



# 21<sup>st</sup> Century Cures Act EVV Mandate

*Sandata Technologies*

HCA Senior & Financial Manager's Retreat  
September 7, 2017

# Agenda

- 21<sup>st</sup> Century Cures Act Overview
- What is Electronic Visit Verification?
- EVV Models and Scorecards
- Value Beyond Compliance



# 21<sup>st</sup> Century Cures Act Overview

## Electronic Visit Verification System Required for Personal Care Services and Home Health Care Services Under Medicaid

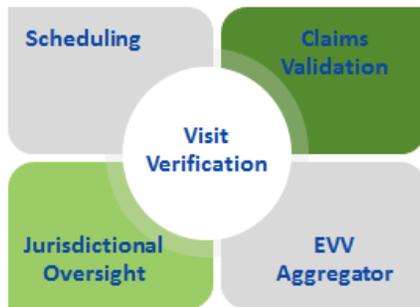
- 1. States that do not comply by the mandated dates will face an escalating penalty:**
  - Personal Care Services: January 1, 2019
  - Home Health Services: January 1, 2023
- 2. The EVV system must verify the following:**
  - Location and Type of service;
  - Individuals Providing and Receiving service;
  - Date and Time the service Begins and Ends.
- 3. States must:**
  - Implement a process to seek input from beneficiaries and caregivers
  - Consult with Agencies and ensure the program:
    - Is minimally burdensome, HIPAA compliant, takes into account existing EVV systems
- 4. CMS will publish best practices by Jan 1, 2018:**
  - Training caregivers on the use of the system and the prevention of fraud
  - Educating family caregivers and members on the use of EVV to prevent fraud

### EVV qualifies for Enhanced Federal Match

- 90% Implementation
- 75% Program Fees



# Electronic Visit Verification (EVV): What is it?



Electronic Visit Verification is a modular technology solution that provides transparency into home based care delivery, supporting provider network optimization while improving the member's quality of care. Modules typically include:

## 1. Scheduling Module

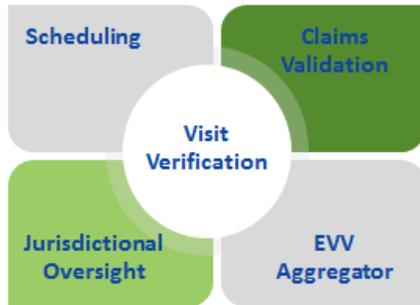
- Scheduler contains data on provider, caregiver, member and authorizations;
- Adherence to authorization is done at the point of scheduling, not after the service is delivered;
- Missed or late scheduled visits create alerts to inform the provider that the member was not served according to the care plan.

## 2. Visit Verification Module

- When the caregiver arrives on site, they “check-in” using a variety of technologies (mobile, telephonic, device, etc.);
- When they leave, they “check-out” via the same means;
- The system accurately captures visit start, stop, duration, and tasks performed



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### 3. Billing Module

- A HIPAA compliant 837 claim is created that contains data tracked during the visit, ensuring the payer only pays for actual time spent on the service rendered to the member;
- Claims for verified visits that fall within the scope of the authorization are submitted to the payer's adjudication system;
- Claims for unscheduled visits or those that fall outside of the scope of the authorization are held until the issue is resolved.

### 4. Aggregator Module

- Supports vendor agnostic EVV programs;
- Allows providers to select EVV vendor that works best for their business;
- Provides the payer with a single uniform source of EVV data and network rules management tools



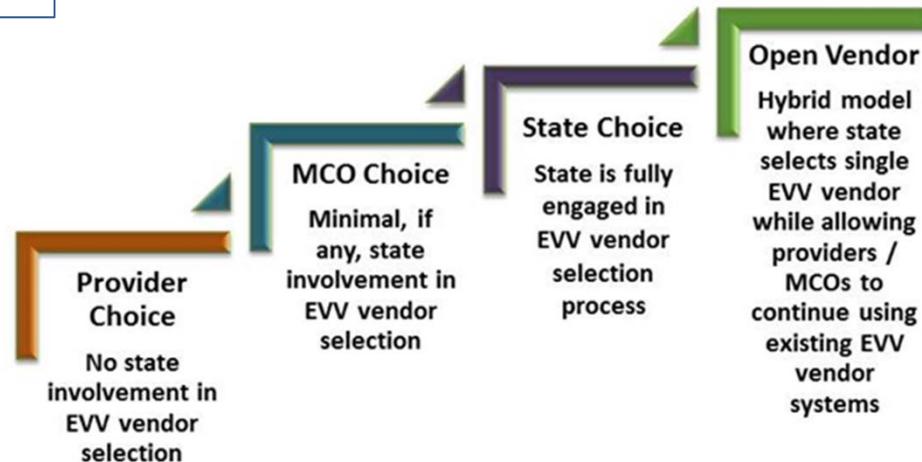
# EVV Program Models

State-level Electronic Visit Verification (“EVV”) programs are a relatively new concept, and today there are **19** States who have programs deployed or in implementation. As these early adopters have explored EVV, four major models have evolved in the market:

***State Medicaid Directors Need to Choose an EVV Model***

- 1. Provider Choice Model**  
(Used by three States);
- 2. MCO Choice Model**  
(Used by three States);
- 3. State Choice Model**  
(Used by eleven States);
- 4. Open Vendor Model**  
(Used by two States).

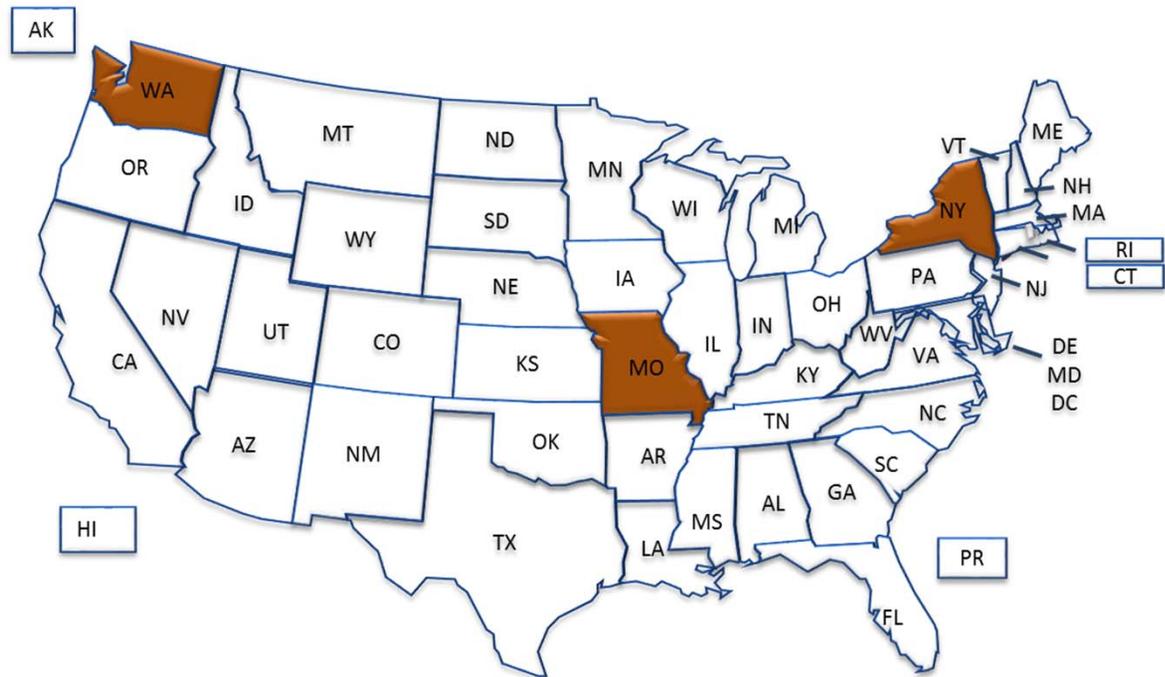
## EVV Program Models



# Provider Choice

States that have implemented this model include:

- Missouri
- New York
- Washington



# Provider Choice

In this model, the state generally requires the provider community to self-fund, select and implement an EVV solution of their choosing. 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.

<b>State</b>	<ul style="list-style-type: none"><li>• The “Unfunded Mandate”</li><li>• Enforcement has generally been “Pay and Chase”</li><li>• Easiest model to implement</li></ul>
<b>Providers</b>	<ul style="list-style-type: none"><li>• All costs are the responsibility of the providers</li><li>• Small agencies &amp; Individual Providers ill-equipped</li><li>• Generally low level of monitoring and compliance</li></ul>
<b>Quality Monitoring</b>	<ul style="list-style-type: none"><li>• Limited access to data</li><li>• Disparity in EVV products - challenging to consolidate data</li><li>• Retrospective audits are typically deployed</li></ul>
<b>Outcomes</b>	<ul style="list-style-type: none"><li>• There are no published studies showing savings attributed to the use of this model</li></ul>

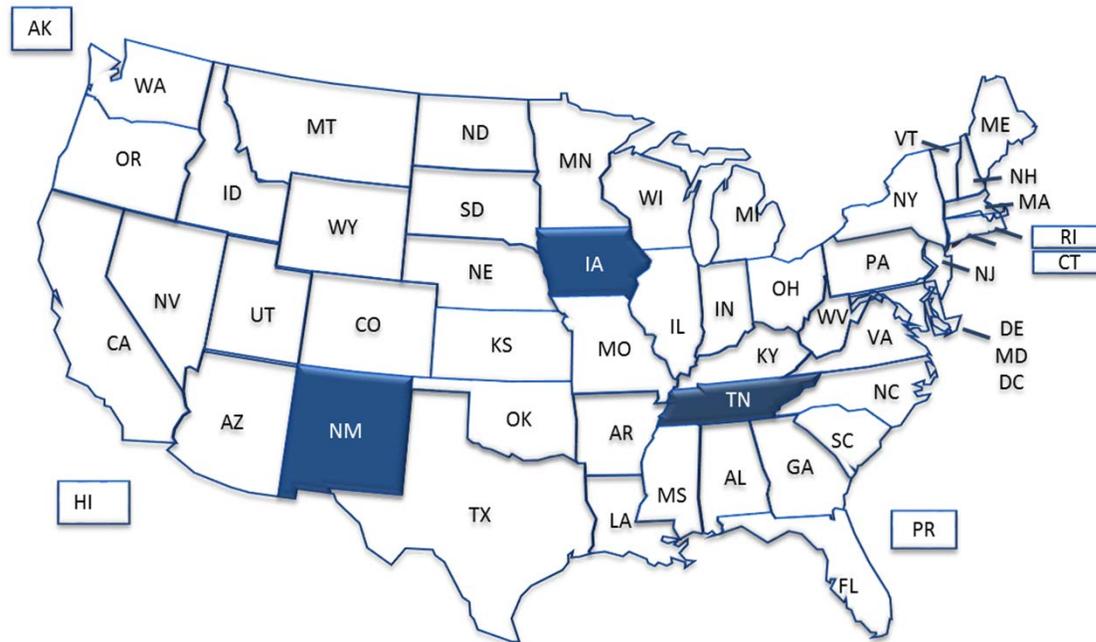
*This Model Can Be Improved with Aggregator Technology*



# MCO Choice

States that have implemented this model include:

- Iowa
- New Mexico
- Tennessee



# MCO Choice

The state requires the MCOs to fund, select and implement an EVV solution of their own choosing. States may or may not set minimum standards for vendor selection and require a minimum set of reporting on EVV activity.

## State

- Low cost model to implement
- Data disparity can be a challenge with multiple EVV solutions
- MCOs may or may not enforce compliance

## Providers

- Multiple MCOs with multiple EVV solutions – Disaster?

## Quality Monitoring

- Data disparity creates challenges for reporting and monitoring
- Disparity in features/functionality from MCO to MCO
- MCOs generally have Analytics capabilities

## Outcomes

- There are no published studies showing savings attributed to the use of this model

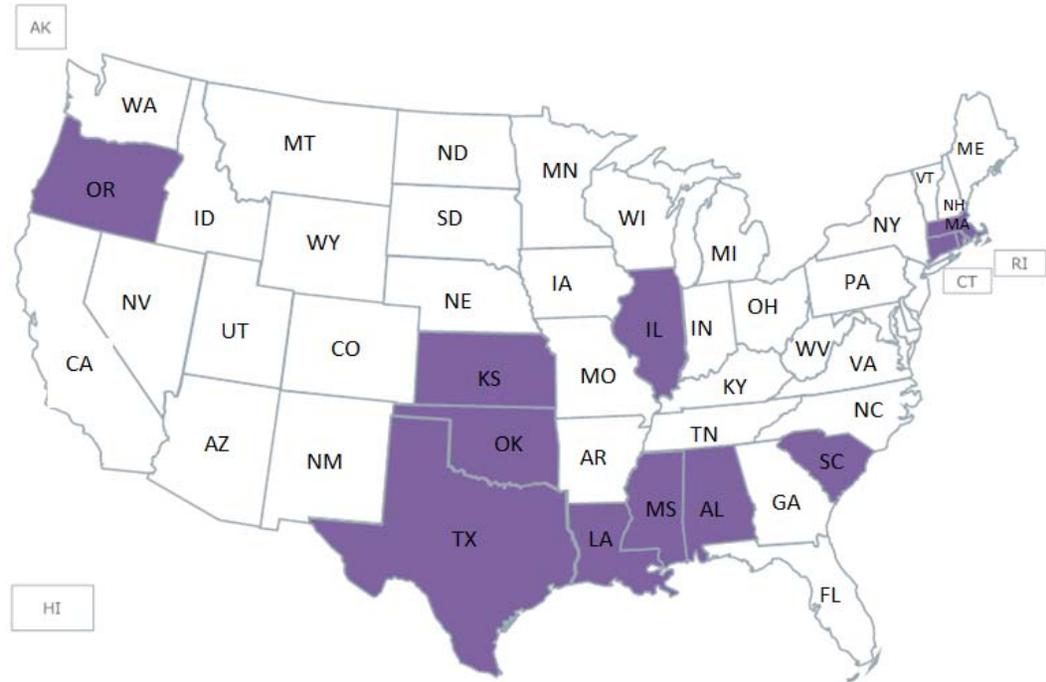
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# State Choice

States that have selected this model include:

- Alabama
- Connecticut
- Illinois
- Kansas
- Louisiana
- Massachusetts
- Mississippi
- Oklahoma
- Oregon
- Rhode Island
- South Carolina
- Texas



# State Choice

The state Medicaid program contracts with a single EVV vendors and mandates that all Providers use that vendor's EVV system. The selected solution is implemented by the state, with states having direct management and oversight over the entire program.

<b>State</b>	<ul style="list-style-type: none"><li>• Qualifies for 90% Implementation match by CMS</li><li>• Qualifies for 75% Operational match by CMS</li><li>• Requires active involvement and management by the state</li></ul>
<b>Providers</b>	<ul style="list-style-type: none"><li>• Providers are provided EVV solution at “no cost”</li><li>• Positive for small agencies or Individual Providers</li><li>• Challenging for larger, technically sophisticated providers</li></ul>
<b>Quality Monitoring</b>	<ul style="list-style-type: none"><li>• Highest level of demonstrated compliance</li><li>• Consistency of real-time data enables transparency</li><li>• Alerting and monitoring of gaps in care</li></ul>
<b>Outcomes</b>	<ul style="list-style-type: none"><li>• Documented savings from 5-50% and Quality metrics have been produced from this model.</li></ul>

*Mature Model That  
Has Delivered  
Documented  
Outcomes*

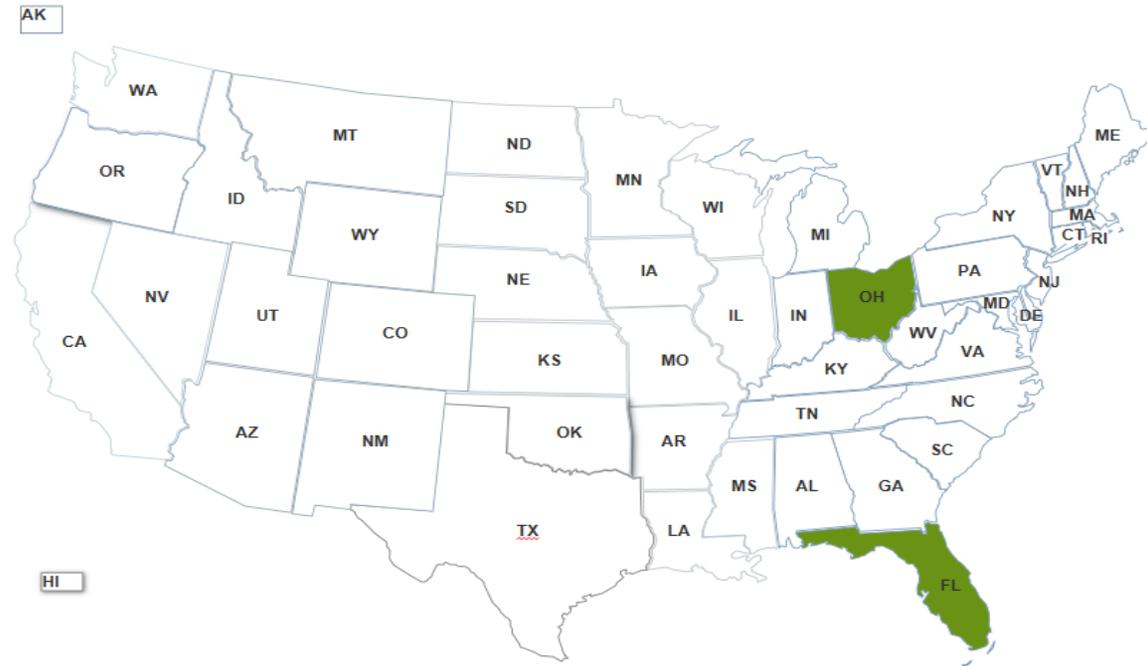


# Open Vendor

A new model currently employed by Ohio.

Florida recently procured an Open solution for the FFS members covered by AHCA.

Many new procurements are selecting this model.



# Open Vendor

The Open Vendor Model is a new hybrid model where the state selects an EVV vendor, and allows Providers to use the state-selected solution at no-cost, or to continue using their current EVV solution. A vendor agnostic Aggregator solution receives data from all EVV systems and provides comprehensive oversight over the entire program – regardless of EVV system used.

## State

- Least disruptive environment, most complexity for state
- Qualifies for CMS Enhanced match: 90% and 75%
- Heavy involvement in procurement and system management

## Providers

- Maximum flexibility: use free system or system of their choice
- Best suited for small and large providers
- Will require integration with state Aggregator solution

## Quality Monitoring

- Expect high level of compliance
- Real-time visit data available to the Payers and Providers
- Alerts can be configured for quality assurance

## Outcomes

- There are no published studies showing savings attributed to the use of this model, but expect similar savings as the State Choice model (5-50%)

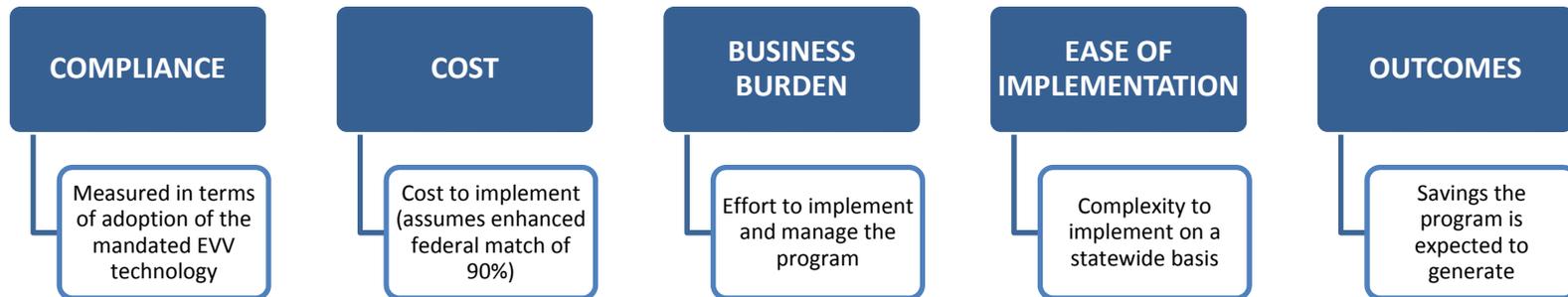


# Scorecard: Evaluating each model

## Factors under consideration by States:

- Concerns regarding fraud, waste and abuse within the provider network
- Impact of new technology to the provider network
- Overall service quality for recipients
- Impact of Managed Care companies to deliver services

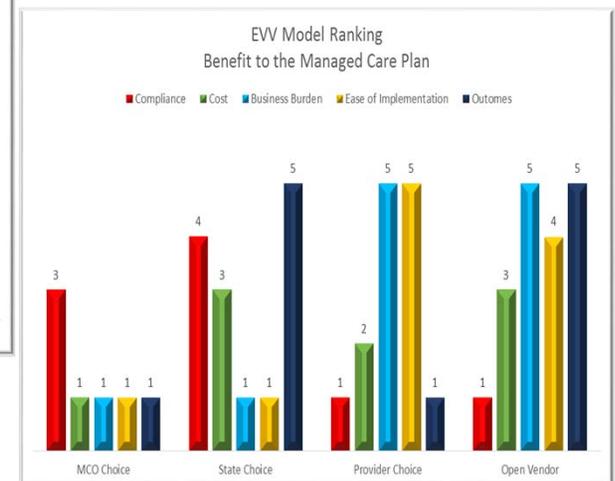
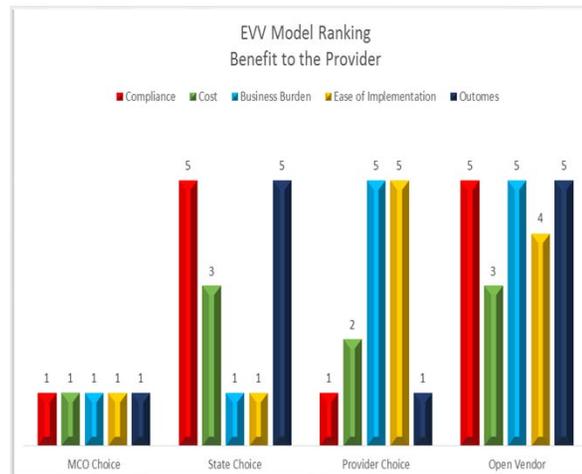
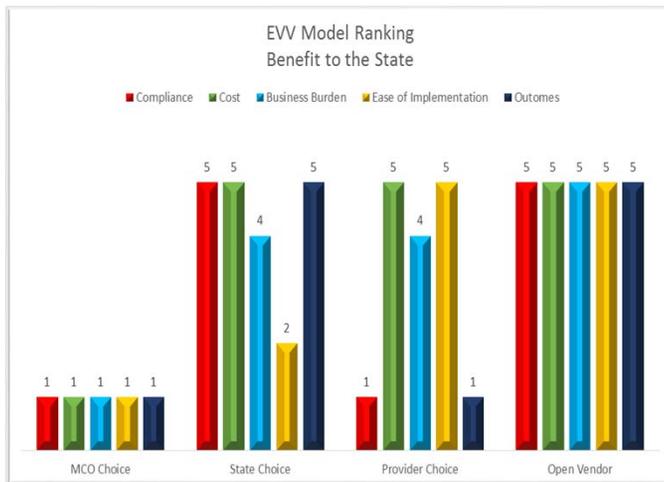
Sandata has scored each of the **Four Models** based on how favorable they are to each of the three constituents - **State, MCO, and Provider** - using the following measures



# Scorecard: Benefits/Value of Each Model

## Scoring the Models

- No model is perfect for all 3 constituents
- Value is in the eye of the beholder
- There are clear preferences



# EVV Model Conclusion

***EVV should maximize the effectiveness of Medicaid programs by ensuring...***

- **Compliance** that is targeted, measured, and enforced
- **Efficiency** through the maximum use of technology
- **Network Satisfaction** through Provider choice & involvement

***Reviewing the various EVV models, two best maximize the effectiveness of Medicaid programs:***

## **1. Open Vendor**

- State provides EVV technology for Providers who need it
- Providers select a solution for EVV (either state-provided, or their own vendor selection)
- State deploys Aggregator to collect EVV data from the Provider community

## **2. Provider Choice**

- Providers select the EVV solution that is compliant with state requirements and best suited for their business
- State may deploy Aggregator to collect EVV data from the Provider community (NY to date has not)



# Embracing the Use of EVV

## Value Beyond Compliance

- Validating Check-in and Check-out times
  - Yesterday’s problem that has been solved with various solutions
- Required data should be viewed as the “minimum”
  - Leverage your daily interactions to capture real-time data
- If you have to use it...*turn it to your advantage!*
  - Embrace DSRIP/PPS/VBP models with EVV capture of quality metrics
    - ER Visits, Pain, Meds Adherence, Flu Shot, Change in Condition, etc.



# Nobody Likes a Mandate

*But your options are limited...*

1. *Fight it*



2. *Influence it*



3. *Embrace it*



4. *Move to Canada, Bahamas, or Mexico* 😊



Thank You

Happy to Address Questions

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