Adverse impact notification sent to Joint Commission on Administrative Rules, House Committee on Appropriations, and Senate Committee on Finance (COV § 2.2-4007.04.C): Yes[1] ☒ Not Needed ☐

If/when this economic impact analysis (EIA) is published in the *Virginia Register of Regulations*, notification will be sent to each member of the General Assembly (COV § 2.2-4007.04.B).

Virginia Department of Planning and Budget
Economic Impact Analysis

12 VAC 30-60 Standards Established and Methods Used to Assure High Quality Care
12 VAC 30-50 Amount, Duration, and Scope of Medical and Remedial Care Services
12 VAC 30-120 Waivered Services
12 VAC 30-122 Community Waiver Services for Individuals with Developmental Disabilities
Virginia Department of Medical Assistance Services
Town Hall Action/Stage: 5039/8364
September 12, 2019

Summary of the Proposed Amendments to Regulation

The Board of Medical Assistance Services ('Board') proposes to amend 12 VAC 30-60 *Standards Established and Methods Used to Assure High Quality Care* in order to implement electronic visit verification (EVV) for personal care services, companion services, and respite services that are provided to qualifying Medicaid beneficiaries. EVV is a telephone and computer-based system by which providers of these services create an electronic record of their arrival and departure times, location, and the services provided at each visit. The electronic record is transmitted to the provider organizations, who are required to submit the electronic records as part of the claim-filing process and then retain the records for a minimum of six years. EVV data can potentially be used to ascertain that every visit billed to Medicaid actually occurred, and also validate that each visit conformed to the recipient's Plan of Care. The Board seeks to add a new section (65), which contains the specific requirements for the implementation of EVV, to 12 VAC 30-60. The bulk of the analysis presented here focuses on the proposed regulations put forth in this section.

[1] Adverse impact is indicated if there is any increase in net cost or reduction in net revenue for any entity, even if the benefits exceed the costs for all entities combined.

In addition, the Board proposes multiple identical amendments to 12 VAC 30-50 *Amount, Duration, and Scope of Medical and Remedial Care Services*, 12 VAC 30-120 *Waivered Services,* and 12 VAC 30-122 *Community Waiver Services for Individuals with Developmental Disabilities*, each one being directed at a specific category of service providers. Each amendment instructs the relevant service providers to implement EVV and directs them to 12 VAC 30-60-65 for additional detail on the requirements. Specifically, these amendments apply to the following services:

- personal care for children receiving early preventative screening, diagnosis, and treatment (12 VAC 30-50-130);
- consumer-directed or agency-directed personal care or respite care specifically for activities of daily living (12 VAC 30-120-766);
- personal care or respite care for those under the Elderly or Disabled with Consumer-Direction Waiver, agency or consumer-directed companion services in the workplace or postsecondary school, and agency or consumer-directed respite services (12 VAC 30-120-924); and
- services for individuals with developmental disabilities receiving community waiver services (12 VAC 30-122-125).

Lastly, the Board seeks to include the amendment requiring EVV in 12 VAC 30-120-930, which provides general requirements for home and community-based providers, to clarify that all types of personal care providers are covered by the EVV requirements, without exception.

Background

The proposed action conforms the requirements of the Medicaid program with the federal *21st Century Cures Act* as applicable to Title XIX concerning electronic visit verification. The *21st Century Cures Act* was signed into law in December 2016 and added § 1903(1) to the *Social Security Act* (SSA). The *Cures Act* includes fiscal penalties for states that failed to implement the EVV requirement for personal care services by January 1, 2019. The 2018 Appropriation Act (2018 Special Session 1, Acts of Assembly Chapter 2, Item 303, LLL) gave the Department of Medical Assistance Services ('DMAS') the authority to implement the EVV requirement prior to the completion of any regulatory process.

In July 2018, Congress enacted H.R. 6042 to delay the onset of the penalties until January 1, 2020; subsequently in January 2019, the Budget Bill was amended (2019 Acts of Assembly Chapter 854) to allow DMAS until October 1, 2019 to implement EVV for personal care services. DMAS expects to meet this deadline and has been working with various stakeholders, including service providers and vendors, to ensure that they implement EVV well in advance of the federal deadline, so as to not risk facing any fiscal penalties.

Estimated Benefits and Costs

Failure to comply with the requirements of the *Cures Act* would have resulted in a small reduction in the Federal Medical Assistance Percentage (FMAP) rate for personal care expenditures in the first year and larger reductions in subsequent years. Given DMAS expended a total of $868 million in 2017 for personal care services (both agency- and consumer-directed) even a small decrease in the FMAP would have cost several million dollars. By implementing EVV before the deadline, in compliance with all the requirements of the federal Centers for Medicare and Medicaid Services, DMAS benefits from avoiding any such penalty. Avoiding the penalty is possibly the most readily quantifiable benefit of implementing this regulation.

Other benefits may accrue to providers, beneficiaries, and DMAS. Provider organizations may use EVV to manage and monitor the delivery of care and services, reduce paper-based recordkeeping, and streamline their own documentation process for submitting insurance claims, which could also lead to faster claim payments as payers use the EVV data to more efficiently detect fraud or waste. Medicaid beneficiaries who utilize personal care services and may have been harmed, either directly or indirectly, by improper payments (fraud or abuse) in personal care provision are now benefited by the increased transparency and accountability provided by EVV. To the extent that improper payments in personal care provision increased DMAS expenditures, the implementation of EVV could reduce those losses.

However, greater transparency and fraud reduction also incurs certain costs. Providers have to contract with vendors to adopt appropriate EVV tools that support their operations. In areas with limited wireless internet connectivity, this could mean using landline telephones or installing devices at the consumer’s home that can be used by the care providers. In areas where wireless connectivity is stronger, EVV vendors may provide mobile applications deployed on the provider’s smartphone or on a tablet or similar device given to the provider. These mobile

applications may combine web-based timesheets with GPS-based location services to collect and transmit very precise data. Depending on the size of the provider organization and the locations in which they operate, these costs could vary widely, but would include both the one-time cost of deploying the technology and training users, and any recurring costs such as technology refresh, network or connectivity charges, and charges for using a data clearinghouse to submit claims and receive remittances from the insurance companies.

Some small providers responded to queries by DPB staff saying that although EVV was not required for their customers with other insurance, they chose to implement it for all their clients so that each caregiver could use the same process for scheduling and entering visit data with all the individuals that they directly served. These providers reported lower costs (less than $10 per member per month) and were located in areas with widespread wireless internet coverage and high rates of smartphone adoption. However, providers in areas without widespread internet coverage reported higher up-front costs of training staff in using multiple EVV tools (using landlines and Wi-Fi) as well as higher ongoing costs (approximately $20 per member per month) and said they could not afford to implement EVV for their non-Medicaid clients. None of the small providers who responded had adopted EVV as a business practice prior to the passage of the *Cures Act*. Furthermore, those who implemented it in time for the initial January 1, 2019 deadline expressed some frustration about the vendor fees that could have been avoided had they known that the deadline would be postponed to October 1, 2019.

In an effort to minimize costs to providers, DMAS convened an EVV Regulation Development Workgroup (‘Workgroup’) and also issued a Request for Information (RFI) from service providers and EVV vendors seeking information on their capacity to implement EVV in the least disruptive manner. Based on the information received, DMAS chose to adopt an ‘open’ model, in which they could parlay the requirements of the *Cures Act* to providers as a broad range of technical specifications, rather than a ‘closed’ model in which providers would have to implement a specific system chosen by DMAS. Hence, providers were given the freedom to work with vendors of their choice, including vendors they were already using for scheduling or payroll.

Based on minutes from the Workgroup’s deliberations, it appears that the fiscal/ employers’ agents (F/EA) for consumer-directed services have been able to transition their

existing timesheets and payroll systems to one that meets EVV requirements. Given that DMAS contracted with an F/EA that for individuals covered by Medicaid fee-for-service receiving consumer-directed personal assistance, this might have set a precedent for other F/EAs acting on behalf of managed care organizations (MCOs). Finally, providers are incentivized to implement EVV simply because it is a required component of filing claims and receiving payments from DMAS. Providers who have been slow to implement EVV will not be paid until and unless they do so.

In the medium- to long- run, regulatory requirements such as EVV could have consequences that may not be apparent in the short run. These requirements impose the greatest burden for the smallest provider groups who may have very minimal capacity for moving beyond the most basic payroll systems. Over time, regulatory requirements that involve significant technology upgrades can encourage market concentration in the industry – small providers eventually find it more cost effective to merge into larger organizations that can afford to have an in-house software development team or can contract with external vendors more competitively.

This process may be underway, as evidenced by the presence of groups such as the Partnership for Medicaid Home-Based Care, a consortium representing the largest home and personal care service providers, MCOs, and EVV vendors. The participating organizations are all corporations, some publicly-traded, that operate across multiple states. These groups, or their member organizations, are well-situated to participate in RFIs, such as the one conducted by DMAS, and submit compelling arguments in favor of the 'open' model that promotes flexibility and efficiency for the providers.

Regulations targeting providers that require technology upgrades also create incentives for Managed Care Organizations (MCOs) to offer technology solutions to the providers in their network and absorb the up-front costs of developing and deploying the technology. Otherwise, they might face providers who want to be reimbursed for the additional costs accrued from complying with such regulations. This in turn will likely prompt MCOs to negotiate higher capitation rates or special payments that cover the cost of regulatory compliance. It would be impossible to isolate the effect of just the EVV requirement on any marginal increase to capitation rates in the future, or determine whether any rate increases are offset by decreases in

improper payments, but it offers an illustration of the process by which one technological upgrade, in this case through regulatory action, could lead to increases in healthcare costs.

Businesses and Other Entities Affected

The proposed amendments affect numerous organizations providing personal care/assistance as well as the individuals receiving these services and possibly their families. In state fiscal year 2017, DMAS estimates that about 68,000 people who used these services would be affected per year. This includes roughly 34,000 individuals in managed care who were eligible for personal care, respite care, and companion care services. (According to DMAS, managed care information is reported as encounter data, without user counts.) In the fee-for-service system, roughly 27,780 individuals used personal care services.

Based on the fee-for-service claims, DMAS estimates that about 600 provider organizations of agency-directed personal care would be affected. DMAS estimates that 90 percent of these are likely to be small businesses. Other private entities affected include Adult Rehabilitation Centers, Area Agencies on Aging, disability support organizations, and organizations with religious affiliations that provide support services, to the extent that the population they serve receives Medicaid coverage. The proposed amendments would also affect vendors that develop and provide software services.

Localities[2] Affected[3]

The proposed amendments do not immediately introduce new costs for local governments. However, these requirements would affect Community Services Boards and Area Agencies on Aging, which are administered by local governments in conjunction with the Department of Behavioral Health and Developmental Services and the Department for Aging and Rehabilitative Services respectively, to the extent that the population they serve receives Medicaid coverage. Localities with greater proportions of Medicaid recipients who utilize personal care services would be disproportionately affected by the proposed regulations.

[2] "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulatory change are most likely to occur.
[3] § 2.2-4007.04 defines "particularly affected" as bearing disproportionate material impact.

Projected Impact on Employment

The proposed amendments are unlikely to affect total employment. In the short run, more jobs may have been created by the demand for new software solutions to meet the EVV requirements. This regulation is unlikely to affect the ongoing shortage of home health care and personal care workers.

Effects on the Use and Value of Private Property

The value of managed care organizations and information technology vendors that provide EVV solutions may increase. Real estate development costs are not affected.

Adverse Effect on Small Businesses[4]:

Types and Estimated Number of Small Businesses Affected

Based on the fee-for-service claims, DMAS estimates that about 600 provider organizations of agency-directed personal care will be affected. DMAS estimates that 90 percent of these are likely to be small businesses.

Costs and Other Effects

The EVV requirements impose the greatest burden for the smallest provider groups who may have very minimal capacity for engaging with more sophisticated software requirements moving beyond the most basic payroll systems. Over time, regulatory requirements that involve significant technology upgrades can encourage market concentration in the industry – small providers eventually find it more cost effective to merge into larger organizations that can afford to have an in-house software development team or can contract with external vendors more competitively.

Alternative Method that Minimizes Adverse Impact

Given the potential for millions of dollars in reduced federal funding for failing to require EVV, there are no clear alternative methods that would meet the requirements of the *Cures Act*. In the absence of the *Cures Act*, alternative systems to reduce fraud or waste such as random site audits, or automated random remote audits could have been considered.

[4] Pursuant to § 2.2-4007.04 of the Code of Virginia, small business is defined as "a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million."

Legal Mandates

General: The Department of Planning and Budget has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007.04 of the Code of Virginia (Code) and Executive Order 14 (as amended, July 16, 2018). Code § 2.2-4007.04 requires that such economic impact analyses determine the public benefits and costs of the proposed amendments. Further the report should include but not be limited to: (1) the projected number of businesses or other entities to whom the proposed regulatory action would apply, (2) the identity of any localities and types of businesses or other entities particularly affected, (3) the projected number of persons and employment positions to be affected, (4) the projected costs to affected businesses or entities to implement or comply with the regulation, and (5)the impact on the use and value of private property.

Adverse impacts: Pursuant to Code § 2.2-4007.04(D): In the event this economic impact analysis reveals that the proposed regulation would have an adverse economic impact on businesses or would impose a significant adverse economic impact on a locality, business, or entity particularly affected, the Department of Planning and Budget shall advise the Joint Commission on Administrative Rules, the House Committee on Appropriations, and the Senate Committee on Finance within the 45-day period.

If the proposed regulatory action may have an adverse effect on small businesses, Code § 2.2-4007.04 requires that such economic impact analyses include: (1) an identification and estimate of the number of small businesses subject to the proposed regulation, (2) the projected reporting, recordkeeping, and other administrative costs required for small businesses to comply with the proposed regulation, including the type of professional skills necessary for preparing required reports and other documents, (3) a statement of the probable effect of the proposed regulation on affected small businesses, and (4) a description of any less intrusive or less costly alternative methods of achieving the purpose of the proposed regulation. Additionally, pursuant to Code § 2.2-4007.1, if there is a finding that a proposed regulation may have an adverse impact on small business, the Joint Commission on Administrative Rules shall be notified.