

Electronic Visit Verification for Personal Care Services: Status of State Implementation

As Medicaid spending on personal care services (PCS) has grown in recent years, so has attention from oversight agencies to the fraud vulnerabilities for this benefit. Spending on Medicaid-covered PCS grew from approximately \$10.9 billion in fiscal year (FY) 2012 to \$13.3 billion in FY 2015 (OIG 2017). In FY 2015, 12 percent of fraud cases investigated by state Medicaid Fraud Control Units (MFCUs) involved PCS, and the number of indictments and convictions of PCS providers and attendants increased by 56 percent and 33 percent from FY 2012 to FY 2015 (OIG 2017).

In 2016, the 21st Century Cures Act (Cures Act, P.L. 114-255) mandated that states adopt electronic visit verification (EVV) systems for Medicaid-covered PCS.¹ EVV systems require providers to electronically verify certain information to confirm that scheduled visits actually occurred. This is intended to reduce opportunities for fraud and improper Medicaid payments for PCS. This fact sheet describes EVV provisions in the Cures Act and how they are being implemented by states.

Overview of EVV Provisions in the Cures Act

The Cures Act required states to implement EVV systems for most PCS delivered to Medicaid beneficiaries. The law also outlined enhanced funding for certain implementation activities and set deadlines states must meet to avoid financial penalties.

Services subject to EVV requirements

Medicaid covers PCS provided in a visit to a beneficiary's home or that occurs in a residential care setting such as an assisted living facility or group home. States are required to implement EVV for all PCS requiring an in-home visit. This includes PCS provided through the following Medicaid authorities:

- Section 1905(a)(24) state plan personal care benefit;
- Section 1915(c) HCBS waivers;
- Section 1915(i) HCBS state plan option;
- Section 1915(j) self-directed personal attendant care services;
- Section 1915(k) Community First Choice state plan option; and
- Section 1115 demonstration projects.

Guidance from the Centers for Medicare & Medicaid Services (CMS) notes that EVV requirements do not apply to congregate residential settings where 24-hour service is available (e.g., group homes) (CMS 2018a). This is because services are available round-the-clock in settings like group homes, and one



provider may be serving more than one individual during the same time period. EVV requirements also do not apply to services provided at Program of All-Inclusive Care for the Elderly sites (CMS 2018a).

Enhanced funding for implementation

The Cures Act provides an enhanced federal medical assistance percentage (FMAP) of 90 percent for the design, development, and installation of an EVV system, and 75 percent for its operation and maintenance, under certain circumstances. This enhanced funding is only available for EVV systems that are operated by the state or a contractor on behalf of the state, but not for other potential arrangements such as an EVV vendor contracted by a managed care organization (MCO)(CMS 2018a).

States must submit an advanced planning document to receive enhanced funding for EVV implementation. As of August 2018, 31 states had submitted advanced planning documents (CMS 2018b).

Deadlines and penalties

The Cures Act requires states to adopt EVV for PCS by January 1, 2019 or face financial penalties; however, the enactment of H.R. 6042 (P.L. 115-222) in July 2018 delayed the implementation deadline until January 1, 2020.²

States that do not adopt EVV by January 1, 2020 will be subject to reduced FMAPs for PCS. The reduction will be 0.25 percentage points in 2020, 0.5 percentage points in 2021, 0.75 percentage points in 2022, and 1 percentage point in 2023 and thereafter. States can apply for up to a one-year exemption from penalties if they demonstrate that they made a good faith effort at implementation but encountered unavoidable delays. CMS will begin to accept applications for good faith exemptions beginning in July 2019 (CMS 2018b).

EVV Design and Implementation

State Medicaid programs must determine who will be responsible for managing the EVV system and which technologies will be used. Below we describe the available options, and the status of implementation.

Choice of EVV model

The Cures Act outlines certain standards that an EVV system must meet. A compliant EVV system must be able to verify the:

- type of service;
- individual receiving the service;
- date of service;
- location where the service was delivered;
- individual provider; and
- time the service began and ended.

CMS has identified five major EVV system models: provider choice, managed care plan choice, state-mandated in-house system, state-mandated external vendor, and open vendor (Table 1).³



TABLE 1. Electronic visit verification system models and state adoption status as of May 2018

Model	Description	Considerations	State adoption
Provider choice	Providers select EVV vendor States set requirements and standards; states also may approve list of EVV vendors if they so choose	With freedom to choose an EVV vendor, providers may be able to use systems already in place Complicates data sharing as the state may have to aggregate data from different systems	MO already operates a provider choice model; AK, NY, UT, WA, and WV plan to adopt
Managed care plan choice	Managed care organization (MCO) selects EVV vendor	With freedom to choose an EVV vendor, MCOs may be able to use systems already in place Complicates data sharing as the state may have to aggregate data from different systems Providers contracted with more than one MCO may be required to use different systems	NM and TN are using or plan to adopt this model NJ is considering this model
State-mandated in-house system	System developed, operated, and managed by the state	Allows the state to standardize its EVV system; no need to aggregate data from different systems Greater state administrative burden as the state has total responsibility over system operation	MD already operates an in-house model GA and MA plan to adopt this model
State-mandated external vendor	State contracts with one EVV vendor	All MCOs and providers must use the state-designated vendor The state has some administrative burden but less than with an in-house system	States that use or plan to adopt this model include AZ, CT, DC, FL, IL, KS, MS, MT, OH, SC, and WV
Open vendor	Hybrid model in which a state contracts with at least one EVV vendor or operates its own system; the state then gives providers or MCOs the option either to use the state system or continue using their own existing EVV system	Complicates data sharing as state may have to aggregate data from different systems Potential complexity may add to the state's administrative burden	LA and TX operate open vendor model MA, ND, and NJ are considering or planning to adopt this model

Note: EVV is electronic visit verification. Washington model choice is as of March 2019.

Sources: MACPAC analysis of CMS 2018c, Graham 2019.



In choosing among these models, states face tradeoffs between the ease of information sharing, administrative burden, and provider burden among other factors. For example, while provider and managed care plan choice models provide more flexibility for providers and MCOs, those models require data across different systems to be aggregated into a common format for the purposes of state reporting and oversight. States wishing to avoid aggregating data across multiple systems might opt for a state mandated in-house system, but developing an in-house system may impose a greater administrative burden on the state.

Choice of EVV technology

EVV systems use different technologies to collect and record information with different advantages and disadvantages (Table 2). Certain technologies may help overcome limited Internet or cellular access in rural or frontier areas. For example, in New Mexico, tablets given to providers can store data for multiple days so that providers only need Internet connectivity once a week to upload visit information (CMS 2016c). Other technologies, such as telephone timekeeping, may require a lower up-front investment but may not provide flexibility for services received away from a beneficiary's residence. States may choose to use more than one technology; for example, to accommodate differences in cellular service strength in different regions (CMS 2018a).

TABLE 2. Electronic visit verification technologies

Technology	Description	Considerations
Telephone timekeeping (telephony)	Provider checks in and out using the beneficiary's landline or a cellular phone	Can be challenging in rural or frontier areas Provides confirmation that attendant is in beneficiary's home, but could restrict receipt of services in the community without backup methods
Web-based global positioning system (GPS)	Uses an application on a smart phone or tablet that captures real-time data with GPS tracking	Use of a smart phone or tablet allows for flexibility in the location where services are received as beneficiaries can add approved locations outside the home Devices may access GPS in areas where cellular or Internet service is limited and preserve information for upload at a later time May raise privacy concerns
One-time password generator	Uses a hardware security device called a fixed object at the beneficiary's home, which produces a one-time password or code that the provider records into the system to verify their presence in the beneficiary's home	Could restrict receipt of services in the community without backup methods



TABLE 2. (continued)

Technology	Description	Considerations
Biometrics	Verifies a provider's identity using voice recognition, fingerprints, iris scan, or facial scan	May raise privacy concerns

Note: EVV is electronic visit verification.

Source: MACPAC analysis of CMS 2018c and NASUAD 2018.

Implementation status

In 2017, CMS and the National Association of Medicaid Directors conducted a survey of the status of EVV implementation. At the time, 11 states—Connecticut, Illinois, Kansas, Louisiana, Maryland, Missouri, Mississippi, New Mexico, South Carolina, Tennessee, and Texas—reported implementing EVV for either PCS or home health services (CMS 2018c, CMS 2017).

Some states are implementing EVV in phases or using pilot programs to identify and address issues before full implementation. CMS considers this a best practice provided that states meet compliance deadlines (CMS 2018c). Ohio, for example, is following a phased approach, implementing EVV for services paid on a fee-for-service basis in 2018. Providers could begin using the system in January 2018, but compliance was not mandatory until July 2018, allowing them time to become familiar with the system. In 2019 and 2020, Ohio plans to execute the second and third phases of EVV implementation; the second phase will incorporate EVV provided through state agencies and MCOs and the third phase will bring in self-directed care and home-based therapy services (Wathen 2018).

Training stakeholders in EVV system operation

In order for EVV to be successful, attendants must be well-trained in the system and the software. Training must be provided both as systems are rolled out for new agencies and attendants, as well as on an ongoing basis to reinforce information for existing providers.

In part, training is a challenge due to the large volume of agencies and attendants that must be trained. For example, Connecticut estimated that in order to meet the new Cures Act requirements, 295 agencies were required to undergo EVV training. Furthermore, the state estimates that 41,000 caregivers are serving 27,000 beneficiaries, with 345,000 visits conducted each month (Bruni 2018). In implementing its EVV system, Connecticut conducted 23 workshops, held 29 webinars, and provided a variety of other resources such as recorded training sessions, job aides, and a tip sheet (Bruni 2018). Maryland offers web-based training on a quarterly basis for current providers and on a monthly basis for new providers, and maintains a library of webinars for on-demand access (CMS 2018c).

CMS has strongly recommended that beneficiaries and their families be educated on EVV systems, as such systems may require their participation (e.g., the use of a telephone or placement of a hardware security device called a fixed object in their home) (CMS 2018c). Outreach to beneficiaries has included information delivered by case managers or state staff, letters, leaflets in enrollment materials, recorded voice messages, and websites (CMS 2018c).



Incorporating EVV into self-directed care programs

Self-directed care programs allow beneficiaries to choose their PCS attendants, and in some cases exercise control over the budget for services. Self-directed care also provides beneficiaries with the flexibility to change their PCS schedules to meet changing needs and activities.

Self-directed care programs require special attention when implementing EVV. CMS recommends building flexibilities into EVV systems to accommodate circumstances common in self-directed care options, such as providing services at multiple locations and last-minute scheduling (CMS 2018c). CMS also recommends that states integrate EVV into existing self-directed care information systems to avoid duplication and limit burdens on providers and financial management service entities that provide services to beneficiaries whose self-directed care programs give them the authority to act as an employer (e.g., assistance processing payroll). For example, in South Carolina, the vendor that provides these services for self-directed care is also the EVV vendor for that program (CMS 2018c). In addition, given the unique aspects of self-directed care models, beneficiaries opting to self-direct their care may need different types of training and education than other beneficiaries (CMS 2018c).

Addressing stakeholder concerns

The Cures Act requires states to engage with stakeholders including beneficiaries, family caregivers, providers, and others when implementing EVV. This process may result in changes to the EVV system. For example, in response to provider feedback, Ohio plans to expand the number of non-English languages its EVV system supports from 5 to 12 (Wathen 2018).

Stakeholders have also raised concerns about beneficiary privacy, particularly with GPS systems (NASUAD 2018). CMS guidance indicates that capturing the location where a service begins and ends is sufficient. Thus, if a service begins and ends at a beneficiary's home, states do not have to track the beneficiary's movement in the community with his or her PCS attendant (CMS 2018a).

Looking Ahead

As states implement EVV, we expect to learn how these systems are affecting care and program integrity.

Use of EVV for monitoring beneficiaries' care

EVV can be used to identify and address gaps in PCS. For example, systems can be used to alert case managers of missed visits in order to schedule backup care (Sandata 2018). CMS guidance also asks states to consider having an EVV system alert them when certain individuals receiving self-directed services are not receiving the amount and duration of services to meet their needs (CMS 2018c). In addition, in states with managed long-term services and supports programs, EVV reports of missed visits can help support monitoring of the adequacy of MCOs' provider networks (MACPAC 2018, Barth 2017).



Potential savings

Over time, Medicaid programs and oversight entities such as the U.S. Department of Health and Human Services Office of Inspector General and state MFCUs will be able to examine the extent to which EVV implementation reduces cases of PCS fraud. The Congressional Budget Office (CBO) estimates that EVV implementation will result in \$290 million in savings over a 10-year period (CBO 2016a). In its score of an earlier bill containing the same EVV requirements that were in the Cures Act, CBO anticipated that, on average, EVV implementation would achieve an average 1 percent reduction in PCS and home health payments across all states, with some states achieving substantially higher than the average and some achieving little to no savings (CBO 2016b).

States and vendors in states that began to implement EVV prior to the Cures Act have estimated some initial savings from EVV. For example, the Texas Health and Human Services Commission estimated 3 to 5 percent savings from EVV implementation (TX HHSC 2015). In South Carolina, the EVV vendor estimated initial savings of 10 percent of what was billed through the system, and ongoing savings of 6 to 7 percent. These savings included both avoided improper payments and savings resulting from the shift to payments in smaller increments (First Data 2009).

Although it has the potential to reduce improper payments, EVV will not completely eliminate opportunities for bad actors to commit fraud. For example, Ohio has begun to identify cases of fraud despite the use of EVV, including one instance where the beneficiary ended the visit but the attendant remained clocked in until the end of the shift (Bruni 2018). Continued monitoring of PCS will be necessary to identify and address new fraud schemes as they arise.

Endnotes

¹ The Cures Act also required states to implement EVV for home health care services, a Medicaid benefit for skilled nursing care delivered in the home. States must implement EVV for home health by January 1, 2023. Given that this is a more limited Medicaid benefit than PCS and has a longer timeline for implementation, this fact sheet focuses on EVV for PCS.

² P.L. 115-222 did not change the implementation deadline for home health.

³ The Cures Act required CMS to collect and disseminate best practices regarding EVV provider training as well as EVV education for beneficiaries and their caregivers. On May 16, 2018, CMS released an informational bulletin fulfilling this requirement (CMS 2018c). Although CMS did not identify a provider audit model, at least one state has proposed to allow providers to contract with a vendor or develop an in-house EVV system (NASUAD 2018). The state would add compliance with EVV requirements to their routine audit process, but would not aggregate the data into a single state system. It is unclear at this time if other states are pursuing this model.

References

Barth, S. 2017. Innovative approaches to HCBS network adequacy in MLTSS-Findings. Presentation at the National Home & Community Based Services Conference, August 29, 2017, Baltimore, MD.
<http://www.nasuad.org/sites/nasuad/files/Final%20HCBS%20Network%20Adequacy.pdf>.



Bruni, K. 2018. Connecticut electronic visit verification (EVV). Presentation at the National Home & Community Based Services Conference, August 27, 2018, Baltimore, MD.
<http://www.nasuad.org/sites/nasuad/files/2018%20HSCB%20Session%202253%20The%20Evolution%20of%20EVV%20Ohio%20and%20Connecticut.pdf>.

Congressional Budget Office (CBO). 2016a. *H.R. 34, 21st Century Cures Act*. Washington, DC: CBO.
<https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr34.pdf>.

Congressional Budget Office (CBO). 2016b. Letter from Keith Hall to Representative Fred Upton regarding “Helping Families in Mental Health Crisis Act of 2015.” July 5, 2016. <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr2646ltr.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018a. *Frequently asked questions: Section 12006 of the 21st Century Cures Act. Electronic visit verification (EVV) systems for personal care services (PCS) and home health care services (HHCS)*. Baltimore, MD: CMS. <https://www.medicaid.gov/federal-policy-guidance/downloads/faq051618.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018b. EVV requirements in the 21st Century Cures Act: Pre-conference intensive. Presentation at the National Home & Community Based Services Conference, August 27, 2018, Baltimore, MD. <http://www.nasuad.org/sites/nasuad/files/5-EVVR~1.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018c. CMCS informational bulletin regarding “Electronic visit verification.” May 16, 2018. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051618.pdf>.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. Section 12006 of the 21st Century Cures Act. Electronic visit verification systems. Session 1: Requirements, implementation, considerations, and state survey results. Presentation for a CMS webinar, December 13, 2018, Baltimore, MD.
<https://www.medicaid.gov/medicaid/hcbs/downloads/training/evv-presentation-part-1.pdf>.

First Data. 2009. *A First Data customer success story: Promising practices in home and community-based services*. Atlanta, GA: First Data. https://www.firstdata.com/downloads/thought-leadership/6726_sc_authenticare_cs.pdf.

Graham, A., Washington State Department of Social and Health Services. 2019. Email to MACPAC, March 12.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. Chapter 3: Managed long-term services and supports: Status of state adoption and areas of program evolution. In *Report to Congress on Medicaid and CHIP*. June 2018. Washington, DC: MACPAC. <https://www.macpac.gov/publication/managed-long-term-services-and-supports-status-of-state-adoption-and-areas-of-program-evolution/>.

National Association of States United for Aging and Disabilities (NASUAD). 2018. *Electronic visit verification: Implications for states, providers, and Medicaid participants*. Washington, DC: NASUAD.
http://www.nasuad.org/sites/nasuad/files/2018%20Electronic%20Visit%20Verification%20Report-%20Implications%20for%20States%2C%20Providers%2C%20and%20Medicaid%20Participants_0.pdf.

Office of the Inspector General (OIG), U.S. Department of Health and Human Services. 2017. *Medicaid fraud control units: Investigation and prosecution of fraud and beneficiary abuse in Medicaid personal care services*. Washington, DC: OIG.
<https://oig.hhs.gov/oei/reports/oei-12-16-00500.pdf>.



Office of the Inspector General (OIG), U.S. Department of Health and Human Services. 2012. *Personal care services: Trends, vulnerabilities, and recommendations for improvement. A portfolio*. Washington, DC: OIG. <https://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf>.

Sandata. 2018. Sandata electronic visit verification. Port Washington, NY: Sandata. <https://www.sandata.com/our-platform/sandata-electronic-visit-verification/>.

Texas Health and Human Services Commission (TX HHSC). 2015. *Electronic visit verification aims to save money, improve service*. Austin, TX: TX HHSC. <https://web.archive.org/web/20150830044337/http://www.hhsc.state.tx.us/stakeholder/2015/july-aug/7.shtml>

Wathen, K. 2018. The Ohio model. Electronic visit verification. Presentation at the National Home & Community Based Services Conference, August 28, 2018, Baltimore, MD. <http://www.nasuad.org/sites/nasuad/files/2018%20HSCB%20Session%202253%20The%20Evolution%20of%20EUV%20Ohio%20and%20Connecticut.pdf>.

