



EVV Requirements in the 21st Century Cures Act Pre-Conference Intensive

**Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services**

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Session Overview

- Discuss Section 12006 of the 21st Century Cures Act (the Cures Act).
 - Overview of the Electronic Visit Verification (EVV) requirements, including penalties for noncompliance and good faith efforts.
 - Overview of the states' EVV implementation status based on 2017 National Association of Medicaid Directors (NAMDM) survey.
 - Description of the common EVV implementation models available.
- Review CMS' promising practice recommendations to states for:
 - EVV model selection and implementation.
 - Training and education for providers and individuals about the EVV system.
 - Ongoing EVV operations.

Overview of EVV Requirements

- The Cures Act requires states to implement an EVV system by January 1, 2020 (as amended by recent legislative action) for Personal Care Services (PCS) and by January 1, 2023 for Home Health Care Services (HHCS).
- Note that the Cures Act is not limited to services explicitly titled PCS or HHCS in the state's waiver or State Plan. If the service includes PCS or HHCS, even if it has a different name or also includes other services, it is subject to EVV.
- Any state that fails to do so is subject to incremental reductions in FMAP up to 1 percent.
- CMS is available for technical assistance in Advanced Planning Document (APD) development and submission.
- States can submit a request for good faith effort exemption. Contact CMS Regional Office analysts for the details of this requirement.
 - The Cures Act provision on good faith effort exemptions does not provide CMS with authority to delay the FMAP reductions for more than one year.

Disclaimer

- In this presentation, we will discuss several states that have implemented EVV and current EVV Models.

CMS is not endorsing any of these models or vendors.

- The purpose of introducing these examples is to help states and stakeholders understand the current EVV landscape.

Discussing these state examples does not imply that they are compliant with the Cures Act.

Overview of the 21st Century Cures Act¹

How does Section 12006 of the Cures Act impact HCBS programs?

- The Cures Act mandates that states require EVV use for Medicaid-funded Personal Care Services (PCS) and Home Health Care Services (HHCS) for in-home visits by a provider.
- Section 12006 of the Cures Act was signed into law on December 13, 2016, and added section 1903(l) to the Social Security Act (the Act).
- The requirement covers all 50 states including the District of Columbia, as well as the territories of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Overview of the 21st Century Cures Act ¹

Other requirements:

- The Secretary of Health and Human Services is required to collect and disseminate best practices regarding:
 - Training individuals who furnish PCS, HHCS, or both, on the use and operation of EVV systems and on the prevention of fraud with respect to the provision of PCS and HHCS.
 - Provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of EVV systems and other means to prevent such fraud.

Required Medicaid Authorities per Section 12006 of The Cures Act

Medicaid PCS Authorities Subject to EVV Requirements

- 1905(a)(24) State Plan Personal Care benefit;
- 1915(c) HCBS Waivers;
- 1915(i) HCBS State Plan option;
- 1915(j) Self-directed Personal Attendant Care Services;
- 1915(k) Community First Choice State Plan option;
- 1115 Demonstration

Medicaid HHCS Authorities Subject to EVV Requirements:

- 1905(a)(7) State Plan Home Health Services
- Home health services authorized under a waiver of the plan

Note: EVV requirements do NOT apply to the Program of All-Inclusive Care for the Elderly (PACE).

Which Services Require EVV?

Personal Care Services (PCS) Definition

- 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.).
- 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, transferring, 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.

Which Services Require EVV?

Personal Care Services (PCS) Definition - Continued

- Note that the Cures Act is not limited to services explicitly titled PCS or HHCS in the state's waiver or state plan.
- If the service includes PCS or HHCS, even if it has a different name or also includes other services, it is subject to EVV.
 - All services requiring an in-home visit that are included in claims under the home health category or PCS categories on the CMS-64 form are subject to the EVV requirement.

Which Services Require EVV?

Personal Care Services (PCS) Definition - Continued

- The following services are not considered PCS for the purposes of EVV implementation and therefore are not subject to Section 12006 of the Cures Act:
 - PCS provided in 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.
 - PCS provided to inpatients or residents of:
 - Hospitals,
 - Nursing facilities,
 - Intermediate care facilities (ICFs) for individuals with intellectual disabilities, or an institution for mental diseases (IMD)
 - PCS that do not require an in-home visit.
 - Services consisting of only IADLs (e.g., chore and homemaker services), as long as they are not billed as PCS.

Which Services Require EVV?

Home Health Care Services (HHCS) Definition

- 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.

Which Services Require EVV?

Home Health Care Services (HHCS) Definition

- For example, when a state covers medical supply services as part of HHCS:
 - **EVV does not apply:** if medical supplies are delivered through the mail, or are picked up at the pharmacy.
 - **EVV does apply:** if a medical supply requires an in-home visit for set-up.
 - The above example applies to both managed care and fee-for-service delivery systems.

Penalties for Non-Compliance with Section 12006 of the Cures Act

- The Cures Act Section 12006(a)(1)(A) requires that states that **do not comply** with the Cures Act by the applicable deadlines will have their Federal Medical Assistance Percentage (FMAP) reduced as shown in the table below.
- Reduction percentages **do not** compound each year.

PCS & HHCS FMAP* Reductions per Year

Year	PCS	HHCS
2020	0.25%	-
2021	0.50%	-
2022	0.75%	-
2023	1%	0.25%
2024	1%	0.25%
2025	1%	0.50%
2026	1%	0.75%
2027 & thereafter	1%	1%

*Per 1915(c) Technical Guide page 259, the **FMAP** is the “Federal Medicaid matching rate for medical assistance furnished under the state plan. FMAP rates are re-calculated annually under the formula set forth in §1903(b) of the Social Security Act.”

Exceptions for Non-Compliance per Section 12006 of the Cures Act

- Per Section 12006(a)(4)(B) of the Cures Act, FMAP reduction will *not apply* if the state has both:
 - Made a “good faith effort” to comply with the requirements to adopt the technology used for EVV; **and**
 - Encountered “unavoidable system delays”
- If the state demonstrates both of the above two requirements, then the FMAP reductions shall **not** apply for calendar quarters in 2020 (for PCS) or for calendar quarters in 2023 (for HHCS).
- States can begin submitting information to CMS in **July 2019** to describe concerns they foresee in adhering to the 1/1/20 effective date for PCS and provide justification that the state has demonstrated a good faith effort.

EVV Requirements per Section 12006 of the Cures Act

EVV Systems Must Verify:

- **Type** of service performed;
- **Individual receiving** the service;
- **Date** of the service;
- **Location** of service delivery;
- **Individual providing** the service;
- **Time** the service begins and ends.

EVV Requirements per Section 12006 of the Cures Act

Flexibility for States

- States may select their EVV design and implement quality control measures of their choosing.

Stakeholder Input Required

- States are required to seek input from other state agencies that provide PCS or HHCS.
- Requires states to seek stakeholder 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

Department of Health and Human Services (HHS) Role

- Required to provide training and educational materials related to best practices to State Medicaid Directors by January 1, 2018.
- CMS' efforts to date to provide training and educational materials include:
 - Conducted a national EVV survey with the National Association of Medicaid Directors (NAMDD) and interviewed a subset of states to discuss best practices identified through survey responses.
 - Conducted training sessions in [December 2017](#) and [January 2018](#). Also conducted a session to discuss Frequently Asked Questions (FAQ) in January 2018.
 - Issued the [CMCS Informational Bulletin \(CIB\)](#) and [Frequently Asked Questions and Answers \(FAQ\)](#) documents in May 2018.

Advance Planning Document and Federal Match

- Federal reimbursement is available 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.
- The “Federal Match” of state costs are the following:

90% Match

- The design, development and installation of EVV.

75% Match

- Operation and maintenance of the system.
- Routine system updates, customer service, etc.

50% Match

- Administrative activities deemed necessary for the efficient administration of the EVV.
- Education and outreach for state staff, individuals and their families.

Advance Planning Document and Federal Match

- Enhanced Federal match may be available for the following:
 - Higher level systems components and vendors for Medicaid enterprise IT projects.
 - Implementing commercial off-the-shelf (COTS) software.
 - Upgrading a state's existing/current EVV system.
 - Refer to CMS' [FAQ document questions 18 - 22](#) for more detail regarding specific costs that might be eligible.
- Enhanced Federal match under 1903(l)(6) is available only if the EVV system costs listed are incurred by the state or its contractor.
- States planning to request funding for the development and implementation of EVV must prepare and submit an Advanced Planning Document (APD) for approval.

Advance Planning Document and Federal Match

- For additional assistance regarding Federal match:
 - States should contact their Regional Office MMIS system lead for assistance with APDs.
 - Refer to 45 CFR Part 95, Subpart F for additional information.
- As of August 20, 2018, 31 states have submitted APDs.

EVV System Considerations for Self-Directed Services

- Accommodate PCS or HHCS service delivery locations with limited or no internet access.
- Avoid rigid scheduling rules, as self-directed services are known for accommodating last-minute changes based on individuals' needs.
- Allow individuals to schedule their services between the individual and the provider.
- Accommodate services at multiple locations for each individual (e.g., not only at home but near home or other community locations).
- Allow for multiple service delivery locations in a single visit.
- Include key stakeholders in the conversation when states determine EVV strategies for self-direction and agency directed services.
- Consider allowing the EVV system to notify the state when an individual is not receiving services in the amount, duration, frequency and scope necessary to meet that individual's needs.
- Integrate existing self-direction systems to avoid duplication and burden on Financial Management Service (FMS).

Considerations for Using Location Services in EVV Systems

- 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 Cures Act’s requirements.
 - CMS notes that there is no requirement to use global positioning services (GPS), but it is one approach for implementing EVV requirements.
 - One 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. However this method may not give caregivers the flexibility to check-in or out from community locations if needed (e.g., if the service starts in the home and ends in another location)
- 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.

Considerations for Using Location Services in EVV Systems

- CMS conducted interviews with eight (8) EVV vendors regarding location tracking and privacy while using EVV systems and found that:
 - While GPS is the standard method for tracking location of services rendered outside the home (e.g., via a smartphone or tablet-based mobile app), no vendors reported using **active, continuous** GPS tracking.
 - Location is only recorded with GPS at the time the worker checks-in at the start of the service and at the time they check-out at the end of the service.
 - Workers install the mobile app on their personal device or a device issued by the state or the provider agency. Vendors did not require a mobile app installation for the individual or family member's device.
 - Secondary verification (e.g., the individual's electronic signature) is sometimes used with GPS to verify the visit began or ended in the correct location

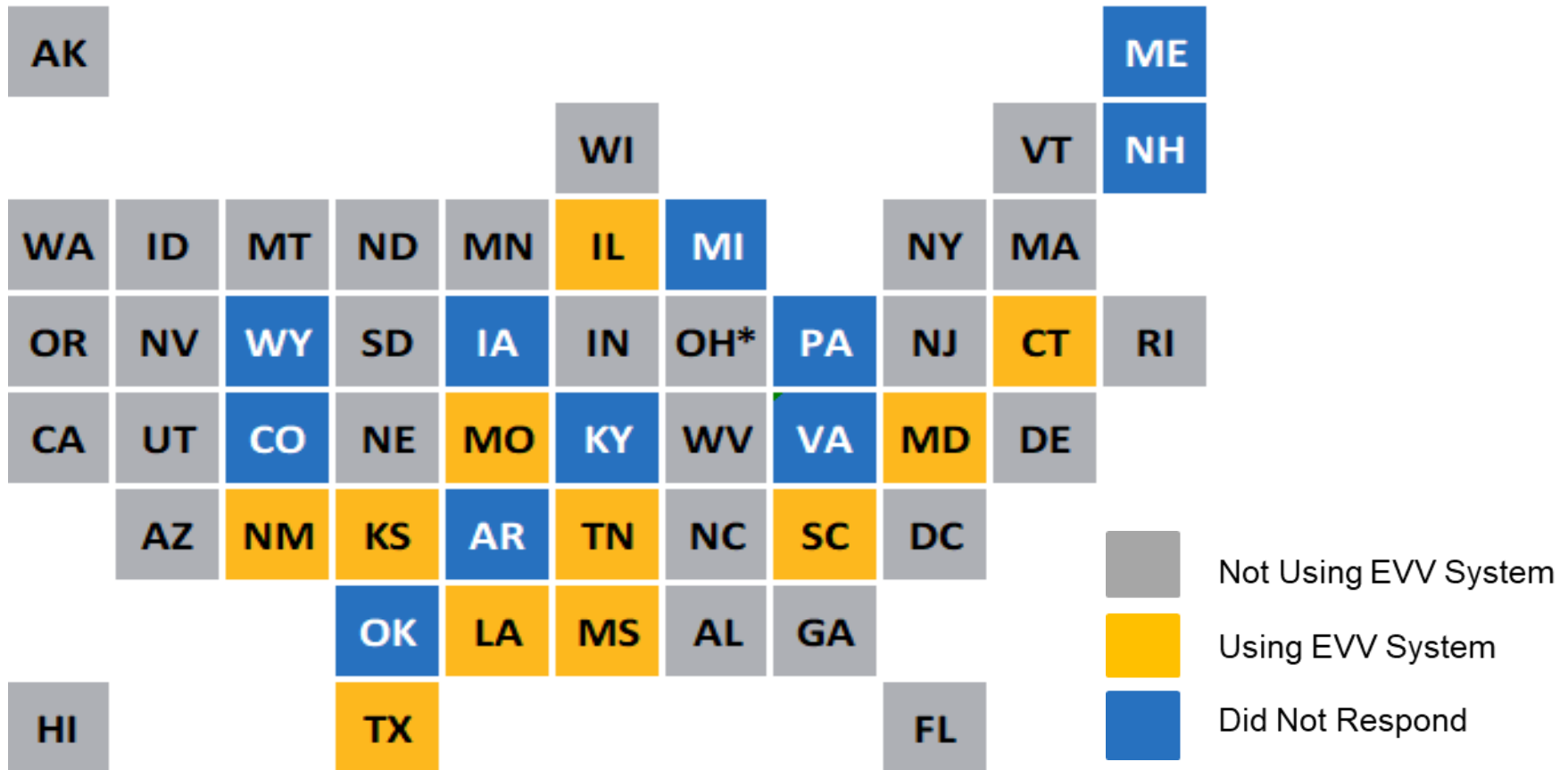
Considerations for Using Location Services in EVV Systems

- States should consider proactively conducting educational outreach to the stakeholder community to address any concerns and to discuss benefits of EVV.
 - Active location tracking throughout the service is one of the most common misconceptions about EVV technology.
 - One vendor recommended using social media platforms as part of an outreach program.
 - Use stakeholder meetings to not only gather feedback but also as an educational opportunity to discuss:
 - How EVV systems' GPS location tracking operates.
 - Why the state must be compliant with EVV elements required by the Cures Act.
 - How preventing fraud, waste, and abuse can benefit individuals. Less wasted funds potentially means more funding available for additional services, reduction of waiting lists, etc.

Considerations for Using Location Services in EVV Systems

- To help ensure the EVV system is both flexible and reliable when verifying community locations, consider:
 - Populating the EVV system with individuals’ anticipated and preferred community locations. Sources of locations could include:
 - Person-Centered Service Plans – obtain a list of individuals’ planned activities.
 - Individuals, families, and case managers.
 - Allowing individuals and families to readily update their lists of community locations, such as by requesting updates through their case manager or through the EVV system’s web portal.
 - A process for reviewing claims for services rendered outside the locations established by the individual (i.e., “exceptions”) and monitoring for outliers. For example, multiple location edit requests in a same day, or every day for a month might flag a further review by the case manager or the provider.
 - Secondary verification, such as requesting the individual’s electronic signature for each check-in/out, used in conjunction with location tracking to further ensure the visit began or ended in the correct location.

11 States Reported Using EVV for PCS and/or Home Health as of September 2017



*Ohio implemented its EVV system after CMS' September 2017 survey was completed.

**Puerto Rico and the U.S. Virgin Islands reported that they did not have an operational EVV for either HHCS nor PCS.

Note: Map is based on information provided by the states and may be incomplete.

EVV Design Models

- There are five major EVV system models implemented by states.
- All five models provide similar solutions but vary with respect to state involvement in vendor selection and EVV management.
 1. **Provider Choice:** Providers select their EVV vendor-of-choice and self-fund its implementation.
 2. **Managed Care Plan (MCP) Choice:** MCPs select their EVV vendor-of-choice and self-fund its implementation.
 3. **State Mandated External Vendor:** States contract with a single EVV vendor that all providers must use.
 4. **State Mandated In-house System:** States create, run, and manage their own EVV system.
 5. **Open Vendor:** States contract with a single EVV vendor or build their own system, but allow providers and MCPs to use other vendors.
- States can choose more than one model.

Promising Practices for EVV Model Selection and Implementation

- There are eight promising practices states should consider when selecting an EVV model that is most suitable for their Medicaid PCS and HHCS programs.
 1. Assess EVV systems, if any, currently used by providers.
 2. Evaluate the state's existing vendor relationships.
 3. Define EVV requirements.
 4. Integrate EVV systems with other Medicaid state systems and data.
 5. Understand technological capabilities.
 6. Solicit stakeholder input.
 7. Assess state staff capacity to develop and/or support the EVV system, including providing user training and education.
 8. Roll out EVV in phases and/or pilots (timeline permitting).

Promising Practices for Training and Education

- Seven promising practices states should consider when developing training for state staff, providers, individuals and their families include:
 1. Inventory all entities / individuals that will be interacting with EVV.
 2. Understand how training responsibilities will vary by EVV model.
 3. Establish a training plan.
 4. Assess state staff capabilities/capacity for developing and delivering training.
 5. Provide training and assistance on an ongoing basis.
 6. Establish an EVV website.
 7. Use multiple approaches for notifying and training individuals and their families.

Promising Practices for Ongoing EVV Operations

- To ensure successful operation of an EVV system, states should clearly outline expectations regarding monitoring.
- States should allow for continuous provider involvement in decisions-making, particularly for states that established state mandated models.

Additional Helpful Tips for States Implementing EVV

- Leverage the APD process.
 - If implemented according to requirements under 45 CFR Part 95 Subpart F, states can receive up to 90% federal match. They would need to apply for federal financial participation (FFP) for expenditures.
- Examine every State Plan and waiver authority cited in the Cures Act and crosswalk against State Plan and waiver authorities offered in your state.
- Crosswalk your state's service definitions and the components of each service definition to the definitions in the Cures Act.

Additional Information Regarding Good Faith Effort Exemption Process

- Requests for good faith effort exemptions should be submitted between July 1, 2019 and November 30, 2019. More details to follow regarding format for these requests.
- When reviewing requests, CMS will consider:
 - Actions the state has performed to adopt EVV and meet the requirements at Section 12006(a) of the Cures Act.
 - The state's proposed EVV model (go to: <https://www.medicaid.gov/federal-policyguidance/downloads/cib051618.pdf> for more information on EVV models).
 - Unavoidable system delays/barriers encountered by the state (if you have any questions on what may constitute an unavoidable delay or barrier please email EVV@cms.hhs.gov or contact your CMS Regional Office).
 - The state's stakeholder engagement process.

Additional Information Regarding Good Faith Effort Exemption Process

Where to Submit the Good Faith Effort Exemption Requests:

- States will be advised to send good faith effort exemption requests to the EVV mailbox at EVV@cms.hhs.gov with the subject line “[State Name] EVV Good Faith Effort Exemption Request.”
- The EVV mailbox will acknowledge receipt of the request.
- Only one request per state should be submitted.

Additional Information Regarding Good Faith Effort Exemption Process

After States' Submission:

- Within 30 days of receipt of the state's request, the CMS EVV mailbox will send a letter attached in an email and signed by the Director of DLTSS confirming that the state's request has been approved.
- If the state's request is not approvable, CMS will inform the state of the reason(s) the request was not approved and will offer to schedule a conference call with the state. The state will have the opportunity to revise and resubmit its request.

Note for All States Submitting Good Faith Effort Exemptions:

- Please be advised that the Cures Act provision on good faith effort exemptions does not provide CMS with authority to delay the FMAP reductions for more than one year. If you have any questions please email EVV@cms.hhs.gov or contact your CMS Regional Office.

Summary

- The Cures Act requires states to implement an EVV system by January 1, 2020 (as amended by recent legislative action) for PCS and by January 1, 2023 for HHCS.
- Any state that fails to do so is subject to incremental reductions in FMAP up to 1 percent.
- CMS is available for technical assistance in Advanced Planning Document (APD) development and submission.
- EVV can be a strong mechanism for ensuring financial accountability of the program, including reduction in unauthorized services, improvement in quality of services to individuals, and reduction in fraud, waste and abuse.
- EVV systems can increase accuracy and quality of PCS and HHCS provided.
- EVV can also increase efficiency through quick electronic billing incorporated into the system immediately after entry.

Summary

- Five common EVV design models were identified. States have the flexibility to choose their EVV design model after gathering feedback with appropriate stakeholders.
- Frequent stakeholder engagement is key to successful implementation.
- There are multiple promising practices for EVV model selection and implementation, training, education, and ongoing EVV operations.
- States may submit requests for good faith effort exemptions to CMS.
- Contact CMS regional office or EVV Mailbox with additional questions or concerns.

Additional Resources

1. EVV Resources Website link:
<https://www.medicaid.gov/medicaid/hcbs/guidance/electronic-visit-verification/index.html>
2. [CMCS Informational Bulletin \(CIB\): Cures Act for Electronic Visit Verification, issued on May 16, 2018.](#)
3. [FAQs: Cures Act for Electronic Visit Verification. Issued on May 16, 2018.](#)
4. Copies of the HCBS Training Series – Webinars presented during SOTA calls are located in below link:
<https://www.medicaid.gov/medicaid/hcbs/training/index.html>
5. See below link for a copy of the 21st Century Cures Act:
<https://www.congress.gov/bill/114th-congress/house-bill/34/text>

Questions & Answers

For Further Information

For questions contact:

EVV@cms.hhs.gov

ATTACHMENT

*Full Text of the Section 12006 of the Cures
Act Part (a) & (b)*

and

H.R. 6042

Section 12006 of the Cures Act Part (a)

Electronic Visit Verification System Required for Personal Care Services and Home Health Care Services Under Medicaid.

- (a) In General – Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (k) the following new subsection:
- (1) Subject to paragraphs (3) and (4), with respect to any amount expended for 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) and furnished in a calendar quarter beginning on or after January 1, 2019 (or in the case of home health care services, on or after January 1, 2023), unless a state requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced –
- (A) in the case of personal care services –
- (i) for calendar quarters in 2019 and 2020, by 0.25 percentage points;
 - (ii) for calendar quarters in 2021, by 0.5 percentage points;
 - (iii) for calendar quarters in 2022, by 0.75 percentage points; and
 - (iv) for calendar quarters in 2023 and each year thereafter, by 1 percentage point; and

Section 12006 of the Cures Act Part (a)

(B) in the case of home health care services –

- (i) for calendar quarters in 2023 and 2024, by 0.25 percentage points;
- (ii) for calendar quarters in 2025, by 0.5 percentage points;
- (iii) for calendar quarters in 2026, by 0.75 percentage points; and
- (iv) for calendar quarters in 2027 and each year thereafter, by 1 percentage point.

(2) Subject to paragraphs (3) and (4), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a state shall –

(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 electronic visit verification systems in use in the state; and
- (iii) is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act);

Section 12006 of the Cures Act Part (a)

(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 personal care services, home health care services, or both under the state plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.

(3) Paragraphs (1) and (2) shall not apply in the case of a state that, as of the date of the enactment of this subsection, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services, so long as the state continues to require the use of such system with respect to the electronic verification of such visits.

(4)(A) In the case of a state described in subparagraph (B), the reduction under paragraph (1) shall not apply –

- (i) in the case of personal care services, for calendar quarters in 2019; and
- (ii) in the case of home health care services, for calendar quarters in 2023.

Section 12006 of the Cures Act Part (a)

(B) For purposes of subparagraph (A), a state described in this subparagraph is a state that demonstrates to the Secretary that the state –

(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.

(5) In this subsection: (A) The term ‘electronic visit verification system’ means, with respect to personal care services or home health care services, 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.

Section 12006 of the Cures Act Part (a)

(B) The term ‘home health care services’ means services described in section 1905(a)(7) provided under a state plan under this title (or under a waiver of the plan).

(C) The term ‘personal care services’ means personal care services provided under a state plan under this title (or under a waiver of the plan), including services provided under section 1905(a)(24), 1915(c), 1915(j), or 1915(k) or under a waiver under section 1115.

6(A) In the case in which a state requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the state or a contractor on behalf of the state, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

(B) Subparagraph (A) shall not apply in the case in which a state requires personal care service and home health care service providers to utilize an electronic visit verification system that is not operated by the state or contractor on behalf of the state.

Section 12006 of the Cures Act Part (b)

(b) Collection and Dissemination of Best Practices – Not later than January 1, 2018, the Secretary of Health and Human Services shall, with respect to electronic visit verification systems (as defined in subsection (1)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), collect and disseminate best practices to State Medicaid Directors with respect to:

- (1) training individuals who furnish personal care services, home health care services, or both under the State plan under title XIX of such Act (or under a waiver of the plan) on such systems and the operation of such systems and the prevention of fraud with respect to the provision of personal care services or home health care services (as defined in such subsection (1)(5)); and
- (2) the provision of notice and educational materials to family caregivers and beneficiaries with respect to the use of such electronic visit verification systems and other means to prevent such fraud.

H.R. 6042: Extension Language

SECTION 1. Delay in reduction of FMAP for Medicaid personal care services furnished without an electronic visit verification system.

(a) In general.—Section 1903(l) of the Social Security Act (42 U.S.C. 1396b(l)) is amended—

(1) in paragraph (1)—

(A) by striking “January 1, 2019” and inserting “January 1, 2020”; and

(B) in subparagraph (A)(i), by striking “2019 and”; and

(2) in paragraph (4)(A)(i), by striking “calendar quarters in 2019” and inserting “calendar quarters in 2020”.

H.R. 6042: Extension Language

SECTION 1. Delay in reduction of FMAP for Medicaid personal care services furnished without an electronic visit verification system.

(b) Sense of Congress on stakeholder input regarding electronic visit verification systems.—It is the sense of Congress that—

(1) the Centers for Medicare & Medicaid Services should—

(A) convene at least one public meeting in 2018 for the purpose of soliciting ongoing feedback from Medicaid stakeholders on guidance issued by the Centers for Medicare & Medicaid Services on May 16, 2018, regarding electronic visit verification; and

(B) communicate with such stakeholders regularly and throughout the implementation process in a clear and transparent manner to monitor beneficiary protections;

(2) such stakeholders should include State Medicaid directors, beneficiaries, family caregivers, individuals and entities who provide personal care services or home health care services, Medicaid managed care organizations, electronic visit verification vendors, and other stakeholders, as determined by the Centers for Medicare & Medicaid Services; and

(3) taking into account stakeholder input on the implementation of the electronic visit verification requirement under the Medicaid program is vital in order to ensure that the Centers for Medicare & Medicaid Services is aware and able to mitigate any adverse outcomes with the implementation of this policy.