National
MLTSS
Health Plan Association

September 2026

Dear Center for Medicaid and CHIP (CMCS) staff,

The National MLTSS Health Plan Association (MLTSS Association) greatly appreciated the opportunity to participate in CMS' Listening Session on Electronic Visit Verification (EVV), held on September 3rd, 2026. During this call, our member representatives, as well as representatives from other Medicaid trade associations, had the opportunity to respond to specific CMS questions about EVV. As the leading organization representing health plans that contract with states to provide managed long-term services and supports (MLTSS) through the Medicaid program, we are uniquely positioned to provide feedback on the nuances of the use of EVV in MLTSS, and we offer specific recommendations below. We welcome further engagement with CMS on this important topic.

Recommendations to Improve the Effectiveness of EVV in Medicaid HCBS

1. **Create a Federal definition of a compliant EVV claim.**
   Because compliance standards differ significantly across states, there is a need for clearer federal definitions of what constitutes a compliant claim. Clearer definitions would make compliance rates comparable across states, reduce the administrative burden on multi-state plans, and give CMS a consistent baseline. This definition should allow flexibility for state-specific requirements (such as state Medicaid programs, labor laws, self-directed models, etc.) Standardized fraud-risk indicators (including overlapping shifts, unusually high caregiver utilization, and geographically impossible visits) would be particularly valuable as data elements. Compliance standards should also require compliant claim for payment and allow payment denial for noncompliant claims. Overall, this definition should prioritize the quality and usability of the data collected, as opposed to adding more data elements.

2. **Create a Federal standard for provider compliance and for manual EVV edits and entries.**
   Currently, most states do not set their own time limits for providers to manually create or edit EVV entries, and default to the timely filing guidelines which can be up to 365 days after the service occurs. We recommend that CMS establish a 30-day limit for manual EVV entries and edits. In addition, many states do not have a minimum standard for provider compliance with utilizing EVV. We recommend that CMS establish a minimum standard of 75% compliance.

3. **Develop guidance and best practices for EVV exceptions.**
   When a service is delivered in good faith, but a technical glitch prevents proper EVV documentation, there is no consistent national process for handling the exception. CMS should develop clearer guidance on EVV exception handling, so states, plans, and providers have a more consistent operational framework. Guidance should address standard exception categories, timeframes for correction, documentation requirements, thresholds for acceptable manual edits, and when exceptions may still support payment.

4. **Require a National Caregiver Unique Identifier for direct care workers/caregivers.**
   Inconsistent worker identification across states and systems weakens EVV's ability to detect duplicate billing and cross-plan fraud and limits broader program-integrity and workforce-tracking efforts. CMS should work with stakeholders to develop a consistent national caregiver identifier, including a mechanism to flag whether a caregiver lives in the same household as the member. This approach would help to address instances of caregivers billing using multiple names or working for two different plans and providing services at the same time for two different clients, thereby strengthening program integrity and workforce tracking efforts.

5. **Move EVV beyond confirming a visit occurred — validate that authorized care was actually delivered.**
   Current EVV data (time, date, location, service type, who delivered/received care) confirms only that a visit happened, not whether the services matched the member's authorized care plan. Services delivered should be matched to an individual's person-centered service plan to provide meaningful documentation to validate services rendered, support FWA investigations, and identify situations in which a visit occurred but the authorized care was not actually delivered. Most EVV vendors have the capability to record the activities provided during a service visit. CMS should build on existing EVV minimum standards so the data can also validate that the billed service aligns with authorization, eligibility, caregiver identity, service type, and expected duration, without overcomplicating access.

6. **Require real-time (or near-real-time) transmission of visit-level EVV data to health plans.**
   Visit-level EVV data isn't always transmitted to MCOs in real time, which limits plans' ability to do pre-payment validation and catch outliers before claims are paid. CMS should require real-time or near-real-time transmission of complete visit-level data so plans can match EVV records to claims and authorizations before payment, where state design permits MCO involvement in that function. The document should also acknowledge more explicitly that prepayment validation does not occur uniformly because state operating models differ. In some states, plans do not control the relevant claims flow or do not receive complete EVV data in time to act before payment. In others, the state performs the validation step directly. As a result, absence of plan-level prepayment validation should not always be interpreted as an MCO operational gap.

7. **Support matching EVV data against eligibility, institutional stay, and other program data to identify services billed when members were unavailable to receive care.**
   Health plans are currently doing this work, in some instances manually, but can leverage reports to identify these areas of risk.

8. **Require preventative controls at the state aggregator level. State aggregators should compile and trend data to better support linking EVV with claims, care management, remote-technology, and critical incident data.**
   EVV data currently sits in a silo. CMS should require state aggregators to validate that visit identifiers are unique and are not reused across members, providers, services, or claims. They should also identify overlapping visits, impossible travel, duplicate service intervals, and billed units exceeding verified visit

duration before returning a compliant response. The aggregator should also analyze visit data across MCOs in the state to flag visits that have either the same member receiving services from multiple providers agencies at the same time, or the same caregiver in multiple home at the same time. Because the aggregator assigns and maintains the visit record, and has access to data across health plans, it is in the best position to prevent a questionable visit from supporting payment rather than relying on each health plan to identify the issue retrospectively.

States should also be required to compile and trend EVV data across MCOs, fee-for-service, and state agencies, and provide technical assistance to states on streamlining EVV data alongside remote-technology-generated data and critical-incident reporting — enabling a fuller picture of service delivery and safety outcomes, not just billing compliance.

9. **Study and standardize EVV enforcement across states, including limiting prolonged "soft launch" periods.** State-by-state EVV enforcement is inconsistent — exception handling, manual edits, live-in caregiver exemptions, and "soft go-live" grace periods vary widely, and prolonged soft-launch periods (during which plans must still pay non-compliant claims) weaken provider accountability. Where providers continue to be paid despite unresolved EVV noncompliance, or where soft-launch periods are prolonged, provider accountability weakens and compliance improvement slows. CMS should study state EVV enforcement approaches and identify best practices that balance accountability, operational feasibility, and provider burden.

10. **Establish CMS-led EVV technical assistance, training, stakeholder engagement, and best-practice dissemination.**
We support CMS developing guidance and stakeholder toolkits that can help states, plans, and other program partners implement services in a timely, appropriate, and consistent manner. We also recommend that CMS establish stronger national training and certification requirements for EVV to ensure that providers understand the importance of and how to use EVV systems accurately that utilize multichannel training modules (i.e. webinars, in-person trainings, etc.). Finally, we recommend that CMS create a national workgroup comprised of individuals with disabilities, older adults, caregivers, MLTSS health plans, and other stakeholders. This workgroup can provide recommendations to further the use and impact of EVV nationwide.

11. **Develop Model Contract Language for State EVV Contracting**:
We encourage CMS to consider creating model contract language and technical specifications to help states procure full scope of EVV capabilities and supports, including:
    - provider network onboarding, registration and support
    - member and authorization management
    - EVV visit verification and exception management, claims validation and conflict management
    - data integration, and reporting and analytics (not just time and attendance but conflict management capabilities)

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State Best Practice Examples

- **Pennsylvania**, **New York**, **Arkansas** and **Texas** are examples of states that already have EVV compliance standards above 75% and may serve as best practices for other states.
- **Texas** has implemented limited pre-payment checks at the state level. The state checks to see if the billed units of service match a valid EVV entry before sending it to the MCO to pay.
- **Pennsylvania** may act as a starting point for research into EVV best practices. MCOs in Pennsylvania have worked together to align on provider compliance standards, including agreeing not to enroll non-compliant providers.
- **Virginia** may be cited as an example of EVV working more effectively where plans are better positioned to use EVV data for provider oversight, compliance monitoring, and payment integrity operations. This supports the broader point that EVV works best when plans have actionable access to data and the ability to operationalize it.
- **Illinois** is a useful example of a state structure as it limits MCO-level prepayment validation because the state processes claims. For that reason, limited plan-level validation in Illinois is not an MCO best-practice gap; it reflects state design and workflow. This state-level variation in processes is important context when assessing why validation is not occurring uniformly across states.
- In **Ohio** and **Indiana**, the state performs EVV pre-validation and provides approval for MCO payment. These states are examples of validation occurring at the state level instead of the MCO level.

The MLTSS Association greatly appreciates the opportunity to provide these recommendations on EVV. When operationalized correctly, EVV can help identify missed services, repeated late visits, incomplete visits, and patterns of unmet need, all of which help to strengthen program integrity as well as ensure that individuals receive the care they need. We welcome the opportunity to continue to collaborate with CMS on this critical issue.

If you have any questions, please feel free to contact me at mkaschak@mltss.org.

Sincerely,



Mary Kaschak
Chief Executive Officer