Electronic Visit Verification and Medicaid Managed Care: A Perfect Storm

Council of State Home Care & Hospice Associations Leadership Conference

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Today's Presenter

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Housekeeping

- Questions – This session is intended to be interactive. Please feel free to ask questions as we go.
- Legal Disclaimer – Portions of this communication may qualify as "Attorney Advertising" in some jurisdictions. However, Baker Donelson intends for it to be used for educational and informational purposes only. This communication also is not intended and should not be construed as legal advice.
- These topics are changing rapidly. This presentation is my best attempt to summarize the current state of play.

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Agenda

- EVV Requirements
- Overview of Implementation
- North Carolina Home Health in Medicaid Managed Care: A Case Study
- Tips and Best Practices for State Home Care & Hospice Associations
- Emerging Issues
- Questions

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What is Electronic Visit Verification?

- Section 12006 of the 21st Century Cures Act requires all State Medicaid agencies to begin using an Electronic Visit Verification (EVV) system for Personal Care Services by January 1, 2021, and for Home Health Care Services by January 1, 2023.
- EVV uses technology to record the times, dates, and specific services that are rendered.
- The purpose of EVV is to help make sure people who should receive services, in fact, receive them.
- States that do not comply are subject to incremental FMAP reductions up to 1% unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays."

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What is an EVV system?

- The term 'electronic visit verification system' means . . . a system under which visits conducted as part of such services are electronically verified with respect to—
  - (i) the type of service performed;
  - (ii) the individual receiving the service;
  - (iii) the date of the service;
  - (iv) the location of service delivery;
  - (v) the individual providing the service; and
  - (vi) the time the service begins and ends.

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To which services does EVV requirement apply?

- All Medicaid PCS and HHCS that require an in-home visit by a provider
- Applies to PCS provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115
- Applies to HHCS provided under 1905(a)(7) of the Social Security Act or a waiver
- Certain services in congregate care settings and consumer-directed services have been exempted

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What else does 21st Cures Act require?

- State Medicaid programs are required to
  - (A) consult with agencies and entities that provide personal care services, home health care services, or both under the State plan (or under a waiver of the plan) to ensure that such system—
    - (i) is **minimally burdensome**;
    - (ii) **takes into account existing best practices and EVV systems in use** in the State; and
    - (iii) is conducted in accordance with HIPAA requirements
  - (B) take into account a **stakeholder process** that includes input from beneficiaries, family caregivers, individuals who furnish personal care services or home health care services, and other stakeholders, as determined by the State in accordance with guidance from the Secretary; and
  - (C) ensure that individuals who furnish services are provided the **opportunity for training** on the use of such system.

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Potential additional State requirements?

- EVV Registration or Procurement
- Beneficiary notice
- Staff training
- Billing components
- Additional substantive data elements

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Implementation Overview

- State Medicaid programs were able to implement EVV requirement in different ways: Closed, Open, or Hybrid (a variations thereof).
- Most states implemented PCS first and then HHCS.
- Most states requested and receive hardship exemptions.
- Despite passage of both deadlines, EVV has not been fully implemented in most states.
- Given complexity of service delivery and billing, home health has been relatively more difficult than PCS.

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North Carolina Home Health Implementation in Medicaid Managed Care: A Case Study

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Important Things We Have Learned

- Payers have their own crosswalk
- In most cases the trigger for a patient getting into the system is the authorization process
- If a range of visits is billed, but any individual visit is rejected by the aggregator, it may bill as a separate claim once fixed, regardless of the rejection reason (ie. Missing or mismatched auth, revenue code, or HCPCS/CPT, etc.)
- Some payers are paying each home health visit as a "claim"

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Important Things We Have Learned

- Due to the process flow, actual denials may not be received
- Clearinghouse access to real-time eligibility, claim status updates, etc. is lost for claims that have no supplies attached
- Claim edits may or may not be able to be made (depending on EVV vendor)

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Tips and Best Practices for State Associations

1. Develop a stakeholder group of member providers with technical, financial, and clinical representation
2. Provide training opportunities (do not rely solely on state or vendors)
3. Engage Medicaid agency early and often
4. Develop strong relationships with EVV vendor(s), Medicaid plans, and hospitals/health systems
5. Establish realistic timeframes
6. Push for data showing claims and payment flow and "minimally burdensome" impact
7. Advocate!
   - Emphasize access to care and administrative burden

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Emerging Issues

1. Staff HR issues
2. CMS oversight and enforcement
3. Data's impact on program integrity and fraud investigations
4. Expansion into other payors (Medicare, Medicare Advantage, VA?)

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Contact Me with Questions

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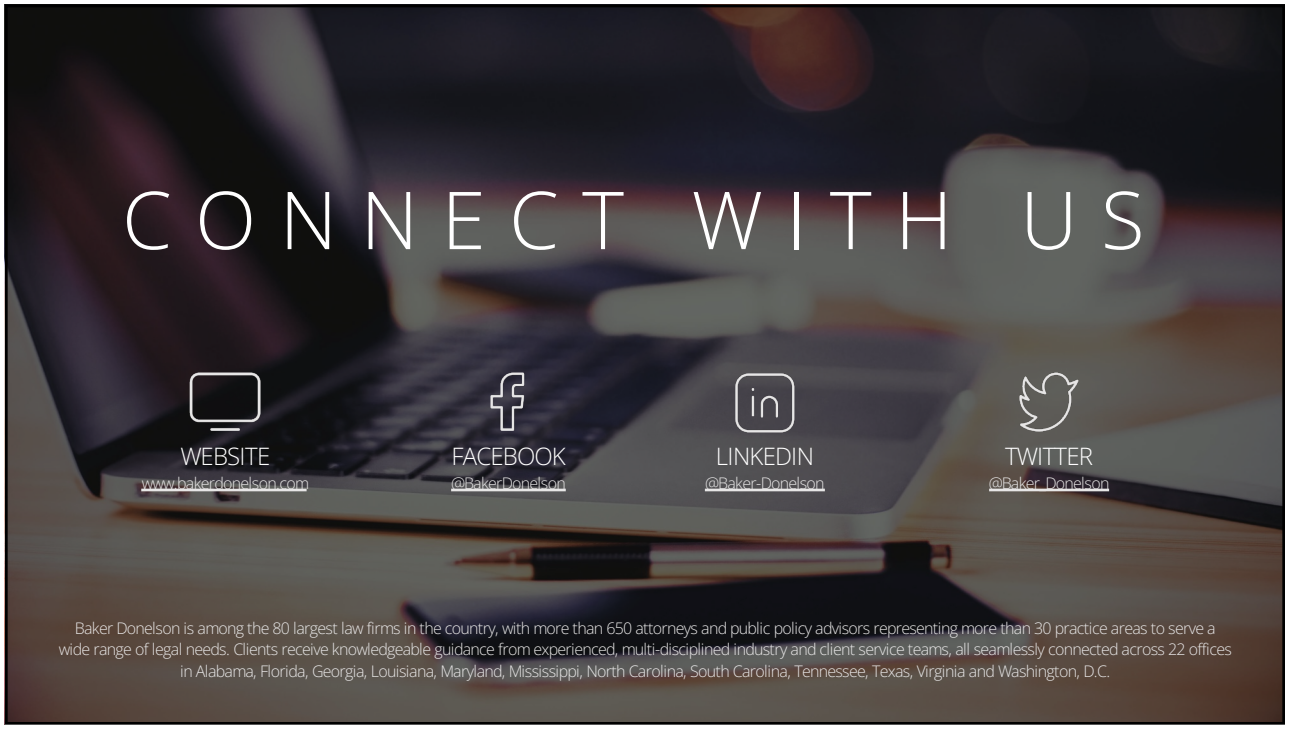

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