to file a proposed rule for legislative review and approval, please submit this Legislative Questionnaire and Financial Impact Statement, and attach (1) a summary of the rule, describing what the rule does, the rule changes being proposed, and the reason for those changes; (2) both a markup and clean copy of the rule; and (3) all documents required by the Questionnaire.

If the rule is being filed for permanent promulgation, please email these items to the attention of Rebecca Miller-Rice, miller-ricer@blr.arkansas.gov, for submission to the Administrative Rules Subcommittee.

If the rule is being filed for emergency promulgation, please email these items to the attention of Director Marty Garrity, garritym@blr.arkansas.gov, for submission to the Executive Subcommittee.

Please answer each question completely using layman terms.

1. What is the official title of this rule?

2. What is the subject of the proposed rule? _____
3. Is this rule being filed under the emergency provisions of the Arkansas Administrative Procedure Act? Yes No

If yes, please attach the statement required by Ark. Code Ann. § 25-15-204(c)(1).

If yes, will this emergency rule be promulgated under the permanent provisions of the Arkansas Administrative Procedure Act? Yes No

4. Is this rule being filed for permanent promulgation? Yes No

If yes, was this rule previously reviewed and approved under the emergency provisions of the Arkansas Administrative Procedure Act? Yes No

If yes, what was the effective date of the emergency rule? _____

On what date does the emergency rule expire? _____

5. Is this rule required to comply with a *federal* statute, rule, or regulation? Yes No

If yes, please provide the federal statute, rule, and/or regulation citation.

6. Is this rule required to comply with a *state* statute or rule? Yes No

If yes, please provide the state statute and/or rule citation.

7. Are two (2) rules being repealed in accord with Executive Order 23-02? Yes No

If yes, please list the rules being repealed.

If no, please explain.

8. Is this a new rule? Yes No

Does this repeal an existing rule? Yes No

If yes, the proposed repeal should be designated by strikethrough. If it is being replaced with a new rule, please attach both the proposed rule to be repealed and the replacement rule.

Is this an amendment to an existing rule? Yes No

If yes, all changes should be indicated by strikethrough and underline. In addition, please be sure to label the markup copy clearly as the markup.

9. What is the state law that grants the agency its rulemaking authority for the proposed rule, outside of the Arkansas Administrative Procedure Act? Please provide the specific Arkansas Code citation(s), including subsection(s).

10. Is the proposed rule the result of any recent legislation by the Arkansas General Assembly?
Yes No

If yes, please provide the year of the act(s) and act number(s).

11. What is the reason for this proposed rule? Why is it necessary?

12. Please provide the web address by which the proposed rule can be accessed by the public as provided in Ark. Code Ann. § 25-19-108(b)(1).

13. Will a public hearing be held on this proposed rule? Yes No

If yes, please complete the following:

Date: _____

Time: _____

Place: _____

Please be sure to advise Bureau Staff if this information changes for any reason.

14. On what date does the public comment period expire for the permanent promulgation of the rule? Please provide the specific date. _____

15. What is the proposed effective date for this rule? _____

16. Please attach (1) a copy of the notice required under Ark. Code Ann. § 25-15-204(a)(1) and (2) proof of the publication of that notice.

17. Please attach proof of filing the rule with the Secretary of State, as required by Ark. Code Ann. § 25-15-204(e)(1)(A).

18. Please give the names of persons, groups, or organizations that you anticipate will comment on these rules. Please also provide their position (for or against), if known.

19. Is the rule expected to be controversial? Yes No

If yes, please explain.

NOTICE OF RULE MAKING

The Department of Human Services (DHS) 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. The projected effective date of the rule is August 1, 2026. There is no fiscal impact.

The Division of Medical Services (DMS) updates Electronic Visit Verification (EVV) rules to align with requirements in the 21st Century Cures Act. EVV is provided for in-home personal care, attendant care, respite care, and home health services. The updates to Section I of the Arkansas Medicaid Provider Manual clarify expectations for the use of EVV, remove ambiguous language, and provide specific EVV provider requirements. As part of the updates, DMS removes the provider application requirement to submit a copy of a W-9 tax form. Instead, DMS adds the requirement to submit a National Provider Identifier (if applicable) for health care providers as defined in 45 CFR § 160.103. New forms will capture information necessary to attest to EVV requirements.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 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 at [ar.gov/dhs-proposed-rules](https://www.ark.gov/dhs-proposed-rules).

Public comments can be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than May 18, 2026. 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.

A public hearing will be held by remote access through Zoom. Public comments may be submitted at the hearing. The details for attending the Zoom hearing appear at [ar.gov/dhszoom](https://www.ark.gov/dhszoom).

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502292178

Elizabeth Pitman, Director
Division of Medical Services

From: [Legal Ads](#)
To: [Lisa Teague](#)
Subject: Re: Full Run AD (r. 318)
Date: Thursday, April 16, 2026 7:03:30 PM
Attachments: [image001.png](#)

CAUTION: External Email

Scheduled for Sun 4/19, Mon 4/20, and Tues 4/21. Thanks again.

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

From: "Lisa Teague" <Lisa.Teague@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>
Sent: Wednesday, April 15, 2026 9:15:58 AM
Subject: Full Run AD (r. 318)

Good morning,

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

- Sunday, April 19, 2026
- Monday, April 20, 2026
- Tuesday, April 21, 2026

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

Invoice to: AR Dept of Human Services

P.O. Box 1437

Slot S535

Little Rock, AR 72203

ATTN: Lakeya Gipson

(Lakeya.Gipson@dhs.arkansas.gov)

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

NOTE: Please reply to this email using “REPLY ALL”



Lisa Teague

Rules & Regulations Coordinator

Arkansas Department of Human Services

Office of Policy and Rules

P: 501.396.6428

lisa.teague@dhs.arkansas.gov

humanservices.arkansas.gov

Privacy Notice: This email may contain confidential information protected by state/federal laws. If you are not the intended recipient, please let the sender know, and delete the message/attachment(s) from your system.

From: [Lisa Teague](#)
To: arkansasregister@sos.arkansas.gov
Cc: [Jack Tiner](#); [Mac Golden](#); [Lakeya Gipson](#); [JAMIE EWING](#)
Subject: DHS/DMS - Propose Filing - EVV - Rule 318
Date: Friday, April 17, 2026 9:00:00 AM
Attachments: [SOS Initial - EVV.pdf](#)
[image001.png](#)

Good morning,

Attached is the proposed rule titled “Electronic Visit Verification (EVV) for In-home Personal Care, Attendant Care, Respite Care, and Home Health”. The public notice will appear in the Arkansas Democrat-Gazette April 19, 20, & 21st, 2026. The public comment period ends May 18, 2026. Please post.

Thank you,



Lisa Teague

Rules & Regulations Coordinator
Arkansas Department of Human Services
Office of Policy and Rules

P: 501.396.6428

lisa.teague@dhs.arkansas.gov

humanservices.arkansas.gov

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FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT _____
BOARD/COMMISSION _____
PERSON COMPLETING THIS STATEMENT _____
TELEPHONE NO. _____ **EMAIL** _____

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE _____

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 no, please explain:

(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 reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

(d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

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 _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Total _____

Next Fiscal Year

General Revenue _____
Federal Funds _____
Cash Funds _____
Special Revenue _____
Other (Identify) _____

Total _____

(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, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year

\$ _____

Next Fiscal Year

\$ _____

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

Current Fiscal Year

\$ _____

Next Fiscal Year

\$ _____

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

Statement of Necessity and Rule Summary

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

Statement of Necessity

The Division of Medical Services (DMS) updates Electronic Visit Verification (EVV) rules to align with requirements in the 21st Century Cures Act. EVV is provided for in-home personal care, attendant care, respite care, and home health services. The updates clarify expectations for the use of EVV, remove ambiguous language, and provide specific EVV provider requirements.

As part of the updates, DMS removes the provider application requirement to submit a copy of a W-9 tax form. Instead, DMS adds the requirement to submit a National Provider Identifier (if applicable) for health care providers as defined in 45 CFR § 160.103. New forms will capture information necessary to attest to EVV requirements.

Summary

DMS updates Section I of the Arkansas Medicaid Provider Manual. Sections 140.00 through 145.400 are revised to state the new EVV rules in compliance with the federal act and the new provider enrollment application process.

Please attach additional documents if necessary

TOC required

141.000 Provider Enrollment

41-1-178-1-
26

Any provider of health care services must be enrolled in the Arkansas Medicaid Program before Medicaid will cover any services provided by the provider to Arkansas Medicaid beneficiaries. Enrollment as a Medicaid provider is contingent upon the provider satisfying all rules and requirements for provider participation as specified in the applicable provider manual, state and federal law. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

All providers must sign all applicable forms that require a signature and the Arkansas Medicaid Provider Contract. The signature must be an original signature or an approved electronic signature of the individual provider. The provider's authorized representative may sign the contract for a group practice, hospital, agency or other institution.

In addition to the information in Section 140.000, Section II of each program's provider manual may contain supplemental provider type specific participation requirements. The provider enrollment functions for the Arkansas Medicaid Program are performed by an independent contractor. The contractor is responsible for provider enrollment services for new providers and changes to current provider enrollment files. Potential providers must complete all appropriate portions of a provider enrollment Application Packet to execute the provider contract. They must also submit a copy of all certifications and licenses verifying compliance with enrollment criteria for the applicable provider type or discipline to be practiced and pay the application fee (if applicable). See Section 141.101 for Application Fees.

Potential providers ~~may~~can learn how to enroll on the [-Provider Enrollment webpage of the DMS website, Arkansas Medicaid website at https://medicaid.mmis.arkansas.gov/](https://medicaid.mmis.arkansas.gov/). Potential providers ~~that~~who are not required to pay application fees may also send the printed form to the Medicaid Provider Enrollment Unit. [View or print the Provider Enrollment contact information.](#)

All subsequent state license and certification renewals must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and FINAL 30 days to comply. Failure to timely submit verification of license or certification renewals will result in cancellation of enrollment in the Arkansas Medicaid Program. [View or print the provider enrollment and contract package \(Application Packet\).](#)

In addition to the submission of the Application Packet, the following forms are required and must be submitted to complete the enrollment process:

- A. ~~W-9 Tax form (DMS-652)~~
- B. ~~—~~ Medicaid Provider Contract (DMS-652)
- ~~CB.~~ PCP Agreement, if applicable (DMS-2608. See Section 171.000 for PCP requirements.)
- ~~DC.~~ EPSDT Agreement, if applicable (DMS-831. See Section 201.000 of the EPSDT provider manual for the EPSDT Agreement.)
- ~~ED.~~ Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.
- ~~FE.~~ Authorization for Electronic Funds Transfer (Automatic Deposit)

F. National Provider Identifier (if applicable) for health care providers as defined in 45 CFR § 160.103

The provider must provide identifying information including the following: name, specialty, date of birth, Social Security number, Federal taxpayer identification number, and the State license or certification number (if applicable). This information is required for the screening processes required by 42 CFR Subpart E.

Each provider must notify the Medicaid Provider Enrollment Unit in writing immediately regarding any changes to its application or contract status, such as:

- A. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.
- B. Change in Federal Employer Identification Number (FEIN) may require the completion of a new enrollment application
- C. Authorization for Electronic Funds Transfer (Automatic Deposit)
- D. Change in practice or specialty
- E. Retirement or death of provider
- F. Name Change Form
- G. Change of Ownership Form (DMS-0688) ([View or print form DMS-0688 – Provider Change of Ownership Information Form.](#))
- H. Address/Email Change Form (DMS-673) ([View or print form DMS-673 – Address/Email Change Form.](#)) **NOTE:** An active email address is required.
- I. Change in Ownership Control (5% or more) or Conviction of Crime ([View or print form DMS-675 – Ownership and Conviction Disclosure.](#))
- J. Disclosure of Significant Business Transactions ([View or print form DMS-689 – Disclosure of Significant Business Transactions.](#))

When the provider has successfully met all requirements, the Medicaid Provider Enrollment Unit will assign a unique Medicaid number to the provider. The assigned provider number is linked to the provider's tax identification number (either a Social Security Number or a Federal Employer Identification Number) and to the provider's National Provider Identifier (NPI) ~~unless the provider is an atypical provider not required to have an NPI if applicable.~~

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Some entities do not qualify for NPIs. Specifically, any entity that does not meet the definition of a health care provider as defined in 45 CFR § 160.103 may not apply for an NPI.

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

145.100 **Legal Basis and Scope of EVV Requirement**

**4-1-248-1-
26**

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

- A. The type of service(s) performed;
- B. The individual receiving the service(s);
- C. The date of the service(s);
- D. The location of service delivery;
- E. The individual providing the service(s); and
- F. 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 beneficiaries receive the services authorized for their support and for which Medicaid is being billed.

The EVV requirement applies to Medicaid ~~PCS~~personal care, attendant care, respite care, and home health 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.

~~Personal Care~~S, attendant care, respite ~~services care~~, and home health services provided to more than one (1) 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~~ personal care, attendant care, respite ~~services care~~, and home health services provided in a group home, assisted living facility, hospital, nursing facility, or other congregate setting.

~~Personal Care~~care, attendant care, respite ~~services care~~, and home health services provided to a student in a public school are not subject to the EVV requirement because they do not involve an “in-home” visit.

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

145.200 EVV Participation Requirements

4-1-248-1-
26

To submit a claim ~~or encounter~~ 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:

- A. Submit and maintain on file with both ~~DHS~~Arkansas Medicaid Provider Enrollment and the ~~State-sponsored~~DHS EVV Vendor the following:
 1. a contact e-mail address for the provider agency/employer of record. The e-mail address must be an address 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.
 2. A contact e-mail address for the rendering provider (RN, LPN, PT, PTA, Home Health Aide, or caregiver). The e-mail address must be active and controlled and regularly checked by the rendering provider. The e-mail address must be unique to the rendering provider and must not be a shared address.
 3. The e-mail addresses submitted by athe provider to ~~DHS~~Arkansas Medicaid Provider Enrollment will be the e-mail addresses used by the ~~DHS~~State-sponsored EVV Vendor ~~to create the provider’s account to access the EVV system.~~;

- B. Submit to DHS an EVV Declaration Form, DMS-9654, identifying the agency's chosen EVV vendor and resubmit with any vendor changes prior to implementation. Agencies choosing a vendor other than the State's shall follow the process for third party EVV system certification outlined in Section 145.400 Third Party EVV System Requirements;
- C. Obtain from DHS a Medicaid Practitioner Identification Number (PIN) for each and every ~~caregiver employed~~rendering provider or contracted by the provider to furnish care for which Medicaid ~~PCS~~personal care, attendant care, or respite care claims may be submitted;
- ~~CD.~~ Ensure the rendering provider is not excluded or debarred from participation in Medicaid under any state or federal law;
- E. Submit, with every claim or encounter for a service subject to the EVV requirement, the PIN for the ~~caregiver~~rendering provider providing the service to the beneficiary. The PIN shall be listed in the field for the Rendering Provider ID number;
- ~~FD.~~ 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~~state-sponsored EVV Vendor or they must use a third-party EVV system that has been certified by the ~~DHS~~state-sponsored EVV Vendor;
- ~~GE.~~ Require ~~caregivers~~rendering providers, that are employed or contracted by the provider, to use EVV for all in-home visits for Medicaid-paid ~~PCS~~ personal care, attendant care, respite care, and home health care and to train the ~~caregivers~~ rendering providers on the use of the provider's chosen EVV system;
- ~~FH.~~ 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 ~~Ensure the rendering provider has met the providers' training requirements~~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);
- ~~GJ.~~ Use a mobile device application, an interactive voice response system (IVR/telephony) via the beneficiary's landline phone, or in some instances, an alternative verification device if approved by DHS, to capture valid EVV visits;
- J. Submit EVV compliant (as detailed in §145.100 of this manual) visits. Edited and manually entered visits are not EVV compliant and should be entered only as a last resort. Providers submitting non-compliant visits that are more than ten percent (10%) of total visits over a three-month timeframe must submit a corrective action plan within fourteen (14) calendar days of written notice, to ensure compliance with EVV requirements. If providers continue to have subsequent instances with more than ten percent (10%) of their total visits being non-compliant after the corrective action plan is implemented, additional sanctions as listed in Section 150.000 may be imposed;
- K. Create and maintain documentation to justify any manual modifications, adjustments, or exceptions made by the provider in the EVV system after a ~~caregiver~~rendering provider has entered or failed to enter any required information;
- ~~HJ.~~ Comply with EVV requirements established by the Centers for Medicare & Medicaid Services (CMS);
- ~~MI.~~ Comply with applicable federal and state laws regarding confidentiality of information about beneficiaries receiving services; and
- ~~NJ.~~ Ensure that ~~Provide~~ DHS may review upon its request, documentation generated by an EVV system or obtain a copy of that documentation at no charge.

The sanctions listed in Section 150.000 Administrative Remedies and Sanctions may be imposed if the provider does not meet the EVV requirements.

For the most up to date information, providers can visit the [Arkansas DHS EVV website](#).

145.300 EVV Claims Requirements

4-1-248-1-
26

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	U2	Agency Attendant -Care Traditional
S5150		Respite Care – In-Home
T1021	TD	Home Health RN Visit, per visit
T1021	TE	Home Health LPN Visit, per visit
T1021		Home Health Aide Visit
S9131	UB	Home Health Physical Therapy by a Qualified Physical Therapy Assistant
S9131		Home Health Physical Therapy by a Qualified Licensed Physical Therapist

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:

- A. The data submitted in the claim;
- B. The data recorded by EVV for the claimed service;
- C. The data in the approved prior authorization or plan of care applicable to the claimed service; or
- D. 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 PCSpersonal care, attendant care, respite care, and Home Health services 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.

~~A. The EVV Requirement also applies to any equivalent services provided to a beneficiary through the Independent Choices 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 the plan of care that is 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

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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 DHState-sponsored EVV Vendor as meeting the following requirements:

- ~~A1.~~ The provider must ~~submit a written attestation~~ that the third-party EVV system meets or exceeds all applicable CMS and DHS requirements using a **DMS-9655 Third-Party EVV System Attestation form**. 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;
- ~~B2.~~ The DHState-sponsored 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
- ~~3C.~~ The third-party EVV system must timely collect and submit to the DHState-sponsored EVV Vendor all data required for EVV verification of a claim, including without limitation:
 - ~~1a.~~ The procedure code and modifier for the service(s) delivered, and the specific ADL/IADL task(s) performed by the caregiver-rendering provider during the visit;
 - ~~2b.~~ Identifying information for the beneficiary, including without limitation the beneficiary's Medicaid identification number;
 - ~~3e.~~ The date of the service(s);
 - ~~4d.~~ The location where the service(s) were delivered;
 - ~~5e.~~ Identifying information for the agency and the individual caregiver-rendering provider 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;
 - ~~6f.~~ Universal Time Code (UTC) for the time the service(s) begins and ends; and
 - ~~7g.~~ EVV capture method (including without limitation telephony, GPS, or fixed visit mobile device application, interactive voice response system (IVR/telephony), or approved alternative verification device) and corresponding validation data (including without limitation phone number, GPS coordinates, or encryption key); For vendors offering use of an alternative verification device, these must be reviewed and approved by DHS to be considered a valid EVV capture method.~~and~~
- ~~D4.~~ By including a caregiver in any EVV data submitted to the DHState-sponsored EVV Vendor, the provider is attesting that all applicable requirements, including without limitation training requirements and background checks, have been satisfied for that caregiver-rendering provider. Claims made for services performed by a caregiver-rendering provider who is excluded or debarred from participation in Medicaid may be denied or rejected and are subject to recoupment.

E. DHS needs to be able to identify services received at home versus in the community. Therefore, all EVV systems must have the capability to identify and report visits taking place outside of a geofence as determined by DHS. The geofence does not prevent services from being provided.

MARKY-UP

TOC required**141.000 Provider Enrollment**

8-1-26

Any provider of health care services must be enrolled in the Arkansas Medicaid Program before Medicaid will cover any services provided by the provider to Arkansas Medicaid beneficiaries. Enrollment as a Medicaid provider is contingent upon the provider satisfying all rules and requirements for provider participation as specified in the applicable provider manual, state and federal law. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

All providers must sign all applicable forms that require a signature and the Arkansas Medicaid Provider Contract. The signature must be an original signature or an approved electronic signature of the individual provider. The provider's authorized representative may sign the contract for a group practice, hospital, agency or other institution.

In addition to the information in Section 140.000, Section II of each program's provider manual may contain supplemental provider type specific participation requirements. The provider enrollment functions for the Arkansas Medicaid Program are performed by an independent contractor. The contractor is responsible for provider enrollment services for new providers and changes to current provider enrollment files. Potential providers must complete all appropriate portions of a provider enrollment Application Packet to execute the provider contract. They must also submit a copy of all certifications and licenses verifying compliance with enrollment criteria for the applicable provider type or discipline to be practiced and pay the application fee (if applicable). See Section 141.101 for Application Fees.

Potential providers can learn how to enroll on the [Provider Enrollment webpage](#) of the DMS website. Potential providers who are not required to pay application fees may also send the printed form to the Medicaid Provider Enrollment Unit. [View or print the Provider Enrollment contact information.](#)

All subsequent state license and certification renewals must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and FINAL 30 days to comply. Failure to timely submit verification of license or certification renewals will result in cancellation of enrollment in the Arkansas Medicaid Program. [View or print the provider enrollment and contract package \(Application Packet\).](#)

In addition to the submission of the Application Packet, the following forms are required and must be submitted to complete the enrollment process:

- A. Medicaid Provider Contract (DMS-652)
- B. PCP Agreement, if applicable (DMS-2608. See Section 171.000 for PCP requirements.)
- C. EPSDT Agreement, if applicable (DMS-831. See Section 201.000 of the EPSDT provider manual for the EPSDT Agreement.)
- D. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.
- E. Authorization for Electronic Funds Transfer (Automatic Deposit)
- F. National Provider Identifier (if applicable) for health care providers as defined in 45 CFR § 160.103

The provider must provide identifying information including the following: name, specialty, date of birth, Social Security number, Federal taxpayer identification number, and the State license or certification number (if applicable). This information is required for the screening processes required by 42 CFR Subpart E.

Each provider must notify the Medicaid Provider Enrollment Unit in writing immediately regarding any changes to its application or contract status, such as:

- A. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.
- B. Change in Federal Employer Identification Number (FEIN) may require the completion of a new enrollment application
- C. Authorization for Electronic Funds Transfer (Automatic Deposit)
- D. Change in practice or specialty
- E. Retirement or death of provider
- F. Name Change Form
- G. Change of Ownership Form (DMS-0688) ([View or print form DMS-0688 – Provider Change of Ownership Information Form.](#))
- H. Address/Email Change Form (DMS-673) ([View or print form DMS-673 – Address/Email Change Form.](#)) **NOTE:** An active email address is required.
- I. Change in Ownership Control (5% or more) or Conviction of Crime ([View or print form DMS-675 – Ownership and Conviction Disclosure.](#))
- J. Disclosure of Significant Business Transactions ([View or print form DMS-689 – Disclosure of Significant Business Transactions.](#))

When the provider has successfully met all requirements, the Medicaid Provider Enrollment Unit will assign a unique Medicaid number to the provider. The assigned provider number is linked to the provider's tax identification number (either a Social Security Number or a Federal Employer Identification Number) and to the provider's National Provider Identifier (NPI) if applicable.

The **National Provider Identifier (NPI)** is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Some entities do not qualify for NPIs. Specifically, any entity that does not meet the definition of a health care provider as defined in 45 CFR § 160.103 may not apply for an NPI.

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

145.100 **Legal Basis and Scope of EVV Requirement**

8-1-26

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

- A. The type of service(s) performed;

- B. The individual receiving the service(s);
- C. The date of the service(s);
- D. The location of service delivery;
- E. The individual providing the service(s); and
- F. 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 beneficiaries receive the services authorized for their support and for which Medicaid is being billed.

The EVV requirement applies to Medicaid personal care, attendant care, respite care, and home health 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.

Personal care, attendant care, respite care, and home health services provided to more than one (1) 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: personal care, attendant care, respite care, and home health services provided in a group home, assisted living facility, hospital, nursing facility, or other congregate setting.

Personal care, attendant care, respite care, and home health services provided to a student in a public school are not subject to the EVV requirement because they do not involve an “in-home” visit.

Additional information regarding EVV is available from the State-sponsored EVV Vendor.

145.200 EVV Participation Requirements

8-1-26

To submit a claim or encounter for any service subject to the EVV requirement, a provider must:

- A. Submit and maintain on file with both Arkansas Medicaid Provider Enrollment and the State-sponsored EVV Vendor the following:
 - 1. A contact e-mail address for the provider agency/employer of record. The e-mail address must be an address 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.
 - 2. A contact e-mail address for the rendering provider (RN, LPN, PT, PTA, Home Health Aide, or caregiver). The e-mail address must be active and controlled and regularly checked by the rendering provider. The e-mail address must be unique to the rendering provider and must not be a shared address.
 - 3. The e-mail addresses submitted by the provider to Arkansas Medicaid Provider Enrollment will be the e-mail addresses used by the State-sponsored EVV Vendor.
- B. Submit to DHS an EVV Declaration Form, DMS-9654, identifying the agency’s chosen EVV vendor and resubmit with any vendor changes prior to implementation. Agencies choosing a vendor other than the State’s shall follow the process for third party EVV system certification outlined in Section 145.400 Third Party EVV System Requirements;
- C. Obtain from DHS a Medicaid Practitioner Identification Number (PIN) for each and every rendering provider or contracted by the provider to furnish care for which Medicaid personal care, attendant care, or respite care claims may be submitted;

- D. Ensure the rendering provider is not excluded or debarred from participation in Medicaid under any state or federal law;
- E. Submit, with every claim or encounter for a service subject to the EVV requirement, the PIN for the rendering provider providing the service to the beneficiary. The PIN shall be listed in the field for the Rendering Provider ID number;
- F. 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 State-sponsored EVV Vendor or they must use a third-party EVV system that has been certified by the State-sponsored EVV Vendor;
- G. Require rendering providers, employed or contracted by the provider, to use EVV for all in-home visits for Medicaid-paid personal care, attendant care, respite care, and home health care and to train the rendering providers on the use of the provider's chosen EVV system;
- H. Ensure the rendering provider has met the providers' training requirements;
- I. Use a mobile device application, an interactive voice response system (IVR/telephony) via the beneficiary's landline phone, or in some instances, an alternative verification device if approved by DHS, to capture valid EVV visits;
- J. Submit EVV compliant (as detailed in §145.100 of this manual) visits. Edited and manually entered visits are not EVV compliant and should be entered only as a last resort. Providers submitting non-compliant visits that are more than ten percent (10%) of total visits over a three-month timeframe must submit a corrective action plan within fourteen (14) calendar days of written notice, to ensure compliance with EVV requirements. If providers continue to have subsequent instances with more than ten percent (10%) of their total visits being non-compliant after the corrective action plan is implemented, additional sanctions as listed in Section 150.000 may be imposed;
- K. Create and maintain documentation to justify any manual modifications, adjustments, or exceptions made by the provider in the EVV system after a rendering provider has entered or failed to enter any required information;
- L. Comply with EVV requirements established by the Centers for Medicare & Medicaid Services (CMS);
- M. Comply with applicable federal and state laws regarding confidentiality of information about beneficiaries receiving services; and
- N. Provide DHS upon its request, documentation generated by an EVV system or obtain a copy of that documentation at no charge.

The sanctions listed in Section 150.000 Administrative Remedies and Sanctions may be imposed if the provider does not meet the EVV requirements.

For the most up to date information, providers can visit the [Arkansas DHS EVV website](#).

145.300 EVV Claims Requirements

8-1-26

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

Procedure Code	Modifier	Service Description
S5125	U2	Agency Attendant Care Traditional
S5150		Respite Care – In-Home
T1021	TD	Home Health RN Visit, per visit
T1021	TE	Home Health LPN Visit, per visit
T1021		Home Health Aide Visit
S9131	UB	Home Health Physical Therapy by a Qualified Physical Therapy Assistant
S9131		Home Health Physical Therapy by a Qualified Licensed Physical Therapist

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:

- A. The data submitted in the claim;
- B. The data recorded by EVV for the claimed service;
- C. The data in the approved prior authorization or plan of care applicable to the claimed service; or
- D. 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 personal care, attendant care, respite care, and Home Health services 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.

145.400 Third Party EVV System Requirements

8-1-26

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 State-sponsored EVV Vendor as meeting the following requirements:

- A. The provider must attest that the third-party EVV system meets or exceeds all applicable CMS and DHS requirements using a [DMS-9655 Third-Party EVV System Attestation form](#). 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;
- B. The State-sponsored 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
- C. The third-party EVV system must timely collect and submit to the State-sponsored EVV Vendor all data required for EVV verification of a claim, including without limitation:
 1. The procedure code and modifier for the service(s) delivered, and the specific ADL/IADL task(s) performed by the rendering provider during the visit;

2. Identifying information for the beneficiary, including without limitation the beneficiary's Medicaid identification number;
 3. The date of the service(s);
 4. The location where the service(s) were delivered;
 5. Identifying information for the agency and the individual rendering provider providing the service(s), including without limitation a Practitioner Identification Number (PIN) as assigned by DHS for the individual who is listed as the rendering provider;
 6. Universal Time Code (UTC) for the time the service(s) begins and ends; and
 7. EVV capture method (including without limitation mobile device application, interactive voice response system (IVR/telephony), or approved alternative verification device) and corresponding validation data (including without limitation phone number, GPS coordinates, or encryption key). For vendors offering use of an alternative verification device, these must be reviewed and approved by DHS to be considered a valid EVV capture method.
- D. By including a caregiver in any EVV data submitted to the State-sponsored EVV Vendor, the provider is attesting that all applicable requirements, including without limitation training requirements and background checks, have been satisfied for that rendering provider. Claims made for services performed by a rendering provider who is excluded or debarred from participation in Medicaid may be denied or rejected and are subject to recoupment.
- E. DHS needs to be able to identify services received at home versus in the community. Therefore, all EVV systems must have the capability to identify and report visits taking place outside of a geofence as determined by DHS. The geofence does not prevent services from being provided.

(A) those individuals who received treatment in an institution for mental diseases under the demonstration project;

(B) those individuals who met the eligibility requirements for the demonstration project but who did not receive treatment in an institution for mental diseases under the demonstration project; and

(C) those adults with a serious mental illness who did not meet such eligibility requirements and did not receive treatment for such illness in an institution for mental diseases.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that summarizes and analyzes the information collected under subsection (a). Such report may be submitted as part of the report required under section 2707(f) of the Patient Protection and Affordable Care Act (42 U.S.C. 1396a note) or separately.

SEC. 12005. PROVIDING EPSDT SERVICES TO CHILDREN IN IMDS.

42 USC 1396d
note.

(a) IN GENERAL.—Section 1905(a)(16) of the Social Security Act (42 U.S.C. 1396d(a)(16)) is amended—

(1) by striking “effective January 1, 1973” and inserting “(A) effective January 1, 1973”; and

(2) by inserting before the semicolon at the end the following: “, and, (B) for individuals receiving services described in subparagraph (A), early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)), whether or not such screening, diagnostic, and treatment services are furnished by the provider of the services described in such subparagraph”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to items and services furnished in calendar quarters beginning on or after January 1, 2019.

SEC. 12006. ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED FOR PERSONAL CARE SERVICES AND HOME HEALTH CARE SERVICES UNDER MEDICAID.

(a) IN GENERAL.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (k) the following new subsection:

“(1)(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 (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2019 (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 2019 and 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—

“(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);

“(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 2019; 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 1905(a)(24), 1915(c), 1915(i), 1915(j), or 1915(k) or under a wavier under section 1115.

“(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.”.

(b) COLLECTION AND DISSEMINATION OF BEST PRACTICES.—Not later than January 1, 2018, the Secretary of Health and Human Services shall, with respect to electronic visit verification systems (as defined in subsection (1)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), collect and disseminate best practices to State Medicaid Directors with respect to—

42 USC 1396b
note.

(1) training individuals who furnish personal care services, home health care services, or both under the State plan under title XIX of such Act (or under a waiver of the plan) on such systems and the operation of such systems and the prevention of fraud with respect to the provision of personal care services or home health care services (as defined in such subsection (1)(5)); and

(2) the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of such electronic visit verification systems and other means to prevent such fraud.

(c) RULES OF CONSTRUCTION.—

42 USC 1396b
note.

(1) NO EMPLOYER-EMPLOYEE RELATIONSHIP ESTABLISHED.—Nothing in the amendment made by this section may be construed as establishing an employer-employee relationship between the agency or entity that provides for personal care services or home health care services and the individuals who, under a contract with such an agency or entity, furnish such

services for purposes of part 552 of title 29, Code of Federal Regulations (or any successor regulations).

(2) **NO PARTICULAR OR UNIFORM ELECTRONIC VISIT VERIFICATION SYSTEM REQUIRED.**—Nothing in the amendment made by this section shall be construed to require the use of a particular or uniform electronic visit verification system (as defined in subsection (1)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)) by all agencies or entities that provide personal care services or home health care under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.).

(3) **NO LIMITS ON PROVISION OF CARE.**—Nothing in the amendment made by this section may be construed to limit, with respect to personal care services or home health care services provided under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.), provider selection, constrain beneficiaries' selection of a caregiver, or impede the manner in which care is delivered.

(4) **NO PROHIBITION ON STATE QUALITY MEASURES REQUIREMENTS.**—Nothing in the amendment made by this section shall be construed as prohibiting a State, in implementing an electronic visit verification system (as defined in subsection (1)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), from establishing requirements related to quality measures for such system.

TITLE XIII—MENTAL HEALTH PARITY

SEC. 13001. ENHANCED COMPLIANCE WITH MENTAL HEALTH AND SUBSTANCE USE DISORDER COVERAGE REQUIREMENTS.

(a) **COMPLIANCE PROGRAM GUIDANCE DOCUMENT.**—Section 2726(a) of the Public Health Service Act (42 U.S.C. 300gg–26(a)) is amended by adding at the end the following:

“(6) **COMPLIANCE PROGRAM GUIDANCE DOCUMENT.**—

“(A) **IN GENERAL.**—Not later than 12 months after the date of enactment of the Helping Families in Mental Health Crisis Reform Act of 2016, the Secretary, the Secretary of Labor, and the Secretary of the Treasury, in consultation with the Inspector General of the Department of Health and Human Services, the Inspector General of the Department of Labor, and the Inspector General of the Department of the Treasury, shall issue a compliance program guidance document to help improve compliance with this section, section 712 of the Employee Retirement Income Security Act of 1974, and section 9812 of the Internal Revenue Code of 1986, as applicable. In carrying out this paragraph, the Secretaries may take into consideration the 2016 publication of the Department of Health and Human Services and the Department of Labor, entitled ‘Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance’.

“(B) **EXAMPLES ILLUSTRATING COMPLIANCE AND NON-COMPLIANCE.**—