State of Vermont
Agency of Human Services
280 State Drive, Center Building
Waterbury, VT 05671-1000
[phone] 802-241-0440
[fax] 802-241-0450
www.humanservices.vermont.gov

Date: August 7, 2018

Re: Public comments received for GCR 18-007: Personal Care Electronic Visit Verification.

The following comments were received for GCR 18-007: Personal Care Electronic Visit Verification.

Comment from an Early Intervention Team Leader:

I do think this will help with accountability and deter Medicaid fraud, how will this work with people who live in remote and rural areas? I am often on backroads to do a home visit and do not have a GPS signal for navigation, nor do families have internet connection to be able to have the person "clock in" and "clock out".

Comment from Vermont Family Network:

Thank you for the opportunity to submit the following comments on the GCR Proposed Policy 18-007. This huge change is one that will require considerable pre-planning and training. While certainly one of the drivers of this is prevention of fraud, and improving budgetary efficiency and accountability, we hope that as Vermont develops its plan of implementation it is done through a lens of quality improvement for all.

Burden on individual and/or provider needs to be minimized.

Provider shortages, as well as the daily complexities encountered by families and individuals with disabilities, make it imperative that the system be as easy to use as possible and not discouraging or overwhelming. Burden can be increased or decreased by details such as:

- Will the "check in" be one time per day, or intermittent?
- Will the EVV be in addition to timesheet recording, or in lieu of?
- Any technology should be accessible and user friendly, allowing individuals to remain "in the driver's seat".
- Needs to be flexible enough to adjust to the intentionally fluid design of self-management. This includes:
    - Last minute changes
    - Multiple destinations in one shift
    - Freedom to develop schedules as needed, not as the system demands.

It may be worthwhile to check in with the state of Tennessee who had some experience and lessons learned in this area and are navigating its way through it.

Technology

Technology is widely inconsistent in our rural state. Whatever system is designed must be prepared for the potential lack of internet access, no land line, or insufficient cell phone signal.

In closing, the system must prioritize the preservation of both an individual's privacy and freedom to interact with the community. Throughout the development and implementation, regular and ongoing participation by individuals, caregivers, and professionals who work with them is of critical importance.

BAYADA®
Home Health Care

354 W. Lancaster Ave
Suite 200
Haverford, PA 19041

June 15, 2018

Department of Vermont Health Access
Attention: Medicaid Policy Unit
280 State Drive
Waterbury, Vermont 05671-1010
AHS.MedicaidPolicy@vermont.gov

RE: DVHA – Electronic Visit Verification (EVV) Stakeholder Comments

Dear DVHA:

On behalf of our more than 700 employees and 1,700 clients in Vermont, BAYADA Home Health Care appreciates the opportunity to provide comments on the Electronic Visit Verification (EVV) system, which will need to be implemented in Vermont for personal care services by January 1, 2019 and for home health care services by January 1, 2023. BAYADA strives to provide the highest quality of nursing, rehabilitative, therapeutic, hospice, habilitation, and assistive care services to Vermont's children, adults, and seniors in the comfort of their homes. We believe our clients and families deserve home health care delivered with compassion, excellence, and reliability; BAYADA's core values.

We are grateful that the Department of Vermont Health Access (DVHA) is seeking input on this proposal from a variety of stakeholders. We understand this document is a small part of a long process. BAYADA has significant experience with EVV systems and EVV system implementation in other states and is happy to be a valuable partner to DVHA. Working together will ensure a smooth transition to statewide EVV compliance. It will also help create a healthy, innovative, and balanced system that can be used as a model for other states.

Provider experience with EVV is rich and in-depth. BAYADA and other providers have been using independently-selected EVV systems for over 15 years. EVV is very popular in the home care industry because it allows providers to verify employees' location, complete documentation, verify hours of work for payroll and billing, and maintain compliance and quality assurance. The vast majority of home health care providers, including BAYADA, supports a statewide EVV requirement and shares the same goals as the state: to ensure a standardized statewide solution that prevents fraud, waste and abuse. Just as the state wants to ensure it reimburses providers for rendered services, providers use EVV to ensure they are paying employees who delivered services. Vermont and home care providers alike wish to benefit from a system that is standardized, functional, fits every party's needs, and prevents extraneous costs and difficulties that could result from patching together existing systems. This is crucial for delivering quality care and for patient outcomes.

The 21st Century Cures Act of 2016, which from here in will be referred to simply as "the Cures Act," mandates that every state implement an EVV system but leaves it up to the state to determine the methods by which to achieve this. Many states have already taken on implementing the EVV requirement. BAYADA applauds the state of Vermont for holding off establishing a system while other states took on the mandate. There are many lessons learned from other states' attempts at implementation. While there are many things to consider regarding creating a well-functioning and effective EVV system, one of the most important lessons to be learned is the inefficiencies that result from implementing a single-vendor closed model, whereby the state mandates that all providers use one EVV software system chosen by the state. On this front, BAYADA applauds DVHA's decision to leverage an "open EVV model."

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The open system has clear advantages over a closed system. BAYADA strongly supports an open EVV system because it is better for the state, the provider, and ultimately, for patient outcomes. The open system ensures quality; lowers state costs on procurement, implementation and training; eliminates state involvement in system issues and enhancements; provides flexibility for providers, vendors and MCOs; and provides states with a single, uniform source of EVV data and network management tools.

One of the major proponents of an open system is that it guarantees quality by supporting innovation. Competition amongst vendors ensures that the EVV system does not remain stagnant. As EVV technology grows and vendors continue to add capabilities and enhance existing software, the system will become increasingly more useful to providers and beneficial to patients. Providers can use technological enhancements to improve their systems, thereby increasing their quality of delivery of care and ultimately leading to better patient outcomes. Encouraging innovation is especially important as the state shifts more services into the managed care model, which by design is meant to encourage creativity in care delivery. It would be contradictory to mandate that all providers use a single vendor, thereby stifling the creativity that would result from a competitive pool of vendors.

An open system provides the flexibility needed for the provider, the vendor and MCOs to stay innovative. An open model allows providers to select the EVV system that works best for them. EVV vendors' software capabilities vary widely, as do providers' needs. The open model allows providers to choose the software that fits their specific needs and goals and allows them to best serve their clients. Because providers vary widely by size, services offered, and business model, it is important that they be able to work with a vendor that suits the company, their caregivers, and ultimately, their clients.

One size certainly does not fit all, and the open system provides for flexibility for the vendor as well. In a closed system, the vendor has no choice but to work with all providers. This single vendor must work to address the questions, issues and needs of an entire state simultaneously. This is especially burdensome when the statewide EVV mandate rolls out on a specific date. In an open system, agencies aren't dependent on one vendor rolling out one solution for an entire state at one time. They can also better rely on the vendor to manage their needs as they know they are not in a pool consisting of all providers within the state.

Further, the open system ensures accountability and provides states with a single, uniform source of EVV data and network management tools. The state-purchased aggregator system brings accountability to the EVV system by taking in data from all EVV systems and applying standardized business rules to ensure visits are properly and consistently verified. The aggregator then generates alerts when visit data does not conform to standards and sends the information directly to the state. In a closed system, the state-selected EVV system is contracted by and implemented by the state, which would have to maintain direct management of the entire program. The open system allows the state to set specific technology standards and maintain comprehensive oversight of the entire program without placing unnecessary burdens on those delivering the care, and also allows the state to focus on data evaluation rather than data capture.

There are many benefits that an open system offers to all parties involved. The open system provides for vendor innovation, leading to quality care while removing cost and support pressures from the state. Additionally, the open system allows providers the flexibility to choose the vendor that works best for them, and vendors the flexibility to "right-size" with providers. The aggregator system allows the state to hold providers accountable while providing the state with regular, standardized data. Combined, these attributes will ultimately lead to a system where fraud, waste, and abuse are minimized and patients are delivered the intended care.

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BAYADA applauds the efforts of DVHA to involve and learn from providers during the design and discovery phase of the EVV project. With regard to the on-going discussions around design of the open model EVV system in Vermont, BAYADA has the following the recommendations:

- Do not require multiple check-in and check-outs when a caregiver is providing multiple services (Personal Care, Homemaking, Companionship, etc.) during a single client visit. Allow to providers to systematically consume the services based upon a single check-in and check-out for the visit.
- Allow providers to access client authorization data via an API. By providing authorization data electronically, providers can ensure their internal billing controls match exactly to those used by the state and/or aggregator.
- Continue to partner with providers on decisions concerning: rounding rules, timeliness of data, data requirements, etc.
- Allow providers to continue to submit claims using the current electronic claims submission process.
- Continue to collaborate with providers to establish reasonable and non-burdensome standards around EVV compliance rules.

BAYADA Home Health Care appreciates the opportunity to submit comments and looks forward to partnering DVHA on the open model EVV project.

Sincerely,

Matt Barbee
Director

VNAs of Vermont
Your Nonprofit
Home Health & Hospice Agencies

TO: AHS Medicaid Policy Unit - AHS.MedicaidPolicy@vermont.gov

FROM: Jill Mazza Olson, Executive Director, VNAs of Vermont

DATE: June 15, 2018

RE: **GCR Proposed Policy 18-007: Personal Care Electronic Visit Verification (Round 2)**

Note: This is a revised version of the comments submitted on March 2 now that more information has become available from CMS. New and revised comments are highlighted in yellow.

Thank you for the opportunity to comment on GCR Proposed Policy 18-007: Personal Care Electronic Visit Verification. We appreciate the department's collaborative and constructive approach to this issue.

We are still exploring this issue with our national partners and with our members. As far as we can discern, there is no state that can serve as a "model" - EVV has proven to be very challenging in every state where it has been implemented. Based on that research, we have some comments on the policy. I expect more will develop as we discuss implementation in greater depth with you. We appreciate that you have re-opened the comment period now that more detail is available from CMS. We recommend opening a third round of comments once the specifications and scope of work have been outlined with more specificity to each member.

1) An "open" system appears to be the best option and allows for the greatest flexibility.

2) Vermont should allow for a telephony approach which is often less expensive, simpler to implement and more reliable than the GPS options. All Vermont agencies have a telephony system in place. We will need to explore in greater depth whether those systems meet all the requirements. Our understanding is that requiring GPS stamping is at the discretion of the state, and that DVHA does not intend to require GPS stamping. Given the cost and complexity of implementing GPS stamping, we appreciate and strongly support that position.

3) The regulatory requirements cannot hinder patient access to services – it must be possible, and easy, for a scheduled visit to be covered by a different PCA if the scheduled PCA is unexpectedly absent. This has apparently been a significant challenge in other states. In addition, it should be possible for an employee to perform more than one service in a single visit without a new administrative burden, particularly one that might interrupt client care.

4) We appreciate the increasingly detailed specifications that DVHA is developing to meet the CMS data aggregation requirements. At this juncture, we recommend that DVHA technical staff begin working directly with each individual member to review their existing electronic health records and outline the scope of work necessary to create an interface. The VNAs of Vermont will provide contact information for IT staff, agency directors, and other relevant leaders as identified by agency directors. The VNAs of Vermont will also provide DVHA a list of each agency and the electronic health record used by the agency.

5) We are concerned about the addition of "homemaker" to the list of services that require EVV. Not all members have implemented EVV for that program. Because this is new information that was shared today on an implementation call, we have not yet been able to obtain member feedback on this issue. We recommend including this issue in your work with individual members.

6) At this juncture, members cannot estimate the potential cost of making the changes that will be necessary to fully comply with the CMS EVV requirements. However, it seems likely that the data aggregation process will – at a minimum – incur start-up costs. There may also be ongoing vendor charges. We feel strongly that any such costs should be borne by the state and not by member agencies. Choices for Care is chronically under-funded and members are already providing the service at a significant loss.

PARTNERSHIP FOR MEDICAID HOME-BASED CARE

May 22, 2018

Submitted via email to AHS.MedicaidPolicy@vermont.gov

AHS Medicaid Policy Unit
280 State Drive, Center Building
Waterbury, VT 05671-1000

RE: Implementation of Federally Mandated Electronic Visit Verification System for Medicaid Personal Care and Home Health Care Services

The Partnership for Medicaid Home-Based Care (PMHC) is providing the following comments related to Vermont's implementation of the federally mandated Electronic Visit Verification (EVV) system for Medicaid personal care services.

PMHC is comprised of organizations representing home care agencies, MCOs and other payers, national and state home care associations, and technology vendors who have come together to improve the quality and integrity of Medicaid funded home and community-based services (HCBS). Recognizing the integral role of home and community-based care in the Medicaid program, PMHC is dedicated to advancing and supporting public policies that bring accountability to and secure the Medicaid program for care recipients and taxpayers alike.

PMHC strongly supports the implementation of an "Open Model" system of EVV. Past state implementations in a "Closed Model" have not met the standard required by the 21st Century Cures Act to be least burdensome to stakeholders. Additionally, unlike a closed model system, implementing an open model system enables states to meet the standards required by the Act and provides benefits to all stakeholders.

States opting for an open model allow providers and MCOs to choose a system that best suits their operation. In this model, states first establish their EVV technology and configuration requirements, rules, and policies. They then purchase an "aggregator system," which is a vendor-agnostic system that takes in data from all EVV systems, applies standardized business rules to ensure visits are properly and consistently verified, and generates alerts when visit data does not conform to these standards. This allows the state to maintain comprehensive oversight of the entire program, regardless of EVV system used.

The open model results in true vendor neutrality and fully supports provider and MCO vendor choice while still allowing states to set specific minimum technology standards. Further benefits of the open model/aggregator system include:

- Vendor-agnostic EVV programs that maintain accountability for the state;
- Flexibility for providers to select the EVV vendor that works best for their business;

300 New Jersey Avenue, NW ▪ Suite 900 ▪ Washington, DC 20001
Phone: 202.742.5274 ▪ Fax 202-315-3490 ▪ www.medicaidpartners.org

- Ability for payers to manage a single, uniform source of EVV data and network rules management tools;
- Opportunities for providers and vendors to innovate and improve EVV systems based on evolving technology enhancements and market forces; and,
- Flexibility for states to keep up with technology changes and necessary innovations.

In a closed model, the state Medicaid program contracts with a single EVV vendor and mandates that all provider agencies use that vendor's EVV system. The selected solution is implemented by the state, and the state maintains direct management and oversight of the entire system.

Many states that have previously implemented closed model systems have encountered significant delays and provider objections. Providers primarily object to a closed model if they have already standardized their business processes around a technology solution that currently meets EVV requirements. The provider now must invest in, manage, train, and support a new system that may not integrate with their core business processes. This complicates their operations and workflows and adds considerable costs.

Given the advantages of an open model system, most states are proceeding toward an open model to meet the requirements under the Act. Additionally, a few states that have previously implemented a closed model system have declared their intent to switch to an open model system. See the attached map for the direction other states are taking.

An open model EVV system is the right choice for states, providers and consumers, on every point of comparison:

- Compliance, as measured by rate of adoption of the mandated EVV technology;
- Cost to the state to implement an EVV program (assumes enhanced federal match of 90%);
- Business burden, including the time and effort the state and providers must expend to implement and manage the program; and,
- Outcomes, including the savings the state expects to recoup based on impacts to fraud, waste, and abuse.

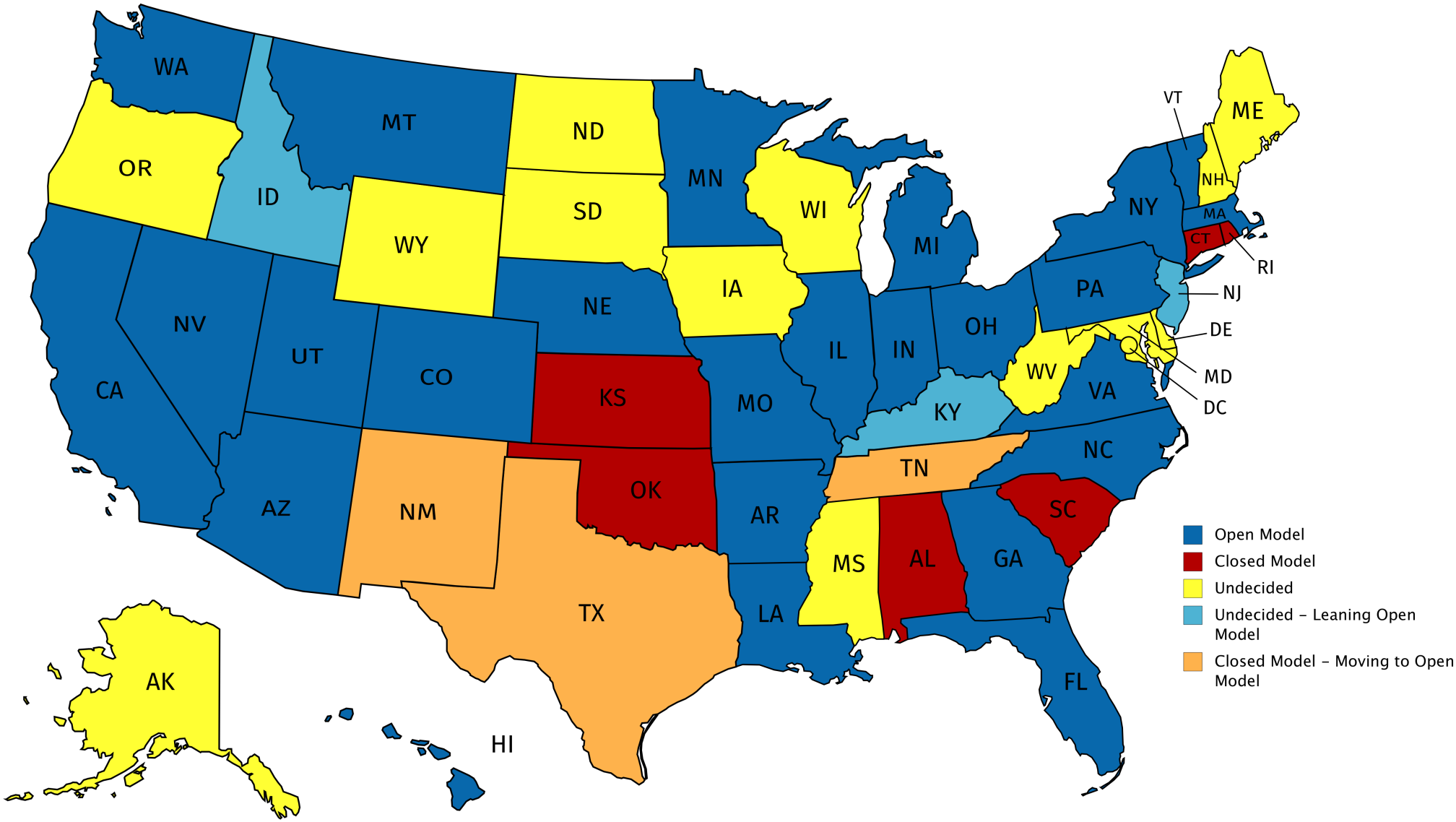
On behalf of the Partnership for Medicaid Home-Based Care, its members, and the individuals that we are privileged to serve, thank you for the opportunity to share our comments and recommendations. If we can be of any assistance or if you have questions, please don't hesitate to contact us at (202) 742-5274.

Kindest regards,

Darby Anderson, Vice Chairman
Chair, PMHC EVV Working Group

PARTNERSHIP FOR MEDICAID HOME-BASED CARE

Electronic Visit Verification Mandates



Source: Partnership for Medicaid Home-Based Care