To: ANCOR Members

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Re: Implementation of Electronic Visit Verification (EVV)

On December 13, 2016, the 21st Century Cures Act (P.L. 114-255) was signed into law, providing new funding and needed reforms for many health-related programs. In addition, the law included requirements for Electronic Visit Verification (EVV) for personal care services and home health services under Medicaid. Read more from ANCOR about the passage of EVV here.

States must implement EVV for personal care services by January 1, 2019 and for home health services by January 1, 2023. States that are not in compliance with EVV requirements by these dates will be penalized with a reduction in their Federal Medical Assistance Percentage (FMAP). Find more EVV implementation resources from Applied Self Direction here.

Although coverage of the statute remains at issue as discussed further in this memo, CMS officials have indicated to ANCOR that they intend to apply impending guidance for EVV requirements to an array of I/DD home and community-based services, thus impacting most ANCOR members. Please review the "key issues" portion of this memo for further details about the scope of the statute and pending guidance.

The purpose of this memo is to better understand the status of state implementation, responses from officials at the Centers for Medicare and Medicaid Services (CMS), the key issues at this point and ANCOR's advocacy and engagement strategy.

State Implementation:

In discussions with ANCOR members and national colleagues, it seems that state implementation of EVV requirements continues to be uneven and somewhat rocky. In a February 12, 2018 letter to Sen. Patty

Murray (D-WA), the State of Washington Department of Social and Health Services outlined many concerns frequently cited by state officials, including:

- Short timeline for implementation
- Cost of implementation
- Lack of CMS guidance or regulation
- Signals in discussions with CMS that the regulation may be interpreted more broadly than intended

Furthermore, from a recent call with State Association Executives (SAE), ANCOR learned that states are still divided as to how or if EVV regulations apply to I/DD services.

CMS Response To Date:

CMS direction on EVV implementation has been minimal thus far and states are awaiting guidance that, under the statute, was to be released by CMS in January of this year. At this time, CMS has issued no formal guidance to states and asserts that it does not have time for the official rulemaking process. Instead, CMS plans to release sub-regulatory guidance in a State Medicaid Director Letter and Frequently Asked Questions document. Neither of these communications provide opportunity for public comment from stakeholders.

Officials at CMS held two webinars in December 2017 and one question & answer call in January 2018 for state officials on EVV implementation. States have also been provided with copies of the following PowerPoint presentations: December 2017 presentation and January 2018 presentation.

Prior to the dissemination of these presentations, ANCOR convened a work group of our members on best practices for implementation. That work group provided feedback to CMS two different times focused on issues including stakeholder input, system design, cost, and training (see the end of this memo for that input)

Key Issues:

The current challenges with EVV implementation are focused on CMS' interpretation of the statute and its application to I/DD services in addition to the logistics of implementing an EVV system in the given timeframe.

- **CMS's interpretation of the EVV statute seems to be overly broad in scope.** In the 21st Century Cures Act, EVV was developed to prevent fraudulent billing for services delivered in consumers' homes. However, ANCOR, states and providers alike are hearing from CMS that EVV may apply to settings other than in-home settings and that I/DD services may be significantly impacted. While colleagues at the National Association of State Directors of Developmental Disability

Services (NASDDDS) have indicated that EVV does not apply to day services, CMS has not confirmed this understanding.

  - There is evidence that the legislative intent of the EVV section of the 21st Century Cures Act was strictly intended to cover personal care and home health services provided to individuals in their homes and not extended to broader HCBS services.
    - Congressman Guthrie (R-KY) initially introduced the EVV legislation and stated at a November 3, 2015 markup that the goal was to protect "seniors and the integrity of Medicaid." Further on the next day of that markup he indicated that the intent was to protect Medicaid recipients that were explicitly "homebound" and not cover non-home based services.

- **CMS has not engaged in formal rulemaking or released official guidance on implementation.** At this time, CMS reports no plans to engage in the formal rulemaking process that includes stakeholder comment on EVV. States are currently attempting to implement EVV based off of information provided in two webinar presentations. Further, CMS has yet to issue sub-regulatory guidance due to states by January 2018 and it is currently less than nine months before the implementation deadline.
- **The timeline for implementation is unreasonably short.** Passage of the 21st Century Cures Act in December 2016 left states and providers only two years to acquire funds from their state legislature "to develop business requirements, seek enhanced federal funding to build the system, procure EVV vendors, and train staff and consumers on the use of the system and equipment."[1] These challenges are compounded for many states due to the timing of their state legislative session. This already tight schedule has been further slowed by the lack of any official or unofficial direction from CMS since December 2017.

Current ANCOR Advocacy and Engagement on EVV:

ANCOR is actively working with its members and stakeholders to develop a reasonable resolution so that EVV may be implemented in a timely and appropriate manner. We are meeting with elected officials, including the author of EVV Rep. Guthrie (R-KY), members of the House Bipartisan Disability Caucus, and other legislative champions, as well as officials at CMS and the Administration for Community Living (ACL) to advocate for a narrow interpretation of the EVV statute, consistent with legislative intent, and a delay in implementation.

ANCOR has also provided the following input to CMS around EVV implementation and the challenges observed in states where it is implemented in the I/DD system.

First Round Input to CMS (October 2017)

- **There needs to be approved EVV vendor list, not one sole state system**
  - We outlined several reasons including:

[1] Feb. 12, 2018 State of Washington Department of Social and Health Services letter to Sen. Murray on EVV implementation

        - Implementation is faster from approved vendor list because then state does not have to push out RFP and take all of the steps to research who the sole vendor should be
        - There will be less liability placed on the state
        - If states want to change something in a system, they don't have to wait for contract to expire as they would with a sole vendor, but rather provide adequate notice
        - The ease of implementation and use of a certain vendor may depend on size of provider – a smaller provider may want to use a vendor with a simpler system while a larger provider may want something more advanced
        - With the cost often going to providers, it is important they have options for which vendor to work with (providers usually pay for training and device used for reporting)
        - A large provider providing various services or services in multiple states may have to use more than one system per service if a state mandates one system for each service - also we should predict situations where MCOs cover these services and how they may choose vendors
- **Training**
    - Needs to be ongoing training by proven expert – e.g. LA had new system developed by previous contractor of other services so those trainers were not experts in EVV (and it has created constant change in the system)
    - Older workers are having trouble using the system – they receive initial training but no option to practice so there are tons of errors that can lead to incorrect billing
    - MITC (note that ANCOR does not endorse any specific company but will note where they may have interesting techniques) has a training/implementation plan that is well thought out and implemented in phases rather than a flip the switch method

- **Payment to providers**
    - Providers need to be paid for cost of implementing the system – we are concerned with the lack of coverage there appears to be in the legislative language of 21st Century Cures
        - Some states are determining that use of staff phones requires stipend to the staffperson – most providers cannot afford unfunded stipends
        - Training is typically paid for by the providers (but they are not reimbursed for it)
    - Concern that states would use one vendor for payment incentive in 6(A) of the legislative text (this also relates to a potential disincentive to having an approved vendor list)
- **Individuals, family members and staff are really confused about the EVV system**
    - Many are afraid the system will be tracking their movements 24/7 so public information on the system is key
- **Mode of EVV**
    - Least expensive way is landline in person served home, whereas mobile devices are being more frequently used
        - Note that Ohio is piloting a program where all persons served would have limited use mobile device for EVV reporting
        - You'll recall from our conversation that ResCare was able to negotiate for flipphones for people served in Washington – but this is rare and related to the ability that ResCare had to negotiate due to their large size

- There are a variety of systems to use with GPS on smart phone, combination of GPS and more specific RFID tag but there are legitimate concerns about accuracy of GPS (see next bullet)
- LA wants to move forward with only GPS system and rid of landlines but there are some rural parts of state without internet access – even where there is internet access, sometimes it does not work in mobile homes with tin roofs, needs to be flexibility in system for differences in providers and issues they are dealing with
- A paper option as a last resort may be worthwhile exploring as a final backup option if devices fail – flexibility for providers matters especially when they are providing these services mainly in the community

Second Round Input for CMS on EVV (November 2017):

- **Provider Payment and Coverage of section 6(A)**
  - ANCOR understands that the intent of the EVV legislation is not to put providers out of business, but to establish a series of way to ensure that services are being delivered.
  - In order to ensure that provider services are protected, it is essential to ensure that the legislation does not create an unfunded cost for Medicaid-funded providers, particularly when they cannot negotiate rates to integrate additional costs.
  - To this end, it will be important that Section 6(A) of the legislation clarifies that 1) states are not incentivized to contract with one sole vendor which could be costly for providers as we laid out in previous remarks, that 2) the clause applies to an aggregator/accumulator that can gather data from multiple vendors approved by the state and selected by providers and 3) it is clear that the increased funding must be in part directed to providers if they incurred costs in the operation and maintenance of a system
- **Adult Foster Care**
  - Although we are quite certain that Congress did not intend coverage of adult foster care in the legislation, we thought it may be important to clarify in the intended FAQ that these services are not included since we have already heard there is confusion.
- **Stakeholder Input**
  - Our members appreciated the level of stakeholder input that was required for the HCBS Settings Rule and would like to see that process replicated with this legislation especially since the stakes are so high (cost, impact on employees and turnover, impact on people served, etc.). The aspects of stakeholder input highly valued include:
    - Multiple avenues to allow individuals to provide input (e.g. in person meetings, by mail, by email)
    - Providing notice of the legislative changes by a designated website, in a major newspaper, by email communication from the state to all providers and to all families served
    - Requirement for state to report a summary of feedback and response to CMS
  - Our members have noted that Arizona and Montana have already begun soliciting feedback and holding webinars, Colorado has also been a state that has communicated well to stakeholders.
  - Providers in Louisiana requested that the state do weekly calls for EVV, but the state has not followed through on that request. Louisiana used weekly calls/technical assistance several years ago as the state transitioned to managed care and it worked very well.

- Another key recommendation is for CMS to hold webinars for stakeholders early on, which was very helpful during the HCBS Settings Rule implementation
- ANCOR also recommends that given multiple states are now embarking on setting up their systems, that the sooner guidance begins to come out, the better and that if it needs to happen in phases that is ideal over waiting for bulk guidance to be ready for issuance (this was a recommendation formed after speaking to providers who felt the guidance was highly needed and states are beginning implementation without it)

- **Self-Directed Services and Set Schedules Generally**
  - Given the increased use of self-directed services as a way to keep individuals out of institutions and offer them more choice over who provides their care and when it is provided, ANCOR encourages guidance to states to allow for flexibility of scheduling for self-directed services. This would also assist in compliance with HCBS Settings rule. Scenarios have arisen in states where they are requested set schedules with the goal of confirming schedules in advance for purpose of oversight management, but the lack of flexibility does not match the inherent nature of self-directed service.
  - With that stated, it is very important to recognize that the issue of having "set schedules" (i.e. entering schedules into a computer system prior to the work being performed) is a problem if it is tied to the EVV system/billing system, regardless of whether a person receives self-directed services or not. (The issue of "set schedules" was one of the reasons Louisiana's previous attempts at EVV failed. The single source vendor that Louisiana was attempting to use required ALL schedules to be entered into the EVV system ahead of time.) The problem with using set schedules tied to the EVV/billing system is that the recipient's schedules are tied to a specific DSP, a specific day, and a specific time. Therefore ANY deviation in the DSP, the day, or the time will result in a "no show." The "no shows" initiate an alert being sent to the provider agency, the case manager, and the state (the owner of the EVV system). <u>This can result in a lot of wasted time, and wasted resources</u>. It can also result in the individual having less control (less flexibility) in his/her schedule. And it can impede a provider's ability to bill for services.
    1. Any change in DSP shows up as a "no show." Example: Susie Smith (DSP) is scheduled to work with Frank from 8:00 – 12:00. Susie calls in sick. The provider agency begins calling other DSPs to cover the schedule. The provider agency contacts the individual to let them know that a different DSP will be there. In the meantime, the case manager and the state have been notified. And the provider agency must go into the EVV system and adjust the schedule with the name of the new DSP so that when the new DSP clocks into the system it matches the EVV schedule. The provider agency can't bill for services until the discrepancy is resolved.
    2. Change of DAY or TIME will show up as a "no show." Example: John Smith (recipient) lives independently, but has a DSP assist him every Tuesday with paying bills, running errands, etc. But John is not feeling well and calls his DSP to see if they can run errands on Wednesday instead. When the DSP does not clock in on Tuesday, it shows up as a "no show" unless the agency has made the change in the system ahead of time (prior to Tuesday).
    3. Many provider agencies already use an electronic scheduling system and will oftentimes require that DSPs notify the agency of any changes ahead of time. And some agencies already use an alert system for individuals whose

health and safety depend on someone being there 24/7. But the use of a scheduling system should be a business decision made by the provider agency. And the use of alerts should be done on a case by case basis.

b. **Recommendation(s):**
    1. Allow provider agencies to select the scheduling system/method that is most appropriate for their agency. (This is a business decision.)
    2. Do not tie the scheduling system to the state's EVV/billing system.
    3. Decide on the use of an alerting component on a case by case basis. It should be person-centered based on what is important TO the person (e.g. structure, control, etc.), and what is important FOR the person (i.e. ensuring health and safety).