Electronic Visit Verification FMAP Reduction

Training Call with States

April 15, 2021

Agenda

I. Welcome

II. Background & Overview of EVV FMAP Reductions

III. Financial Management Reporting in MBES

IV. Process for Managed Care FMAP Reductions

V. Technical Assistance & Resources

VI. Questions

Background

The Cures Act was signed into law December 13, 2016, adding section 1903(*l*) to the Social Security Act (the Act).

- Under the provision, states must implement electronic verification systems (EVV) by:
  - January 1, 2020 for Medicaid personal care services (PCS), and
  - January 1, 2023 for Medicaid home health care services (HHCS).
  - Congress provided the option for a one-year good faith effort extension for PCS, which was granted to all states, territories and DC (except TN).
- Beginning January 1, 2021, states must have compliant EVV systems for PCS or receive an FMAP reduction.
- CMS does not have authority to waive this statutory requirement.

Definitions

Definition of PCS

- Services supporting Activities of Daily Living (ADLs) and/or both ADLs and services supporting Instrumental Activities of Daily Living (IADLs), no matter the service name or if it is bundled with other services.
  - ADLs: Examples include movement, bathing, dressing, toileting, transferring, and personal hygiene.
  - IADLs: Examples include meal preparation, money management, shopping, and telephone use.

Definitions

PCS that require the use of EVV

- EVV is mandatory for any PCS requiring an in-home visit, whether under a fee for service or managed care delivery system, provided under:
  - 1905(a)(24) state plan personal care benefit
  - 1915(c) home and community based services waivers
  - 1915(i) home and community based services state plan option
  - 1915(j) self-directed personal attendant care services
  - 1915(k) Community First Choice state plan option, and
  - 1115 demonstration projects.

Definitions

PCS that do not require the use of EVV

- PCS that do not require an in-home visit include PCS provided:
  - in congregate residential settings where 24 hour service is available with shift-based care reimbursed on a per-diem basis;
  - by a live-in caregiver;
  - provided via telehealth; and/or
  - provided to inpatients or residents of an institution.

Definitions

EVV Compliance Specifications:

- Compliance means that the state has an EVV system operational, has trained providers in the use of the system, and requires all providers to use the system to electronically verify the six required data points, including the following:
  1. Type of service performed
  2. Individual receiving the service
  3. Date of the service
  4. Location of service delivery
  5. Individual providing the service
  6. Time the service begins and ends
- The state's compliance is affirmed in the EVV survey completed by the state.
- Integration of EVV and claims billing is not required for compliance, but may be required for certification of the EVV system through the Advance Planning Document process.
- A state is not considered out of compliance for issues that are commonly accounted for in the state's error rate.

Financial Management
MBES Reporting

- Effective January 1, 2021: 0.5 percentage point FMAP reduction to certain PCS expenditures for states without compliant EVV systems
- CMS will update state compliance quarterly and will update the Medicaid Budget and Expenditure System (MBES) accordingly
- Effective second quarter FY 2021, new expenditure reporting on the CMS-64.9 MAP series of forms
- Effective third quarter FY 2021, prior period adjustment reporting will be available

Financial Management
MBES Reporting

MBES Changes on the CMS-64.9 Base and Waiver Forms

- Line items for MCO have been added to the CMS-64.9 series of forms:
  - Line 18A6, 18B1f, and 18B2f
  - Entry will be on a feeder form POP-UP screen

- Line 23A and Line 23B Personal Care Services lines will now have feeder form POP-UP entry lines

Financial Management
MBES Reporting

3 Sub-categories lines are available on the new feeder form POP-UP screen

- a. EVV Required Compliant
- b. EVV Required Not Compliant
- c. EVV Not Required
  - States that are compliant with EVV requirements will only have to enter on the “EVV Required Compliant” line
  - States that are not compliant will be required to enter information on all 3 sub-categories lines, if applicable

Financial Management
MBES Reporting

Demonstration of MBES reporting

Managed Care FMAP Reductions

PCS Claiming Methodology for Managed Care Capitation Rates

- States will develop a methodology to identify the portion (percentage or dollar amount) of the managed care capitation rates, per rate cell, that is attributable to non-compliant PCS.

- CMS will review and approve the state's PCS claiming methodology for each managed care program providing non-compliant PCS.

- The 0.5% FMAP reduction is applied to the reported PCS expenditures each quarter until the state comes into compliance.

CMS Review of the PCS Claiming Methodology

- Evaluate the state's submitted PCS claiming methodology to determine the reasonableness and appropriateness:
  - For the enrolled population and benefit structure of the program; and
  - Of the assumptions and adjustments used in determining the PCS claiming methodology.

- Evaluate completeness and sufficiency of the underlying justifications, evidence, and documentation to reasonably support the PCS claiming methodology.

- Submissions must include adequate detail to allow CMS (or its designees/actuaries) to determine compliance including that the data, assumptions, and methodologies used for the PCS claiming methodology development are:
  - consistent with Agency-recognized and accepted accounting/actuarial principles and practices; and
  - appropriate for the populations and services.

State's PCS Claiming Methodology Submission Requirements

- The base data for the PCS claiming methodology must be the same underlying base data and time period used to determine the actuarially sound rates for each rate cell.

- The PCS claiming methodology must reasonably reflect PCS costs built into the capitation rates within the state's managed care program for PCS.

- Justification and evidence provided must be complete and sufficient and comply with federal statute and regulations.[1]

- Failure to include appropriate documentation may result in additional CMS questions and/or requests to obtain the information as part of our review.

[1] Federal regulations include managed care regulations, 42 CFR Sec. 438.

Components of State's PCS Claiming Methodology

- Identification of base data per rate cell for the population and benefit structure of each state program
- Appropriate and reasonable adjustments
- Any other rate or policy issues that impact the PCS claiming methodology
- Description of the state's process to evaluate whether the PCS claiming methodology is appropriate if rates are amended over a rating period or needs to be revised[1]

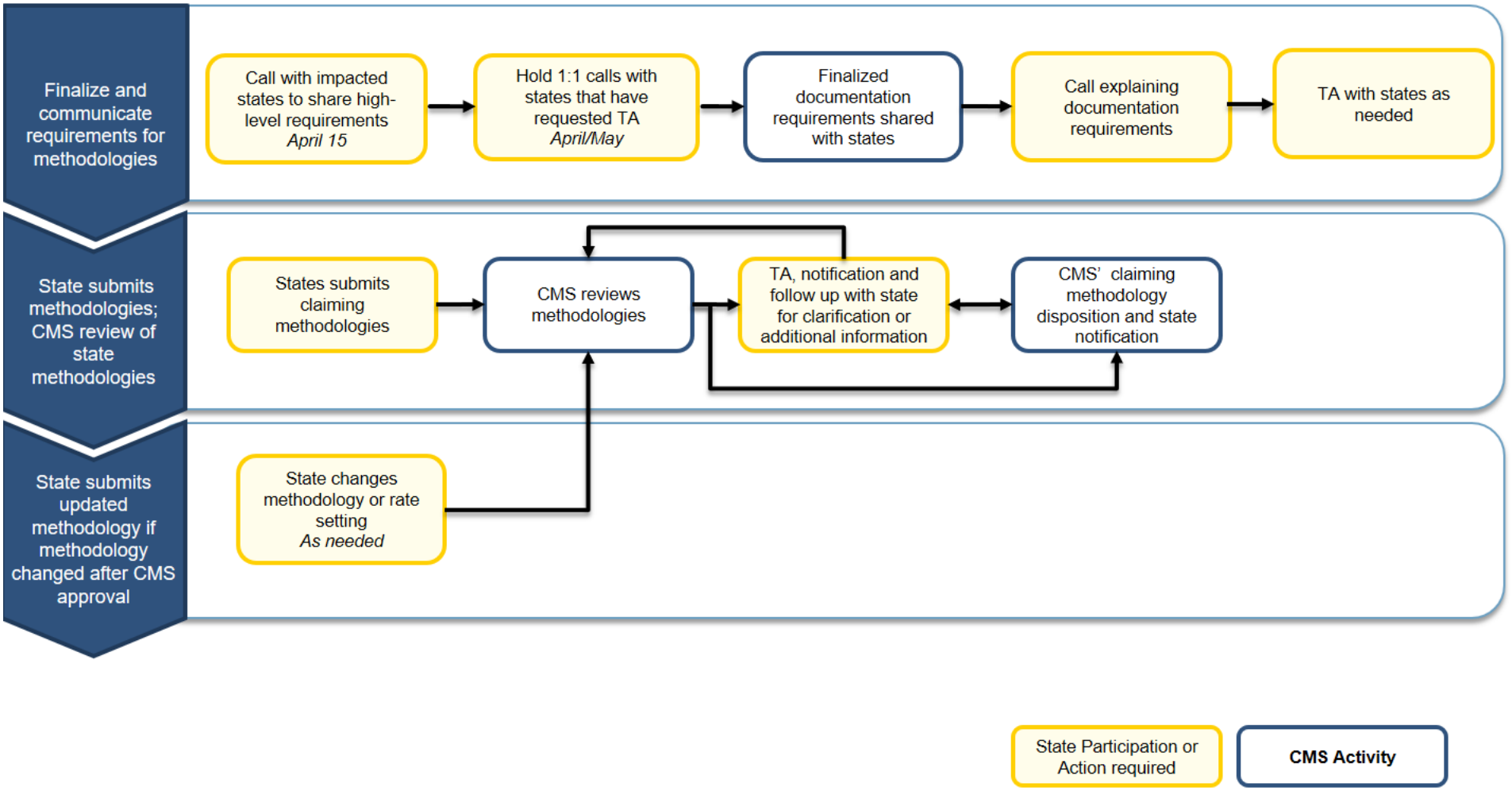
[1] Revised PCS claiming methodologies must also be submitted to CMS for approval.

Components of State's PCS Claiming Methodology (continued)

Base Data

- Description of sources of data used for the base data (e.g., encounter data, fee-for-service data, or other sources)
- Assurance that the base data for the claiming methodology is the same as the base data and time period used in developing the actuarially sound rates
- Description of any data quality issues or concerns identified with respect to identifying PCS costs built into the capitation rates

PCS Claiming Methodology Review Process



Technical Assistance & Resources

TA:

- For EVV Policy and Managed Care Questions – EVV@cms.hhs.gov
- For MBES Questions – Contact your CMS Financial Management Lead

Resources:

- CMS EVV mailbox address: EVV@cms.hhs.gov
- EVV Q&As: https://www.medicaid.gov/federal-policy-guidance/downloads/faq051618.pdf

Questions