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)

Provisions of the Legislation

1. Q: **What does section 12006 of the 21st Century Cures Act require?**

   A: Section 12006 of the 21St Century Cures Act (the Cures Act), P.L. 114-255, added Section 1903(l) of the Social Security Act (SSA). Section 1903(l) provides that states must require the use of an electronic visit verification (EVV) system for personal care services (PCS) and home health care services (HHCS) that require an in-home visit by a provider.

2. Q: **Does section 1903(l) apply to all Medicaid PCS?**

   A: The section 1903(l) requirement applies to personal care services (PCS) requiring an in-home visit that are provided under the Medicaid state plan or under a waiver program or demonstration project under the following Social Security Act provisions and their implementing regulations:

   1) SSA Section 1905(a)(24) state plan personal care benefit
   2) SSA Section 1915(c) home and community-based services waivers
   3) SSA Section 1915(i) home and community-based services state plan option
   4) SSA Section 1915(j) self-directed personal attendant care services
   5) SSA Section 1915(k) Community First Choice state plan option
   6) SSA Section 1115 demonstration projects

   For purposes of the electronic visit verification (EVV) requirement under SSA section 1903(l), the definitions of "personal care services" and "self-directed personal assistance services" at 42 CFR §§ 440.167 and 441.450 apply, as do any state-specific definitions of the term or similar terms (e.g., personal attendant services, personal assistance services, attendant care services, etc.) in CMS-approved state plan amendments, waivers, and demonstration projects under section 1915(c), (i), (j), or (k), and section 1115. States should also refer to descriptions of the service in CMS guidance, such as the State Medicaid Manual (CMS Manual Pub. #45) section 4480. The definition of "personal care services" is not uniform across all the authorities under which it can be covered as a Medicaid benefit, but in general, it consists of services supporting Activities of Daily Living (ADL), such as movement, bathing, dressing, toileting, and personal hygiene. Personal care services can also offer support for Instrumental Activities of Daily Living (IADL), such as meal preparation, money management, shopping, and telephone use.

   Personal care services that are provided to inpatients or residents of a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or an institution for mental diseases, and personal care services that do not require an in-home visit, are not subject to the EVV requirement.

3. Q: **Does section 1903(l) apply to all HHCS?**

   A: Section 1903(l) applies to home health services requiring an in-home visit that are described in section 1905(a)(7) of the SSA and provided under the state plan or under a waiver of the state plan (such as a Section 1915(c) waiver or a waiver under a Section 1115 demonstration).

4. Q: **Does the EVV requirement apply to the Program of All-Inclusive Care for the Elderly (PACE) program?**

   A: CMS does not interpret the EVV requirement to apply to PACE program services. In CMS's view, PACE is a separate Medicaid benefit listed in section 1905(a)(26) of the Social Security Act, and that provision is not cited in section 12006(a)(5)(C) of the Cures Act.

5. Q: **States often choose alternate titles for personal care services or bundle them within other service definitions (e.g., respite, in-home living supports). Is the Cures Act definition limited to just those services explicitly titled "personal care services" in a state's state plan or waiver program?**

   A: All services requiring an in-home visit that are included in claims under the home health category or personal care services category on the CMS-64 form are subject to the EVV requirement. In addition, services furnished under waivers or demonstration projects that meet the statutory or regulatory definition of a "home health service" or "personal care service" must meet the EVV requirement, even if they are bundled into a different service or furnished through a managed care provider. In other words, if the service includes personal care services or home health services, even if it has a different name or also includes other services, it is subject to EVV.

6. Q: **The Medicaid home health benefit is defined through regulation to include (a) nursing services, (b) home health aide services, (c) medical supplies, equipment, and appliances. At the state's option, the benefit may also include physical therapy, occupational therapy, and speech pathology and audiology services. Is EVV required for all of the services included in a state's home health benefit?**

   A: SSA Section 1903(l)(1) specifies that the EVV requirement applies to "personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this title (or under a waiver of the plan)…". Similarly, section 1903(l)(5)(B) defines home health services for purposes of the EVV requirement to mean "services described in section 1905(a)(7) provided under a state plan under this title (or under a waiver of the plan)." Therefore, any home health services that the state has opted to cover under the state plan or under a waiver of the plan, and that require an in-home visit, would be subject to the EVV requirement. For example, if a medical supply is delivered through the mail, or is picked up at the pharmacy, EVV does not apply. However, if a medical supply requires an in-home visit for set-up, then EVV applies. This applies to both managed care and fee-for-service delivery systems.

7. Q: **What type of EVV system must be used?**

   A: Section 12006(c)(2) provides that section 1903(l) cannot be construed to require the use of a particular or uniform EVV system. However, section 1903(l)(5)(A) provides that the system must be

able to electronically verify, with respect to visits conducted as part of personal care services or home health care services, the following:

1) the type of service performed;
2) the individual receiving the service;
3) the date of the service;
4) the location of service delivery;
5) the individual providing the service; and
6) the time the service begins and ends

Section 1903(l)(2) also requires states to provide for a stakeholder process to allow input into the state's implementation of the EVV requirement from providers of PCS and home health services, beneficiaries, family caregivers and other stakeholders.

8. Q: **When do states need to comply with this requirement?**

A: An EVV system must be in place for personal care services starting January 1, 2019 (*there is an extension provided for States making the new compliance date 01/01/2020). An EVV system must be in place for Home Health Services starting January 1, 2023 If a state demonstrates to the Secretary (1) that the state has made a good faith effort to comply with the EVV requirements (including by taking steps to adopt the technology used for an electronic visit verification system), and (2) that the state, in implementing such a system, has encountered unavoidable system delays, then the FMAP reductions shall not apply for calendar quarters in 2019 (for personal care services) or for calendar quarters in 2023 (for home health care services).

9. Q: **What happens if a state does not implement the EVV requirement?**

A: Section 1903(l) requires a decrease in the Federal Medical Assistance Percentage (FMAP) rate if EVV is not implemented. For calendar quarters in 2019 and 2020, FMAP for PCS is decreased by .25 percentage points. FMAP is reduced by 0.5 percentage points for calendar quarters in 2021 and by 0.75 percentage points for calendar quarters in 2022. For calendar quarters in 2023 and each year thereafter, FMAP is reduced by 1 percentage point. For home health care services, the same increments apply, but the FMAP reductions do not start until 2023. Thus, for home health care services, for calendar quarters in 2023 and 2024, FMAP is decreased by .25 percentage points. For calendar quarters in 2025, FMAP is reduced by .5 percentage points. For calendar quarters in 2026, FMAP is reduced by .75 percentage points. For calendar quarters in 2027 and each year thereafter, FMAP is reduced by 1 percentage point.

CMS notes that the legislation exempts the FMAP reductions only for calendar quarters in 2019 for EVV implementation in PCS and only for calendar quarters in 2023 for EVV implementation in HHCS for states that have made a good faith effort to comply with requirements. This good faith effort applies to states that have taken steps to adopt the technology used for an EVV system AND have encountered "unavoidable system delays". States may begin submitting information to CMS in July 2018 to describe concerns they foresee in adhering to January 1, 2019 effective date for PCS and provide justification that the state has demonstrated a good faith effort. CMS will be working with states on an individual basis to determine if both conditions of a good faith effort are present.

10. **Does the Cures Act require EVV to be used if the care recipient and worker live together?**
    No. The Cures Act only requires EVV to be used for "in-home visits". CMS has ruled that services provided by live-in workers do not constitute "in-home visits".

11. **If a worker's shift beings in the home but ends in the community (or vice versa) am I required to have EVV for the entire shift?**
    Worker shifts that begin in the home and end in the community (or vice versa) only require EVV for the portion of the shift that takes place in the home.

12. **Can web-based electronic timesheets with dual verification meet Cures Act requirements for EVV system?**
    No. CMS confirmed that web-based electronic timesheets with dual verification will not meet Cures Act requirements for EVV systems.

State Specific Variations

13. Q: **Are there any implementation flexibilities for states with legislatures that only meet every two years, and will not meet again prior to the January 1, 2019 effective date for EVV systems in personal care services? Can states demonstrate a good faith effort in implementation activities and avoid the reduction in FMAP?**

    A: Section 1903(l)(4) allows a state to demonstrate that it ``*…(i) has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); and (ii) in implementing such a system, has encountered unavoidable system delays".* If the state can make such a demonstration, FMAP will not be reduced for calendar quarters in 2019 (for PCS) or 2023 (for home health care services). It is important to note there is no extension beyond these specified quarters in these specific years.

    CMS will take variables such as legislative cycles into account when determining whether individual states meet the criteria for the good-faith exception to the requirement. However, CMS will expect states to demonstrate that they have made good faith efforts to meet the dates required in the Cures Act; this could include, but not be limited to, the state demonstrating steps taken to adopt and implement the technology used for an EVV system.

14. Q: **How does CMS anticipate states implementing EVV requirements in frontier or rural areas?**

    A: Section 1903(l) does not include an exception for frontier or rural areas but does give states discretion in determining the type(s) of systems that would work best. States should, therefore, determine which EVV system works best for them, including for their frontier or rural areas, so long as the system captures the six verification criteria specified in the statute (i. service type; ii. Individual receiving the service; iii. date of service; iv. location of service delivery; v. individual providing the service; and vi. begin and end times of service). States may implement more than one EVV system to account for differences in geography, the strength of cellular networks, etc.

Implementation Flexibilities

15. Q: **Must states implement a specific type of EVV system?**

A: No. As long as all of the statutorily mandated information is collected on personal care and home health care services requiring an in-home visit by a provider, states have significant discretion to utilize the system(s) of their choosing. CMS does not endorse one type of system over another. In a concurrent guidance mandated by the legislation to describe best practices of EVV system implementation, CMS described some examples of systems that facilitate the integration of existing systems, along with implications for states, provider and beneficiaries when specific models of EVV are selected by the state.

16. Q: **Does an EVV system require the Medicaid beneficiary to have an Internet connection, a cell phone, or a landline?**

A: No. CMS notes that there are a number of options available within an EVV system. CMS believes there are EVV system options that meet the six verification criteria specified in the legislation without relying upon a Medicaid beneficiary to supply any technology, including those in which the provider has a phone or electronic tracker available to staff and/or the service recipient. The state should explore all options available and determine what best fits the needs of the state.

17. Q: **How can EVV be implemented in ways that minimize privacy concerns, particularly around the need to capture location information through the EVV system?**

A: The Cures Act does not require states to capture each location as the individual is moving throughout the community. Services either starting or stopping in the individual's home are subject to EVV requirements and capturing the location in which the service is started and stopped is sufficient for meeting the minimum requirements specified in the Cures Act. CMS notes that states may choose to require more information as a factor to control for fraud, waste, and abuse. State Medicaid Agencies have a good deal of discretion in selecting the EVV system(s) that will most effectively meet their needs. CMS also notes that there is no requirement to use global positioning services (GPS), but it is one approach for implementation of the EVV requirements. A common alternative to GPS is Interactive Voice Response, which requires the caregiver to check-in and out using a landline or cellular device located at the individual's home.

Self-Direction Implications

18. Q: **How can states implement EVV systems in self-directed personal care programs in ways that adhere to program flexibilities?**

A: CMS recognizes the hallmarks of self-directed programs such as beneficiary selection of service provider and flexibility in determining optimal service provision timeframes. CMS encourages states to select EVV systems that facilitate accommodation of self-directed models by ensuring flexibilities such as fluid scheduling modifications, choice of worker, engagement in community activities, and proper interaction with Financial Management Services (FMS) entities. As with all programs, including self-directed programs, EVV systems are also encouraged to have processes for troubleshooting and communication of roles and responsibilities.

Federal Funding Availability

19. Q**: Is enhanced Federal Match available for administrative costs for providers or managed care organizations to contract with their preferred EVV vendors?**

A: No. CMS does not have the authority to provide an enhanced federal match for administrative costs for providers or managed care organizations. However, enhanced match may be available to states for mechanized claims processing and information retrieval systems (e.g., MMIS) in 1903(a)(3) for software programs or equipment interfaces necessary to receive data from managed care vendors into the MMIS as this will enhance states ability to use data and automation to improve efficiency of the Medicaid program.

In some instances, providers may incur costs to purchase EVV devices and/or equipment themselves. In those instances, the costs associated with the purchase of the EVV devices and/or equipment could be built into the rate paid to the provider for the rendering of services. Please check with your RO for technical assistance on provider payment rates.

20. Q: **Is enhanced Federal Match available for state expenditures on tools necessary for EVV implementation, such as phones, internet access, fobs, tablets, etc. for providers or individuals receiving services?**

A: No. CMS does not have the authority to provide enhanced federal match for administrative costs for providers or individuals receiving services.

Next Steps

21. Q: **Will CMS require states to demonstrate the use of EVV in their MMIS as a condition for receiving enhanced Federal Match under 1903(l)(6)? If so, how should states ensure the necessary EVV data are captured?**

A: EVV systems supported with enhanced federal funding should provide for the necessary interfaces or data exchanges that are appropriate to ensure that the MMIS provides a comprehensive management tool for efficient, effective, and economical administration of Medicaid. CMS is considering options for reviewing EVV systems as part of the Medicaid Enterprise Certification Toolkit (MECT) process. CMS will work with states to provide additional guidance in this area.

22. Q: **Will CMS require states to demonstrate the use of EVV systems relative to provider claims and tracking of services in the MMIS, as a condition for reimbursement of expenditures for PCS and HHCS services?**

A: Yes. States can demonstrate this in a variety of ways, through direct interface with the MMIS, or other conceptually equivalent methods or processes, including through the use of decision support systems and automated or ad hoc data analytics (See the State Medicaid Manual (SMM) Part 11225).

The U.S. Department of Health & Human Services (HHS) uses a variety of methods to monitor state claims for expenditures and for improper payments. Our reviews and determinations are established using several different approaches, including CMS 64 reviews, Financial Management reviews (FMR), CMS Payment Error Rate Measurement Program (PERM) Reviews, MMIS Data Reviews, Medicaid Integrity Contractor (MIC) Audits, and findings from the HHS Office of Inspector General (HHS OIG) and Single State Audits. Reviews start with the expenditure claim from the state and work back to the source documentation (e.g., provider claims and related documentation) that supports the claim. In the course of audits or reviews, we anticipate that EVV systems that are integrated with MMIS will enhance states' ability to identify, document, edit, and track claims and expenditures for PCS and HHCS paid through the MMIS. As an example, for a PCS claim, a state could obtain the number of assessment hours a client was authorized, verify the number of hours services were provided using the EVV system, and match that to prior authorization and payment activity in the MMIS. The match can occur directly in the MMIS, or through a conceptually equivalent method or process as mentioned above. CMS anticipates that the EVV system will help increase the state's ability to validate the provision of services and monitor the accuracy of payments to providers thereby detecting and addressing instances of potential fraud, waste and abuse.

General

1. **What services will require EVV?**
   Personal care services (PCS) and home health care services (HHCS) that require an in-home visit by a provider (a list of services can be located on the EOHHS EVV webpage under the link for the Sandata Third Party EVV addendum V1.0).

2. **Do I have to use EVV?**
   In order to continue to provide services subject to EVV and be reimbursed, you will be required to use EVV beginning on 01/01/2020. If you do not use an EVV system, claims submitted may not be paid or payment may be taken back.

3. **What is the expected timetable for deployment, education, and training on the EVV system?**
   EOHHS will be sending out regular updates on the progress of the implementation. Notifications will be sent out via email as well as update to our EOHHS EVV webpage. EVV training for the Sandata closed system will take place when implementation is completed. Agencies will gain access to their EVV systems once they have completed training. The full EVV system will be available for use prior to go live, providing agencies time to familiarize themselves with the system and begin using it prior to the 01/01/2020 implementation date. Providers who are using an Alt. EVV system will complete self-paced online training as part of their testing and validation process with Sandata.

4. **Who is paying for the EVV system?**
   If a provider chooses to use a third-party vendor, the provider will pay for the EVV system, including EVV system implementation, provider agency EVV training, and ongoing recurring EVV fees. If a provider uses the current, Sandata EVV system, the State pays for that system.

5. **Will I need additional staff to manage EVV?**
   No, you should not need additional staff to manage EVV. It is very important that you make sure that both your caregiver staff and office staff are fully trained and compliant with EVV, which will ensure a smooth and successful EVV implementation for your agency.

6. **Who do I call if I have a question or concern about EVV?**
   If the question or concern is around the overall EVV program, you should direct your concern to Meg Carpinelli (Margaret.carpinelli@ohhs.ri.gov). If you have questions or concerns regarding the use of the Sandata EVV system, please contact Sandata EVV Customer Success at RIcustomercare@sandata.com to address your concern.

7. **Do I have to buy my caregivers smartphones?**
   No, you will not be required to buy your caregivers smartphones for EVV. The ability to use Mobile Visit Verification is OPTIONAL, and up to you and the caregiver.

   In those instances when a phone is unavailable, and the provider is using the current Sandata EVV system, a Fixed Visit Verification Device may be installed in a client's home which is used to obtain a random unique number for use in checking in/checking out when a phone is later available.

8. **Why is The State of Rhode Island implementing an EVV system?**
   Congress passed a federal law requiring state Medicaid programs to implement an EVV system for home and community-based services. The law is commonly referred to as the 21st Century Cures Act. The provisions of the Cures Act that address EVV can be found in section 12006 of H.R. 34 (114th Congress) (2015-2016).

9. **How long is it between when visit information is entered and when I can see it in the Sandata EVV portal?**
   Visit information is generally available in the Sandata EVV Portal in near real-time.

10. **I am an agency and have my own EVV system. How do I interface with Sandata?**
    Please see the EVV Business Requirements for Alternate EVV Data Collection Components http://www.eohhs.ri.gov/ProvidersPartners/ElectronicVisitVerification(EVV).aspx to see if your system meets the requirements to participate in the EVV program using an alternate EVV system.

11. **How can I ensure that I receive all the information I need about the EVV program?**
    All information on EVV and the project implementation can be located at http://www.eohhs.ri.gov/ProvidersPartners/ElectronicVisitVerification(EVV).aspx

Aggregator

1. **Do I have to use the Sandata EVV system?**
   Providers may choose to use an alternate EVV data collection system.

2. **If I am already using an EVV technology, do I have to switch to the State of Rhode Island's Medicaid EVV system?**
   You may continue to use your current EVV system, but you must meet EVV business requirements and Sandata technical specifications. Both the business requirements and the technical specifications are available on the State's website http://www.eohhs.ri.gov/ProvidersPartners/ElectronicVisitVerification(EVV).aspx .
   Providers will be responsible for working with Sandata and for any interface costs charged by their vendors if they choose to use their own system.

3. **What if my Alternate EVV System vendor cannot map its values to Sandata's field values?**
   The data in the aggregator must be consistent across the program. Therefore, Alternate EVV Systems must send the same values in the format and manner specified in the technical specification. You must use Sandata's EVV system if your vendor cannot accommodate the values, format, or interface requirements defined in the Alternate EVV System Technical Specifications: http://www.eohhs.ri.gov/ProvidersPartners/ElectronicVisitVerification(EVV).aspx

4. **If my alternate vendor already went through the Sandata certification process, do I need to complete the certification process also?**
   Yes. Even though one agency has an approved interface to the aggregator, it does not guarantee it will work for your agency. You must complete the testing process to ensure the interface works with your Alternate EVV System and to gain Sandata' s interface certification.

5. **When must I complete my interface to the Aggregator?**
   EVV implementation is planned for 01/01/2020. If you choose to use an alternate EVV system at the start of the program, we recommend that you complete the certification process at least 60 days prior to going live. This will ensure ample time to enter the required information.

6. **How do I start the certification process?**
   If you plan to use an alternate EVV system, please contact RIAltEVV@sandata.com to initiate the process to link to the Sandata aggregator. We recommend that your system be approved and functional at least 60 days before the planned 01/01/2020 EVV implementation date. It is important to allow sufficient time for development and testing. If you have questions about using an alternate EVV system, please email Sandata EVV Customer Care RIAltEVV@sandata.com or call 1-855-781-2079.

Mobile Visit Verification and Telephony Visit Verification

1. **What happens if the EVV device or Sandata Mobile Connect app cannot connect to the system?**
   If GPS or cellular coverage is not a viable option for a specific visit, you can use telephony or manual visit verification to capture visitor information.

2. **Are the phone numbers used to call in visit verification toll-free?**
   Yes

3. **Does the caregiver have to use a phone in the individual's home for telephony?**
   The caregiver can use any phone that has a phone number associated with the member to record a visit using telephony.

Implementation

1. **What Internet browsers does the Sandata EVV system support?**
   As of September 1st, 2019, the Sandata system is accessible using the standard web browsers including:

- Chrome Version 76
- Firefox Version 68
- Internet Explorer 11

***NOTE* while Sandata EVV works with Microsoft Edge and Safari, Sandata has not formerly certified these browsers.**

Sandata supports the most current version of the listed browsers as well as backward compatibility for one previous version.

2. **Who is responsible for installing the Sandata EVV system?**
   There is nothing to install. Your agency, including all administrative users, will access the EVV system via the web. It will require a current web browser and sufficient internet connectivity. It will not require additional IT resources or systems. You will receive access to your web-based EVV system upon completion of training.

Training

1. **How many employees can I send to training?**
   Each provider number can send a total of two employees to any webinar training. There is no limit on the number of employees who can participate in the self-paced, on-line training. Please make sure to check your emails for training registration updates.