



Section 12006 of the 21st Century CURES Act

Electronic Visit Verification Systems

Session 1: Requirements, Implementation, Considerations, and State Survey Results

Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services
December 2017

Overview of the Sessions

- There are **two** sessions of the presentation, each covering different topic areas.
- **Session 1** is split into two parts.
 - Part 1 – 21st Century CURES Act Provisions under Section 12006
 - Discuss the 21st Century CURES Act (the CURES Act) 114 U.S.C. 255 (enacted December 13, 2016) requirements.
 - Define authorities and services impacted by the CURES Act.
 - Explain Electronic Visit Verification System (EVV) requirements under the CURES Act.
 - Part 2 – Current State of EVV
 - Provide current status of EVV.
 - Highlight CMS' current efforts to assist states.
 - Review results of EVV survey performed in partnership with National Association of Medicaid Directors (NAMDD).
- **Session 2** will discuss promising practices for states with EVV.
 - Session 2 will be held in January 2018. Please look out for SOTA emails for updates on this presentation.

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.

Overview of the 21st Century CURES Act

Understanding the CURES Act

Overview of the 21st Century CURES Act¹

What is it?

- The CURES Act is designed to improve the quality of care provided to individuals through further research, enhance quality control, and strengthen mental health parity.

How does the CURES Act apply to HCBS programs?

- Section 12006 of the CURES Act requires states to implement an EVV system for Personal Care Services (PCS) by 1/1/19 and for Home Health Care Services (HHCS) by 1/1/23.

Other Requirements:

- The Secretary of Health and Human Services is required to collect and disseminate best practices regarding:
 - The training on the operation of EVV systems for individuals who furnish PCS, HHCS, or both.
 - The provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of EVV.

Penalties for Non-Compliance with Section 12006 of the CURES Act

- The CURES Act (Section 12006(a)(1)(A)) requires that states that do not comply with the CURES Act by the applicable deadlines will have their Federal Medical Assistance Percentage (FMAP) reduced as shown in the table below.

PCS & HHCS FMAP Reductions per Year

Year	PCS	HHCS
2019	0.25%	-
2020	0.25%	-
2021	0.50%	-
2022	0.75%	-
2023	1%	0.25%
2024	1%	0.25%
2025	1%	0.50%
2026	1%	0.75%
2027 & thereafter	1%	1%

- Per 1915(c) Technical Guide, the **FMAP** is the “Federal Medicaid matching rate for medical assistance furnished under the state plan. FMAP rates are re-calculated annually under the formula set forth in §1903(b) of the Social Security Act.”²

Exceptions for Non-Compliance per Section 12006 of the CURES Act

- Per Section 12006(a)(4)(B) of the CURES Act, FMAP reduction will *not apply* if the state has both:
 - Made a “good faith effort” to comply with the requirements to adopt the technology used for EVV; **and**
 - Encountered “unavoidable delays” in implementing the system
- Discuss with CMS Central Office (CO) or Regional Office (RO) Analysts if the state believes that it meets both of these requirements.

EVV Requirements per Section 12006 of the CURES Act

EVV Systems Must Verify:

- **Type** of service performed;
- **Individual receiving** the service;
- **Date** of the service;
- **Location** of service delivery;
- **Individual providing** the service;
- **Time** the service begins and ends.

Department of Health and Human Services (DHHS) Role

- Required to provide training and educational materials related to best practices to state Medicaid directors by *January 1, 2018*.
- Details of CMS' plans are discussed in later slides.

EVV Requirements per Section 12006 of the CURES Act (Continued)

Flexibility for States

- States may select their EVV design and implement quality control measures of their choosing.

Stakeholder Input Required

- States are required to seek input from other state agencies that provide PCS or HHCS.
- Requires states to seek stakeholder input from:
 - Family caregivers
 - Individuals receiving and furnishing PCS/HHCS; and
 - Other stakeholders.

Available Federal Support for States

- If the EVV system is operated by the state or a contractor on behalf of the state as part of a state's Medicaid Enterprise Systems, the state may be reimbursed through the Advanced Planning Document (APD) prior approval process. The "Federal Match" of state costs are the following:
 - 90% Federal Match for costs related to the
 - Design, development and installation of EVV.
 - 75% Federal Match for costs related to the
 - Operation and maintenance of the system.
 - Routine system updates, customer service, etc.
 - 50% Federal Match for:
 - Administrative activities deemed necessary for the efficient administration of the EVV.
 - Education and outreach for state staff, individuals and their families.

Available Federal Support for States – Continued

- States planning to request funding for the development and implementation of EVV must prepare and submit an Advanced Planning Document (APD) for approval.
- States should contact their Regional Office MMIS system lead for assistance with APDs.
- Refer to 42 CFR Part C, 45 CFR Part 95, and the State Medicaid Manual Part 11 for additional information.
 - Please contact **Eugene Gabriyelov** at **eugene.gabriyelov@cms.hhs.gov** if you have any questions regarding this process.

Overview of the 21st Century CURES Act

Important Terms and Definitions

Required Medicaid Authorities per Section 12006 of The CURES Act

Medicaid PCS Authorities Subject to EVV Requirements

- 1905(a)(24) State Plan Personal Care benefit;
- 1915(c) HCBS Waivers;
- 1915(i) HCBS State Plan option;
- 1915(j) Self-directed Personal Attendant Care Services;
- 1915(k) Community First Choice State Plan option;
- 1115 Demonstration

Medicaid HHCS Authorities Subject to EVV Requirements:

- 1905(a)(7) State Plan Home Health Services
- Home health services authorized under a waiver of the plan

Which Services Require EVV?

Personal Care Services (PCS)

- Medicaid covers PCS for eligible individuals through Medicaid State Plan options and/or through Medicaid waiver and demonstration authorities approved by CMS.
- Consists of services supporting Activities of Daily Living (ADL), such as movement, bathing, dressing, toileting, transferring, and personal hygiene.
- Offers support for Instrumental Activities of Daily Living (IADL), such as meal preparation, money management, shopping, and telephone use.

Home Health Care Services (HHCS)

- Medicaid covers HHCS for eligible individuals as a mandatory benefit through the Medicaid State Plan and/or through a waiver as an extended state plan service approved by CMS.
 - This is known as the home health benefit, and CMS is equating HHCS as described in the 21st Century CURES Act with the longstanding home health benefit mentioned at section 1905(a)(7) of the Social Security Act.

Potential Benefits of EVV

Improves program efficiencies by:

- Eliminating the need of paper documents to verify services.
- Facilitating flexibility for appointments and services.

Strengthens quality assurance for PCS and HHCS by:

- Improving Health and Welfare of individuals by validating delivery of services.
 - It is important to note that EVV is not a complete replacement for on-site, in-person case management visits.

Aims to reduce potential Fraud, Waste, and Abuse (FWA):

- Validates services are billed according to the individual's personalized care plan by ensuring appropriate payment based on actual service delivery.
- Is part of the pre-payment validation methods that allows individuals and families to verify services rendered.

Considerations for Self-Directed Services ³

The EVV system should:

- Accommodate PCS or HHCS service delivery locations with limited or no internet access.
- Avoid rigid scheduling rules as self-directed services are known for accommodating last-minute changes based on individuals' needs.
- Allow individuals to schedule their services between the individual and the provider.⁵
- Accommodate services at multiple approved locations for each individual (e.g., not only at home but near home or other community locations).
- Allow for multiple service delivery locations in a single visit.
- Include key stakeholders in the conversation, when states determine EVV strategies for self-direction and agency directed services.

Summary – Part 1

Part 1 - 21st Century CURES Act Provisions under Section 12006

- The CURES Act requires states to implement an EVV system by January 1, 2019 for PCS and by January 1, 2023 for HHCS.
- 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.
- EVV can be a strong mechanism for ensuring financial accountability of the program, including reduction in unauthorized services, improvement in quality of services to individuals, and reduction in fraud, waste and abuse.
- EVV systems can increase accuracy and quality of PCS and HHCS provided.
- EVV can also increase efficiency through quick electronic billing incorporated into the system immediately after entry.

EVV Design Models

Part 2 – Current State of EVV

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 models⁴:
 1. Provider Choice
 2. Managed Care Organization (MCO) Choice
 3. State Mandated External Vendor
 4. State Mandated In-house System
 5. Open Vendor
- States can choose more than one model.

Note: Information provided is based on research and using publicly available data. CMS is not endorsing any of these models or vendors. These examples may not be compliant with current law.

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 Organizations (MCOs).

Considerations

- Single or small provider agencies may find it technologically or financially burdensome (this can be offset by 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 EVV utilization among providers.

Note: Information provided is based on research and using publicly available data. CMS is not endorsing any of these models or vendors. These examples may not be compliant with current law.

2. MCO Choice Model

Definition

- MCOs 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 MCO(s).

Considerations

- This would be applicable to HCBS programs primarily using MCOs for service delivery.
- Providers may require additional administrative support if multiple MCOs 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.

Note: Information provided is based on research and using publicly available data. CMS is not endorsing any of these models or vendors. These examples may not be compliant with current law.

3. State Mandated External Vendor 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 MCOs already operating an EVV system might express concerns with having to adopt a new system.

Note: Information provided is based on research and using publicly available data. CMS is not endorsing any of these models or vendors. These examples may not be compliant with current law.

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.

Note: Information provided is based on research and using publicly available data. CMS is not endorsing any of these models or vendors. These examples may not be compliant with current law.

5. Open Vendor Model

Definition

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

Overview

- States maintain oversight and receive funding for implementation while also allowing vendor choice for providers and MCOs 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.

Note: Information provided is based on research and using publicly available data. CMS is not endorsing any of these models or vendors. These examples may not be compliant with current law.

Findings from the National EVV Survey

Survey Overview

EVV Survey

- NAMD distributed an electronic survey to all 50 states, territories and the District of Columbia (collectively “the states”) regarding EVV implementation.
- The survey elicited the following information on states’ progress in implementing EVV:
 - EVV models and vendors states currently use or plan to use;
 - Contractual requirements, policies and procedures related to EVV;
 - Stakeholder engagement strategies for EVV;
 - EVV education and training for individuals, families, providers, and state staff;
 - Technical assistance offered to individuals, families, and providers;
 - State’s oversight methods; and
 - Lessons learned and promising practices.

Survey Overview – Continued

Methodology

- Findings are based on an analysis of 40 complete surveys submitted by 37 states, two territories, and the District of Columbia between July 17, 2017 and September 17, 2017.
 - Data is self-reported by states, and therefore was not standardized prior to analysis.
 - States submitting complete surveys did not always respond to all questions that were presented to them.
 - States with surveys that indicated there was an operational EVV* program, but that responded to fewer than eight survey questions, received a follow-up request.
 - If a state did not reply to our follow-up request, their survey was excluded.
 - If the follow-up request was due to a state submitting multiple surveys and we did not receive clarification on which to use, we included the survey with the most recorded responses.

*An operational EVV program is defined as a state that reported having a state-run EVV program for at least some state plan or waiver services.

Survey Timeline

July 17,
2017

- Survey opened.
- Distributed by NAMD.

August 31,
2017

- Presented preliminary findings at NASUAD HCBS Conference.

September
17, 2017

- Survey closed and data analysis and interviews began.

December
2017

- Survey data analyzed.
- Shared results with states.

January
2018

- CMS to issue further guidance to states regarding EVV.

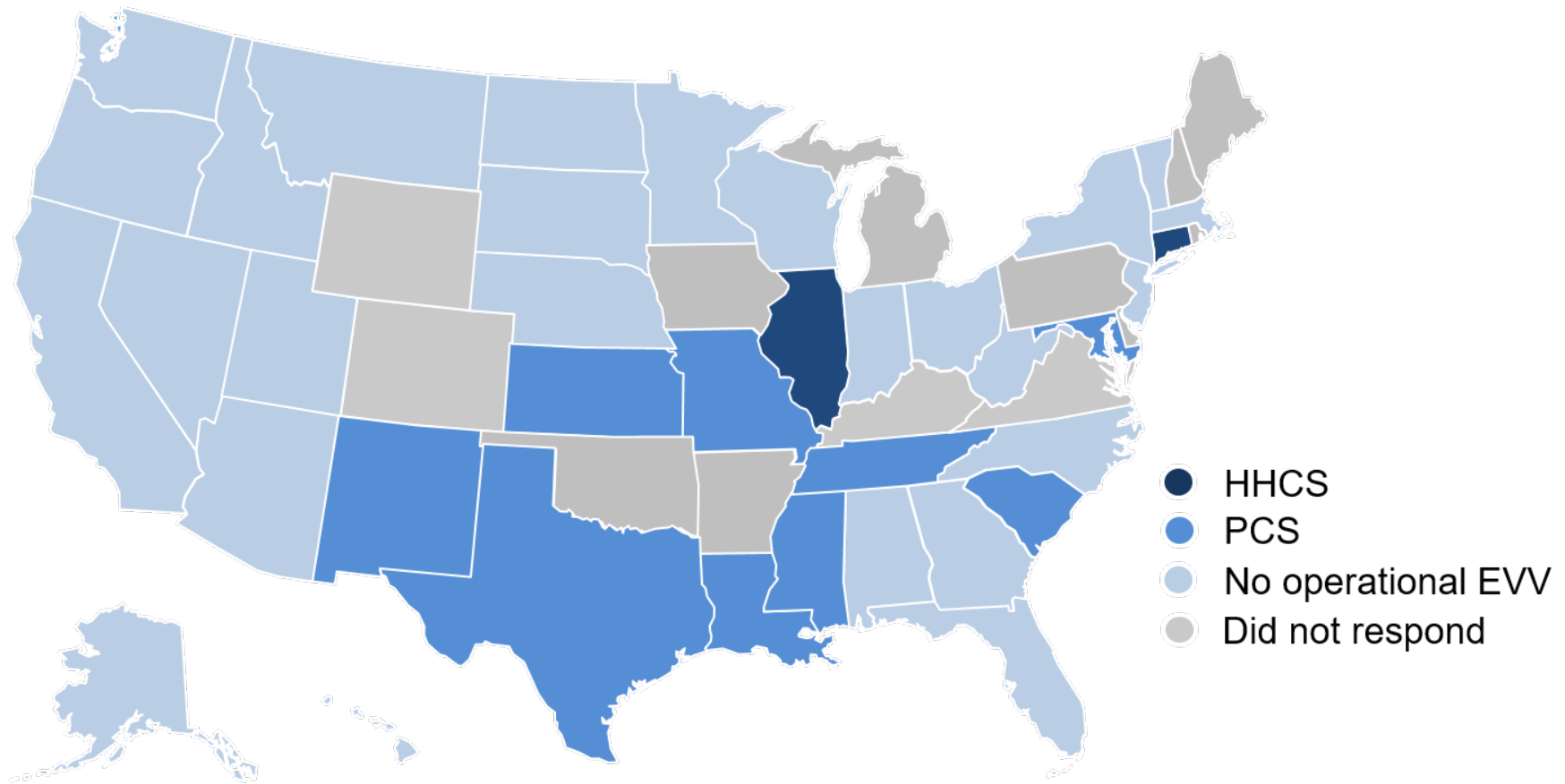
Survey Findings

EVV National Overview as of 9/17/17

- 11 states reported having implemented EVV for either PCS or HHCS.
 - 9 states have implemented EVV for PCS.
 - Two states, CT and IL, have implemented EVV for HHCS.
 - No states have implemented EVV for both PCS and HHCS.
- 29 states reported having not implemented an operational EVV for either PCS or HHCS.
- Remaining states and territories either did not respond to the survey or submitted an incomplete survey.

Survey Findings

EVV National Overview as of 9/17/17



*The District of Columbia, Puerto Rico and the U.S. Virgin Islands all reported that they did not have an operational EVV for neither HHCS nor PCS.

Note: Map is based on information provided by the states and may be incomplete.

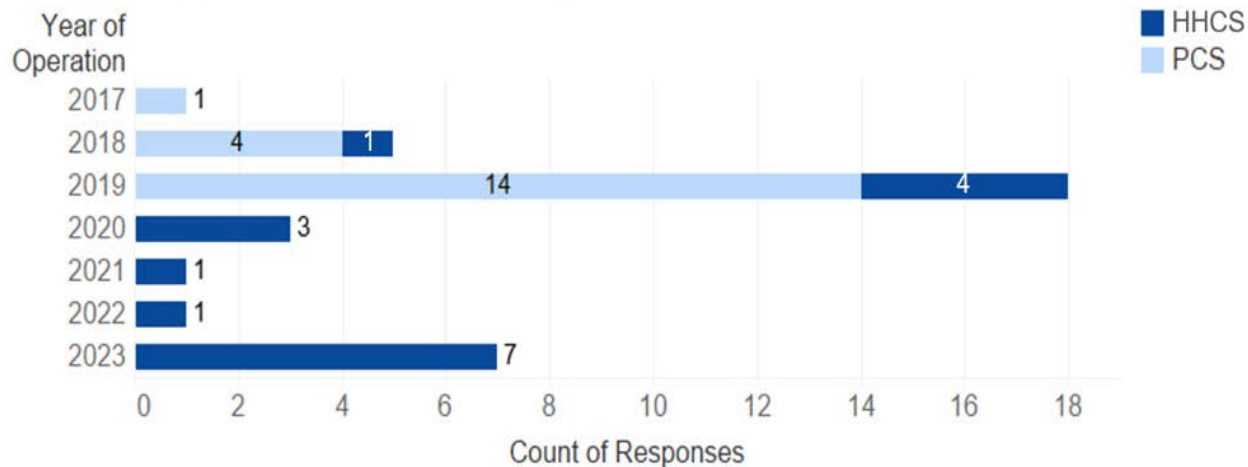
Survey Findings

Planned Implementation Dates

- For states reporting that they do not have an operational EVV program for PCS and/or HHCS:
 - **19** reported plans to implement EVV for **PCS** by January 1, 2019.
 - **17** reported plans to implement EVV for **HHCS** by 2023.

Planned EVV Operation Start Year

Q11 / 13. Expected Go Live Date for Operational EVV

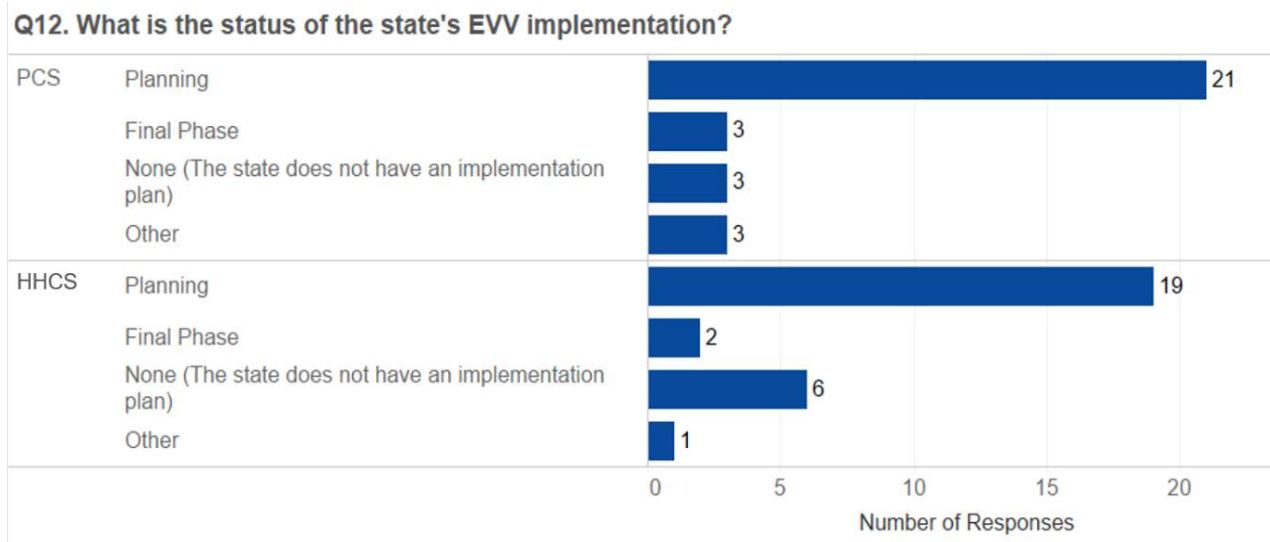


Survey Findings

Status of EVV Implementation

- Most states that reported not having implemented an EVV for PCS and/or HHCS are still in the planning stages.
- 3 states responded that their state does not currently have plans for implementing EVV for PCS.

Implementation Status



Survey Findings

EVV Model Type for States Operating EVV

- The State Mandated External Vendor model is the most frequently used model for states currently operating EVV.

EVV Model by State – States Currently Operating EVV

	State Mandated External Vendor	MCO Choice	Open Vendor	State Mandated In-House	Provider Choice
PCS	<ul style="list-style-type: none"> Kansas South Carolina Mississippi 	<ul style="list-style-type: none"> New Mexico Tennessee 	<ul style="list-style-type: none"> Louisiana Texas 	Maryland	Missouri
HHCS	<ul style="list-style-type: none"> Connecticut Illinois 				

* States were allowed to indicate any applicable options in the survey and therefore responses are not mutually exclusive.

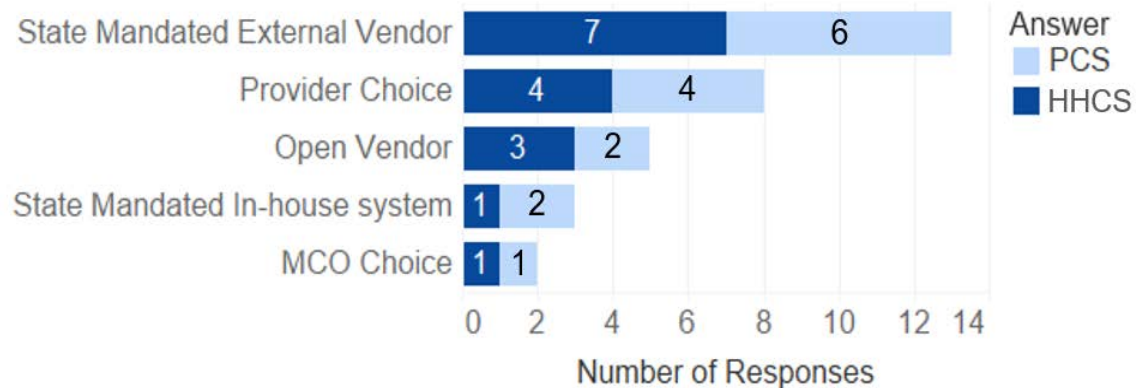
Survey Findings

Planned EVV Model Types

- The State Mandated External Vendor model is the most frequently planned model for states reporting that they are not currently operating an EVV for PCS and/or HHCS.

EVV Models Planned for Implementation

Q21. EVV Models That Will be Used for PCS and HHCS

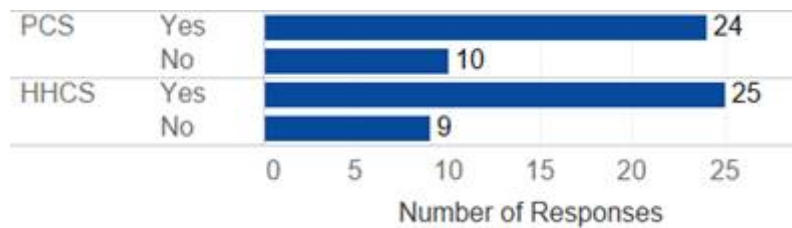


- Five states reported that they are undecided on what model to use.

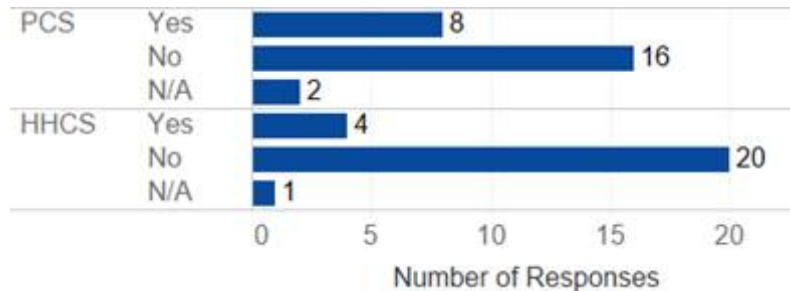
Survey Findings

EVV Implementation Funding

Will the state apply for Enhanced FMAP?^



Has the state completed an Advanced Planning Document?*



- 24 states reported that they plan to apply for enhanced FMAP for the implementation of EVV for PCS.
- 25 states reported that they plan to apply for enhanced FMAP for the implementation of EVV for HHCS.
- 8 states reported having completed an Advanced Planning Document (APD) for PCS.
- 4 states reported having completed an APD for HHCS.

^: Not all of the 40 states responding to the survey completed this question.

*: This question only generated if the state indicated it plans to apply for enhanced FMAP. For the PCS section of this graph, the total response count is higher than the universe of 24 states responding to this question because two states chose to provide more than one response, such as Y and N/A.

Survey Findings

EVV Compliance

- Most states with operational EVV reported incorporating EVV requirements into their overall monitoring of providers.
- States currently operating EVV cited multiple entities that monitor compliance, such as:
 - Caseworkers.
 - State Program Integrity Offices.
 - EVV Program Managers.
- Methods reported to enhance EVV compliance include:
 - Implementing monitoring processes to address provider systems where oversight is lax (e.g., providers that do not have adequate monitoring for EVV).
 - Conducting pilots prior to the state-wide rollout of EVV.
 - Implementing EVV in phases.

Survey Findings

EVV Technology and Functionality

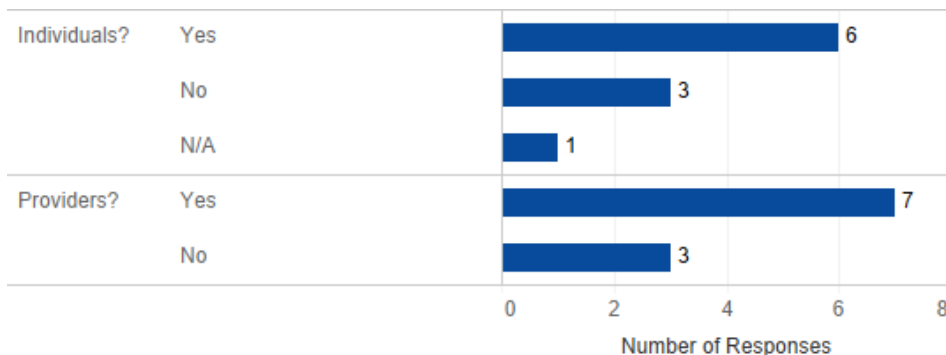
- EVV requires integration of technology to successfully document delivery of services. States have implemented various measures, including:
 - Landlines.
 - Smartphones and tablets (including GPS enabled tablets) for when a landline is unavailable.
 - A one-time password generator for when a landline is unavailable.
 - Bio-metrics (e.g., fingerprint, voice-recognition, etc.) to verify that the correct caregiver is checking in for the service.

Survey Findings

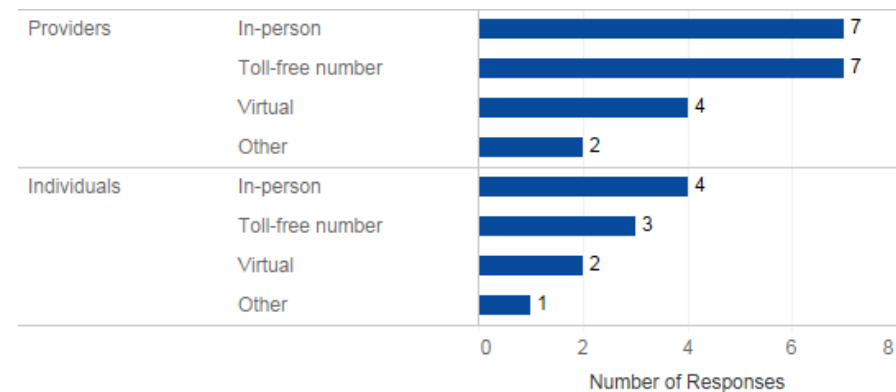
EVV Technical Assistance

- 6 of the 11 states that reported having an operational EVV indicated they offer technical assistance to both individuals and providers. One state provides technical assistance to providers only.*
- In-person assistance or toll-free numbers are the most commonly reported way of providing technical assistance.

Is Technical Assistance Offered to Individuals and/or Providers?



Type of Technical Assistance Provided to Individuals and/or Providers[^]



* = One state selected 'not applicable' answer for technical assistance to individuals.

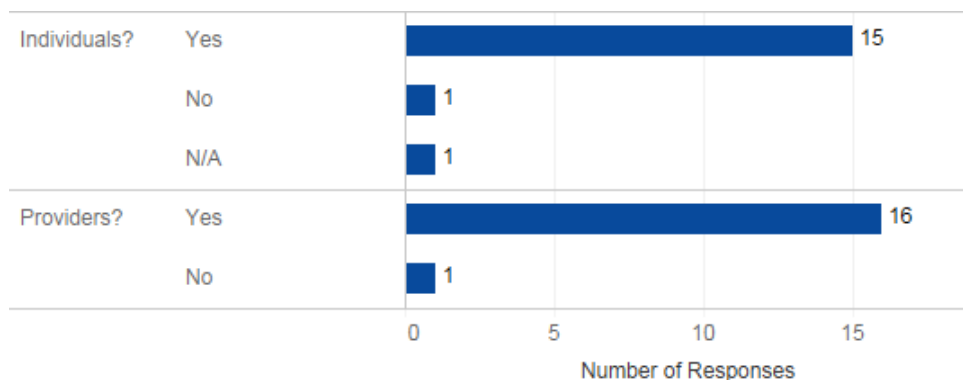
[^] = States were allowed to indicate any applicable options in the survey and therefore responses are not mutually exclusive.

Survey Findings

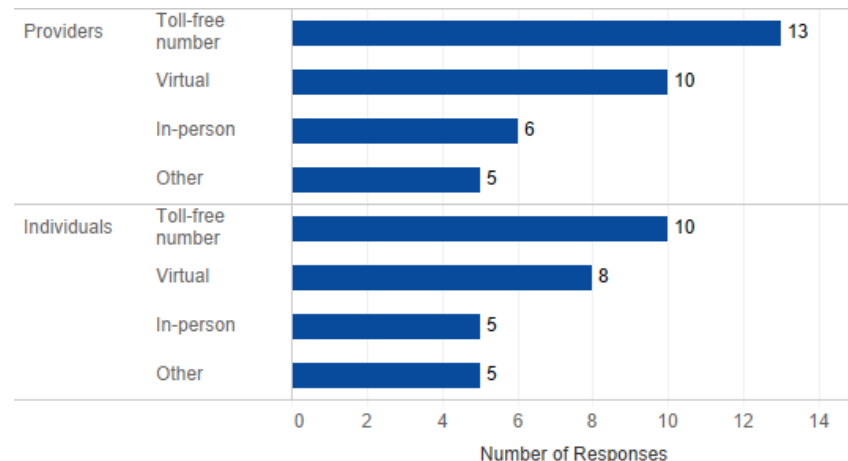
EVV Technical Assistance (Continued)

- 15 of the states that reported they do not have an operational EVV indicated that they plan to provide technical assistance to individuals.
- One state reported it will provide technical assistance to providers only.*
- Toll-free numbers or virtual meetings were the most commonly reported plans to provide technical assistance.

Will The State Offer Technical Assistance to Individuals and/or Providers?*



Technical Assistance Methods to be Provided Once EVV Is Implemented^



* = Not all states without operational EVV answered this question. One state selected 'not applicable' answer for technical assistance to individuals.

^ = States were allowed to answer any applicable options in the survey and therefore responses are not mutually exclusive.

Survey Findings

EVV Education and Training for Individuals and their Families

- States currently operating or planning to implement EVV reported various methods of notifying individuals and their families of EVV, including:
 - Bulletins / Letters.
 - Websites.
 - During person-centered planning meetings.
 - During stakeholder meetings.
 - During intake.
- 3 states that reported they have an operational EVV for PCS indicated they provide training to individuals and their families.
- Training topics covered included responsibilities of the individual, rights to change providers, appointment times, the prevention of FWA, and self-direction.

Survey Findings

EVV Education and Training - Providers

- 7 of the 11 states that reported having an operational EVV for either PCS or HHCS indicated they provide initial and ongoing training to providers.*
- Training is delivered through the following means:
 - In-person by instructor-led classes
 - Virtually
 - One-on-one settings
- Can be provided by state staff or a contractor

** Not all states operating EVV choose to answer this question. In addition, states are allowed to choose multiple responses and therefore responses are not mutually exclusive. Accordingly, the total PCS count is higher than the universe of 7 states.*

Survey Findings

EVV Education and Training – State Staff

- 7 of the 11 states that reported having an operational EVV for either PCS or HHCS indicated they provide initial training to state staff.
- **The 3 most common training topics were:** Compliance, data capturing and reporting, and software.

Topics Covered in State Staff Training*



* States were allowed to indicate any applicable options in the survey and therefore responses are not mutually exclusive.

Survey Findings

Costs and Potential Savings in EVV Implementation*

- EVV technology is relatively new, and many states are still early in the planning and implementation process. Therefore, little information was available on costs and potential savings.
- EVV systems can result in overall operational cost savings to the state. Examples include:[^]
 - Maryland, which implemented EVV in 2014, reported that it has saved approximately \$18 million since program implementation.
 - Connecticut projects savings between \$11 million and \$19 million.

* = Not all states responding to the survey completed this section.

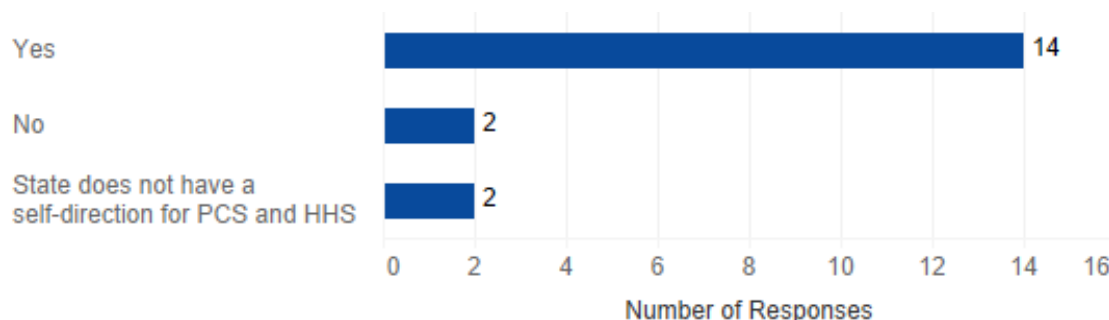
[^] = Data is self-reported by states and no break-down of the costs were provided.

Survey Findings

*Self-Direction**

- 7 of the 11 states that reported having an operational EVV indicated that they also require EVV use for self-directed services.
- 14 states reported plans to integrate their EVV system with self-direction systems, which will allow states to build on the programs already established by Financial Management Services (FMS) providers as opposed to installing a new system.
 - **NOTE:** These systems must meet all applicable federal requirements.

Will the State's EVV System Integrate with Existing Self-Direction Systems?



* Not all states responding to the survey completed this section.

Summary – Part 2

Part 2 - Current State of EVV

- Five common EVV design models were identified. States have the flexibility to choose their EVV design model.
- Survey finding highlights include:
 - 11 states reported having implemented EVV for either PCS or HHCS.
 - 29 states reported having not implemented an operational EVV for either PCS or HHCS.
 - Most states that reported not having implemented an EVV for PCS and/or HHCS are still in the planning stages.
 - State Mandated External Vendor model is the most frequently used model for states currently operating EVV.
 - Most states with operational EVV reported incorporating EVV requirements into their overall monitoring of providers.

References

1. 21st Century CURES Act, 114 U.S.C. 255 (2016). Text available online: <https://www.congress.gov/bill/114th-congress/house-bill/34/text?q=%7B%22search%22%3A%5B%22electronic+visit+verification%22%5D%7D&r=8>
2. CMS. “Application for a §1915(c) Home and Community-Based Waiver: Instructions, Technical Guide and Review Criteria.” January 2015. (p. 295).
3. Applied Self Direction. “Electronic visit verification (EVV) implementation tip sheet for self-direction programs.” Available online: <http://www.appliedselfdirection.com/news/evv-implementation-tip-sheet-self-direction-programs>
4. Sandata Technologies. “Electronic visit verification program models: national EVV mandate for states.” January 6, 2017. Available online: https://www.sandata.com/wp-content/uploads/2017/04/EVV-National-Mandate-Models_Sandata.pdf

Additional Resources

- 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>

- 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