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200.000 HOME HEALTH GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Home Health Providers

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Home Health providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. Only home health agencies licensed to operate in Arkansas may participate in the Arkansas Medicaid Home Health Program.

B. A provider participating in the Arkansas Medicaid Home Health Program must be currently licensed by the Division of Health Facility Services, Arkansas Department of Health, as a Class A Home Health Agency.

C. A provider participating in the Arkansas Medicaid Home Health Program must be currently certified by the Arkansas Home Health State Survey Agency as a participant in the Title XVIII (Medicare) Program.

D. Providers participating in the Arkansas Medicaid Home Health Program must maintain documentation of current licensure and certification in their Medicaid provider enrollment files.

E. ~~All owners, principals, employees, and contract staff of a home health provider must submit to an independent, national criminal background check, identity verification, and fingerprinting. Background checks must be repeated every three years.~~ The following individuals employed or contracted with a home health provider must comply with criminal background checks and central registry checks as required by law currently codified at Arkansas Code Annotated §§ 20-33-213 and 20-38-101 et seq.:

1. Owners;
2. Principals;
3. Operators;
4. Employees; and
5. Applicants (prior to the extension of a job offer).

Central registry checks under this section must include the:

1. Child Maltreatment Central Registry;
2. Adult and Long-Term Care Facility Resident Maltreatment Central Registry; and
3. Certified Nursing Assistant/Employment Clearance Registry.

Enrolled providers must submit copies of license and certification renewals to the Provider Enrollment Unit, Division of Medical Services (DMS), within 30 days of the issuance of those documents. **View or print Provider Enrollment Unit contact information.**

216.600 Plan of Care Requirement for Participants in the Home and Community Based Waiver Programs

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When developing plans of care for individuals who participate in home and community based services (HCBS) waiver programs, such as ~~ElderChoices or Alternatives for Adults with Physical~~

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~~Disabilities~~ARChoices in Homecare, providers must communicate with the registered nurse employed by the Department of Human Services (DHS RN) in charge of the case, in order to coordinate the home health plan of care and the HCBS plan of care. See Section I for additional information and requirements.