



EVV Requirements in the 21st Century Cures Act

**Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services**

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Session Overview

- Review details of the five different Electronic Visit Verification (EVV) implementation models.
- Discuss CMS' promising practice recommendations to states for:
 - EVV model selection and implementation.
 - Training and education for providers and individuals about the EVV system.
 - Ongoing EVV operations.
- Explain CMS' current efforts to assist the states and future plans.

Summary of the Intensive Session

- The Cures Act requires states to implement an EVV system by January 1, 2020 (as amended by recent legislative action) for Personal Care Services (PCS) and by January 1, 2023 for Home Health Care Services (HHCS).
- Note that the Cures Act is not limited to services explicitly titled PCS or HHCS in the state's waiver or State Plan. If the service includes PCS or HHCS, even if it has a different name or also includes other services, it is subject to EVV.
- Any state that fails to do so is subject to incremental reductions in FMAP up to 1 percent.
- CMS is available for technical assistance in Advanced Planning Document (APD) development and submission.
- States can submit a request for good faith effort exemption. Contact CMS Regional Office analysts for the details of this requirement.
 - 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.

Disclaimer

- In this presentation, we will discuss several states that have implemented EVV and current EVV Models.

CMS is not endorsing any of these models or vendors.

- The purpose of introducing these examples is to help states and stakeholders understand the current EVV landscape.

Discussing these state examples does not imply that they are compliant with the Cures Act.

EVV Design Models

- EVV design models vary mostly by state involvement in vendor selection and EVV system management.
- Our research has identified five EVV design models:
 1. Provider Choice
 2. Managed Care Plan (MCP) Choice
 3. State Mandated External Vendor
 4. State Mandated In-house System
 5. Open Vendor
- States can choose more than one model.

1. Provider Choice Model

Definition

- Providers select their EVV vendor-of-choice and self-fund its implementation.

Overview

- States can recommend a preferred list of vendors that meet the requirements and standards set by the State Medicaid Agency (SMA) or Managed Care Plans (MCPs).

Considerations

- Single or small provider agencies may find it technologically or financially burdensome (this can be offset by the state's rate construction).
- States will need to create a higher level system that collates data from multiple qualified vendors.
- May be more beneficial for a state with high existing EVV utilization among providers.

2. MCP Choice Model

Definition

- Managed Care Plans (MCP) select their EVV vendor-of-choice and self-fund its implementation.

Overview

- States may set minimum standards for EVV vendor selection and require certain data collection from the MCPs.

Considerations

- This would be applicable to programs primarily using MCPs for service delivery.
- Providers may require additional administrative support if multiple MCPs use different EVV systems and/or vendors because they must integrate multiple systems with the providers' own internal systems for billing or time tracking.
- States will need to create a higher level system that collates data from multiple qualified vendors.

3. State Mandated External Model

Definition

- States contract with a single EVV vendor that all providers must use.

Overview

- Model guarantees standardization and access to data for the state.
- The state is directly involved in the management and oversight of the program.

Consideration

- Providers with no existing EVV system may benefit from documentation efficiencies at no maintenance cost to them.
- Providers and MCPs already operating an EVV system might express concerns with having to adopt a new system.

4. State Mandated In-House Model

Definition

- States create, run, and manage their own EVV system.

Overview

- The state directly manages and oversees the program.
- This model allows standardization and access to data for the state and could be built into the existing MMIS structure.

Consideration

- States can hire a contractor/vendor(s) to assist in building its customized system.
- The state needs to consider if they have the knowledge, capacity, and financial resources to implement this model.

5. Open Vendor Model

Definition

- States contract with a single EVV vendor or build their own system, but allow providers and MCPs to use other vendors.

Overview

- States maintain oversight and receive funding for implementation while also allowing vendor choice for providers and MCPs who already have an EVV system in place.
- The state-contracted vendor/in-house system serves as the default system for the state.

Consideration

- States can implement an “open model” in which a system aggregates EVV data from both the state-contracted vendor/in-house system and third-party vendors.

Promising Practices for EUV Model Selection and Implementation

Overview of Promising Practices

- There are eight promising practices states should consider when selecting an EVV model that is most suitable for their Medicaid PCS and HHCS programs.
 1. Assess EVV systems, if any, currently used by providers.
 2. Evaluate the state's existing vendor relationships.
 3. Define EVV requirements.
 4. Integrate EVV systems with other Medicaid state systems and data.
 5. Understand technological capabilities.
 6. Solicit stakeholder input.
 7. Assess state staff capacity to develop and/or support the EVV system, including providing user training and education.
 8. Roll out EVV in phases and/or pilots (timeline permitting).

1. Assess EVV Systems Currently Used by Providers

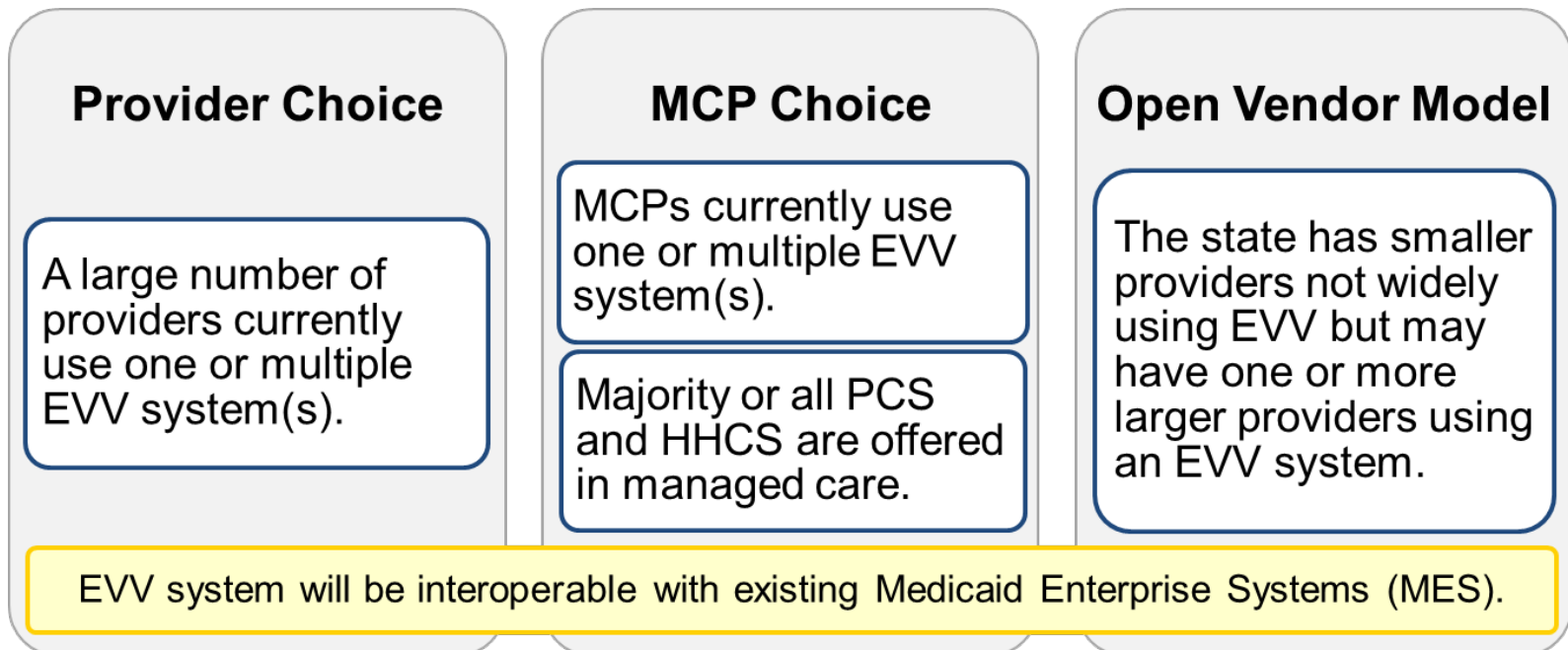
- The Cures Act and 1903(I) of the Act requires a state to *consult* with PCS and HHCS agencies regarding the following areas:
 - Whether the implementation is minimally burdensome to the state and agencies.
 - Evaluation of existing best practices and EVV systems in use in the state.
 - Compliance with HIPAA privacy and security standards.
- Service providers will be heavily impacted by the state's decision regarding EVV implementation. Therefore, solicit how the providers are currently using EVV systems before choosing a model.

1. Assess EVV Systems Currently Used by Providers

- To conduct the assessment, CMS recommends a survey to providers and MCPs.
- In the survey, consider including the following topic areas / questions:
 - Whether the provider / MCP has adopted an EVV system, if EVV is not a state mandate.
 - What EVV system is currently in place and descriptions of its capabilities.
 - What is currently working and what is not.
 - Suggestions to improve an existing system.

1. Assess EVV Systems Currently Used by Providers

- While each state and provider landscape is unique, there are certain provider landscapes that are better accustomed to supporting each of the five primary EVV models.



1. Assess EVV Systems Currently Used by Providers

State Mandated In-house

The state has the expertise and resources to develop its own EVV system, including training and educational materials.

State Mandated External Vendor

The state prefers to use an external EVV vendor for some or all services.

Providers are not widely using EVV, or EVV systems being used do not meet the state's needs or the requirements of the Cures Act.

Note that regardless of the model chosen, states must reasonably ensure that the existing EVV systems all or substantially meet the Cures Act and 1903(I) of the Act.

2. Evaluate the state's existing vendor relationships

- Evaluating the state's existing vendor relationships allows the state to determine whether existing EVV programs are appropriately integrated with the state's databases.
- An EVV vendor's ability to interface with a MMIS, eligibility, and/or prior authorization system will simplify the implementation process and lower operational efforts.
- Where provider agencies are using one or more EVV systems, CMS recommends states evaluate whether existing systems truly meet the state's needs, or may serve the state's needs with some changes.

2. Evaluate the state's existing vendor relationships

- Questions that states may want to consider when vetting a current EVV vendor include:
 - What has been the experience of individuals receiving services, and providers using the system?
 - What is the rate of data entry errors among providers?
 - Has the EVV system been shown to reliably verify type of service performed, individual receiving the service, date of the service, location of service delivery, individual providing the service, and time the service begins and ends? How are these verified?
 - What is the extent to which the EVV system covers the services subject to section 1903(l)? What is the EVV vendor's plan for scaling-up the current system to ensure complete coverage?
 - Is the EVV system interoperable with the state's Medicaid Enterprise Systems (MES)?
 - Has the EVV system resulted in demonstrable savings to the state's Medicaid program through reduced fraud, waste and abuse?

2. Evaluate the state's existing vendor relationships

- Following a comprehensive review of the state's current vendor relationships and contracting/procurement rules, the state may identify an organization that already is providing or can provide EVV services by contract.
 - **State Example:** Connecticut's MMIS vendor had an existing relationship with an EVV vendor that could efficiently tie into the current care authorization and claims authorization/billing data managed by the state without going through the time and expense of an RFP process.
 - It is essential that states understand their EVV landscape prior to choosing a model to avoid problems during implementation.
 - Evaluate the vendors for their experience in EVV and adhere to the state's contracting / procurement laws.
 - Selection of an incorrect model or a vendor with limited or no experience with EVV could result in losing the efficiencies gained up front.

3. Define EVV Requirements

- It is essential that states establish clear policies and procedures about EVV systems to ensure that the providers:
 - Use systems that comply with the Cures Act, and
 - Meet the requirements of the state’s implementation model.
- Applies to all models, but most impactful for Provider Choice and Open Vendor models.
- A consistent and streamlined set of requirements helps the state better control and monitor the vendors being used throughout the state and is important if the state will be developing a data aggregator.

3. Define EVV Requirements

- As a monitoring requirement, CMS recommends states monitor and hold providers accountable for data exceptions. Examples of exceptions include:
 - Missing or invalid check-in / check-out
 - Incorrect entry of the EVV ID by caregiver
 - Caregiver checked-in from unverified phone number

4. Integrate EVV systems with other Medicaid state systems and data

- Integrate EVV systems with MMIS, Eligibility and Enrollment (E&E), prior authorization system and Financial Management systems.
- An EVV vendor's ability to interface with other systems will simplify the implementation process and lower operational efforts.
 - Strengthens the oversight capabilities of EVV;
 - Allows data to flow through the EVV system in a more timely manner and push updated information to the provider; and
 - Helps to monitor for fraud, waste and abuse.
- **State Example:** Maryland uses a state mandated internal system, and integrated their case management system with their EVV system to ensure payment is only made for pre-authorized hours listed in a participant's service plan.

4. Integrate EVV systems with other Medicaid state systems and data

- States using one of the three “choice” models for EVV (provider, MCP or open vendor) need to develop a data aggregation solution to consolidate data from different EVV systems.
 - Under a state-mandated model, which uses a single EVV system, data is captured and housed in a central location.
 - Choice models will require data collection from multiple systems or providers so the state will need to create a data aggregation solution.
- **State Example:** In Ohio, which is a state-mandated model, certain providers may still use their own EVV systems, but only if those systems meet state-specified interface requirements so that they can feed data directly into the state’s EVV system.

5. Understand technological capabilities

- As states make decisions about their EVV system, they should establish a list of requirements for how the in-home visit-capture technology will be used. Some questions to consider include:
 - Will the state allow providers to access a mobile application through the personal mobile phone of the personal care service provider or home health worker?
 - Will the selected technology require cellular service?
 - Are there limitations to accessing cellular service in rural areas?
 - Will the technology reside with the individual rather than with the provider?
 - How do needs for EVV system implementation differ across providers?

5. Understand technological capabilities

- Regardless of the technology used, ensure privacy of the individuals receiving services and compliance with the applicable Federal and state rules, such as HIPAA.
 - The Cures Act does **not** require states to capture *each location* as the individual is moving throughout the community.
 - Personal Care Services either starting or stopping in the individual's home are subject to EVV requirements, and **capturing the location in which the service is started and stopped** is sufficient for meeting the requirements specified in the Cures Act.
 - Global Positioning System (GPS) is not required for EVV compliance.
 - Another option is Interactive Voice Response technology (IVR). This requires caregivers to check in and out using a landline or cellular device in the individual's home.
 - **State Example:** Connecticut has three available options for verifying services delivered inside the home, including client phone line verification, mobile visit verification and fixed visit verification devices.

5. Understand technological capabilities

- Considerations for EVV implementation in rural areas:
 - The Cures Act does not require telephone access and/or internet connection for individuals receiving services to comply with the EVV requirement as long as the system meets the six minimum data requirements.
 - States can consider multiple options, such as batch reporting of data when there is not a sufficient cellular signal available.
- **State Example:** New Mexico issues tablets to providers with capabilities to store data up to seven (7) days and upload the visit data at a later date. Service providers would only need internet access once a week and could focus more on service delivery than connecting to the internet.

6. Solicit stakeholder input

- States should conduct outreach to:
 - Individuals and their families, including individuals with self-directed services (if applicable);
 - Advocacy groups for PCS, HHCS, and/or HCBS populations;
 - Provider agencies, individual caregivers, and associations;
 - State employees that have been involved in the following:
 - EVV procurement process (e.g., state's procurement or legal department);
 - Medicaid Fraud, Waste and Abuse investigations (e.g., Medicaid Fraud Control Units, Attorney General/Inspector General);
 - Information Technology team and vendors.
 - Other state agencies involved in the delivery of Medicaid services.

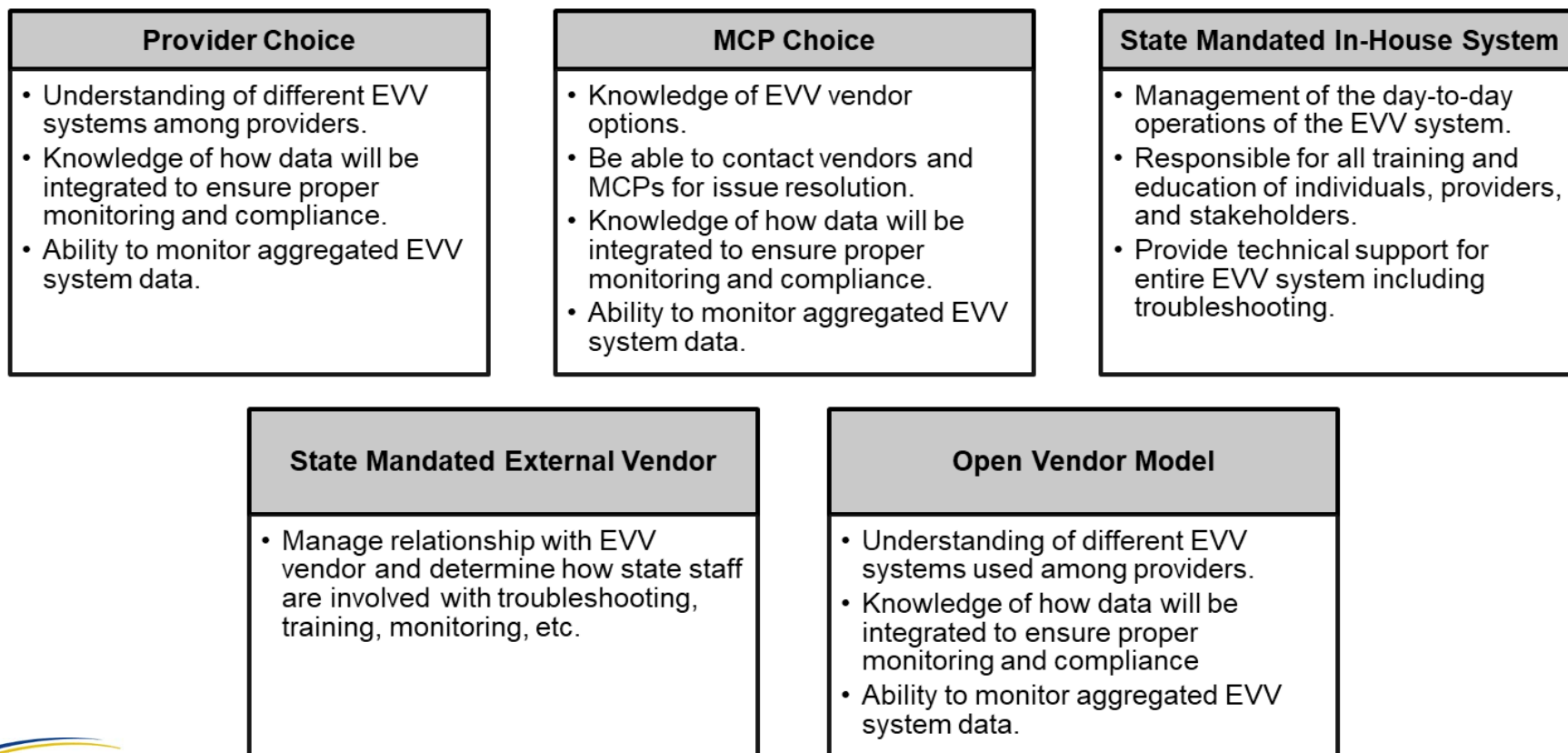
6. Solicit stakeholder input

- CMS encourages states to select EVV systems that accommodate self-directed models by ensuring flexibilities such as:
 - Fluid scheduling modifications
 - Choice of worker
 - Engagement in community activities
 - Proper interaction with FMS entities
- The chosen EVV system should have processes in place to troubleshoot and communicate roles and responsibilities to both self-directed and provider agency PCS and HHCS service providers.
- **State Example: Massachusetts**
 - Mailed letters to beneficiaries and providers with information regarding the proposed EVV system.
 - Held multiple public listening sessions in 2017. Dates and locations of these sessions were included in the letters mailed to beneficiaries and providers.
 - Established an EVV website that included a dedicated email address for questions and concerns regarding EVV implementation.

7. Assess State Staff Capacity to Develop and/or Support the EVV System

- Depending on the model, state staff are involved in many different capacities.

State Staff Capabilities and Involvement



7. Assess State Staff Capacity to Develop and/or Support the EVV System

- **State Example: Texas**

- Texas currently operates a modified open vendor model with two EVV vendors eligible for selection by provider agencies.
- The number of full-time EVV Operations staff is being expanded from four to seven.
- Full-time staff is currently augmented by three part-time contract business analysts engaged in business process analysis.
- Full-time staff conduct program operations, vendor management, policy development, and contract development.
- They provide managed care organization and provider agency training and compliance reviews.
- They also train all state staff with EVV-related responsibilities, such as contract monitors and case managers.

8. Rollout EVV in Phases and/or Pilots (Timeline Permitting)

- Conducting pilots or a phased rollout allows states to identify potential bugs and provider challenges encountered with the technology and training/education materials to ensure they are addressed before implementation.
- States should also consider less stringent compliance thresholds during system rollout. This has several advantages including:
 - Allowing states to work with providers to make sure that they are using the system accurately and to provide additional technical assistance if necessary.
 - Allowing states time to validate thresholds and test monitoring processes before they begin to penalize providers.

8. Rollout EVV in Phases and/or Pilots (Timeline Permitting)

- Conducting a pilot and/or implementing in phases cannot impede a state's ability to meet the timeline requirements dictated in the Cures Act.
- **State Example:** South Carolina emphasized the importance of rolling out EVV in pilots prior to full implementation based on its experience with systematic issues encountered when it rolled out its EVV.

Promising Practices for Training and Education

Promising Practices for Training and Education Overview

- Seven promising practices states should consider when developing training for state staff, providers, individuals and their families include:
 1. Inventory all entities / individuals that will be interacting with EVV.
 2. Understand how training responsibilities will vary by EVV model.
 3. Establish a training plan.
 4. Assess state staff capabilities/capacity for developing and delivering training.
 5. Provide training and assistance on an ongoing basis.
 6. Establish an EVV website.
 7. Use multiple approaches for notifying and training individuals and their families.

1. Inventory All Entities/Individuals That Will Be Interacting with EVV

- States should identify all potential training recipients and make sure the state's training plan covers them, including but not limited to:
 - Individual service recipients
 - Individual caregivers
 - Family members and/or guardians
 - Provider agencies
 - State staff across all agencies
- Even if the state will not be the primary provider of the training, it is still the state's responsibility to make sure the appropriate training is made available for all EVV stakeholders involved in the provision or receipt of PCS and/or HHCS.

2. Understand How Training Responsibilities Vary by EVV Model

- The type of EVV model selected by the state has a direct impact on the level of state effort for EVV training.
 - The state mandated in-house system model requires the most state involvement.
 - Provider choice or MCP choice models delegate more of the training and education responsibilities to the providers and MCPs.
 - A state mandated external model can allow states to contract with the EVV vendor to provide training.
- Regardless of the model, the state needs to play an active role in developing training requirements.
- The state also needs to consider whether and/or which EVV training will be mandatory or optional for each audience.
 - To ensure that individuals providing PCS and HHCS have the opportunity for training on the use of the EVV system, CMS strongly recommends that states consider making training mandatory for providers and their staff.

2. Understand How Training Responsibilities Vary by EVV Model

- **State Example: Ohio**

- Surveyed providers in advance to learn providers' training preferences and times ahead of time.
- Plans to meet with providers monthly to discuss areas of concern.
- Plans to use call center data (i.e., feedback from providers and individuals) and provider concerns to formulate training topics.
- Vendor will have on-site quality managers for providers having difficulties with EVV.
- To obtain EVV login or provider ID, providers are required to complete vendor's online training course.

- **State Example: Connecticut**

- Provider training is mandatory and strongly recommended this requirement as a good practice.
- Before a Connecticut provider receives access to the EVV system, two provider staff members must complete a 12-chapter web-based learning management system available on the state's public website at no cost.

3. Establish a Training Plan

- States or their EVV vendors should develop a detailed strategy for who is providing what training and education and how they plan to engage and train providers and individuals as early as possible.
- Many challenges exist when trying to train and educate providers and individuals on EVV.
 - For providers, competing priorities between implementing a new system and maintaining their ongoing operations.
 - For providers and individuals, time constraints can limit ability to attend in-person training.

3. Establish a Training Plan

- Key training strategy considerations include:
 - Identifying training materials that are suitable for state staff, providers and individuals and family members.
 - Identifying methods by which training may or may not be delivered.
 - Establish timing and frequency of training for various audiences.
 - More than 90 days prior to go-live: may require retraining closer to implementation date.
 - Less than 30 days prior to go-live: may not provide sufficient lead time.
 - Identifying persons responsible for training development and delivery.
 - Establishing means of monitoring the effectiveness of training.
 - Establishing potential penalties for noncompliance with training requirements.

3. Establish a Training Plan

- A typical training cycle might be:

More than 90 days prior to go-live:

- Provide high level overview and timeline of the EVV implementation and general areas of responsibility

30-90 days prior to go-live:

- Conduct large scale, mandatory training through in-person sessions and webinars;

Within 30 days of go-live:

- Perform triage and critical updates/reminders

3. Establish a Training Plan

- At minimum, states should consider the following topics/content when developing a comprehensive training plan:

Audience	Suggested Topics
Providers	<ul style="list-style-type: none">• EVV requirements.• Software training, including details of how to use the system, data capturing (including offline) and running system reports; system hardware usage; and how to request technical assistance• Benefits to providers to promote buy-in, such as faster claims processing, potentially faster payments to providers, easier and faster tracking of appointments, easier and faster appointment changes, improved documentation, and less paperwork;• Consequences for not using EVV system (e.g., penalties and sanctions).• Improvements in program integrity efforts.

3. Establish a Training Plan

Audience	Suggested Topics
Individuals Receiving Services	<ul style="list-style-type: none">• EVV requirements.• Advantages of EVV (including the role of EVV in improving beneficiary management and improved oversight of their services).• Responsibilities of the beneficiary regarding EVV, including how to change appointment times (if applicable in the EVV system), how EVV enhances the prevention and detection of fraud, waste and abuse, any special issues regarding self-direction, and how to get help.
State Staff	<ul style="list-style-type: none">• EVV requirements.• “How to” topics, including compliance monitoring, data capturing, reporting, software and system updates, and how the EVV system can be used in program integrity efforts.

4. Assess State Staff Capabilities/Capacity for Developing and Delivering Training

- States should evaluate their own experience in developing and disseminating training and educational materials for similar new technologies that are used by populations similar to those enrolled in Medicaid PCS and HHCS programs.
- States can use many different methods to educate both individuals and providers including:
 - Webinars
 - In-person trainings
 - E-mail notices
 - Mailed educational materials
 - Dedicated EVV websites
- If state staff do not have the capabilities/capacity to develop and deliver training, consider using a contractor or EVV vendor.

5. Provide Training and Assistance on an Ongoing Basis

- After implementation there will be an ongoing need for training, including providers and individuals and their families new to the program and those providers and individuals having EVV compliance issues.
 - **State Example 1: Connecticut** initiated a bi-monthly newsletter after implementation which helps providers navigate EVV by answering common questions and providing assistance for resolving common issues.
 - **State Example 2: South Carolina** conducts training every quarter for providers and will provide one-on-one training, if requested.
- States should provide resource lists that direct providers and individuals to various types of technical assistance that may be needed during and after implementation.
- States that have already implemented EVV most commonly use in-person assistance or toll-free numbers to provide technical assistance.
 - Typically, the EVV vendors will have an EVV help desk/hotline for questions about the use of their systems.

6. Establish EVV Websites

- States should establish a website to disseminate training and other information related to the EVV program.
- Examples of states using EVV websites:
 - **Connecticut:** EVV bulletins for providers and individuals and their families around training, new EVV system features, FAQs, etc.¹
 - **Louisiana:** EVV memos and updates for providers, details about the benefits of EVV for providers, and provider testimonials.²
 - **Maryland:** Training information and webinar sessions for providers about EVV topics.³
 - **Massachusetts:** EVV information for providers and individuals and their families, plus information about stakeholder data gathering meetings.⁴
 - **Texas:** EVV information for providers and individuals and their families, including which providers must use EVV, description of how EVV works, how providers get started with EVV, contacts to call with questions, copies of EVV letters to individuals/members, and a news & alerts section with continually updated EVV information.⁵

7. Use Multiple Approaches for Notifying and Training Individuals and their Families

- CMS strongly recommends that states ensure that beneficiaries receiving PCS and HHCS, and their families, are educated about the changes that will take place with the implementation of EVV.
- States, providers, and MCPs should take a combined role in notifying individuals of the changes that will take place with the implementation of EVV. Common methods to inform individuals and families include:
 - Communications from case managers and/or caregivers
 - Mailings and educational materials
 - Leaflets in enrollment packets
 - IVR / “robo” calls
 - EVV websites

7. Use Multiple Approaches for Notifying and Training Individuals and their Families

- Communications from caregivers and case managers can be the most effective because they regularly see the individual and family and are typically the primary points of contact in the various programs.
 - States should encourage these staff to be prepared to explain EVV to individuals both during and after implementation.
 - **State Example:** Maryland, South Carolina and Texas noted that in addition to sending letters, they also relied on case managers for assistance in notifying and explaining EVV to individuals and their families.
- States should consider some type of verification process that the individual has been notified of EVV.
 - Texas requires individuals, with assistance from their case manager, to review and sign a rights and responsibilities form confirming their understanding of EVV.

Promising Practices for Ongoing EVV Operations

Promising Practices

Ongoing EVV Operations

Monitor Service Delivery

- States should clearly outline expectations regarding monitoring.
- By whom, when and how providers will be monitored is essential for all parties to understand so services are provided timely and accurately and providers are compensated appropriately for those services.
- CMS recognizes distinctions in HHCS and PCS service visits.
 - Services offered in 24 hour settings are separate from the “home visits” that are subject to EVV requirements. EVV requirements do not apply to PCS and HHCS provided in those settings.
 - Services consisting only of instrumental activities of daily living (e.g., chore and homemaker services) are not subject to EVV requirements as long as they are not billed as PCS.

Promising Practices

Ongoing EVV Operations

Involve Providers in Decision-Making

- Keeping providers involved and soliciting feedback, even after the EVV system has been implemented, will increase the likelihood of a successful implementation and ongoing success.
- Multiple states who participated in the survey and/or interviews repeated the positive results of engaging providers as early as possible and continuously throughout the program's evolution.
 - **State Example: Texas** conducts monthly EVV workgroups with their vendors, providers and MCPs to discuss how the program is operating and any issues that have arisen.
 - This feedback process also allows for continuous improvement to the state's EVV.

Additional Helpful Tips for States Implementing EVV

- Leverage the APD process.
 - If implemented according to requirements under 45 CFR Part 95 Subpart F, states can receive up to 90% federal match. They would need to apply for federal financial participation (FFP) for expenditures.
- Examine every State Plan and waiver authority cited in the Cures Act and crosswalk against State Plan and waiver authorities offered in your state.
- Crosswalk your state's service definitions and the components of each service definition to the definitions in the Cures Act.

CMS' Ongoing Support to States for EVV Implementation

EVV Guidance Website

- CMS established a EVV guidance website.
<https://www.medicare.gov/medicaid/hcbs/guidance/electronic-visit-verification/index.html>
- The site includes the following additional resources:
 - CMCS Informational Bulletin for EVV, issued May 16, 2018.
 - EVV FAQ document, issued May 16, 2018.
 - Two EVV PowerPoint presentations CMS conducted in December 2017 and January 2018.
 - A PDF form to request EVV Technical Assistance (TA)

EVV Technical Assistance

- EVV TA is available to State Medicaid Agencies with the State Medicaid Director's approval. Topics can include:
 - Assist with determining the most appropriate EVV model for the state.
 - Provide guidance regarding the Cures Act.
 - Supply promising practice examples of EVV systems.
 - Review and provide opinions regarding policy documents related explicitly to EVV implementation.
 - Review the proposed language for 1915(c) Waiver Application, Appendix I-1 related to EVV.
 - Review the proposed language for 1915(c) Waiver Application, Appendix I-2-d related to EVV.
- EVV TA form is available in PDF at the following link:
 - <https://www.medicare.gov/medicaid/hcbs/downloads/technical-assistance/evv-ta.pdf>
- One of the CMS contractors will reach out to the state representative regarding next steps.

Summary

- Five common EVV design models were identified. States have the flexibility to choose their EVV design model after gathering feedback with appropriate stakeholders.
- Promising practices for EVV model selection and implementation include:
 - Assess EVV systems currently used by providers.
 - Evaluate existing vendor relationships.
 - Define EVV Requirements.
 - Integrate EVV systems with other state systems and data.
 - Understand technological capabilities.
 - Solicit stakeholder input.
 - Assess state staff capacity to develop and/or support the EVV system.
 - Rollout EVV in Phases and/or Pilots (Timeline Permitting).

Summary

- Promising practices for training and education 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.

References

1. Connecticut Electronic Visit Verification. Available online:
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2. Louisiana Electronic Visit Verification. Available online:
<http://dhh.louisiana.gov/index.cfm/subhome/40>
3. Maryland Electronic Visit Verification Online Training. Available online:
<http://www.ltsstraining.org/>
4. Massachusetts Electronic Visit Verification. Available online:
<http://www.mass.gov/eohhs/consumer/insurance/masshealth-member-info/pca/mytimesheet-electronic-visit-verification-evv.html>
5. Texas Electronic Visit Verification. Available online:
<https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/electronic-visit-verification>

Additional Resources

1. EVV Resources Website link:
<https://www.medicaid.gov/medicaid/hcbs/guidance/electronic-visit-verification/index.html>
2. [CMCS Informational Bulletin \(CIB\): Cures Act for Electronic Visit Verification, issued on May 16, 2018.](#)
3. [FAQs: Cures Act for Electronic Visit Verification. Issued on May 16, 2018.](#)
4. Copies of the HCBS Training Series – Webinars presented during SOTA calls are located in below link:
<https://www.medicaid.gov/medicaid/hcbs/training/index.html>
5. See below link for a copy of the 21st Century Cures Act:
<https://www.congress.gov/bill/114th-congress/house-bill/34/text>

Questions & Answers

For Further Information

For questions contact:

EVV@cms.hhs.gov

ATTACHMENT

*Full Text of the Section 12006 of
the Cures Act Part (a) & (b)*

and

H.R. 6042

Section 12006 of the Cures Act Part (a)

Electronic Visit Verification System Required for Personal Care Services and Home Health Care Services Under Medicaid.

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

(1) Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services or home health care services requiring an in-home visit by a provider that are provided under a state plan under this title (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2019 (or in the case of home health care services, on or after January 1, 2023), unless a state requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced –

(A) in the case of personal care services –

- (i) for calendar quarters in 2019 and 2020, by 0.25 percentage points;
- (ii) for calendar quarters in 2021, by 0.5 percentage points;
- (iii) for calendar quarters in 2022, by 0.75 percentage points; and
- (iv) for calendar quarters in 2023 and each year thereafter, by 1 percentage point; and

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(B) in the case of home health care services –

- (i) for calendar quarters in 2023 and 2024, by 0.25 percentage points;
- (ii) for calendar quarters in 2025, by 0.5 percentage points;
- (iii) for calendar quarters in 2026, by 0.75 percentage points; and
- (iv) for calendar quarters in 2027 and each year thereafter, by 1 percentage point.

(2) Subject to paragraphs (3) and (4), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a state shall –

(A) Consult with agencies and entities that provide personal care services, home health care services, or both under the state plan (or under a waiver of the plan) to ensure that such system –

- (i) is minimally burdensome;
- (ii) takes into account existing best practices and electronic visit verification systems in use in the state; and
- (iii) is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act);

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(B) take into account a stakeholder process that includes input from beneficiaries, family caregivers, individuals who furnish personal care services or home health care services, and other stakeholders, as determined by the state in accordance with guidance from the Secretary; and

(C) ensure that individuals who furnish personal care services, home health care services, or both under the state plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.

(3) Paragraphs (1) and (2) shall not apply in the case of a state that, as of the date of the enactment of this subsection, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services, so long as the state continues to require the use of such system with respect to the electronic verification of such visits.

(4)(A) In the case of a state described in subparagraph (B), the reduction under paragraph (1) shall not apply –

- (i) in the case of personal care services, for calendar quarters in 2019; and
- (ii) in the case of home health care services, for calendar quarters in 2023.

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(B) For purposes of subparagraph (A), a state described in this subparagraph is a state that demonstrates to the Secretary that the state –

(i) has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); and

(ii) in implementing such a system, has encountered unavoidable system delays.

(5) In this subsection: (A) The term ‘electronic visit verification system’ means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to –

(i) the type of service performed;

(ii) the individual receiving the service;

(iii) the date of the service;

(iv) the location of service delivery;

(v) the individual providing the service; and

(vi) the time the service begins and ends.

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(B) The term ‘home health care services’ means services described in section 1905(a)(7) provided under a state plan under this title (or under a waiver of the plan).

(C) The term ‘personal care services’ means personal care services provided under a state plan under this title (or under a waiver of the plan), including services provided under section 1905(a)(24), 1915(c), 1915(j), or 1915(k) or under a waiver under section 1115.

6(A) In the case in which a state requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the state or a contractor on behalf of the state, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

(B) Subparagraph (A) shall not apply in the case in which a state requires personal care service and home health care service providers to utilize an electronic visit verification system that is not operated by the state or contractor on behalf of the state.

Section 12006 of the Cures Act Part (b)

- (b) Collection and Dissemination of Best Practices – Not later than January 1, 2018, the Secretary of Health and Human Services shall, with respect to electronic visit verification systems (as defined in subsection (1)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), collect and disseminate best practices to State Medicaid Directors with respect to:
- (1) training individuals who furnish personal care services, home health care services, or both under the State plan under title XIX of such Act (or under a waiver of the plan) on such systems and the operation of such systems and the prevention of fraud with respect to the provision of personal care services or home health care services (as defined in such subsection (1)(5)); and
 - (2) the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of such electronic visit verification systems and other means to prevent such fraud.

H.R. 6042: Extension Language

SECTION 1. Delay in reduction of FMAP for Medicaid personal care services furnished without an electronic visit verification system.

(a) In general.—Section 1903(l) of the Social Security Act (42 U.S.C. 1396b(l)) is amended—

(1) in paragraph (1)—

(A) by striking “January 1, 2019” and inserting “January 1, 2020”; and

(B) in subparagraph (A)(i), by striking “2019 and”; and

(2) in paragraph (4)(A)(i), by striking “calendar quarters in 2019” and inserting “calendar quarters in 2020”.

H.R. 6042: Extension Language

SECTION 1. Delay in reduction of FMAP for Medicaid personal care services furnished without an electronic visit verification system.

(b) Sense of Congress on stakeholder input regarding electronic visit verification systems.—It is the sense of Congress that—

(1) the Centers for Medicare & Medicaid Services should—

(A) convene at least one public meeting in 2018 for the purpose of soliciting ongoing feedback from Medicaid stakeholders on guidance issued by the Centers for Medicare & Medicaid Services on May 16, 2018, regarding electronic visit verification; and

(B) communicate with such stakeholders regularly and throughout the implementation process in a clear and transparent manner to monitor beneficiary protections;

(2) such stakeholders should include State Medicaid directors, beneficiaries, family caregivers, individuals and entities who provide personal care services or home health care services, Medicaid managed care organizations, electronic visit verification vendors, and other stakeholders, as determined by the Centers for Medicare & Medicaid Services; and

(3) taking into account stakeholder input on the implementation of the electronic visit verification requirement under the Medicaid program is vital in order to ensure that the Centers for Medicare & Medicaid Services is aware and able to mitigate any adverse outcomes with the implementation of this policy.