Electronic Visit Verification Program Models

National EVV Mandate – A Guide For States

Increasing the Capacity to Care
Improving the Process of Home Care

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National EVV Mandate – An Introduction

On December 8, 2016 President Obama signed into legislation the 21st Century Cures Act. Section 12006 of the bill, Electronic Visit Verification System Required for Personal Care Services and Home Health Care Services Under Medicaid, is a call for action. Section 12006 directs States to require the use of an Electronic Visit Verification (“EVV”) system for Medicaid-provided personal care services and home health services. States that do not require a system for personal care services and home health services by the mandated dates will face an escalating reduction in FMAP funding.

The EVV system must verify the following:
- Date of service;
- Location of service;
- Individual providing service;
- Type of service;
- Individual receiving service; and
- Time the service begins and ends.

To see the full requirements, please click on 21st Century Cures Act.

In preparation for compliance with this mandate and to ensure no reduction in FMAP funding after January 1, 2018, States must begin to consider the impacts of this legislation, specifically the impact on cost, provider networks, and most importantly quality of service.

Sandata Technologies, (“Sandata”) is a national leader in delivering EVV solutions and we worked closely with the sponsors of this bill, the Congressional Budget Office, the National Association of Home Care Providers, and the Alzheimer’s Foundation to provide input and expert testimony on Electronic Visit Verification.

We are pleased to provide this white paper to share our expertise in the various options for deploying EVV, lessons learned, and key areas for States to consider as you evaluate this new requirement. Our expertise is derived from over 38 years of experience delivering EVV solutions to the home care Provider market, and over seven years of experience delivering EVV solutions to the Payer market. Over the years, we have had the opportunity to work with nine State Medicaid agencies, six Managed Care Organizations, and over 3,500 homecare agencies. Based on this experience, this document explores the most commonly deployed State EVV program models and analyzes the impact of each model for key stakeholders.
What is Electronic Visit Verification?

Electronic Visit Verification is a method used to verify visit activity for services delivered as part of home and community based services programs. EVV offers a measure of accountability to help ensure that individuals who are authorized to receive those services actually receive care. At its most basic functionality, EVV is designed to help verify that services billed for home care are for actual visits made. EVV is often used by payers to help target and reduce fraud, waste and abuse and ensure that individuals receive the documented care they need. Providers typically use EVV, even in the absence of a Payer mandate, to manage and monitor the delivery of care.

EVV vendor solutions range from a simple electronic timesheet capture via the web to more sophisticated solutions including telephony and mobile applications with GPS capabilities for use by caregivers that actually compare visits against authorizations/plans of care to ensure the individual is receiving services at the right location exactly as prescribed. Since their initial entry into the market, EVV solutions have been continually evolving to meet the growing needs of the home care community. For example, EVV functionality has recently expanded to extract additional value from the caregiver-patient interaction and have been used to identify health-status changes at the point-of-care. In addition, EVV has also been used to collect beneficiary signature as an attestation that services were delivered. More recently, mobile devices have been installed at the beneficiary's home loaded with EVV and other mobile applications to support additional program needs.

In a December 2011 study, the Department of Health and Human Services asked States, Managed Care Entities and CMS to identify their major concerns regarding managed Medicaid fraud, waste and abuse. The primary concern was related to services billed but not rendered. The widespread potential for fraud in Medicaid home care programs and the potential savings achieved when using visit verification solutions was one of the rationales behind including EVV in the Cures Act. The Congressional Budget Office scored the Cures legislation and attributed EVV with saving $290M between Fiscal Years 2017 – 2026.

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1 Daniel Levinson, Inspector General, Department of Health and Human Services, Office of Inspector General, “Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards”, December, 2011.
Overview of EVV Models

State-level Electronic Visit Verification ("EVV") programs are a relatively new concept, and today there are 17 States who have programs deployed or in implementation. As these early adopters have explored EVV, four major models have evolved in the market:

1. **Provider Choice Model** (Used by three States);
2. **MCO Choice Model** (Used by three States);
3. **State Choice Model** (Used by ten States); and
4. **Open Vendor Model** (Used by one State).

**Figure 1. States can choose from a variety of EVV program models which vary in terms of level of State involvement, complexity and funding.**

The following section explores each of these models in depth.
Provider Choice

An unfunded mandate is one of the quickest and easiest ways for a State to be compliant with the new federal mandate. In this model, the State requires the provider community to self-fund, select and implement an EVV solution of their choosing, generally by a required deadline. Some States have offered a preferred vendor list for providers to select from, while other States have simply established a minimum set of standards for vendor selection. Along with standards, some States also require a minimum set of reporting on EVV activity.

Where This Model is Used

States that have implemented or are contemplating implementing this model include:
- Missouri
- New York
- Washington

Stakeholder Impacts

State: The Unfunded Mandate is a “low cost” model for the State, as all of the expense of selecting, implementing, and ongoing use of the EVV solution is paid for by the provider community. States using this model avoid the expense of the procurement process. No data integration between the State and the system is generally required, and unless the State decides to measure or monitor the program (i.e. compliance with minimum standards, review of reporting, etc.) there is low overhead cost to manage the program.

Providers: All costs associated with EVV are the responsibility of the home care providers. Some provider agencies may not be technically savvy enough to successfully select and deploy an EVV solution nor financially stable enough to pay for such a system. This model can be especially challenging for the Individual Providers in a State. The increased burden to procure, implement, and pay for EVV solutions has resulted in providers requesting additional reimbursement from the State in order to support EVV programs, or to be out of compliance with the EVV requirement.

Quality Monitoring: In this model, the State generally does not have access to visit data to support quality monitoring of the network unless they implement audits and fund the staff to spot check the providers. Without checks and balances (monitoring, reporting, etc.), use of EVV is generally lower in these types of programs over other models. Inconsistency in
features and functionality across vendors compound the issue of trying to evaluate quality care delivery across multiple systems.

**Outcomes:** Without enforcement or monitoring, States should not expect to materially change provider behavior and, to date, there are no published studies showing any savings or reduction in fraud, waste and abuse in States using this model.

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**MCO Choice Model**

Similar to the provider select model, the State requires the MCOs who manage Medicaid beneficiaries through their Long-Term Supports and Services programs to self-fund, select and implement an EVV solution of their own choosing. States may set minimum standards for vendor selection and require a minimum set of reporting on EVV activity. In States where there is more than one MCO, a multi-EVV vendor situation may occur if each MCO selects a different EVV vendor, adding to program complexity with respect to data and reporting inconsistencies.

**Where this Model is Used**

States that have implemented or are contemplating implementing this model include:
- Iowa
- New Mexico
- Tennessee

**Stakeholder Impacts**

**State:** This model is also a “low cost” model for the State, as most of the expense of selecting, implementing, and ongoing use of the EVV solution is paid for by the MCOs (although MCOs will likely expect financial relief in the form of reimbursement rates). States using this model also avoid the expense of the procurement process. No data integration between the State and the EVV system is necessarily required, and unless the State decides to measure or monitor the program (i.e. compliance with minimum standards, review of reporting, etc.) there is low overhead cost to manage the program.

**Providers:** For providers, this model is the most challenging and it introduces significant inefficiency, burden and cost to the provider network. In States where more than one MCO manages beneficiaries, providers who contract with more than one MCO may be forced to use multiple EVV systems based on which MCO is managing the beneficiary. Providers have to allocate more time for training multiple systems, caregivers have to know which
EVV system to use for a given beneficiary and back office staff use and maintain multiple systems for scheduling, billing and payroll processes. From a logistical standpoint, providers do not achieve any benefits of operational efficiencies from EVV system compliance.

**Quality Monitoring:** In this model, the State may or may not have access to visit data to support quality monitoring of the network as that is the role of the MCOs. In a multi-EVV vendor environment, use of EVV may be lower due to the reasons stated above. Inconsistency in features and functionality across vendors compound the issue of trying to evaluate quality care delivery across multiple systems.

**Outcomes:** To date, we have not seen outcomes published that show any savings have been generated using this model. We anticipate challenges with the State’s ability to measure outcomes across MCOs who use various EVV vendor solutions primarily due to the differences in data elements that each vendor may be able to capture and/or report on.

**State Choice Model**

In this model, the State Medicaid program contracts with a single EVV vendor and mandates that all Provider Agencies use that vendor’s EVV system. This model provides assurances that the EVV system selected will include State specified technical and compliance controls that enforce visit verification through policy, thereby minimizing fraud, waste, abuse and errors. States that choose this model seek to ensure standardization across providers. The selected solution is implemented by the State, often in six months or less, with States having direct management and oversight over the entire program. Contracting may be done through an existing contractual relationship (i.e. MMIS vendor) or via a formal procurement process. In either case, an enhanced FMAP is available which first requires the State develop and submit an Advance Planning Document to CMS.
WHERE THIS MODEL IS USED

This model has historically been the most widely used model and is in use or being implemented by:

- Connecticut
- Florida
- Illinois
- Kansas
- Mississippi
- Oklahoma
- Oregon
- Rhode Island
- Texas
- South Carolina

STAKEHOLDER IMPACTS

State: In this model, the State mandates the use of the system and pays for 10% of the implementation costs, with the 90% match for services including purchasing and implementation, program management and provider monitoring. The single EVV vendor model qualifies for an enhanced match of 75% for ongoing program operational costs. CMS's March 31, 2016 letter to Medicaid Directors\(^3\) encourages States to utilize modular Commercial Off The Shelf solutions to support Medicaid delivery systems. States can then move forward with EVV after receiving approval of the Advance Planning Document by CMS.

This model requires the greatest investment of State resources for vendor selection and ongoing vendor management. States following this model are typically fully engaged and responsible for all aspects of the EVV program including:

- Establishing minimum vendor and EVV technology requirements;
- Managing the procurement process;
- Vendor demonstrations, vendor selection, award and contracting;
- Implementation activities including defining program business rules across the program, stakeholder outreach, etc.;
- Program oversight; and
- Vendor management.

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**Providers / Managed Care Organization:** In State procured, single vendor solution, providers are given an EVV system at no cost and required to use the system. Benefits to those providers who previously did not rely on electronic tools include the ability to use a “free” system to create back office process efficiencies, eliminate many paper-based processes and more tightly manage their remote workforce. If the State uses MCOs to manage their network, the EVV system can also be integrated with the MCOs to improve business process for all.

Managed Care Organizations can also use this State-provided solution to uniformly manage home care providers across their network. States often allow MCOs access to reporting and/or real-time data to help MCOs measure providers against specific benchmarks.

The challenge for providers that have already standardized their business processes around technology solutions (internally built or 3rd party solutions), is that the provider now must manage, train, and support a new system that is disparate from their core business systems. For Providers that already have a technology solution in place, this model requires them to support a new system that was not chosen by them, thus complicating their operations and workflow. Another objection to this model is that it constrains the free market and for these reasons, this model is falling out of favor in the industry.

**Quality:** In this model, the highest levels of EVV compliance are achieved with easy access to quality reports at all levels of the State system as well as data for State auditing and investigations. Alerts may be triggered to the State / MCO care managers for late/missed visits (schedules would be required), additional beneficiary needs, etc. to reduce gaps in care and to support enhanced care coordination.

**Outcomes:** This model has the best savings outcomes and maximizes the State’s return on investment for EVV programs as demonstrated by third-party independent studies. Examples of independent outcomes include:

**Florida:** [Florida Medicaid and Public Assistance Strike Force Reports](#) for 2011 and 2012 Stated that AHCA realized:
- $19M savings (46%) for Miami-Dade County alone in Year 1 of the program
- $3.5M in additional savings for Miami-Dade County in Year 2 (15% lower dollar amount of claims paid than in Year 1).

Please also click on [Telephonic Home Health Services Delivery Monitoring and Verification (DMV) Program](#) report for AHCA’s first year EVV results.
Oklahoma: Oklahoma published Interactive Voice Response/Authentication: A Pilot Study from their initial pilot EVV program in 2008 showing:

- 8% decline in visits/month
- 0.5 more visits per member per month representing a slight increase
- Decrease in total reimbursed units
- Decrease in per member per month cost
- 12-day decrease on average in lag time per claim payment per month representing a significant decrease in the average days lag between dates of service delivery to receipt of payment

South Carolina: A Promising Practice report posted by Medstat on CMS’ repository of Promising Practices in Home and Community-Based Services (HCBS) has shown South Carolina has saved 10% of total billings by billing on six-minute increments and reducing fraudulent services.

Open Vendor Model

The Open Vendor Model is a new hybrid model – where the State is responsible for selecting a vendor to provide EVV solutions while simultaneously allowing all Providers and MCOs who already have an EVV system to keep their existing system, or to choose a system that best suits their operation. In this model, States establish the technology requirements and configuration, rules and policies regarding the program, and purchase an EVV system on behalf of and at no cost to their Providers who do not currently have an EVV system of their own. In addition, States who offer this, elect to “open the model” to third party EVV systems. Providers and MCOs can opt to use their own EVV systems currently in use. In essence, this model results in true vendor neutrality and fully supports the concept of vendor choice when it comes to Providers and MCOs.

In this Open Model, once a visit is completed, a vendor agnostic Aggregator system takes in data from all EVV systems and applies standardized business rules to ensure the visits are properly verified and ultimately paid, generates alerts as needed and provides comprehensive oversight over the entire program – regardless of EVV system used.

This new model is currently being implemented in Ohio. It is likely that other States will look to Ohio as a leading option for meeting the new mandate as it offers the most flexibility for the Providers and MCOs, while still allowing the State to maintain quality oversight. As with the Single Vendor model, the State pays for 10% of the costs, with the 90% match including purchasing and implementation, program management and provider monitoring; this model also qualifies for an enhanced match of 75% for ongoing program operational costs.
WHERE THIS MODEL IS USED

This is a new model currently employed by Ohio and still in the implementation stage. Phase 1 of the project is scheduled to go live in 2017.

STAKEHOLDER IMPACTS

State: In this model, some system costs may be shared with Providers and MCOs who maintain their own systems. For example, in Ohio the State has purchased the EVV solution and Aggregator Solution. Providers who wish to use their own EVV solution continue to pay the vendor and do not receive any supplemental reimbursement from the State. Another aspect of the model is the requirement that all EVV systems in use must meet specific minimum technology standards. Similar to that of the Single Vendor model, the State is responsible for the costs associated with:

- Procuring, purchasing and implementing the State-offered solution (for Providers and MCOs without an EVV system);
- Program management; and
- Monitoring and data integration/aggregation across all systems.

Allowing Providers and MCOs to retain their current systems adds a dimension of complexity for the State as vendors may not have parity in their offering or capabilities. States opting for this model will be fully engaged beginning with establishing requirements, procurement, through vendor selection and beyond managing the entire program. Selecting a vendor who has the ability to aggregate disparate EVV data so the State can apply a standard set of visit rules and one that helps the States simplify program management through comprehensive reporting and oversight over the entire EVV program is of utmost importance.

Providers and Managed Care Organizations: For Providers and MCOs who select their own systems, the impact to their operations is expected to be minimal. Providers and MCOs with systems that already meet the minimum standards continue to use their systems and maintain existing processes as before. However, for providers who contract with more than one MCO, a scenario could occur by which providers may be required to use multiple systems to manage their business. One MCO may opt for the State-offered EVV system while another MCO chooses to use their own. This would place a potentially significant burden on the Providers and adds possible inefficiencies to the care model, thus this scenario should be avoided if possible.
Quality: In this model, a higher level of EVV compliance is achieved as the State can measure utilization through policy (including incentives and/or penalties). In addition, a high level of care coordination is achieved through data aggregation resulting in improved health outcomes for the beneficiary. As visit data continuously enters the aggregation system, alerts may be triggered to the State or MCO care managers for late/missed visits additional beneficiary needs, etc.

Outcomes: Higher savings and return on investment with this model compared to the unfunded mandate are expected for two reasons.

1) States have strong influence on system utilization; and
2) States require non-State EVV systems meet minimum requirement thresholds making them comparable to the State-offered solution.

Conclusion

Each State must carefully evaluate its unique environment in order to select the EVV model that is right for their program while complying with the new mandate. Factors to consider include concerns impacting fraud, waste and abuse, impacts to the provider network, and how states are using managed care companies to deliver services. Sandata has summarized each of the models based on how favorable they are to the state, the providers, and the MCOs using the following measures:

- Compliance – measured in terms of rate of adoption of the mandated EVV technology;
- Cost – cost to the state to implement (assumes enhanced federal match of 90%);
- Business Burden – how much time and effort the state must expend to implement and manage the program;
- Ease of implementation – how easy or challenging is the program to implement on a statewide basis; and
- Outcomes – how much savings will the state expect to recoup based on impacts to fraud, waste and abuse.
EVV is a strong tool to support the delivery of care and provides much needed transparency to the needs of the State’s most vulnerable citizens. We look forward to supporting you as you evaluate the new mandate and how you will craft a plan for your State’s compliance.

For a personalized consultation (including cost and ROI analysis) please contact Sandata at spmsales@sandata.com.