ELECTRONIC VISIT VERIFICATION

Stakeholder Convening Report

New York State Department of Health
Office of Health Insurance Programs

Division of Long Term Care
Division of Operations and Systems
One Commerce Plaza
Albany, NY 12207

Department of Health | Office of Health Insurance Programs

TABLE OF CONTENTS

1. ACKNOWLEDGEMENTS 2

2. BACKGROUND 3

2.1 Electronic Visit Verification Summary 3

2.2 Stakeholder Identification 3

2.3 Methods of Engagement 4

2.3.1 Dedicated WebPage 4

2.3.2 EVV Survey 4

2.3.3 Regional Listening Sessions 4

3. FEEDBACK 6

3.1 EVV Survey Results 6

3.2 Feedback Themes 7

3.2.1 Privacy and Security 7

3.2.2 Accessibility 8

3.2.3 Availability 8

3.2.4 Programmatic Impacts 9

3.2.5 Costs and Funding 9

3.2.6 Timeline 10

3.2.7 Decision-Making 10

3.2.8 Training 10

4. NEXT STEPS 10

4.1 Milestones 10

4.2 Continued Stakeholder Engagement 11

4.3 EVV NEXT STEPS 11

5. APPENDIX A: SURVEY RESULTS 12

1. ACKNOWLEDGEMENTS

During the three-month period from May 30th to July 18, 2019 the New York State Department of Health (NYSDOH), Office of Health Insurance Programs which administers New York's Medicaid Program, held a series of in-person Listening Sessions in locations throughout the State and web-based sessions to receive input on the State's implementation of the Electronic Visit Verification (EVV) requirements for Medicaid-funded personal care and home health care services as required under the federal 21st Century Cures Act from Medicaid beneficiaries, family caregivers, providers, advocates, and other stakeholders.

The report that follows presents a summary of the feedback received at those sessions and responses to a survey of personal care and home care providers. Video and/or audio of the full sessions is available at https://www.health.ny.gov/evv.

The Department extends its appreciation and thanks to those that attended the Listening Sessions to provide their input, and NYS Technology Enterprise Corporation (NYSTEC) Consulting and the Departments' Public Affairs Group for supporting of the public sessions.

2. BACKGROUND

2.1 ELECTRONIC VISIT VERIFICATION SUMMARY

The federal 21st Century Cures Act (the Cures Act) was signed into law on December 13, 2016, mandating that states implement EVV for all Medicaid-funded personal care services (PCS) and home health care services (HHCS) that require an in-home visit by a provider. States were originally required to implement EVV for all Medicaid-funded PCS by January 1, 2019 and HHCS by January 1, 2023. On July 30, 2018, Congress passed a bill to delay the implementation requirement for one year. States are now required to implement EVV for all Medicaid- funded PCS by January 1, 2020. The implementation date for HHCS remains unchanged. Failure to comply with this mandate will result in incremental reductions in Federal Medical Assistance Percentages (FMAP) of up to 1%. States can apply for a one-time, one-year good faith effort (GFE) extension. The “good faith effort” applies if the state has taken steps to adopt the technology used for an EVV system and has encountered “unavoidable delays”.

In CMS’ December 2017 presentation on “EVV Requirements, Implementation, Considerations, and State Survey Results,” CMS reported several potential benefits of EVV, including: ensuring timely service delivery for members, real-time service gap reporting and monitoring, reducing the administrative burden associated with paper timesheet processing, and generating cost savings from the prevention of fraud, waste, and abuse. In addition, CMS reported EVV aims to strengthen quality assurance by improving the health and welfare of individuals through validation of delivery of services.

The Cures Act requires that EVV systems capture:

- Service type
- Individual receiving the service
- Date of service
- Location of service delivery
- Individual providing the services
- Begin and end times of service

States may select their own EVV design and implement quality control measures of their choosing. The Cures Act requires that states seek options that are minimally burdensome and meet the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). It also requires that states seek input from stakeholders including beneficiaries, family caregivers, individuals furnishing PCS or HHCS, other state agencies that provide PCS or HHCS, and other stakeholders determined by the state. Each state must identify and engage stakeholders in this process.

2.2 STAKEHOLDER IDENTIFICATION

As part of the planning process and to meet the stakeholder engagement requirements of the Cures Act NYSDOH has actively sought input from key stakeholder groups and will continue to work with them through the EVV implementation process.

Stakeholders providing feedback include Self-Directed and Consumer Directed Personal Assistance Program consumers, consumers in Community Habilitation/Skills Acquisition, Maintenance, and Enhancement (SAME), provider agency consumers, Fiscal Intermediaries (FIs), vendors, providers and agencies, advocacy groups, stakeholder family members, aides and caregivers, and Managed Care organizations.

2.3 METHODS OF ENGAGEMENT

NYSDOH has provided several channels for stakeholders to receive updates on the program and provide input on the State's implementation of EVV requirements under the Cures Act. Below is a summary of each channel.

2.3.1 DEDICATED WEBPAGE

NYSDOH launched a webpage on May 16, 2019 dedicated to EVV (www.health.ny.gov/EVV). The webpage hosts information on the Cures Act, EVV, and what New York is doing to meet the requirements of the mandate. There is also a calendar of events and a Frequently Asked Questions (FAQs) page. The State is dedicated to maintaining and updating the EVV website to help ensure all stakeholders are informed on progress made toward EVV implementation.

Stakeholders may sign up for the EVV Listserv which provides updates regarding the EVV program. Updates include new event announcements and information, EVV program updates and policy guidance. Stakeholders can sign up for the EVV Listerv by emailing listserv@listserv.health.state.ny.us with the following: SUBSCRIBE EVV-L YourFirstName YourLastName.

NYSDOH created a help desk email address EVVhelp@health.ny.gov for stakeholders to provide general feedback and comments, and for any assistance or guidance related to EVV education and implementation. The Department has received 184 inquiries from stakeholders since May 2019. Topics include but are not limited to: general EVV information, the EVV Survey, EVV regional Listening Sessions and EVV feedback.

2.3.2 EVV SURVEY

The NYSDOH sent an EVV Survey to providers that are potentially subject to EVV. The goal of the survey was to help NYSDOH determine the landscape of providers and existing infrastructure to consider, and potentially leverage, in determining the best approach to implementing EVV. NYSDOH received 146 responses from provider organizations. The results of the survey are summarized in section 2.1 below.

2.3.3 REGIONAL LISTENING SESSIONS

From May to July 2019, the NYSDOH conducted regional Listening Sessions to collaborate with stakeholders regarding the implementation of EVV as required by the Cures Act. NYSDOH hosted eight in-person sessions across the State and two webinars (including one in the evening) to accommodate those who were unable to attend an in-person session.

Each session dedicated the first half hour to introductions and a presentation to provide background on the Cures Act and EVV. The next two to three hours allowed for questions, comments, feedback, and concerns from stakeholders. Each session was open to the public and announced on the New York State EVV Website and through the Medicaid Redesign Team (MRT) and EVV Listservs. The sessions were attended by consumers and/or their family members, providers and agencies, advocates and advocacy

groups, vendors, and stakeholders from other State agencies such as the Office for People with Developmental Disabilities (OPWDD) and the Office of the Medicaid Inspector General (OMIG).

The following Listening Sessions were held by the Department. As shown in the table below, collectively, attendance exceeded 1,000 registered attendees.

Date	Location	Registered Attendees
5/30/2019	Albany/Capital District	71
6/05/2019	Rochester	55
6/17/2019	Long Island	95
6/18/2019	New York City Session 1	137
6/24/2019	Lake Placid	16
6/27/2019	Online Webinar	250
7/09/2019	New York City Session 2	155
7/11/2019	Online Webinar	191
7/17/2019	Buffalo	38
7/18/2019	Syracuse	31

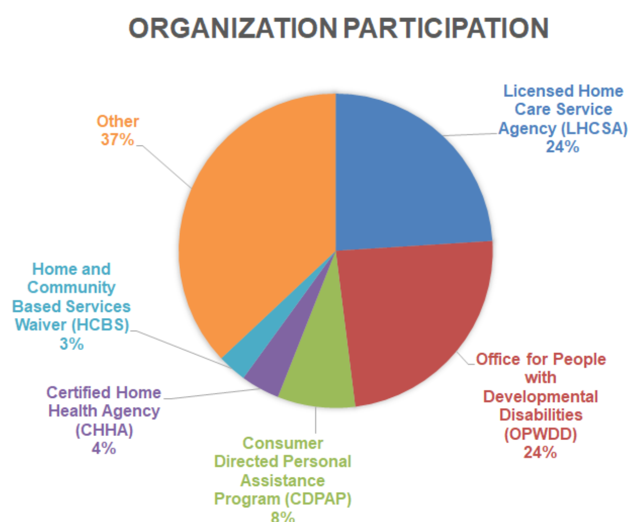
3. FEEDBACK

Stakeholders have provided, and continue to provide, valuable input and recommendations for EVV implementation in New York.

3.1 EVV SURVEY RESULTS

The EVV Survey was sent to providers who billed Medicaid (i.e., eMedNY) for more than $100,000 of Personal Care Services and/or Home Health Care Services with dates of service in calendar year 2018 (using billing rate codes). The survey was sent to the individual contact the provider identifies in eMedNY.

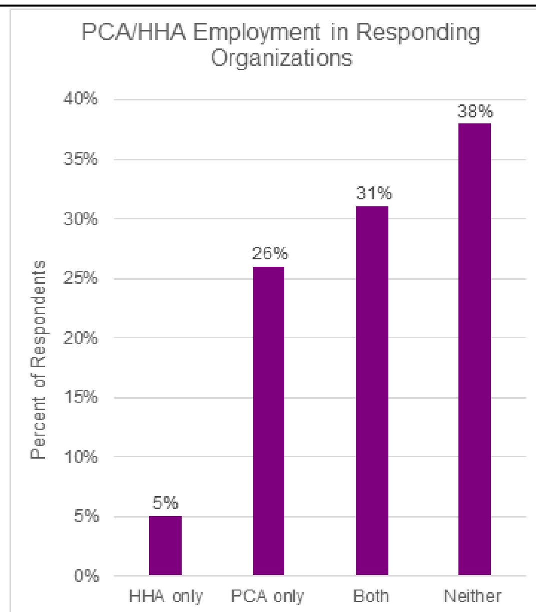
Figure 1: Organization Participation



NYSDOH received 146 responses for a 20% response rate.

Figure 1 shows that of the 146 surveys received, 24% are Licensed Home Care Service Agencies (LHCSA), 24% are providing services through the Office for People with Developmental Disabilities (OPWDD), 8% are delivering services under CDPAP, 4% are Certified Home Health Agencies (CHHAs), 3% are delivering Home and Community Based Services Waiver (HCBS), and the remaining 37% is made up of various other organizations (e.g., non-profits, group homes, day habilitation centers, social service providers, and volunteers).

Figure 2: PCA/HHA Employment in Responding Organizations



Thirty-one percent of respondents employ both Home Health Aides (HHAs) and Personal Care Aides (PCAs), 26% employ only PCAs, and 5% employ only HHAs. Thirty-eight percent of respondents indicated they do not employ HHAs or PCAs. These respondents indicated they provide OPWDD related services, case management services, are non-profit agencies, or identified their organization type as 'other'.

Nearly one-half of respondents reported they serve populations in both rural and urban areas, while 35% serve strictly urban areas and 15% serve strictly rural areas.

The survey showed that one-half of the respondents were aware of the EVV mandate under the Cures Act, and the other one-half were not.

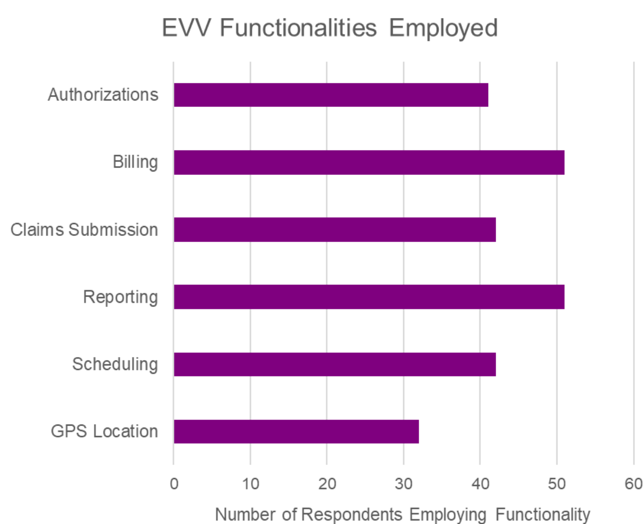


Figure 3: EVV Functionalities Employed

Forty-six respondents indicated they now have EVV in place. Those respondents reported employing a wide range of existing EVV technologies, infrastructure, and processes. Thirty-two percent of those with an EVV in place reported their current EVV solution is compliant with the Cures Act. Technologies in use include, but are not limited to non-smartphone cell phones, applications accessed through smart phones, in home key-fobs, and landlines. Approximately one-half of those respondents with an EVV in place reported using GPS in EVV data collection, and over-two thirds utilize EVV systems that incorporate functionality in addition to that required by the Cures Act including: scheduling, reporting, claims submission, billing, and authorizations.

Full EVV Survey results can be found in Appendix A: EVV Survey Results.

3.2 FEEDBACK THEMES

Many central themes emerged from the stakeholder feedback received from the regional Listening Sessions, including important issues and concerns regarding privacy and security, accessibility and availability, programmatic impacts, cost and funding, timelines, decision-making, and training were the seven main themes voice by stakeholders.

3.2.1 PRIVACY AND SECURITY

New York's consumers expressed concern about how EVV data will be used, echoing concerns nationally regarding the implementation of the federal law. Consumers raised concerns that the use of EVV is an invasion of privacy, and the potential for it to go beyond the federal requirements, including tracking of movements in the community, and activities and conversations. In addition, consumers expressed concern that EVV information could expose individuals escaping domestic violence or abuse to significant risks. Stakeholders indicated there must be transparency on what data will be shared, with whom, and for what purposes, and what protections would be in place to ensure their personal data is secure. In addition to privacy and security issues, consumers expressed concern that EVV data would be used to make decisions about the need and authorization for services.

Some consumers indicated they oppose the use of global positioning systems (GPS), biometrics, and/or geofencing as invasive and an undue burden. Vendors and developers stated that geo-fencing techniques are often found to be inaccurate. Additionally, some consumers opposed verification utilizing personal biometric data (including but not limited to fingerprint or iris scan, and facial or voice recognition). Others objected to the use of photographic verification requiring a daily picture of the provider and consumer together as means to verify services.

The predominant message from consumers is that privacy violations and invasive measures infringe on basic human rights. Consumers feel that these measures discriminate against disabled individuals. A consumer specifically pointed out that able-bodied individuals are not subject to being tracked by GPS; being disabled and receiving support and care as a necessity should not be grounds for invasive measures and privacy infringements.

Some consumers also expressed that EVV will drive their care workers to quit, citing low wages and existing difficulty finding workers.

Consumers also requested robust data and privacy protections for themselves and for their aides. They sought assurances from NYSDOH that location data will not be used to make invasive inferences about their lifestyle choices or to justify denial of service. Consumers requested the State consider the California model, and its interpretation of location, where community is not attached to coordinates but simply captured as 'community' for privacy.

3.2.2 ACCESSIBILITY

Consumers, family members/caregivers and advocates urged that EVV accommodate the accessibility needs of individual users. Important accessibility features requested include but were not limited to:

- Magnifiers or Zooming, Adjustments to Fonts, and Screen Reading
- Color Contrast, Color Filters, Grayscale
- Voice Commands and Hands-Free Software
- On-Screen Keyboards and Text-to-Speech Software
- Features that can tell computers and humans apart (i.e., (CAPTCHA) Methods).

Stakeholders advocated that systems require multiple language-supported interfaces to meet the linguistic diversity of users. Introducing a new system without requiring support for multiple languages would be an additional challenge for many and could further incentivize care workers to leave the industry. Furthermore, some stakeholders requested exceptions for religious beliefs; particularly for religions with objections to electronic device use on the Sabbath.

3.2.3 AVAILABILITY

Stakeholders pointed out that geographic areas with limited or no internet or cellular connectivity ("dead-zones") need to be considered. Without a cellular or internet connection, stakeholders asked how an EVV system will collect data and send it to the system's server in a timely manner. Stakeholders were also concerned about the impact solutions that are connected to billing and payroll could have on timely and accurate compensation. For example, EVV systems that are reliant on internet connectivity, care workers in "dead-zones," or technologically limited areas may compromise timely and accurate compensation. Stakeholders requested that NYSDOH provide clearly defined policies on how to address these issues.

While some stakeholders raised concerns about the availability of EVV technologies and systems, some providers said that once fully implemented, EVV systems would be an asset in assisting organizations in meeting quality measures and standards. Some stakeholders indicated the use of GPS and geofencing can be beneficial by ensuring consumers receive the services they need and allows agencies to be alerted if an aide does not show up for their shift. This kind of instant information can assist the agency with

making necessary adjustments in the schedule and staffing to ensure the consumer has an aide that day. Several providers provided examples of how their EVV systems have been configured to address some of the concerns raised. For example, providers explained that EVV systems that use GPS to collect location data, do not continuously track throughout the duration of the service; rather the GPS is only functional when the caregiver is clocking the start and end times of their shift.

3.2.4 PROGRAMMATIC IMPACTS

Stakeholders requested clarity on the scope of impacted programs.

Providers who serve multiple programs expressed the need to know which of their services are subject to the requirements of EVV. Larger providers and other impacted stakeholders also asked if the existing Verification Organization (VO) program will be maintained, modified, ended, or otherwise impacted by EVV. The Office of the Medicaid Inspector General (OMIG) currently requires home health agencies and personal care providers exceeding $15 million in Medicaid fee-for-service and/or Medicaid Managed Care reimbursements contract with a VO. VOs are required to perform pre-claim reviews of claims data collected in EVV systems.

Some care workers are providing services to multiple individuals simultaneously (for example, to multiple consumers living in the same home) and wanted to know how EVV will impact this model of service delivery. Other care workers are family members of consumers and noted that it is difficult to identify clear start and end times.

Self-directed consumers both in New York and nationally, have requested that the unique character of their programs be respected either through exemptions from EVV requirements, or through tailoring solutions and technologies to their programs. They also expressed concerns that EVV fundamentally undermines the spirit of independence that is central to self-directed programs, and that their autonomy to hire and fire aides will be compromised. Many consumers emphasized that self-directed programs give them the control and freedom that able-bodied individuals inherently have in their own lives. The use of EVV will diminish the control self-direct consumers now have.

3.2.5 COSTS AND FUNDING

Provider stakeholders requested that the state fund or offset the cost of implementation and maintenance for current or future EVV systems as current reimbursement may not provide funding for these systems.

Some providers already invested in EVV systems and processes and are concerned that they may be forced to switch to a State-mandated solution. Many are seeking clarity on New York State requirements or are seeking information on potential Center for Medicaid and Medicare Services (CMS) certifications, to secure some assurance that their investments will be protected.

While upfront and ongoing costs of an EVV system are major concerns of stakeholders, some providers stated that EVV systems can help reduce fraud and increase compliance. Some providers expressed that EVV systems can have a positive financial impact.

Consumers noted that EVV systems that require consumers to have certain technology (e.g., data plans, internet, cell phones, devices) may not be affordable for many consumers.

3.2.6 TIMELINE

Many stakeholders expressed skepticism that an EVV system can be properly implemented before the Cures Act deadline of January 2020 for personal care services. Providers who have already implemented EVV systems have indicated it takes about 6 –12 months to implement.

While stakeholders agreed with New York State's plan to apply for the GFE extension, some stakeholders questioned whether CMS will approve its request.

3.2.7 DECISION-MAKING

Stakeholders wanted to know the decision-making process New York State will use to select an EVV solution, if they will be involved in that process, and how decisions will be communicated. Suggested methods of communicating decisions include paper mailings, coordination with provider organizations, and a second round of Listening Sessions. Some noted that the DOH team working on the implementation of EVV lacks representation from the disabled community.

Stakeholders (especially self-directed consumers and advocates) requested meaningful participation in the form of work-groups, a second round of Listening Sessions, and surveys.

3.2.8 TRAINING

Stakeholders wanted to know who will be responsible for training and related expenses. Consumers, providers, and FIs all highlighted the financial and other costs such as time, labor, and training. Providers and FIs concerned that effective training cannot be completed before the Cures Act PCS implementation deadline. Consumers and FIs are concerned that their personal assistants may lack the technical capabilities to quickly complete training.

Consumers stated the need for training to be accessible and available in multiple languages.

Providers that have trained their staff on existing EVV systems are concerned that their investment could be lost if they are forced to re-train in a different system. Providers also recounted training-related communications problems with vendors like disagreements over responsibilities and poor service levels. Consumers and FIs expressed that is should not be the responsibility of FIs or aides to take on the role of IT Support.

4. NEXT STEPS

The statewide tour of regional Listening Sessions provided NYSDOH with important and helpful feedback and input from stakeholders. As NYSDOH prepares for the next steps in implementation the State is committed to continuous engagement with stakeholders.

4.1 MILESTONES

NYSDOH has developed four major milestones for planning and implementing EVV consistent with federal law. The first milestone consists of initial information gathering from stakeholders including conducting Listening Sessions, and a provider survey to assess the current landscape. This milestone is complete and the subject of this report. The second milestone includes formulating EV implementation options, taking into consideration the input received from milestone one, developing a strategy and executing a strategy.

The third milestone will include implementation of the selected option, including but not limited to technology, cost, training, and working with an EVV vendor or vendors, if necessary. And the fourth and final milestone includes evaluation and monitoring of the implemented operation.

4.2 CONTINUED STAKEHOLDER ENGAGEMENT

Throughout the remainder of the process NYSDOH will continue to involve stakeholders regarding decisions and best practices.

Upcoming opportunities for stakeholder engagement will be posted to the NYS EVV Website at www.health.ny.gov/EVV. NYSDOH will also notify the public via the EVV Listserv. To sign up for the EVV Listserv, email listserv@listserv.health.state.ny.us with the following: SUBSCRIBE EVV-L YourFirstName YourLastName. Any questions, comments, or additional feedback is welcomed to the EVV Help Email at EVVHelp@health.ny.gov.

4.3 EVV NEXT STEPS

NYSDOH is committed to continuously engaging stakeholders as it takes the next steps to implement EVV. To date, NYSDOH has been planning for the EVV strategy and implementation, gathering information via the EVV Survey, research into EVV solutions adopted by other states, and regional Listening Sessions. The first round of Listening Sessions is complete and that information is compiled. The summary data is provided in this convening report.

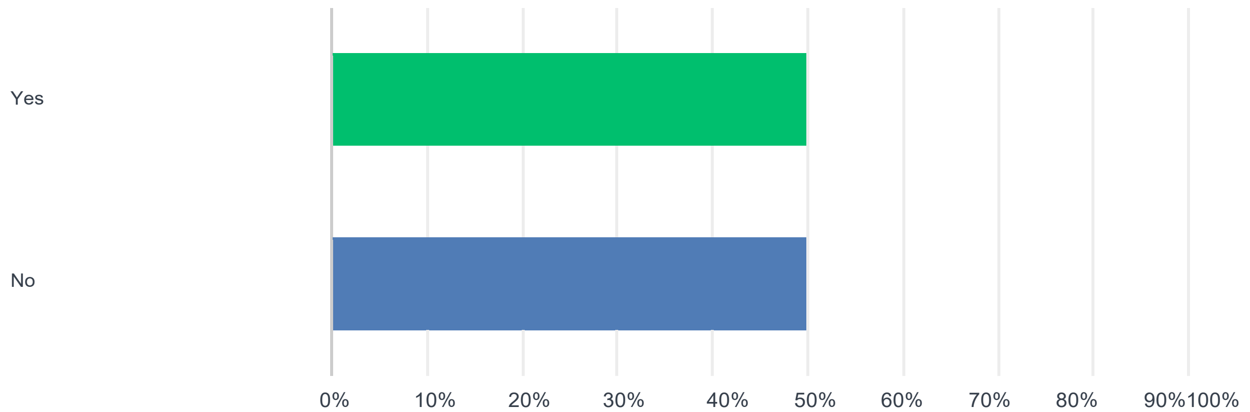
NYSDOH will next review the options for EVV solutions, taking into consideration the feedback and information we have gathered. The statewide regional Listening Sessions provided NYSDOH with important and helpful feedback and input from stakeholders. To collect information on the types of systems and approaches for implementing EVV that carefully consider that stakeholder feedback, NYSDOH will issue an EVV Request for Information (RFI). The State will summarize and share with stakeholders the elements of the vendor responses received. The information received will then be used to help determine NYS's strategy, formulate a plan for EVV implementation, and begin execution against that plan.

As we define our plan for EVV implementation and determine the EVV model for NYS, we will continue to engage with stakeholders to ensure smooth and well-informed implementation and training for the NYS workforce impacted by EVV. We will monitor the implementation, and update and adjust our EVV solution as necessary.

5. APPENDIX A: SURVEY RESULTS

Q1: Are you familiar with the Cures Act and its EVV system requirements?

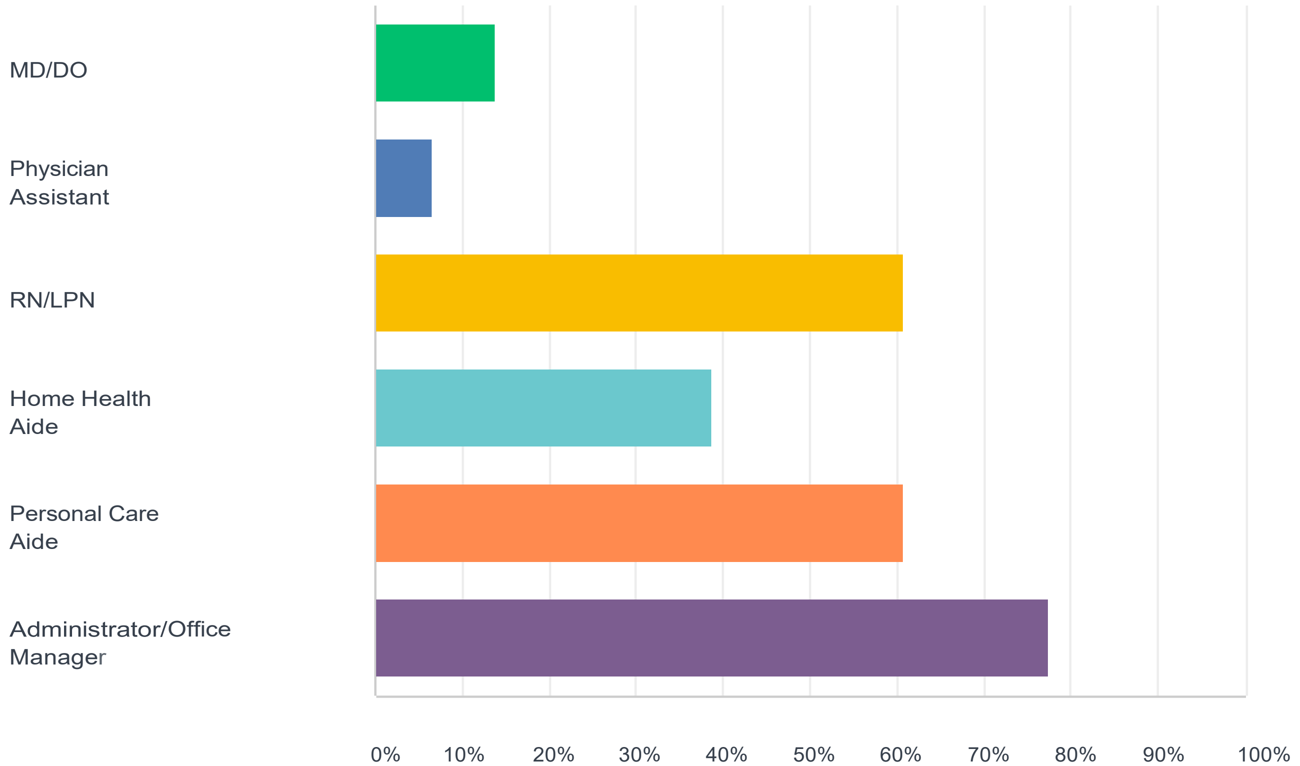
Answered: 145 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	50.34%	73
No	49.66%	72
TOTAL		145

Q2: What type of service providers are employed by your organization? (Select all that apply)

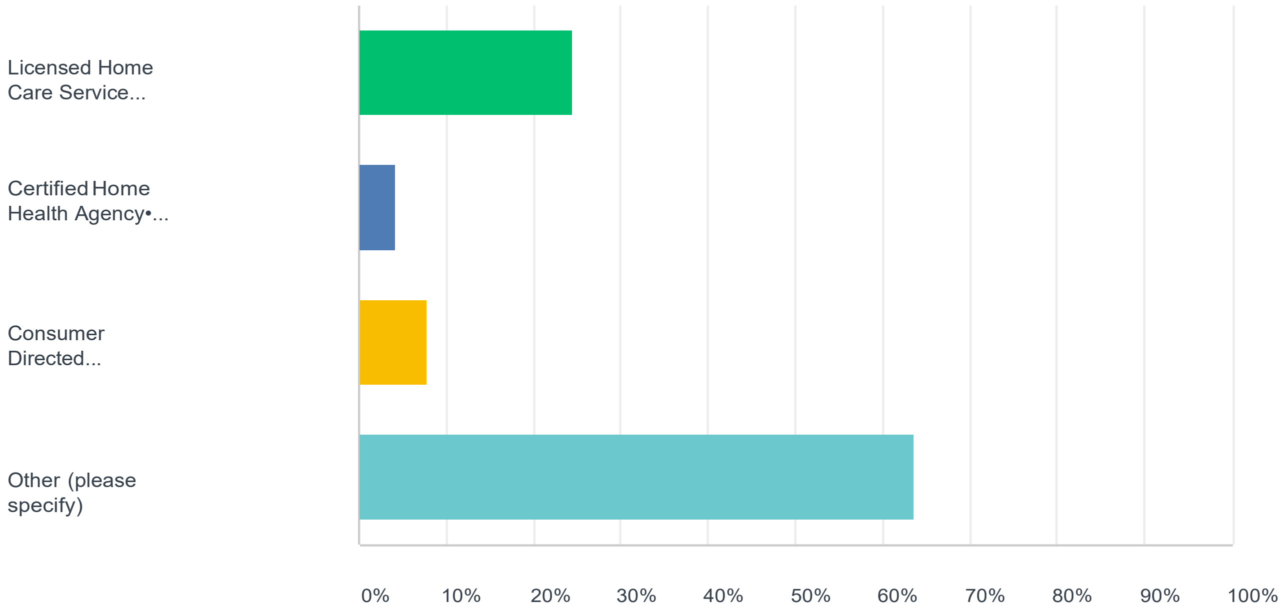
Answered: 137 Skipped: 9



ANSWER CHOICES	RESPONSES	
MD/DO	13.87%	19
Physician Assistant	6.57%	9
RN/LPN	60.58%	83
Home Health Aide	38.69%	53
Personal Care Aide	60.58%	83
Administrator/Office Manager or Assistant	77.37%	106
Total Respondents: 137		

Q3: What is your organization type?

Answered: 143 Skipped: 3



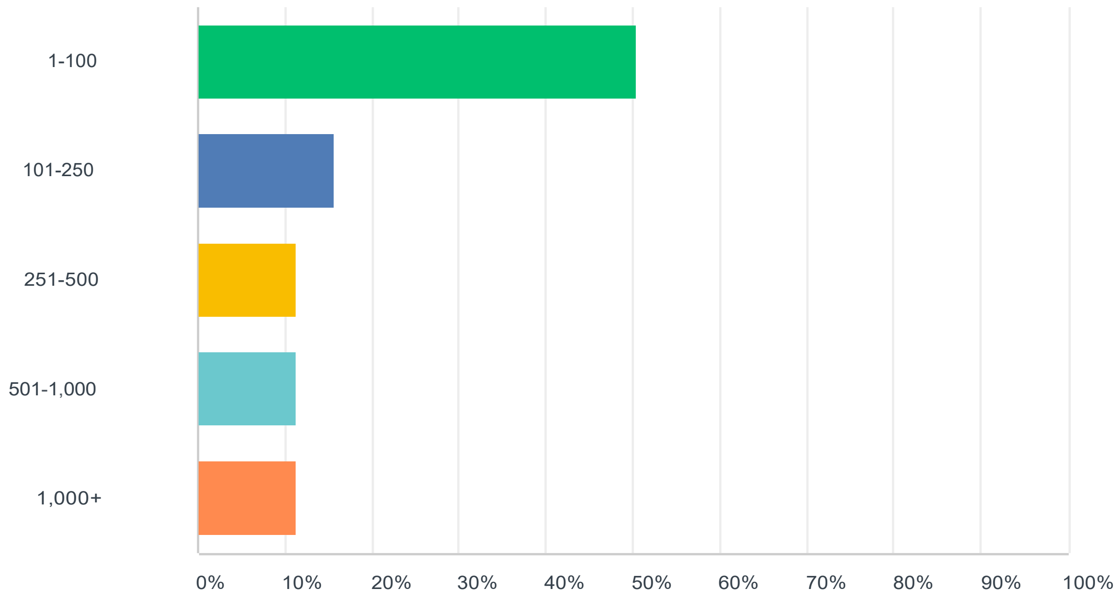
ANSWER CHOICES	RESPONSES	
Licensed Home Care Service Agency (LHCSA)	24.48%	35
Certified Home Health Agency (CHHA)	4.20%	6
Consumer Directed Personal Assistance Program (CDPAP)	7.69%	11
Other (please specify)	63.64%	91
TOTAL		143

Breakdown including those who selected ‘Other’:

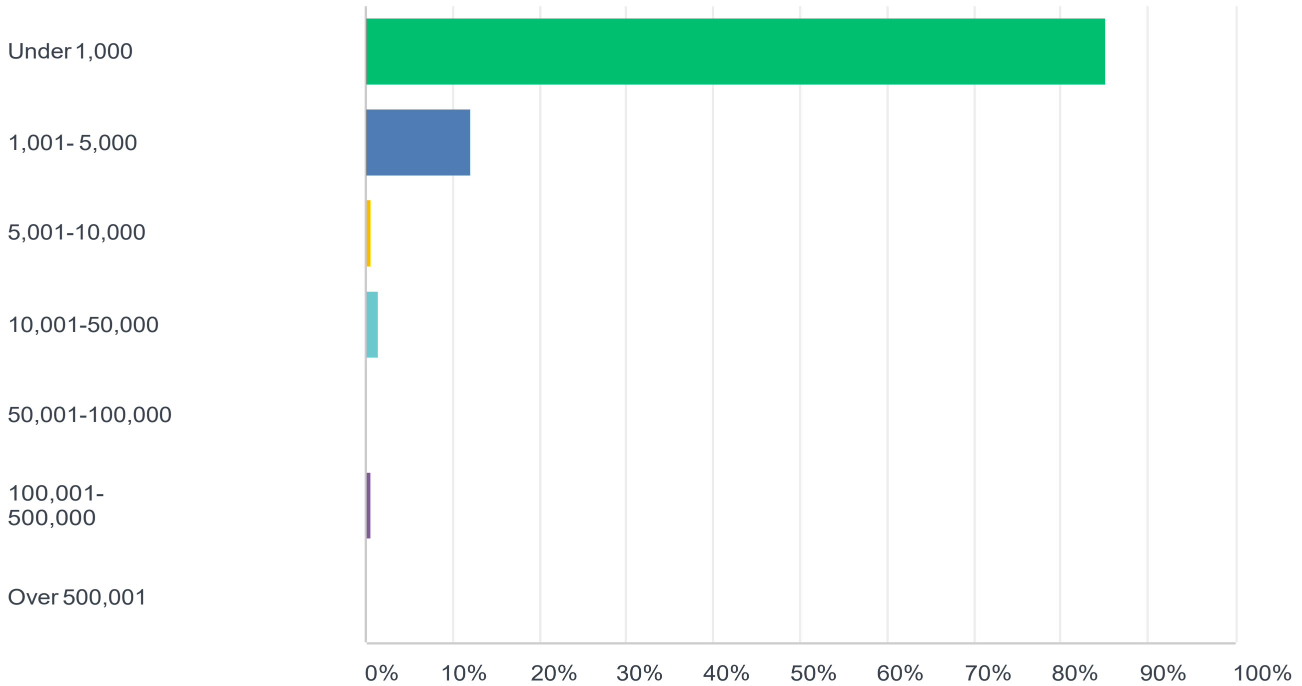
OPWDD: 35/143 =24.48%
HCBS Waiver: 4/143 = 2.8%
Other Not Specified: 52/143 = 36.36%

Q4: How many individuals in your organization provide personal care or home health care services? (Do not include administrative staff)

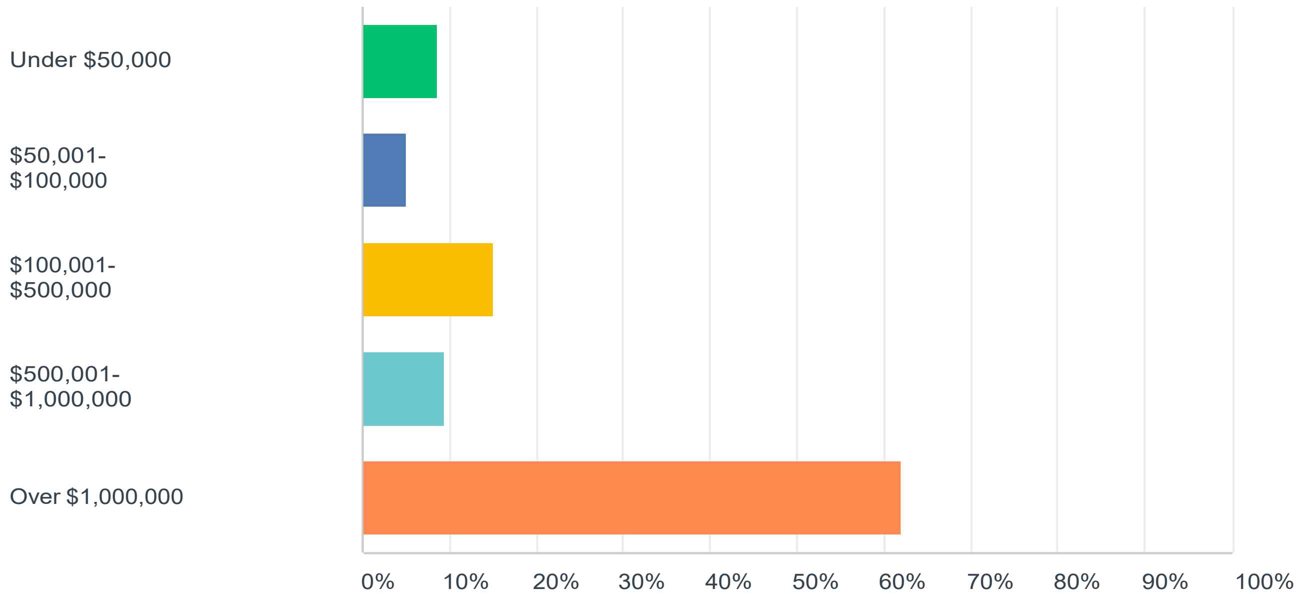
Answered: 133 Skipped: 13



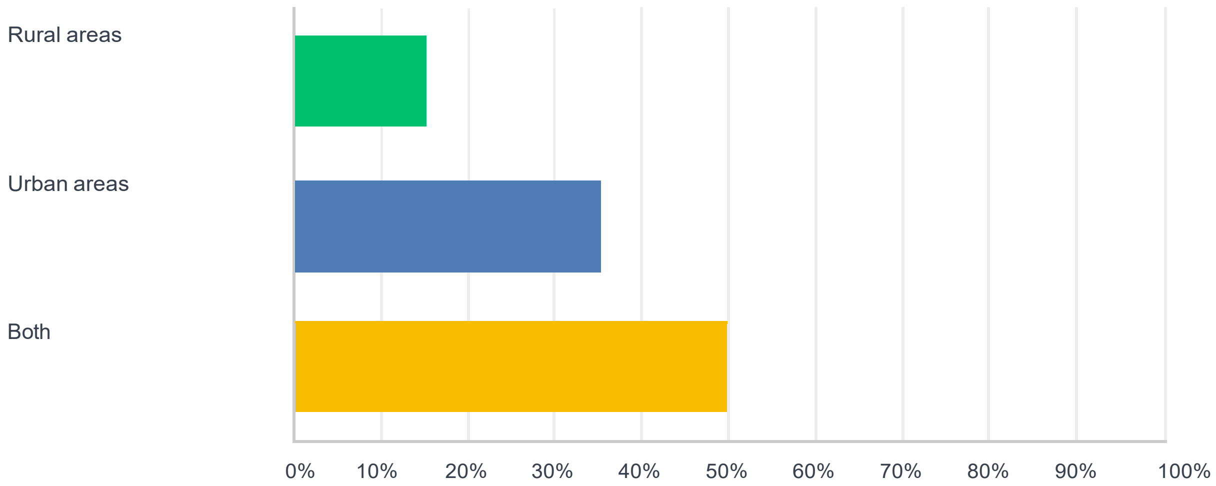
ANSWER CHOICES	RESPONSES	
1-100	50.38%	67
101-250	15.79%	21
251-500	11.28%	15
501-1,000	11.28%	15
1,000+	11.28%	15
TOTAL		133



ANSWER CHOICES	RESPONSES	
Under 1,000	85.11%	120
1,001- 5,000	12.06%	17
5,001-10,000	0.71%	1
10,001-50,000	1.42%	2
50,001-100,000	0.00%	0
100,001 - 500,000	0.71%	1
Over 500,001	0.00%	0
TOTAL		141



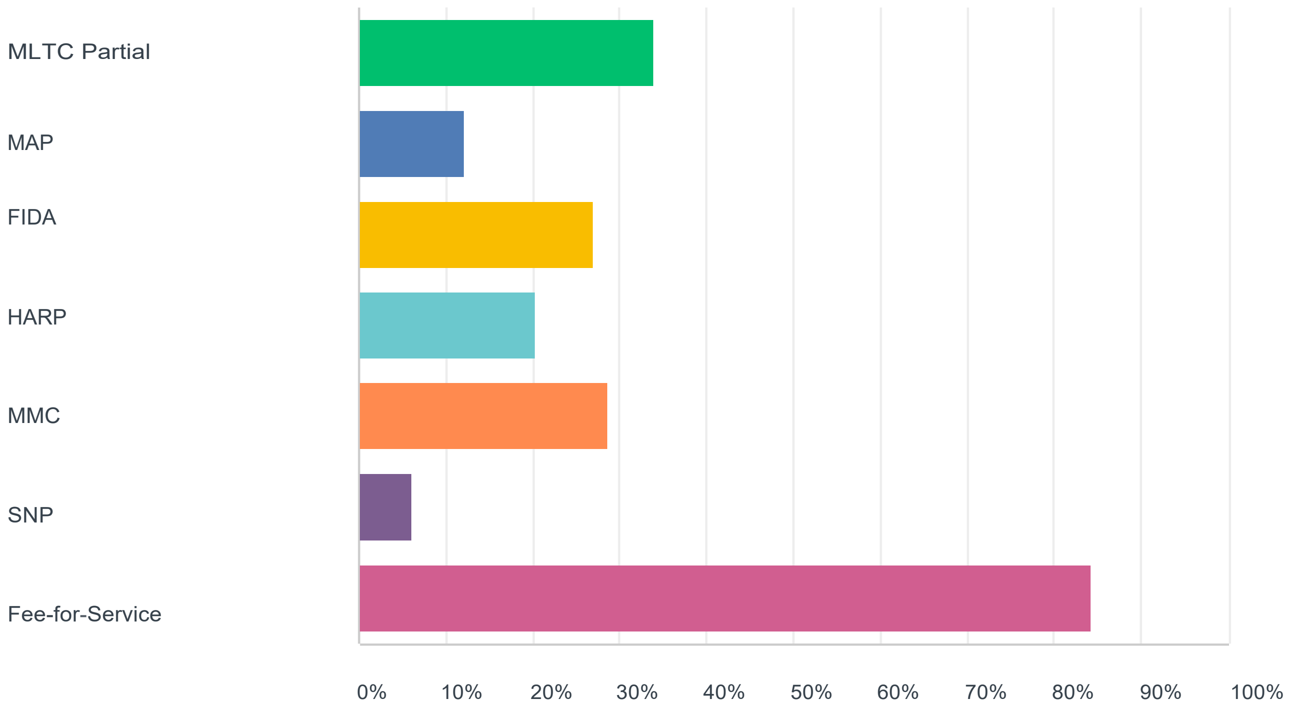
ANSWER CHOICES	RESPONSES	
Under $50,000	8.63%	12
$50,001 - $100,000	5.04%	7
$100,001 - $500,000	15.11%	21
$500,001 - $1,000,000	9.35%	13
Over $1,000,000	61.87%	86
TOTAL		139



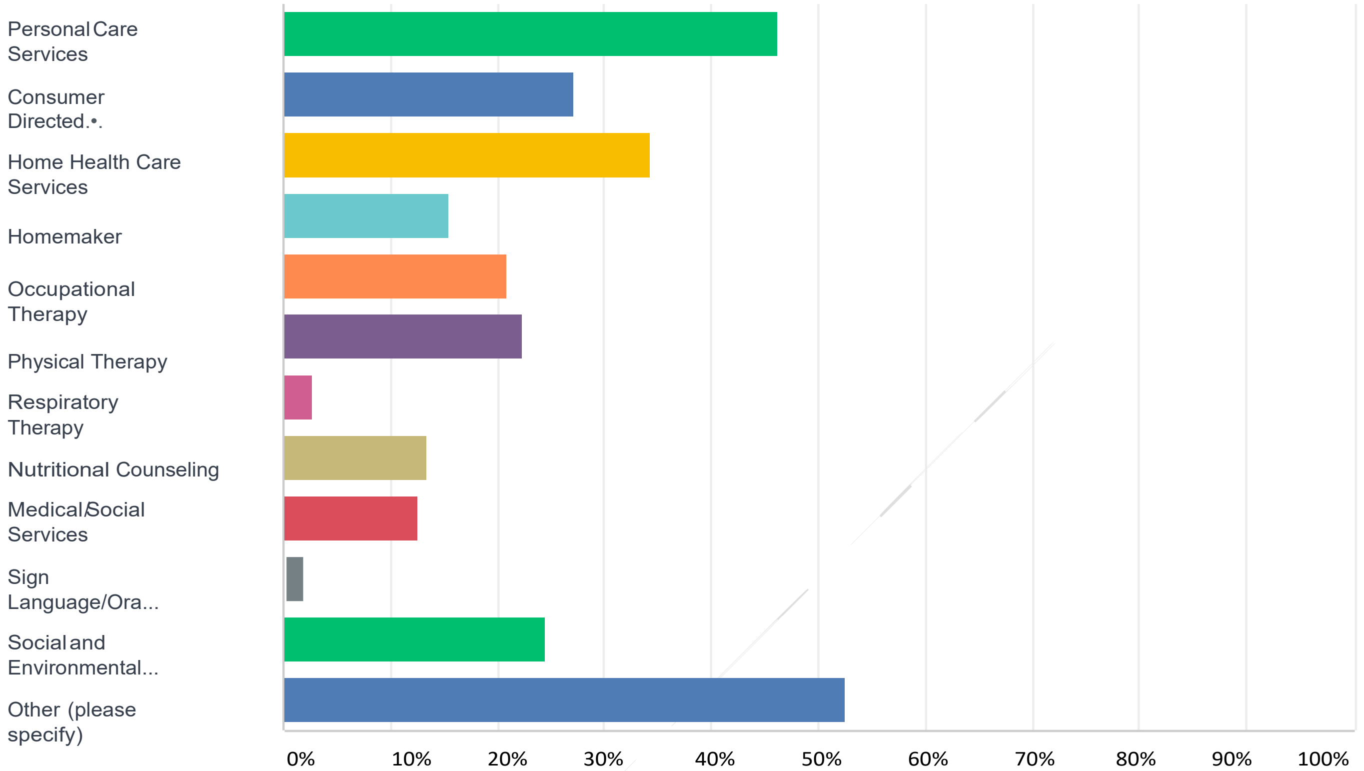
ANSWER CHOICES	RESPONSES	
Rural areas	15.28%	22
Urban areas	35.42%	51
Both	49.31%	71
TOTAL		144

Q8: What Medicaid Managed Care product(s) does your organization contract with? (Select all that apply)

Answered: 133 Skipped: 13



ANSWER CHOICES	RESPONSES	
MLTC Partial	33.83%	45
MAP	12.03%	16
FIDA	27.07%	36
HARP	20.30%	27
MMC	28.57%	38
SNP	6.02%	8
Fee-for-Service	84.21%	112
Total Respondents: 133		

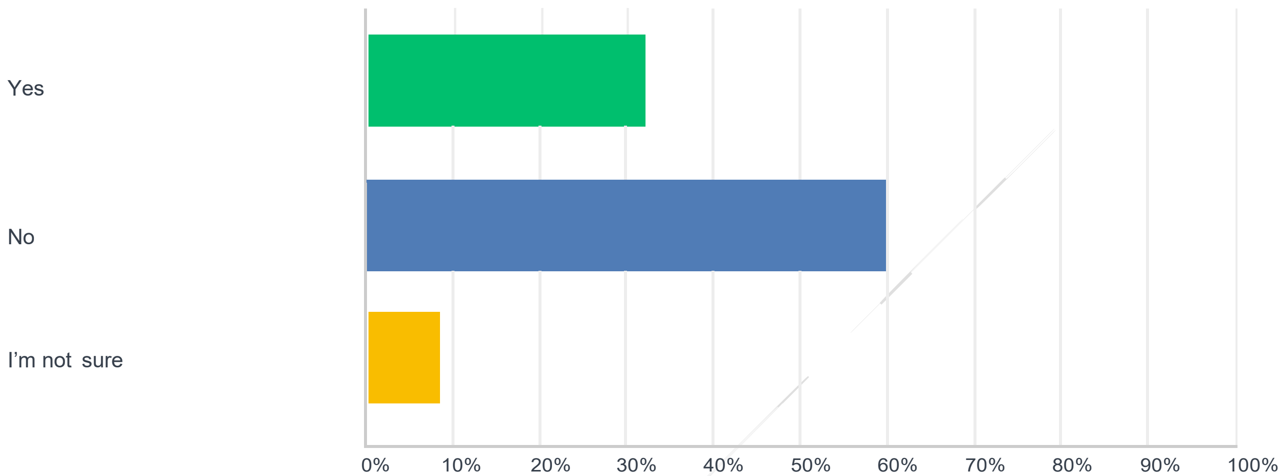


ANSWER CHOICES	RESPONSES	
Personal Care Services	46.15%	66
Consumer Directed Personal Assistance	27.27%	39
Home Health Care Services	34.27%	49
Homemaker	15.38%	22
Occupational Therapy	20.98%	30
Physical Therapy	22.38%	32
Respiratory Therapy	2.80%	4
Nutritional Counseling	13.29%	19

Medical Social Services	12.59%	18
Sign Language/Oral Interpreter	2.10%	3
Social and Environmental Supports	24.48%	35
Other (please specify)	52.45%	75
Total Respondents: 143		

Q10: An EVV system electronically verifies: the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends. Do you/your organization currently use an EVV program that meets this definition? (If No, skip to question #14)

Answered: 144 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes	31.94%	46
No	59.72%	86
I'm not sure	8.33%	12
TOTAL		144

Q11: If you/your organization currently uses an EVV program, please provide the name of the vendor.

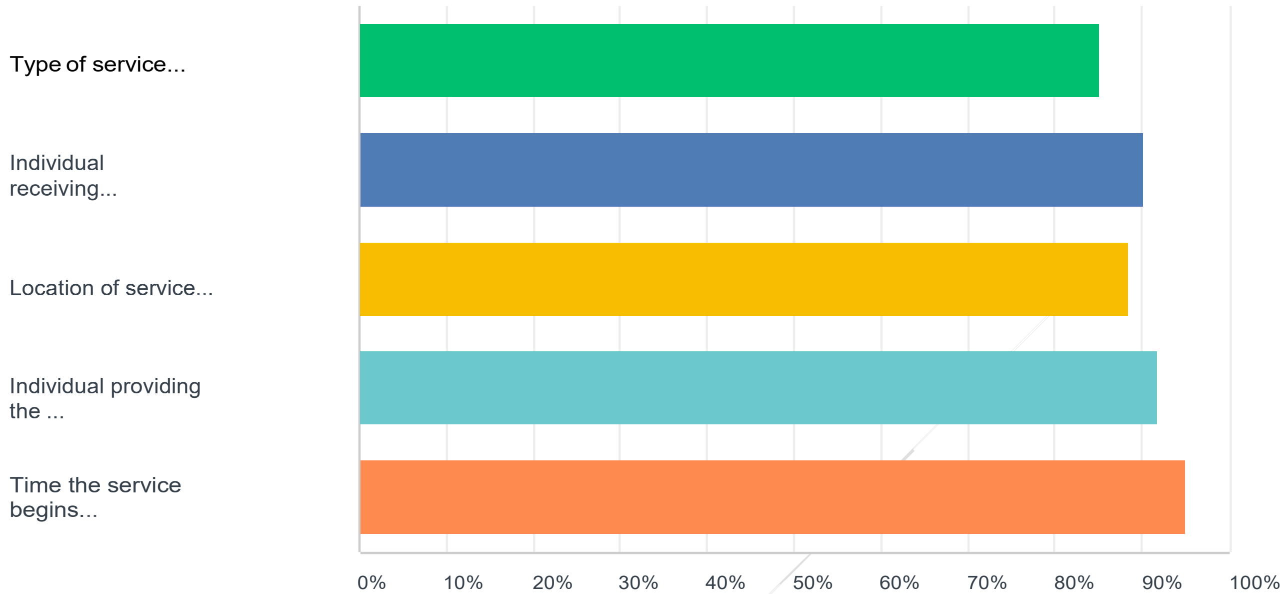
Answered: 52 Skipped: 94

Vendors that organizations are currently using include:

- Accumedic
- Accupoint
- ADP
- AxisCare
- CareWatch
- Cell Trak
- Chronotek
- Clear Care Inc.
- eVero
- HHA Exchange
- HomeCare Homebase
- Netsmart Technologies
- Precision Care
- Provider Soft
- Riversoft
- Sandata
- Therap Services

Q12: What data elements are collected by your organization's EVV program or similar program? (Select all that apply)

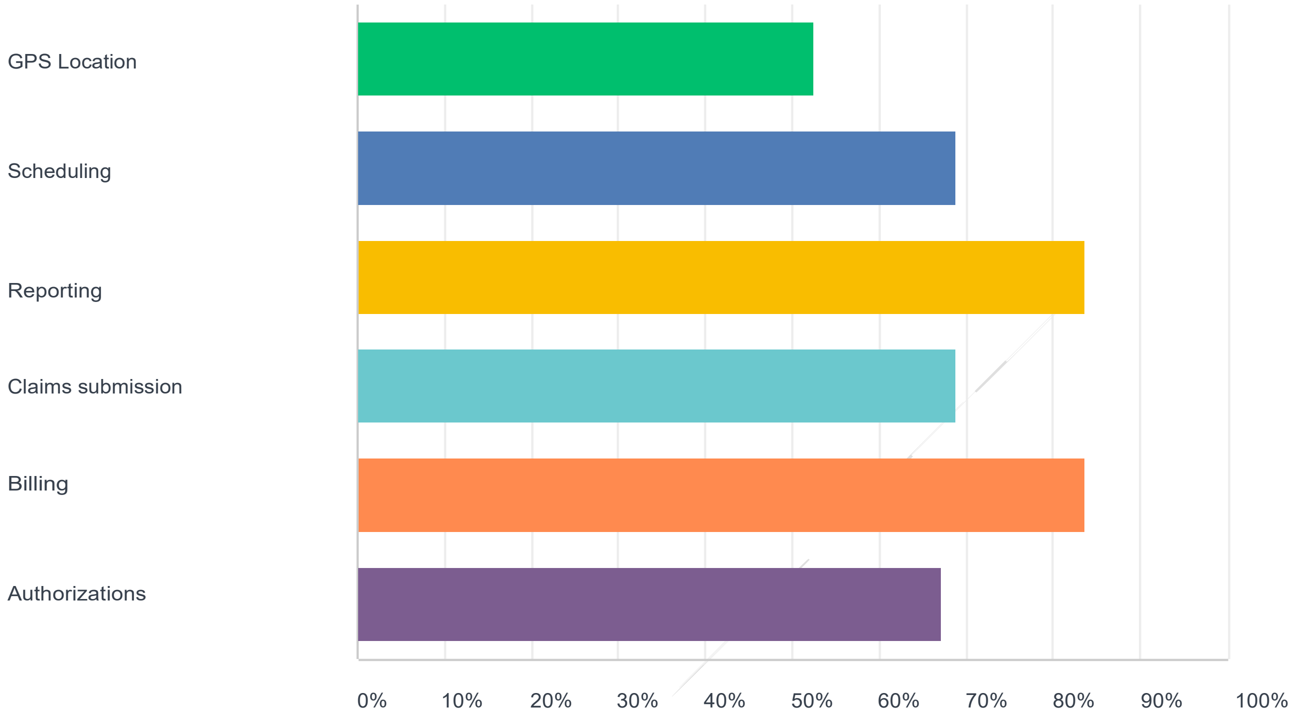
Answered: 61 Skipped: 85



ANSWER CHOICES	RESPONSES	
Type of service performed	85.25%	52
Individual receiving services	90.16%	55
Location of service delivery	88.52%	54
Individual providing the service	91.80%	56
Time the service begins and ends	95.08%	58
Total Respondents: 61		

Q13: What functionality does your organization's EVV program or similar program have? (Select all that apply)

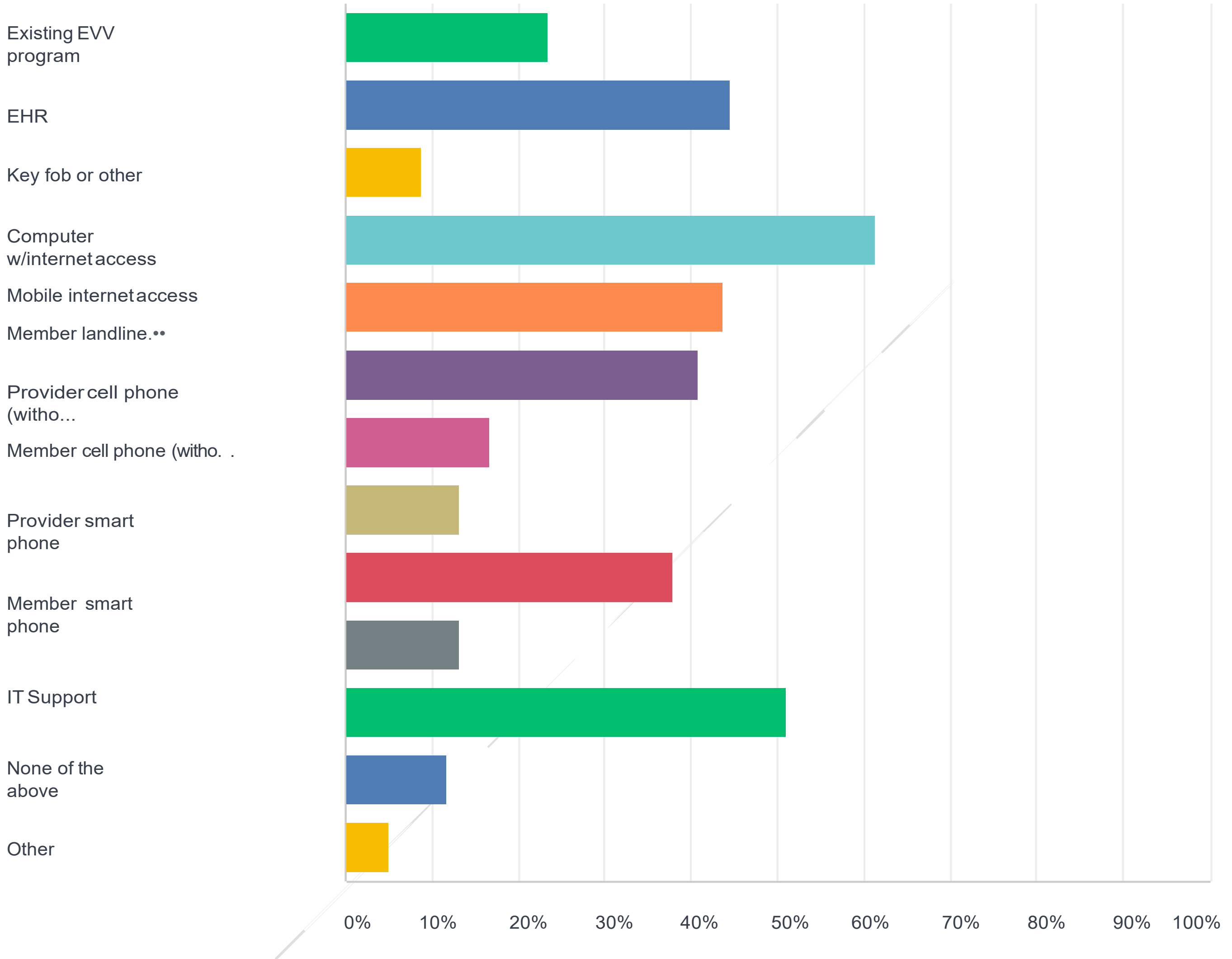
Answered: 61 Skipped: 85



ANSWER CHOICES	RESPONSES	
GPS Location	52.46%	32
Scheduling	68.85%	42
Reporting	83.61%	51
Claims submission	68.85%	42
Billing	83.61%	51
Authorizations	67.21%	41
Total Respondents: 61		

Q14: What existing infrastructure do you/your organization have in place to support an EVV program? (Select all that apply)

Answered: 137 Skipped: 9



ANSWER CHOICES	RESPONSES	
Existing EVV program	23.36%	32
Electronic Health Record program	44.53%	61
Key fob or other in-home GPS logging device	8.76%	12
Computer with internet access	61.31%	84
Mobile internet access	43.80%	60
Member landline telephone	40.88%	56
Provider cell phone (without smart phone capabilities)	16.79%	23
Member cell phone (without smart phone capabilities)	13.14%	18
Provider smart phone	37.96%	52

Member smart phone	13.14%	18
IT Support	51.09%	70
None of the above	11.68%	16
Other (please specify)	5.11%	7
Total Respondents: 137		