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## CMCS Informational Bulletin

**DATE:** May 16, 2018

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Center for Medicaid and CHIP Services

**SUBJECT: Electronic Visit Verification**

CMCS is issuing this informational bulletin in accordance with section 12006(b) of the 21<sup>st</sup> Century Cures Act (the Cures Act)<sup>1</sup> in order to assist states in implementing electronic visit verification (EVV) systems for Medicaid personal care services (PCS) and home health care services (HHCS). The Cures Act requires the Secretary of Health and Human Services to collect and disseminate best practices to State Medicaid Directors with respect to (1) training individuals who furnish PCS, HHCS, or both, on the use and operation of EVV systems and on the prevention of fraud with respect to the provision of PCS or HHCS; and (2) the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of EVV systems and other means to prevent such fraud. This bulletin shares strategies related to EVV training and education for providers and other stakeholders, including beneficiaries and family caregivers, along with other factors that states, the District of Columbia, and US territories (collectively referenced in this bulletin as states) should consider when implementing 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, which mandates that states require EVV use for Medicaid-funded PCS and HHCS for in-home visits by a provider. States are required to implement EVV for PCS by January 1, 2019 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 over the first five years of the requirement that will eventually reach 1 percent. There is a limited exception for the first year of the requirement if the state has both made a good faith effort to comply with the EVV requirements and has encountered unavoidable 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 Social Security Act, and HHCS provided under 1905(a)(7) of the Social Security Act or under a waiver or demonstration project (e.g., 1915(c) or 1115 of the Social Security Act).

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<sup>1</sup> 21<sup>st</sup> Century Cures Act, Pub. L. No. 114-255, § 12006, 130 Stat. 1033, 1275-78 (2016).

Section 1903(l)(5)(A) defines EVV as “a system under which visits conducted as part of such [PCS and HHCS] 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.” In implementing the EVV requirement, states are required to consult with providers of PCS and HHCS, seek stakeholder input, consider existing best practices and EVV systems in use in the state, ensure the opportunity for provider training, and ensure the EVV system is minimally burdensome and that its use is compliant with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). Further, nothing in section 1903(l) can be construed to limit provider selection, to constrain beneficiaries’ choice of caregiver, or to impede the way care is delivered.

This bulletin is intended to provide state Medicaid agencies and other state agencies operating programs for Medicaid beneficiaries with promising practices with regard to EVV implementation, particularly as it pertains to EVV training and education. To identify the strategies included in this bulletin, we completed the following:

1. Literature Review: We conducted a literature review of the current landscape of EVV that included publicly available information from states and other sources to understand states’ progress toward EVV implementation and meeting the section 1903(l) requirements.
2. Nationwide Outreach to Medicaid Agencies: In support of the states and in collaboration with CMS, the National Association of Medicaid Directors (NAMMD) solicited information about each state’s approach to complying with section 1903(l) with respect to operationalizing EVV, including the use of vendor(s); systems development; policies and procedures; education and training for state staff, providers, and individuals; oversight and technical assistance; and lessons learned.
3. Targeted State Interviews: After reviewing the survey results, we performed follow-up interviews with five states (Connecticut, Maryland, Texas, South Carolina, and Ohio) that were selected based on the degree of existing compliance with Section 1903(l) requirements. Four of the five states interviewed had an operational EVV system, and Ohio was in the final phase of implementing EVV.
4. Stakeholder feedback: We solicited feedback from multiple stakeholder and advocacy groups and incorporated into this bulletin where appropriate.

## **EVV Models**

There are five major EVV system models implemented by states that we are addressing in this bulletin. All five models provide similar solutions but vary with respect to state involvement in vendor selection and EVV management. The section that follows provides an overview of each major EVV model, based on the results of feedback from the states reporting that they have adopted or are planning to adopt the model. The five models discussed are:

1. Provider Choice Model
2. Managed Care Plan (MCP) Choice
3. State Mandated In-house System
4. State Mandated External Vendor
5. Open Choice Model.

Please note that section 12006 of the Cures Act requires that states have flexibility in the type of EVV model they wish to implement, as long as the model or approach selected meets statutory requirements, including compliance with the HIPAA privacy and security standards. CMS does not endorse any one model, but notes that any model selected by the state must be able to generate the information required of EVV systems at section 1903(l)(5)(A): the type of service performed, the individual receiving the service, the date of service, the location of service delivery, the individual providing the service, and the beginning and ending times of the service. CMS notes that the EVV legislation includes the following language at section 12006(c)(2) of the Cures Act: “Nothing in the amendment made by this section shall be construed to require the use of a particular or uniform electronic visit verification system ... by all agencies or entities that provide personal care services or home health care under a State plan under title XIX of the Social Security Act (or under a waiver of the plan).” CMS has interpreted this language as prohibiting CMS from mandating a state to use a particular or uniform system, rather than prohibiting a state from selecting that option.

#### *Provider Choice Model*

In the provider choice model, providers select their EVV vendor of choice and self-fund EVV implementation. States set requirements and standards for EVV vendors, including specific data collection requirements. States using this model may or may not provide an approved list of EVV vendors. Single or small provider agencies may find this model technologically or financially burdensome as the providers are likely to incur higher costs than under other models. States may mitigate the financial burden on providers by incorporating costs associated with the purchase of EVV devices and/or equipment in the rate methodology used to develop the rate paid to the provider for the rendering of services.

In the provider choice model, other than setting standards for EVV systems generally, the state might have little or no involvement in the selection of the provider’s EVV vendor, which may complicate a state’s access to EVV data, and its ability to report and link EVV data to claims, care plan authorizations, and the Medicaid Management Information System (MMIS). States implementing this model could have the added administrative burden of developing a data aggregation solution to collect and consolidate data from different EVV systems in order to ensure compliance with section 1903(l), as well as for program integrity, provider monitoring, and MMIS integration purposes. Aggregating data from providers’ EVV vendors would provide states the ability to validate the provision of PCS and HHCS and monitor accuracy of payments to providers, thereby offering states another tool to detect and address instances of fraud, waste, and abuse. As noted in the conclusion of this bulletin, such aggregation systems may be eligible for enhanced federal funding. Missouri currently operates a provider choice model, and Alaska, New York, West Virginia, and Utah report plans to adopt this model.

### *MCP Choice Model*

The MCP choice model is like the provider choice model, but under it, Managed Care Plans<sup>2</sup> (MCPs), rather than providers, select and reimburse their EVV vendor solution. As the state would be mandating the MCP to contract with an EVV vendor, the state must include the expected expenditures related to contracting with the vendor within their capitation rates paid to the MCPs in order for the rates to be determined actuarially sound. The minimum standards outlined by the state will need to be included within the contract with the MCP for EVV vendor selection as well as details about the specific data collection from the MCP(s). A state that offers PCS and HHCS in both managed care and fee-for-service (FFS) environments will also need to ensure EVV coverage for services provided under the FFS system (e.g., by implementing another model discussed in this bulletin).

Providers may feel the most burden in this model, especially if states have multiple MCPs, as providers may have to train on and use more than one EVV system, adopt multiple forms of technology, and navigate several vendor helplines. Further, complications may arise for providers integrating multiple EVV systems with their payroll and scheduling systems. These factors have the potential to result in higher administrative costs to providers. States should take steps to ensure that having multiple EVV systems does not impact the consistency of EVV implementation across the state since EVV functionality may differ by vendor. States should outline a common reporting framework to receive the data from the MCPs in order to ensure data are collected in a manner consistent with the data storage and use abilities within state systems. Currently, there are three states (New Mexico, Tennessee, and New Jersey) using or planning to adopt this model.<sup>3</sup>

### *State Mandated In-House Model*

In a state mandated in-house system model, the state develops, operates, and manages its own EVV system. This model allows standardization and access to data for the state without a need to aggregate data from diverse external EVV systems. The administrative burden on the state is greater compared to other models as the state would develop, implement, and manage its own EVV system. In addition, even where the state outsources training the state is responsible for ensuring the development and dissemination of training, including technical training on use of the system, to state staff, providers, and individuals and their families. States may find that providers and MCPs within their state already operate an EVV system, which may lead to provider and MCP concerns about the adoption of a new system. Conversely, providers and MCPs that are not currently operating EVV may benefit from this model in that it simplifies the process for selecting and implementing an EVV system. Maryland operates a state mandated in-house model, and Georgia reports plans to adopt this model, as does Massachusetts for its personal care program.

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<sup>2</sup> Managed Care Plans means a managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP) or primary care case management (PCCM) entity

<sup>3</sup> New Jersey is currently in the planning stages of EVV implementation and will utilize the MCP choice model and/or open vendor model for PCS and HHCS.

### *State Mandated External Vendor Model*

In the state mandated external vendor model, states contract with a single EVV vendor to implement a single EVV solution. The state requires that all MCPs (if applicable), providers, and individuals and their families use that system to document services. This model guarantees standardization and access to all data for the state since it uses one vendor. The state has direct involvement in the management and oversight of the EVV program, which should promote compliance with EVV requirements. In addition, this may be less costly for the state than building an EVV system.

There is an administrative burden for states in choosing and contracting with an EVV vendor as well as costs associated with management of the system. (As noted below, enhanced federal matching funds may be available for such costs.) Providers and MCPs already operating an EVV system might express concerns with adopting a new system. The state and/or its EVV vendor and/or any outsourced contractor must also provide all education and training on the EVV operations, including technical training on use of the system, to individuals, their families, and providers. The state is ultimately responsible for ensuring this occurs. Twelve states report using or have plans to adopt this model: Arizona, Connecticut, Florida, Illinois, Kansas, Mississippi, Montana, Ohio, South Carolina, Washington, West Virginia, and the District of Columbia.

### *Open Vendor Model*

An open vendor model is a hybrid model where the state contracts with at least one EVV vendor or operates its own EVV system while still allowing providers and MCPs with existing EVV systems to continue to use those systems. In other words, providers and MCPs have the option of using the state's system (which may be appealing to organizations that do not have a current system), or continuing to use their own system. States are responsible for the development and implementation of policies and procedures regarding the EVV program and maintaining oversight. The open vendor model allows providers and MCPs with existing EVV technology the flexibility to maintain use of their current systems; however, in order to comply with Cures Act requirements that EVV systems are to address issues of fraud, waste and abuse, it is likely the state will require some level of integration between EVV solutions. Some states using the open vendor model have a list of preferred EVV vendors.

States can implement an "open model" in which a system aggregates EVV data from both the state-contracted vendor and third-party vendors. Similar to provider and MCP-based models, states would need to develop a data aggregation solution and specify the data to be collected from the providers and MCPs. Each EVV system would then report standardized data to the state and each system would have the flexibility to be implemented according to the basic set of requirements identified in section 1903(l) and any other requirements established by the state. States should consider additional administrative burdens associated with overseeing and maintaining the system with multiple vendors. The state-selected EVV vendor(s) and the MCPs, **and** providers might take on the responsibility of providing technical training on the use of the system, except where the provider is using a state-operated EVV system, in which case the state, even if outsourced, would be responsible for ensuring that training is appropriate and completed.

Louisiana and Texas are currently operating the open vendor model. North Dakota and Massachusetts report plans to implement this model. New Jersey is also considering this option.

## **Implementation Strategies**

The EVV requirements outlined in section 1903(l) have prompted states to take a close look at how they will implement or update their EVV systems. While requirements outlined in section 1903(l) summarize the general guidelines for developing an EVV system, there are many decisions states should make when selecting, implementing, and operating an EVV model and system. Through the outreach and interviews with states and stakeholders, we identified promising practices for states to consider as they implement EVV. This section outlines strategies for selecting and implementing an EVV model, training providers and other stakeholders (including individuals receiving services monitored by EVV), operating an effective EVV system, and implementing EVV for self-direction.

### *Promising Practices for EVV Model Selection & Implementation*

EVV systems can be developed to meet the unique needs of each state. Understanding how states have implemented and operationalized EVV systems in the past can provide valuable insight into key considerations for states looking to implement an EVV system. Based on states' implementation experiences, this section highlights eight actions states should consider when selecting the EVV model most suitable for their Medicaid PCS and HHCS programs:

- 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)

We discuss each action in further detail below:

#### Assess EVV Systems Currently Used by Providers

As required by section 1903(l), the state Medicaid agency must consult with agencies and entities within the state that provide PCS or HHCS, or both, to ensure that the EVV system is minimally burdensome, that it takes into account existing best practices and EVV systems in use in the state, and that it is conducted in accordance with the HIPAA privacy and security standards. Regardless of the EVV model that is implemented by a state, the providers delivering the services are most heavily impacted by the state's decision. One of the most important decisions a state will make is whether to mandate a single EVV system or allow providers to choose the EVV system they will use to comply, at a minimum, with the section 1903(l) requirements. Assessing how providers currently use EVV is an important step in determining the best EVV model for the state.

When there is a high rate of providers operating their own EVV systems, states may want to consider the option to allow providers to use their existing EVV, rather than mandating that providers transition to an EVV system chosen by the state, provided those existing systems meet the requirements of section 1903(l).

As outlined in Table 1 below, while each state and provider background is unique, there are certain landscapes that may better lend themselves to supporting each of the five primary EVV models.

Table 1: Supporting Background, by Model

Model	Supporting Background
<b>Provider Choice</b>	A large number of providers currently use one or multiple EVV system(s) that provide a reasonable foundation for compliance with section 1903(l), and will be interoperable with existing Medicaid enterprise systems.
<b>MCP Choice</b>	MCPs currently use one or multiple EVV system(s) that provide a reasonable foundation for compliance with section 1903(l), and will be interoperable with existing Medicaid enterprise systems; the majority or all PCS and HHCS are offered in managed care.
<b>State Mandated In-house System</b>	Providers are not widely using EVV, or EVV systems being used do not meet the state’s needs or the requirements of 1903(l); the state has the expertise and resources to develop its own EVV system, including training and educational materials.
<b>State Mandated External Vendor</b>	Providers are not widely using EVV, or EVV systems being used do not meet the state’s needs or the requirements of 1903(l); the state prefers to use an external EVV vendor for some or all services.
<b>Open Vendor Model</b>	The state has smaller providers not widely using EVV but may have one or more larger providers using an EVV system that provides a reasonable foundation for compliance with section 1903(l), and will be interoperable with existing Medicaid enterprise systems.

To conduct this assessment, states should reach out to providers and MCPs as applicable, to gather information about whether they have adopted an EVV system. The state may want to consider issuing a survey with questions targeted at understanding what is in place currently and what capabilities are available. It could be to the providers’ advantage to share this information to help guide the state on what is currently working or what has not been successful. This type of activity will also help the state ensure it takes into account existing best practices and EVV systems in use in the state, as required by section 1903(l).

Evaluate the State’s Existing Vendor Relationships

Depending on the structure of the state, agencies that offer similar services may exist under different state departments, local entities, or provider agencies. States should determine strategies for gathering information from other agencies. A survey or questionnaire soliciting information from relevant departments can be an effective means for gathering information.

As a best practice, states should also evaluate their existing relationships with vendors of EVV systems before implementing the EVV requirement. 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 an MMIS, eligibility, and/or prior authorization system will simplify the implementation process and lower

operational efforts. A vendor's experience with other states and agencies could also provide valuable information about data integration. Questions that states may want to consider when vetting a current EVV vendor include:

- What has been the experience of beneficiaries and providers using the system (e.g., helpdesk responsiveness, ease of use, ability to integrate with third party payroll and scheduling systems, common complaints)?
- What is the rate of data entry errors among providers (e.g., missing/invalid check-ins, incorrect beneficiary or provider information, etc.)?
- 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 (e.g., adapting software, developing new training materials)?
- Is the EVV system interoperable with the state's Medicaid enterprise systems?
- Has the EVV system resulted in demonstrable savings to the state's Medicaid program through reduced fraud, waste and abuse?

A review of a state's current vendor relationships and contracting/procurement rules may also uncover that the state has a contractual relationship with a firm that can provide EVV services. For 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. Procurement rules allowed Connecticut to move ahead with the EVV implementation without a Request for Proposal (RFP) process, saving Connecticut considerable time and expense. However, states should note that while it may be simpler in the short term to utilize an already established vendor for EVV, if a state selects an incorrect model or a vendor with limited or no experience with EVV, any efficiencies gained up front will be lost to the time, effort, and costs required to correct issues and/or switch vendors in the future. States should also follow applicable procurement law, including applicable law about when competitive bidding is required.

Where provider agencies are using one or more EVV systems, those EVV vendors may have an inherent advantage in sustaining the status quo, but states should evaluate whether those EVV systems truly meet the state's needs, or may serve the state's needs with some changes.

### Define EVV Requirements

It is essential that states establish clear policies and procedures about EVV systems in order to ensure that providers use systems that comply with the requirements of section 1903(l) and with the state's implementation model. For states that utilize an open vendor model or provider choice model, having a consistent and streamlined set of requirements will help the state better control and monitor the systems being used throughout the state, and thus help the state comply with its obligations under section 1903(l). For example, states should have requirements for how edits and changes regarding PCS or HHCS service visits are made in the system. Providers should be

monitored and held accountable for exceptions to the data that must be recorded and reported under section 1903(l) (e.g., missing or invalid check-in/out data that must be manually cleared in order to confirm a visit) in the EVV system. Some examples of visits that may lead to exceptions include instances where there is a check-in for a scheduled visit but no check-out, a caregiver entered an incorrect EVV ID, or a caregiver checked-in from an unconfirmed phone number and therefore cannot establish that s/he was present to render the service. In addition, if the state (or an MCP) intends to use a data aggregator to monitor providers using multiple EVV systems, it is important that providers clearly understand what is required of their EVV systems. Missouri, which uses a provider choice model for EVV, emphasized the importance of communicating state specific requirements to providers so they are aware of what their individual EVV systems must be able to do and how they must be able to report to the state.

#### Integrate EVV Systems with Other State Medicaid Systems and Data

States that integrate their EVV systems with other state Medicaid data systems are better equipped to oversee and monitor the delivery of PCS and HHCS. Integration of EVV data with other Medicaid state data systems, including the MMIS, Eligibility and Enrollment (E&E) system, prior authorization system and Financial Management Systems (FMS) employed for self-direction, strengthens the oversight capabilities of EVV. In addition, integration with these systems allows data to flow through the EVV system more efficiently and provides updated information to the caregiver. Data integration can also help in efforts to increase program integrity. For example, Connecticut's systems are integrated to confirm a match between the EVV visit data, service authorization data, and the claims system. Any claim generated that exceeds the authorized service amount is reduced in payment to the amount authorized and reduced to the confirmed visit data. Maryland, which uses a state mandated internal system, 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.

States utilizing one of the three "choice" models for EVV (provider, MCP, or open), which rely on agencies and providers to use their own EVV systems, should ensure that data from these systems can be used by the state's Medicaid systems in order to provide oversight to detect for fraud, waste and abuse. At a minimum, states using a choice model will need to develop a data aggregation solution to collect and consolidate data from different EVV systems. Ideally, all EVV systems in use in a state would be fully integrated with state Medicaid systems. Under the two state mandated models – in-house system and external vendor – the single EVV system captures all data and houses it in a central location. However, when there are multiple systems, states will need to aggregate the data into a central location. EVV vendors can often provide data aggregation capabilities so that a state can collect data from multiple systems. A state should work with the vendor to develop standard system requirements and then ensure all EVV systems meet state-specified interface requirements to send data to the state's aggregator system. For 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.

### Understand Technological Capabilities

States should understand available technology solutions, determine what solutions may be most appropriate for the state, and identify the challenges that may be encountered using those solutions. As states make decisions about their EVV system, they will want to establish a list of requirements for how the technology collecting in-home visit information will be used. Some questions to consider:

- 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?

Louisiana uses the Global Positioning System (GPS) to verify the location of service delivery provided, which increases flexibility in where individuals can receive services. If an individual wants to receive services outside of his/her home, having the ability to add the location to the approved list of locations for that member allows for increased freedom and independence. Increased use of GPS may allow for services to be provided more flexibly.

New Mexico benefited from issuing tablets to providers with capabilities to store data for up to seven days. A large portion of the state is rural and has limited cellular coverage. Using tablets with the ability to store visit history allows a provider to deliver services over multiple days without uploading those visits to the EVV system frequently. Only once a week would the provider need internet connectivity to upload the visits and ensure they were appropriately documented. By overcoming this challenge, providers can focus on the delivery of services rather than spend extra time attempting to get a cellular signal or connect to the internet at each visit. Such batch reporting may not be necessary in more urban areas of a state.

### Solicit Stakeholder Input

Section 1903(l) also requires states to gather stakeholder input about EVV. Early communication from the state to its stakeholders helps to build an understanding and trust among all parties. Stakeholders that states should consider conducting outreach to include:

- Individuals and their families, including family caregivers and individuals with self-directed services, if applicable
- Organizations that represent the interests of individuals receiving PCS and HHCS
- Provider agencies and individual caregivers that provide PCS and/or HHCS
- Unions representing provider workforces
- State procurement/contract/legal departments that have been involved, or may be involved, in the EVV procurement process
- State Attorney General/Inspector General with knowledge of Medicaid programs, program integrity, and other issues that pertain to appropriate delivery of services and payments for those services
- State information technology vendors
- Other state agencies involved in the delivery of Medicaid services

- Other appropriate state vendors, such as state vendors that assist with IT work in the state or licensing entities.

States are encouraged to use a variety of methods to allow stakeholders to provide input. States should also provide notice of any legislative changes to all affected providers and families in multiple formats (e.g., designated websites, major newspapers, email, etc.). In preparation for EVV implementation in Ohio, the state convened stakeholder meetings with provider associations and beneficiaries, developed an online video about EVV and how EVV will impact providers, conducted individual calls to providers, and distributed a survey to providers seeking their EVV training preferences. It also organized compliance work stream meetings with its Medicaid Fraud Control Unit to develop EVV policies and procedures.

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

As states work to select their EVV model, it is important that the state department(s) that will be involved with operating the EVV program understand the expectations required by the different models in terms of skills and resources required for the planning, development, implementation, and ongoing operations of the EVV program. It is also important to understand what the state will do, versus what may be done through vendors. As highlighted in Table 2 below, the level of involvement and resources required of state staff will vary by EVV model.

The state should assess the staff capacity and resources it will need to implement a particular model, as well as how to address any mitigation strategy to compensate for lack of staff (e.g., through some combination of hiring, training and/or resource reallocation). This should involve a detailed assessment covering all aspects of EVV development, implementation, and operations, including what state staff can do themselves and what work they might outsource.

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.

Table 2: State Staff Involvement

Model	State Staff Functions
Provider Choice	<ul style="list-style-type: none"> <li>• Understanding of different EVV systems used in the provider community</li> <li>• Knowledge of how data will be integrated to ensure proper monitoring and compliance</li> <li>• Ensure providers’ EVV systems meet the state’s standards for implementing statutory Cures Act requirements.</li> <li>• Ability to monitor aggregated EVV system data</li> </ul>
MCP Choice	<ul style="list-style-type: none"> <li>• Knowledge of EVV vendor options</li> <li>• Be able to contact vendors and MCPs for issue resolution</li> <li>• Knowledge of how data will be integrated to ensure proper monitoring and compliance</li> <li>• Ability to monitor aggregated EVV system data</li> </ul>

Model	State Staff Functions
<b>State Mandated In-house System</b>	<ul style="list-style-type: none"> <li>• Management of the day-to-day operations of the EVV system (may also be provided through a vendor, subject to applicable procurement law)</li> <li>• Responsible for all training and education of individuals, providers, and stakeholders</li> <li>• Provide technical support for entire EVV system, including troubleshooting</li> </ul>
<b>State Mandated External Vendor</b>	<ul style="list-style-type: none"> <li>• Manage relationship with EVV vendor and determine how involved state staff will be with troubleshooting, training, monitoring, etc.</li> <li>• Ability to monitor aggregated EVV system data</li> </ul>
<b>Open Vendor Model</b>	<ul style="list-style-type: none"> <li>• Understanding of different EVV systems used in the provider community</li> <li>• Knowledge of how data will be integrated to ensure proper monitoring and compliance</li> <li>• Ensure providers' EVV systems meet the state's standards for implementing statutory Cures Act requirements.</li> <li>• Ability to monitor aggregated EVV system data</li> </ul>

### Roll Out EVV in Phases and/or Pilots (Timeline Permitting)

As long as doing so does not impede a state's ability to meet the implementation timeline requirements dictated in section 1903(l), implementing EVV in phases and conducting pilots prior to the state-wide roll-out of EVV promotes provider compliance and allows the state to identify and resolve issues on a smaller scale. South Carolina emphasized the importance of rolling out EVV in pilots prior to full implementation based on its experience with major systematic issues encountered when it rolled out its EVV. Conducting pilots or a phased rollout allows states to identify potential bugs and provider challenges encountered with the technology and training and education materials to ensure they are addressed before implementation.

### *Promising Practices for Training and Education*

Section 1903(l) requires states to ensure that individuals who provide PCS or HHCS are provided the opportunity for training on the use of the EVV system, and we encourage states to make this training available to other stakeholders. In particular, we strongly recommend that states make training available to beneficiaries receiving these services and their family members. Based on the experiences of states that have implemented EVV, there are a number of factors that states should consider when planning for EVV training of state staff, providers, and individuals and their families. These factors include the following:

- Inventory all entities / individuals that will be interacting with EVV
- Understand how training responsibilities vary by EVV model
- Establish a training plan
- Assess state staff 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

### Inventory All Entities / Individuals that will be Interacting with EVV

Regardless of the EVV model chosen, the state should conduct an inventory of all entities/individuals that will be using EVV and make sure that the state's training plan covers all applicable provider agencies and individual caregivers, as well as any other key stakeholders whom the state determines might benefit from the training, such as individuals receiving care (including, where applicable, their family members or guardians). 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. Strategies for ensuring providers and other stakeholders (such as beneficiaries and their families) are receiving training on the EVV system are discussed later in this section.

#### 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 training on use of the EVV system. The state mandated in-house system model will call for the most state involvement, while providers and MCPs might take on greater responsibility for providing technical training and education to provider staff on use of the system under the provider choice or MCP choice models.

In the case of a state mandated in-house system developed and maintained by the state, the state is responsible for developing and disseminating training and education on how to use the EVV system, whether that training is carried out by state staff or is contracted out to a third party and overseen by the state. In Maryland, state staff conducted in-person trainings throughout the state. In 2012, the state also recorded one of these trainings and distributed a DVD to providers who were unable to participate in the onsite training. As technology has progressed, Maryland now offers quarterly web-based training to current providers, monthly web-based training for new providers, and has a library of webinars that are available on demand through their website.

For training and education purposes, states with a single state mandated external vendor may contract with the EVV vendor to provide all necessary training and education on use of the system. Alternately, the state might rely on some combination of EVV vendors, MMIS contractors, provider enrollment agencies (i.e., an agency that recruits and enrolls direct service workers on behalf of the SMA). This could be a contracted entity or local non-state entity. For example, Ohio and its single EVV vendor plan to conduct monthly meetings to discuss areas of concern or updates with providers. In addition, Ohio will be using call center data and provider information to formulate training topics that may be of assistance to providers. The state's vendor also has a quality manager on-site to assist in providing additional training for providers who are struggling with EVV. In addition, Ohio will require providers to complete the EVV vendor's online training to get a provider ID/EVV login credential to use the system. To optimize provider participation, Ohio surveyed providers to assess training preferences and times to schedule trainings across the state, which helped to ensure that the vendors' trainings were appropriately tailored to Ohio's needs and preferences. In contrast, if providers or MCPs are choosing their own EVV vendor, each vendor would likely take on a significant role in training providers on technical aspects of using the system. Regardless of the model, the state should still develop training requirements so providers and individuals understand the requirements and systems in place for EVV.

States that contract with one EVV vendor should have the ability to review and approve all the vendor-provided communications. However, if a state does not mandate one vendor and decides to allow providers/MCPs to select their own EVV vendor, the vendor, MCP, or provider could provide technical training on use of the system to provider staff, within certain state defined parameters. For the MCP Choice model, the state may wish to use the MCP contract as the

vehicle for implementing the requirement to give providers an opportunity for training on use of the system, but the state should examine and approve the training materials, make recommendations, and (if needed) require changes based on state requirements. States could also require providers and MCPs to measurably demonstrate the effectiveness of their training.

States should consider whether EVV training will be mandatory or optional for each audience. In light of section 1903(l)'s directive that states 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. In follow-up interviews, Texas noted that making provider training mandatory could have improved the implementation of EVV. Connecticut indicated that it makes training mandatory for providers and strongly recommended this requirement as a good practice. Before a Connecticut provider receives access to the EVV system, (i.e., provider ID/EVV log-in credentials), two provider staff members must complete a 12-chapter web-based learning management system available on the state's public website at no cost. The provider log-in credentials are required to file claims and receive payment. Ohio has the same requirement.

### Establish a Training Plan

Training providers and other stakeholders on how to use an EVV system effectively takes significant time and effort. When an EVV program is being implemented, providers will have to balance continuing their current operations with learning how things will operate in the future. Other individuals requiring training will also balance competing priorities. This may make it difficult to get providers and other stakeholders to participate in trainings. States or their vendors should have a detailed strategy for how they engage and train providers and other stakeholders as early as possible. Some key training strategy considerations include identifying:

- Types of training materials suitable for state staff, providers, Medicaid participants, and family members
- Methods by which training may or may not be delivered
- Timing and frequency of training for various audiences – generally, training delivered more than 90 days in advance of implementation may lead to a need for retraining closer to the implementation date. Training delivered within 30 days of implementation could compete with the logistics of the overall implementation and may not give everyone enough lead time. 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; and
  - Within 30 days of go-live: Perform triage and critical updates/reminders
- Persons responsible for the development and delivery of training for various audiences
- Means of monitoring the effectiveness of training and ongoing processes by which training and education can be modified or improved
- Potential penalties for noncompliance with training expectations
- The state maintains ultimate responsibility for reviewing/approving training and ensuring that it is implemented.

Table 3 includes topics/content states should consider when developing a comprehensive training plan:

Table 3: Recommended Training Topics

Audience	Topics
<b>Providers</b>	<ul style="list-style-type: none"> <li>• EVV requirements</li> <li>• 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</li> <li>• 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;</li> <li>• Consequences for not using EVV system (e.g., penalties and sanctions)</li> <li>• Improvements in program integrity efforts</li> </ul>
<b>Individuals (receiving services)</b>	<ul style="list-style-type: none"> <li>• EVV requirements</li> <li>• Advantages of EVV (including the role of EVV in improving beneficiary management and improved oversight of their services)</li> <li>• 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.</li> </ul>
<b>State Staff</b>	<ul style="list-style-type: none"> <li>• EVV requirements</li> <li>• “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.</li> </ul>

By establishing specific requirements regarding how EVV vendors deliver training to providers and individuals, the state can have more confidence that everyone using the system has a necessary foundation of knowledge about EVV and each stakeholder’s responsibilities.

Assess State Staff Capacity for Developing and Delivering Training

The provision of effective and timely training and education materials for providers and other stakeholders is critical to the successful rollout of any EVV program. States may use several different resources to deliver training to providers and other stakeholders, including individuals who will/are receiving services, EVV vendors, provider enrollment agencies, State Medicaid Agencies, and MMIS contractors. Educating individuals receiving services and their family members may not require the significant systems training that is necessary for providers, but providing this education will make the delivery of services as simple and consistent as possible. .

States can use many different methods to provide education on EVV, including webinars, in-person trainings, email blasts, mailed educational materials, and dedicated EVV websites. Connecticut noted that during the initial implementation, the MMIS vendor staff provided in-person training to provider groups, but that might not be feasible in states that are geographically larger and/or have more providers. In these cases, the state may consider delivering training through webinars and online self-guided training.

Provide Training and Assistance on an Ongoing Basis

States should keep in mind that training needs will be ongoing, whether for providers, individuals, and family members new to the program, or for those providers and individuals having EVV compliance issues. In the follow-up interviews, Connecticut noted that after implementation, a bi-monthly newsletter was initiated to help providers navigate EVV by answering common questions and providing assistance with frequent issues. The state also

maintains a dedicated web page with EVV updates and an ongoing FAQ document. After implementation, South Carolina conducts training every quarter for providers and will do one-on-one training, if requested. In managed care states, MCPs should also be working with the state and the EVV vendors make training available to providers and other stakeholders on an ongoing basis.

States and/or EVV vendors should provide a resource list that directs providers and other stakeholders 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. Texas stated that the EVV vendors have responsibility to train/answer questions on their respective systems. The state trains provider agencies on other items, such as why EVV is required, how to apply relevant codes in the documentation, and what reports the state and MCPs review when examining provider agency compliance.

### Establish EVV Websites

States could establish a website to disseminate training and other information related to the EVV program. Connecticut, Louisiana, Maryland, Massachusetts and Texas all maintain EVV websites. Highlights of information provided on each site include:

- Connecticut: EVV bulletins for providers and individuals and their families about training, new EVV system features, FAQs, etc.<sup>4</sup> Connecticut's MMIS contractor also maintains an important messages webpage for providers.<sup>5</sup>
- Louisiana: EVV memos and updates for providers, details about the benefits of EVV for providers, and provider testimonials.<sup>6</sup>
- Maryland: Training information and webinar sessions for providers about EVV topics.<sup>7</sup>
- Massachusetts: EVV information for providers and individuals and their families, information about stakeholder data gathering meetings.<sup>8</sup>
- Texas: EVV information for providers and individuals and their families, including which providers must use EVV, EVV initiative service and billing codes, a description of how EVV works, how providers get started with EVV, contacts to call with questions, copies of EVV bulletins for individuals/members, and a news & alerts section with continually updated EVV information.<sup>9</sup>

### Use Multiple Approaches for Notifying and Training Individuals and their Families

While providers are most impacted by EVV because of the potential changes to their operating and billing processes, the individuals receiving services will also see changes in what happens during visits from service providers. CMS strongly recommends that states ensure that

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<sup>4</sup> <http://portal.ct.gov/dss/Health-And-Home-Care/Electronic-Visit-Verification/Electronic-Visit-Verification>

<sup>5</sup> [https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=EVV+IM+Update10.pdf&URI=Important\\_Message%2fEVV+IM+Update10.pdf](https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=EVV+IM+Update10.pdf&URI=Important_Message%2fEVV+IM+Update10.pdf)

<sup>6</sup> <http://dhh.louisiana.gov/index.cfm/subhome/40>

<sup>7</sup> <http://www.ltsstraining.org/>

<sup>8</sup> <http://www.mass.gov/eohhs/consumer/insurance/masshealth-member-info/pca/mytimesheet-electronic-visit-verification-evv.html>

<sup>9</sup> <https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/electronic-visit-verification>

beneficiaries receiving PCS and HHCS, and their families, are educated about MCP the changes that will take place with the implementation of EVV.

While an important goal of EVV is to help ensure that individuals receive more consistent, higher quality care, these changes may create some uncertainty for an individual who is used to things being done a certain way. Some of those changes may include:

- Check-in/out process – The service provider may be required to use the individual’s phone, a cellular phone, or tablet to document his/her arrival and departure time, particularly when the EVV system documents the providers location based on a land line.
- Devices installed in the home or provided to individual – Some EVV systems require a small random number generator (i.e., an electronic device that generates a code when a caregiver begins and ends their shift, which the caregiver then calls in to the EVV system) to be inconspicuously placed in the home. In addition, some states are providing tablets or devices to individuals that providers will use to document their visits.

Through the outreach and interview process, we identified a number of common methods states used to inform individuals and their families of the changes that will occur with EVV systems:

- Communications from case managers and/or state staff
- Mailings and educational materials, e.g., please see the letter to individuals from Connecticut<sup>10</sup>, Massachusetts<sup>11</sup>, and Texas<sup>12</sup>
- Leaflets in enrollment packets
- Interactive Voice Response (IVR) / “robo” calls, (CMS notes that these must be done in accordance with applicable Federal requirements)
- EVV websites

While websites and mailings can provide valuable information, the individual will likely better understand what EVV is and how it impacts their services from meeting with a case manager or service provider. The case manager and provider should be regularly seeing the individual and family and are typically the primary points of contact with the program through which services are being provided. States should encourage these staff to be prepared to explain EVV to individuals, not only during the implementation but on an ongoing basis.

Several of the interviewed states, including Maryland, South Carolina, and Texas, noted that individuals were sent an informational letter about EVV. These states also relied on case managers for assistance in explaining EVV. Texas indicated that additional materials on rights and responsibilities and the purpose of EVV are presented to individuals as they become eligible for services that require the use of EVV. By offering the information through two methods, the individual may receive the information by mail and have a follow up conversation with the case manager to ask any questions and get clarification on any potential issues. States may also

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<sup>10</sup> [http://portal.ct.gov/dss/Health-And-Home-Care/Electronic-Visit-Verification/Electronic-Visit-Verification \(PB16-44\)](http://portal.ct.gov/dss/Health-And-Home-Care/Electronic-Visit-Verification/Electronic-Visit-Verification(PB16-44))

<sup>11</sup> <http://www.mass.gov/eohhs/docs/masshealth/pca/evv-pca-consumer-letter.pdf>

<sup>12</sup> <https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/long-term-care/evv/LettertoIndividualsRequestingServices03022015.pdf>

consider implementing some type of process to verify that the individual has received the notification about EVV, such as requiring the return of a signed/dated form.

### *Promising Practices for Ongoing EVV Operations*

To ensure the successful operation of an EVV system, states should clearly outline expectations regarding monitoring. Who will monitor providers, and when and how providers will be monitored, is essential for all parties to understand so services are provided timely and accurately, and providers are appropriately compensated for services. South Carolina consistently monitors the delivery of services through EVV by validating the service type and hours against what was authorized for that time-period for each individual. In the event services exceed what is outlined in the individual's person-centered service plan, there may be a review of the service plan to determine if the increased services were appropriate and the individual needed those services.

Finally, states should allow for continuous provider involvement in decision-making. Particularly for states that established state mandated models, keeping providers involved and soliciting feedback, even after the EVV system has been implemented, will increase the likelihood of a successful operation. When concerns arise, it will benefit the state to be as proactive as possible in developing a resolution. Multiple states that participated in the outreach and/or interviews, including Texas, New Mexico, and South Carolina, described the positive results of engaging providers as early as possible and continuously throughout the program's evolution. Texas specifically 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.

### *Considerations for Self-Direction*

As states design their EVV systems, they should consider how self-directed programs that use PCS or HHCS will be affected. While the strategies discussed earlier in this bulletin are germane to self-direction, there are additional factors specific to these types of programs that states should consider. For example, it is recommended that states integrate with existing self-direction systems to avoid duplication and limit the burden on financial management service (FMS) entities and providers, provided the current systems meet section 1903(l) requirements. In addition, the EVV system should be flexible enough to accommodate PCS or HHCS service delivery locations with limited or no internet access, accommodate services at multiple locations for each individual, allow for multiple service delivery locations in a single visit, allow individuals to schedule their services with the provider, and avoid rigid scheduling rules (because self-directed services typically must respond to last-minute changes based on beneficiary needs).<sup>13</sup> States should consider allowing provider agencies to select the scheduling system (i.e., a platform that the provider uses to schedule appointments with the individual) or scheduling method that is most appropriate for their agency, because it may be difficult to preserve the flexibility inherent to self-directed programs if the provider has to use the scheduling system in a

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<sup>13</sup>Applied Self-Direction. "Electronic Visit Verification Tip Sheet for Self Direction Programs," (2017). Available online: <http://www.appliedselfdirection.com/resources/evv-implementation-tip-sheet-self-direction-programs>

state's mandated EVV system. In addition, if warranted by an individual's person-centered service plan, states may want to consider allowing the EVV system to notify the state when an individual who self-directs is not receiving services in the amount, duration, frequency and scope necessary to meet that individual's needs.

According to the results of our outreach, six states operating EVV also require EVV use for self-directed services. One of these states, South Carolina, uses its FMS vendor for their EVV solution. In addition, South Carolina provides training to self-directing individuals separate from the training provided to individuals receiving services under traditional models. Louisiana is planning a similar approach. As more states adopt EVV technology and utilize self-direction models, development of training programs specific to this model may be essential to the successful operation of EVV.

### **Next Steps**

We remind states that enhanced federal funding may be available for their EVV system per section 1903(1)(6) if the state's EVV system is operated by the state or by a contractor on behalf of the state. Federal funding at an enhanced FMAP rate may also be available for state aggregator systems that collate EVV data from multiple EVV vendors. To the extent that EVV is an automated data processing (ADP) system, the advanced planning document (APD) requirements under 45 CFR Part 95, Subpart F would apply.

Please contact your state's Regional Office MMIS Lead for more information regarding the process for claiming the enhanced federal match. Please also refer to the EVV Frequently Asked Questions document available at <https://www.medicaid.gov/medicaid/hcbs/index.html> for more information regarding federal funding availability and other provisions in section 12006 of the Cures Act. If you would like additional technical assistance regarding EVV implementation, please refer to the link above or email the CMS EVV mailbox at [evv@cms.hhs.gov](mailto:evv@cms.hhs.gov).