



ELECTRONIC VISIT VERIFICATION

*Implications for States, Providers, and
Medicaid Participants*

MAY 2018



The National Association of States United for Aging and Disabilities (NASUAD) represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary leadership, the advancement of state systems innovation, and the articulation of national policies that support home and community-based services for older adults and individuals with disabilities. NASUAD's members oversee the implementation of the Older Americans Act, and many also function as the operating agency in their state for Medicaid waivers that service older adults and individuals with disabilities. Together with its members, the mission of the organization is to design, improve, and sustain state systems delivering home and community-based services and supports for people who are older or have a disability, and their caregivers.

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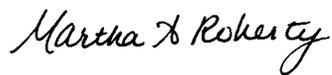
ACKNOWLEDGEMENTS

In 1996, an Ohio nurse designed and patented the first Electronic Visit Verification (EVV) tool to help combat fraud and abuse in the home care industry. Twenty years later, Congress enacted the 21st Century CURES Act which requires Medicaid programs to implement EVV for personal care beginning January 1, 2019 and home health care beginning January 1, 2023. Whether it is building state health exchanges, no wrong door web interconnected portals, or electronic care plans, states have long histories of implementing complex and challenging technology solutions, and EVV represents yet another difficult requirement with an expedited timeline for compliance. States face a number of challenges with EVV implementation, including decisions on whether the solution should be a single statewide vendor or if providers should choose their own; building support for the change among stakeholders; and being able to link the data to the right platforms in order to ensure interoperability and collect relevant, timely data for program improvement.

One of the key roles an association plays is the exchange of information, promising practices, and technical support between states. This exchange is especially important during times of change. On emerging issues such as EVV, early implementer states provide valuable lessons learned and we acknowledge their important contribution to this effort. We are especially thankful to the state staff, including Darryl Washington in Oklahoma, Patti Killingsworth in Tennessee, Pamela Kyllonen, GP Mendie, and Marie Donnelly in Florida, and Kathy Bruni in Connecticut, for taking the time to share their valuable insights in this report.

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Sincerely,



Martha A. Roherty
Executive Director

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EXECUTIVE SUMMARY

On January 1, 2019, new federal requirements for Electronic Visit Verification (EVV) go into effect, mandating the use of EVV for Medicaid funded personal care services. EVV technology has been available for more than two decades, but prior to the passage of the 21st Century CURES Act in December 2016, EVV was optional for states, providers, and managed care organizations. The CURES Act requires state Medicaid programs to implement EVV for Medicaid funded personal care services in 2019, and for Medicaid funded home health care services in 2023. Many states, providers who offer personal care and home health services, managed care organizations, EVV vendors, and other stakeholders are assessing what the CURES Act requirements entail, the process and timeline for ensuring compliance, and considerations that must be addressed when developing a plan of action. This paper provides information on the current state of EVV; the new requirements set forth in the CURES Act including methods for stakeholder engagement and addressing those concerns; the role of the Centers for Medicare & Medicaid Services (CMS); and the approaches states may consider in the lead up to a January 1, 2019, implementation.

Overview of Electronic Visit Verification: What It Is and How It Is Currently Being Used

Electronic Visit Verification is a technology solution which electronically verifies that home and community-based services are actually delivered to people needing those services. EVV was originally patented in 1996 by Michelle Boasten, a nurse from Akron, Ohio, who spent much of her career combatting fraud and waste in home healthcare. She focused on efforts to strengthen home and community-based services, and in particular, home health.



Michelle Boasten

Over the past two decades, payers and providers of home and community-based services have implemented EVV for purposes of program integrity, including reducing billing errors and preventing fraud, waste and abuse. EVV can also serve as a powerful tool to improve quality of service and enhance participant health, experience of care, and quality of life outcomes.

EVV verifies that services billed for home and community-based personal care or home health services are for actual visits made, providing accountability and ensuring that people who are authorized to receive services actually receive the expected care. Many providers use EVV to monitor and manage delivery of care, including:

- Improving accuracy of service delivery;
- Verifying visits on a real-time basis;
- Automating missed visit alerts to more quickly implement back-up plans;
- Validating hours of work;
- Eliminating billing data entry mistakes;
- Reducing costs related to paper billing and payroll; and
- Using reports, metrics and analytics for strategic planning, budgeting, and audits.

EVV technology continues to evolve and improve, with multiple vendors available to states, managed care organizations (MCOs), and providers. The functionality of some EVV solutions has expanded the role of the personal care or home health care aide, also known as a direct care worker, by providing them the opportunity to identify health status alerts in real time. EVV also enables the capturing of a participant signature for additional confirmation of personal care services (PCS) or home health care services (HHCS) prior to payment. If the participant does not sign, or if the signature captured does not match previously captured signatures, the agency may reach out to the participant prior to paying the claim to determine if the personal care or home health aide performed all the services. Start time, end time, and duration are also captured in the EVV solution. As a result, if a visit is scheduled for two hours, and the PCS or HHCS aide is only there for one hour, the system can generate a flag to determine if all the services authorized were performed.

There are several technologies used for EVV, including: telephone timekeeping with caller identification (ID) verification; web or phone-based applications using Global Positioning Service (GPS) verification; and a one-time password generator using a key Fixed Object (FOB) or other device. Recently, some EVV vendors began using biometrics such as fingerprints or retinal scans to verify that the worker assigned is actually providing the service.

In many cases, the personal care aide is assigned a unique ID, often called a Personal Identification Number (PIN), and the verification replaces the employee name and signature on a paper timesheet in these technologies. There may also be a unique identifier for the participant, and service codes for different services rendered at the visit, available for billing and authorization purposes.

EVV solutions often use one or more strategies that enable providers of PCS and HHCS to verify that the services were delivered at the appropriate time and location. Examples of these different types of technologies, as well as benefits and potential concerns associated with them, include:

Telephone Timekeeping or Telephony

This EVV strategy generally requires the use of the participant's telephone at the time of the visit. It can utilize a landline available in the participant's home, or a smartphone/cell phone used by the personal care provider or the participant when a landline is not available. This solution provides a simple and readily available way to verify that the service provision has occurred, as well as to capture the location of the service at the participant's home. However, there could be challenges in rural and frontier areas where landlines may not be available and cellular service may be limited or not reliable. Additionally, requiring that check-in and check-out occur from the participant's landline could restrict the ability of the person to receive services in the community. Additional backup systems or alternative options may be required to ensure that the EVV solution does not inadvertently result in participant isolation.

Web-based Global Positioning Service (GPS) Verification

This relies on a mobile application, which is a GPS-enabled "clock" that indicates when service begins and ends. The worker "clocks in" and "clocks out" using their smartphone or tablet. Some providers prefer to invest in a tablet that is left in the participant's home, which is used by the worker to clock in or out. EVV captures real-time data, which had not previously been available for PCS and HHCS. Using independent, accurate GPS tracking of location coordinates and start time of the visit and comparing that data with the scheduled visit enables the identification of potential fraud prior to a claim being paid. This solution allows services to be delivered in a variety of settings, which can accommodate self-directed models as well as community integration. In many cases, the solution can also be used even if cellular service is not available since many devices continue to access GPS data even with no service. In this instance, data including the time and location of service can be uploaded once the device reenters an area with service.

A potential concern with this solution is regarding individual privacy and comfort with the GPS tracking. Some program participants and employees may be concerned with this type of information being collected and stored by state governments, managed care plans, or provider agencies. In such instances, robust safeguards on the information as well as active engagement with individuals who use PCS, providers, and other stakeholders will be important in order to alleviate potential concerns.

One Time Password Generator

This solution uses a “fixed object,” known as a key FOB or just FOB, which is placed in the home of the participant and is attached to something in the home, like a drawer pull. The FOB generates a one-time password or code when the care provider arrives and when they leave. This allows the EVV to verify that the caregiver was actually in the specified location when they checked in. Similar to landlines, this solution may restrict the ability of participants to receive services outside of the home. Therefore, states may wish to consider alternative solutions used in conjunction with this model to ensure that community integration is accommodated and maintained.

Biometrics

This EVV solution verifies that the appropriate personal care aide is the actual person providing the service, using biometric identifiers such as voice recognition, fingerprints, iris or facial scan. Voice recognition has been in place for a while; however, newer models are also integrating additional biometric markers. Although this is an emerging model, some providers may express privacy concerns associated with the collection, storage, and use of this personal information.

According to a 2017 survey conducted by the National Association of Medicaid Directors (NAMMD), in collaboration with CMS, states have taken widely varied approaches to the use of EVV. The survey was conducted to support states and inform CMS and other stakeholders as they move towards implementation of the CURES Act EVV requirements.¹ In August and December 2017, CMS presented analyses of the NAMMD survey via a State Operations Technical Assistance webinar to states and other stakeholders. Forty surveys were returned and of those states, nine reported that they had already implemented EVV for PCS and two reported that they had implemented it for HHCS. Notably, no state reported implementing EVV for both PCS and HHCS.

The New Driver Behind EVV: The 21st Century CURES Act

Enacted on December 13, 2016, the CURES Act is considered to be landmark legislation for health care quality improvement through innovation. It includes funding to combat the opioid epidemic, reauthorizes the National Institutes of Health and funds new research, streamlines the development of new drugs, provides continued support for the interoperability of health information systems, and it sets forth significant behavioral health provisions including strengthening mental health parity. Section 12006 of the CURES Act requires state Medicaid programs to implement EVV for personal care and home health care, or face reductions in the federal medical assistance percentage (FMAP) beginning in 2019 for PCS, and in 2023 for HHCS.

¹ <https://www.medicaid.gov/medicaid/hcbs/downloads/training/evv-presentation-part-1.pdf>

Why is EVV in the CURES Act?

An effective, well-planned and implemented EVV system strengthens state Medicaid personal care and home health care services, by detecting and preventing fraud, waste, and abuse and improving the quality of PCS and HHCS. Data from the U.S. Department of Labor Bureau of Labor Statistics projects that employment for personal care service providers will grow by 26 percent from 2014–2024, due to demographic growth in the population needing these services, but more importantly, because people prefer to receive services in their own homes. As demand for Medicaid home and community-based services continues to grow, so do concerns about oversight and program integrity.

The U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) has, since 2006 and earlier, investigated and issued reports on Medicaid personal care services, and in 2010 it published a report called “Inappropriate Claims for Medicaid Personal Care Services.”² During an 11 month period, the report found that 18 percent of PCS claims were undocumented, and there was no record for two percent of the claims, amounting to \$63 million in undocumented Medicaid payments. In December 2012, the HHS OIG issued a Portfolio Report on Personal Care, titled “Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement,”³ which has resulted in CMS publishing an Informational Bulletin;⁴ two Medicaid Fact Sheets on preventing fraud, waste and abuse in 2015⁵ and 2017;⁶ and the 2016 publication (and subsequent 2017 update), of a booklet called “PCS: Preventing Medicaid Improper Payments for Personal Care Services.”⁷

Since 2013, HHS OIG has raised concerns about the progress of recommendations made in the 2012 Portfolio report. In October 2016, the HHS OIG sent a memo to CMS Deputy Administrator for the Center for Medicaid and CHIP Services (CMCS) titled “Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services,”⁸ recommending that CMS issue regulations to “more fully and effectively use its authorities to improve oversight and monitoring of PCS programs across all states.” The Investigative Advisory cites significant concerns about improper payments, lack of enforcement, and participants at risk of harm, including examples collected in coordination with state Medicaid Fraud Control Units (state MFCUs). Finally, the Advisory lists recommendations made in the 2012 Portfolio report that CMS had not yet fully adopted, including requiring that claims identify dates of service and the PCS worker that provided the service, both of which are included in the CURES Act requirements.

² <https://oig.hhs.gov/oei/reports/oei-07-08-00430.pdf>

³ <https://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf>

⁴ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib121316.pdf>

⁵ <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-improperpayment-factsheet-082914.pdf>

⁶ <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-prevent-improperpayment-factsheet.pdf>

⁷ <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/pcs-prevent-improperpayment-booklet.pdf>

⁸ <https://oig.hhs.gov/reports-and-publications/portfolio/ia-mpcs2016.pdf>

“States do not have sufficient controls for individuals entering participant homes to provide Medicaid-funded services.” —2016 OIG Investigative Advisory

The Investigative Advisory also discussed the HHS OIG involvement in the National Health Care Fraud Takedowns, in which PCS fraud is identified as a key area of focus, and provided examples illustrating PCS fraud schemes as well as examples of PCS and patient harm. According to federal data Medicaid improper payments for PCS amounted to \$29.1 billion in fiscal year 2015, up significantly from \$14.4 billion in federal fiscal year 2013.⁹ With mounting evidence that the integrity of the Medicaid PCS program has serious vulnerabilities, the HHS OIG and the state MFCU’s continue to investigate and help states identify fraud, waste and abuse.

In an effort to combat this growing and costly vulnerability in the Medicaid program, the EVV mandate was included in the CURES Act. EVV, when implemented in the manner required by the CURES Act, is expected to improve accountability, program integrity, and reduce fraud, waste, and abuse in PCS and HHCS. The Congressional Budget Office anticipated that the EVV mandate will save \$290 million over a 10 year period, which provided funding for other provisions in the CURES Act.¹⁰ Following passage of the CURES Act, in May 2017, the HHS OIG testified before the US House of Representatives Committee on Energy and Commerce Subcommittee on Oversight and Investigations. Titled “Combatting Fraud, Waste, and Abuse in Medicaid’s Personal Care Services Program,” the testimony refers to the implementation of the CURES Act EVV requirements as a positive step towards improved program integrity in PCS, and provides examples that demonstrate that “better data leads to better enforcement and reduced costs.”¹¹

“21st Century CURES includes some promising steps forward to safeguard beneficiaries and make better data available for the PCS program by requiring that all states implement electronic visit verification systems (EVVS) by 2019. The law requires that EVVS collect information on who receives and who provides the service; the service performed; and the date, time, and location of the service. As states begin implementing these new requirements, it will be important to ensure that the data gathered is complete, accurate, and timely.” —2017 OIG testimony

⁹ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/Downloads/2015MedicaidandCHIPImproperPaymentsReport.pdf>

¹⁰ <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/br34amendment5.pdf>

¹¹ <http://docs.house.gov/meetings/IF/IF02/20170502/105909/HHRG-115-IF02-Wstate-GrimmC-20170502.pdf>

OKLAHOMA

EVV has been a part of one Oklahoma 1915(c) HCBS Medicaid waiver since 2009. The EVV system was first piloted in 2009 and then became a statewide requirement in 2010 as part of the *ADvantage* Waiver Program. *ADvantage* is a HCBS waiver for older adults and individuals with physical disabilities, and has utilized a state-mandated vendor system since its adoption of EVV. The Oklahoma Department of Human Services-Aging Services procures an EVV vendor and requires all applicable waiver providers to utilize the state-contracted EVV vendor. The provider types that are required to utilize EVV include case management and in-home care providers, which are providers who offer skilled nursing, personal care, respite, and therapy services. The Oklahoma EVV vendor has changed several times over the past 10 years of implementation, while the state's requirements for both the vendor and waiver providers have remained consistent.

Oklahoma adopted EVV to offer the waiver providers and the state a greater degree of accountability regarding tracking service delivery, claims processing and billing. The state's one-vendor system allowed the state greater levels of oversight regarding state-wide provider adoption, the functionality, and performance. The one-vendor system provides the state with capability to have real-time access to the data input into the EVV web portal through all check-in/check-out methods, as well as have real-time access to information regarding providers' claims and billing at the provider and participant level. The utilization of the EVV one-vendor system in Oklahoma allows the state to assist with EVV training, billing and claims resolution and utilize data from a host of reports to assure health and safety of the waiver participants.

Implementing EVV: The Role of CMS

The CURES Act sets forth specific responsibilities related to EVV for CMS. CMS, in partnership with states, is responsible for the administration of the Medicaid program, and therefore, must implement the Medicaid EVV requirements. CMS' specific responsibilities include:

- Collecting and disseminating best practices to state Medicaid directors, with respect to training individuals who furnish personal care or home health services, as well as family caregivers and participants. The training should be about the EVV system, how it operates, and prevention of fraud. In addition, it should include best practices with respect to the provision of notice and educational materials to family caregivers and participants regarding the use of EVV and the role of EVV as a means for preventing fraud.
- Tracking state progress and implementation timeframes, and making adjustments to the FMAP paid to states that do not meet compliance deadlines, in accordance with the reductions outlined in Table 1 on the following page.
- Reviewing state EVV submissions, including descriptions of implementation, oversight, and monitoring processes in state plan amendments and waiver applications.

- Providing assistance to states and other stakeholders, including surveys, webinars, technical assistance, frequently asked questions documents, and other sub-regulatory guidance. This guidance may include information to support state implementation processes, CMS reporting requirements, or direction on what constitutes a “good faith effort” to comply, or an “unavoidable system delay.”
- Establishing and managing an Advanced Planning Document process for review and approval/disapproval of state requests for enhanced match when the EVV system is operated by the state (or a contractor) as part of the Medicaid Enterprise System.

TABLE 1. SCHEDULE OF FMAP REDUCTIONS FOR NON-COMPLIANCE

YEAR	PERSONAL CARE	HOME HEALTH
2019	.25%	N/A
2020	.25%	N/A
2021	.5%	N/A
2022	.75%	N/A
2023	1%	.25%
2024	1%	.25%
2025	1%	.5%
2026	1%	.75%
2027 & after	1%	1%

As part of its implementation activities, CMS has conducted three webinars and one Question and Answer (Q&A) session to provide states with guidance and information to implement the EVV requirements. The webinar slide decks are available on the NASUAD or CMS websites, and can be accessed as follows:

- **August 2017: Requirements, Implementation, Considerations, and Preliminary State Survey Results.**
<http://www.nasuad.org/sites/nasuad/files/EVV%20Requirements%20Presentation.pdf>
 This webinar covers details of the provisions in section 12006 of the CURES Act, including the Medicaid services and authorities affected, penalties for non-compliance, EVV system verification requirements, stakeholder engagement expectations, and a role for CMS including the process of approval of state requests for enhanced Medicaid federal match. The webinar also covered the five EVV design models that CMS has identified, benefits of EVV, considerations for self-directed services, and preliminary results of the all-state survey that CMS conducted in partnership with NAMD, which provides feedback from some states regarding the current EVV landscape.

- **December 2017:** *Requirements, Implementation, Considerations, and State Survey Results.*
<https://www.medicicaid.gov/medicaid/hcbs/downloads/training/evv-presentation-part-1.pdf>
 This webinar provides a recap of the information presented in the August 2017 webinar, with several updates: a slight change to the definition of PCS; information on the potential benefit to reduce fraud, waste, and abuse is added; and more detail on the all-state survey conducted in partnership with NAMD is included. The survey findings begin on slide 25 of the webinar, and provide more detailed information on the status of EVV, as reported by the 37 states that participated in the survey. This includes information on models currently operating as well as planned models, a status on the states requesting enhanced FMAP for system implementation and operations, self-reported initial cost savings data, and experience with implementing EVV in the self-directed model.
- **January 2018:** *Promising Practices for States using EVV.*
<https://www.medicicaid.gov/medicaid/hcbs/downloads/evv-presentation-part-2.pdf>
 This webinar presents promising practices based on research and review of state and EVV vendor experience with EVV implementation, including information on EVV model selection and implementation, training and education of providers, participants and their families, and state staff, as well as ongoing EVV operations and monitoring.

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) collect and disseminate best practices to State Medicaid Directors with respect to: 1) training individuals who furnish personal care services and home health services and 2) the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of such EVV systems and other means to prevent fraud.”—*21st Century CURES Act*

CMS also led a Q&A session in late January 2018. During the Q&A, CMS discussed a future State Medicaid Directors’ letter and a formal Q&A document, which at the time were moving through the clearance process for release in the near future. CMS continues to work with the HHS OIG and state MFCUs to improve program integrity and oversight.

Implementing EVV: What States Need to Know

The state has significant responsibility regarding the implementation of EVV. The responsibilities of EVV implementation will likely involve both the state Medicaid agency as well as agencies that administer aging, disability, and long-term services and supports. These entities are commonly known as “operating agencies” and are frequently responsible for issues such as beneficiary and provider outreach, enrollment, education, and audits. The actual delineation of functions will differ depending upon the administrative structure of a state; therefore, we discuss the responsibilities of the state broadly in this section for ease of readability.

The law details:

- The consequences for not complying with the law;
- Specific elements that must be electronically verified;
- Applicability of the requirements for personal care and home health services;
- Flexibility for implementation;
- Enhanced FMAP for building the EVV system; and
- Expectations for stakeholder engagement and training.

Reduction in FMAP

The CURES Act provides a specific schedule detailing the FMAP reduction timeframes and amounts. Table 1 (found on page 8) provides the schedule CMS will implement to reduce FMAP over time for those states that are out of compliance with the EVV requirement. CMS has stated that FMAP reductions will only apply to Medicaid expenditures specific to PCS or HHCS.

The CURES Act also provides for relief if states are unable to come into compliance by the deadlines, if the state demonstrates that it has made a “good faith effort to comply with the requirements” set forth in the Act, “including by taking steps to adopt the technology used for an Electronic Visit Verification system,” and “in implementing such a system, has encountered unavoidable system delays.”

This relief is available to states *only* for the first year of the mandate, i.e. 2019 for PCS and 2023 for HHCS. After that, the FMAP reductions in Table 1 (found on page 8) go into effect regardless of unavoidable delays or challenges experienced by the state.

TENNESSEE

Tennessee implemented EVV as part of its statewide adoption of managed long-term services and supports in 2010, and the MCOs have been required to use EVV since they began delivering services. The state EVV model started out as an MCO choice program, which was selected because the state did not have time for a competitive RFP in conjunction with all of the other MCO implementation activities. Under the MCO choice model, the state Medicaid agency designed the system requirements and specifications but directed the MCOs to select a vendor and operationalize the system. As part of this, the state provided additional funding to the MCOs to help them purchase an EVV. Initially, all three of the MCOs chose the same EVV provider, which turned out to be a good thing for direct care providers since they were all able to work with one system. However, each health plan wanted to implement the system in an individualized manner which stretched the vendor thin.

The overall implementation process was challenging for health plans, providers, and vendors. A lot of time and energy was devoted to implement the system in terms of state policy development, stakeholder engagement, information technology development. Staff time and resources at the state, providers, and MCOs were devoted to ensure that implementation was successful. Although providers never had to pay for the actual EVV technology, a number of providers indicated that there were administrative burdens regarding training, staff oversight, and related items in order to meet the requirements.

In subsequent years, two MCOs opted to change vendors. This created different challenges, particularly for large providers that use EVV for scheduling and staffing purposes. These providers are now potentially operating across multiple systems, which can be very challenging for providers to align in order to manage their internal workflow.

One challenge associated with the MCO choice model is that the data goes from providers to health plans and then to the state. This data could be filtered and is not always available to the state in a timely manner. Tennessee has therefore expressed interest in creating a management system where a provider may use any EVV vendor it chooses, as long as the vendor meets minimum standards and can send data to the state. In this model, the state becomes the repository of the EVV information. However, there is some concern about how the information would be shared in a timely manner with the MCOs who must pay for specific claims. If Tennessee does move to a provider choice model, the state would include a backup default system to be used for free if providers are unable to afford their own EVV system.

Tennessee has also worked to align their EVV with self-direction that is available to participants in the state Medicaid program. In the beginning of implementation, the state was very clear that all self-direction information would flow through EVV. However, there were a number of issues with implementation since EVV vendors were not necessarily prepared for the level of flexibility and complexity inherent in self-direction models. This created challenges for participants and direct care workers. The state ultimately worked with their financial management system (FMS) to leverage an alternative system that provides payroll and scheduling for participant direction. This removed self-direction from the broader EVV system and afforded more choice and autonomy to participants. The state intends to ensure that the FMS EVV will comply with CURES, which means that they will likely continue to have a parallel FMS system for self-direction. This strategy is intended to continue providing participants with flexibility and autonomy to set and modify their schedules based on their own needs and preferences.

Medicaid PCS and HHCS Services Subject to EVV Requirement

Under the CURES Act, any PCS or HHCS delivered through the following Medicaid authorities are included:

- Home health care services described in Section 1905(a)(7) of the Social Security Act and provided through the Medicaid state plan, as well as any waiver of the state plan.
- Personal Care Services described in Sections 1905(a)(24), 1915(i), 1915(j), and 1915(k) of the Social Security Act, as well as any waiver of the state plan (including 1915(c) waivers and 1115 demonstration projects).

Although the CURES Act is clear about the statutory authorities where the EVV requirements apply, there is some ambiguity regarding the exact scope of services covered by the mandate. Some benefits may not be explicitly defined as PCS by a state but may include supports that are essentially the same services. For example, some states offer a broad and flexible array of services called “community integration” that can include, based on the needs and preferences of the individual, PCS supports to help the person leave their house and engage in work or leisure activities in the community. In this scenario, the PCS components of the service may be subject to the EVV mandate. Similarly, some residential providers, such as Assisted Living, offer personal care to individuals as part of their services. Preliminary guidance from CMS indicates that these PCS may also require EVV, though policymaking is ongoing and a final determination has not been made.

Elements of PCS and HHCS to Be Electronically Verified

The CURES Act is very specific about the components of each PCS or HHCS visit to be verified; they include:

- The type of service performed;
- The individual receiving the service;
- The date of the service;
- The location of service delivery;
- The individual providing the service; and
- The time the service begins and ends.

Enhanced FMAP

Enhanced FMAP is available to states if the EVV system is operated by the state or a state contractor as part of the Medicaid Enterprise System. In order to qualify for the enhanced FMAP, the state must submit and receive approval for an Advanced Planning Document.

The CURES Act provides for 90 percent FMAP for costs related to the design, development, and installation of EVV; 75 percent FMAP for costs related to operations and maintenance of the system and routine updates or customer service; and 50 percent FMAP for administrative activities necessary for efficient operations as well as outreach and education. One of the seven conditions and standards for receiving enhanced FMAP is interoperability, or seamless exchange of information and data across systems. In choosing an EVV vendor, states should take into

consideration how the EVV system or systems integrate(s) with other systems, including the Medicaid Management Information System, Electronic Health Records, and care management applications.

It is important to note that this enhanced federal funding is available only for state-developed systems. Costs incurred by MCOs or providers to develop and implement an EVV system are not eligible for enhanced federal funds; however, the state can choose to recognize these costs in the rates paid to MCOs or providers.

Stakeholder Engagement and Training

The CURES Act requires states to take into account the considerations of a variety of stakeholders as they plan, design and implement EVV, including providers, participants, family caregivers, people who provide direct care, and other stakeholders.

The CURES Act requires that states “consult with agencies and entities that provide personal care services, home health care services, or both...to ensure that such system is i) minimally burdensome; ii) takes into account existing best practices and EVV systems in use in the state; iii) is conducted in accordance with the requirements of HIPAA privacy and security law.”

It also requires that “a state shall 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...”

Training requirements are clearly articulated as well:

“a state shall ensure that individuals who furnish personal care services, home health care services, or both...are provided the opportunity for training on the use of such system.”

Implementing EVV: State Program Design and Implementation

Each state has the responsibility to implement EVV in accordance with the CURES Act, but there is significant latitude in the specific approaches a state make take. The 2017 NAMD/ CMS survey of states found that there is wide variation in the status of implementation with less than a year to go before the legislative deadline. While not all states participated in the survey, it provides insight into the approaches that states should consider, best practices, and lessons learned in states that have implemented EVV prior to the mandate in CURES. Based on the survey results and other information collection activities, the CMS training webinars provided useful information to states about the current state of EVV. CMS identified five design approaches to EVV implementation and shared them in December 2017.¹²

CMS identified five design models:

- Provider Choice;
- Managed Care Organization Choice;
- State-Procured Vendor;
- State-Developed Solution; and
- Open Vendor.

- 1. Provider Choice:** In this model, the state sets minimum standards for the EVV system and allows each provider to select their own vendor or system to use. The benefits of this model are that it enables different providers to work with vendors that best suit their needs. Challenges include ensuring that providers have the capacity and financial resources to contract with a vendor and implement the system, as well as ensuring that all EVV systems are interoperable with each other. Providers may also seek to have some of the costs of implementing an EVV system in their payment rates. To ensure that the CURES Act requirements are met, states may need to establish a system to aggregate and analyze the EVV information on a statewide basis in real time for analysis and program integrity purposes.
- 2. Managed Care Organization Choice:** In states that use MCOs to deliver some or all Medicaid funded PCS or HHCS, the state could allow MCOs to select their own EVV vendor (akin to the provider choice model). MCO network providers would then use the EVV system mandated by the MCO with which they are contracted. Benefits of this model include an integration of MCO claims data with EVV data, as well as devolving the responsibility for provider contracting to the MCOs, thus avoiding a state procurement. Challenges include the reality of providers holding multiple MCO contracts having to use different EVV systems for the same services as well as the likely demand by the MCOs for the state to recognize at least some of the costs of implementing an EVV system in the MCOs' capitation rates. Similar to the provider choice model, states may need to establish a system to aggregate and analyze the EVV information from its MCOs.

¹² <https://www.medicaid.gov/medicaid/hcbs/downloads/training/evv-presentation-part-1.pdf>

- 3. State-Procured Vendor:** In this model, the state competitively procures an EVV vendor that all providers in the state must use. The statewide model allows providers to access EVV without procuring their own systems. Providers may still have to make some effort to properly implement and interface with the state’s EVV system. In states that utilize MCOs for PCS or HHCS, the state would need to ensure that MCO encounter and payment data is aligned with EVV information. A significant consideration for this model is the sometimes lengthy state procurement process with a looming January 2019 implementation date.
- 4. State-Developed Solution:** In this model, the state develops its own EVV system. Similar to the procured vendor model, the system is funded by the state and operates statewide. This provides many of the same benefits and potential challenges as the procured vendor model. While it alleviates the need for a procurement, it does add a significant new workload for the state, since it would require robust IT resources, infrastructure, and staffing within the agency.

CONNECTICUT

Connecticut began EVV implementation in November 2015 with a provider meeting to outline the process and implementation schedule. The system became operational on January 1, 2017, for in-home services that are paid on an hourly basis, and then on April 1, 2017 for home health services. Connecticut uses a single statewide contract with an external vendor to operationalize the system, and the state believes it is fully compliant with the CURES Act requirements. Connecticut believes that the benefits of the statewide system include the integration with its existing MMIS vendor, as well as operating one single system for the department to oversee. In Connecticut, providers must use the state contracted system for scheduling, service authorization, EVV, and other functions. This allows the state to ensure that all of the system elements are coordinated with each other. The state has also ensured that the EVV system is tied to the claims payment process, as part of their program integrity oversight.

Throughout the process, the state has engaged the provider and participant communities to ensure that the system is responsive to their needs and concerns. Connecticut stressed the importance of robust stakeholder engagement with all affected entities to ensure that the system does not create undue hardship or result in adverse outcomes. The state performed extensive outreach, established a dedicated website¹³ with information on the system, the process, and the timelines, and also conducted numerous forums to solicit feedback. The state also included a “soft launch” where providers could use EVV in order to familiarize themselves with the system prior to final implementation. This soft launch period was extended and the implementation date was delayed due to provider concerns.

¹³ <http://portal.ct.gov/DSS/Health-And-Home-Care/Electronic-Visit-Verification/Electronic-Visit-Verification>

5. **Open Vendor Model (also known as “Hybrid” Model):** This model provides both a statewide, state-managed (either procured or state-developed) system which is available to providers or MCOs who wish to use it, but also allows providers and MCOs to select their own EVV vendor. Such a system would need to ensure interoperability across all EVV systems and may also require a state level aggregation function.
6. **Provider Audit Model:** In this model, which was not included in CMS’ list of options but has been proposed by at least one state to comply with the CURES Act, the state directs providers to establish a process to ensure that services are electronically verified and that all of the CURES mandated information is captured. The providers have latitude to contract with the vendor of their choice or to develop an in-house EVV system. The state will not establish a statewide aggregation system or provide a statewide system that providers can use if they do not have the capacity to develop or procure their own EVV infrastructure. The state will ensure that providers are compliant with the EVV requirements during the routine provider audit process.

FLORIDA

In 2009, the Florida Legislature included measures to address fraud and abuse in the Florida Medicaid program. One component of the bill directed the Agency for Health Care Administration (Agency) to implement a home health agency monitoring pilot project in Miami-Dade County. As a result of this mandate, telephone-based electronic visit verification (EVV) system was competitively procured and implemented effective July 1, 2010, to verify utilization and delivery of home health services rendered through the state’s fee-for-service delivery system. The system used voice biometrics and provided an electronic billing interface for these services. In 2012, the legislature expanded the project to additional counties in the state that were deemed cost effective and also included private duty nursing and personal care services. In 2016, the Agency requested some changes, which were passed by the legislature, to allow flexibility to be able to procure updated EVV technologies that would best meet the needs of the provider community in Florida while being cost-effective for the state.

The initial EVV program utilized landline telephones for call-in and call-out, as well as voice biometrics and a random number generator called Fixed Visit Verification Device. This technology was restrictive and did not provide providers or participants with flexibility in scheduling or service delivery. The new EVV program utilizes a global positioning system (GPS) equipped mobile (smart phone) application that captures begin and end times when providers render services. The application automatically uploads this information to the state’s contracted EVV system to enable seamless verification of the service and provider claims billing. The new system’s EVV technology allows real-time scheduling/rescheduling as needed, helps reduce human error, and lowers the burden on providers by reducing steps required to have services verified.

Implementing EVV: Other State Considerations

Setting Goals and Defining Requirements

State Medicaid and operating agency staff and leadership should begin the process of implementing EVV by identifying the goals for their EVV program implementation. While some states will focus on preventing, identifying, and eliminating fraud, waste and abuse, others will be motivated by the impact on the state budget. States will also be interested in improving system interoperability, which includes better data exchange between disparate systems. States may also strive for increased accountability and better monitoring, while others may use EVV to bolster quality improvement efforts. States may want to use EVV to improve backup systems for missed services. The goals and objectives should reflect the state's stakeholder engagement efforts, which includes recognition of the concerns and priorities of participants, caregivers and direct care workers.

The EVV program gives home health providers the option to use the Agency's contracted EVV system at no cost to them. Providers who do not wish to use the contracted EVV system may use approved EVV "third-party integration systems." Third-party integration means that a home health provider who has an EVV system may continue to use it to capture and send data to the Vendor EVV claims system for billing.

Beginning January 1, 2019, which coincides with the new managed care health plan contracts, health plans will also be required to have an EVV system in place. Similar to the fee-for-service approach, the health plans can use their own vendors. The Agency will monitor the health plans and ensure that there is EVV information associated with encounter data as part of their oversight activities, but they will not be doing any systematic collection and aggregation of EVV data from the plans. The intent is that providers will use the system that each health plan chooses. Some health plans are giving providers a specific mobile phone to use, while others are directing providers to use a specific application on their own phone.

As part of the implementation, the EVV contract required extensive in-person training and webinars to be available. Podcasts of the training are also available. The training details the use of the scheduling dashboard, the smart-phone mobile application, and the claims portal. Florida has requested provider input and made modification to training guides and the system in response to their feedback. Florida also used providers to help test the system during implementation.

The goal-setting process should be clearly defined in order to ensure that subsequent decisions and design choices reflect the overarching desires of the state agency. As part of the development, states also must establish clear policies and procedures for implementing EVV. States with a participant self-direction program must also consider implications of an EVV system for its fiscal management/fiscal employer (FM/FE) provider. Because many FM/FE systems have the capacity to track the kind of information that must be collected under the CURES Act, the state should clearly address the overlapping functions.

Stakeholder Engagement

States need to solicit and use input gathered from a wide variety of stakeholders before making any decisions on which model to implement, specific technology, and all other aspects of implementing EVV to meet the requirements of the Act. CMS identifies soliciting stakeholder input as one of eight promising practices for EVV model selection and implementation, and recommends that states consider outreach to individuals and their families including participants in self-direction programs, advocacy groups, provider organizations (including direct care workers), and state employees responsible for both procurement (if appropriate) and program integrity. CMS also recognizes that state staff involved in information systems management, deployment, and oversight will be key stakeholders in the successful implementation of EVV.

Addressing the Unique Concerns of Participants with Disabilities

Effective and transparent stakeholder engagement is critical to the success of EVV in self-direction programs. The NAMD/CMS survey of states found that 14 states indicated that they plan to integrate their EVV system with their existing self-direction management systems and processes. As noted above, the FM/FE providers already have systems that collect much of this information. Some participants and other disability advocates have expressed concerns about EVV, including PCS or HHCS aides not getting paid, technology limitations in rural areas, and invasion of privacy that will accompany GPS-enabled systems in particular. Active and engaged discussions with stakeholders is critical to addressing issues such as:

- Accommodating service delivery locations with limited or no internet access;
- Affording participants the flexibility to schedule their services based upon their own needs and preferences;
- Ensuring that the system does not require rigid scheduling and can accommodate last-minute changes;
- Enabling services to be provided at multiple locations for each individual;
- Allowing for multiple service delivery locations in a single visit; and
- Providing participants with the ability to review and approve all timesheets.

Existing Vendor Capacity and Relationships

As required in the CURES Act, states must confer with and evaluate existing EVV vendor relationships, such as those systems already in use by provider agencies, and make determinations about the capacity of those systems to meet the CURES requirements. This assessment will help the state to determine the preferred design model which, as the Act requires, “is minimally burdensome” and “takes into account existing best practices and electronic visit verification systems in use in the state.”

Develop Implementation Plan

After soliciting stakeholder input, the state should develop a plan to implement, monitor, and oversee their EVV system. An important initial consideration will be the process and timeline for procuring the system; the plan should reflect the selected design. Some states will need to issue a request for proposals (RFP), while others may be able to use an existing preferred vendor list. Some states may also need or wish to release a request for information to inform their RFP development. The plan should clearly delineate the interoperability parameters and payment considerations, such as:

- Will the EVV architecture have the capacity to submit claims directly to the MMIS?
- Will it interface with the care plan for each participant?
- Will it connect with the Electronic Health Record for the participant?
- How will service preauthorization be used by the EVV?
- What kind of post-payment audits will be employed to improve program integrity?

Training Plan

The training plan should be a component of the implementation plan, but because it is featured expressly in the Act, it is worth identifying as a critical element for compliance with the Act. States that have implemented EVV as well as EVV vendors with experience underscore the importance of training and suggest that it is a critical element of success in deploying and operating EVV. Examples of training include pre-launch onsite training, self-directed online training for ongoing support, technical assistance webinars and conference calls, and a help-desk operating during business hours and beyond. Vendors, provider agencies, and states all report that the most successful training is done collaboratively, involving all stakeholders. In its January 2018 webinar, CMS identified seven promising practices related to training and education, with significant detail and examples of each practice. All seven should be considered by states as they develop their training plan.

- Inventory/identify all training target populations;
- Understand the variations and nuances of the EVV model used;
- Assess state resources and capacity for conducting training;
- Establish a training plan;
- Use multiple approaches of notification of training;
- Make training available on an ongoing basis; and
- Create various approaches to customer service, including a website.

Readiness Review

Several states with existing EVV systems stressed the importance of a robust readiness review process. This process is necessary to ensure that the information technology infrastructure is complete and operational prior to implementation, and ensures that providers, health plans, and the state have adequate staffing and appropriate processes in place to properly use the EVV systems. The readiness review should also include testing to ensure that all EVV systems are interoperable and can effectively share information with each other appropriately.

Soft Launch Strategy

One commonly used strategy when implementing EVV is to utilize a “soft launch” approach. In this type of implementation, the state requires that EVV be submitted in accordance with a claim, but does not initially deny payment based upon a lack of data or incorrect use of EVV. Instead, the state agency uses the information and errors to provide additional technical assistance and training targeted to key problem areas and providers that are struggling with the technology. The soft launch period can last for a specified period of time, such as six or twelve months, to give all entities enough time to acclimate to the new requirements. Once the soft launch period is over, the EVV system(s) can begin denying claims if the system is not properly used.

Monitoring and Oversight

CMS also included two promising practices for ongoing EVV operations in the January 2018 webinar: monitor service delivery and involve providers in decision-making. Many states have emphasized the importance of including providers, including provider agencies, direct service providers, and self-direction participants, in the process prior to, during, and post-implementation to ensure successful deployment and ongoing operations. Soliciting feedback from providers plays a critical role in continuous quality improvement, and will ensure that the EVV system functions well and at maximum capacity. In addition to soliciting ongoing input from these groups, states should also establish a feedback loop for participants who do not self-direct, as well as family caregivers and other end users of PCS and HHCS.

In order to monitor the ongoing operations of EVV, states will need to establish reporting requirements and develop a framework for monitoring which provides the requirements and expectations set forth to measure success of the program. CMS has been clear in its expectations that the EVV system description and outputs are included in ongoing 1915(c) waiver operations, including service definitions, provider qualifications, and the impact of EVV on the financial health of the program. It is anticipated that future communications from CMS will provide guidance on expectations for reporting. At a minimum, states should establish reporting requirements for the EVV system that provides data collected regarding the six elements of data to be collected for every PCS or HHCS per the CURES Act.

Openness to New and Updated Technology

Early adopter states often used older technology as part of their initial EVV launches, such as landline phone-based technology. As new models of verification became available, such as smartphone applications, these states frequently updated the methods used for EVV.

EVV and Quality Improvement

EVV improves financial accountability such as reducing unauthorized services and decreasing fraud, waste, and abuse in PCS and HHCS, while increasing efficiency of billing and authorizations. In addition to improving program integrity, EVV can also support better quality of PCS and HHCS. For participants receiving PCS and HHCS, EVV can improve visit compliance, decrease missed and late visits, and improve care delivery by providing real-time access to reporting changes in health status, and real-time notification of hospitalization or other events. For PCS and HHCS providers, EVV can decrease late or missed visits and improve schedule adherence. EVV can also assist with establishing automated workflow that reduces administrative burdens related to paper timesheets and other legacy systems. These systems can be tied to innovative tools for timesheets and can increase productivity through efficiency with staffing and scheduling. Additionally, the extensive data available will improve accuracy of actual vs. authorized billable units which can help when developing service plans and allocating appropriate and sufficient resources for the individual. For CMS, states, and MCOs, EVV can provide the data necessary to support and improve quality of care, strengthen the utilization of back-up plans to ensure that a participant receives services when their direct care worker misses a visit, improve operational efficiencies within claims adjudication, and eliminate self-reporting errors in claims processing.

STATE CONSIDERATIONS FOR EVV IMPLEMENTATION

EVV IMPLEMENTATION APPROACH	BENEFITS	CHALLENGES
Provider Choice	<ul style="list-style-type: none"> • Providers have flexibility to select best system for their needs • State does not have to procure and administer an EVV system 	<ul style="list-style-type: none"> • Smaller providers may struggle with resource and capacity to procure EVV • Interoperability must be addressed • State may need to have some way to aggregate information and ensure compliance • State cannot claim enhanced FMAP for provider implementation costs
Managed Care Organization Choice	<ul style="list-style-type: none"> • State can delegate procurement to MCOs • Integration of MCO claims/encounter data and EVV • Providers can use the MCO system(s), alleviating burden 	<ul style="list-style-type: none"> • State may need to have some way to aggregate MCO information and ensure compliance • State cannot claim enhanced FMAP for MCO implementation costs • Providers that contract with multiple plans may struggle with different systems
State-Procured Vendor	<ul style="list-style-type: none"> • State can secure enhanced match for IT development and installation • Providers have centralized platform to use without running their own procurements, alleviating burden • Centralized platform facilitates linking EVV with MMIS claims data 	<ul style="list-style-type: none"> • State procurement processes can be lengthy and arduous • Providers must have capacity/IT to access state system • States with MCOs may have a disconnect between claims/encounter data and EVV

STATE CONSIDERATIONS FOR EVV IMPLEMENTATION *(continued.)*

EVV IMPLEMENTATION APPROACH	BENEFITS	CHALLENGES
State-Developed Solution	<ul style="list-style-type: none"> • State can secure enhanced match for IT development and installation • Providers have centralized platform to use without running their own procurements, alleviating burden • Centralized platform facilitates linking EVV with MMIS claims data 	<ul style="list-style-type: none"> • States will need skilled IT and management personnel which can be a struggle to hire and retain • Providers must have capacity/IT to access state system • States with MCOs may have a disconnect between claims/encounter data and EVV
Open Vendor/Hybrid Model	<ul style="list-style-type: none"> • State can secure enhanced match for IT development and installation of state-run system • Providers have centralized platform to use without running their own procurements, alleviating burden if they choose • Providers have the option to select their own EVV system if they would prefer • Centralized platform facilitates linking EVV with MMIS claims data 	<ul style="list-style-type: none"> • State procurement processes can be lengthy and arduous • Providers must have capacity/IT to access state system • Need to ensure that all systems are interoperable, which could create challenges if system is modified or upgraded
Provider Audit Model	<ul style="list-style-type: none"> • No need for statewide procurement for aggregation system or state-provided EVV option • Providers have ability to select vendor that best suits their need • EVV compliance is verified as part of a preexisting audit function • No need to ensure that systems meet interoperability standards 	<ul style="list-style-type: none"> • Providers may not have financial or administrative capacity to establish EVV, and no state-provided system is available • State cannot secure enhanced FMAP for IT development and installation • State does not have ability to link EVV with claims, and must do a post payment audit to verify compliance • Inability to use EVV data for quality improvement processes

CONCLUSION

Set forth in section 12006, the CURES Act mandates that states implement EVV for PCS by January 1, 2019, and HHCS by January 1, 2023. The Act also requires meaningful stakeholder engagement and training in order to successfully launch and operate the EVV system. CMS has provided significant technical assistance including detailed promising practices, all of which is available on [Medicaid.gov](https://www.medicaid.gov). Some states are positioned well, and have already deployed EVV, while others are in the beginning of a statewide assessment or procurement. There are also states in the process of launching an EVV system, and their experience can provide insight on both successful approaches, and pitfalls to avoid. A key to success is clear and transparent communication about the goals for the program as well as ongoing involvement by affected parties. With those elements in place, implementation of the CURES Act mandate is more likely to create minimal disruption to participants and providers.



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