

National MLTSS Health Plan Association

Electronic Visit Verification (EVV) White Paper

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Background

Electronic Visit Verification (EVV) technology is used to confirm that home- and community-based services (HCBS) are delivered to people who need those services. EVV encompasses a number of different technologies, including:

- Telephonic timekeeping,
- Web, tablet, or phone-based applications using GPS verification,
- Key FOBs with one-time passwords, and
- Biometric sensors.¹

As part of the 21st Century Cures Act, which was enacted in December 2016 and subsequently amended, state Medicaid programs are required to implement EVV for all Medicaid-funded personal care services by January 2020, and for Medicaid-funded home health care services by January 2023. Noncompliant states will face FMAP reductions.

EVV Requirements under 21st Century Cures Act

The Cures Act specifies a number of requirements states must meet in implementing EVV systems for their Medicaid programs. These requirements include:

- Electronically verifying all of the following elements:
 - Type of service provided
 - Individual receiving service
 - Date of service
 - Location of service delivery
 - Individual providing service

¹ <https://cdpaanys.org/wp-content/uploads/2018/06/EVV-Self-Direction-Consumer-Advocates-report.pdf>

- Time service begins and ends
- Engaging various stakeholders in planning, designing, and implementing EVV policies. These stakeholders include providers, participants, caregivers, and direct care workers.
- Taking into account existing EVV infrastructure and best practices within the state when selecting and implementing a model.
- Developing a thorough training plan as part of the state’s implementation plan. CMS identified and suggested seven training practices all states should consider adopting,² but did not require states to do so.

EVV Implementation Models

CMS has identified five design approaches which states can use to implement EVV that are built around existing Medicaid models around the country:

- Provider Choice Model: The state sets minimum standards for EVV systems and allows each service provider to select a qualifying system.
- MCO Choice Model: The state sets minimum standards for EVV systems and allows each MCO to select a qualifying system for their network providers to use.
- State-Procured Vendor Model: The state selects one EVV vendor for all providers in the state, using a competitive bid process.
- State-Developed Solution: The state develops its own EVV system, to be used by all providers and/or plans in the state.
- Open Vendor Model: The state selects or develops a statewide EVV system available to all providers and MCO, but also allows providers and MCOs to select their own vendor that meets minimum standards.

In addition to CMS’s five models, states have proposed a sixth Provider Audit Model. In a Provider Audit model, the state would direct providers to establish a process to ensure that services are electronically verified, but would not establish a statewide aggregation system or state-developed EVV option.

The State of EVV Adoption

States have already started adopting mandatory EVV for their Medicaid programs. As of December 2017, 11 states had implemented EVV mandates, and another 8 had either submitted or planned to submit implementation plans to CMS for approval.³ These states that

² <https://www.healthmanagement.com/blog/electronic-visit-verification-implications-states-providers-medicaid-participants/>

³ <https://www.sandata.com/wp-content/uploads/2017/08/Sandata-HMA-EVV-Survey-Response-Report-2017.pdf>

adopted EVV prior to the Cures Act deadline include both MLTSS states⁴ and non-MLTSS states⁵ have States have expressed a variety of goals for implementing EVV systems.⁶ Some states focus on preventing fraud, waste, and abuse, some focus on accountability and payment accuracy, and others may emphasize quality measurement and improvement. Some states, such as Maryland and Connecticut, have attributed substantial healthcare savings to EVV implementation.⁷

Most states have opted to let providers select their own EVV systems. Thirty-one (31) states have either already selected or are favoring “open models,” which include both the Open Vendor Model and the Provider Choice Model.⁸ Of the remaining states, 14 are undecided about which EVV model to implement.

In general, states have focused on meeting the Cures Act minimum requirements rather than expanding the use or content of EVVs. Even states that implemented EVV prior to the Cures Act have not generally innovated beyond the minimum data requirements in the legislation.

CMS has instructed states to solicit input from relevant stakeholders, including individuals using HCBS, family caregivers, advocacy groups, provider organizations, direct care workers, and state program employees. Consumer advocacy groups have expressed concerns that states have focused more on policy design and implementation planning than on stakeholder engagement. Advocates have encouraged states to engage consumers and families during the early policy planning stages, rather than seeking buy-in only after completing EVV policy design.

In a July 2018 letter, CMS confirmed that EVV systems are subject to HIPAA privacy and security protections.⁹ States are now working to identify HIPAA-compliant data privacy practices for their EVV programs. Some best practices states should consider include:

- Communicating to consumers, in easy-to-understand terms, exactly how gathered information will be used and to whom it will be sent;
- Ensuring data aggregated by the state and CMS is not used by fiscal intermediaries or EVV vendors for marketing or other purposes;¹⁰
- Limiting the mandatory use of GPS tracking and biometrics to ensure EVV systems are minimally invasive;

⁴ **MLTSS states with EVV mandates** include Illinois, Kansas, New Mexico, South Carolina, Tennessee, and Texas

⁵ **Non-MLTSS states with EVV mandates** include Connecticut, Louisiana, Maryland, Missouri, and Mississippi.

⁶ NASUAD (2018). *Electronic Visit Verification: Implications for States, Providers, and Medicaid Participants*. Available from: <http://www.nasuad.org/sites/nasuad/files/2018%20Electronic%20Visit%20Verification%20Report-%20Implications%20for%20States%2C%20Providers%2C%20and%20Medicaid%20Participants.pdf>

⁷ <https://www.medicare.gov/medicaid/hcbs/downloads/training/evv-presentation-part-1.pdf>

⁸ http://medicaidpartners.org/wp-content/uploads/2018/05/EVV-State-Map_05162018.pdf

⁹ <https://mitcagencies.com/cms-confirms-evv-is-subject-to-hipaa/>

¹⁰ <https://cdpaanys.org/wp-content/uploads/2018/09/EVV-Self-Direction-Consumer-Advocates-report.pdf>

- Preventing unauthorized access to EVV data using multi-factor authentication, data encryption, or cryptographic key management;¹¹ and
- HIPAA compliance training for both providers and software vendors.

The EVV System Landscape

The EVV landscape includes roughly 15 vendors¹² who serve most states, MCOs, and HCBS service providers. Two vendors – First Data and Sandata – are the most frequently used vendors among the 14 states that had EVV system mandates in May 2018.¹³ Several states with open models have selected Sandata as the state-preferred system, even though providers can select their own EVV vendor.

Some EVV systems use only one form of technology for data entry, such as telephonic timekeeping or key FOBS, while others support multiple technology interfaces. States with closed EVV models may require providers to use a specific EVV technology, while other states, such as Texas, permit personal care attendants to use whichever input technology they prefer.¹⁴

Despite a relatively small number of EVV vendors, EVV systems vary greatly with little standardization. Without data standardization or interoperability between EVV systems, states will have difficulty interpreting the EVV data providers and MCOs collect or using that data to make policy and care-related decisions.

Limitations of EVV

Focus on workforce accountability

EVV has traditionally been used to identify and prevent fraud, waste, and abuse, and therefore, EVV systems are designed around workforce accountability. Under older models, direct care workers would use a touchtone phone-based system to log the tasks they completed in the home. Newer models generally rely on smartphone apps with questions that cover more and more detailed information about in-home visits. There has been added interest at increasing the level of information that is garnered from an EVV-connected visit, ranging from subjective patient status (e.g. "I don't feel well today") to real-time transmission of vital signs. The hope is to maximize the clinical information that the personal care attendant or home health aide is able to input based on what their clinical degree and licensure will allow. This information could

¹¹ <https://www.hipaajournal.com/hipaa-compliance-best-practices-8809/>

¹² **EVV vendors include:** Axxess; Caretime; Clock In Clock Out, Inc.; Direct Care Innovations; eVero Corporation; GT Independence, Inc.; HHA Exchange; Medware Information Systems, Inc.; MITC; Public Partnerships LLC; QuickSolvePlus, Inc.; Sandata Technologies; Sinq Technologies; Tellus, LLC; and Therap Services LLC

¹³ <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051618.pdf>

¹⁴ <https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification>

be used to monitor quality of care and quality of life, as well as to trigger reassessment of need or alert acute care providers to immediate health care concerns.

Lack of EVV standardization

Some state implementation models, including the “open models” (Provider Choice and Open Vendor Models) and MCO Choice model, allow multiple EVV systems to operate in the same state. Although there are relatively few major EVV vendors, there is little standardization between specific EVV systems. Some systems only incorporate the minimum data elements defined by the Cures Act while others require providers to upload additional information, such as complete personal care assistant schedules to verify arrival times.¹⁵ Variation in EVV data elements, data coding, and technology limits interoperability between systems. Without standardization, states will have difficulty aggregating EVV data collected by providers and MCOs, interpreting the data they collect, or using that data to make policy decisions.

Although EVV has the potential to improve the quality of HCBS and coordination with the broader continuum of care, the technology needed to support EVV is not always available. EVV systems not only lack standardization and interoperability between each other, they often lack interoperability with EHR systems, self-direction systems, Medicaid claims processing systems, and MCO case management systems. Without an adequate IT infrastructure to support it, EVV will have limited ability to improve the value of in-home supports or the broader care continuum.

Consumer privacy

HCBS participants and consumer advocates have raised significant concerns about data privacy. First, even relatively minimal personal support services are covered by location verification requirements. Any personal care or home health care service that is at least partially provided in the LTSS participant’s home needs to have the beginning and end locations recorded. Often, the easiest way for states to satisfy this requirement is to verify every service *just in case* any of the service takes place in the home and to track the location of the entire service episode. Many consumers and consumer advocates already worry about how states and EVV vendors will use location data and have requested that states verify location without requiring GPS tracking. Individuals using HCBS also worry that EVV will limit or prevent individuals from leaving their home if it is the only approved location recognized by the EVV system.

Second, individuals receiving HCBS worry about having their daily activities, or their service providers, unreasonably monitored by State Medicaid agencies. Consumer advocates caution states not only about the data states may require EVVs to include, but also the data caregivers and direct support workers may volunteer about the individual’s home and/or lifestyle.

¹⁵ Partnership for Medicaid Home-Based Care (2018). *Understanding the Electronic Visit Verification (EVV) National Mandate*. Available from: <http://medicaidpartners.org/wp-content/uploads/2017/07/PMHC-White-Paper-Understanding-the-Electronic-Visit-Verification-EVV-National-Mandate.pdf>

Especially for individuals who self-direct their services, states should make sure individuals both understand the data that may be transmitted, and consent to that data being collected. Consumer and worker advocates also worry that the increased tracking and privacy concerns will cause some personal care attendants to seek alternate careers, thus shrinking an already limited supply of employees.

Consumer financial burdens

Consumer advocates have voiced concerns about the cost burden EVV may impose on individuals receiving HCBS. The requirements of the 21st Century Cures Act implicitly assume that all individuals receiving HCBS or their providers have access to a landline phone, reliable internet connections, and/or smart mobile devices. While many, and perhaps most, individuals will have access to one or more of these options, those who don't may be unduly burdened by EVV requirements. Most people who receive HCBS have limited incomes and resources, and may not be able to buy EVV-compatible devices if one is not provided to them. In addition, individuals living in areas with limited or no internet access, including many rural areas, will be unable to use EVV systems that rely on online portals or smartphone apps.

Self-direction and flexibility

Consumer advocates also have a number of concerns about how EVV will interact with self-direction of services. Individuals who choose to self-direct their services want to have flexibility in scheduling their in-home services, and to be able to receive services at sites of care outside of their homes, such as workplaces, restaurants, and social gatherings. Fourteen states plan to integrate their Medicaid EVV systems with existing self-direction management systems or have already done so, and some EVV vendors promote a "self-direction suite" for their EVV software.¹⁶ However, the majority of states have not announced plans to coordinate EVV and self-direction systems, prompting consumers to ask whether both systems will be implemented independently of each other. If EVV systems are simply added onto existing self-direction systems, the new requirements imposed on consumers by EVV may inhibit the flexibility self-direction requires and which self-directing individuals have historically enjoyed.

Consumers worry that some EVV systems may not permit flexibility of check-in locations or times and may not collect the information most relevant to consumers' needs and experiences. These limitations would conflict with the goals of self-direction programs, which attempt to maximize the autonomy and mobility of individuals with disabilities. Therefore, consumers and consumer advocates have pushed for EVV to permit flexible scheduling, flexible service locations, and integration with existing financial management system (FMS) data infrastructures.

¹⁶ www.appliedselfdirection.com/file/835/download?token=v2gvdwRF

Recommendations and Future Directions

We believe that EVV and other data collection technologies have the potential to improve care coordination and facilitate better quality of life for HCBS participants. However, to maximize the value of data collection in the home, policymakers and system vendors should approach data collection not as a fraud, waste, and abuse issue, but rather as a component of creating a streamlined information flow that monitors and informs plans of care, helps ensure that backup systems are in place to address missed visits, and identifies issues where other health interventions may be necessary. We encourage state policymakers to focus on the needs of a coordinated LTSS system as a whole, and what role EVV should play in that system.

Holistic electronic data collection

EVV traditionally collects timekeeping information and focuses on compliance. However, to collect and utilize the data most relevant to effective care coordination and quality of life improvement, in-home data systems should incorporate more holistic data collection that helps caregivers and care teams address HCBS participants' needs. In addition to the core EVV data elements, holistic data collection should include:

- Available clinical data about the individual;
- Data for quality improvement;
- Interoperability with case management, financial management, and self-direction systems the state already uses; and
- Ways to connect direct support workers and caregivers with care teams.

A holistic approach to data collection facilitates better system connectivity and care coordination, reduces siloing of activities, and helps address the needs of all stakeholders. Both states and private companies have begun experimenting with person-oriented, holistic data collection that can incorporate and expand upon the core functions of EVV.

Communication between care teams and in-home providers

Direct support workers and caregivers, by virtue of their direct and frequent contact with HCBS participants, are in a unique position to provide care teams with insights about their clients' needs, and to monitor and communicate changes in their clients' health conditions. Therefore, integrating direct care workers not only empowers care workers, it enables clinical care teams to utilize in-home providers' unique insights and relationships with their clients.

Data collection systems located in the homes of individuals using HCBS, whether EVV or otherwise, present a unique opportunity to connect remote members of the care team to direct support workers' insights about individuals' conditions and needs, potentially even in real time.

Standards for EVV Data Elements and IT Systems

While we support open models that allow providers to pick their own EVV vendors, we also encourage stronger standardization among EVV systems. Different EVV systems operating in the same state may collect different levels of information and may transmit that information in different ways, while health plans want providers to deliver a standard data set and a standard data format for ease of use.

Data Elements

Although the Cures Act creates a standard set of required data elements, the Act does not establish common data element definitions nor standards for data collection, coding, or transmission. Without such standardization, states will struggle to aggregate data and EVV systems will lack interoperability. Therefore, states should standardize how EVV data elements are collected, coded, and transmitted.

CMS's eLTSS Initiative, launched in November 2014, provides an example of how data elements could be standardized. The eLTSS Initiative identifies components or data elements needed for the electronic creation, sharing, and exchange of person-centered service plans.¹⁷ As part of this project, the Office of the National Coordinator for Health Information Technology (ONC) is creating a centralized Data Element Library which maps assessment instrument data elements to accepted health IT standards. This Data Element Library ensures that different assessment instruments collect responses that can be accurately compared against each other. States could use a similar system to ensure that EVV systems are compatible with each other and with other data systems used in the state.

In addition to standardizing the core EVV data elements, states should consider creating standard protocols for expanding EVV data collection. As discussed elsewhere in this paper, the existing core data elements for EVV may not be sufficient for encouraging coordinated HCBS delivery and holistic quality of life improvement for individuals. As part of their stakeholder outreach efforts, states should identify what data is most valuable for health plans to receive, what data vendors are able to provide, and what data individuals are comfortable volunteering to design minimum data sets required to be transmitted during each visit to the home. Any additional EVV elements created in this way should adhere to standardized data collection, coding, and transmission protocols to facilitate aggregation and interoperability.

If some but not all states are prepared to expand EVV beyond the core Cures Act required elements, modulization of data elements should be considered to simplify states' adoption of relevant data elements. States could work together to create standard "modules" of related data elements and collection standards that align with specific quality measurement goals. Standardized modules of data elements outside of the core CURES Act requirements would

¹⁷ <https://oncprojectracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home>

enable states to selectively collect the EVV data most relevant to their quality objectives without disrupting core EVV data collection. As with the core CURES Act data elements, these modules would require standardization of definitions, collection, coding, and transmission to facilitate analysis and interoperability between states.

IT Systems

In addition to data element standards, states should define information technology system standards to ensure interoperability and data usability. At a minimum, EVV should meet requirements that are set against Medicaid or Medicare care management programs used in the state. If the state has assessment requirements or CMS Medicare Model of Care requirements, EVV data should be held to those same standards so that data can be shared, rather than siloed.

To maximize data coordination across the care continuum, EVV should have interoperability with:

- Electronic health records (EHRs),
- Financial management systems (FMS),
- Self-directed service management systems, and
- State and MCO case management systems.

States should also consider data transaction standards such as those endorsed by Health Level Seven International (HL7) to ensure interoperability.

Case Studies: Promising Data Models

Several states and private companies have begun experimenting with electronic data collection and aggregation, providing insights into ways states can create more holistic LTSS data systems.

Georgia TEFT program

The state of Georgia's TEFT demonstration program uses data interoperability to support care team communication and coordination, and to support HCBS members with care-related decisions. The Georgia Tech Research Institute team designed a person-oriented portal which organizes all care team members – case managers, service providers, family caregivers, and more – around the individual receiving services, rather than having silos of activity. The person-oriented portal allows care team members to communicate directly with each other and with the individual and collects both paper and electronic records in a centralized location for better coordination.

CareHeroes

CareHeroes (<http://careheroes.org/>) is a data platform that facilitates integration of direct support workers with clinical care teams; communication between individuals seeking HCBS, direct support workers, and care managers; and EVV. The primary objectives of the platform are:

- To integrate direct support workers more meaningfully into interdisciplinary care teams;
- To create two-way communication between direct support workers and care coordinators/managers;
- To track in-home activity and collect data; and
- To recognize workers for their contribution.

By combining these data and communication functions, CareHeroes creates the infrastructure needed to improve care coordination and quality, while also addressing the EVV requirements of the 21st Century Cures Act.

CareHeroes has already been adopted by Anthem with a non-exclusive contract in several markets. The system is currently used in states such as Iowa, Florida, New Jersey, and Virginia. So far, states are still exploring CareHeroes and have not utilized its full functionality. If used to its fullest potential, CareHeroes offers many ways to improve the connectivity and coordination of LTSS without being restricted to the accountability framework traditionally used in EVV design.

Carina Care

Carina Care (<https://www.carinacare.com>) is a sophisticated job matching registry for consumer-directed programs in Washington state. This free online tool helps connect In-Home Care Clients and Individual Providers who are contracted with the state's Department of Social and Health Services (DSHS). While not an EVV system, Carina Care demonstrates how states can create greater communication between direct support workers and their clients, and could be expanded to include communication with care teams as well.

The state of Washington is currently supporting the development of this innovative startup. While Carina Care has interim and long-term deliverables to meet for the state, they are free to take the model to other markets.