Meeting Title	Electronic Visit Verification (EVV) Learning Collaborative: Achieving and Monitoring Compliance With the Cures Act
Date	Thursday, November 14, 2019
Time and Location	1:00 p.m. – 3:00 p.m. WebEx
Dial-In Information	Dial: 1-833-612-0014 Conference ID: 5275018
Web Conference	https://lewisellis.webex.com
Meeting Facilitator	Centers for Medicare & Medicaid Services (CMS)
Note Taker	Sarah Vintorini
Attendees	**BerryDunn:** Jason Hargrove, Beth Jenckes, Jessica Lindley, and Sarah Vintorini
Attachments	N/A

Meeting Purpose: The CMS Division of Long-Term Services and Supports (DLTSS) has launched Electronic Visit Verification (EVV) Learning Collaboratives for states, CMS, and other stakeholders to openly discuss system design and implementation of EVV for Personal Care Services (PCS) and Home Health Care Services (HHCS), per the section 12006 of the 21st Century Cures Act (the Cures Act). The goal of these meetings is to foster collaboration across CMS, state agencies, and other stakeholders by providing a forum to share information and discuss issues, promising practices, and experiences related to the Cures Act and EVV.

The topic of this fifth Collaborative is **Achieving and Monitoring Compliance with the Cures Act** and will cover strategies for communicating expectations surrounding compliance, achieving compliance with the Cures Act and state regulations, and monitoring compliance, according to the agenda included below. CMS has also included a slide from the previous Collaborative with strategies for successfully implementing EVV solutions, as a summary of the fourth session.

PLEASE NOTE: These notes should accompany the slide deck the group reviewed during the EVV Learning Collaborative call. The information below is what was covered in addition to the slides and should not be considered a summary of that information.

Agenda Items

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1.	Introductions The meeting began at 1:06 p.m. Panelists: • Nevada (NV) ○ Kirsten Coulombe, Social Services Chief III Division of Health Care Financing and Policy Nevada Department of Health and Human Services • Oklahoma (OK) ○ David Ward, Community Living Services Coordinator Oklahoma Health Care Authority • Virginia (VA) ○ Tim Catherman, Program Manager Division for Aging and Disability Services Virginia Department of Medical Assistance Services
2.	Timeline and Strategies for Compliance CMS said as of the date of the conference call, the Good Faith Effort (GFE) exemption has not changed. It has been monitoring trends for states' delays of EVV implementation and highlighted the following as the most common reasons: • Engagement of stakeholders • Procurement issues • System interoperability issues Compliance Survey • Federal Matching Assistance Percentage (FMAP) reduction is evaluated and determined during each quarter a state is not in compliance. FMAP reduction only applies to Personal Care Services (PCS) at this time. • The Compliance Survey will be available for use on November 18, 2019. • State Medicaid Directors who do not have a GFE exemptions must submit their survey results by December 31, 2019. • The Compliance Survey will need to provide an attestation statement confirming, documenting, and describing EVV compliance for PCS.

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3.	Panel Discussion:
	Each panelist provided an overview as to what activities has taken place in his/her state since the previous collaborative call in January 2019. Activities reported are summarized below:
	
	VA
	• VA has conducted a lot of research since the first EVV Learning Collaborate held in January 2019. Some of our activities included:
	  ○ Provider and member outreach
	  ○ 10 presentations to associations
	  ○ Two webinars to providers
	  ○ Six town hall meetings for providers
	  ○ Direct emails to providers
	• VA's website is a very effective outreach tool. VA has responded to over 1,300 emails to date.
	• VA has conducted a soft launch, using actual claim submissions. Providers are given the opportunity to address issues during this transition time.
	• VA is implementing a hard compliance on January 1, 2020.
	NV
	• After pushing the live date back, NV recently went live with its EVV solution.
	• NV is utilizing a phased approach to implementing EVV.
	• NV started a pilot with one large and one small test agency. The two test agencies provided feedback before the full rollout.
	• NV's go-live date was September 29, 2019.
	• NV provided a three-day training to providers.
	• NV's outreach activities continue, which include monthly meetings and regular town hall meetings.
	OK
	• OK was initially operating a closed EVV model but has changed to an open model.
	• When OK first started EVV, prior to the Cures Act, the solution was targeted to the aging population.
	• After the Cures Act made EVV mandatory, OK looked at the entire population.
	OK received a letter from the provider association including many small EVV solutions, asking that the State solution include an aggregator.

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	Good Faith Effort Exemption (GFE) The panel discussion shifted to the topic of the GFE. The panelists shared their rationale for seeking the extension and what activities were prioritized during that time. The discussion by state is summarized below: NV • NV started the Request for Proposal (RFP) process in 2018. The extension allowed NV more time with the selected vendor. • NV participated in Advisory councils, Tribal councils, Medicaid Advisory Committee, town halls, and worked with providers. • Receiving the GFE allowed NV additional time to get answers and not rush stakeholders. OK • Needed an extension because they ran into concerns from stakeholders. • OK works with six 1915c Home and Community-Based Services (HCBS) programs and four with Development Disabilities Services (DSS), which is a medically fragile waiver. • As a result, the state had to procure and rewrite a new contract, which set them back four to six months. • CMS approved the contract, and OK's implementation goal is March 1, 2020. • OK is trying to procure one vendor. *Engagement* CMS said that many states used additional time during the extension to conduct stakeholder engagement. The panelists were asked to share stakeholder engagement highlights, effective outreach strategies, and if they penalize for noncompliance. The discussion by state is summarized below: OK • OK holds quarterly regional meetings and held an open stakeholder engagement meeting. • OK currently has small town halls throughout the state for the consumer-directed services option. Meeting topics are designed around member concerns. Two main concerns are privacy and user-friendliness. VA • With well over 20,000 Consumer Direct members in VA, a lot of outreach is required. VA's outreach approach includes activities such as: ○ Introduction letter mailed to members highlighting concepts and requirements of EVV.

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	○ Webinar series explaining EVV and how to handle it. ○ Town hall meetings where vendors showcase the use of smart device applications, allowing recipients to experience using the application, and providing the opportunity to ask questions. ○ Vendor webinars which are well received by those who take advantage of the opportunity. ○ Informing members that they will investigate anyone who is not compliant by January 1, 2020. If members are simply refusing, then the member will be referred to the agency for direction. VA reminded members they have agreed to follow the rules. ○ Work with stakeholders to address member concerns regarding privacy. *Data Aggregation and Verification - Must capture six data elements* CMS asked the panelists to discuss how the required six data elements are being collected in their state. The discussion by state is summarized below: NV • NV has an open model and a data aggregator is being used. • The EVV Solution is Authenticare from First Data. • The system allows providers to bill directly from EVV to the Medicaid Management Information System (MMIS). All services must be billed from Authenticare to help ensure all six data elements are captured. • Managed Care Organizations (MCO) are required to use an aggregator. VA • Team avoids the term “aggregator” because it has different meanings. • VA is a managed care state. One of the VA health plans uses the term aggregator for its EVV. • To keep it consistent, VA communicates they received the information and it is then maintained within the defined collection and reporting. • VA issued an 837-page report for information so all EVV information comes in with the claim or encounter. • VA started EVV October 1, 2019. Plan is to monitor encounter claims from Fee-for-Service (FFS) vendor and MCOs. • The system was built to require all six data elements on the claim. VA is monitoring the claims to help ensure all required data is included • For FFS, if data is not there, it impacts their payment. • MCO will do a post review to help ensure it is capturing the data. OK

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	• Engaged members, providers, member advocates to help determine system. • Vendor will have information that is expected with the one-to-one match before going to MMIS at Home Healthcare Authority. If not a one-to-one match, the claim is stopped. There are multiple places to pick up errors before the claim goes to the MMIS for payment. Must have all six data points. *VA has a mechanism for messaging with providers. CMS asked VA to talk about the messaging. VA's messaging mechanism:* • Uses direct messaging with providers if providers are not entering the six data elements. • Works with providers to submit the information. VA is working with its EVV vendor to help ensure the vendor is compliant. Sometimes that leads to direct conversations with the vendor if the provider does not understand. Then the EVV vendor may communicate with the clearing house to help ensure it has the right standards and conditions in place to process. VA has found that some clearing houses have edits built in to keep claims clean. Vendors are helping to ensure the edits are in place so the claims can get through as clean. • VA said that they are working with MCOs to incorporate EVV review in their Fraud, Waste, and Abuse office. *CMS encourages states to use the data from EVV during the claims adjudication process. *Paying Providers* *CMS asked the panelists to discuss how do they handle missing data and whether that omission effects payment to the providers.* The discussion by state is summarized below: VA • Requires six data elements within the EVV claim. If there are issues with the claim submission, VA notes it on the remittance and includes a description of what needs to be corrected so payment are not impacted. This process will remain in place until January 1, 2020. After January 1, the claim will be denied if there is no matching EVV data. • Is very specific about how the data elements are reported – data type. • Is educating the provider community on the use of modifiers so the second visit will be paid without penalty. With EVV claims, there are multiple line items for the same date of visit. Many systems have built in that the second visit will automatically be denied as a duplicate claim. • Is working with MCOs to use the same methodology on reviewing claims.

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	OK
	• Uses mostly an exception process based on location.
	• will stop the claim from going to payment source if location data is missing or bad, or without prior authorization attached.
	NV
	• Uses a hierarchy of what is allowed, starting with using mobile device, then verification through telephone, then as a last resort, through web-based claim.
	  ○ If a personal attendant does not have a mobile device and the member does not have a landline, then a web-based claim will be allowed.
	  ○ Working with CMS for guidance on threshold on web-based claims.

4.	Questions and Answers During the next section of the collaborative call, participants were given the opportunity to submit questions for discussion. Those questions were sometimes asked to the general group while other times they were targeted to specifically CMS. In addition, CMS facilitated questions and asked the panelists to share their experience on the given topic. Questions and answers are summarized below: Q for CMS: *If a state is not compliant in time, does enhanced funding stop?* A: No, the Advanced Planning Document (APD) is still valid. Certification is tied to enhanced funding and the APD process. The Outcomes-Based Certification (OBC) process is separate from the EVV Compliance Survey. Q for OK: *Technically, how are the six data elements being transferred to the state?* A: Vendor has a form or template that providers must utilize to import that information. Template has all the information, plus a few other data elements that providers load. It is then passed to the aggregator. It is not through an Application Programming Interfaces (API). Q for NV: *If there are issues with phone service in rural areas, how are providers expected to handle collection and submission?* A: There is the option to designate a recipient in “frontier mode” so it captures information in offline mode and then uploads when service is available.

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	Q for NV: *How do you determine which method of communication a member should provide?* A: Our preference is to have the least impact on members. Preference is that providers enter EVV data with their own mobile devices. Providers know their recipients well, so their due diligence is to find out if the recipient has a landline. NV engaged Case Managers in part of outreach for1915c waivers. Case Managers are included in the 1915c provider training. Q for CMS from Andrew Cosge with Home Care Association of New York State: *Regarding August guidance on live-in caregiver, New York has cases where* the provider lives with the client *a few days a week. Does the guidance apply if the caregiver doesn't live with the client permanently?* A: One of the ways to determine live-in caregiver would be how the state defines primary residence of the caregiver. If it is the same as the member, that would be a live-in caregiver. CMS recognizes states may want to consider how it meets a state's service delivery model. Q from CMS: *Whose responsibility is it to train providers and recipients?* A: OK has been working with EVV vendors for training with providers. There is a weekly call with the vendors and providers. A: NV has biweekly calls with vendors and providers. Vendor handles all things related to the system, and the state addresses any policy concerns. In implementation, most calls are claims issues. Providers have a touchpoint with vendors. Q from CMS: *What is the process for talking with providers about audits?* A OK: OK has developed and published error codes that providers are familiar with. It's related to claim errors. Providers know about the error codes. A VA: VA has not done any auditing focused on EVV. However, the EVV record is a claim, and all claims are monitored by MCOs and the Department of Medical Assistance Services (DMAS) under the normal fraud, waste, and abuse program. There is an inspection, but we're not denying any claims now based on EVV compliance. MCOs and DMAS will be looking at the claims after January 1, 2020 to help ensure claims contain the proper information.

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	Q from CMS: *How is the state monitoring training on the provider system?* A VA: On the agency-directed side, VA is leaving that up to agency. If there is any need for a manual adjustment, somebody in the provider's office has the authority to adjust the aide's time. On the consumer-directed side, VA is working with the vendor to help ensure applications are as user-friendly as possible. Training is available on the EVV website but is not mandated. Q from CMS: Although EVV is not required to track live-in caregivers*, can a state collect this information?* A: With an open model, the provider and MCO can determine that they'll use EVV for additional services or checks and balances for their own program integrity efforts—That is allowed in the Cures Act. Q from CMS: *Do any of the panelists' states require or allow an individual who is receiving services to validate those services have been received?* A: OK: For consumer-direct, OK is considering the option for member to enter a code at check-in and checkout on mobile app as a secondary verification. A: VA: VA requires a secondary verification by the member. VA turned EVV system into the timesheet—it previously had to be signed off by the member. Q from CMS: *Did states release or mandate a training plan? If so, did you get feedback on it?* A VA: VA is going through a training plan now. We wanted to coordinate with vendor and providers so when vendor does a training, providers are available. VA is moving to online interactive training and wants to help ensure providers can use that system. VA has received good feedback so far. Q from CMS: *Is there a threshold for the number of manual EVV entries?* A NV: NV is working with CMS to identify a threshold. Have not identified a threshold amount yet.

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	A VA: VA has not established a threshold; however, providers are being advised that as they become more comfortable with the system the amount of manual adjustments should decrease. Q for VA: *Is your self-directed model employer or budget authority?* A: Employer authority model. As oversight for EVV, we are looking at claims that come in. MCOs are submitting reports to demonstrate EVV compliance at this point. Q for NV: *How do you help ensure secondary verification for self-directed*? A: If member is not able to sign off, then the employer of record will sign off. Sign-off does not have to happen immediately—can go to a web portal later or go to smart device to sign off.
5.	Next Steps • CMS said to reach out to HCBSEVVLC@navigant.com for further information regarding EVV and today's presentation. • The sixth Learning Collaborative will be held by CMS sometime in early 2020, after the Cures Act deadline. An agenda will be emailed prior to the session. • The session concluded at 3:00 p.m.