NASUAD
National Association of States
United for Aging and Disabilities

1201 15th Street NW
Suite 350
Washington, DC 20005
Phone 202-898-2578
Fax 202-898-2583
www.nasuad.org

April 23, 2018

Seema Verma
Administrator
U.S. Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma:

On behalf of the National Association of States United for Aging and Disabilities (NASUAD), I am writing to request expedited guidance regarding the 21st Century CURES Act's requirements that states implement Electronic Visit Verification (EVV) for personal care and home health services. NASUAD represents the 56 officially designated state and territorial agencies on aging and disabilities. Each of our members oversees the implementation of the Older Americans Act (OAA), and many also serve as the operating agency in their state for Medicaid waivers and managed long-term services and supports programs that serve older adults and individuals with disabilities. Together with our members, we work to design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability and for their caregivers.

As you know, the CURES act includes requirements that states have EVV in place for personal care services (PCS) by January 1, 2019 and for home health care services by January 1, 2023. PCS delivered without EVV will be subject to a 0.25% reduction in the federal share of Medicaid expenditures (FMAP) in 2019, and this reduction increases each year until it reaches 1% in 2023. Our members are increasingly concerned about their ability to implement EVV in a timely fashion, given that the deadline is less than nine months away and there has yet to be any formal guidance regarding a number of important issues, including the scope of services subject to the mandate, the nature of information that must be collected, and the criteria for receiving a good faith exemption from the FMAP reductions during 2019.

According to the CURES act statute, the EVV mandate applies to PCS delivered through the following authorities: 1905(a)(24), 1915(i), 1915(j), and 1915(k) of the Social Security Act, as well as any waiver of the state plan (including 1915(c) waivers and 1115 demonstration projects). However, this definition is not necessarily straightforward given that PCS may be defined in a number of different ways within the Medicaid program. CMS has provided initial guidance that PCS, for the purposes of the mandate, are services that support an individual accomplish activities of daily living (ADLs) and/or instrumental activities of daily

living (IADLs).[1] This definition does not yet provide clear guidance around the exact services that would be subject to an FMAP reduction in absence of EVV. For example, some states include PCS as a component of a larger bundled service, such as a waiver service that provides "community integration" supports to individuals. Similarly, states may have companionship services that include incidental assistance with ADLs and IADLs. It is unclear at what threshold the EVV mandate would apply.

Similarly, the CURES act requires that EVV be applied to PCS requiring an in-home visit by a provider. However, preliminary guidance from CMS indicates that the agency may be considering an expansive definition of home for this requirement, which could result in the EVV mandate applying to assisted living, group homes, and other licensed facilities that provide 24 hour care. This creates challenges for states that began implementation under the assumption that EVV is only required for PCS in an individual's home, as well as for states that wish to see CMS' final policy on included services prior to finalizing system requirements.

Additional ambiguity exists around the exact nature of information that should be collected by the EVV system. For example, the CURES act requires that EVV document the following data elements:

- The type of service performed;
- The individual receiving the service;
- The date of the service;
- The location of service delivery;
- The individual providing the service; and
- The time the service begins and ends.

Although most of these are straightforward, further guidance is required around issues such as location of service delivery. Some providers and program participants have resisted the use of global positioning service (GPS) tracking under EVV, and CMS has indicated that GPS data may not be required. However, it is unclear how a state might collect location information without GPS information, particularly when a service begins and ends in separate locations.

Because states are struggling with understanding exactly which services and what data they should include within their EVV systems, it is creating challenges for developing system requirements and technical specifications. This then prevents them from developing advance planning documents, which are required to receive enhanced federal funding for information technology development and installation, as well as from drafting requests for proposals to secure an EVV contractor. Given the lengthy timeframe required for open and fair procurement processes, coupled with the subsequent IT development and installation processes, it is extremely unlikely that any state will be able to establish an EVV system by the January deadline unless they already had one in place. Furthermore, even states with existing systems may not meet all of the CURES Act requirements, depending upon the final guidance that CMS ultimately releases.

Although the Cures Act includes a potential reprieve from the matching fund reduction for states that made "good faith effort" and encountered "unavoidable delays" in implementing an EVV system, it is unclear what a state must do to secure such an exemption. Furthermore, CMS has clarified that the

[1] https://www.medicaid.gov/medicaid/hcbs/downloads/training/evv-presentation-part-1.pdf

exception is limited and would only apply for one year. A number of states will likely need to make modifications to their implementation plans in response to final CMS guidance, which will then require that they secure funding from the legislature, acquire CMS approval for enhanced funding, develop and administer an open and fair procurement, and install the system. Many state legislatures have already adjourned or will do so in the coming weeks, which would require state agencies to submit these requests in the 2019 session. We therefore do not believe that the compliance deadlines are reasonable or achievable for states, even with a 12 month delay in the FMAP penalties.

Because of this, NASUAD strongly encourages CMS to release guidance as expeditiously as possible with the following clarifications: (1) Provide clear definitions on the PCS included within the EVV mandate, and clarify that licensed residential settings such as assisted living and group homes are not subject to the requirements; and (2) Establish a liberal definition for the good faith exemption given that states do not yet have CMS guidance to use for their system development.

NASUAD is working to help our states understand the CURES Act requirements and to provide them with guidance and assistance as they implement their EVV systems. We are ready to provide any assistance needed to ensure that the systems are implemented in a thoughtful manner that alleviates any FMAP penalties on states and achieves the CURES Act goals of reducing fraud, waste, and abuse while improving participant health and wellbeing. Please feel free to contact Damon Terzaghi at dterzaghi@nasuad.org with any questions you may have, as well as with any opportunities to collaborate regarding assistance and outreach to states.

Sincerely,

Martha A. Roherty

Martha A. Roherty
Executive Director
NASUAD

Cc:
Tim Hill, Acting Director for the Center for Medicaid and CHIP Services
Calder Lynch, Senior Counselor to the Administrator
Michael Nardone, Director of the Disabled and Elderly Health Programs Group, CMCS