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Section 12006 of the 21st Century CURES Act Electronic Visit Verification Systems

Requirements, Implementation, Considerations, and Preliminary State Survey Results

Disabled and Elderly Health Programs Group

Center for Medicaid and CHIP Services

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Overview

This session is split into two parts.

- **Part 1 – 21st Century CURES Act Provisions under Section 12006**
  - Discuss the 21st Century CURES Act (the Act) 114 U.S.C. 255 (enacted December 13, 2016) requirements in detail.
  - Define authorities and services impacted by the Act.
  - Explain Electronic Visit Verification System (EVV) requirements under the Act.
- **Part 2 – Current State of EVV**
  - Provide current status of EVV.
  - Highlight CMS' current efforts to assist states.
  - Review preliminary results of EVV survey performed in partnership with National Association of Medicaid Directors (NAMD).

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Training Objectives

- Provide an overview of EVV requirements for Personal Care Services (PCS) and Home Health Care Services (HHCS) in section 12006 of the Act.
- Explain the benefits of implementing EVV.
- Discuss different models states can implement to fulfill EVV requirements.
- Introduce CMS' plans for assisting states with meeting the Act's requirements and share preliminary findings from the recently-completed NAMD EVV survey.

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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 Act.

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Overview of the 21st Century CURES Act

Part 1:

21st Century CURES Act Provisions Under Section 12006[1]

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Overview of the 21st Century CURES Act

What is it?

- The 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 Act apply to HCBS programs?

- Section 12006 of the Act requires states to implement an EVV system for PCS and HHCS.

How does this Impact States?

- All state Medicaid PCS and HHCS are required to comply with the Act's requirements by:
  - **PCS:** January 1, 2019
  - **HHCS:** January 1, 2023

Section 12006 of the Act Part (a)

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

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

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

(A) in the case of personal care services –

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

Section 12006 of the Act Part (a) - Continued

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

(i) for calendar quarters in 2023 and 2024, by 0.25 percentage points;

(ii) for calendar quarters in 2025, by 0.5 percentage points;

(iii) for calendar quarters in 2026, by 0.75 percentage points; and

(iv) for calendar quarters in 2027 and each year thereafter, by 1 percentage point.

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

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

(i)is minimally burdensome;

(ii)takes into account existing best practices and electronic visit verification systems in use in the state; and

(iii)is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act);

Section 12006 of the Act Part (a) - Continued

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

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

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

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

(i) in the case of personal care services, for calendar quarters in 2019; and

(ii) in the case of home health care services, for calendar quarters in 2023.

Section 12006 of the Act Part (a) - Continued

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

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

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

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

(i) the type of service performed;

(ii) the individual receiving the service;

(iii) the date of the service;

(iv) the location of service delivery;

(v) the individual providing the service; and

(vi) the time the service begins and ends.

Section 12006 of the Act Part (a) - Continued

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

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

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

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

Section 12006 of the Act Part (b)

(b) Collection and Dissemination of Best Practices – Not later than January 1, 2018, the Secretary of Health and Human Services shall, with respect to electronic visit verification systems (as defined in subsection (1)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), collect and disseminate best practices to State Medicaid Directors with respect to:

(1)training individuals who furnish personal care services, home health care services, or both under the State plan under title XIX of such Act (or under a waiver of the plan) on such systems and the operation of such systems and the prevention of fraud with respect to the provision of personal care services or home health care services (as defined in such subsection (1)(5)); and

(2)the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of such electronic visit verification systems and other means to prevent such fraud.

Overview of the 21st Century CURES Act

Understanding the Act

Penalties for Non-Compliance with Section 12006 of the Act

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

- 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]

PCS & HHCS FMAP Reductions per

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%

EVV Requirements per Section 12006 of the 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 Act

Flexibility for States

- Allows states to select their EVV design and implement quality control measures of their choosing.

Stakeholder Input Required

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

EVV Requirements per Section 12006 of the Act

Other Requirements for EVV systems:

- "Minimally burdensome".
- HIPAA-compliant.

In Addition:

- States must consider best practices.

Implementing an EVV system does <u>not</u>:

- Limit "the services provided or provider selection" or "constrain individuals' choice of caregiver, or impede the way care is delivered."
- Establish employer-employee contracts with the entity that provides PCS or HHCS.

Exceptions for Non-Compliance per Section 12006 of the Act

- Per Section 12006(a)(4)(B) of the 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.

Available Federal Support for States

- If the 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 Act

Applicable Medicaid Authorities for PCS:

- 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

Applicable Medicaid Authorities for HHCS:

- HHCS provided under section 1905(a)(7) of the Social Security Act or under a waiver of the plan.

What are Personal Care Services?

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 non-medical services supporting Activities of Daily Living (ADL), such as movement, bathing, dressing, toileting, transferring, and personal hygiene.
- Depending on the Medicaid authority, states can also include PCS for the following:
  - Instrumental Activities of Daily Living (IADL), such as meal preparation, money management, shopping, telephone use, etc.
  - Intermittent (i.e., less than 24/7 coverage) residential habilitation services that encompass services delineated under personal care.

What are Home Health Care Services?

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.

Benefits of EVV

Improves program efficiencies by:

- Eliminating the need of paper documents to verify services.
- Enhancing efficiency and transparency of services provided to individuals through quick electronic billing.
- Supporting individuals using self-direction services and facilitates 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.
- Potentially including individuals' and family's service satisfaction surveys to collect additional quality data.

Benefits of EVV – Continued

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

- The DHHS Office of the Inspector General (OIG) identified Medicaid PCS and HHCS billings as an ongoing issue to monitor, but has recognized EVV as a "positive step towards safeguarding beneficiaries."[3,4]
- 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.
  - EVV should be included in Appendix I-2-d of states' HCBS waiver application as a billing validation test for financial accountability assurance.
  - For more information on billing validation, refer to Ensuring the Integrity of HCBS Payments: Billing Validation Methods.

Considerations for Self-Directed Services

Flexibility

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 beneficiary needs.
- Allow individuals to schedule their services between the individual and the provider.[5]

Considerations for States with Self-Directed Services

Accessibility

The EVV system should:

- Accommodate services at multiple approved locations for each individual (e.g., not only at home but near home or at son/daughter's home).
- Allow for multiple service delivery locations in a single visit.

Stakeholder Participation

- Include key stakeholders in the conversation, when states determine EVV strategies for self-direction and agency directed services.[5]

EVV Design Models

Part 2 – Current State of EVV

EVV Design Models

- EVV design models vary mostly by state involvement of vendor selection and EVV system management.
- Our research has identified five EVV design models:
  1. Provider Choice
  2. Managed Care Organization (MCO) Choice
  3. State Mandated External Vendor
  4. State Mandated In-house System
  5. Open Vendor[6]
- 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).[7]

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.

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 Example

- Allowed providers to choose a system that suits them best.
- The state set a series of requirements for acceptable EVV systems such as:
  - Requiring GPS for mobile device or a telephone/electronic device attached to the individual's home.
  - Requiring that EVV system billing reports document:
    - Types of services provided;
    - Date and time services were provided;
    - Manual modifications or adjustments, such as modifying the times of the visit.[7]

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 Example – Continued

- EVV systems were required to include the following:
  - Identity of the individual receiving care and the caregiver;
  - Exact date and time services were given;
  - Type of service provided;
  - Allow for changes in care plan approved by the Medicaid Agency;
  - Produce reports from data entered; and
  - Capability to backup and archive data.[7]

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.
- Providers with no existing EVV system may benefit from documentation efficiencies at no maintenance cost to them.

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 – Continued

Considerations

- States carry more responsibility when choosing and contracting with a single EVV vendor. These include:
  - Identifying and establishing minimum EVV requirements for the EVV vendor.
  - Procuring and selecting a vendor.
  - Managing and monitoring the vendor.
- States must also provide training on the system.
- Providers and MCOs may already have an existing EVV 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.

3. State Mandated External Vendor Model Example

Overview

- State Medicaid Agency (SMA) contracted with an EVV vendor and required
providers to use the vendor's EVV system.

Grace Period

- Providers with existing EVV vendor contracts were allowed a grace period for the termination of those contracts.
  - For example, if the state implements a rule in August 2017 but a provider has an existing contract with another EVV vendor that expires December 31, 2017, then the grace period would last from August 2017 through December 31, 2017.
- Providers with existing EVV contracts were encouraged to use this grace period to train staff.[8]

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 Example - Continued

Training Efforts

- The following trainings were provided by the state to providers:
  - EVV Provider Compliance Training – overview of state's requirements
  - Vendor Software Training – how to operate the EVV system

State's Monitoring Efforts

- The state performed compliance monitoring on providers every quarter for at least 90 percent compliance.
  - Providers who failed to comply were subject to "the assessment of liquidated damages, the imposition of contract actions, and/or the corrective action plan process."
- Dates for monitoring were randomly assigned and spread out over the year to account for review efficiency and accuracy for the state. [8]

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.
- States can hire a contractor/vendor(s) to assist in building its customized 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.

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 – Continued

Considerations

- States choosing this option have greater responsibilities as they design and implement their own system. Some of the responsibilities include:
  - System selection;
  - Timeline and methods of implementation;
  - System testing and stakeholder feedback;
  - Integration of existing systems used by providers, such as MCOs' own EVV system.
  - Maintenance and on-going monitoring of system; and
  - Additional staff hiring to provide training and technical assistance.
  - After successful implementation, states can benefit from a fully customized system that meets the states' unique needs.
- Individuals, families, and providers must be trained on and comfortable with the 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.

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.
- 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.
- The state-contracted vendor/in-house system serves as the default system for the state.

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 – Continued

Considerations

- Encourages provider and MCO choice.
  - Providers and MCOs can implement their own EVV system suitable to individuals, families, and provider's own operational needs.
  - States can also offer providers and MCOs the option of using the states' own system.
- States may provide a list of EVV requirements that any system must satisfy and/or list of preferred EVV 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.

Survey Overview

Preliminary 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 regarding EVV implementation.
- The survey elicited the following information on states' progress in implementing EVV:
  - EVV vendors states currently use or plan to use;
  - Policies and procedures related to EVV;
  - Education and training for individuals, families, providers, and state staff regarding effective use of EVV;
  - Technical assistance offered to individuals, families, and providers;
  - State's oversight methods; and
  - Lessons learned and best practices identified during implementation process.

Survey Overview – Continued

Survey responses will:

- Allow NAMD and CMS to share best practices and lessons learned as states go through EVV development and implementation.
- Inform the provision of potential education, training activities, and technical assistance.

States that completed the survey will be better prepared to meet the Act's requirements and avoid potential FMAP penalties.

Survey Overview – Continued

Methodology

- Preliminary survey results are based on complete state survey submissions received between Monday, July 17, 2017 and Monday, August 7, 2017.
- Data represents survey submissions from 32 states, including one territory and the District of Columbia.
- Five states submitted duplicated submissions. Responses were only counted once for these states.

Preliminary Survey Findings

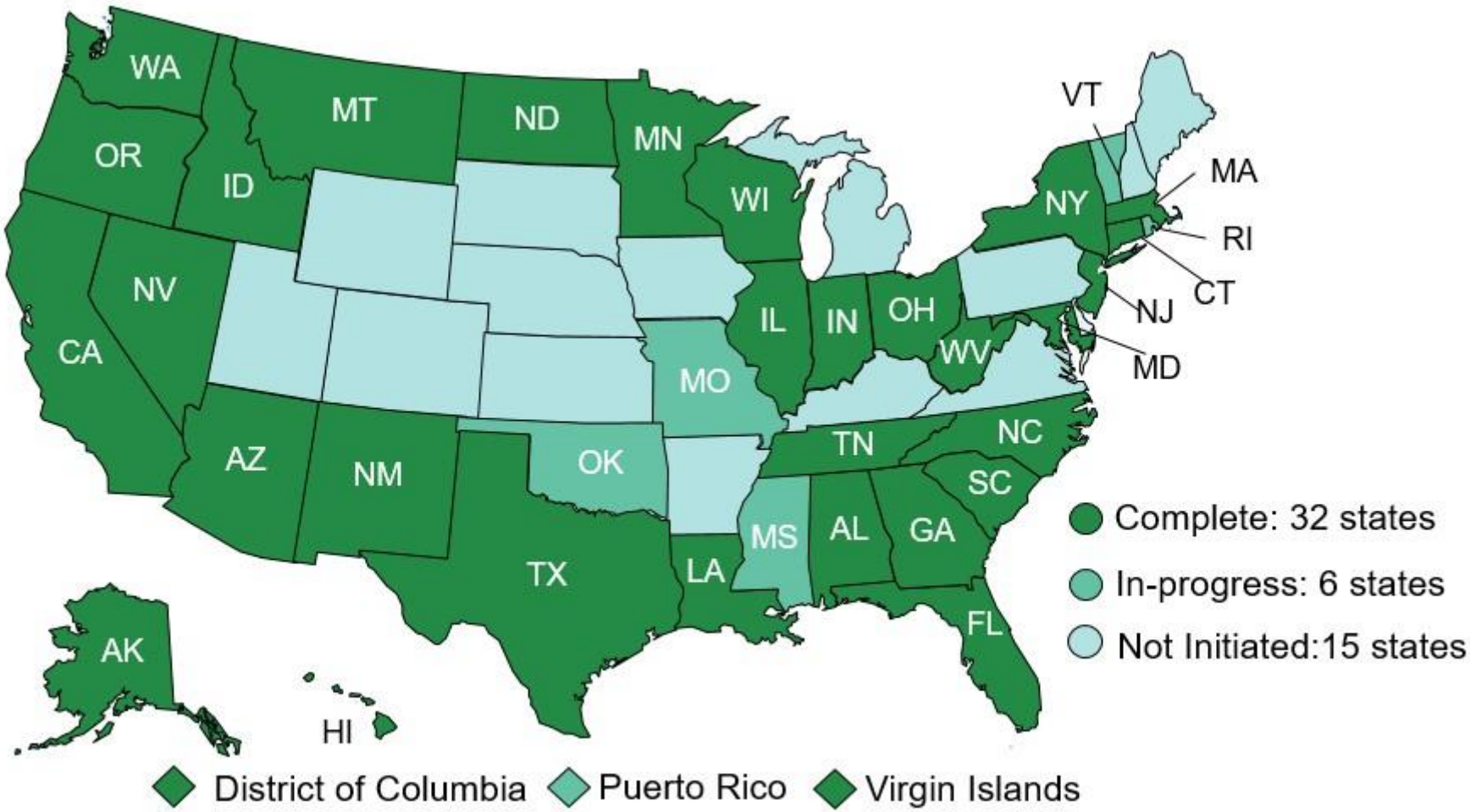
Survey Completion Status By State

EVV Survey Status

- **Complete**: The respondent has completed the demographic section of the survey and provided valid responses to most if not all questions related to the status of the state's EVV.
- **In-progress**: The respondent started the EVV survey but has not yet submitted the survey.
- **Not Initiated**: The respondent has not started the survey.

Preliminary Survey Findings as of August 7, 2017

Survey Completion Status By State

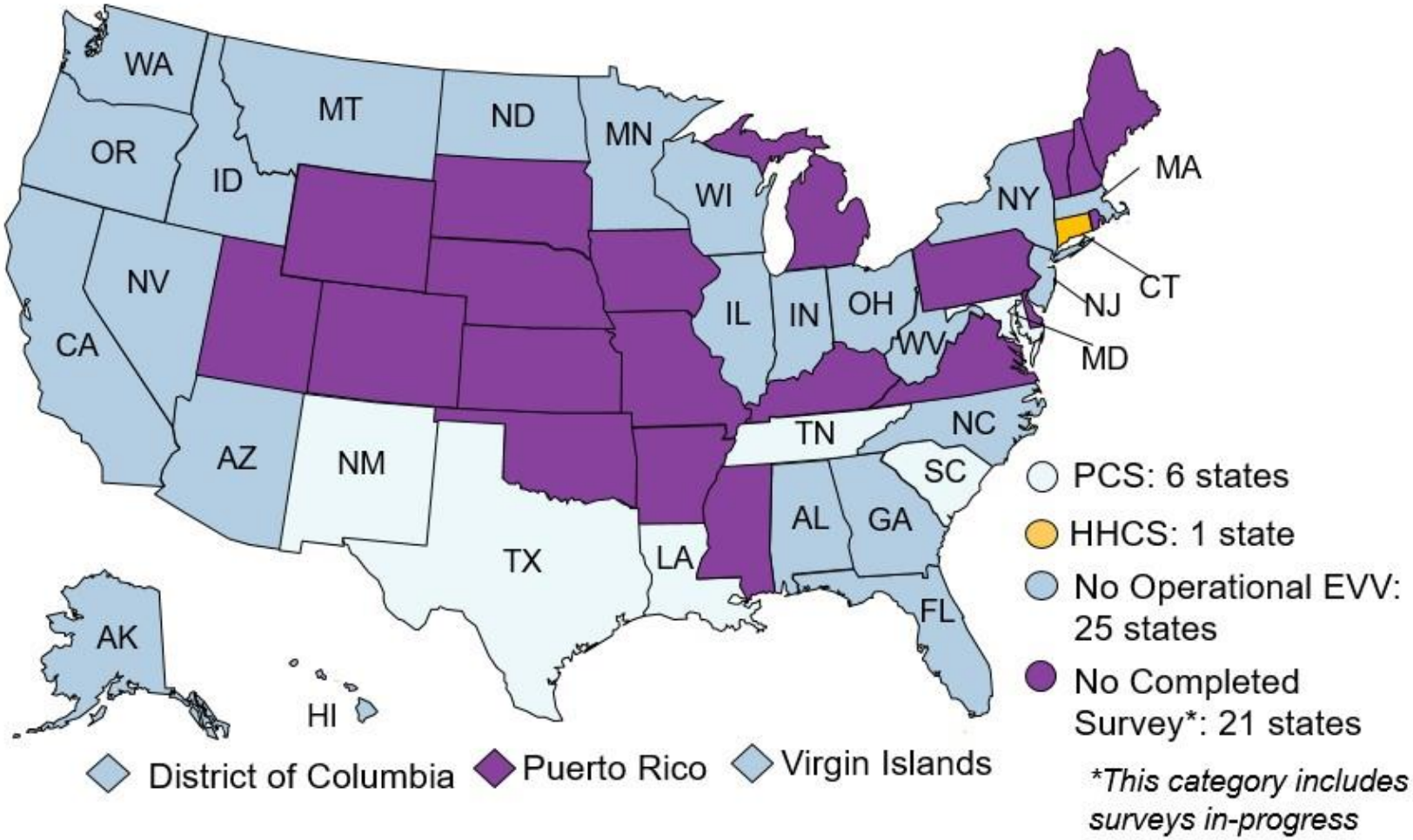


Note: Preliminary survey results are based on complete state survey submissions received between July 17 – August 7, 2017.

Preliminary Survey Findings as of August 7, 2017

States Currently Operating EVV

States Currently Operating EVV



Preliminary Survey Findings as of August 7, 2017

States Currently Operating EVV – Implementation Date

- Of the seven states reporting an operational EVV for PCS or HHCS, six provided their EVV implementation date.

EVV Date of Implementation

Implementation Date	PCS	HHCS
Prior to 2016	4	0
2016	1	0
2017	1	1

Note: Preliminary survey results are based on complete state survey submissions received between July 17 – August 7, 2017.

Preliminary Survey Findings as of August 7, 2017
States Currently Operating EVV – Model Type

- All seven states reporting an operational EVV for PCS or HHCS identified the EVV Model they are using.

EVV Model Type

Model Type	PCS	HHCS
Provider Choice	1	0
MCO Choice	2	0
State Mandated In-House	0	0
State Mandated External Vendor	1	1
Open Vendor	1	0
Other	1	0

Note: Preliminary survey results are based on complete state survey submissions received between July 17 – August 7, 2017.

Preliminary Survey Findings as of August 7, 2017
Status of Future EVV Implementation

- States reported the following information regarding their EVV implementation status:

Implementation Status

Implementation Status	PCS	HHCS
Planning	17	19
Procurement	0	0
Final Phase	3	2
Completed	4	1
Delayed	1	0
Other	4	1
None	3	6
No Response	0	3

- Reason cited for delay is "Contract negotiations."
- Other comments regarding implementation status included:
  - State issued a Request for Information (RFI) for EVV Systems.
  - Contract under development with vendor.
  - Information has been released to the provider community.

Note: Preliminary survey results are based on complete state survey submissions received between July 17 – August 7, 2017.

Preliminary Survey Findings as of August 7, 2017
Status of Future EVV Implementation

- Approximately half the states without an operational EVV for PCS and/or HHCS indicated plans to implement EVV in the near future.
  - 15 out of 32 states that reported not having operational EVV for PCS and/or HHCS indicated an anticipated operational date by 2023.
    - 6 states provided an operational date by 2019 for PCS and 2023 for HHCS.
    - 6 states anticipated operation date by 2019 for PCS.
    - 3 states reported anticipated operational date by 2023 for HHCS.

Note: Preliminary survey results are based on complete state survey submissions received between July 17 – August 7, 2017.

Preliminary Survey Findings as of August 7, 2017
Enhanced FMAP Requests for EVV Implementation

- Of 25 states that have yet to implement EVV, the majority reported plans to apply for enhanced FMAP.
  - 20 indicated that they will apply for an enhanced FMAP for both PCS and HHCS.
- However, only 10 states have completed an Advanced Planning Document (APD) to start the process to obtain the enhanced FMAP.
  - 7 indicated that they have completed an APD for PCS.
  - 13 indicated that they have *not* completed an APD for PCS.
  - 3 indicated they have completed an APD for HHCS.
  - 17 indicated that they have *not* completed an APD for PCS.

Note: Preliminary survey results are based on complete state survey submissions received between July 17 – August 7, 2017.

Helpful Tips for States Considering EVV

- The survey can help states identify and organize ongoing EVV activities to reach a comprehensive understanding of EVV in your state.
- Leverage the APD process.
- Examine every state plan and waiver authority covered under statute.
- Crosswalk your state's service definitions to the definitions in the Cures Act.
- More information will be forthcoming. Look closely for the guidance that will be provided around January 2018.

Summary

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

- The 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 strengthens states' HCBS waiver applications (appendix I-2-d) as a mechanism of 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 increase accuracy and quality of PCS and HHCS provided.
- EVV also increases efficiency through quick electronic billing incorporated into the system immediately after entry.

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.
- CMS is currently working with NAMD and contractors to determine best practices for meeting section 12006 of The Act.

References

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6. 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

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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

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