

Understanding the Electronic Visit Verification (EVV) National Mandate

On December 13, 2016, President Obama signed into law the 21st Century Cures Act. Section 12006 of the Act – “Electronic visit verification system required for personal care services and home health care services under Medicaid” – is a call for action.

This section directs states to require the use of an Electronic Visit Verification (EVV) system for Medicaid-funded personal and home health care services. The EVV system must verify the following:

- Date of service
- Location of service
- Individual providing service
- Type of service
- Individual receiving service
- Time the service begins and ends

States that do not have EVV requirements in place by January 1, 2019 for personal care services and January 1, 2023 for home health care services will face an escalating reduction in the federal medical assistance percentage (FMAP).

As states begin to consider how to comply with this mandate and to ensure no reduction in FMAP funding, it is imperative they understand the potential impacts on cost, provider networks, and most importantly, an individual’s ability to self-direct their services and the quality of those services.

We are pleased to provide this guide to share our expertise in the deployment of EVV, lessons learned from states with EVV requirements already in place, and key areas for states to consider as they evaluate this new requirement.

EVV Overview: What Is Electronic Visit Verification?

EVV verifies visit activity for in-home and in-community care services delivered and offers a measure of accountability to ensure that individuals receive the care and services they need and are authorized to receive.

At its most basic, EVV is a tool that can help safeguard that only verified home care visits are billed, supporting program integrity as well as quality and safety goals. Payers therefore often rely on EVV to target and reduce fraud, waste, and abuse.

Providers, meanwhile, may use EVV to manage and monitor the delivery of care and services, streamline paper-based transactions, and reduce duplication of effort in documenting services – even in the absence of a payer mandate.

This speaks to the evolution of EVV options as vendors add new functionalities to meet the growing needs of the home care community. Solutions today may range from simple, web-based timesheet capture to sophisticated telephony and mobile applications. For example, some EVV mobile applications use GPS-based location services to validate a caregiver visit against authorizations or plans of care, ensuring each individual is receiving services at the right location, as authorized.

As EVV technology grows, the role of EVV is expanding to deliver additional value to caregiver-consumer interactions – from identifying health-status changes at the point of care to electronically collecting consumer signatures to confirm the delivery of services. Special mobile devices can also be installed at the consumer’s home, with EVV and other applications preloaded to support additional program needs.

With such diverse functionalities and benefits available as well as significant variation in cost, states must carefully weigh their options before determining the EVV systems they will require.

System Models: Closed vs. Open Systems

The 21st Century Cures Act gives states a large degree of freedom with EVV, so long as minimum functionality requirements are met. Each state response may therefore be somewhat different.

For instance, some states have opted to mandate specific EVV vendors, which is known as a “closed model.” Other states may prefer to remain vendor-agnostic, which is known as an “open model.” It is important for states to understand the differences between these two models.

Closed Model

In a closed model, the state Medicaid program contracts with a single EVV vendor and mandates that all provider agencies use that vendor’s EVV system. The selected solution is implemented by the state, and the state maintains direct management and oversight of the entire program. Contracting is typically handled through an existing contractual relationship (e.g., MMIS vendor) or via a formal procurement process.

This model ensures technical and compliance standardization across providers. Providers that have not previously used an EVV system may gain important benefits, including the ability to improve back-office process efficiencies, eliminate many paper-based processes, and more tightly manage their remote workforce.

However, many states with closed-model systems have encountered significant delays and provider objections.

Providers primarily object to a closed model if they have already standardized their business processes around a specific technology solution that may even meet the EVV requirements. The provider now must invest in, manage, train, and support a new system that may not integrate well with their core business processes. This complicates their operations and workflows.

Closed systems are typically not built to interface with a provider’s existing scheduling and payroll systems. These providers must therefore work in two separate systems to accomplish what was previously managed through one system controlled by the provider.

A closed model may also include states that have moved to Managed Long-Term Services and Supports (MLTSS), in which an MCO selects and requires a specific system to be utilized by all providers. More problematic, if there are multiple MCOs in a state and each selects their own system, the provider network is placed in the untenable environment of using multiple solutions, depending on the MCO responsible for the member.

This would require every caregiver to know which system to use to manage the care, and caregivers would need to be trained on the use of multiple solutions. Further, such a model creates significant inefficiencies for providers trying to manage billing with multiple systems.

Another key objection to the closed model is that it constrains the free market. For these reasons, the closed model is falling out of favor in the industry.

Open Model

States opting for an open model allow providers and MCOs to choose a system that best suits their operation. In this model, states first establish their EVV technology and configuration requirements, rules, and policies. They then purchase an “aggregator system,” which is a vendor-agnostic system that takes in data from all EVV systems, applies standardized business rules to ensure visits are properly and consistently verified, and generates alerts when visit data does not conform to these standards. This allows the state to maintain comprehensive oversight of the entire program, regardless of EVV system used.

The open model results in true vendor neutrality and fully supports provider and MCO vendor choice – while still allowing states to set specific minimum technology standards. Further benefits of the open model/aggregator system include:

- Vendor-agnostic EVV programs that maintain accountability for the state
- Flexibility for providers to select the EVV vendor that works best for their business
- Ability for payers to manage a single, uniform source of EVV data and network rules management tools
- Opportunities for vendors to improve EVV systems based on evolving technology enhancements and market pressures
- Flexibility for states to keep up with technology changes and necessary innovations

EVV System Implementation: Keys to Success

Moving from a historically paper-driven system to an automated system within the Medicaid home care service industry brings many challenges for states. Developing implementation strategies with care and thought is therefore key to success for everyone involved.

Timeframe

As with new technology, the opportunities to capture new efficiencies encourages programs to adopt the new solution quickly. It is our experience, however, the adoption of sweeping change quickly can have an adverse effect on overall caregiver and consumer support for the new system.

The rapid adoption of a new solution often fails to account for the reality that a state may have hundreds of service providers – or more – that must become compliant. Providers may also need time to train Personal Care Aides (PCAs), particularly those who may be new to their roles (given high turnover rates in the industry) or those who may not be familiar or comfortable with technology. These challenges can make it especially difficult to adopt EVV technology on a quick timeline.

System Capabilities

State decision makers should carefully consider the level of precision they need from providers. Under the federal mandate, state-required EVV systems must – at a minimum – verify the date, type, and location of service; caregiver and recipient; and start and end time of service. However, some systems require so much detail that providers and employees are soon overwhelmed.

Under the federal mandate, EVV needs to verify date, type and location of service, provider and recipient of service, and start and end time of service. Until all providers and direct care employees have mastered these basics, mandating the capture of additional information or adding layers of sophistication should be undertaken cautiously.

Several system implementations have required providers to upload schedules into the EVV system with the exact times for each appointment. If the PCA arrives for the appointment even 10 minutes late, the visit is held up for reconciliation by the provider. Another system requires a case manager to intervene if the visit is performed by a PCA other than the one originally scheduled to provide the care. This level of required detail certainly did not exist in the pre-EVV paper-based environment. To require a rapid adoption of this level of detail immediately could compound provider and consumer frustration and slow down PCA adoption of the technology.

We therefore recommend that states begin by engaging a full range of stakeholders including providers, individuals and their families, health plans and other involved entities to collect input and/or feedback before implementing any new systems or enhancements. States should begin with the basics and plan to enhance the system capabilities over time. Until all providers and direct care employees have mastered these basics, mandating the capture of additional information or adding more layers of sophistication should be undertaken cautiously.

Reporting

A key benefit of EVV technology is it allows for exception-based reporting of important metrics. Instead of requiring an exhaustive list of metrics needed to approve every visit, our collective experience suggests it is better to present some metric reporting on a trended basis and not require every metric for visit approval.

A few basic performance metrics that can be reported after the delivery of care and services include:

- Total number of visits
- Visits with a change in staff
- Visits starting late
- Visits exceeding expected duration of authorized care
- Missed visits

Eliminating Redundancies

As previously noted, closed-model EVV implementations to date have not gone smoothly. In large part, this is because the closed model requires providers to redefine or, worse, duplicate processes necessary to manage their business.

For instance, too many EVV implementations require collection of a signed paper documenting the time-in and time-out from the client as well as the capture of this same data in an EVV system.

There should only be one source of truth for visit documentation; the technology should either be trusted or not. Eliminating the paper requirement creates a built-in incentive for both providers and PCAs to adopt an EVV system. However, the ongoing requirement to submit paper timesheets lowers PCA use of the technology. After all, if they turn in a signed document, they are required under Department of Labor regulations to be paid, regardless of their compliance with the EVV system.

EVV Mandate Funding: State-Directed Programs

The 21st Century Cures Act provides funding to states to meet the EVV mandate. Specifically, the Act states: (6) (A) In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

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

Under both open and closed system models, states pay 10% of costs, while the federal government 90% match includes purchasing and implementation, program management, and provider monitoring. States also qualify for an enhanced match of 75% for ongoing program operational costs.

EVV in Self-Directed Programs

There are unique factors in implementing EVV within self-directed programs that require some enhancements or alternative solutions for implementation. And yet, we believe the benefits to the state and recipients of care are as evident in self-directed care as in traditional agency care.

As an example, although capturing the location where services start is an important component of any EVV system, in a self-directed program, these services may not be required to initiate from the recipient's home. The EVV system, therefore, should be enhanced to allow for flexibility in scheduling at the care recipient's direction, even last-minute flexibility based on the individual's desire, and for providing the recipient the means to approve worker hours as needed.

With enhancements such as these, EVV will not limit the participant's control over their own budget expenditures. The use of EVV should facilitate efficiency for care recipients, caregivers, and state program administration, as well as ensure an appropriate level of accountability that is necessary in any taxpayer-funded program.

Conclusion

The Partnership for Medicaid Home-Based Care strongly encourages states to adopt open systems to meet the EVV requirements of the 21st Century Cures Act. Factors to consider include concerns about fraud, waste, and abuse; impacts to providers; the role states expect MCOs to play in the oversight and management of EVV with their network providers; system flexibility to meet scheduling/location of services needed by individuals; and solutions for addressing any infrastructure or technological limitations, such as those that may exist in rural areas.

We believe that the open model is the right choice for states, providers and consumers, on every point of comparison:

- Compliance, as measured by rate of adoption of the mandated EVV technology
- Cost to the state to implement an EVV program (assumes enhanced federal match of 90%)
- Business burden, including the time and effort the state and providers must expend to implement and manage the program
- Outcomes, including the savings the state expects to recoup based on impacts to fraud, waste, and abuse

**For more information, please contact us at (202) 827-6494
or visit our EVV help site at medicaidpartners.org**

Partnership for Medicaid Home-Based Care Members

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