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DEPARTMENT OF HUMAN SERVICES

Legislative Report

Electronic Visit Verification System

Stakeholder Recommendations

Disability Services

January 2018

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Executive summary

Introduction

The 2017 Minnesota Legislature directed the Minnesota Department of Human Services (DHS) to establish implementation requirements and standards for an electronic service-delivery documentation system to comply with the 21st Century Cures Act for personal care services by 2019 (see the legislation section for text of Minnesota legislation). For state-provided visit verification systems, the 21st Century Cures Act guarantees federal reimbursement for:

- 90 percent of the state's costs for system design, development or installation
- 75 percent of the costs of ongoing system operation and maintenance.

States take on financial risks when they do not implement electronic visit verification in accordance with the 21st Century Cures Act. Those risks include a reduction in the Federal Medical Assistance Percentage beginning in 2019, with the penalty increasing annually (up to a 1 percent reduction by 2023).

Background and methods

To meet legislative requirements for electronic visit verification, DHS conducted research on other state models and implementation to:

- Identify what lessons were learned by other states
- Determine what electronic visit verification systems can look like
- Identify available verification methods in different systems.

In addition, DHS held stakeholder meetings and community conversations to share information with stakeholders about new requirements. During those meetings, we collected input about stakeholder preferences and various system features.

Stakeholders groups included:

- Direct support workers
- Agencies that provide personal care assistance (PCA) services
- People who use personal care services
- Home health service providers
- Managed care organizations
- Electronic visit verification vendors
- Other interested parties.

Stakeholder recommendations

Stakeholder recommendations (in particular, recommendations from people who use personal care services), reflect the need for person-centered practices. Stakeholders prioritized that government and service providers must listen to what is important to service recipients for creating and maintaining a full and enjoyable life in the community. The recommendations are framed within the requirements of the 2017 Minnesota Session Law requirements, which state that the electronic visit verification solution(s):

Are minimally administratively and financially burdensome to a provider

Providers prefer a hybrid model that:

- Offers the option of using existing provider systems or subscribing to a state-offered system
- Allows for automatic correction of errors upon submission of data
- Ensures cost offsets
- Provides 24/7 technical support
- Does not hinder future hiring unintentionally due to employees feeling unnecessarily burdened by the process required to use the system.

Are minimally burdensome to the service recipient and the least disruptive to the service recipient in receiving and maintaining allowed services

Recipients prefer a statewide system that:

- Is accessible and easy to use
- Is available in multiple languages
- Has an offline option for capturing visit information
- Does not require the use of personal equipment, such as cell phones, for verification
- Allows for flexibility in scheduling, including unscheduled services
- Can be used wherever services are provided
- Allows the person using services to see and verify data before it is sent.

Consider existing best practices and use of electronic service delivery documentation and are consistent with DHS policies related to covered services, flexibility of service use and quality assurance

Existing best practices and policies support the implementation of a system that:

- Does not limit the locations where services may be provided
- Does not require set schedules, but also allow for set schedules if appropriate
- Enables service recipients to view and, if needed, correct verification data before it is sent
- Provides the ability to modify timecards to correct errors, if needed
- Offers multiple languages for training
- Offers 24/7 technical support
- Maintains ongoing stakeholder involvement.

DHS recommendations

When deciding on a recommendation, DHS considered three models of electronic visit verification system implementation:

- **State choice:** The state selects an electronic visit verification vendor or builds an electronic visit verification system. Providers then must use that vendor or system.
- **Provider choice:** Providers select which vendor to use. Sometimes the state provides a list of approved vendors, and sometimes the state provides a list of standards that the vendor must meet.
- **Hybrid:** The state offers an electronic visit verification vendor, but providers may use a different vendor if it meets state standards.

DHS recommends proceeding with a hybrid model of implementation for electronic visit verification. A hybrid model:

- Includes a state-purchased electronic visit verification system(s)
- Allows any provider to choose an alternative system that meets minimum requirements set by the state
- Includes a data aggregator.

The data aggregator would compile data statewide from both providers using their system of choice as well as providers using the state-provided option. It would provide a single repository of data that would support post-payment review of claims for personal care services that require electronic visit verification. A third-party aggregator would allow the state to get the most capability to identify fraud, waste, abuse and error from an electronic visit verification system, without requiring the state to create and install expensive new technology.

The hybrid model meets the widest range of needs, minimizes burden and provides the greatest flexibility to providers, service recipients and workers. This approach allows providers to select an electronic visit verification system that works best for their business while maintaining accountability to the state. Allowing for flexibility in vendor selection encourages innovation, competitive pricing and technological advances among vendors.

As we go forward, the recommendations included in this report provide high-level guidance for what should be included in an electronic visit verification system in Minnesota. Operationalizing this work will require continued input and collaboration from the stakeholder community.

DHS will expand stakeholder engagement in the future to include providers of home and community-based services provided through Medicaid waivers. Recent clarification from the Centers for Medicare & Medicaid (CMS) requires electronic visit verification for home and community-based services provided through a Medicaid waiver if the service includes assistance in activities of daily living or instrumental activities of daily living.

Legislation

Laws of Minnesota 2017, 1st Spec. Sess. chapter 6, article 1, section 49

Sec. 49.
ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM.

Subdivision 1.
Documentation; establishment.
The commissioner of human services shall establish implementation requirements and standards for an electronic service delivery documentation system to comply with the 21st Century Cures Act, Public Law 114-255. Within available appropriations, the commissioner shall take steps to comply with the electronic visit verification requirements in the 21st Century Cures Act, Public Law 114-255.

Subd. 2.
Definitions.
(a) For purposes of this section, the terms in this subdivision have the meanings given them.
(b) "Electronic service delivery documentation" means the electronic documentation of the:
(1) type of service performed;
(2) individual receiving the service;
(3) date of the service;
(4) location of the service delivery;
(5) individual providing the service; and
(6) time the service begins and ends.
(c) "Electronic service delivery documentation system" means a system that provides electronic service delivery documentation that complies with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.
(d) "Service" means one of the following:
(1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625, subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; or
(2) community first services and supports under Minnesota Statutes, section 256B.85.

Subd. 3.
Requirements.
(a) In developing implementation requirements for an electronic service delivery documentation system, the commissioner shall consider electronic visit verification systems and other electronic service delivery documentation methods. The commissioner shall convene stakeholders that will be impacted by an electronic service delivery system, including service providers and their representatives, service recipients and their representatives, and, as appropriate, those with expertise in the development and operation of an electronic service delivery documentation system, to ensure that the requirements:
(1) are minimally administratively and financially burdensome to a provider;
(2) are minimally burdensome to the service recipient and the least disruptive to the service recipient in receiving and maintaining allowed services;

(3) consider existing best practices and use of electronic service delivery documentation;

(4) are conducted according to all state and federal laws;

(5) are effective methods for preventing fraud when balanced against the requirements of clauses (1) and (2); and

(6) are consistent with the Department of Human Services' policies related to covered services, flexibility of service use, and quality assurance.

(b) The commissioner shall make training available to providers on the electronic service delivery documentation system requirements.

(c) The commissioner shall establish baseline measurements related to preventing fraud and establish measures to determine the effect of electronic service delivery documentation requirements on program integrity.

Subd. 4.

Legislative report.

(a) The commissioner shall submit a report by January 15, 2018, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services with recommendations, based on the requirements of subdivision 3, to establish electronic service delivery documentation system requirements and standards. The report shall identify:

(1) the essential elements necessary to operationalize a base-level electronic service delivery documentation system to be implemented by January 1, 2019; and

(2) enhancements to the base-level electronic service delivery documentation system to be implemented by January 1, 2019, or after, with projected operational costs and the costs and benefits for system enhancements.

(b) The report must also identify current regulations on service providers that are either inefficient, minimally effective, or will be unnecessary with the implementation of an electronic service delivery documentation system.

EFFECTIVE DATE.

This section is effective the day following final enactment.

Introduction

The 2017 Minnesota Legislature directed the Minnesota Department of Human Services to establish implementation requirements and standards for an electronic service delivery documentation system to comply with the 21st Century Cures Act (see Appendix A for text of the federal legislation). The 21st Century Cures Act requires electronic visit verification for personal care services by 2019.

DHS designated its Disability Services Division (DSD) to collect stakeholder input and develop recommendations for electronic visit verification implementation. DSD contracted with Minnesota Management Analysis and Development to facilitate the stakeholder input process and summarize the stakeholder recommendations. DSD emphasized that the process and recommendations must reflect person-centered practices. Person-centered practices require government and service providers to listen to what is important to service recipients for creating and maintaining a full and enjoyable life in the community.

Background and methods

Electronic visit verification requirements

The 21st Century Cures Act and Laws of Minnesota 2017, 1st Spec. Sess. chapter 6, article 1, section 49 require states to work with stakeholders involved with personal care and home health to ensure electronic visit verification:

- Is minimally burdensome to providers
- Is minimally burdensome to service recipients
- Does not limit services provided
- Does not impede the manner in which care is delivered.

Electronic visit verification must be effective in preventing fraud in balance with the minimally burdensome requirements.

According to the 21st Century Cures Act, electronic visit verification must verify, at a minimum, six data elements related to the service:

- Type of service performed
- Who received the service
- Date of service
- Location of service delivery
- Who provided the service
- When the service begins and ends.

The timecard systems typically used by personal care providers capture five of the six required data elements. Some lack location information.

The 21st Century Cures Act requires electronic visit verification for personal care services by 2019. For state-provided systems, it guarantees federal funding for:

- 90 percent of the state's costs for system design, development or installation
- 75 percent of the costs of ongoing system operation and maintenance.

This funding match applies only to state-provided electronic visit verification systems. It does not apply to electronic visit verification systems operated by non-state entities (e.g., service providers).

States take on financial risks when they do not implement electronic visit verification in accordance with the 21st Century Cures Act. Those risks include a reduction in the Federal Medical Assistance Percentage beginning in 2019, with the penalty increasing annually (up to a 1 percent reduction by 2023).

If states have made a "good-faith effort" to fully implement the system, they can have a grace period if it is not in place by 2019 or if the implementation process encountered "unavoidable system delays." DHS has requested clarification from the Centers for Medicare & Medicaid Services (CMS) on the issue of good-faith effort and

unavoidable delays. Additionally, the 21st Century Cures Act specifies the law's electronic visit verification prohibitions must not be "construed as establishing" a Fair Labor Standards Act employer-employee relationship.

CMS has said it will provide additional guidance on which specific personal care and home health services are required to implement electronic visit verification (as required by the 2019 deadline). Personal care assistance (PCA) services and direct support in Consumer Directed Community Supports were the focus throughout the stakeholder engagement process used for this report, with the understanding that personal care provided through other home and community based services might be in scope as well.

On Dec. 13, 2017, CMS hosted a webinar training about electronic visit verification. During the webinar, the CMS clarified that any home and community-based service provided through a Medicaid waiver would need to meet the electronic visit verification requirement if the service included any assistance in activities of daily living or instrumental activities of daily living. DHS is analyzing which home and community based services will need to comply with the electronic visit verification requirement by Jan. 1, 2019.

DHS conducted background research on several areas of interest identified by the stakeholder group, including:

- Other state models of implementation
- Lessons learned in other states
- An overview of what electronic visit verification systems can look like
- Verification methods available in different systems.

Design and functionality

Electronic visit verification system implementation tends to fall into three primary models relevant to services in Minnesota:

- **State choice:** The state selects an electronic visit verification vendor or builds an electronic visit verification system. Providers then must use that vendor or system.
- **Provider choice:** Providers select which vendor to use. Sometimes the state provides a list of approved vendors, and sometimes the state provides a list of standards that the vendor must meet.
- **Hybrid:** The state offers an electronic visit verification vendor, but providers may use a different vendor if it meets state standards.

The stakeholder work group requested information about what electronic visit verification systems can look like and the various options available for verification. To conduct research in this area, consultants reviewed available information about electronic visit verification vendors and systems. DHS asked vendors who routinely attended stakeholder meetings to complete a worksheet describing their systems. Worksheet questions were designed in collaboration with the stakeholder work group.

Electronic visit verification systems can look like one or more of the following:

- An app and website tied to a database with one or more of the following:
    - The ability to use the direct support worker's or service recipient's provided device
    - A tablet or mobile device located in the service recipient's home
    - RFID tags (i.e., small radio frequency identification devices for identification and tracking purposes) and/or QR codes (i.e., a machine-readable label) in the service recipient's home, which is then scanned with the worker's phone
- Telephonic-visit verification when smart phones and internet access are not available
- An offline option, which involves a device in the service recipient's home that generates an in/out code the direct support worker enters when connectivity is available.

Electronic visit verification systems potentially could use a wide variety of verification methods. Some systems provide a single verification method and others provide many options for verification. Verification methods may include, but are not limited to:

- Biometric components (e.g., fingerprints, voiceprints, signatures or photographs)
- Telephony
- Global Positioning Systems
- Smart phones
- Landlines
- Website portals
- Alternative devices that may generate random numbers to verify a time and place of a service.

Use of electronic visit verification in Minnesota and other states

Minnesota

The 21st Century Cures Act and Laws of Minnesota 2017, 1st Spec. Sess. chapter 6, article 1, section 49 require the state to consider existing best practices. DHS systematically has not yet collected information about current use of electronic visit verification by providers in Minnesota. In the coming months, DHS plans to survey providers of personal care assistance, home health services and home and community based services to learn more about the existing use of electronic visit verification systems in Minnesota. Informal communications at stakeholder meetings and community conversations suggest some providers have implemented electronic visit verification systems, and some have not. Suggestions for the implementation of electronic visit verification based on the experience of Minnesota providers are included in the recommendations section.

DHS' Disability Services Division requested information about electronic visit verification implementations in Connecticut, Ohio and Texas. In collaboration with the Minnesota Management Analysis and Development and with input from the stakeholder group, DSD developed an interview process to use for collecting information from these states. A Management Analysis and Development consultant contacted Connecticut, Ohio and Texas state employees who had expertise about system implementation. These conversations elicited a high-level overview of each state's electronic visit verification system, as well as any lessons learned that the state shared.

Connecticut

Connecticut uses the state choice model and has selected a single vendor that all providers must use. Verification is done by service-recipient landline, cellphone or a last-resort device affixed in the home that generates random numbers. Direct support workers use a smart phone application on the worker's phone. During the electronic visit verification implementation, Connecticut found providers needed to hire temporary staff to help with the administrative burden of the electronic visit verification. In response to the unexpected administrative burden on providers, Connecticut has made several costly system modifications to give additional features to providers, such as scheduling and claim submission.

Connecticut representatives advise other states to make every attempt to use service recipient or worker phones for verification since the alternate device is much more difficult to manage. They also say continued stakeholder engagement has been critical to Connecticut's success. Finally, Connecticut recommends learning upfront about provider electronic visit verification systems to better understand the impact of statewide implementation.

Ohio

Ohio is implementing a hybrid model of electronic visit verification. The state provides an electronic visit verification vendor option, but providers may use their own electronic visit verification system if it meets state requirements. Each service recipient uses a Mobile Visit Verification device. The Mobile Visit Verification device essentially is a smart phone with no street value that only can access the electronic visit verification application. The state pays for the device, shipping costs and the data plan. Most verification is done using telephony, but other verification options are available. Ohio representatives framed the electronic visit verification implementation in terms of quality-of-care rather than cost savings.

Unexpectedly, Ohio learned providers had to hire staff to:

- Process electronic visit verification transaction exceptions
- Determine which transactions had errors
- Determine which transactions required additional information or processing.

Ohio representatives also recommended (as a best practice) that Minnesota address service-recipient concerns and the spread of misinformation related to privacy and location tracking early and assertively. In addition, if working with a vendor, Ohio recommends being very specific about requirements and not accepting vague responses. Finally, Ohio indicated ongoing stakeholder meetings and close community ties enabled the implementation.

Texas

Texas implemented an electronic visit verification model that combines state choice and provider choice models. Because providers indicated they wanted a choice of electronic visit verification vendors, Texas selected five vendors from which provider could choose. Since system implementation began in 2010, three of those vendors have dropped out, leaving two vendors. Most verification is done using a home landline. If that is not feasible, a small alternative device is installed in the service recipient's home. These devices have been problematic, and, currently, at least 3,000 devices require repair each week.

Texas representatives recommend other states spend time upfront working out technical issues related to data integrity. Related to this point, they recommend timelines for implementation be reasonable to ensure the state can properly address technical challenges. Finally, like Connecticut and Ohio, Texas has an ongoing stakeholder input process.

Methods for stakeholder and community input

Management Analysis and Development facilitated seven stakeholder meetings and seven community conversations from Aug. 29, 2017, to Dec. 11, 2017. Stakeholder meetings were held to build a shared understanding of issues and perspectives related to electronic visit verification and ultimately lead to consensus on recommendations. Community conversations were an opportunity for people to attend a single meeting to learn about issues related to electronic visit verification and provide input.

Stakeholder meetings

DHS used its Disability Services Division stakeholder email list and website to communicate stakeholder-meeting times and locations. To increase visibility, DHS also asked participating stakeholders to spread the word to other interested stakeholders. Stakeholder meetings were open to any person interested in attending. Most of the stakeholder meetings were held in state office buildings with one meeting held in a public library. Two of the stakeholder meetings (Nov. 6, 2017 and Dec. 11, 2017) included a webinar.

The original intent of the stakeholder meetings was to find a core group of self-selected volunteers to build common knowledge and to identify areas of consensus to inform recommendations. Attendance at stakeholder meetings steadily grew, with both regular and new attendees coming to each meeting. Since each stakeholder meeting included new attendees, the facilitator devoted a portion of most meetings to educate the group about the basic requirements of electronic visit verification and the 21st Century Cures Act (see Appendix D for presentation content used in several meetings). The facilitator spent the rest of the meeting gathering input from stakeholders through large-group interaction, small-group work and webinar input. Management Analysis and Development provided note takers for each meeting (see Appendix B for an overview of stakeholder meetings, including date, location and topics discussed).

Depending on the number of attendees, facilitators invited stakeholders to identify themselves by name and their role either to the large group or at individual tables. However, identification was not required. In each meeting, stakeholders in attendance represented service recipients, service providers, vendors, direct support workers, managed care organizations and other or unidentified roles.

Not all stakeholders stayed for the entire meeting, so participation numbers varied over the course of each meeting. More than 40 participants called in to the webinars. Between 10 and 50 in-person participants attended each stakeholder meeting.

In all stakeholder meetings, stakeholders provided input on their preferences for electronic visit verification implementation, such as:

- Preferred model type
- How to make electronic visit verification minimally burdensome for providers and service recipients
- What a flexible electronic visit verification system should look like
- What verification might look like.

Early stakeholder meetings focused on building common knowledge, such as the requirements of the 21st Century Cures Act, information about data integrity and current processes used in Minnesota. Later stakeholder

meetings devoted more time to developing preferences for a potential Minnesota electronic visit verification system model and discussing minimally burdensome solutions.

At the stakeholder meetings on Nov. 6, 2017, and Dec. 11, 2017, facilitators asked stakeholders to:

- Make recommendations related to the topics outlined in state statute
- Make suggestions regarding quality assurance in an electronic visit verification system
- Identify what efficiencies or improvements could be achieved by implementing an electronic visit verification system.

Community conversations

DHS also used its Disability Services Division stakeholder email list and website to communicate meeting times and locations for community conversations. Community conversations were a method of sharing information about the 21st Century Cures Act and Minnesota-specific work related to electronic visit verification. These conversations also were a method to gather input from citizens interested in attending a single meeting instead of the series of stakeholder meetings. DHS hosted community conversations in numerous locations around the state in an effort to foster engagement in Greater Minnesota. Two webinar-based community conversations were added based on stakeholder feedback.

Attendees who chose to identify their role represented recipients of services, direct support workers, providers, vendors and family members of service recipients. At each community conversation, the facilitator devoted a portion of the meeting to educating attendees about the requirements for electronic visit verification in Minnesota and the 21st Century Cures Act. Similar to the stakeholder meetings, community-conversation participants provided input about preferences in these key areas:

- How to make electronic visit verification minimally burdensome for providers and service recipients
- What a flexible electronic visit verification system should look like
- Preferences for verification.

See Appendix C for a summary of stakeholder feedback from community conversations.

Stakeholder recommendations

The composition of the stakeholder group was dynamic, with both regular and first-time participants attending the meetings. The initial intent of the stakeholder group was to build common knowledge before developing consensus on recommendations. Given that new attendees came to each meeting, facilitators shifted to providing a thematic analysis of stakeholder preferences and feedback gathered from previous meetings. The stakeholders reviewed that information and provided final feedback on stakeholder preferences at the Nov. 6, 2017 and Dec. 11, 2017 meetings. The participant recommendations may not represent the perspectives of all stakeholders or a consensus of views. Recommendations in this section are reflective of consistent themes heard across stakeholder meetings and community conversations unless otherwise noted.

Stakeholders shaped the recommendations and shared different perspectives. For example, providers who were already using an electronic visit verification system tended to recommend a provider choice or hybrid model. In contrast, direct support workers and service recipients, who might be required to learn many electronic visit verification systems, tended to recommend a state choice model. While the participants of the community conversations did not explicitly create recommendations, the preferences expressed in those conversations are reflected in the stakeholder-meeting recommendations.

Many of the recommendations reflect the shared value of person-centered practices, especially among people who receive services. Examples of these recommendations include the ability to verify services provided at any location or time and a choice in verification methods when a person feels some methods are too intrusive. For person-centered practice recommendations, see the sections on minimally burdensome to recipients of services and least disruptive and best practices: verification strategies and technologies.

The recommendations below are grouped under headings that relate to the legal requirements for the electronic visit verification system. These requirements state that the electronic visit verification solution(s):

- Are minimally burdensome (administratively and financially) to a provider
- Are minimally burdensome to the service recipient and the least disruptive to the service recipient to receive and maintain allowed services
- Consider existing best practices and use of electronic service delivery documentation
- Are consistent with DHS policies related to covered services, flexibility of service use and quality assurance.

Minimally burdensome to provider

Providers who already use an electronic visit verification system prefer to continue using their system rather than switching to a different system. Providers who do not currently have an electronic visit verification system indicated a preference for a state-provided electronic visit verification. Small providers said they did not have the financial means to implement an electronic visit verification on their own and preferred a state-provided electronic visit verification system.

Several recommendations for minimizing the burden on providers received multiple endorsements from the workgroups at the Nov. 6, 2017 stakeholder meeting:

- Providers want the ability to correct mistakes in electronic visit verification transactions
- Providers who currently have a system in place do not want to change the systems they are using
- Providers want to incur minimal initial and ongoing costs due to electronic visit verification (If there are costs, providers want them to be offset with benefits. If providers need staff to support or maintain the system, that added expense must be reflected in rates or revenue. Electronic visit verification cannot be an unfunded mandate)
- Small providers want the state to understand requirements that are not burdensome to large providers may be burdensome to small providers.

Stakeholders also requested 24/7 technical support for an electronic visit verification system. They want a system that does not require providers to add additional staff and one that is available in multiple languages. Providers also want an offline option for entering visit data. Providers are concerned that if the system is difficult for staff to use, it might be more difficult to hire and retain employees.

Minimally burdensome to recipients of services

People who use personal care services prefer a statewide system. They say it would be easier to navigate a single system, and that the state should be responsible for accessibility, ease of use and troubleshooting. Service recipients and direct support workers expressed concern about having to learn and use multiple systems under a hybrid or provider choice model.

Several recommendations for minimizing the burden on service recipients received multiple endorsements from the workgroups at the Nov. 6, 2017 and Dec. 11, 2017 stakeholder meetings:

- The electronic visit verification system must be flexible in order to schedule services and accommodate multiple caregiving scenarios (including direct support workers who live with service recipients or shared care with one worker caring for multiple people at the same location)
- The electronic visit verification needs to be accessible to people with disabilities
- The system should be available in multiple languages
- There should be an offline option for capturing visit information.

Service recipients expressed concerns about the requirement that the location of services be electronically verified. They wanted assurance that HIPAA data privacy requirements would be maintained and that location would not be tracked other than for verification of services. Stakeholders had concerns about where location data would be stored, who would have access to it and for what purposes it would be used. Stakeholders expressed the importance of an electronic visit verification system that could be used wherever services were provided, since personal care and home health services can be provided at home or wherever normal life activities take a service recipient. Stakeholders also requested the ability to capture care provided in response to unscheduled and/or urgent needs. Many stakeholders did not want to be required to use personal equipment (e.g., telephones or cell phones) for verification. Stakeholders from PCA provider agencies stated it is common for a worker or service recipient to have limited or no access to a personal cell phone because of a monthly plan with minute/data limits, geographic limitations or financial costs. Other recommendations included 24/7 technical support, simple instructions and easy-to-use processes and the ability for the service recipient to see and verify data before it is sent.

Least disruptive and best practices: Flexibility and quality assurance

Service recipients indicated verification must not limit the locations where services may be provided. Stakeholders provided multiple endorsements for three recommendations about flexibility and quality assurance:

- Service recipients should be able to view and, if needed, correct verification data before it is sent
- The electronic visit verification system must allow for clocking in and out at any time and allow for both set and unset schedules when appropriate
- The electronic visit verification system should provide the ability to modify timecards to correct errors, if needed.

Other recommendations in this category included allowing modifications to service location, offering multiple languages for training, offering 24/7 technical support and having the system check for worker overlap across and within providers.

Least disruptive and best practices: Verification strategies and technologies

Stakeholders discussed several verification strategies throughout the stakeholder meetings, including:

- Telephonic-visit verification using a code
- Swiping recipient's state ID in a device
- A still shot or video of the services being provided
- Biometric voice printing of the worker
- A service recipient signature
- Fingerprint verification of the worker
- A photograph of the service recipient and worker
- The Global Positioning System location of the worker at clock-in and clock-out.

This category of recommendations had more widely diverging and strongly held views than other categories. For example, some were strongly opposed to using biometric data for verification, while others recommended using a fingerprint or having a photograph as an option. Some stakeholders were strongly against using Global Positioning Systems for verification and were concerned data could be used for other types of tracking. This tension between stakeholders highlights the importance of a system with multiple options for verification.

Direct support workers and service recipients expressed many different and individualized concerns, including:

- Limited internet access in rural areas
- Lack of comfort with technology generally and limited knowledge about smart phone usage
- Privacy concerns with verification methods such as Global Positioning Systems and photography

Multiple options for verification allow service recipients to select the method that best fits their individual preferences. Some stakeholders expressed concern that requiring direct support workers to use technology for verification may drive them out of the workforce and worsen the current worker shortage. However, other stakeholders felt a system with multiple verification options might help retain the current workforce.

Stakeholders consistently recommended:

- Having backup verification methods in case of device failure
- Using a phone (cell or landline)
- Giving service recipients a choice about which verification method is most appropriate for their individual circumstances.

One recommendation was that verification should be provided in multiple languages. Another recommendation was to anticipate how any verification method can be used fraudulently and to build in safeguards against that potential fraud. Finally, people who use services wanted the ability to view and correct verification data.

Least disruptive and best practices: How can electronic visit verification add value?

Stakeholders provided multiple endorsements for these two ways that electronic visit verification could add value by improving:

- Data integrity with the change from paper to electronic time documentation
- The information shared with service recipients.

Service recipients and their families expressed that having a portal specifically for their use to access relevant data (e.g., number of hours remaining in a service agreement) would help maintain a person-centered approach. Other recommendations for adding value included reducing errors for timesheets and billing and providing downloadable data to enable payroll and billing. An electronic visit verification that interfaces with current systems could add value, as would the ability to generate needed reports through the electronic visit verification. Finally, if the electronic visit verification could help prevent fraud or enable a faster audit process, stakeholders indicated that would also add value.

Best practices: What would electronic visit verification allow us to stop doing?

Stakeholders provided multiple endorsements for two processes that electronic visit verification could eliminate:

- Paper timesheets
- The Personal Care Assistance Services Mandated Service Verification required by Minn. Stat., §256B.0705.

Stakeholders also mentioned electronic visit verification could prevent providers from being blamed for direct support workers' timesheet errors.

Base-level system and enhancements

Stakeholders largely affirmed a base-level electronic visit verification system should capture the minimum required six data elements per the 21st Century Cures Act and allow providers to continue service delivery in a flexible and person-centered fashion. The base-level system should:

- Include flexibility around scheduling, location of services and service recipient choice of verification methods
- Be available in multiple languages
- Provide adequate training and technical support.

Enhancements to the base-level system could provide additional functionality and reporting features such as payroll, billing, reports and hours remaining for services.

Conclusion

DHS appreciates the time and energy invested by stakeholders in both the community conversations and the stakeholder work group. A clear theme identified through these meetings (and echoed in the other states' research) is the need for a strong, ongoing partnership between DHS and providers, direct support workers, service recipients and their families. Operationalizing this work will require continued input and collaboration from the stakeholder community.

DHS will expand future stakeholder engagement to include providers and recipients of home and community-based services through the state's Medicaid waivers. CMS recently required that home and community-based services through Medicaid waivers must meet the electronic visit verification requirement if the service includes assistance in activities of daily living or instrumental activities of daily living.

The recommendations in this report provide high-level guidance for what should be included in an electronic visit verification system in Minnesota. DHS recommendations begin by outlining the base-level system and include possible future enhancements. Based on both input from stakeholders and lessons learned in other states, DHS recommends a simple, base-level system, with later enhancements once providers, workers and service recipients have mastered the system.

Base system recommendations

Model for implementation

DHS recommends proceeding with a hybrid model of implementation for electronic visit verification. A hybrid model includes a state-purchased electronic visit verification system(s), but also allows providers to choose an alternative system that meets minimum requirements set by the state. More specifically, DHS recommends using a hybrid model that allows for the following:

- Providers to choose any electronic visit verification system that meets minimum requirements determined by the state and the 21st Century Cures Act
- The state to provide the option of an off-the-shelf electronic visit verification system to all providers who do not have or do not wish to develop their own system. (This involves the state contracting with one or more electronic visit verification vendors to develop and operate a system that meets the requirements outlined in the 21st Century Cures Act. The state or contractor would be responsible for configuring the system(s) to meet specific requirements, as well as enrolling and training providers. The vendor(s) would be responsible for ongoing maintenance, updates and technical assistance to providers.).

Cost considerations

The initial costs of implementing the hybrid model are projected to be affordable within the appropriation that accompanied Laws of Minnesota 2017, 1st Spec. Sess. Ch. 6, art. 1, sect. 49 with a federal financial participation rate of 50 percent. These costs include:

- The acquisition of an electronic visit verification system by the state
- An aggregator of the data collected through that system and through provider-selected systems
- The initial training necessary for providers to use the system.

These cost projections do not include the costs of providers using the state-selected electronic visit verification system. If a provider chooses to use the state-provided system, they may need to pay a subscription to use the system. Electronic visit verification system costs often are based on the number of workers or recipients using the system. Providers would also need to allocate time for staff to learn the system and ensure consistent use. Providers choosing to select their own electronic visit verification system would be responsible for all costs related to their selection along with ensuring training opportunities for workers and service recipients.

DHS recommends the development of cost-sharing mechanisms to support providers in meeting this new requirement, including the costs of ongoing use and maintenance. DHS is developing estimates of rate increases that providers could use to fund compliance with this new mandate and alternative cost-sharing mechanisms. These cost-sharing mechanisms would be eligible for a federal financial participation rate of at least 50 percent. DHS would pursue federal approval of an enhanced federal financial participation rate of 75 percent for the costs of the state-provided system operation and maintenance, as well as 90 percent federal funding for the cost of the state-provided system's design, development and installation.

Minimum system requirements

All providers, regardless of whether they are using the state-provided system or a system of their own choosing, must comply with collecting the minimum requirements as outlined in the 21st Century Cures Act, including:

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

Providers must report these required minimum data elements to DHS using a file format and submission specifications that will be determined at a later date.

Both state-provided and provider-selected systems must:

- Be flexible and user-friendly, including allowing access to services provided outside the home
- Accommodate people with disabilities and follow all state and federal laws, rules, regulations and guidelines
- Accommodate support in multiple languages
- Maintain security and privacy

- Make alternatives to telephony available to record visit verification
- Document changes to system data after the provider has recorded their time (e.g., who made the change, date of change, reason for change)
- Have the capacity to produce reports on service delivery that can be used for verification and audits
- Have the capacity to accommodate future enhancements (e.g., interfacing with a Global Positioning System, biometric identification).

Third-party data aggregator

DHS recommends contracting with a vendor to develop or purchase a third-party data aggregator. The aggregator would compile data statewide from both providers using their system of choice and providers using the state-provided option. The aggregator would provide a single repository of data to support post-payment review of claims for personal care services requiring electronic visit verification. Potential future enhancements to the aggregator could enable pre-payment review to identify non-reimbursable claims due to potential fraud, waste, abuse or error. Since a third party would handle the collection and normalization of the data, the state would get the most capability to identify fraud, waste, abuse and error from an electronic visit verification system without creating and installing expensive new technology.

Recommendations for future enhancements

DHS will apply for an enhanced, federal financial participation match for implementation and maintenance through the CMS approval of an Advanced Planning Document to make recommended enhancements. Beyond funding capabilities, it is important that providers master the base-level system and related requirements before moving into system enhancements.

Future enhancements to the state-provided system could include:

- Integration with billing and claims submission, which would enable pre-payment review of claims
- Verification of specific details about the type of service provided and adherence to care plans
- Use of biometric identifiers to verify the identities of the people receiving and providing services (e.g., fingerprints, photos, facial recognition or voice recognition).

Recommendations for future enhancements must also meet the requirements to be minimally burdensome and least disruptive. DHS will recommend any enhancements in consultation with providers, direct support workers, service recipients and their families, as well as other state agencies involved in the regulation of personal care and home health services.

Recommendations justification

Based on the feedback during the stakeholder meetings, DHS determined the hybrid model with a data aggregator meets the widest range of needs, minimizes burden and provides the greatest flexibility to providers, service recipients and workers. Allowing for flexibility in vendor selection encourages innovation, competitive pricing and technological advances among vendors.

A hybrid model allows providers to select an electronic visit verification system that works best for their business while maintaining accountability to the state. It allows providers who have already invested in an electronic visit verification system to continue using their investment, while providers who have not yet purchased a system can elect to use the state-provided system or another vendor of their choosing based on their needs and finances. Providing a state-provided vendor option allows smaller providers with less capacity or interest in choosing their own system to meet electronic visit verification system requirements with minimal burden.

This model also allows providers the opportunity to select an electronic visit verification system that will be the easiest for their workers to use. Ease of use for workers helps providers to better recruit and retain staff in an era of workforce shortage. Over time, providers who select the state-provided system may experience the added benefit of having a workforce and group of service recipients that are accustomed to using the state-provided system, thus lessening the burden of training.

By choosing to offer an existing, off-the-shelf electronic visit verification system rather than developing its own, DHS will be in better position to meet the Jan. 1, 2019 deadline for implementing this requirement for personal care services.

Finally, the hybrid model supports person-centeredness, as any system in Minnesota must comply with the requirements to not disrupt services, allow flexibility of service location and provide adequate training for users. Service recipients can choose to work with a provider using a system that best meets their individual needs.

Appendix A: 21st Century Cures Act

Language

H.R.34 - 21st Century Cures Act, 114th Congress (2015-2016) Public Law No: 114-255 (12/13/2016), Sec. 12006

SEC. 12006. 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:
``(l)(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 .25 percentage points;

``(ii) for calendar quarters in 2021, by .5 percentage points;

``(iii) for calendar quarters in 2022, by .75 percentage points; and

``(iv) for calendar quarters in 2023 and each year thereafter, by 1 percentage point; and

``(B) in the case of home health care services--

``(i) for calendar quarters in 2023 and 2024, by .25 percentage points;

``(ii) for calendar quarters in 2025, by .5 percentage points;

``(iii) for calendar quarters in 2026, by .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);

``(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.

``(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.

``(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(i), 1915(j), or 1915(k) or under a wavier 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 a contractor on behalf of the State.''.

(b) <<NOTE: 42 USC 1396b note.>> 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 (l)(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
(l)(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.

(c) <<NOTE: 42 USC 1396b note.>> Rules of Construction.--

(1) No employer-employee relationship established.--Nothing in the amendment made by this section may be construed as establishing an employer-employee relationship between the agency or entity that provides for personal care services or home health care services and the individuals who, under a contract with such an agency or entity, furnish such services for purposes of part 552 of title 29, Code of Federal Regulations (or any successor regulations).

(2) No particular or uniform electronic visit verification system required.--Nothing in the amendment made by this section shall be construed to require the use of a particular or uniform electronic visit verification system (as defined in subsection
(l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)) by all agencies or entities that provide personal care services or home health care under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.).

(3) No limits on provision of care.--Nothing in the amendment made by this section may be construed to limit, with respect to personal care services or home health care services provided under a State plan under title XIX of the Social Security Act (or under a waiver of the plan) (42 U.S.C. 1396 et seq.), provider selection, constrain beneficiaries' selection of a caregiver, or impede the manner in which care is delivered.

(4) No prohibition on state quality measures requirements.--Nothing in the amendment made by this section shall be construed as prohibiting a State, in implementing an electronic visit verification system (as defined in subsection (l)(5) of section 1903 of the Social Security Act (42 U.S.C. 1396b), as inserted by subsection (a)), from establishing requirements related to quality measures for such system.

Appendix B: Stakeholder meeting overview

The table below provides a high-level overview of presentations and topics discussed at each stakeholder meeting. A version of this table was provided to the stakeholder group at meetings. DHS updated the table over time as additional research areas were identified. Stakeholders representing service recipients, service providers, vendors, direct support workers, managed care organizations and other or unidentified roles attended each stakeholder meeting.

Meeting focus	Date(s)	Location
Meeting overview: Organization and background • DHS staff presented foundational PowerPoint to frame the issue of electronic visit verification along with state and federal requirements • Defined purpose of stakeholder group and community conversations • Solicited stakeholder input on framing of questions to ask community conversation attendees • Identified interest areas of the stakeholder group and additional information needed **Next steps:** • Complete the participant information form to indicate their interest in the topic. • Help communicate to their constituencies about the upcoming community conversations. • Send topic requests to build common knowledge to project team	Aug. 29, 2017, 2-4 p.m. Sept. 11, 2017, 2-4 p.m.	444 Lafayette Road, St. Paul, MN 55155 Elmer L. Andersen Building, 540 Cedar St., St. Paul, MN 55101
Meeting overview: Build common knowledge • DHS staff presentation on program integrity data and current processes in Minnesota • Stakeholder discussion on presentation and clarification of what information would be helpful about vendors and electronic visit verification systems **Next steps:** • Discuss implementation models in other states and electronic visit verification system	Sept. 28, 2017, 10 a.m.-12 p.m.	Elmer L. Andersen Building, 540 Cedar St., St. Paul, MN 55101
Meeting overview: Build Common Knowledge • Overview of implementation models in other states • Overview of electronic visit verification systems and methods of verification • Group debrief on presentations **Next steps:** • Community conversations update from facilitators • Determination of whether an additional meetings is needed after Oct. 30, 2017	October 10, 2017, 10:30 a.m.-12:30 p.m.	444 Lafayette Road, St. Paul, MN 55155

Meeting focus	Date(s)	Location
Meeting overview: Build common knowledge • Review of foundational PowerPoint • Community conversations summary of themes • Overview of interviews with other states • Discussion of presentations **Next steps:** • Additional meeting on Nov, 6, 2017 • Discussion of final steps for stakeholder group	Oct. 30, 2017 2-4 p.m.	444 Lafayette Road, St. Paul, MN 55155
Meeting overview: Development of recommendations • DHS staff presented an overview of the common knowledge built over a series of public meetings about electronic visit verification • Discussion of comments and concerns already shared by stakeholders and community conversation participants • Development of recommendations to make electronic visit verification work well in Minnesota • Worksheet to provide feedback on areas of consensus **Next steps:** • Discuss next steps for legislative report • A group of attendees requested the Nov. 6, 2017 meeting be repeated to solicit further input on areas of consensus	Nov. 6, 2017 1-4 p.m.	Freeman Building, 625 Robert St. N, St Paul Webinar/call-in option
Meeting overview: Development of recommendations • Overview of the common knowledge built over a series of public meetings about electronic visit verification • Discussion of comments and concerns already shared by stakeholders and community conversation participants • Development of recommendations to make electronic visit verification work well in Minnesota • Worksheet to provide feedback on areas of consensus	Dec. 11, 2017 1-3 p.m.	Maplewood Library 3025 Southlawn Dr. Maplewood, MN 55109 Webinar/call-in option

Appendix C: Community conversation summary

The seven community conversation meeting dates, locations and number of attendees were as follows:

- Sept. 18, 2017, 1-3 p.m. – Fergus Falls Public Library, 1505 Pebble Lake Road, Fergus Falls, Minn. – 1 attendee
- Sept. 22, 2017, 1-3 p.m. – Kandiyohi County Health and Human Services, 2200 NE 23rd St., Wilmar, Minn. – 4 attendees
- Oct. 3, 2017, 1-3 p.m. – Rochester Public Utilities, 4000 E. River Road, Rochester, Minn. – 4 attendees
- Oct. 6, 2017, 1-3 p.m. – St. Louis County Government Services Center, 320 W. Second St., Duluth, Minn. – 8 attendees
- Oct. 11, 2017, 1-3 p.m. – Brooklyn Park Library, 8500 W. Broadway Ave., Brooklyn Park, Minn. – 19 attendees
- Oct. 13, 2017, 2:30-4:30 p.m. – webinar only – 30 attendees
- Oct. 18, 2017, 2:30-4:30 p.m. – webinar only – 55 attendees.

In-person, community conversations included the electronic visit verification-overview presentation provided by a DHS Disability Services Division representative, along with a worksheet and discussion about flexibility, minimally burdensome requirements and technology use. Webinar community conversations used a similar format but collected input through the phone, web polls and short-answer text boxes in the webinar software.

To make the electronic visit verification system minimally burdensome, community conversation participants offered the following suggestions:

- Provide useful reports for provider agencies
- Interface with other systems, like payroll and billing
- Allow for tracking of travel and other non-billable time
- Automatically check timesheets for overlap/double-booked time
- Not put the cost burden on agencies, direct support workers or service recipients
- Provide grants, rate increases, stipend or reimbursements to those who have already purchased systems if DHS were to select a statewide system
- “Not cost anybody money. That’s a big thing—whether it’s DHS or providers—we can’t afford another hit, we’re getting hit with requirements repeatedly. Consumers can’t afford it and neither can PCAs”
- Not put the cost burden on agencies, direct support workers, or service recipients;
- Not limit choice by putting some providers out of business
- “If we’re talking about a device, it has to be something the provider didn’t pay for. With the rates we get, with the wages we have to pay PCAs, we can’t pay for that. Not if we have to have QP and schedulers and office managers—not if we have to run a professional service. We shouldn’t have to have more expense than what we have already to get this system”
- Consider that some direct support workers run out of data/minutes on their personal phones by the end of the month
- Requiring the workers or recipients to have a personal device with minutes/data at all times would be prohibitive to some: “... [if] they do the minutes, and their contract goes off and you can’t get a hold of them. For either the client or the PCA”

- Service recipients: Some cannot afford a landline, cell phone or internet (or they live in an area without access to cell/internet)
- Should not deny billing claims unnecessarily
- "Say a PCA worked 10.25 hours one day, and only have 10 hours left in service agreement, it shouldn't deny the whole thing because it's a quarter unit over."

To minimize the administrative burden of the electronic visit verification system for staff, community conversation participants offered the following suggestions:

- Offer multiple methods of verification (i.e., redundancies)
- Provide a waiver or Plan B option for when systems fail/devices are lost/method cannot be used for another reason, like limited internet or cell service
- Consider a percent of compliance for agencies
- Ease of use
- Easy clock in/out ability
- Correction of mistakes option
- Training and support available
- Electronic visit verification needs to accommodate shifts occurring outside the home, including starting the shift without the service recipient present
- Scheduling—both pre-set schedule and no pre-set schedule (PCA choice) need to be options
- Need to consider live-in direct support workers who provide care for a family member 24/7 but only get paid X number of hours per day (should they have to clock in/out continually?)
- Offered in multiple languages
- ADA compliant (i.e., accessible to people with multiple disabilities;
- Not require workers or service recipients to purchase things to work or receive services (e.g., cell phones, Global Positioning Systems)
- Not financially penalize direct support workers, agencies or service recipients who experience technical difficulties
- Not make the workforce shortage worse (i.e., requiring direct support workers to use/purchase technology may drive some out of the workforce).

Webinar polling during the two community conversations that had an online component indicated that 26 community conversation participants preferred the hybrid model, nine preferred provider choice, and seven preferred a state-developed system (i.e., a variation of state choice where the state builds rather than buys an electronic visit verification system). Forty participants did not express a model preference.

Asked to choose as many options as desired from a list of options, community conversation participants participating by webinar offered the following preferences regarding electronic visit verification methods (number of responses in parentheses):

- Telephonic-visit verification using a code (24)
- Swipe recipient's state ID in device (15)
- Still-shot photo or video of caregiving session (3)
- Biometric voice printing of direct support worker (10)
- Service-recipient signature (22)

- Fingerprint verification of direct support worker (18)
- Photograph of service recipient and direct support worker (8)
- Global Positioning System (GPS) location of the direct support worker at clock-in and clock-out (21)
- No answer (30).

Appendix D: Overview presentation from stakeholder and community conversation meetings

DEPARTMENT OF HUMAN SERVICES

Electronic Service Delivery Documentation

Disability Services Division
August 29, 2017

21st Century Cures Act

Electronic Visit Verification (EVV) for:

- Personal care services by January 2019
- Home health services by January 2023

Personal care services include services authorized through the Medicaid State Plan and the Medicaid waivers.

21st Century Cures Act

Electronic Visit Verification must verify:

- Type of service performed
- Who received the service
- Date of service
- Location of service delivery
- Who provided the service
- When the service begins and ends

21st Century Cures Act

States must work with stakeholders involved with personal care and home health to ensure:

- EVV is “minimally burdensome”
- Consideration of best practices and existing use of EVV
- EVV system is HIPAA-compliant and secure
- Training opportunities are available to providers of personal care and home health services

21st Century Cures Act

- EVV must not
  - Limit services provided
  - Limit provider selection
  - Constrain an individual's selection of a worker
  - Impede the manner in which care is delivered
- States are not required to use a particular or uniform system
- CMS is required to issue detailed guidance in 2017

2017 Minnesota Session Laws

What's different or in addition to federal requirements?

Minnesota Department of Human Services (DHS) must:

- Consider other electronic service delivery documentation methods in addition to EVV
- Consider existing best practices and use of electronic service delivery documentation

2017 Minnesota Session Laws

Minnesota Department of Human Services (DHS) must ensure that EVV is:

- Minimally administratively and financially burdensome to providers
- Minimally burdensome to people using services and least disruptive to services
- Consistent with policies related to covered services, flexibility of service use, and quality assurance

2017 Minnesota Session Laws

DHS must:

- Ensure that EVV is effective for preventing fraud when balanced with the requirements to minimally burden providers and people using services.
- Establish baseline measurements related to fraud prevention and performance measurements for the improvement of program integrity.

2017 Minnesota Session Laws

DHS must submit a legislative report by January 15, 2018 with recommendations for:

- Essential elements for a base-level system to be implemented by 2019
- Enhancements to the system with cost projections and cost/ benefit analysis
- Elimination of regulations deemed inefficient, ineffective or unnecessary once the system is implemented

EVV and person-centered services

Tips on EVV implementation from Applied Self Direction

- People using personal care services live in cities, small towns, on farms and remote communities.
  - An EVV system needs to have flexibility and adaptability related to internet access or mobile devices. A successful EVV system will accommodate limited or no internet access where personal care service is delivered.

EVV and person-centered services

Tips on EVV implementation from Applied Self Direction

- **Like all of us, people using personal care services experience last-minutes changes and unexpected challenges.**
  - An EVV system should avoid rigid scheduling rules. A successful EVV system will allow for ease of schedule changes based on the person's needs.

EVV and person-centered services

Tips on EVV implementation from Applied Self Direction

- People may not always be able to call in the moment work begins or end the shift as soon as work ends. Mistakes will also happen. Correcting our errors is an everyday experience and should not result in financial hardship.
  - An EVV system should not make it difficult to retroactively adjust shift start or end times nor create lengthy payment delays when mistakes happen. A successful EVV system will facilitate efficient communication for problem-solving when mistakes occur.

EVV and person-centered services

Tips on EVV implementation from Applied Self Direction

- **People using personal care services are typically on the go – running errands, meeting friends, going to work, enjoying their hobbies & living full lives in the community.**
  - An EVV system should be as mobile as the people using it. A successful EVV system will support individuals to get services wherever the person lives his/her life and not only in the home or nearby the home.

EVV and person-centered services

Tips on EVV implementation from Applied Self Direction

- **People using personal care services have responsibilities for directing their services. Individuals approving their workers' timesheets is a critical component of participant direction.**
  - An EVV system should be designed to keep participants "in the driver's seat." A successful EVV system will provide a variety of accessible means for people to approve service hours, using both innovative and standard technologies.