MERCER

EVV Market Analysis

Summary of Findings

New Hampshire Department of Health and Human Services
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Contents

1

Introduction

As more individuals chose to receive care and services in their home and with the rise of Home and Community Based Services (HCBS) in the Medicaid program, came the need to ensure that individuals were receiving the right care at the right time from the right person. Challenges by home care agencies in monitoring workers' delivery of services drove early Electronic Visit Verification (EVV) methods. Early technology involved the use of telephony for Direct Support Professionals (DSPs) for clocking in and out of a shift at an individual's home. Mandates within the 2010 Affordable Care Act that required states to stop Medicaid payments to providers when there is credible evidence of fraud resulted in some states' early adoption of visit verification systems for certain HCBS services. [1]

The passage of the 21st Century Cures Act (Cures Act) in 2016 mandated the EVV of Medicaid funded personal care and home health services. Since the passage of the Cures Act, the market for EVV technologies has grown resulting in a variety of EVV products currently available. This analysis conducted for the New Hampshire Department of Health and Human Services (NH DHHS) reviews and analyzes various states' EVV implementation, EVV products currently on the market as well as information regarding potential costs for the procurement and implementation of an EVV system.

[1] https://en.wikipedia.org/wiki/Electronic_visit_verification

2

Research Analysis

In order to gain a comprehensive understanding of existing State specific EVV information as well as national EVV trends, Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, completed a review and analysis of publically available information. Documents reviewed included NH DHHS resources, the Centers for Medicare & Medicaid Services (CMS) resources and advisories, an industry white paper and materials focusing on EVV and self-directed services published by ADvancing States (formerly NASUAD).[2]

Key themes identified include:

- Addressing privacy concerns is paramount. States must ensure their EVV system is Health Insurance Portability and Accountability Act (HIPAA)-compliant and make clear to participants how information gathered will be used and with whom it will be shared.
- Many states needed additional time to implement EVV for personal care services. In response to this, CMS allowed states to request a Good Faith Effort (GFE) exemption to the January 1, 2020 deadline. NH DHHS requested and was granted a GFE by CMS on November 21, 2019, which allowed the state to avoid federal medical assistance percentage (FMAP) reductions in calendar year 2020.
  - While states with GFEs are not subject to FMAP reductions in 2020, they will be subject to incremental FMAP reductions beginning with 0.5 percentage points for calendar quarters in 2021 if they have not implemented an EVV system by January 1, 2021.
- CMS has identified five design approaches that states can use to implement EVV, which are built around existing Medicaid models around the country. These design approaches are listed below. NH DHHS has indicated it is planning to implement the most flexible approach via an Open Vendor model.
  - **Provider Choice Model**: The state sets minimum standards for EVV systems and allows each service provider to select a qualifying system.
  - **Managed Care Organization (MCO) Choice Model**: The state sets minimum standards for EVV systems and allows each MCO to select a qualifying system for their network providers to use.

[2] The information provided in Appendix A summarizes each resource, describes key concepts and provides the relevant document or document link.

  - **State-Procured Vendor Model**: The state selects one EVV vendor for all providers in the state, using a competitive bid process.
  - **State-Developed Solution**: The state develops its own EVV system, to be used by all providers and/or plans in the state.
  - **Open Vendor Model**: The state selects or develops a statewide EVV system available to all providers and MCOs, but also allows providers and MCOs to select their own vendor that meets minimum standards.

- Expectations for EVV were refined over time with CMS providing additional clarifications regarding EVV requirements in several key areas including:
  - EVV requirements do not apply when the caregiver providing the service and the beneficiary live together.
  - EVV requirements do not apply to the delivery, set-up and/or instruction on the use of medical supplies, equipment or appliances.
  - If a personal care or home health care service is provided both in the home and in the community during the same visit, EVV is only required for the portion of the service rendered in the home; however, states may choose to require more information to control fraud, waste and abuse.
- Individuals and advocates have expressed concern regarding how implementation of an EVV system could potentially impact self-direction, particularly, as related to flexibility in scheduling. States are strongly encouraged to build an EVV system that allows for compliance with the Cures Act while preserving the greatest possible level of choice, control and flexibility.
- CMS has transitioned its systems certification process to an outcomes-based approach, or “Outcomes-Based Certification" (OBC) designed to ensure that systems that receive federal financial participation (FFP) are meeting the business needs of the state and of CMS. EVV is the first system to which CMS is applying an outcomes-based approach for certification.
- Information sharing and eliciting stakeholder input are key to the successful development and acceptance of a state’s EVV system. NH DHHS has made significant progress in this area as evidenced by the following resources found on the NH DHHS web page at https://www.dhhs.nh.gov/dcbcs/beas/evv.htm:
  - Information about the 21st Century Cures Act EVV requirements
  - NH DHHS Guiding Principles for EVV Implementation
  - Stakeholder engagement materials and EVV stakeholder input/feedback
  - Information about the NH DHHS EVV Advisory Council

- EVV Provider Survey results
- EVV Frequently Asked Questions (FAQ) document
- Projected timeline for EVV implementation
- Link to the NH DHHS dedicated email address for requesting information and/or providing feedback

2020 NH DHHS EVV Provider Survey

Introduction

Mercer conducted a survey of Personal Care and Home Health Care (HHC) providers.[3] The purpose of the survey was to seek feedback on proposed EVV design features as well as elicit information from providers who currently operate or are in the process of purchasing and/or implementing an EVV solution. The survey was posted on June 5, 2020 and was available for online completion until July 3, 2020.

General Overview

A total of eighty surveys were initiated. Upon review, it was found that a number of providers submitted more than one survey response. While duplicate surveys from the same provider were removed from the total number of respondents, feedback from duplicate surveys was considered. Likewise, some surveys were incomplete; however, information from partially completed surveys was considered. Forty six provider agency responses are summarized in this report.

Summary of Results

Most respondents were either provider agency Executive Directors (46%) or Administrative/Other staff (50%). All counties within the state were represented and all populations subject to EVV were represented. The majority of respondents (73%) indicated they do not currently have an EVV system. Twenty two percent are implementing or currently using a system and 5% are in the process of purchasing a system.

When asked about technology infrastructure, most providers (27%) indicated they have computers with internet access and information technology (IT) support (19%). Fewer (15%) reported using an electronic health record (EHR) and even fewer indicated having tablets with internet access (12%) and mobile internet access (12%). Very few respondents provide cell phones or smart phones and if they do, they are generally provided to management level staff, not DSPs or HHC workers.

[3] A full report of the EVV Vendor Survey results can be found at https://www.dhhs.nh.gov/dcbcs/beas/evv.htm

Providers with an EVV system were asked to identify the name of the vendor used by their organization. The following vendors were identified: ClearCare, MITC, ERSP, Home Care Home Base, Brightree, Mobile Care, Riversoft-Elvis, CareWatch, Ankota and Kantime.

Some providers implemented an EVV system as early as 2013. Most began to electronically verify visits between 2017 and 2019. Implementation timelines ranged from 30 to 270 days (average 103 days); the time from go-live to routine operation ranged from 14 to 180 days (average 77 days). Cost estimates for initial implementation ranged from $1,775 to $300,000 (average $38,707). Ongoing operational costs averaged $24,237.

Most respondents (73%) do not currently have an EVV system. Twenty-two percent are implementing or currently using an EVV system and 4% are purchasing a system. Providers operating an EVV system indicated the minimum visit verification information required under the 21st Century Cures Act is being captured. To address the provision of EVV in rural/urban areas where connectivity of technology infrastructure is limited or non-existent, providers use telephony (30%), manual entry (40%), and other methods (30%) such as mobile applications with an offline mode and tablets that capture real time data and synchronize when back in a coverage area. One provider commented that this has not been an issue. Twenty percent of providers indicated their systems provide accommodations for staff/individuals specific to Limited English Proficiency. None indicated accommodations for individuals with visual, hearing or physical impairments but several provided comments indicating they could request modifications to their systems and noted availability of a mobile application for accommodations that has not yet been utilized.

Modes of data collection for providers who currently operate an EVV system include land line telephone-used only with limited connectivity (19%), fixed in home devices-also used only with limited connectivity (5%), cell phone (14%), cell phone with GPS (29%), tablet (19%), computer with WiFi (10%) and other unspecified modes (5%).

When asked which modes of data collection are most desirable for inclusion in an EVV system, the top three responses were for tablet-cellular, with WiFi, and/or GPS (52%), cell phone with GPS (43%) and computer WiFi (41%). Several respondents commented that DHHS should consider funding EVV data collection devices.

Respondents commented on data management and security features that are most important to them, including the ability to store encrypted data on a device for uploading later (63%), data encryption when the device is at rest or when data is transmitting (59%), role based security for the various modules with multiple levels of access control (52%), cloud based information storage with data encryption (41%) and provider specific dashboards and other reporting capabilities (36%).

Seventy percent of respondents indicated they support one statewide EVV system for data collection and data aggregation which allows for other systems currently operating to continue to be utilized. Fourteen percent said they do not support this model and 16% indicated “maybe” with regard to their

level of support. Eighty four percent expressed support for an “exceptions” process in the system to allow providers to correct errors/mistakes within state prescribed timeframes.

3

EVV Implementation Analysis

A Review of Selected States

Mercer analyzed nine states' EVV planning and implementation. The states were selected based on their use of the open EVV model in order to allow for appropriate comparison to New Hampshire. The states reviewed are in different stages of implementation. For example, Texas implemented some components of EVV for certain services as early as 2011 and has been statewide with EVV since 2015, while Massachusetts is in the early stages of implementation. As part of this analysis Mercer reviewed status of implementation, vendor, stakeholder processes, system features, challenges and other important notes.

Highlights among the states reviewed include:

- Robust stakeholder processes with dedicated EVV webpages, mailboxes to which questions can be submitted, meetings and webinars with various stakeholder groups and targeted outreach to providers/individuals in self-directed programs
- EVV systems that include the following features:
  - EVV application on smart device
    - Bring your own device (BYOD) model
    - State purchased devices
  - Scheduling module
  - Interface with prior authorization information
  - Reporting capabilities
  - Off-line functionality
- Challenges included:
  - RFP process taking longer than anticipated
  - Adequate funding
  - Time to configure state specific system requirements even with Commercial off-the-shelf (COTS) products

  - Changes to the system as a result of stakeholder feedback

- Other highlights include:
  - Several states are planning to implement personal care and home health services simultaneously (AZ, DE, NC)
  - Other non-mandatory services included in EVV: private duty nursing (PDN), homemaker, chores
  - MCOs choose their own systems in some states

Additional details of each state reviewed can be found in Appendix B.

4

Analysis of EVV Industry Standards & Best Practices

Although some EVV products have been on the market for many years, the widespread use of EVV is relatively new with technologies and practices still emerging. As a result a set of widely adopted industry standards and best practices has yet to emerge. What we have seen are best practices and standards developed by various national organizations as well as CMS. These practices and standards are intended to help improve states' development and implementation of their EVV systems.

The EVV Workgroup for the Home Care and Hospice industries published a standard for verification of visits. Their standard listed that at a minimum, EVV systems should have:

1. The ability to record the exact date services are delivered
2. Record the exact time the services begin and exact time the services end
3. Verify the telephone number or location from which the services are registered
4. Include a mechanism to verify whether their employees are present (e.g., at the beginning and end of a visit) at the location and time where services are to be provided for the recipient
5. Require a personal identification number unique to each caregiver and, if appropriate, a unique password established by said caregiver
6. If required by a state or other jurisdiction, the system must have a proven biometric identification system for purposes of identifying the caregiver beyond the entry of a personal identification number and/or unique password
7. Be capable of producing reports of services delivered, tasks performed, recipient's identity, beginning and ending times of service, date of service in summary fashion that constitutes adequate documentation of service
8. Must be HIPAA compliant
9. Must insure at least daily back-up of all data collected

10. Due to the mission critical nature of such a documentation system, it must demonstrate a viable disaster recovery mechanism allowing for its use within 12 hours of any disruption to services, subject to exceptional circumstances such as war and other disasters of national scope[4]

CMS has published and promoted best practices in EVV model selection, training and implementation.

The promising practices states should consider when selecting an EVV model include:

- Assess EVV systems, if any, currently used by providers
- Evaluate the state's existing vendor relationships
- Define EVV requirements
- Integrate EVV systems with other Medicaid state systems and data
- Understand technological capabilities
- Solicit stakeholder input
- Assess state staff capacity to develop and/or support the EVV system, including providing user training and education
- Roll out EVV in phases and/or pilots (timeline permitting)

The promising practices to consider when developing training include:

- Inventory all entities/individuals that will be interacting with EVV
- Understand how training responsibilities will vary by EVV model
- Establish a training plan
- Assess state staff capabilities/capacity for developing and delivering training
- Provide training and assistance on an ongoing basis
- Establish an EVV website
- Use multiple approaches for notifying and training individuals and their families

Operational promising practices as described by CMS include:

[4]http://blog.richterhc.com/electronic-visit-verification-best-practices-for-home-healthcare-providers

- States should outline expectations regarding monitoring.
- States should allow for continuous provider involvement in decisions-making, particularly for states that established state mandated models.
- States should leverage the Advanced Planning Document (APD) process. If implemented according to requirements under 45 CFR Part 95Subpart F, states can receive up to 90% federal match.
- States should examine every State Plan and waiver authority cited in the Cures Act and crosswalk against State Plan and waiver authorities offered in their state.
- States should crosswalk their state's service definitions and the components of each service definition to the definitions in the Cures Act.[5]

Additionally, CMS, through their articulation of the OBC requirements for EVV systems, is driving industry standards and best practices.[6]

OBC is designed to ensure that EVV systems receiving FFP meet the business needs of the state and of CMS. EVV certification is structured around the following elements:

- **Outcome statements**: These describe the desired results once the system is implemented. CMS-provided outcomes are based on the Cures Act.
- **Evaluation criteria and required evidence**: These correspond to outcome statements and are used by the state and CMS to evaluate the system's functionality and its compliance to laws, regulations and industry good practices.
- **Key performance indicators (KPIs)**: These metrics support the outcome statements and are used to track the performance of the system over time.

In order to qualify for enhanced FFP, states' EVV solutions (whether solely data aggregation functions or a state-procured, beneficiary-facing software suite):

- Must comply with the appropriate security and privacy requirements of HIPAA, and
- Must accurately capture the required six data elements listed in the section 1903(l)(5) of the Act and use the data to edit claims and review encounter data.

[5] https://www.medicaid.gov/medicaid/home-community-based-services/guidance/electronic-visit-verification-evv/index.html

[6] https://www.medicaid.gov/medicaid/data-systems/outcomes-based-certification/electronic-visit-verification-certification/index.html

In addition, state-operated EVV solutions that are beneficiary-facing:

- Must include training and stakeholder outreach, per section 1903(l)(2) of the Act
- Must be accessible to persons with disabilities, per the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973, 36 CFR Part 1194, 42 CFR 431.206 and 45 CFR Part 80
- Must provide support for non-native English speakers, per the Civil Rights Act of 1964 and the Affordable Care Act of 2010

EVV implementation for self-directed programs is a specific concern for individuals who direct their own services. As a result, best practices for EVV implementation in self-directed programs have been developed. These include:

- An EVV system that supports self-direction needs to have flexibility and adaptability related to internet access and mobile devices. A successful EVV system will accommodate limited or no internet access where personal care service is delivered.
- An EVV system that supports self-direction would avoid rigid scheduling rules. A successful EVV system will allow individuals to schedule their workers as they choose, including making frequent schedule changes. Scheduling must occur only between the participant and his or her worker.
- An EVV system that supports self-direction will be as mobile as the people using it. A successful EVV system will support individuals getting services wherever the individual lives his/her life, not only in the home, near the home or at a pre-approved set of locations.
- An EVV system that supports self-direction will be user friendly and intuitive to use. A successful EVV system will offer practical options for training end-users, especially the participant employers and the workers.
- An EVV system that supports self-direction is designed to keep participants “in the driver’s seat”. A successful EVV system will provide a variety of accessible means for individuals to approve service hours, using both innovative and standard technologies.
- An EVV system that supports self-direction will make it easy to retroactively adjust shift start or end times and will not result in lengthy payment delays when mistakes happen. A successful EVV system will facilitate efficient communication for problem-solving when mistakes occur.
- An EVV system that supports self-direction will be designed for integration with existing investments in automation to avoid duplication of effort and expenditures. A successful EVV system will build on the efforts of Fiscal Management Service (FMS) providers rather than mandating implementation of new systems if current systems meet federal requirements.
- State-wide EVV implementation plans that support self-direction will be developed in concert with all of the key stakeholders, specifically with the input of individuals who self-direct their services. A successful EVV system will not only meet the federal requirements for EVV, but will also provide useful tools that facilitate operation of self-directed programs.

- Self-direction is simple in concept, but complex in management of the payments, tax and labor rules. FMS are a unique set of services that has taken the FMS industry two decades to master. Beware of an EVV vendor who tells you they can “do payroll, too” and you do not need an FMS provider. FMS is much more than payroll.[7]

[7] https://www.appliedselfdirection.com/resources/evv-implementation-tip-sheet-self-direction-programs

5

Analysis of EVV Solutions

There are a variety of EVV solutions available to states including:

- EVV as a Component of Another System
- Custom Built EVV Systems
- Stand Alone COTS EVV Systems

EVV as a Component of Another System

As the home care industry has grown, many agencies that provide services through Medicare, Medicaid and Commercial insurance have adopted the use of software systems to help aid in their day to day operations. These range from comprehensive systems that include electronic medical record, care coordination, billing, scheduling, EVV and training functionality to simpler systems that include scheduling and EVV capabilities. These systems focus on the specific needs of the home care industry and have evolved over time. They typically are not used as Medicaid state-wide EVV systems. An example of this type of system is the Alora Health system.

Custom Built EVV Systems

Some states have chosen to develop custom EVV systems and/or software specific to their organizational needs.

In Oregon, the state chose to add EVV functionality to their existing authorization and billing system called the eXPRS Payment System (eXPRS). Providers are required to use this system unless they have a system of their own. Functionality added to eXPRS included the ability for workers to use a mobile device to enter time worked as well as location of where services where provided.

The State of Maryland uses its *LTSSMaryland* system, which is the case management, enrollment, clinical assessments, service authorization, critical event reporting, claims submission, and EVV system for the majority of Medicaid's fee-for-service (FFS) home and community-based services. The *LTSSMaryland* system houses Medicaid's current EVV solution, called In-home Supports Assurance System (ISAS). This is a clock-in, clock-out system for personal care services that has been in place since 2013. *LTSSMaryland* is a custom solution designed and hosted by FEI systems.

Stand Alone COTS Systems

Guidance issued by CMS in 2016 clarifying the ability for states to receive enhanced federal match for the purchase and use of COTS systems as well as Software-as-a-service" or "SaaS" has increased the appeal of these systems throughout the Medicaid Enterprise System, including EVV. COTS systems are standardized products sold in the commercial market that can be modified to some degree.

"Software-as-a-service" or "SaaS" refers to a system using a software platform owned by a vendor (not the State) that manages and licenses the software "on a pay-for-use or subscription basis, centrally hosted, on-demand, and common to all users." In recent years, CMS has encouraged states to move away from custom state specific IT solutions towards the use of COTS products and SaaS as they believe they better support modularity and allow states to leverage solutions.[8]

As a result of this shift there has been tremendous growth in the use of EVV COTS solutions. A review of states as well as a review of EVV products available on the market shows that COTS systems are the predominant EVV solution used by State Medicaid Agencies. COTS solutions are currently offered by a variety of software companies such as First Data (aka Fiserv), Sandata and Tellus.

Mercer conducted an analysis of systems that have been implemented or are in the process of implementation in other states/public sector institutions or service delivery systems. The results of this analysis are shown below.

[8] https://www.covingtondigitalhealth.com/2016/05/cms-issues-guidance-encouraging-the-use-of-commercial-off-the-shelf-technology-and-software-as-a-service-for-medicaid-eligibility-and-enrollment-systems/

Company	Features	State(s)/Clients	Contact/Website
Alora Health	Originally designed to support home health agency administrative and clinical functions; integrates EVV functionality. **SaaS**: Application on mobile device, tablet, laptop, iPad; GPS, telephony and offline services. Paperless timesheet option. **COTS**: Tailors solution to meet the requirements and processes of state Medicaid agencies.	Primarily serving providers of home care services. • California • Colorado • Florida • Indiana • Massachusetts • Minnesota • Ohio • Pennsylvania • Texas • Virginia • Wisconsin	https://www.alorahealth.com/evv-software/
Caretime	**SaaS**: Telephonic, application on mobile device, fixed device and voice-bot for point of care data collection; GPS; biometric voice verification; document visit details, notes and tasks; late and no-show alerts; billing and payroll components; reporting capabilities; integrates with other software; options for self-direction. **COTS**: Can either use the Caretime system or request a customized EVV solution. Includes care portal for individuals, family members.	Primarily serving providers of home care services, fiscal agents of consumer directed services. Also contracted with ACOs and MCOs.	https://caretime.us/evv/

Company	Features	State(s)/Clients	Contact/Website
CareWatch	**SaaS**: Telephonic, application on mobile device and one time password (fixed device) capabilities for point of care data collection; scheduling module; alerts for missed visits; electronic signature; interface with EHR; real time data collection; care plan interface. Portal allows for viewing visits in real time. **COTS**: Can customize system to meet provider needs.	Primarily serving providers of home care services.	http://www.carewatch.com/
First Data/Fiserv	**SaaS**: Telephonic, application on mobile device and fixed device capabilities for point of care data collection; real-time reporting/dashboards and monitoring and alerts of late and missed visits; automated claims and billing; scheduling and payroll module; mobile and web portal; voice biometrics. **COTS**: Customized to meet provider/state needs.	• South Carolina • Oklahoma • Kansas • Alabama • Arkansas • Delaware • Texas • Colorado • Pennsylvania • Nevada: data aggregator • Also provides EVV systems to MCOs in New Mexico	https://www.fiserv.com/

Company	Features	State(s)/Clients	Contact/Website
FEI Systems: CareVisit	**SaaS**: Telephonic, application on mobile device and one time password (fixed device) capabilities for point of care data collection; voice print verification system; GPS; fully integrated web application for reporting including ad hoc reporting capabilities; direct billing component; interoperability with eligibility systems and MMIS. Alert management, beneficiary portal. **COTS**: Configurable and scalable for future needs.	Currently operating an EVV system in 34 states and counties.	https://www.feisystems.com/solutions/long-term-services-and-supports/carevisit-evv/
HHAeXchange	**SaaS**: Telephonic, application on mobile device for point of care data collection; scheduling, billing and payroll modules; documentation of duties/tasks; late arrival alerts; reporting capabilities. **COTS**: Customized to meet provider needs.	Primarily serving providers of home care services. Contracts with MCO's in: • Arkansas • Florida • Hawaii • New Jersey • New York • North Carolina • Pennsylvania	https://hhaexchange.com/electronic-visit-verification-software-solution/

Company	Features	State(s)/Clients	Contact/Website
Sandata	**SaaS**: Telephonic, application on mobile device and fixed device capabilities for point of care data collection; biometric voice recognition; alerts for missed visits; task validation; options for consumer self-direction; reporting capabilities and data integration; care plans and scheduling modules. **COTS**: Customized to meet state/provider needs.	• Arizona • Hawaii's • Colorado • Connecticut • Indiana • Illinois • Maine • New York • Ohio • Pennsylvania • Rhode Island • Tennessee • Wisconsin	https://www.sandata.com/
Tellus	**SaaS based platform**: Data aggregation; reporting and dashboard capabilities, including reporting for CMS OBC. Uses Smartphones with mobile application; location-based services that lock or erase lost devices; caregiver alerts and messaging. **COTS**: Customized to meet state/provider needs.	• Florida • Georgia • Kentucky • Nebraska • Also contracts with MCOs including: • Anthem • United Healthcare • Aetna • Magellan Health	https://4tellus.com/electronic-visit-verification/
Medsys	Telephony, GPS, member/provider portals, exception tracking, alerts, off-line functionality, real time communication via instant chat, electronic signature, claims and billing, forms, payroll and reporting.	• Missouri • Washington • Illinois • Virginia	https://www.medsyshcs.com/

Additionally, Mercer reviewed and analyzed common EVV features and which EVV systems included which features. Most systems include the following features: GPS for location verification, scheduling capabilities, electronic signature capture and off-line functionality. Additional details of this analysis can be found in Appendix C.

Device Options

In response to a DHHS inquiry regarding device options, Mercer researched visit collection methods as well as other state's device solutions. Various technologies and devices are used to collect visit data, including:

- Mobile Visit Verification (MVV): A GPS enabled mobile application downloaded on a smartphone or tablet.
- Telephonic Visit Verification (TVV): A system accessed via toll-free number, accessible 24 hours a day, 7 days a week.
- Fixed Visit Verification (FVV) Device: A device kept in the service recipient's home used to verify visits, sometimes used in conjunction with a landline or when no landline or cellular service is available.

When the device used for verification is noted as provided by the EVV vendor, this is generally a result of the state having contracted with the EVV vendor to supply the device. Costs for devices are eligible for 50% FFP. The information below provides a breakdown of how a selection of states have chosen to approach the provision of EVV devices.

State	MVV	TVV	FVV	Who Provides the Technology	Comments	EVV System Launch Date	Link
Colorado	√	√		Technology is provided by the Service Provider or Direct Services Worker (DSW). Can use service recipient's landline or cell phone if acceptable to the recipient.	Vendor web portal is also available for verification.	Soft launch October 2019	https://www.colorado.gov/hcpf/electronic-visit-verification-frequently-asked-questions
Ohio	√	√		Technology is provided by the EVV Vendor.	Repurposed cell phones are provided to the recipient and maintained by the recipient.	January 2018	https://www.medicaid.ohio.gov/Portals/0/Initiatives/EVV/FAQforEVV.pdf

State	MVV	TVV	FVV	Who Provides the Technology	Comments	EVV System Launch Date	Link
Texas	√	√	√	For TVV, can use service recipient's landline if acceptable to the recipient. Fixed device is provided by the EVV Vendor.	It appears MVV is provided using DSWs device.	Projected for July 2020	https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/what-is-evv.pdf
Alabama	√	√		Technology is provided by the DSW.	MVV is the preferred method; if no cell connectivity, the check-in and check-out information is stored locally on the phone until connectivity is reestablished; then details are forwarded to the EVV system. If using TVV, service recipient's landline is used. If no EVV method is available, the DSW calls their supervisor, provides the EVV required info and the supervisor logs it into the EVV system portal.	October 2017	https://medicaid.alabama.gov/documents/6.0_LTC_Waivers/6.1_HCBS_Waivers/6.1.10_LTC_Meetings/6.1.10_EVVM_Provider_FAQs_6-23-17.pdf
Arizona	√	√	√	Technology is provided by the Service Provider or the DSW for MVV. Can use service recipient's landline for telephony if acceptable to the recipient. Fixed device is provided by the EVV Vendor.	The state is exploring options for supporting the cost of cell/mobile devices moving forward.	January 2021	https://www.azahcccs.gov/AHCCCS/Initiatives/EVV/#FAQ

State	MVV	TVV	FVV	Who Provides the Technology	Comments	EVV System Launch Date	Link
Connecticut	√	√	√	Caregiver uses the service recipient's cell or landline for telephony if acceptable to the recipient.		December 2016 for PCS, February 2017 for HHS	https://portal.ct.gov/DSS/Health-And-Home-Care/Electronic-Visit-Verification/Electronic-Visit-Verification/FAQ

6

Analysis of EVV Interviews and Vendor Demonstrations

Vendor Interviews

Mercer conducted telephone interviews with four EVV Vendors shown in the table below. A standardized interview questionnaire was developed and utilized, covering areas such as system functionality, system features, training approaches and experience with self-directed services.

EVV Vendor	Interview Date
HHAeXchange	May 21, 2020
Fiserv (formerly known as First Data)	May 21, 2020
Medsys	May 21, 2020
Tellus	May 21, 2020

Key Interview findings

All of the vendors interviewed indicated their systems offered Cures Act required EVV functionality as well as exceptions tracking, prior authorization tracking, dashboard and reporting features, offline documentation capability, real time alerts for late or missed visits as well as billing and payroll functionality. All indicated they offer a COTS product that can be customized to meet the state's needs; all of the systems offer Software-as-a-service" or "SaaS".

Medsys and Fiserv indicated they have a portal for member access; all have a provider portal.

Fiserv and Tellus offer in-person training; all offer web based training. All of the vendors except for HHAeXchange provide training to members.

All of the vendors indicated their system utilizes a mobile phone application (viewed as the preferred device for visit verification) and all offered at least one additional option for verification such as telephony or a fixed device. Fiserv described a feature in its application that allows for direct access to 911 for emergencies.

Tellus and HHAeXchange shared that they have some experience with EVV and self-directed services; Medsys and Fiserv indicated they routinely support EVV systems for individuals who self-direct their services.

Most of the vendors indicated they added features to their EVV system to address COVID-19. Some examples of additional or enhanced features include adding procedure codes for telephonic visits and to tracked missed visits related to COVID-19, screening tools to check for COVID-19 symptoms and adding functionality to report on COVID-19 specific issues or concerns.

None of the vendors interviewed have completed the CMS OBC process to date; however, Fiserv indicated it is currently actively pursuing OBC in a state for their AuthentiCare product. The interview template can be found in Appendix D.

EVV Vendor Demos

Mercer facilitated three online vendor demonstrations for key NH DHHS staff by the vendors shown in the table below. Each of the vendors giving a demonstration provided follow up materials such as PowerPoint decks or informational product sheets.

EVV Vendor	Interview Date
Tellus	June 15, 2020
Fiserv	June 17, 2020
Sandata	May 27, 2020

All of the vendors demonstrated a high level of understanding of the 21st Century Cures Act EVV requirements and all provided a visual demonstration of how each product meets the EVV requirements of the Cures Act.

Additional features found across all of the product demonstrations include dashboard and reporting features, offline documentation capability, real time alerts for late or missed visits as well as claims processing, billing and payroll functionality.

All operate primarily using a mobile application with GPS functionality and all offer an alternative device or telephony. All of the vendors indicated their system has a data aggregator.

The Sandata and Fiserv systems have a caregiver/member portal; Tellus does not.

All of the vendors are currently providing EVV services across multiple states and all have experience with self-directed services with Sandata and Fiserv having the most experience in this area.

Sandata is the only system certified through the CMS OBC process.

7

Conclusion

EVV as a technology and as a national practice continues to evolve. As EVV vendors have responded to the needs of State Medicaid Agencies their systems have evolved and will continue to evolve. Early State implementers of EVV have learned lessons through their implementations that have contributed to national best practices in the areas of training and implementation. New Hampshire is well positioned to take advantage of lessons learned from other states as well as state of the art technology.

Based on the review and analysis contained within this market analysis, Mercer recommends:

- DHHS select through a competitive procurement process an EVV vendor who has a COTS product with a SaaS delivery model
- Utilization of a BYOD model for data collection, with the availability of devices supplied by the vendor (included in EVV vendor contract) as a backup for DSPs and individuals who have no other means for visit data collection
- Continuation of stakeholder engagement activities throughout the State's implementation
- Submission of the Implementation Advanced Planning Document (I-APD) to secure enhanced FFP for EVV design, development and implementation activities as well as maintenance and operations

Appendix A
Research Analysis

The following is an analysis of NH DHHS resources, CMS resources and advisories, an industry white paper, materials focusing on EVV and self-directed services and ADvancing States (formerly NASUAD) EVV resources. The information provided in the table below summarizes each resource, provides the relevant document or document link and identifies key points.

New Hampshire DHHS Resources		
NH DHHS EVV Web Page	https://www.dhhs.nh.gov/dcbcs/beas/evv.htm	• NH DHHS developed a web page to inform the public about the process for implementing EVV which includes the following information: – Overview of the 21st Century Cures Act and EVV requirements – NH DHHS Guiding Principles for EVV implementation – Information regarding the NH DHHS EVV Advisory Council, meeting schedule and links to meeting materials – Stakeholder engagement materials and links to stakeholder feedback sessions – Information about Stakeholder Feedback Sessions – Information about MCO/Provider meetings – Results from the EVV Provider Survey – Link to the NH DHHS dedicated email address for requesting information and/or providing feedback: EVV@dhhs.nh.gov – Projected timeline for EVV implementation – Frequently Asked Questions (FAQ) document – List of proposed Medicaid services that will require EVV (subject to change)

New Hampshire DHHS Resources		
NH EVV Good Faith Effort Exemption Approval	See Attachment A: NV EVV GFE Approval Letter	• NH DHHS requested an EVV Good Faith Effort (GFE) exemption which was granted by CMS on November 21, 2019. • As a result of this exemption being granted — CMS will not apply federal medical assistance percentage (FMAP) reductions in calendar year 2020. — If the state is not fully compliant by January 1, 2021, FMAP reductions will be applied beginning in the first quarter of 2021 and every quarter thereafter until the state achieves compliance.
NH DHHS EVV Provider Survey	See Attachment B: EVV Survey Monkey Results 1-2018	• NH DHHS conducted a preliminary EVV Provider Survey in January 2018. Key findings include: — 41 respondents, representing Hospice, Home and Community Based Services providers Home Health Agencies, other agencies — Most respondents indicated they did not have an EVV system in place — Those with EVV systems are primarily tracking home health care visits — EVV system functionality, in addition to required elements, includes scheduling, reporting, claims submission, service authorizations

CMS Resources and Advisories		
CMS Informational Bulletin August 8, 2019	See Attachment C: CMS EVV Information Bulletin	• Key takeaways from this CMS August 8, 2019 Informational Bulletin include: — EVV requirements do not apply when the caregiver providing the service and the beneficiary live together. — EVV requirements do not apply to the delivery, set-up, and/or instruction on the use of medical supplies, equipment or appliances. — If a personal care or home health care service is provided both in the home and in the community during the same visit, EVV is only required for the portion of the service rendered in the home; however, states may choose to require more information to control fraud, waste and abuse.
CMS Electronic Visit Verification (EVV) Outcomes Based Certification	https://www.medicaid.gov/medicaid/data-and-systems/downloads/outcomes-based-verification/evv-certification.zip	• The CMS has begun to transition its systems certification process to one that evaluates how well Medicaid information technology systems support desired business outcomes while reducing the burden on states. • This streamlined, outcomes-based approach, or "Outcomes-Based Certification" (OBC), is designed to ensure that systems that receive federal financial participation are meeting the business needs of the state and of CMS. • EVV is the first system to which CMS is applying an outcomes-based approach to certification. • This October 2019 Outcomes Based Certification link includes the following resources: — EVV Certification 1.0 EVV Release Notes — EVV Certification 1.0 EVV Guidance — EVV Certification 1.0 EVV Evaluation Criteria and KPIs — EVV Certification 1.0 EVV Intake Form

CMS Resources and Advisories		
CMS EVV Update	See Attachment D: CMS EVV Update Aug 2018	• This August 2018 CMS EVV update provides information about the new timeline for states to implement EVV for personal care services. • Under the new timeline, states are required to implement EVV for personal care services by January 1, 2020, or otherwise be subject to FMAP reductions as follows: — 0.25 percentage points for calendar quarters in 2020 — 0.5 percentage points for calendar quarters in 2021 — 0.75 percentage points for calendar quarters in 2022 — 1 percentage point for calendar quarters in 2023 and each year thereafter • States that have not implemented EVV by January 1, 2020 will be subject to FMAP reductions unless they have both made a "good faith effort" to comply and have encountered "unavoidable system delays." • States with GFE exemptions will not be subject to FMAP reductions in 2020, however, will be subject to incremental FMAP reductions beginning with 0.5 percentage points for calendar quarters in 2021 if they have not implemented an EVV system by January 1, 2021.
CMS PowerPoint EVV Requirements in the 21st Century Cures Act	http://www.appliedselfdirection.com/sites/default/files/EVV%20Requirements%20in%20the%2021st%20Century%20Cures%20Act%20Intensive.pdf	• This August 2018 PowerPoint presentation was presented by CMS at the ADvancing States/ NASUAD conference and provides an overview of: — 21st Century Cures Act requirements — EVV Requirements — APD and federal match opportunities — EVV and Self-Directed services — EVV system models — Information about the Good Faith Effort Exemption Process

Industry White Paper		
EVV White Paper: National MLTSS Health Plan White Paper; EVV White Paper	http://mltss.org/wp-content/uploads/2019/02/MLTSS-Assn-EVV-White-Paper-1-25-19.pdf	• This January 2019 White Paper provides information on the following: — Overview of EVV requirements — EVV models — Notes that, in addition to CMS' five models, states have proposed a sixth potential model called the Provider Audit Model. − This proposed method would allow states to direct providers to establish a process to ensure that services are electronically verified, but would not establish a statewide aggregation system or state-developed EVV option. − There is no evidence to suggest that CMS is considering this model. — Recommends industry best practices: − Communicating to consumers, in easy-to-understand terms, exactly how gathered information will be used and to whom it will be sent − Ensuring data aggregated by the state and CMS is not used by fiscal intermediaries or EVV vendors for marketing or other purposes − Limiting the mandatory use of GPS tracking and biometrics to ensure EVV systems are minimally invasive − Preventing unauthorized access to EVV data using multi-factor authentication, data encryption, or cryptographic key management − Providing HIPAA compliance training for both providers and software vendors. — Provides the "landscape" of current EVV providers nationally

EVV and Self-Directed Services		
Applied Self-Direction Frequently Asked Questions (FAQ) document submitted by NH DHHS	Link to DHHS Document 1.6f: http://www.appliedselfdirection.com/sites/default/files/EVV%20FAQ%206.28.19.pdf	• This June 2018 document is a Frequently Asked Questions document produced by the advocacy association Applied Self-Direction and is intended as "A Quick Guide to Understanding EVV." The document is geared toward responding to service recipient concerns regarding: – Privacy and the ability for the system to track an individual's whereabouts – Applicability of the requirement to the services they are receiving
EVV: A Blueprint for Self-Direction; Applied Self-Direction; November 2018	http://www.appliedselfdirection.com/resources/electronic-visit-verification-evv-blueprint-self-direction	• This blueprint focuses on the following aspects of EVV from the perspective of individuals who self-direct their services: – Philosophy of self-direction versus traditional agency directed services – Key EVV system functionality necessary to support participant choice, control and flexibility in self-direction – Emphasis on flexibility in scheduling – Need for protocols for EVV system use in areas without internet access – Participant approval of hours logged by workers in the EVV system – An "ideal workflow" for supporting choice and control and complying with EVV requirements – Overall emphasis is on building an EVV system that allows for sufficient flexibility for individuals who self-direct and whose services may "flex" in terms of scheduling, based on needs

ADvancing States Resources		
EVV Informational Resources from ADvancing States (formerly known as NASUAD) submitted by NH DHHS	See Attachment E: 2018 Electronic Visit Verification Report	• In 2018 and 2019, ADvancing States hosted an EVV workgroup for states and developed a series of informational documents, including a PowerPoint presentation, email advisories and updates from a workgroup supported by the organization. These documents were used to advise states and other stakeholders on a variety of EVV related issues. • NH DHHS participated in workgroup meetings and provided a number of documents related to the following topics: – EVV requirements and timelines – The 21st Century CURES Act – Implications for States, Providers, and – Medicaid Participants – Approaches to system implementation – Program design options – How an EVV system can be used in quality improvement efforts – Good Faith Effort Extensions – Questions and Answers from CMS on key issues – IT system outcomes based certification requirements – Information from CMS regarding the Live-In caregiver exemption – Clarification regarding inapplicability of Durable Medical Equipment (DME) as an EVV service

ADvancing States Resources		
ADvancing States EVV Report: Implications for States, Providers and Medicaid Participants	Link to DHHS Document 1.6b http://www.advancingstates.org/sites/nasuad/files/2018%20Electronic%20Visit%20Verification%20Report-%20Implications%20for%20States,%20Providers,%20and%20Medicaid%20Participants.pdf	• This report provides an overview of EVV requirements as of May 2018 including: – An Overview of Electronic Visit Verification – The 21st Century Cures Act – The role of CMS in implementing EVV – The information needed for states to know to implement EVV successfully – EVV program design options – State considerations when implementing an EVV system – Information about how states can utilize an EVV system as part of its Quality Improvement activities

Appendix B

EVV Implementation Analysis

A Review of Selected States

State	EVV Model	Vendor	Status of Implementation	Stakeholder Process	System Features	Challenges	Other Notes
Arizona	Open Vendor	Sandata	Implementation planned for June 2020	• Established a dedicated EVV webpage where information is posted • Public forums throughout the state to elicit feedback • Meetings with established provider, family and/or advocacy groups to share information and receive feedback • Provider survey • Provider Advisory Committee • MCO Advisory Committee • Created an EVV mailbox where	• Alerts to CM and provider agency for late/missed visits • Offers a variety of visit methods, for example, mobile application (BYOD and State supplied), telephony and fixed device • Includes task list • Scheduling functionality • Authorization module that transmits authorizations from MCOs to providers	• Business rules development took longer than anticipated • Even though COTS product purchased, it took time for state specific configuration • Length of time for CMS to approve contract with vendor	• Contract includes Hawaii • Requires individual and/or authorized representative verification after every visit • Includes private duty nursing (PDN), respite, homemaker and respiratory therapy • Implementing PCs and Home Health services at same time • Requiring live caregivers to be subject to EVV

State	EVV Model	Vendor	Status of Implementation	Stakeholder Process	System Features	Challenges	Other Notes
				questions can be submitted			
Arkansas	Open Vendor	PCG (FFS program only)	January 1, 2021 Pilot in summer of 2019	• Held information webinars for stakeholders • Established a dedicated EVV webpage where information is posted • Email blasts to stakeholders • In-person meetings with key stakeholders • Provider survey	• BYOD • Application on smart device • Scheduling component • Produces 837 file for claims • Offline mode • Website with provider, member view that enables users to see visit data, create reports, manage users, etc.	• Protests during the request for proposal (RFP) period • Provider readiness	• MCOs responsible for choosing own EVV solution • Arkansas Total Care uses Home Health Agency (HHA) Exchange offered to their contracted providers for free
Delaware	Open Vendor	Vendor selected but not announced	January 1, 2021	• Established a dedicated EVV webpage where information is posted • Public forums throughout the state to elicit feedback • Attended provider association meetings to share information and elicit feedback • Provider survey	• Ability to interface with multiple systems, for example, Medicaid management information systems, CM systems, DIHN, etc. • BYOD and State purchased device for data collection	• RFP process took longer than anticipated • Multiple priorities within Medicaid	• Implementing PCs and Home Health services at the same time • Includes homemaker, chores, respiratory and respite services

State	EVV Model	Vendor	Status of Implementation	Stakeholder Process	System Features	Challenges	Other Notes
				• Advisory Committee • Created an EVV mailbox where questions can be submitted	• Alerts for late/missed visit to provider, CM, authorized representative • Scheduling, service planning, claims processing modules • Off-line functionality • Reporting and dashboards with role based access		
Florida	Open Vendor	Tellus (FFS program only)	January 1, 2021	• Posted FAQ on website • Maintains an EVV mailbox • Convened multiple stakeholder meetings • Disseminated EVV newsletters	• Smart phone application • Dashboard • Claims portal	• System interoperability issues due to privacy and security concerns • The need for more requirement analysis and system design sessions than originally planned • Extensive configuration modifications that needed to be made to the vendor's off-the-shelf solution	• Includes PDN, homemaker and respite • Piloting use of EVV for applied behavioral analysis services • MCOs responsible for choosing own EVV solution • Several of State's MCOs contract with HHAeXchange and some use Tellus

State	EVV Model	Vendor	Status of Implementation	Stakeholder Process	System Features	Challenges	Other Notes
Louisiana	Open Vendor	Statistical Resources, Inc. (SRI)	February 2018	• Maintaining an EVV website and mailbox • Convening in-person meetings and trainings with providers, self-direction employers and case management agencies	• Application on smart phone, tablet, PC • GPS verification • Real time access to data at provider, work and individual level • Interface with PA data • Electronic access to RA • Data exportable to Excel and other formats • DSW training tracking	• System interoperability issues with regards to services provided through the Early and Periodic Screening, Diagnostic and Treatment benefit • The need to develop an alternate self-direction solution as a result of CMS' August 2019 guidance	• March 1, 2016 for home and community-based services provided outside of home (center-based, vocational and transportation) • EVV system is part of the Louisiana Service Reporting System (LaSRS) operated by the State's data and prior authorization contractor SRI • Providers with third-party EVV systems must upload data to LaSRS daily; also requires attestation by providers and its EVV vendor that certain requirements are met

State	EVV Model	Vendor	Status of Implementation	Stakeholder Process	System Features	Challenges	Other Notes
							• Providers required to supply devices to staff. “Cost offset by administrative savings from elimination of the data entry requirement…” • State suggests providers pay a small subsidy to DSWs using their own devices to cover data usage; per Louisiana 1% of a gigabyte, which is 1% of the smallest data plan • Canceled First Data contract for failure to complete tasks needed for a successful launch (2015)
Massachu-setts	Open Vendor	Optum (MyTimesheet Application)	Summer of 2020 (pilot was targeted for Spring of 2020)	• Convening public listening sessions • Maintaining an EVV website and mailbox	• Application on smart phone or other type of device • GPS • Web based portal for provider use • Scheduling functionality	• Ongoing contract negotiations with its EVV vendor • The need to develop solutions to issues identified by stakeholders	• Self-directed programs will use Optum solution • Will be used for some Non-Medicaid programs

State	EVV Model	Vendor	Status of Implementation	Stakeholder Process	System Features	Challenges	Other Notes
				• Providing written and face-to-face education to consumers and their families	• BYOD model • Off-line functionality	• Complexities around system interoperability	• Including homemaker services • Provider attestation for alternate EVV systems
North Carolina	Open Vendor	Undecided	January 1, 2021	• Surveying stakeholders impacted by EVV • Conducting regional provider trainings • Maintaining an EVV website and inbox • Outreaching to self-directed workgroups • Convening an EVV stakeholder meeting to present on EVV requirements, the State's design model and implementation timeline • Developed a communications plan that will engage stakeholders in each affected	• Features unknown at this time. RFP for vendor has not been issued	• Veto of a budget bill that included funding for EVV, which has delayed the issuing of the RFP • Transition to managed care which requires significant system reconfiguration, and the State cannot integrate EVV until this project is complete	• Implementing PCs and Home Health services at the same time • Implementing MCO and FFS programs at the same time • Considering a pilot • North Carolina MCOs (Carolina Complete Health, AmeriHealth Caritas of North Carolina, United Healthcare Community Plan of North Carolina and WellCare of North Carolina) have partnered with HHAeXchange. MCO contracted providers can use HHAeXchange or their own system (with data sent to

State	EVV Model	Vendor	Status of Implementation	Stakeholder Process	System Features	Challenges	Other Notes
				program and will convene a focus group for beneficiaries and their families			HHAeXchange data aggregator)
Rhode Island	Open Vendor	Sandata	Partial Implementation 2016/2017	• Maintaining an EVV website • Convening meetings with providers, MCOs, fiscal intermediaries and beneficiaries	• Scheduling module • Reporting module • Claims submitted from system into Medicaid claims portal • Interface with authorization data • Variety of data collection methods: — Application on smart device — Telephony — Fixed devices	• Some providers have not selected which EVV system or third-party vendor they will be utilizing. This has led to delays in provider integration with the State aggregator, piloting the EVV system, stakeholder meetings and implementing work plans • Logistical issues for self-directed services • Technical issues identified by MCOs	• FFS providers who use state system are currently operational • MCOs and providers with third-party systems—go-live has been delayed
Texas	Open Vendor	First Data, Data Logic (Vesta)	Partial implementation for some programs and/or services in certain areas of the state starting	• Maintaining an EVV-dedicated website • Convening ongoing meetings with MCOs, providers, Medicaid members	• Application on worker or provider issues smart phone, telephony and “alternate/fixed” devices	• Legislation requiring the State to develop an open model • The need to address stakeholder	• Includes in-home respite • State is not implementing personal care services and Home

State	EVV Model	Vendor	Status of Implementation	Stakeholder Process	System Features	Challenges	Other Notes
			in 2011 as a result of state legislation. Statewide since 2015	and Consumer Directed Services (CDS) participants	• Portal associated with aggregator for providers, FMSAs, MCO's, State staff • Data can be exported via portal	concerns regarding onboarding, training and policy • Complexities in allocating CDS funding for EVV devices • Changes made to EVV business requirements as a result of stakeholder feedback during pilot evaluation sessions, which has led to delays in EVV system onboarding and training for the State's expanded EVV vendor pool	Health services at the same time • State has on-going monitoring plan for EVV provider compliance • EVV consumer rights and responsibilities form • Moving to an open model • Providers and FMSAs may choose to use a proprietary EVV system instead of a system from the State EVV vendor pool (currently, two vendors) • MCOs may choose their own EVV vendors • Accenture built/operates data aggregator

Appendix C

Analysis of EVV Features

Provider Features Include:	GPS EVV	Telephony	Member and Provider portals	Scheduling	Exception tracking/ alerts (no shows)	Faxing	Real-time Communications	Secure Email	PA Tracking	Offline documentation	Electronic signature capture
Alora Health	X	X		X		X		Internal only	X	X	X
MEDsys Software Solutions	X	X	X	X	X		X (Instant chat)			X	X
First Data/Fiserv	X	X	Interactive provider dashboards	X	X		X	X	X	X	X
FEI Systems	GPS Geo-fencing	X, w/automatic number identification	Provider portal has scheduling, beneficiary safety monitoring, billing/claims review, alert & exception mgmt, ease of use for member review	X	X		Secure real-time communications between office-based personnel and community-based care workers				
Sandata	X w/GPS enabled devices	X using Automatic # ID, wave files of recorded login voices	Participant portal - view/edit and approve visits & timesheets; provider portal - view/edit visits and timesheets; ability to make approved corrections to common errors	X	X		Alerts can be sent via text or email			Fixed visit verification (patented)	
Tellus	X	X	Providers only	X	X		X	X	X	X	X
HHAeXchange	X	X	Providers only	X	X		X	X	X	X	
Vesta EVV (DataLogic Software Inc.)		X		X							
HealthStar LLC (A CareBridge Health Company)	X			X	X		X				
PrimeCare Technologies is not an EVV, only aggregator		X		X						X	X
Therap	X			X	X					X	X

Provider Features Include:	Forms	Assessments	Billing & Claims	Payroll	Employee Credentialing	Reporting	Other Features
Alora Health		X	X	X	X	X	
MEDsys Software Solutions	X		X	X		X	
First Data/Fiserv			X	Flexible reporting to assist in payroll processing		X	
FEI Systems			Timely & configurable data, uses FEI's EDI engine, HIPAA compliant, ease of interfacing w/MMIS			Beneficiary safety monitoring & reporting	Service location flexibility
Sandata	Requires Santrax Point-of-Care solution?	Requires Santrax Point-of-Care solution?	Front-end visit detail & claims validation against Pas; ability to export visit data for billing purposes	Require Santrax Agency Mgmt solution		Email and visit maintenance dashboards & robust reporting for quality oversight	Client visit and tasks validation option - allows participant to confirm the visit length and tasks entered by the caregiver as completed
Tellus			X			Real time data analytics and reports	
HHAeXchange			X	X		X	
Vesta EVV (DataLogic Software Inc.)			Transmits verified visits to payers for claim validation; billing feature is available to providers at an additional fee			Comprehensive reporting features	Creates visit logs based on schedules; the visits are verified against the visit log (as opposed to a PA); says it makes certain patients are receiving the service hours they are authorized to receive
HealthStar LLC (A CareBridge Health Company)							GPS tools for mobile fleets of vehicles, for NEMT
PrimeCare Technologies is not an EVV, only aggregator						X	
Therap				Reporting for payroll		Over/under utilization, over/under scheduling, over/under staff working hrs, services not provided at required locations	

Appendix D

EVV Vendor Interview Template

Introduction

We are conducting research on behalf of New Hampshire's future procurement of an electronic visit verification system (EVV) utilizing the open model approach.

Background

Section 12006 of the Cures Act stipulates that states will be subject to a reduction in Federal Medical Assistance Percentages (FMAP) if they do not implement Electronic Visit Verification (EVV) for personal care services by January 1, 2020, and for home healthcare services by January 1, 2023. CMS provided New Hampshire with a one-year Good Faith Effort extension for personal care services.

General

1. Provide a brief overview of your EVV system.
2. Have any of these solutions been certified by CMS? If yes, please describe.
3. Will you provide us with a document or website link that outlines all of the features and functionality offered by your solution(s)?
4. How many members and/or providers does your solution(s) typically support?
5. Describe your solution's capabilities for supporting multiple languages and 508 compliance.
6. Describe your organization's training and end-user support capabilities.
7. How many years has your organization been supporting EVV?
8. List the states that are or will be utilizing your solution(s). Describe whether these are a state 'sponsored' solutions, or MCO selected solutions, or provider preferred solutions.
9. Please describe your experience working with self-directed programs services.
10. Please describe how long it typically takes to implement your solution: from contract signature to system go-live.
11. Are you able to provide pricing information for your solution?

Infrastructure

12. What type of infrastructure do you provide (ex: Platform as a Service (PaaS), Software as a Service (SaaS)), or something else?

13. Can you provide a high-level description of your solutions' framework and/or technical architecture?

14. Do you offer geographically dispersed data centers? Are all of your data centers located in the US? Any offshore? Are they dedicated data centers with 24x7 support?

15. Describe your approach to business continuity and disaster recovery, including information on how you have handled the COVID-19 situation.

16. Do you offer an on-premises solution? If so, what are the differences between your hosted solution versus an on-premises implementation?

Features/Functionality

17. Which of the following features does your solution support?

Feature	Describe capabilities	Requires alternate approach
Integration		
Data Aggregation		
GPS and Telephony		
Member and Provider Portals		
Exception tracking, alerts & no shows		
Real-time communications		
Secure emails		
Scheduling		
Prior authorization tracking		
Offline functionality/documentation		
Electronic signature capture		
Billing & Claims		
Reporting & Analytics		
Task List		

18. Describe any value-added services that your company typically provides as part of an awarded contract (e.g., consulting services pre- and post- implementation such as assistance with initial setup, additional training, etc.)

Attachment A: NV EVV GFE Approval Letter

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Disabled and Elderly Health Programs Group

November 21, 2019

Mr. Henry Lipman
Office of Medicaid Business and Policy
New Hampshire Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301-6521

Dear Mr. Lipman:

I am writing to inform you that CMS is granting approval of New Hampshire's electronic visit verification (EVV) good faith effort exemption request. CMS has determined that your state's request is in accordance with section 1903(1)(4)(B) of the Social Security Act, as added by section 12006(a) of the 21st Century Cures Act (Cures Act). Specifically, your state has made a good faith effort to comply with EVV requirements by issuing a Request for Proposals (RFP) for a consultant to assist with defining EVV requirements and developing a RFP for vendor selection. The state indicated that the consultant contract will include stakeholder engagement activities, including soliciting feedback from external stakeholders through public forums, surveys, and other means proposed by its contractor. The state has also launched an EVV website. CMS recommends that the state follow the promising practices for training, communication, and education outlined in CMS' May 16, 2018 Informational Bulletin when carrying out its stakeholder engagement activities.

In addition, your state has encountered unavoidable delays when implementing its EVV system, including a delay in procuring its consultant due to a change in department contract staff and the diversion of staff to work on opioid issues. This delayed stakeholder engagement activities and defining EVV requirements. The state also cited budget/legislative appropriation issues, indicating that although proposed, the state budget for FY 2020 did not include funding for EVV.

Because your state has sufficiently demonstrated it has made a good faith effort to comply with EVV requirements and has encountered unavoidable delays, CMS will not apply federal medical assistance percentage (FMAP) reductions in calendar year 2020. Please be advised that the Cures Act provision on good faith effort exemptions does not provide CMS with authority to delay the FMAP reductions for more than one year. Therefore, if the state is not fully compliant by January 1, 2021, FMAP reductions will be applied beginning in the first quarter of 2021 and every quarter thereafter until the state achieves compliance. If you have any questions please email EVV@cms.hhs.gov or contact your CMS Regional Office.

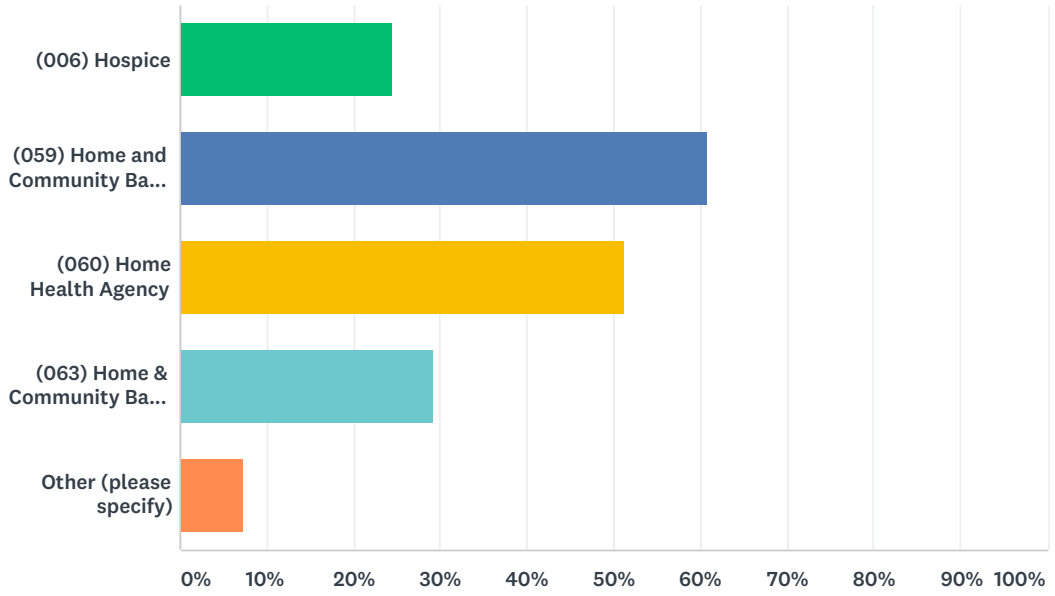
Sincerely,

Ralph F. Lollar, Director for
Division of Long Term Services and Supports

Attachment B: NH EVV Survey Monkey Results 1-2018

Q1 Please indicate your provider type(s): (Select all that apply)

Answered: 41 Skipped: 0



ANSWER CHOICES	RESPONSES	
(006) Hospice (1)	24.39%	10
(059) Home and Community Based Services (HCBS) – Elderly & Chronically Ill (ECI) Waiver Program Services - Choices for Independence (CFI) (2)	60.98%	25
(060) Home Health Agency (3)	51.22%	21
(063) Home & Community Based Care (HCBC) Developmental Disabled (DD) (4)	29.27%	12
Other (please specify) (5)	7.32%	3
Total Respondents: 41		

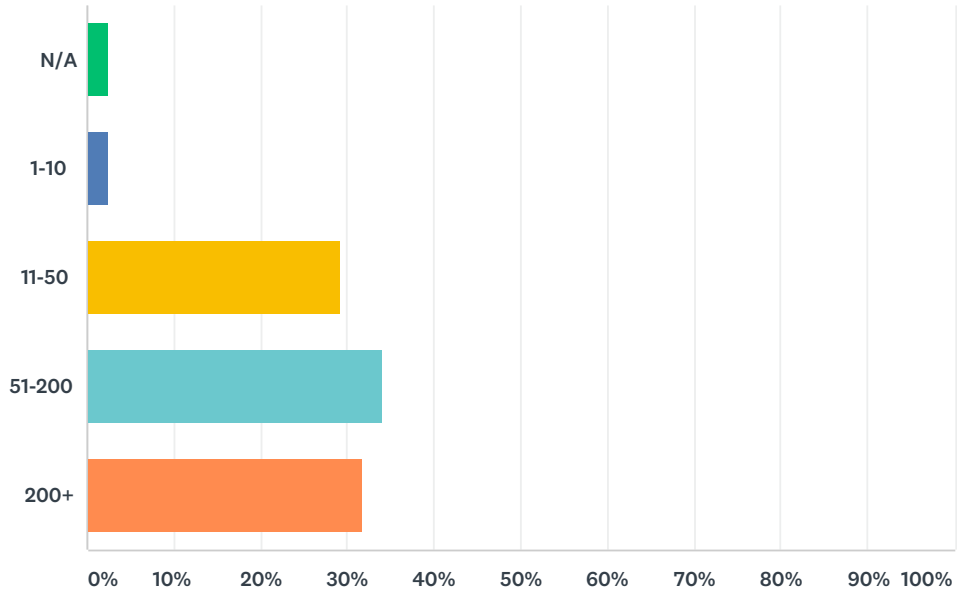
BASIC STATISTICS

Minimum	Maximum	Median	Mean	Standard Deviation
1.00	5.00	3.00	2.62	1.05

#	OTHER (PLEASE SPECIFY)	DATE
1	State Plan for Personal Care Attendant Services	1/5/2018 9:35 AM
2	809	12/28/2017 5:30 PM
3	private duty	12/27/2017 2:43 PM

Q2 Number of Individuals Employed:

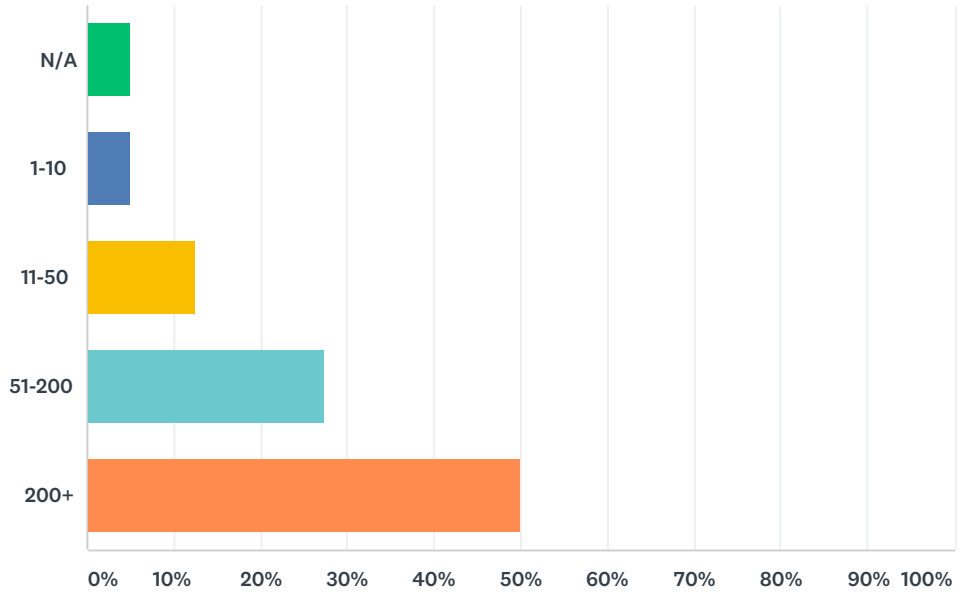
Answered: 41 Skipped: 0



ANSWER CHOICES	RESPONSES	
N/A	2.44%	1
1-10	2.44%	1
11-50	29.27%	12
51-200	34.15%	14
200+	31.71%	13
TOTAL		41

Q3 Number of Members Served:

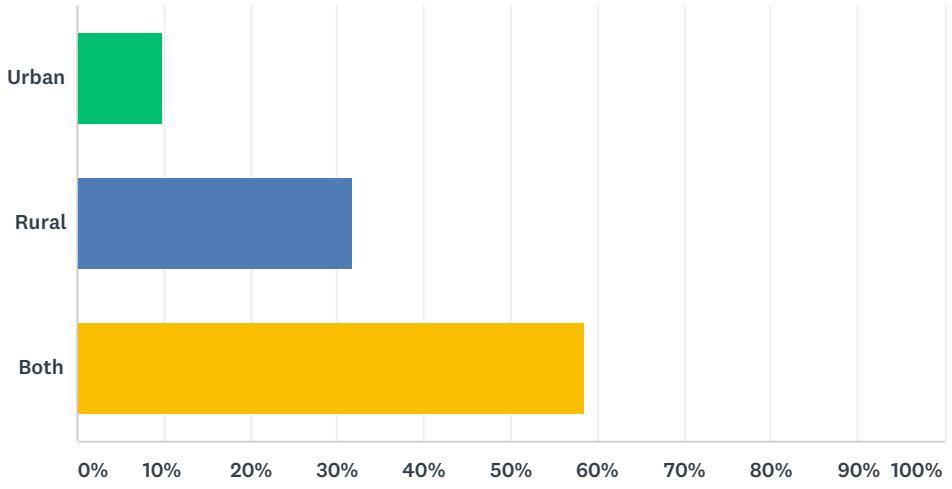
Answered: 40 Skipped: 1



ANSWER CHOICES	RESPONSES	
N/A	5.00%	2
1-10	5.00%	2
11-50	12.50%	5
51-200	27.50%	11
200+	50.00%	20
TOTAL		40

Q4 Where Do You Provide Services? (Select all that apply)

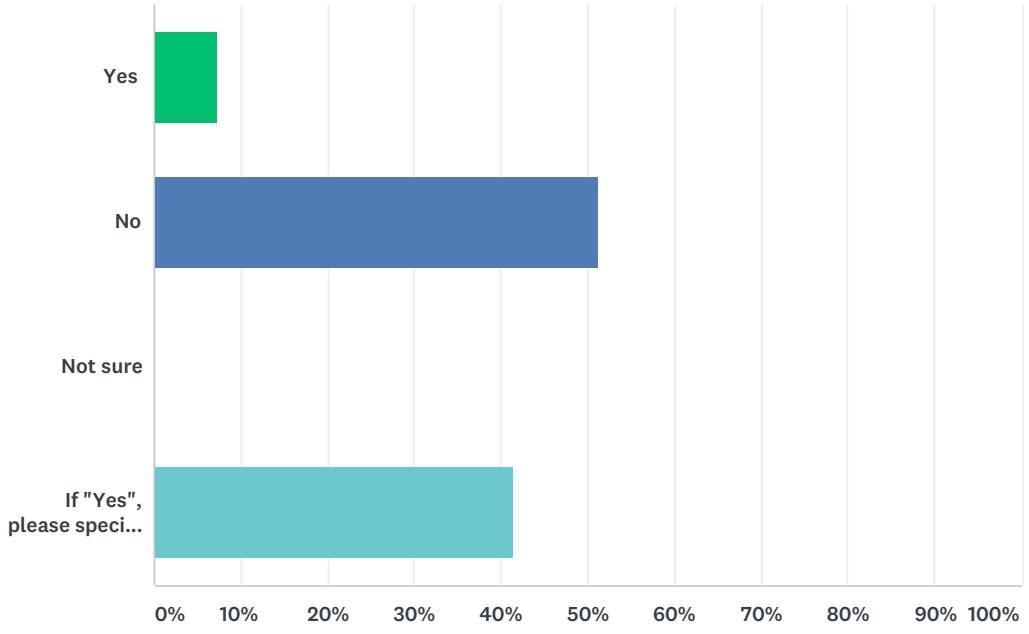
Answered: 41 Skipped: 0



ANSWER CHOICES	RESPONSES	
Urban	9.76%	4
Rural	31.71%	13
Both	58.54%	24
Total Respondents: 41		

Q5 Do you/your agency currently use an EVV program, or something similar that uses Global Positioning System (GPS) or alternative electronic location tracking application to verify visits?

Answered: 41 Skipped: 0



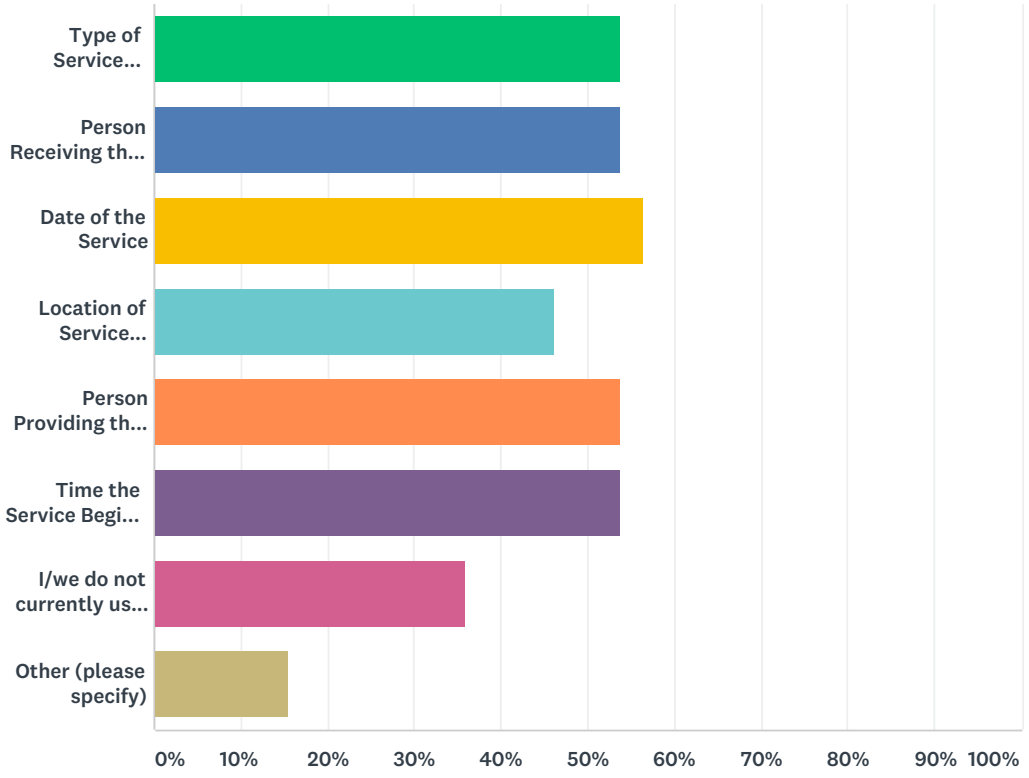
ANSWER CHOICES	RESPONSES	
Yes	7.32%	3
No	51.22%	21
Not sure	0.00%	0
If "Yes", please specify which system	41.46%	17
TOTAL		41

#	IF "YES", PLEASE SPECIFY WHICH SYSTEM	DATE
1	Netsmart- Mobile Lite for Homemakers & LNA's	1/31/2018 2:20 PM
2	ClearCare	1/28/2018 4:28 PM
3	Followme and Brightree	1/16/2018 6:46 PM
4	Homecare Homebase	1/16/2018 10:04 AM
5	Kinnser	1/15/2018 9:58 AM
6	CLEARCARE	1/11/2018 9:54 AM
7	CellTrak and we are implementing Netsmart Mobile Tablet this month	1/9/2018 8:52 AM
8	McKesson - Mobile for Home Health Aides	1/8/2018 2:09 PM
9	We use a telephony system which requires the employee to use the telephone at the client's home	1/5/2018 3:50 PM
10	MITC Software (MITCSoftware.com)	1/5/2018 12:02 PM
11	In Process of implementation , Advance System , tracking mechanism is through verifying that it is the consumer phone number within the system	1/5/2018 9:35 AM

12	Telephony	12/28/2017 5:30 PM
13	McKesson EMR Telephony system	12/27/2017 2:43 PM
14	HomeTrack system/Telephony	12/27/2017 10:14 AM
15	Home Trak	12/26/2017 4:30 PM
16	Alora	12/23/2017 2:47 PM
17	carewatch	12/22/2017 12:55 PM

Q6 With the EVV program, or something similar, you/your agency currently use, what data elements are collected? (Select all that apply)

Answered: 39 Skipped: 2



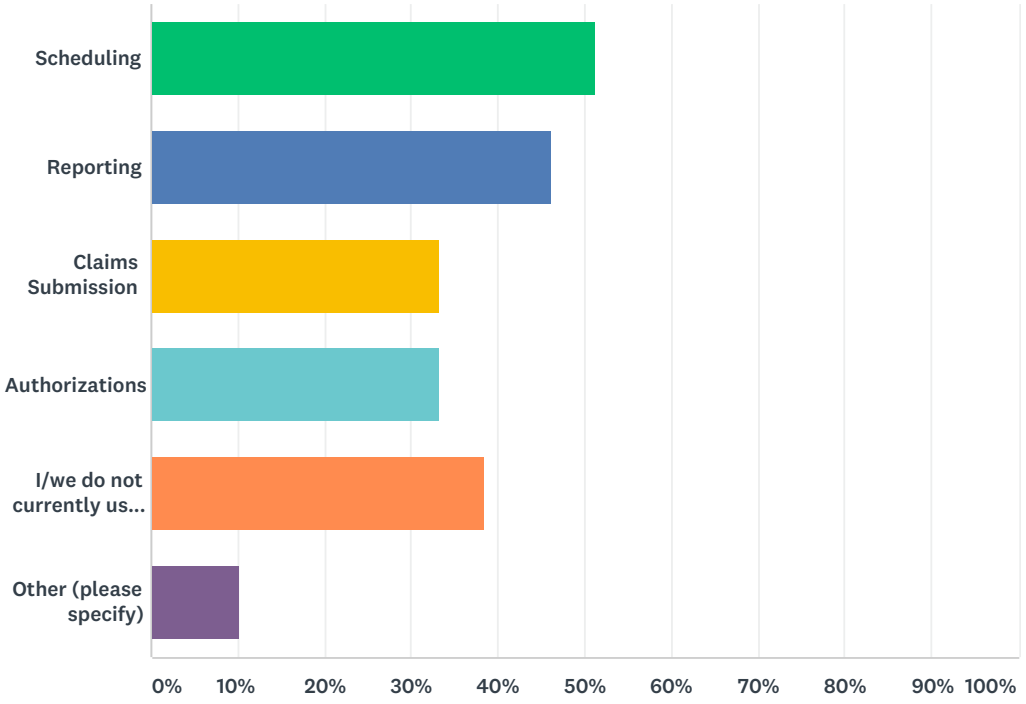
ANSWER CHOICES	RESPONSES	
Type of Service Performed	53.85%	21
Person Receiving the Service	53.85%	21
Date of the Service	56.41%	22
Location of Service Delivery	46.15%	18
Person Providing the Service	53.85%	21
Time the Service Begins and Ends	53.85%	21
I/we do not currently use an EVV program or anything similar	35.90%	14
Other (please specify)	15.38%	6
Total Respondents: 39		

#	OTHER (PLEASE SPECIFY)	DATE
1	Mileage and Care Plan charting	1/31/2018 2:20 PM
2	Data collected on paper, then entered into electronic medical record	1/29/2018 10:18 AM
3	I turned it off currently as it was preventing staff from clocking in as the GPS system does not work correctly.	1/28/2018 4:28 PM
4	Patient Signature	1/8/2018 2:09 PM

5	In process of implementation	1/5/2018 9:35 AM
6	Have EMR but it doesn't currently use GPS	12/26/2017 1:06 PM

Q7 With the EVV program, or something similar, you/your agency currently use, what functionality does it have? (Select all that apply)

Answered: 39 Skipped: 2



ANSWER CHOICES	RESPONSES	
Scheduling	51.28%	20
Reporting	46.15%	18
Claims Submission	33.33%	13
Authorizations	33.33%	13
I/we do not currently use an EVV program or anything similar	38.46%	15
Other (please specify)	10.26%	4
Total Respondents: 39		

#	OTHER (PLEASE SPECIFY)	DATE
1	visit documentation	1/31/2018 2:20 PM
2	Data collected on paper, then entered into electronic medical record	1/29/2018 10:18 AM
3	Just a few reports that are relavent to our business	1/28/2018 4:28 PM
4	Full functionality in EMR except GPS	12/26/2017 1:06 PM

Q8 What was the cost to set up your existing EVV program, or something similar?

Answered: 27 Skipped: 14

#	RESPONSES	DATE
1	Not known, part of system conversion	1/31/2018 2:20 PM
2	N/A	1/31/2018 9:07 AM
3	Unknown	1/30/2018 1:05 PM
4	N/A	1/29/2018 10:18 AM
5	approximately $1500 for initial costs without reinforcement and oversight	1/28/2018 4:28 PM
6	N/A	1/18/2018 12:14 PM
7	.50/shift for each employee	1/17/2018 9:49 AM
8	536,450	1/16/2018 10:04 AM
9	$50/ month	1/15/2018 9:58 AM
10	$1500 SETUP COST,$300-$400 PER MONTH	1/11/2018 9:54 AM
11	$5,000 for CellTrak; $5000 for Netsmart mobile	1/9/2018 8:52 AM
12	Unknown	1/8/2018 2:09 PM
13	unknown, we have been using the systems since 2010	1/5/2018 3:50 PM
14	$25,623 Implementation Costs + 27,067 C.B. Cost = $59,635 plus ongoing annual base fees $48,592	1/5/2018 12:02 PM
15	$2.5 million	1/5/2018 9:35 AM
16	N/A	1/4/2018 11:10 AM
17	Set-up $650,000 with a $20,000 monthly maintenece fee plus hardware costs	1/4/2018 8:40 AM
18	N/A	1/3/2018 2:15 PM
19	$500.00	12/28/2017 5:30 PM
20	costs $2000/month - but it's part of a much larger, and expensive, EMR	12/27/2017 2:43 PM
21	N/A	12/27/2017 10:14 AM
22	UNKNOWN	12/27/2017 10:07 AM
23	$2100/month	12/26/2017 4:30 PM
24	Not used	12/26/2017 4:01 PM
25	several hundred thousand - have had since 2003	12/26/2017 1:06 PM
26	$1500 roughly to set up	12/23/2017 2:47 PM
27	8,000.00	12/22/2017 12:55 PM

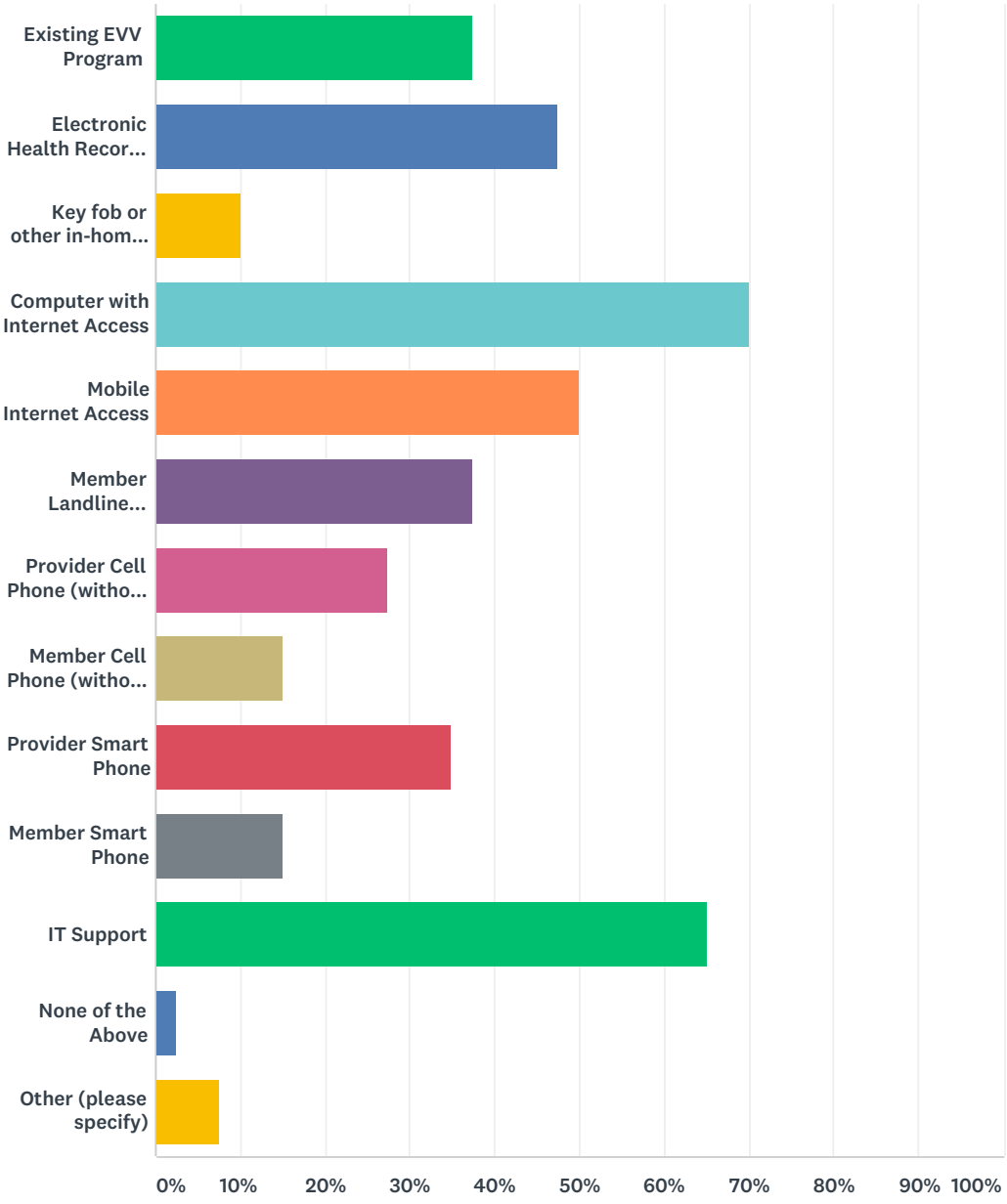
Q9 What is the name of your existing EVV program, or something similar?

Answered: 29 Skipped: 12

#	RESPONSES	DATE
1	Netsmart- Mobile Lite	1/31/2018 2:20 PM
2	N/A	1/31/2018 9:07 AM
3	HealthWyse (EMR)	1/30/2018 1:05 PM
4	N/A	1/29/2018 10:18 AM
5	ClearCare	1/28/2018 4:28 PM
6	Clear Care	1/25/2018 9:05 AM
7	N/A	1/18/2018 12:14 PM
8	Rosemark Scheduling system	1/17/2018 9:49 AM
9	Brightree	1/16/2018 6:46 PM
10	Homecare Homebase	1/16/2018 10:04 AM
11	Kinnser	1/15/2018 9:58 AM
12	CLEARCARE	1/11/2018 9:54 AM
13	CellTrak & Netsmart Mobile Tablet	1/9/2018 8:52 AM
14	McKesson	1/8/2018 2:09 PM
15	Vortex Connect	1/5/2018 3:50 PM
16	MITC Workforce Management Solutions	1/5/2018 12:02 PM
17	Advance System	1/5/2018 9:35 AM
18	N/A	1/4/2018 11:10 AM
19	HomeCare HomeBase	1/4/2018 8:40 AM
20	N/A	1/3/2018 2:15 PM
21	Generations - Telephony	12/28/2017 5:30 PM
22	Telephony functionality in our McKesson EMR	12/27/2017 2:43 PM
23	Telephony	12/27/2017 10:14 AM
24	DIAL N DOCUMENT AND CONTINULINK	12/27/2017 10:07 AM
25	Home Trak	12/26/2017 4:30 PM
26	Not used	12/26/2017 4:01 PM
27	Netsmart Homecare	12/26/2017 1:06 PM
28	AloraHealth	12/23/2017 2:47 PM
29	carewatch	12/22/2017 12:55 PM

Q10 What existing infrastructure/hardware do you/your agency have in place to support an EVV program? (Select all that apply)

Answered: 40 Skipped: 1



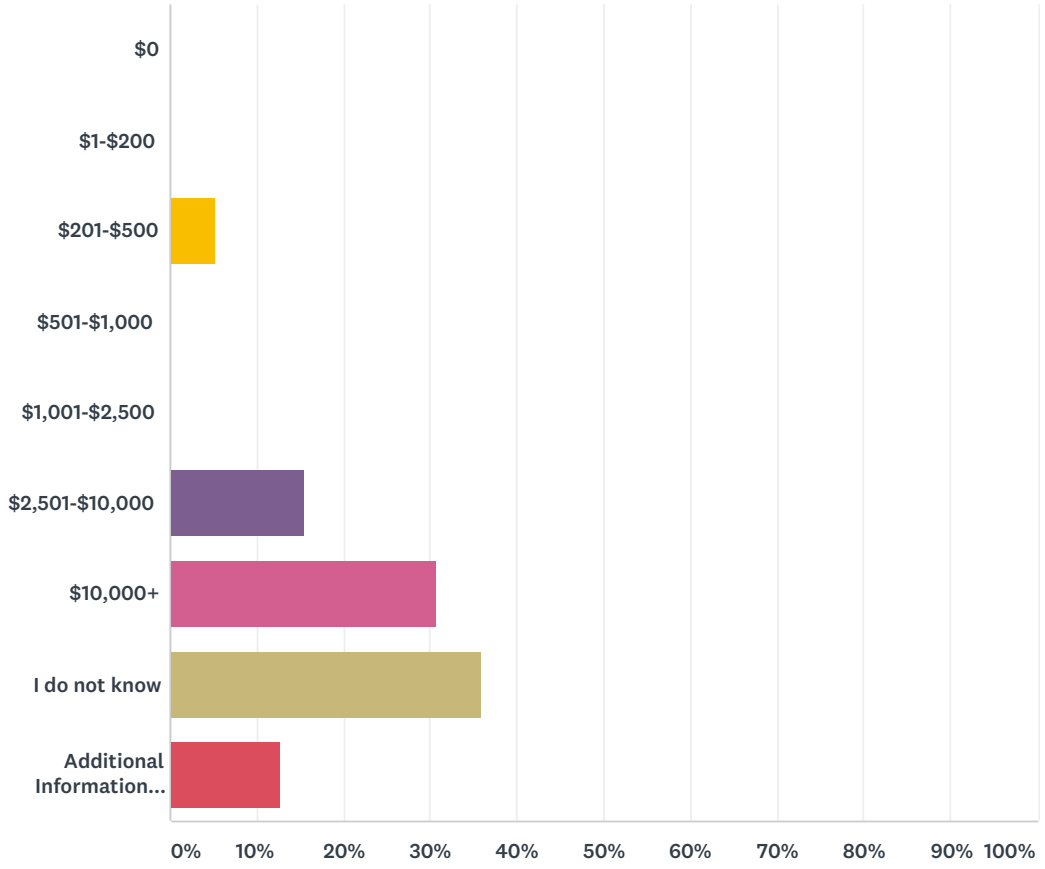
ANSWER CHOICES	RESPONSES	
Existing EVV Program	37.50%	15
Electronic Health Record (EHR) Program	47.50%	19
Key fob or other in-home GPS-logging device (A key fob is a small hardware device, often on a key chain, with built-in authentication used to collect time and location information which is connected to a secure network.)	10.00%	4
Computer with Internet Access	70.00%	28
Mobile Internet Access	50.00%	20

Member Landline Telephone	37.50%	15
Provider Cell Phone (without smart phone capabilities)	27.50%	11
Member Cell Phone (without smart phone capabilities)	15.00%	6
Provider Smart Phone	35.00%	14
Member Smart Phone	15.00%	6
IT Support	65.00%	26
None of the Above	2.50%	1
Other (please specify)	7.50%	3
Total Respondents: 40		

#	OTHER (PLEASE SPECIFY)	DATE
1	many, but not all, members have dedicated land or cell lines	1/22/2018 3:45 PM
2	Attendant workers don't have cell phones , consumers reluntant to allow usage of their personal phone . Consumer' s have limited data plans and can't afford access to the internet	1/5/2018 9:35 AM
3	we support agency cell phones for a majority of staff, but not currently with PCSPs or HM	12/27/2017 2:43 PM

Q11 What is your expected current and/or anticipated annual cost to implement an EVV program? (Please provide your best estimate to include staff training, agency oversight, etc. and any details you wish to share)

Answered: 39 Skipped: 2

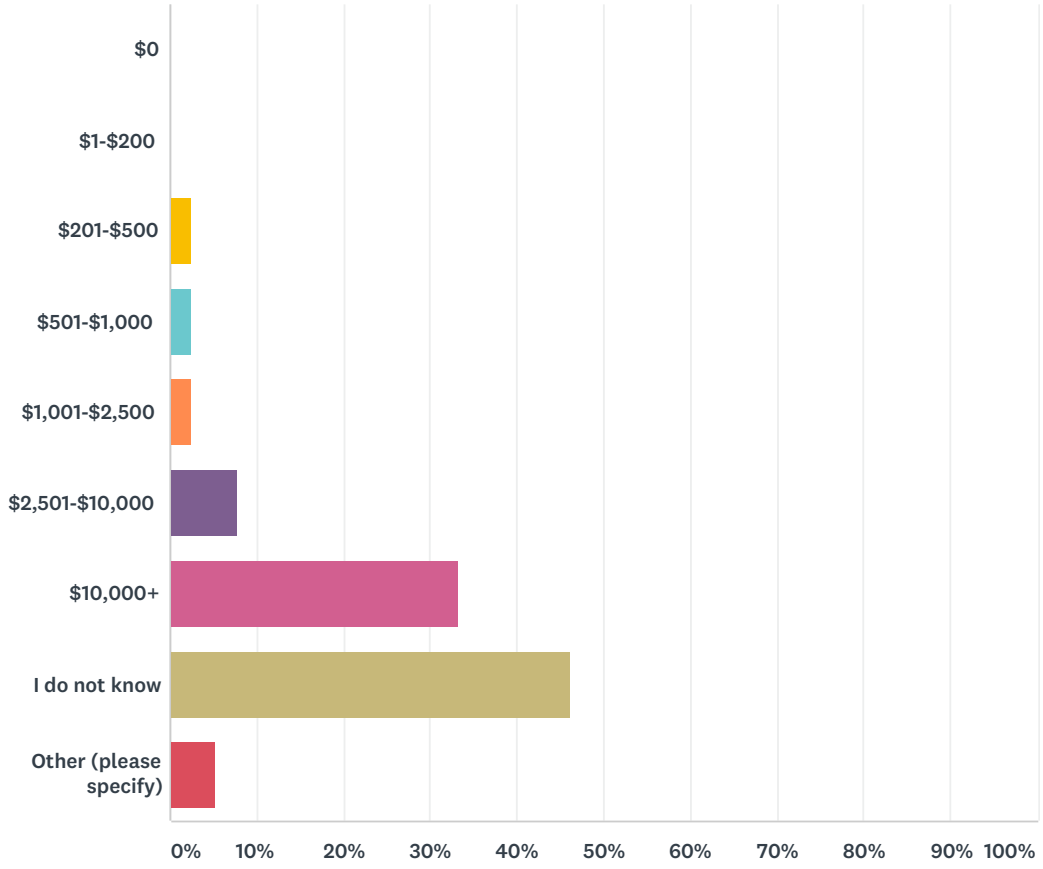


ANSWER CHOICES	RESPONSES	
$0	0.00%	0
$1-$200	0.00%	0
$201-$500	5.13%	2
$501-$1,000	0.00%	0
$1,001-$2,500	0.00%	0
$2,501-$10,000	15.38%	6
$10,000+	30.77%	12
I do not know	35.90%	14
Additional Information (please specify)	12.82%	5
TOTAL		39

#	ADDITIONAL INFORMATION (PLEASE SPECIFY)	DATE
1	N/A, already implemented	1/9/2018 8:52 AM
2	This estimate includes Community Bridges Costs of implementation, training etc. In addition to incremental MITC invoiced implementation fees.	1/5/2018 12:02 PM
3	The cost far exceeds $10,000 .	1/5/2018 9:35 AM
4	as we currently use an EVV, will depend onf state requirements for required staff	12/27/2017 2:43 PM
5	never looked into this	12/26/2017 4:01 PM

Q12 What is your expected Cost for Technology and Devices (purchase of devices, data plans, internet access, etc.) to participate in an EVV program? (Please provide your best estimate and any details you wish to share)

Answered: 39 Skipped: 2

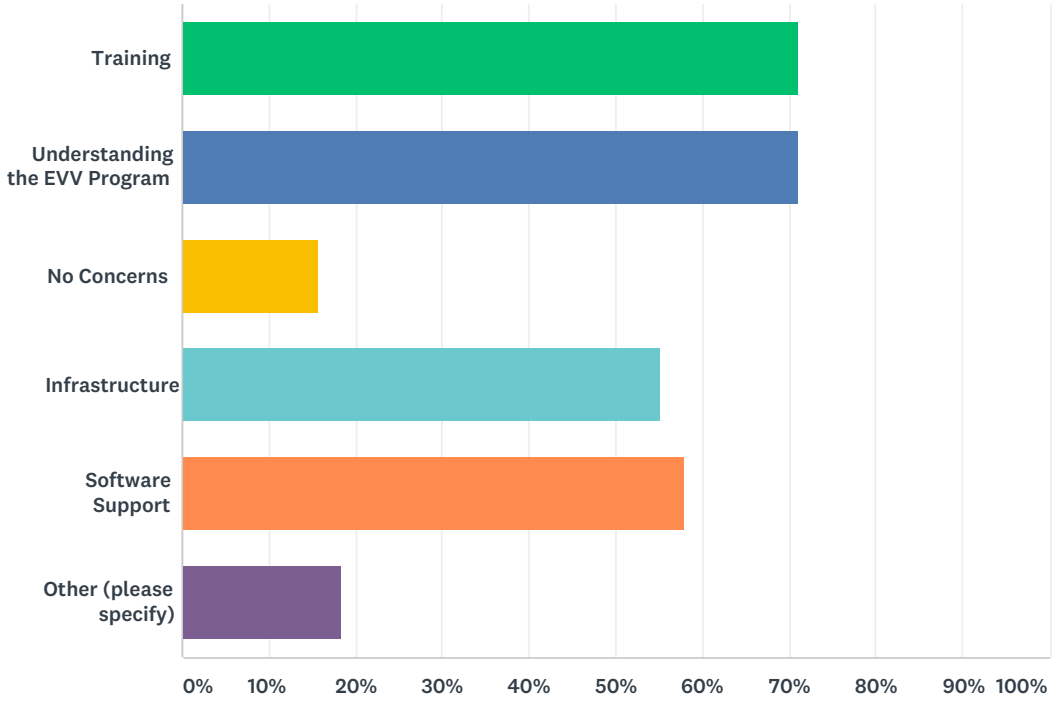


ANSWER CHOICES	RESPONSES	
$0	0.00%	0
$1-$200	0.00%	0
$201-$500	2.56%	1
$501-$1,000	2.56%	1
$1,001-$2,500	2.56%	1
$2,501-$10,000	7.69%	3
$10,000+	33.33%	13
I do not know	46.15%	18
Other (please specify)	5.13%	2
TOTAL		39

#	OTHER (PLEASE SPECIFY)	DATE
1	Includes Community Bridges costs as well.	1/5/2018 12:02 PM
2	The Cost far exceeds $10,000 ; currently we support over 500 consumers who would need the technology and the support to use technolgy, recognizing the ongoing fees associated as well as maintainence and upgrades	1/5/2018 9:35 AM

Q13 Please identify areas you/your agency would need support with participating in an EVV program: (Select all that apply)

Answered: 38 Skipped: 3



ANSWER CHOICES	RESPONSES	
Training	71.05%	27
Understanding the EVV Program	71.05%	27
No Concerns	15.79%	6
Infrastructure	55.26%	21
Software Support	57.89%	22
Other (please specify)	18.42%	7
Total Respondents: 38		

#	OTHER (PLEASE SPECIFY)	DATE
1	Regulatory Education	1/28/2018 4:28 PM
2	Funding to support costs	1/22/2018 3:45 PM
3	NEED HELP IN ALL AREAS TO PARTICIPATE	1/18/2018 12:14 PM
4	connection to claims submission	1/5/2018 3:50 PM
5	comment to no concerns: if MITC remains the vendor	1/5/2018 12:02 PM
6	State supply the phones / tablet and the ongoing support to manage .State to provide the financial support to the provider for all the above areas.	1/5/2018 9:35 AM
7	Funding	1/4/2018 11:10 AM

Attachment C: CMS EVV Information Bulletin

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: August 8, 2019

FROM: Calder Lynch, Acting Deputy Administrator and Director

SUBJECT: Additional EVV Guidance

The purpose of this Informational Bulletin is to respond to frequently asked questions regarding the applicability of electronic visit verification (EVV) requirements to beneficiaries with live-in caregivers, services rendered partially in the home, and to the provision of medical supplies, equipment and appliances as part of the Medicaid home health benefit. This guidance also addresses the use of web-based electronic timesheets as a method of EVV.

Background

Section 12006(a) of the Cures Act, signed into law on December 13, 2016, added section 1903(l) to the Social Security Act (the Act), which mandates that states require EVV use for Medicaid-funded personal care services (PCS) and home health care services (HHCS) for in-home visits by a provider. States are required to implement EVV for PCS by January 1, 2020 and for HHCS by January 1, 2023. Otherwise, the state is subject to incremental reductions in Federal Medical Assistance Percentage (FMAP) matching of PCS and HHCS expenditures that will eventually reach and continue at 1 percent until the state is compliant. There is a limited exception for the first year of both PCS and HHSC implementation if the state has made a good faith effort to comply with the EVV requirements and has encountered unavoidable systems delays in implementation of an EVV system. Implementation of EVV applies to PCS provided under the state plan or a waiver of the plan, including under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115 of the Act, and HHCS provided under 1905(a)(7) of the Act or under a waiver or demonstration project (e.g., 1915(c) or 1115 of the Act).

CMS released an Informational Bulletin and Frequently Asked Questions (FAQs) document in May 2018 to assist states in their EVV implementation efforts and provide clarification on EVV requirements.[1] In addition, CMS held a nationwide public forum in November 2018 to hear concerns from stakeholders regarding EVV implementation.[2] The attached FAQs are intended to provide further clarification on EVV requirements in response to concerns and questions identified by states and stakeholders.

[1] CMS website with EVV guidance
[2] Transcript and audio of the EVV Open Door Forum

Frequently Asked Questions – June 2019

1) Do EVV requirements apply if the individual receiving personal care or home health care lives with the caregiver providing the service?

No, EVV requirements do not apply when the caregiver providing the service and the beneficiary live together. PCS or HHCS rendered by an individual living in the residence does not constitute an "in-home visit". However, states are encouraged to apply appropriate oversight to services provided in these circumstances to curb fraud, waste and abuse. Additionally, states may choose to implement EVV in these instances, particularly when using discrete units of reimbursement, such as on an hourly basis.

2) Do EVV requirements apply to the component of home health services authorizing the provision of medical supplies, equipment or appliances?

No, EVV requirements do not apply to this component of the home health benefit. The delivery, set-up, and/or instruction on the use of medical supplies, equipment or appliances do not constitute an "in-home visit."

3) If a personal care or home health care service is provided both in the home and in the community during the same visit, is that service subject to EVV requirements?

EVV is only required for the portion of the service rendered in the home; however, states may choose to require more information to control fraud, waste, and abuse. EVV methods states can use for capturing services rendered partially in the home may include:

a) Capturing the specific location where the service starts and stops, regardless if that location is in the home or community.
b) Using the terms "home" and/ or "community" as the designation in the EVV system for location. The location data element transmitted to the state is indicated as either "home" or "community" depending on the location of the check-in/out. The specific community location (e.g., coordinates, address, etc.) would not be transmitted.
c) Capturing only the specific home location, but the start and stop times for the full service unit. For example, if a service visit starts in the community and ends in the home, the caregiver would check in from the community to note the visit's start time (without recording location), check in again when they enter the home to begin recording the location, and then check out when they leave the home to note the visit's end time.

Methods b) and c) above are presented as options for alleviating privacy concerns regarding tracking of community locations while ensuring that the location of any portion of a service delivered in the home is recorded. States may select the approach that best aligns with their systems and program integrity goals. CMS takes no position on which option should be selected by a state, or on the technological implications for implementing methods b) or c).

4) Are web-based electronic timesheets with dual verification a permissible form of EVV?

No. Most states' EVV systems use GPS and/or landlines to capture the location of PCS and HHCS. As an alternative, stakeholders proposed the use of web-based timesheets in which the time and location of service delivery is entered by the caregiver and authenticated by the beneficiary. However, web-based timesheets alone do not provide the state with auditable confirmation of the data entered by the provider and approved by the individual. Consequently such a system would not be sufficient for electronically verifying the six data elements required by section 1903(l)(5)(A) of the Act for PCS or HHCS services rendered during an in-home visit.

5) Who can I reach out to with additional questions?

Please email EVV@cms.hhs.gov with questions or concerns.

Attachment D: CMS EVV Update Aug 2018

EVV Update: Deadline to Implement EVV for Personal Care Services Delayed until 2020

On July 30, 2018, legislation was passed to amend Section 1903(l) of the Social Security Act to delay the timeline for states to implement electronic visit verification (EVV) for personal care services by one year. The legislation does not affect timelines for home health care services. Previously, states were required to implement EVV for personal care services by January 1, 2019, or otherwise be subject to Federal Medical Assistance Percentage (FMAP) reductions as follows:

- 0.25 percentage points for calendar quarters in 2019,
- 0.25 percentage points for calendar quarters in 2020
- 0.5 percentage points for calendar quarters in 2021
- 0.75 percentage points for calendar quarters in 2022
- 1 percentage point for calendar quarters in 2023 and each year thereafter

Under the new timeline, states are required to implement EVV for personal care services by January 1, 2020, or otherwise be subject to FMAP reductions as follows:

- 0.25 percentage points for calendar quarters in 2020,
- 0.5 percentage points for calendar quarters in 2021
- 0.75 percentage points for calendar quarters in 2022,
- 1 percentage point for calendar quarters in 2023 and each year thereafter

States that have not implemented EVV by January 1, 2020 will be subject to FMAP reductions unless they have both made a "good faith effort" to comply and have encountered "unavoidable system delays." States with good faith effort exemptions will not be subject to FMAP reductions in 2020, however will be subject to incremental FMAP reductions beginning with 0.5 percentage points for calendar quarters in 2021 if they have not implemented an EVV system by January 1, 2021. Please be advised that the provision on good faith effort exemptions does not provide CMS with authority to delay the FMAP reductions for more than one year.

CMS had previously indicated that it would accept requests for good faith efforts starting in July, 2018. However given the passage of this legislation, requests should be submitted to CMS in July, 2019. Please contact the CMS EVV mailbox at EVV@cms.hhs.gov for questions or concerns.

Please be advised that EVV resources published on Medicaid.gov prior to July 30, 2018 may reference dates that are impacted by this change.

Attachment E: 2018 Electronic Visit Verification Report

Electronic Visit Verification

Implications for States, Providers, and Medicaid Participants

MAY 2018

NASUAD
National Association of States United for Aging and Disabilities

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.

Electronic Visit Verification

Implications for States, Providers, and Medicaid Participants

NASUAD
National Association of States United for Aging and Disabilities

Contents

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.

Many individuals contributed to this report. I want to express my sincere appreciation to the NASUAD Board of Directors who helped to spearhead NASUAD's work on EVV. The initial draft of this report was written by Jen Burnett, a former NASUAD board member and former Deputy Secretary of Pennsylvania's Office of Long Term Living. NASUAD staff member Damon Terzaghi added valuable updates on federal policies and interviewed the states for their insights. NASUAD's Deputy Executive Director, Camille Dobson, was responsible for managing the overall effort.

Sincerely,

Martha A Roherty

Martha A. Roherty
Executive Director

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St. Paul, MN

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 Tme 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 (NAMD), 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 NAMD 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.

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[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 2015[5] 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.

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[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*

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.

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

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*

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[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/hr34amendment5.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 AD*vantage* Waiver Program. AD*vantage* 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.medicaid.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.medicaid.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 website[13] 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	• Providers have flexibility to select best system for their needs • State does not have to procure and administer an EVV system	• 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	• State can delegate procurement to MCOs • Integration of MCO claims/encounter data and EVV • Providers can use the MCO system(s), alleviating burden	• 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	• 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	• 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	• 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	• 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	• 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	• 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	• 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	• 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. 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.

NASUAD
National Association of States
United for Aging and Disabilities

National Association of States
United for Aging and Disabilities
1201 15th Street NW, Suite 350
Washington, DC 20005
Phone: 202-898-2578
www.nasuad.org