ELECTRONIC VISIT VERIFICATION (EVV)

SUMMARY

Over the last few weeks, there has been a lot of 'buzz' around the implementation of the Electronic Visit Verification (EVV) system and what this will mean for TPA members. While we can't forecast the future, what we can do is simplify what you need to know about the EVV to begin preparing to respond and work with ODP to advocate for what's best for the organization and persons served.

BACKGROUND

- ★ EVV as a concept dates back to 1996; originally invented for home health services by Michelle Boasten, the concept made its way to CMS in 1999 when Thomas Hoyer, policy maker for post-acute services, learned about the solution and developed a national vision for EVV to 'bring accountability to the industry'.

- ★ In 2016, this vision was codified into law under the ***CURES Act***. Originally passed as part of the Affordable Care Act, this law was designed to help accelerate medical product development and bring new innovations, advances, and accountability to the US Healthcare system in an effort to achieve the triple aim (better care, healthier people, and lower costs). While the bill addressed a range of issues including the opioid epidemic and the FDA drug approval process, the bill established legal requirements and penalties for provider implementation of the EVV.

- ★ While EVV is focused on accountability, one of the key challenges of the policy is that it doesn't replace Medical Record documentation. While it is designed to collect date, time, location, individual receiving the service, individual providing the service, and service – the provider is still required to complete documentation to substantiate the claim for payment.

COMPLIANCE MANDATE

Section 12006 of the bill imposes a reduction in the Federal Medicaid Assistance Percentage (FMAP) for states that do not implement an EVV solution for personal and/or home health care services that require an in-home visit and are paid for using state-plan Medicaid funds or Medicaid waiver funds - and the penalty increases over time. There are two compliance deadlines:

January 2019: EVV must be used for personal care services
January 2023: EVV must be used for Home Health Services

The bill further modifies Section 1903 of the Social Security Act:

"...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…by a 0.25% each year of noncompliance up to 1% by 2023."

WHAT YOU NEED TO KNOW

- ★ This funding match applies only to state-provided EVV systems. States take on financial risks when they do not implement EVV in accordance with the Cures Act.

- ★ The law further indicates that if states have made a "good-faith effort" to fully implement the system, they can have a grace period if it is not in place by 2019 or if the implementation process encountered "unavoidable system delays." Though CMS is still working to clarify how they define a "good-faith effort" and "unavoidable delays", this is important as we work with ODP on a solution.

- ★ On Dec. 13, 2017, ***CMS clarified that any home and community-based service provided through a Medicaid waiver would need to meet the EVV requirement if the service included any assistance in activities of daily living or instrumental activities of daily living***. ODP must work carefully now with CMS and Providers to analyze which home and community based services will meet the 'personal care service' definition to comply with the EVV requirement by Jan. 1, 2019 and which do not.

- ★ Several states have been early adopters and give us insight on what the user experience will look like and how best to advocate for the least disruptive implementation. The solutions include a wide range of options; including mobile apps and websites tied to a database with the ability to use the direct support worker's or service recipient's device to telephonic-visit verification when smart phones and internet access are not available and an offline option, which involves a device in the person served home that generates an in/out code the direct support worker enters when connectivity is available.

LESSONS LEARNED FROM EARLY ADOPTER STATES

- ★ **CONNECTICUT:** The state opted for single vendor system. Direct support workers use a smart phone application on the worker's phone to process the EVV. During the EVV implementation, Connecticut found providers needed to hire temporary staff to help with the administrative burden of the electronic visit verification. In response to the unexpected administrative burden on providers, Connecticut has made several costly system modifications to give additional features to providers, such as scheduling and claim submission. Connecticut representatives recommend that ***states make every attempt to use service recipient or worker phones for verification since the alternate device is much more difficult to manage***.

- ★ **OHIO:** The state implemented a hybrid model (e.g. offering a selected state vendor BUT giving providers the option to select a vendor that meet the states requirements. Each person served uses a mobile visit verification device (which is essentially a smart phone with no street value that is distributed by the state with a state data plan on the device). The state framed the EVV as a quality of care initiative rather than cost savings and fraud reduction initiative during the course of the implementation. Ohio representatives reported learning that the burden on providers was largely around hiring staff to determine when there are errors and how to correct them. Ohio representatives recommended that ***states focus on addressing service recipient concerns and the spread of misinformation related to privacy and location tracking early in the implementation***.

- ★ **TEXAS:** Similar to Ohio, also adopted a hybrid model. Texas selected (5) vendors from which a provider could choose. Most verification is done using a home landline. If that is not feasible, a small alternative device is installed in the person served home. State representatives report that the devices have been problematic, and, currently, at least 3,000 devices require repair each week (which is unsustainable). Texas representatives recommend other ***states spend time upfront working out technical issues related to data integrity***. Further, they recommended appropriate timelines for implementation be reasonable to ensure the state can properly address technical challenges.

The common lesson learned among all three states is that ***ongoing stakeholder input is absolutely critical***.

EVV ADVOCACY TIPS FOR TPA MEMBERS

- Based on recommendations from early adopter states, persons served and direct support workers expressed concern about having to learn and use multiple systems under a hybrid or provider choice model. This is a key consideration as our members work with the state in selecting solutions; many early adopter states indicate a statewide system is easier to navigate and this helps with trouble shooting and assuring accessibility.

- Based on the experience of early adopter states, persons served and their families expressed concerns about the requirement that the location of services be electronically verified. TPA members should work with the state to select a solution that assures that HIPAA data privacy requirements would be maintained in the EVV system and that location would not be tracked for any other purpose than for verification of services. The EVV system should be accessible wherever services are provided (since personal care services can be provided at home or wherever normal life activities take an individual) and we believe TPA members should advocate for a state solution that includes 24/7 technical support with simple instructions and easy-to-use interfaces and processes that allow for persons served and their families to see and verify data before it is sent to the state for processing.

- To minimize the provider burden, TPA members should have the ability to correct mistakes in EVV transactions.

- Implementation of an EVV will inevitably have some cost implications for TPA members. It's important to advocate that such costs be minimized and be offset with benefits. If providers need staff to support or maintain the system, any added expense by TPA members must be reflected in rates for reimbursement. EVV as a system cannot be an unfunded mandate in Pennsylvania!

- TPA is committed to working with ODP in support of selection of a solution to help them understand requirements that are not burdensome to large providers may be burdensome to some of our smaller provider members. ODP should not adopt a system that requires providers to add additional staff and offer a system that is available in multiple languages. The system should have an offline option for entering visit data and assure that it's easy to train and use to avoid further exacerbating the workforce crisis with direct service workers (e.g. driving direct support workers out of the workforce and worsen the current worker shortage).

- TPA members should advocate for a system that is flexible in order to schedule services and accommodate multiple caregiving scenarios (e.g. direct support workers who live with individuals or shared care with one worker caring for multiple people at the same location)

- TPA members should advocate for a system that is both accessible to individuals and their families to help maintain a person-centered approach and the system should seamlessly interface with current electronic medical record (EMR) systems.