WHAT PROVIDERS NEED TO KNOW ABOUT FEDERAL AND STATE EVV PLANS

FROM A LEADER IN AGENCY WORKFORCE MANAGEMENT SOLUTIONS

www.mitcsoftware.com
WHAT PROVIDERS NEED TO KNOW ABOUT FEDERAL AND STATE EVV PLANS

INTRODUCTION
MITC is a national leader in delivering EVV solutions. Hundreds of providers use MITC for EVV in states with and without EVV mandates.

MITC is pleased to provide this ebook to share our expertise in the various options for deploying EVV, lessons learned from successful and unsuccessful state mandates, and key areas for providers and states to consider. Our expertise is derived from 26 years of experience with EVV technology. MITC has provided EVV solutions to providers that selected MITC to solve workforce management problems and those looking to ensure compliance with state mandates. Many of our provider customers are very knowledgeable about EVV, how it works, and what doesn’t work so well.

THE HISTORY OF EVV
EVV is not new. It is important to understand this. Providers have voluntarily used EVV (often previously referred to as Telephone Timekeeping) for over a decade to eliminate the costs and risks of paper timesheets for in-home programs, and expedite the processing of payroll and billing. If implemented well, providers of all sizes and the service recipient benefit.

Typical benefits can include:

- Real-time verification of visits
- Automated missed visit notification
- Elimination of costs and risks of paper timesheets
- Better control of service delivery
- Elimination of payroll and billing data entry
- Favorable billing and payroll outcomes
- Audit readiness, less danger of having to repay billing

“Prior to using MITC, attendants would submit paper timesheets. We had a whole team who checked and submitted them. Then we had an entire team dedicated to entering the timesheets into the system. They have been combined in to one team.”

– Alyssa Schafer, CDS Timesheet Compliance Manager at Paraquad in Missouri
However, when a government agency mandates a solution, providers get nervous and justifiably concerned. The biggest cost in implementing technology is not the upfront purchase price. The largest expenses are included in the secondary costs of training front-line service providers (often in high turnover environments), ancillary equipment and services that might be required (smartphones and data plans), maintenance of equipment, deployment, integration with payroll and billing, back-office service provider training, and those associated with how well the EVV system handles day-to-day issues (see State EVV Program Models).

In addition, some states (CT, FL, IA, IL, KS, LA, MO, MS, NM, OK, OR, RI, SC, TN, TX, and WA) prior to the 21st Century Cures Act (2016) have deployed or tried to deploy mandatory EVV systems in one or more programs.

In December 2011, the Department of Health and Human Services asked states, Managed Care Entities, and CMS to identify the major concerns regarding Medicaid fraud, waste, and abuse. The primary concern related to services billed but not provided.

NEW FEDERAL GOVERNMENT REQUIREMENTS (21ST CENTURY CURES ACT)

On December 13, 2016 the 21st Century Cures Act (CURES) came into law. Section 12006 of the legislation, Electronic Visit Verification System Required for Personal Care Services and Home Health Services Under Medicaid, is a call for action. This section directs states to require the use of Electronic Visit Verification (EVV) for Medicaid-provided personal care services and home health services.

The CURES Act contains a new Medicaid requirement for use of Electronic Visit Verification (EVV), which allows the individual providing service to record electronically the exact date, real start and end time, and location of a visit.

The act leaves states to decide their own implementation strategies. EVV is required to be in place by 2019 for personal care services, and 2023 for home health services but these dates may be pushed back.

“We had issues when we used to be paper. Now we have a little more control. As time goes on, employees realize they can’t get away with friends writing down their time or buddy punching. If employees say the phone wouldn’t answer, I can show call logs that assist with where mistakes were made or determine if it was a system issue or perhaps a user problem. We don’t lose time I’m sure we were losing before.”

– Carrie Zielinski, IT Technical Trainer at Clearbrook in Illinois
With states in charge of the means to carry out the requirement, providers may be forced into an ineffective state-run program, a limited number of vendor choices, or a platform that requires integration with multiple EVV systems.

The bill noted that the federal government would fund 90% of the costs attributed to the design, development, or installation of an EVV system and 75% of the operation and maintenance costs. The funding would go to the states to execute their compliance plans. However, there are currently no fixed dollars budgeted and many unanswered questions, such as what funding will be appropriated and how much will each state get.

Providers need to engage with their states to ensure the state selects an EVV strategy that works for providers, and does not end up as yet another burden. Not all EVV solutions are equal.

States and providers will be considering the impacts of this legislation, specifically the impact on cost, providers, and service.

The Congressional Budget Office scored the CURES legislation and attributed EVV with saving $290M over 10 years. Given the size of the overall Medicaid budget, it is not clear at this point what priority the Federal government will give to EVV deployment. However, states and providers are already active in this area, so providers need to be knowledgeable about the issues to ensure that the EVV solution(s) selected are the best for the providers and not just for the state.

**WHAT IS EVV?**

Electronic visit verification is widely used by providers and government entities. Providers have had experience using EVV systems they selected independently for at least 15 years. Provider experience is richer and has more depth than any other. Providers use EVV for compliance and quality assurance, to verify employee’s location, complete documentation, verify hours of work for payroll and billing, and streamline payroll and billing.

EVV is typically used for real-time verification of:

- Date of service
- Time service starts and ends
- Location of service using Caller-ID or GPS
- Individual providing service (care giver)
- Type of service
- Individual receiving service
The two main technologies used for EVV are telephone timekeeping with Caller-ID verification and web clock with GPS verification. Both technologies have their advantages and disadvantages. Both are generally acceptable to Medicaid auditors in preference to paper timesheets, as long as the technology is compliant with Medicaid regulations for electronic documentation.

**HOW DOES EVV WORK?**

Both telephone timekeeping and web clock require the employee to clock in with a unique ID, often known as an employee PIN (Personal Identification Number). The employee PIN replaces the employee name and signature on a paper timesheet.

Both identify the service recipient being served, typically using a service recipient PIN. If the service recipient receives multiple services, the employee enters a service code for billing and authorization.

Telephone timekeeping usually involves the service provider using the service recipient’s landline or cell phone. While many service recipients no longer have access to landlines, 59% of people still do, making telephone timekeeping a practical possibility. According to the Centers for Disease Control as of July 2015, two percent of people have no phone, nine percent have just a landline, 48 percent have a landline and a cellphone, and 41 percent have just a cellphone. Obviously, the advantage of telephone timekeeping is that, apart from paying for the 800 number call if the call is long distance (typically 1c), there is no need for the agency to provide any equipment or data plans.

If the service recipient does not have a landline or cell phone, there are government programs that provide subsidized phone service. If the service recipient’s landline phone is out of service, usually Medicaid will accept a call from a cell phone in preference to resorting to paper timesheets.

Web clock’s advantage is that tracking is not reliant on the client having a landline or cell phone. However, the downside is the cost of the phone, data plans, and internet access (or lack of it), and employees forgetting to charge the battery (with GPS enabled and active, battery life is shorter than usual). GPS is accepted as verification of services. If web clock is combined with employee self-service, the employees have access to their timesheets, schedules, PTO balances, PTO requests, open positions, training classes, W-2s, payroll check stubs, service recipient information, and more all from their smartphone.
OTHER FEATURES OF EVV:

- No-show alerts report missed visits in real time
- Optional text alerts for managers to confirm visits started
- Check awake calls for overnight shifts
- Administrators and managers can watch or review visits as they take place
- Variance to schedule, budget, and authorization reporting
- Restricted clock-in if budget exceeded
- Capture documentation
- Voicemail messages to pass onto caregivers, such as service recipient updated (ex. Mary’s meds have changed)
- HR alerts regarding training, licenses, and more

STATE EVV PROGRAM MODELS

State-level EVV programs vary. Many states have deployed or tried to deploy EVV in certain programs. The models vary in details.

At this point in time, the savings to Medicaid are unclear, and it is certainly not clear which model saves the most. While Florida has produced some savings statistics, the statistics are from 2011 and 2012 and do not account for additional costs providers may have borne or the cost of the EVV solution.

All that can definitely be known is that where providers voluntarily funded and implemented EVV, while providers have changed vendors, very few providers have gone back to paper timesheets. The record of state-selected solutions is more mixed.

A. PROVIDER CHOICE

Provider Choice model requires the provider to select and fund an EVV solution of their choosing from a vendor whose EVV solution meets requirements and complies with Medicaid rules for electronic documentation.

With this model, the state avoids the expense of the procurement process. Data integration for billing authorization maybe required. The state may audit the provider for compliance, particularly to review records manually added or adjusted. Providers may be required to justify an excessive amount of edits.

This model was used in Missouri, where 600 providers made the transition by mid-2015. Although the providers had to procure, implement, and pay for the EVV solution, providers generally supported this choice as the providers were left in control of the vendor and timing. This was particularly the case with larger providers. Smaller providers were less receptive.
Providers had the freedom to choose the vendor that best fit in with their overall needs and budgets. The providers had control of other issues, such as roll out timing, transition training, choosing cloud or customer-hosted options, and more.

Most importantly, all vendors have to provide state-of-the-art, affordable solutions, otherwise the vendor risks the provider switching to another vendor. The state and provider are guaranteed long-term flexibility.

Providers can be reimbursed through rate adjustments to benefit from any savings at the state or federal level.

**Quality Monitoring:** The state can control instances of overlapping services and unauthorized services through the state reimbursement system. Audits of providers can be conducted remotely through the submission of original data or by traditional methods of funding audits of providers.

While individual providers may experience difficulties with selecting and deploying an EVV solution, overall the providers in Missouri were satisfied with the results for their providers and service recipients.

**Risk Assessment:** While individual providers may make unwise decisions, in Missouri the majority of providers were satisfied with their choice.

**B. MCO CHOICE**

With MCO choice, the state requires Managed Care organizations to fund, select, and implement an EVV solution of their choice. This option can be challenging for providers, who have little or no say in the vendor chosen or services provided to ensure the transition is smooth. Where there are multiple MCOs, providers could potentially be forced to use multiple EVV solutions.

**Risk Assessment:** Different MCOs could make better or worse decisions on the EVV solution based on their own priorities (price), handicapping providers with an ineffective system.

**C. STATE CHOICE**

The state contracts with a single EVV vendor. This model involves the state procuring, funding, selecting, and implementing an EVV solution of their choice and managing the concerns and complaints from providers. Legal challenges to the bidding process may occur.

While state choice assures the state has the greatest control and, in theory, the greatest savings, it also increases risk exponentially. The state bidding rules may not result in
the selection of the optimum vendor, creating widespread dissatisfaction and inefficiencies across all providers.

With state choice, the providers use a “free” system. Challenges for providers occur if the provider has already selected their own EVV solution and hidden costs (see What is EVV?) if the state-selected system does not integrate with other vendors, and disrupts the providers existing policies, practices, and procedures.

The free market is constrained.

*Risk Assessment:* The state could make a better or worse decision on the EVV solution based on their own priorities (price), handicapping providers with an ineffective system.

Once implemented, a state selected solution might be very difficult to change. Louisiana has experienced two failed roll-outs at considerable cost and inconvenience to the state and providers.

**D. OPEN VENDOR MODEL**

The state provides an EVV solution while simultaneously allowing providers and MCOs to keep their existing EVV system that is already integrated into their operations, or allows providers to choose between the state system and a solution of the providers choosing. This model is being considered in Ohio.

*Risk Assessment:* The state could make a better or worse decision on the EVV solution that few providers chose to use for one reason or another.

**QUESTIONS FOR PROVIDERS TO ASK**

1. **Smartphones:** If the EVV system only supports the use of smartphones with GPS, who pays for the phones and data plans? What happens if the battery is dead due to GPS usage or the individual providing service “forgot” their phone? What if there is no internet service? What is there to stop the individual providing service using these smartphones for other purposes? Who pays for the smartphones if the individual providing service does not return it when they leave the position?
2. **Telephones:** If the service recipient does not have a landline phone or will not let the individual providing service use the service recipient’s cell phone, can the individual providing service make a cell phone call or does the individual providing service need to use the internet with GPS? (According to the Centers for Disease Control, as of July 2015, two percent of people have no phone, nine percent have just a landline, 48 percent have a landline and a cellphone and 41 percent have just a cellphone).

3. **Exceptions:** What happens if the individual providing service forgets to clock in or out? How are exceptions handled?

4. **Over midnight shifts:** How does the EVV system handle overnight shifts? Does the EVV system automatically clock a service provider out/in or does the individual providing service have to remember (unlikely)?

5. **Missing Records:** How is the individual providing service notified that there are missing records? How does the EVV record get fixed? How are incomplete visit records managed?

6. **Inaccurate Records:** What happens if the individual providing service clocks in later than the actual start time due to an incident at the service recipient’s location? How does the individual providing service handle this situation? Clock in anyway and enter a request for a change? Not clock in and request a missing record be added?

7. **Employee Self-Service:** Does the individual providing service have access to their records? Can the individual providing service submit requests to complete missing punches or documentation, or do provider managers have to chase the records down?

8. **Consumer Self-Service:** Does the service recipient have any access to their records?

9. **Approval:** How do managers approve payroll and billing?

10. **Documentation:** Will the individual providing service be required to complete documentation as well as clock in and out? Will billing be accepted if the documentation is incomplete?

11. **Other programs:** If the agency has individuals providing service who work in other programs not impacted by EVV, how can other individuals providing service clock in and out of one system? If the individual providing service works in multiple programs, some covered by an EVV mandate and others not, how are the time and attendance records combined?

12. **Overtime:** Does the EVV system contain any provision to alert or stop the individual providing service from clocking in if the individual providing service is in overtime?
13. **Authorizations, Budgets:** Will the individual providing service be allowed to clock in if the service recipient has no more billable hours? Will the agency get reimbursed for these hours if the individual providing service is allowed to clock in?

14. **Pay Rates:** If the individuals providing service are paid multiple pay rates, how is this captured?

15. **Per Visit Pay:** If the individuals providing service are paid a flat amount, how is this captured?

16. **Payroll:** How is integration with payroll supported?

17. **Scheduling:** How is integration with scheduling supported?

18. **HR:** How is integration with HR supported?

19. **Shared Supports:** How are shared supports handled (where more than one service recipient receives services at the same location during the same visit)?

20. **Shared Services:** How are shared services handled for billing and tracking authorization (where a service recipient receives more than one service during the same visit)?

21. **Rounding:** Are start and end times rounded to 15-minute units? If so, what happens to the “missing” minutes. The service provider is obligated to pay the individuals providing service, but is the state obligated to reimburse?

Many of these issues are of less concern in a voluntary provider implementation, as work-arounds can always be designed and approved. With the state involved, it is important to know what solutions are available for all situations.

---

**ABOUT MITC**

MITC provides modular workforce management solutions and services to support all the needs of agencies – time & attendance, scheduling, HR, workforce analytics, payroll and billing integration, and more. Visit www.mitcsoftware.com to learn more.