

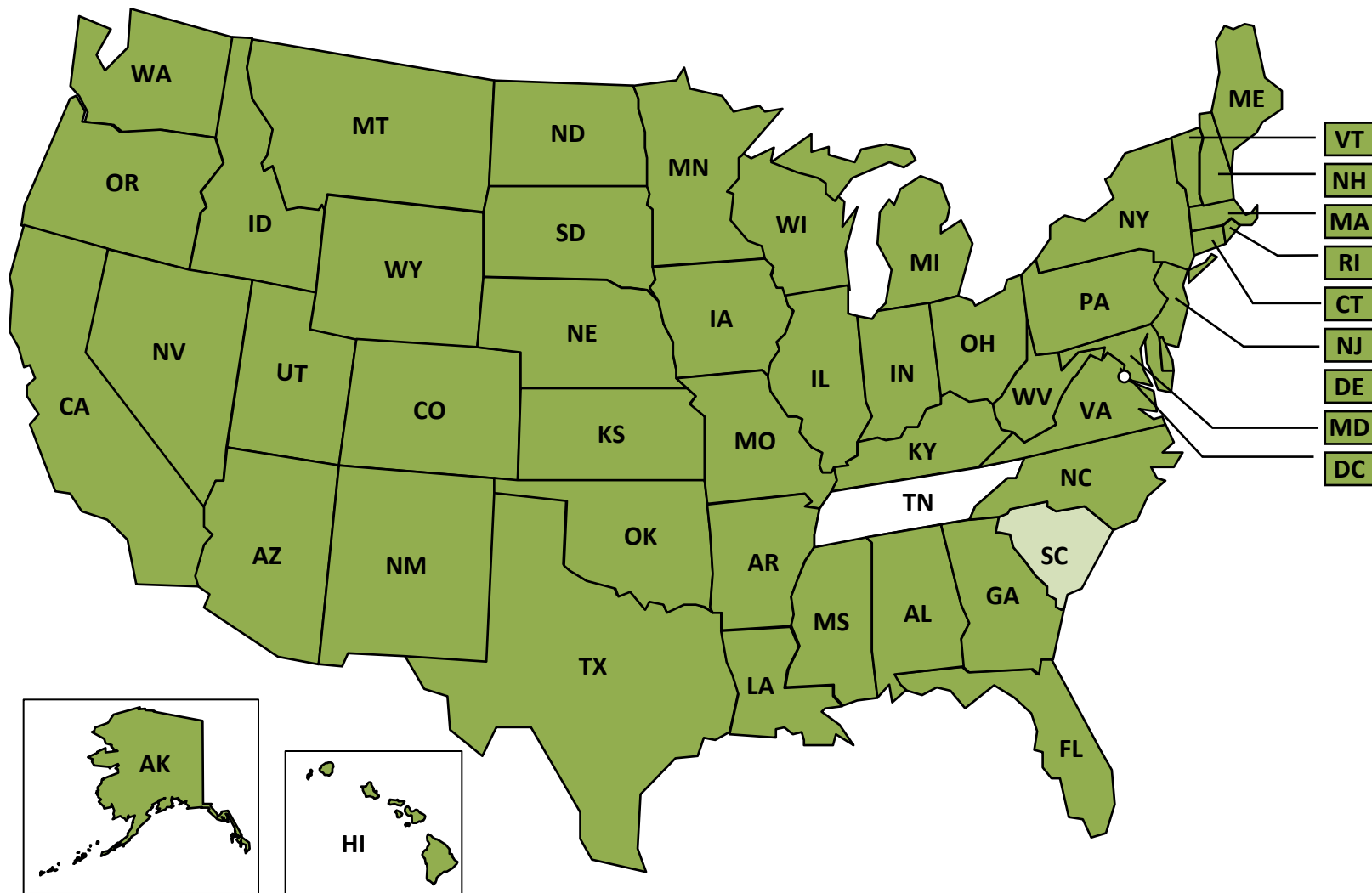
# Examining the Unavoidable Delays to EVV Implementation

February 26, 2020

# Overview

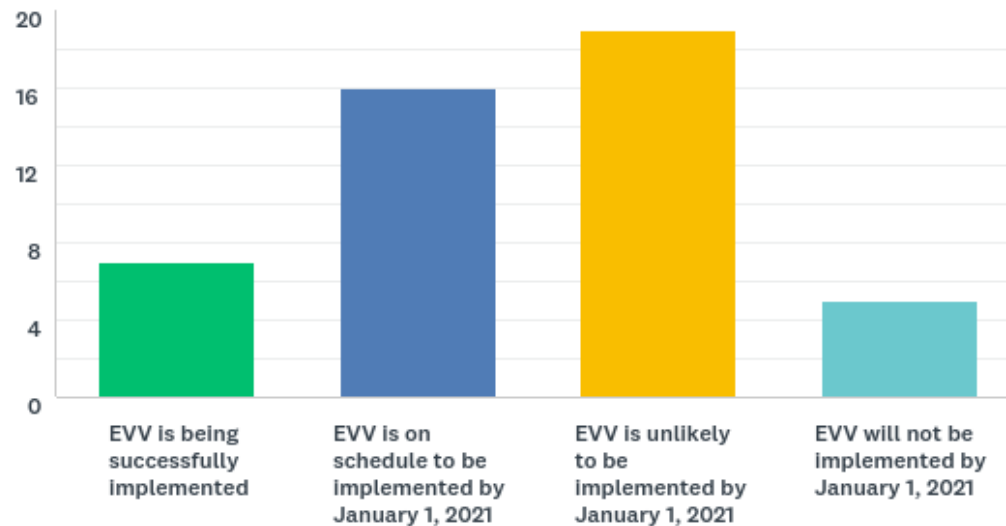
- States were required to implement EVV for Medicaid personal care services by January 1, 2020, unless they submitted a good faith effort exemption request to CMS by November 30, 2019 and received approval.
- CMS is not authorized to delay FMAP reductions for states beyond January 1, 2021
- CMS published all approval letters online
  - <https://www.medicaid.gov/medicaid/home-community-based-services/guidance/electronic-visit-verification/good-faith-effort-exemption-requests-state-requests/index.html>
- ASD has summarized the approval letters for easy reference
  - <http://www.appliedselfdirection.com/resources/evv-good-faith-effort-extension-reasons-state>

# EVV Good Faith Exemption Approval



# Member Poll

Q2 In the state(s) I serve, I think that (select all that apply for FMS providers working with multiple states):



# Reasons for Unavoidable Delay: Major Themes



# Top 10 Reasons for Delay

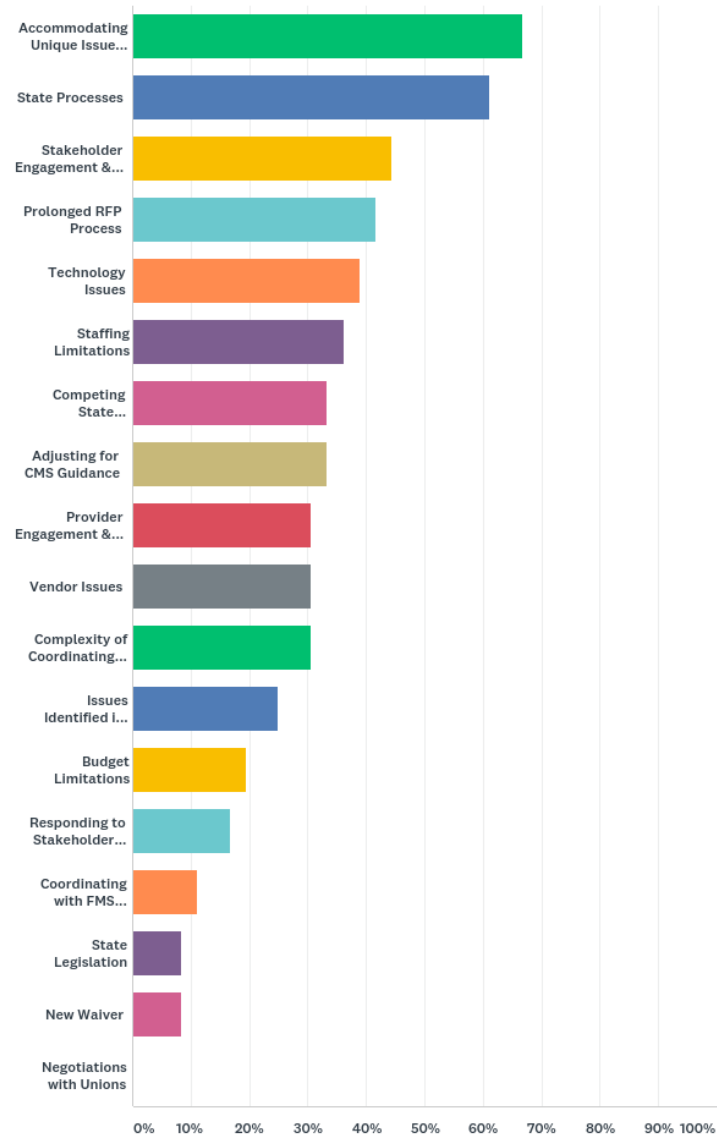
1. Prolonged RFP Process
2. Technology Issues
3. Competing State Priorities
4. Budget Limitations
5. Provider Engagement and Training
6. State Processes
7. Stakeholder Engagement and Training
8. Responding to Stakeholder Feedback
9. Accommodating Unique Issues of Self-Direction
10. Staffing Limitations

# Additional Reasons for Delay

11. Adjusting for CMS Guidance
12. Vendor Issues
13. Complexity of Coordinating with Numerous Agencies
14. Issues Identified in Implementation
15. Coordinating with FMS Providers
16. State Legislation
17. Negotiations with Unions
18. New Waiver

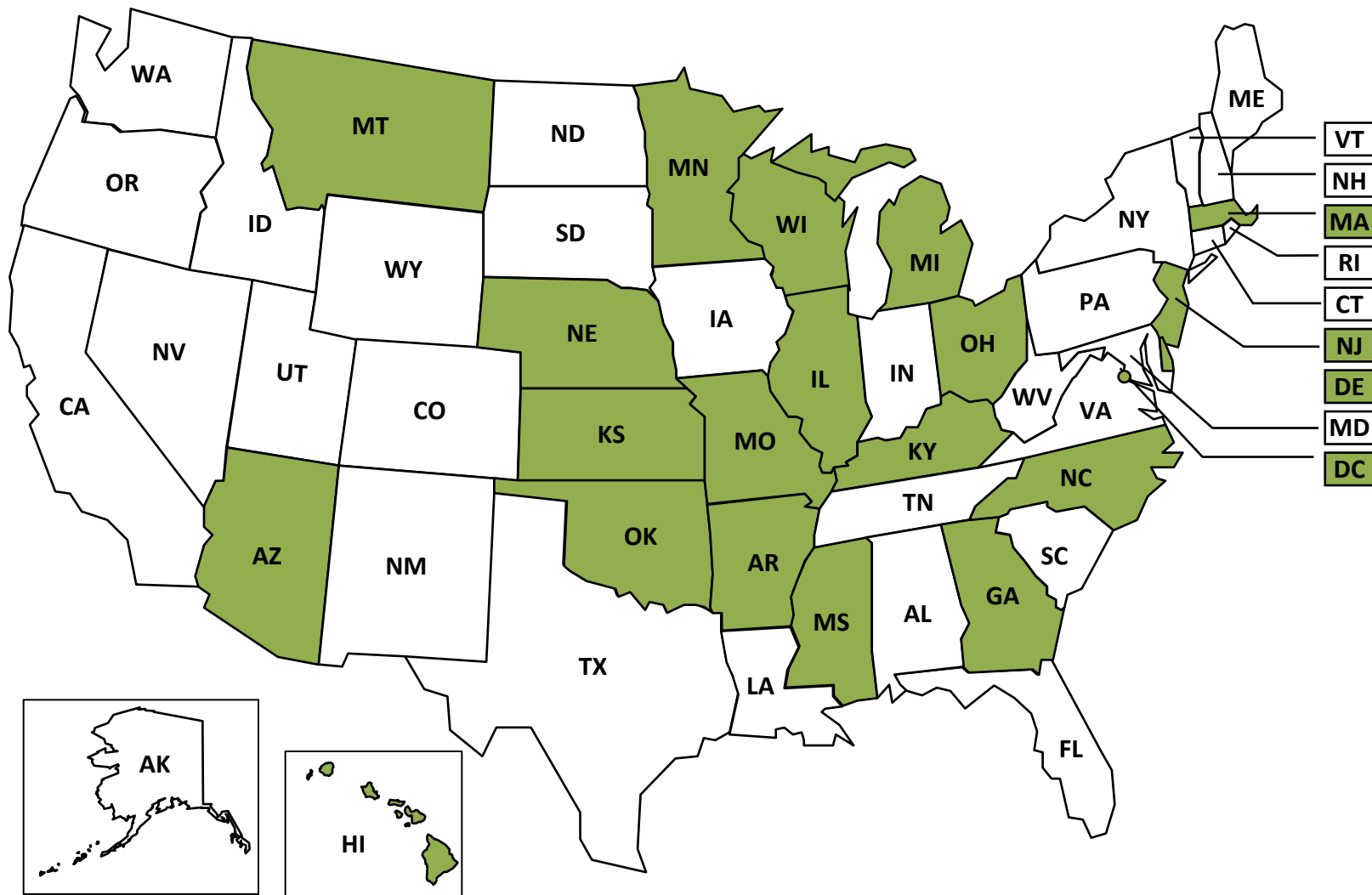
# Member Poll

Q3 Which of the following factors have impacted EVV implementation in the state(s) you serve (select all that apply):





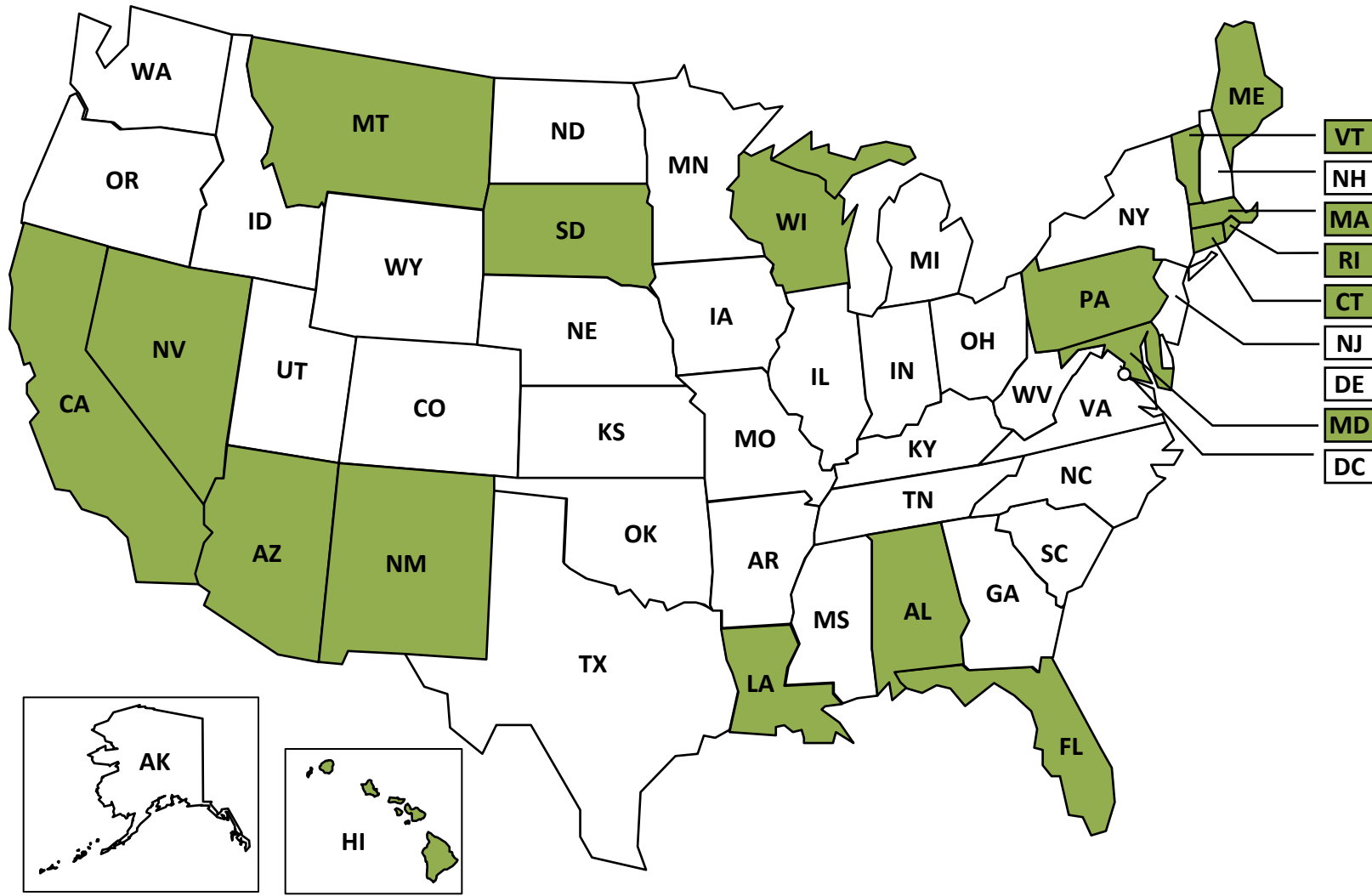
# Prolonged RFP Process (21 states)



# Prolonged RFP Process

- Diverse range of issues resulted in a prolonged RFP/procurement process for states seeking to secure EVV vendor(s)
  - Examples: Protests prior to awarding a contract, need to incorporate stakeholder feedback, volume of questions from potential vendors, prolonged contract negotiations, veto of a budget bill, etc.
- States that have yet to begin the RFP process may expect delays will be likely
- Completing an RFP process is an early step in EVV implementation, many future complications may still arise

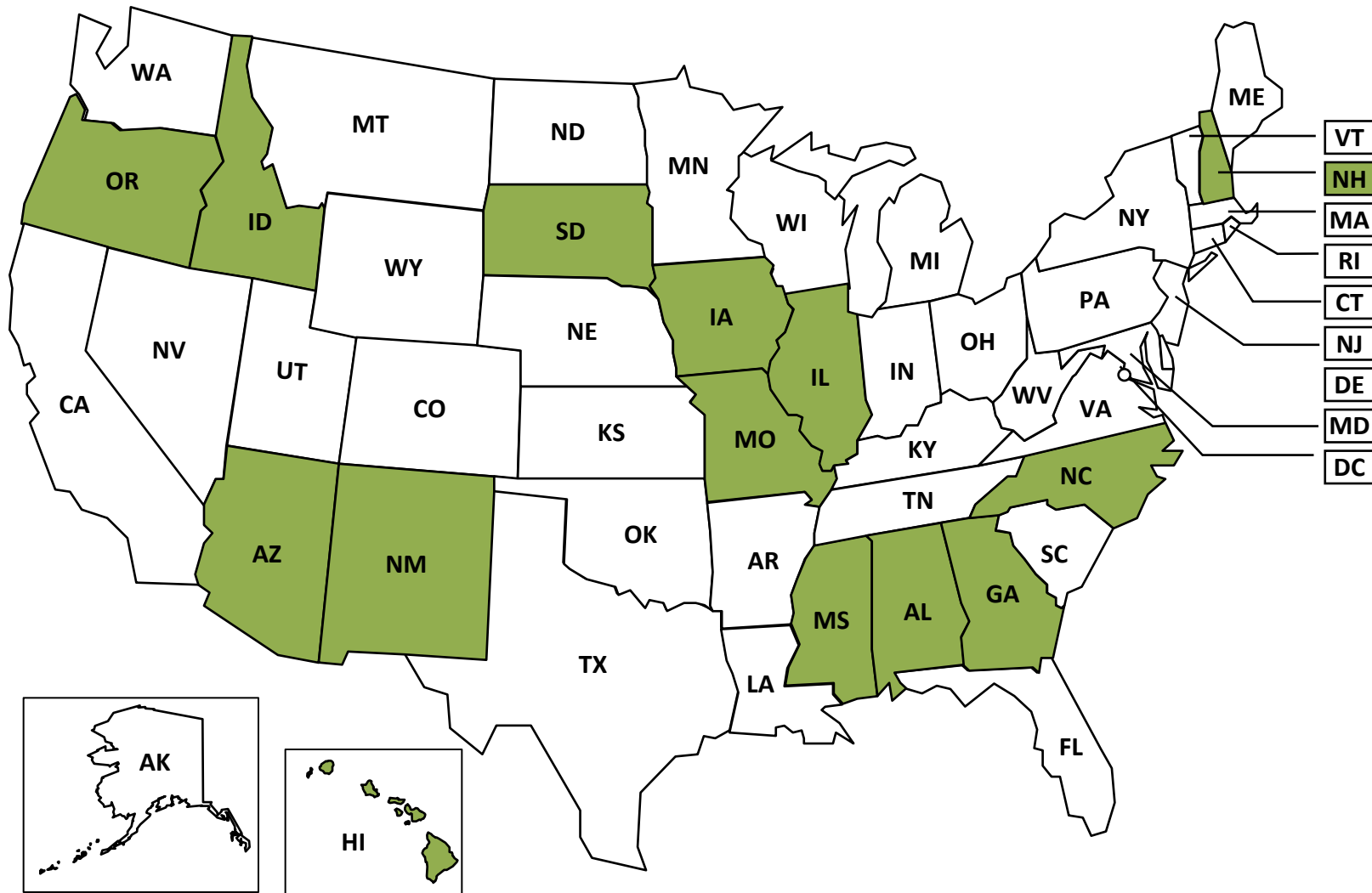
# Technology Issues (18 states)



# Technology Issues

- The most common technology issue was “system interoperability” cited by 9 states
  - According to the Cures Act, the term 'interoperability' means such health information technology that— "(A) enables the secure exchange of electronic health information with, and use of electronic health information from, other health information technology without special effort on the part of the user; "(B) allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law; and "(C) does not constitute information blocking as defined in section 3022(a).”
- The need for custom configuration was also mentioned by a few states

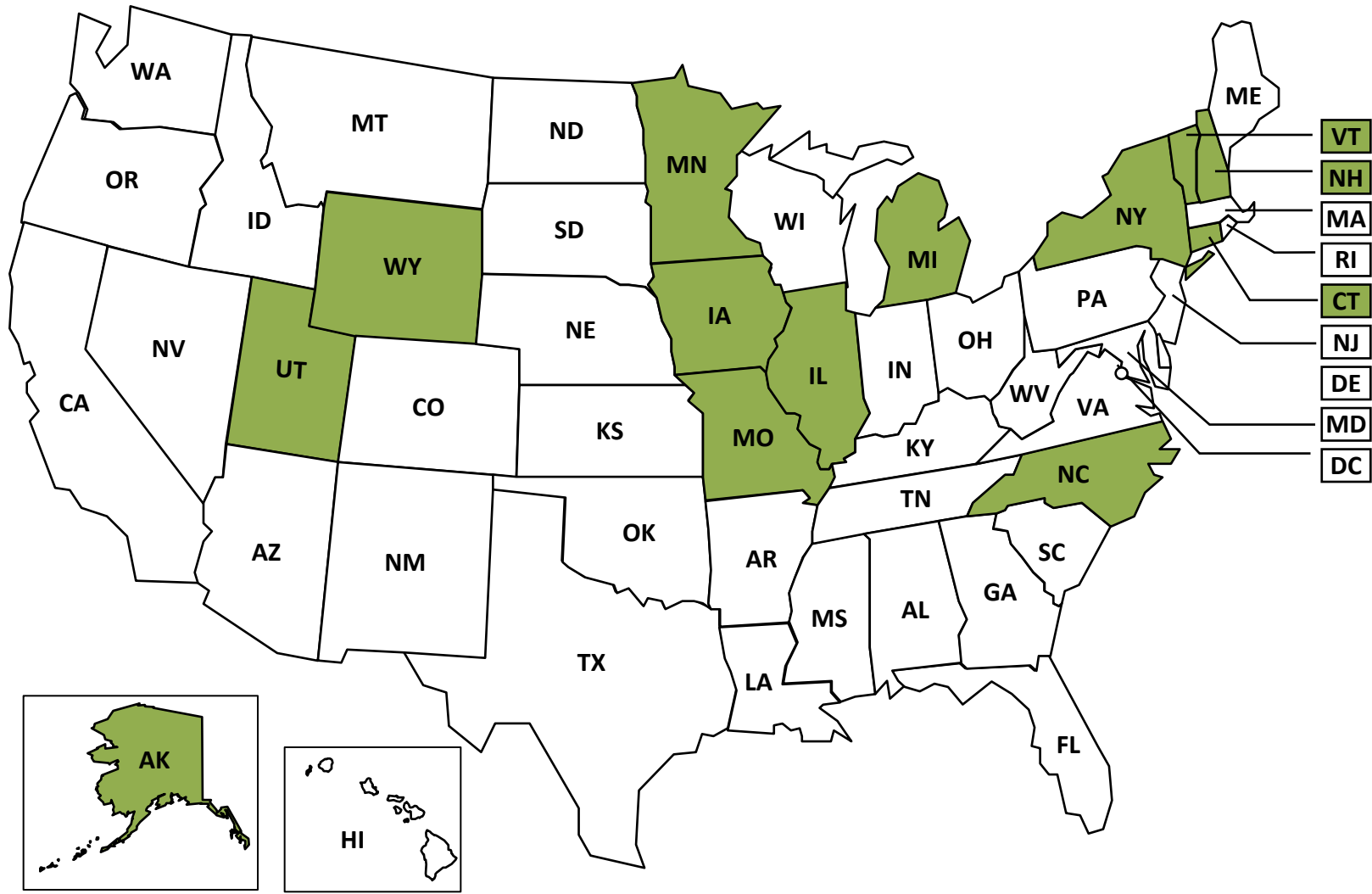
# Competing State Priorities (14 states)



# Competing State Priorities

- These states were challenged by balancing EVV implementation with other competing state priorities, including:
  - ❑ Other CMS/Medicaid Initiatives, including Medicaid Expansion, CMS Corrective Action Plan (CAP) recommendations
  - ❑ Managed care transitions
  - ❑ Technology investments, including modernization of Medicaid Management Information System (MMIS)
  - ❑ Response to natural disasters
  - ❑ Response to opioid crisis
- Closely related to staffing and budget limitations

# Budget Limitations (13 states)

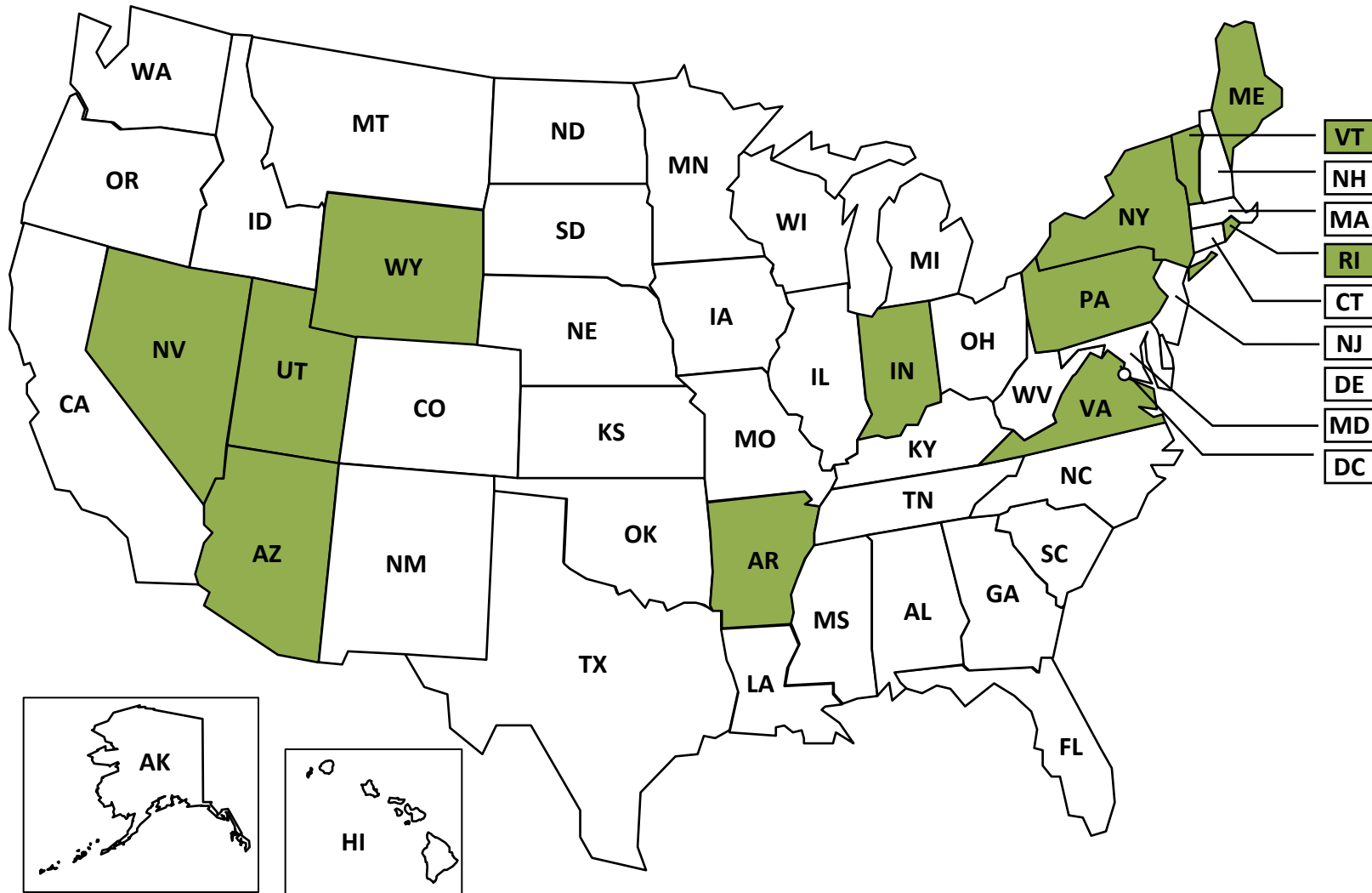


# Budget Limitations

- Among states that were held back in their EVV implementation by budget limitations, several noted funding hinged on state legislation
- The start-up and maintenance cost of EVV implementation to states is not yet known



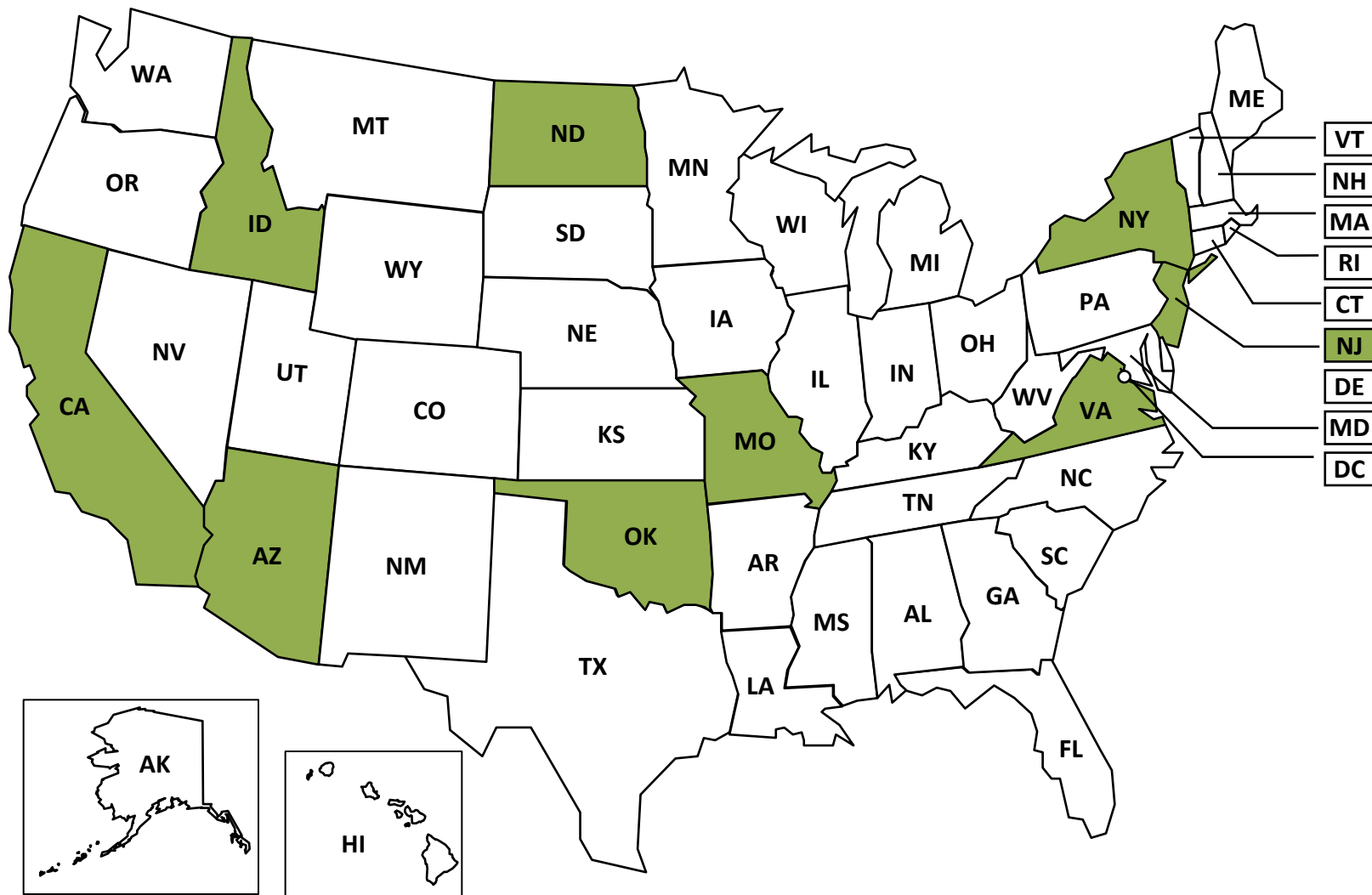
# Provider Engagement & Training (12 states)



# Provider Engagement & Training

- Many states cited needing more time to proactively conduct outreach to providers, while in other states providers were slow to implement EVV or needed more time for training, to address technical issues, etc.
- The nature of provider issues will vary in states depending on the chosen EVV implementation model.

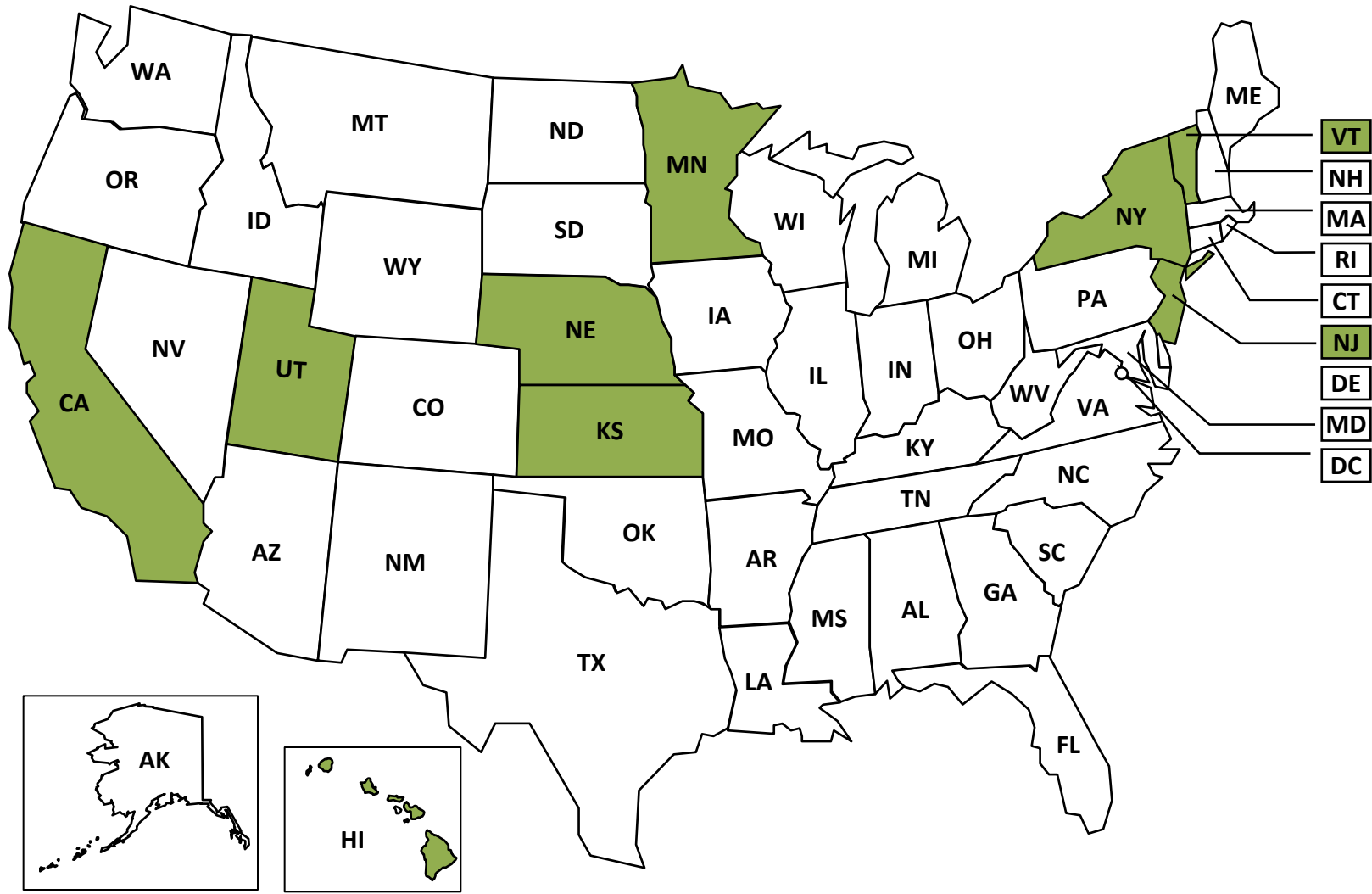
# State Processes (9 states)



# State Processes

- Some states cited various idiosyncratic state processes that have drawn out EKV implementation, such as:
  - Lengthy RFP/project approval process
  - Mandatory timeframe for budget approval
  - Promulgation process for regulations

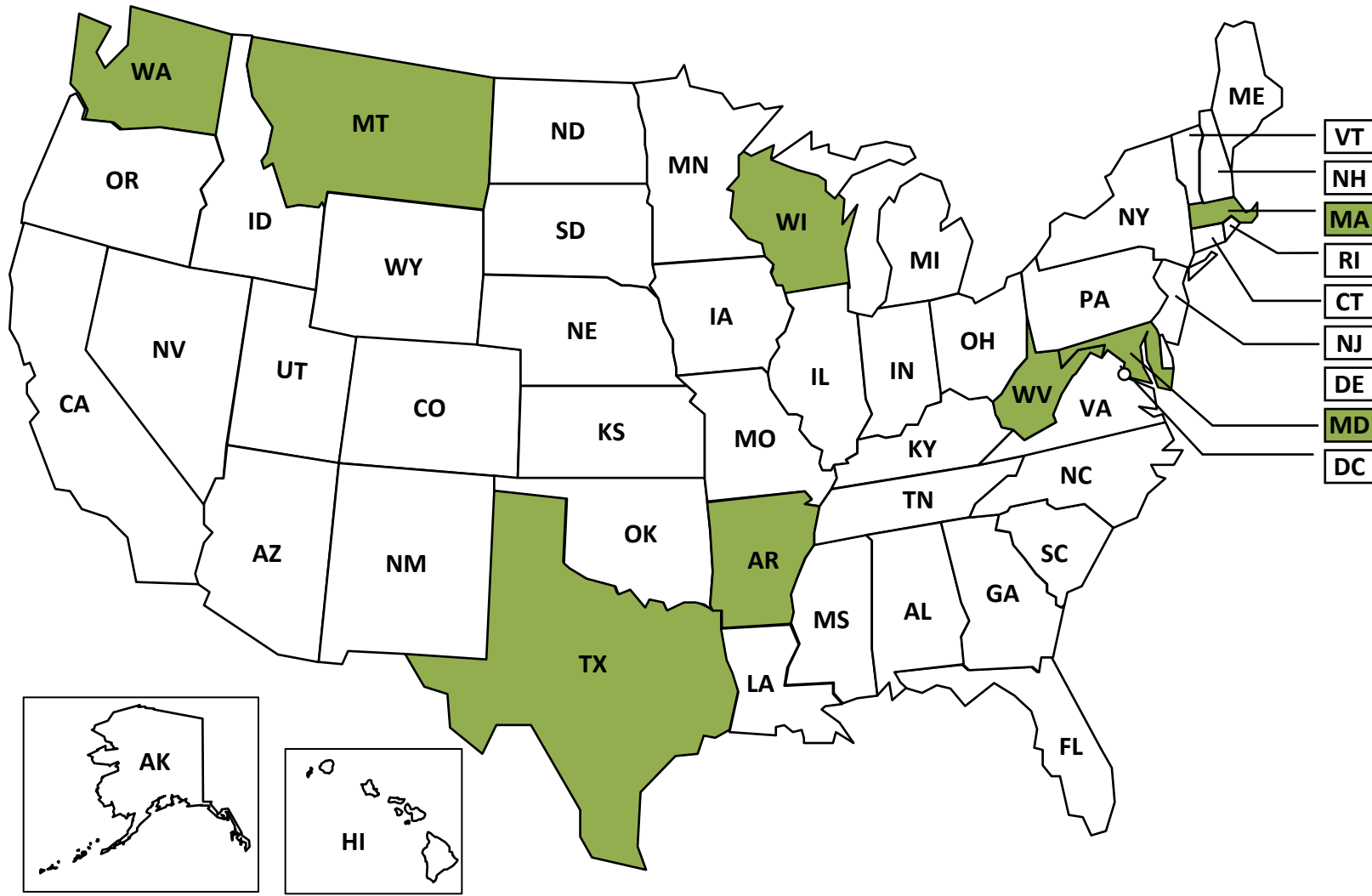
# Stakeholder Engagement & Training (9 states)



# Stakeholder Engagement & Training

- Several states needed additional time to gather feedback from stakeholders to inform EVV implementation and to train them to participate in EVV
- In New Jersey, the state specifically sought more time to allow outreach to individuals who self-direct their services

# Responding to Stakeholder Feedback (8 states)

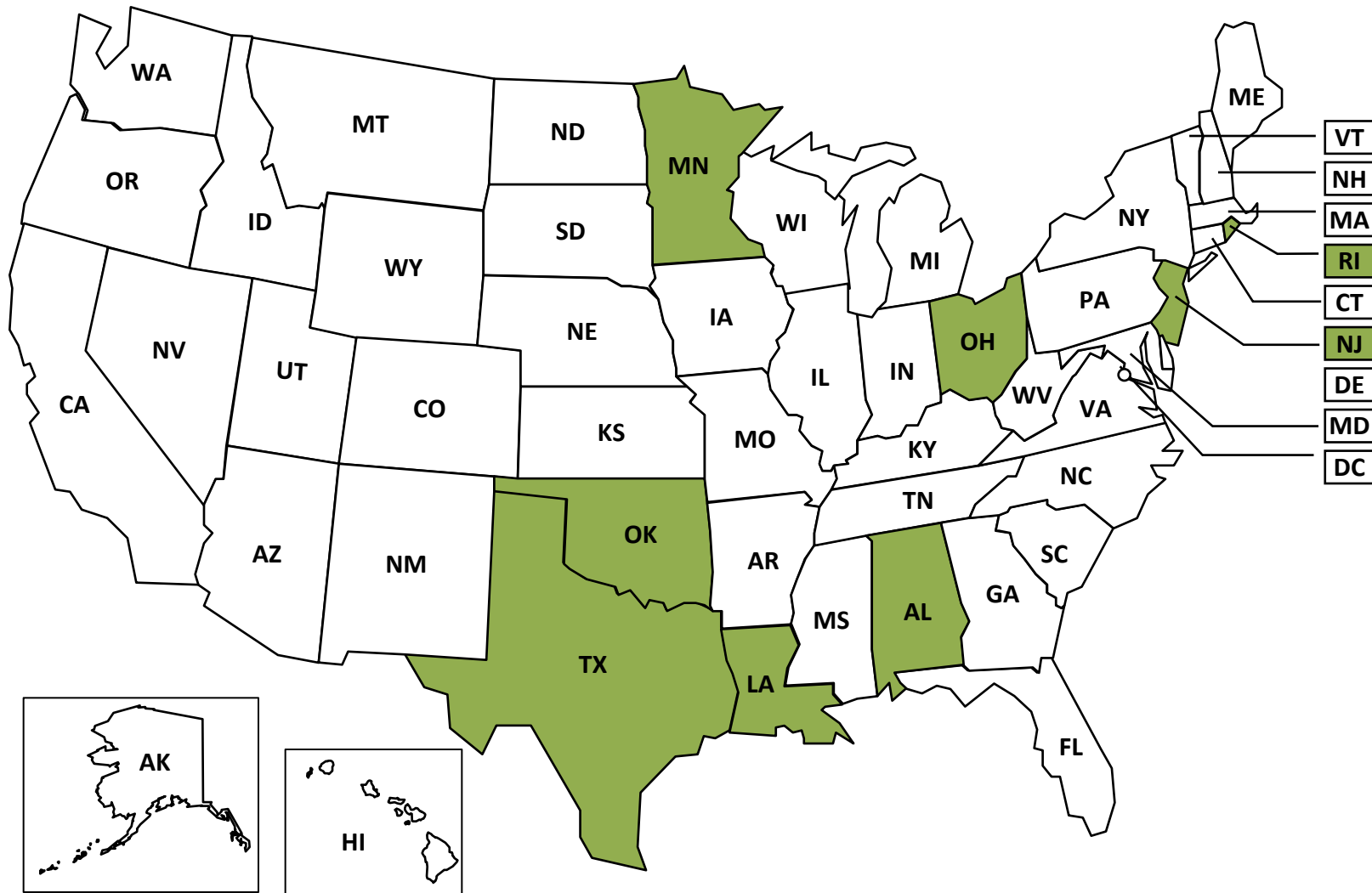


# Responding to Stakeholder Feedback

- Several states had already engaged stakeholders for feedback and needed to delay implementation to allow time to respond to issues stakeholders raised such as:
  - ❑ Staged, regional implementation to allow sufficient time for provider engagement and training
  - ❑ Stakeholder concerns raised in pilot stage
  - ❑ Cancelling initial RFP for a vendor as a result of feedback
  - ❑ Concerns regarding onboarding, training, and policy
  - ❑ Changes to EVV business requirements
  - ❑ Working with stakeholders to determine how to address concerns related to live-in caregivers
  - ❑ Incorporating stakeholder feedback in EVV vendor requirements
  - ❑ Changes in scope



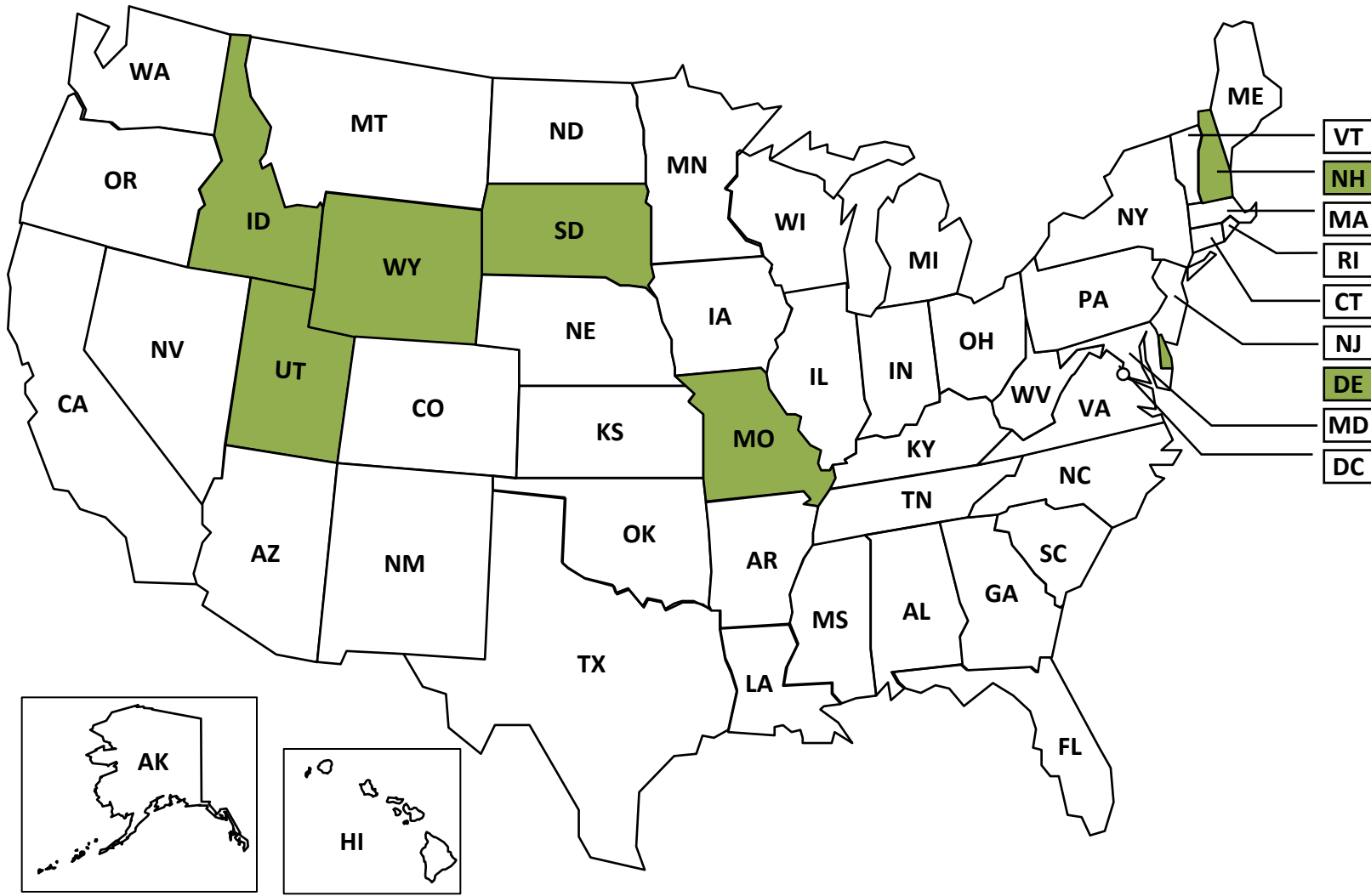
# Accommodating Unique Issues for Self-Direction (8 states)



# Accommodating Unique Issues for Self-Direction

- We are hearing that some states are implementing EVV in traditional services before rolling out to self-directed programs. Therefore, we may expect additional states to encounter delays as they roll-out EVV with self-direction programs in the coming year
- Delays related to self-direction included:
  - ❑ Additional software testing and training required
  - ❑ The need to develop an alternate self-direction solution as a result of CMS's August 2019 guidance on web-based electronic timesheets
  - ❑ Additional outreach needed for self-directing population
  - ❑ Implementing workaround for self-directed individuals who do not have access to cell phones and/or computers
  - ❑ Allocating funding for EVV devices

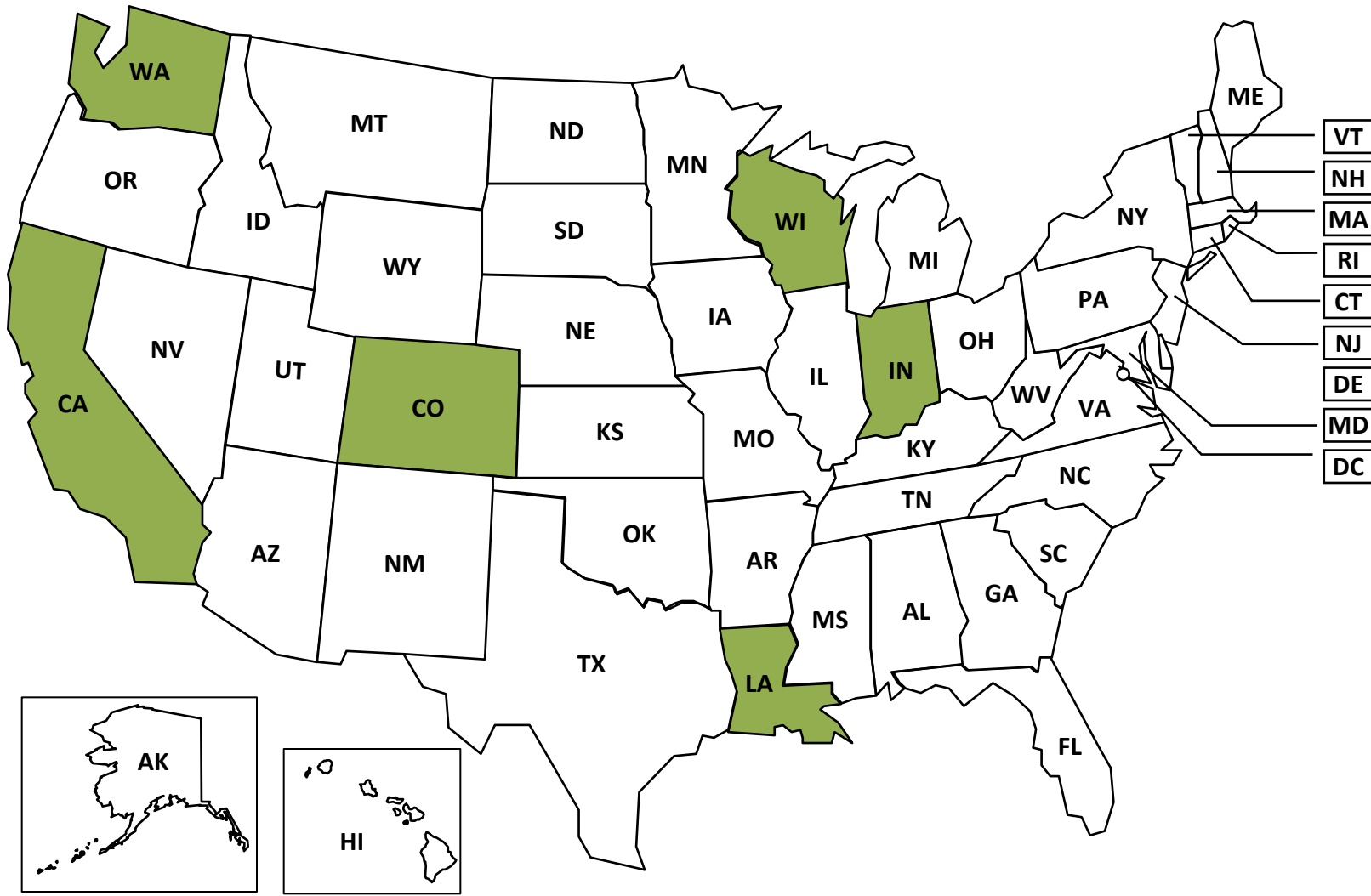
# Staffing Limitations (7 states)



# Staffing Limitations

- Staffing limitations included issues such as staff turnover, competing priorities for a small staff, limited budget to make new hires, and staff vacancies

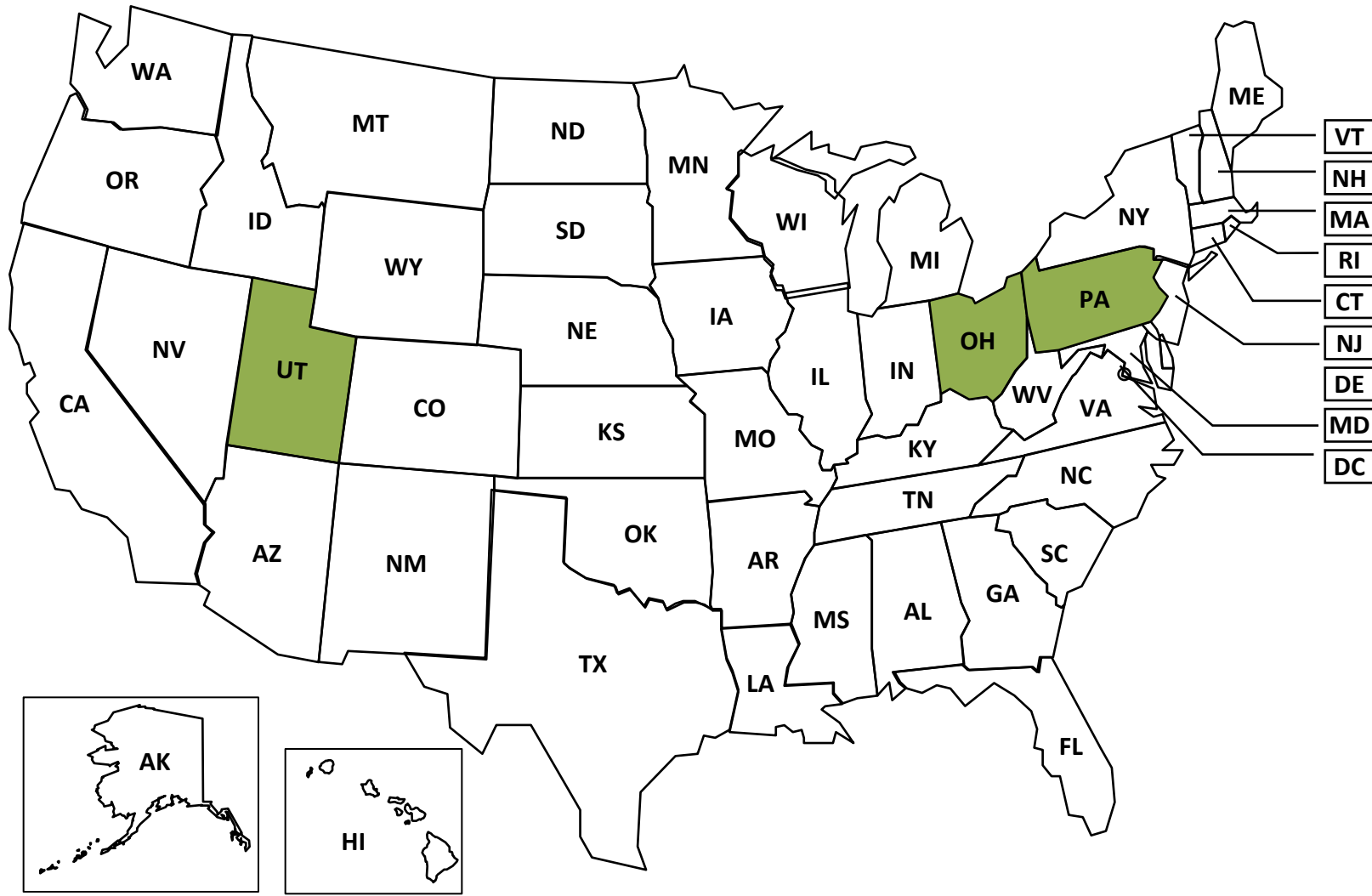
# Adjusting for CMS Guidance (6 states)



# Adjusting for CMS Guidance

- States needed to revisit or revise their implementation approach in response to CMS guidance.
- Specifically, guidance related to live-in caregivers and electronic timesheets impacted many states.

# Coordinating with FMS Providers (3 states)



# Coordinating with FMS Providers

- Efforts to coordinate with FMS providers included:
  - The need for FMS vendors to develop EVV interfaces (OH)
  - The need for an amendment to the state's contract with its FMS vendor to include a requirement for EVV (PA)
  - Delays in integrating FMS agencies into the EVV system (UT)



# Member Poll: Further Reasons for Delay

- Two major issues identified by state, FMS, and stakeholder members:
  1. Lack of access to resources
  2. Disorganization and delays in communication

# Lack of Access to Resources

Biggest hold up seems to be the barrier for stakeholders in having the technology needed and being receptive to attending training and the roll out process. Some areas being served do not have strong connectivity and the idea that attendants can go to an area where there is connectivity and upload data is not an option for many in very rural areas. It's one of the many reasons why applying EVV to self-direction as a mandatory requirement does not work for many in the country. Many in the country do not have access to technology as others do. Alternatives that don't rely on smartphones or gps enabled tablets such as IVR require the person to report back to their homes rather than have the opportunity to be fluid in their community or setting of their choice. (FMS Member)

# Lack of Access to Resources

Barriers to use by those without the equipment needed, cognitive abilities, language barriers, internet access unreliable, poverty.

(FMS Member)

Extreme rurality of the state means there are areas with limited or no internet/cell service available.

(State Member)

15% of our direct care staff do not have smart phones. Telephony option is only valid with landlines, which many folks no longer own.

(Stakeholder Member)

Lack of smart phones or understanding of smart phones in self-directed programs.

(FMS Member)

# Disorganization and Delays in Communication

While the State originally had a strong outline and drive to complete setup years ago, a handful of unexpected issues led them to go completely silent on all EVV developments. (Stakeholder Member)

Our biggest technology challenge is in multiple states that have contracted with [an EVV vendor] - no standard implementation requirements from state to state, last minute details and requirements on claims matching. (Stakeholder Member)

Lack of a firm approach or any kind of timeline. Lack of consistent stakeholder engagement.

(FMS Member)

No clear direction from our state on EVV. They are rumored to have contracted with a consultant who will be spearheading the EVV topic in order to find solutions for our provider agencies. (FMS Member)

# Discussion & Questions



# Next Steps

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