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CENTERS FOR MEDICARE & MEDICAID SERVICES
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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 the territories identified at Social Security Act 1101(a)(1) too?**

   A: Yes. There is no definition of "state" unique to section 12006. Accordingly, the definition of "state" at section 1101(a)(1) of the Social Security Act also applies with respect to section 1903(l). That definition includes the District of Columbia, as well as the territories of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

3. 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.

CMS is aware that PCS are provided in a variety of settings, including in congregate residential programs such as group homes, assisted living facilities, etc. Stakeholders have questioned whether the EVV requirements apply to PCS provided in those settings offering 24 hour service availability. CMS interprets the reference in the statute to an "in-home visit" to exclude PCS provided in congregate residential settings where 24 hour service is available. This interpretation recognizes inherent differences in service delivery model where an employee of a congregate setting furnishes services to multiple individuals throughout a shift, and services provided to an individual during an in home "visit" from someone coming to a home to provide PCS as specified in the EVV statute. Consistent with this difference in service delivery model, typical reimbursement for services provided in these congregate settings utilizes a per diem methodology, rather than discrete per "visit" or per service payment structures. Therefore, CMS finds that services provided in a congregate residential setting are distinct from an "in home visit" subject to EVV requirements under the statute.

4. 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).

5. 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 at 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.

6. 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. See question 3 for additional description of PCS subject to EVV requirements.

7. 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.

8. 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.

9. 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. 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).

10. 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 the 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.

State Specific Variations

11. 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.

12. 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, strength of cellular networks, etc.

Implementation Flexibilities

13. 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 integration of existing systems, along with implications for states, provider and beneficiaries when specific models of EVV are selected by the state.

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

    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.

15. 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

16. 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

17. Q: **Is federal reimbursement available for implementing an EVV system?**

    A: Yes. To the extent that EVV is an automated data processing (ADP) system, the Advanced Planning Document (APD) requirements under 45 CFR Part 95 Subpart F would apply. If the system will be operated by the state or a contractor on behalf of the state – the state may apply for federal financial participation (FFP) for expenditures to receive 90% federal match for the design, development or installation of such a system, and 75 percent federal match for the operation and maintenance of the system. States should seek the enhanced federal through the APD process. To assist states in applying for federal funding, CMS will provide technical assistance to help streamline and expedite the review and approval process. States are encouraged to contact their Regional Offices to initiate this assistance.

18. Q: **Is enhanced Federal Match available to states for the implementation of a higher level system that unifies multiple operational vendors (e.g., for the purposes of collating data from providers' EVV vendors at the state level, such as an aggregator system)?**

    A: Yes. CMS will consider enhanced matching funds for higher level systems components and vendors for Medicaid enterprise IT projects that adhere to the principles and requirements described in Federal Policy Guidance found at SMD # 16-009 (June 27, 2016) Re: Mechanized Claims Processing and Information Retrieval Systems – APD Requirements; and SMD # 16-010 (August 16, 2016) RE: CMS-2392-F Mechanized Claims Processing and Information Retrieval Systems – Modularity. This policy guidance is available at https://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html

19. Q: **Is enhanced Federal Match available to states for buying an EVV system "off the shelf"?**

    A: Yes. Certain costs associated with implementing Commercial Off the Shelf (COTS) software may be eligible for enhanced funding. Such costs include:

    - At the 90 percent federal matching rate -- the initial licensing fees, and minimum necessary costs to analyze the suitability of COTS or hosted software, installation, configuration and integration of the COTS or hosted software solution, and modification of existing state software to ensure interoperability and coordination of operations.
    - At the 75 percent federal matching rate -- ongoing licensing fees during maintenance and operation, including usual and customary charges for routine software updates or upgrades, and any associated modifications to customization that might be required.

    Please note that the enhanced federal match under 1903(l)(6) is available only if the EVV system is operated by the state or a contractor on behalf of the state; thus, the costs listed above would have to be incurred by the state or its contractor. Please contact your RO for more information.

20. 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 authority to provide 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.

21. Q: **Is enhanced Federal Match under 1903(l)(6) available to states for costs associated with upgrading a state's existing/current EVV system to align with Cures Act requirements?**

    A: Yes. CMS will consider costs associated with upgrading a state's existing/current EVV system to be eligible for enhanced matching rates (i.e., the 90 and 75 percent match rates) if the system is operated by the state or a contractor of the state. Please consult with your RO MMIS lead for guidance.

22. 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 authority to provide enhanced federal match for administrative costs for providers or individuals receiving services.

<u>Next Steps</u>

23. 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.

24. 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 Contactor (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 provision of services and monitor accuracy of payments to providers thereby detecting and addressing instances of potential fraud, waste and abuse.

25. Q: **How does a state describe EVV information in state plan amendment (SPA), waiver, or section 1115 demonstration project applications?**

A: CMS is currently reviewing this issue and will advise states where in SPA, waiver, and demonstration project applications the state should reflect the state’s commitment to and implementation of EVV. We will communicate with states on an individual basis based on specific submissions.