

## Electronic Visit Verification Technologies

*Solutions to help reduce Fraud, Waste and Abuse and increase visibility*



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# Solution Overview

For over 36 years, Sandata has been and remains 100% focused on delivering solutions for the home care industry. Sandata's core focus is innovation in technology to support all key stakeholders in home care. Where many of our competitors focus only on single components of the home care and/or government markets, Sandata is the only company that provides solutions and value for all of the constituents in the home care continuum including recipients, caregivers, home care providers and payers.

Sandata's comprehensive solution suite benefits all stakeholders in the HCBS continuum.

**Recipients: Sandata maximizes the value of every in-home touch via:**

- Supporting Plan of Care connection and verification;
- Triggering pre-emptive alerts for recipient condition changes;
- Supporting fulfillment of 'care alerts' or 'gaps in care';
- Facilitating comprehensive care that includes personal and clinical services; and
- Ensuring the Five Rights of Care™ - the right recipient, the right caregiver, the right services, the right location, and the right time.

**Providers: Sandata maximizes the efficiency of home care providers via:**

- Offering all-payer, multi-state solutions supporting comprehensive business models;
- Creating efficient management processes for clinical and non-clinical services;
- Reducing paper and administrative overhead through the implementation of automated workflows and best practices; and
- Supporting staff management and credentialing.

**Payers: Through seamless integration, Sandata maximizes connectivity and improves the provider-payer experience via:**

- Supporting care plan integration with automated data feeds;
- Establishing efficient methods for accurate, streamlined bilateral financial transactions including billing and payment;
- Supporting provider network profiling and best practices; and
- Providing impact analysis to reduce fraud while maximizing savings and health outcomes.

Sandata's Electronic Visit Verification technology suite can be deployed quickly and easily on a statewide scale. Once live, our technology immediately begins generating savings as demonstrated in our third party outcomes studies.

Sandata offers a flexible and configurable set of solution modules designed to help payers create a personalized program that meets the needs of all stakeholders. Each component of our recommended suite of solutions is described in detail below.

1. **Electronic Visit Verification™** - multiple technology options to capture caregiver time and tasks at the point of care in near real-time;
2. **Agency Management** - a powerful scheduling and billing engine designed to maximize efficiency for providers;
3. **Claims Validation** - validates claims data against authorizations and EVV-captured data before claims are submitted and adjudicated;
4. **Reporting**, including Standard, Jurisdictional Views, and Data Extracts – detailed reporting and near-real time oversight over service delivery for the Payer’s entire network.

## ELECTRONIC VISIT VERIFICATION

EVV is the keystone of the solution and allows for remote collection of HCBS visit data improving accuracy and processing timeframes that are often caused by human error associated with manual paper processes. The data that is collected is available in near-real time for analysis and reporting. Our powerful combination of patented solutions for visit verification is called our Assured Coverage™ program and includes:

- Telephone Visit Verification™ (“TVV™”) – TVV uses Automatic Number Identification (“ANI”) technology to validate telephone calls to log in and log out, recording time and location and tasks performed in near real time.
- Mobile Visit Verification™ (“MVV”) – near real time GPS technology, verifying caregiver location and visits via GPS enabled devices (mobile phones and tablets).
- Fixed Visit Verification™ (“FVV™”) - patented technology to verify visits when no landline or cellular service is available. Caregivers press a button for a system generated number at the start and end of each visit. The number is then entered into the EVV system when a phone line is available and translated to an exact date and time stamp for the visit.

### Telephone Based Solution



- Uses ANI to match caller’s phone number to EVV database

### Mobile Visit Verification



- Triangulates location using GPS
- Available for Tablets or Smartphones

### Patented Fixed Visit Verification Device



- Device which allows for a disconnected check in/check out process

Through our "Assured Coverage" Program, Alaska DHSS can feel confident that multiple technologies ensure visit verification is occurring at the point-of-care; helping to guard against allegations of fraud and abuse, while improving care. Sandata works with each payer

hand in hand to provide the right set of visit verification technologies to meet the specific needs of your home care programs.

## AGENCY MANAGEMENT

Agency Management is software for home care scheduling and billing, used by the providers to manage their business. Sandata offers flexible options to incorporate advanced, automated scheduling and billing tools for home care providers. Scheduling and billing functionality options include:



- *Santrax® Agency Management* – our Agency Management system is proven to improve accuracy in both the delivery of service as well as the billing for those services, ensuring higher standards of care delivery, program and cost efficiencies, and transparency among all stakeholders in the chain of care (See detailed description below); or
- *Third-Party Agency Management Integration* – an optional integration of EVV data with third-party scheduling and billing vendors.

Our Santrax Agency Management module is a powerful billing and scheduling engine designed to maximize efficiency for providers. Santrax Agency Management incorporates creation of schedules from authorizations with real time validation. The Advanced Scheduling Module provides proximity and attributes searching, with real-time validation of staff compliance. Schedules can be viewed in a calendar, weekly or detailed format. A configurable alert system provides enhanced visibility and compliance tracking for administrators of schedule variances.

## CLAIMS VALIDATION

Unfortunately, billing errors and fraud are widespread in home care. Millions of dollars are lost through fraud, waste and abuse. One of the most powerful tools available to combat billing fraud is claims validation. With claims validation, the only claims that are paid are claims that are supported with or linked to properly validated visits. Sandata offers multiple processes that ensure a claim is valid and matches against EVV data. Claims validation options include:



- *Pre Submission Claims Validation* – our fully integrated EVV-Agency Management system automates the remote acquisition of service data, the processing of service data against authorizations, and the automatic generation of 837 claims for those



services that match the submission criteria as defined by the Department. This ensures that any claim that is submitted has proper visit verification, meets the requirements of the authorization and is directly submitted as a clean claim to the payer (described in detail below).

- *Post Submission Claims Validation* – for Agencies that have their own Agency Management and Billing process, integration of EVV visit data with Payer’s claims adjudication systems.

Sandata’s integrated Agency Management solution includes our comprehensive claims validation process; ensuring the only claims that are transmitted for payment are clean claims (claims that have been verified against the authorization as well as matched to a properly electronically verified visit). Providers generate electronic billing files once the visit is properly verified. Electronic 837 claims files are transmitted directly to the Payer for adjudication and payment. This reduces the number of incorrect claims that get to the Payer, putting the burden on the Provider to bill correctly the first time. The result is less work effort for all and improved accuracy in billing.

Figure 1 provides a visual representation of the end to end solution set available for payers.



**Figure 1: Sandata provides an end-to-end solution to control costs and manage care for HCBS Members.**

# Value Proposition

Sandata assists the Payer by providing innovative, cost effective, and time savings solutions for improving the accuracy, quality and oversight of HCBS waiver programs. The table below summarizes the benefits of implementing Santrax Payer Management.

Detailed Value Proposition	
Issue	Santrax Payer Management
<b><i>Maintaining HCBS Program Information</i></b>	<ul style="list-style-type: none"> <li>Automatically collects, stores, and maintains HCBS visit data from the point of care;</li> <li>Helps to ensure the integrity of visit information by reducing manual data entry/paper forms;</li> <li>Ensures all visits match an authorization; and</li> <li>Allows for direct transmission of data (members, providers, authorizations, claims) between EVV system and Payer</li> </ul>
<b><i>Fraud, waste and abuse</i></b>	<ul style="list-style-type: none"> <li>Helps to ensure that only visits electronically verified against authorized services and limits are paid, mitigating the potential for fraudulent claims and reducing the workload for claims adjudicators and program integrity staff;</li> <li>Supports existing program integrity resources through the ability to efficiently audit and investigate service records via jurisdictional oversight and reporting; and</li> <li>Provides accountability and additional controls for HCBS agency and self-directed programs – high risk areas for fraud, waste and abuse.</li> </ul>
<b><i>Quality of Care</i></b>	<ul style="list-style-type: none"> <li>Supports HCBS members through improved coordination, monitoring, and management of service delivery;</li> <li>Allows for provider oversight and compliance and supports provider/member auditing via Jurisdictional Views;</li> <li>Provides real-time alerts to provider agencies for late or missed visits that can be immediately addressed by home care agency management improving the client experience and allowing members to safely remain in their homes; and</li> <li>Ensures visits are happening as expected and that members are receiving care as authorized - reducing gaps in care.</li> </ul>
<b><i>Claims Processing</i></b>	<ul style="list-style-type: none"> <li>Helps to expedite the claims submission–payment cycle resulting in improved provider satisfaction; and</li> <li>Helps to prevent the submission of services that do not match the authorization and have not been properly verified.</li> </ul>
<b><i>Data Quality, Analytics, and Availability</i></b>	<ul style="list-style-type: none"> <li>Provides access to real time home care service delivery data, monitoring tools, and comprehensive reporting on utilization giving care coordinators / administrative stakeholders full oversight to ensure the quality of your HCBS Programs, improve service delivery and monitor agency trends; and</li> </ul>

Detailed Value Proposition	
	<ul style="list-style-type: none"> <li>Provides a tool for payers to manage and compare provider agencies and establish benchmarks for care delivery to implement Pay for Performance (P4P) programs and/or assess penalties thus improving the overall quality of the program.</li> </ul>
<b><i>Budget Neutrality</i></b>	<ul style="list-style-type: none"> <li>Automates manual and paper-based processes, removing potential human error or time sheet 'rounding' by caregivers, thus reducing overall claims cost; and</li> <li>Reduces claims costs through automated visit validation, increased efficiencies, and the application of consistent business rules (e.g. payment rounding rules) across provider networks.</li> </ul>



# Outcomes

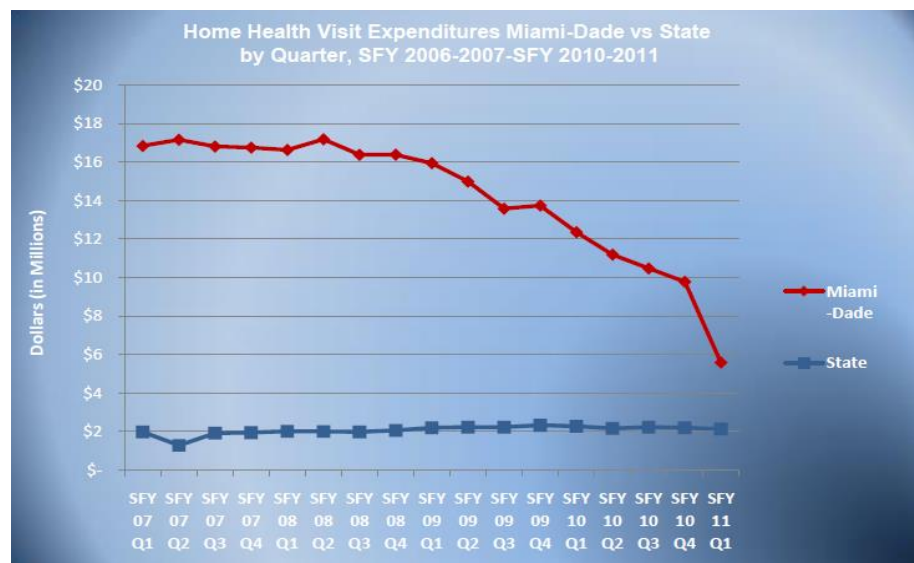
Sandata can provide **proven, independent, third-party** outcomes for customers who use our solution sets. We have summarized our outcomes below and included Appendix A which has more detailed information about outcomes from our deployments.

## FLORIDA'S AGENCY FOR HEALTH CARE ADMINISTRATION

In 2009, the Florida Legislature passed Senate Bill 1986, which authorized the Agency for Health Care Administration to implement pilot projects in Miami-Dade Payer to prevent the overutilization of home care services and to control, verify and monitor the delivery of home care services. The state issued an RFP on December 7, 2009, which was subsequently awarded to Sandata. The program launched March 1, 2010, on schedule. The state expanded the program statewide for additional services; the expansion launched October 1, 2012, on time and on budget.

### Results

The program reduced claims costs by \$5M in the first seven months of operation, representing a 50% drop in claims volume as shown in Figure 2.



**Figure 2: Miami-Dade realized a 50% drop in claims volume and \$5M reduction in claims cost in less than a year.**

For more details on AHCA's study, the complete report can be found by clicking on this link: [Florida DMV Report](#).

Further, the 2011 Annual report of Florida's Medicaid and Public Assistance Strike Force Report states that AHCA reported a decrease of 50% in claims paid for home care visits in

SFY 2010-2011 when compared to the prior year and that the program also resulted in a reduction in home care visits by 51% during the same time period.

The second evaluation year, 2012, fared just as well. According to the 2012 Strike Force Annual Report, year two of the Delivery Monitoring and Verification (“DMV”) program is expected to have generated substantial additional savings for Medicaid expenditure in Miami-Dade Payer. Preliminary statistics show that ***the dollar amount of claims paid in year two of the program was 15% lower than in year one, resulting in an estimated additional savings of \$3.5M. The second year’s savings are in addition to the \$19M cost reduction achieved in the programs first year.***<sup>1</sup>

### TEXAS DEPARTMENT OF AGING AND DISABILITY SERVICES (“DADS”)

On March 1, 2011, the Texas DADS launched a pilot program for EVV in Region 9. The program has since expanded and over 700 Texas providers use Sandata’s EVV solution.

#### Results

Results showed the following:

- 5% - 7.75% gross savings in the first four months of operations;
- 5% decrease in hours delivered to authorized hours; and
- 3.6% net savings.

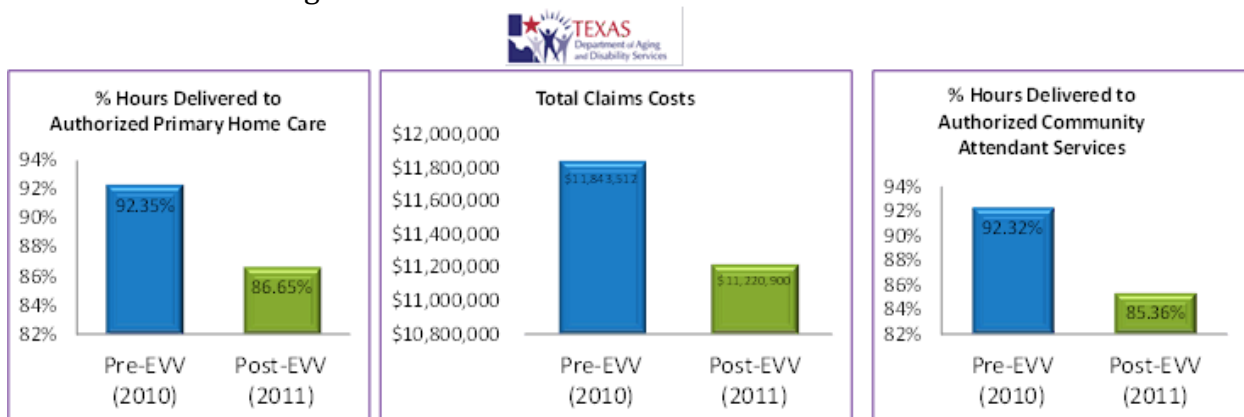


Figure 3: Outcomes from the Texas Department of Aging and Disability Services.

### TENNCARE PROGRAM

As Tennessee moved their Medicaid members to Managed Care, TennCare required their MCOs to choose an EVV Vendor. All three TennCare MCOs independently selected Sandata as their EVV vendor. This is the first and only successful deployment of EVV in a member

<sup>1</sup> Note: AHCA uses Sandata’s fully integrated EVV and Agency Management system, Santrax® Payer Management, which combines EVV, scheduling, payroll and billing in one system.

preferred scheduling environment. Member Preferred scheduling allows the recipients to specify when their visits should start, either through a specific time or a window of time. The MCOs are then required to authorize and ensure that care is delivered at that specific time or liquidated damages are assessed.

Tennessee's EVV program goal was to ensure care was delivered and reduce gaps in care. Analysis of EVV data shows that of the visits that were missed, 32% were successfully made up; preventing gaps in care and ultimately reducing overall claims costs for non-home and community based care and the results below demonstrate the program's success.

## Results

The TennCare MCO EVV program was launched in August 2010. According to their presentation for the National Association of Medicaid Directors on October 29, 2012, TennCare stated that their Electronic Visit Verification system helps ensure fiscal accountability and provides immediate notification/resolution of potential gaps in care. In just two years, TennCare has achieved the following results using Sandata's EVV system:

- 97% of all in-home services scheduled over the last year were provided; of those visits that did not occur as scheduled, the overwhelming majority (roughly 75%) were initiated by the member (not the provider); back-up plans are required in either case; and



**Key Design of MMLTSS**

**TennCare CHOICES**  
in Long-Term Services and Supports

- Began as a legislative initiative:  
*The Long-Term Care Community Choices Act of 2008*
- Integrates LTSS (NF and HCBS for E/D into existing managed care program via 1115 waiver and MCO contract amendments
- Enrollment target for HCBS supports controlled growth while developing sufficient community infrastructure to provide care (persons transitioning from a NF and certain persons at risk of NF placement are exempt)
- Cost and utilization managed via individual benefit limits and individual cost neutrality cap
- Blended capitation payment for physical, behavioral and LTSS (duals/non-duals; LOC)
- MCOs at full risk for all services, including NF (not time-limited)
  - Risk-adjustment for non-LTC rate component rate based on health plan risk assessment scores – John Hopkins ACG Case-Mix System – using MCO encounter data
  - Risk-adjustment for LTC component of the rate based on mix by setting (NF vs. HCBS)
- Consumer directed options for core HCBS using an employer authority model
- Electronic Visit Verification system helps ensure fiscal accountability and provides immediate notification/resolution of potential gaps in care
- State leadership, collaboration, and strong contract requirements are key; CRA available at:  
<http://www.tn.gov/tenncare/forms/middletnmco.pdf>

**TennCare**

**Figure 4: Design of the Managed Care Choices Program by TennCare.**

- > 99.75% of all scheduled in-home services provided over the last year were on time.

## STATE OF OKLAHOMA

In 2008, the Oklahoma Department of Human Services published a study from a pilot of Interactive Voice Response/Authentication using all of Sandata's modules.<sup>1</sup>

### ***Evaluation Methodology***

The pilot analyzed the following measures:

- Service delivery and service reimbursements:
- Service visits per member per month;
- Reimbursed units per member per month;
- Reimbursed units per visit per member per month;
- Total reimbursement per member per month;
- Operational efficiency; and
- Number of lag time days from date of service delivery to date of claim payment.

All measures are based upon MMIS claims paid data records organized by month of service delivery. Measures were assessed for 1,724 unduplicated individuals served by two provider agencies participating in the pilot. Measures were compared for Pre and Post EVV periods during the five-month period immediately prior to EVV introduction and the five-month period of EVV use.

### ***Results***

The EVV pilot produced the following impacts:

- Visits per month declined on average, by 8% (about 1 visit less per month);
- Units reimbursed per visit increased slightly on average, 0.5 more visits per member per month;
- Total reimbursed units decreased;
- Cost per member per month decreased; and
- The average days lag between dates of service delivery to receipt of payment decreased significantly (an average 12-day decrease in lag time per claim payment per month). The provider experiencing the longest payment lag time in the Pre EVV period experienced the greatest improvement in payment lag from Pre to Post EVV representing a decrease of 18 days (almost a 2.5-week improvement in performance).

Based upon these analyses, Oklahoma concluded that ***“the implementation of an EVV system appears to offer potential benefits to providers and to the state. Specifically, providers may benefit from improved efficiency of operation including more timely claims payment from the state.”*** The EVV system provides a verifiable means to assure the public that tax dollars are expended only for services delivered. The EVV system reduced the average number of reimbursed units and thus the average state expenditure per member per month.

# Pricing Proposal

Sandata is pleased to provide pricing information and return on investment analysis per your request. Sandata's solution, and therefore our pricing, is offered in a modular format.

We have included the following sample estimates for your review:

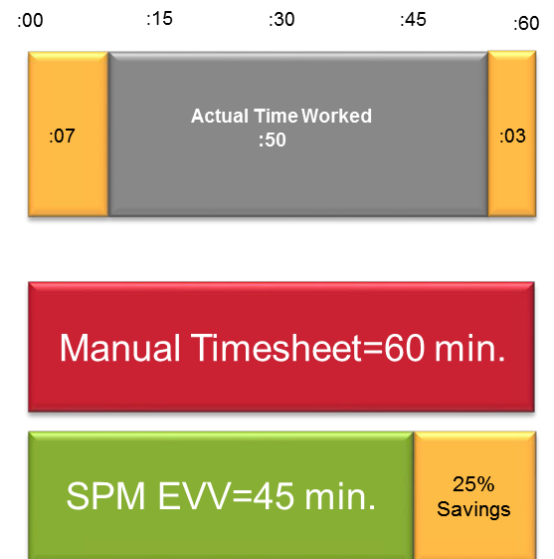
- Personal Care Attendant Pricing Sample and ROI Estimate
- Multiple Program Pricing Sample and ROI Estimate

For the ROI estimates, we are using conservative numbers of 5%, 8% and 12% projected savings. As reflected in the outcomes sections, we have shown savings of 8% to 50% throughout our deployments.

## WHAT DRIVES ROI?

Sandata directly impacts fraud, waste and abuse by capturing and reporting actual time worked by the caregiver. This improved accuracy drives savings as shown below:

- Improved accuracy
  - Direct reporting of time: After working 54 minutes, most people will round up their timesheet to report 60 minutes of work. By removing the provider's ability to "round up", Sandata drives 10% savings for every visit where the provider started late and/or left early.
  - Unit based services using a 7/8 rule: For a schedule of one hour where 45 minutes are actually worked, workers often report a full hour which leads to 4 units billed instead of the 3 units that were actually worked. In this example, restricting the provider to only billing 3 unites instead of 4 results in a 25% savings on every visit where this occurs.
- Fictitious visits cannot be billed as there is no corresponding visit verification;
- Billing limited to proper authorization limits – no overbilling of the authorization is allowed;
- Disciplines are tracked to ensure the proper service level (and appropriate rate) is being billed based on the work delivered (i.e. if a personal care attendant performs the service, the provider cannot bill at a higher RN rate).



**Figure 1: Example of savings by using EVV over manual entry.**

## PRICING SAMPLE – ONE-TIME FEES.<sup>2</sup>

This sample will walk through what a pricing model would look like for an implementation for two different population sets in Alaska. This pricing is broken this down into 3 main sections. The first section will focus on One-Time Fees. The second and third sections will focus on reoccurring transactional fees for PCA only and All HCBS population implementations, respectively. The one-time fee section applies to either model assuming one implementation date. Please note that all sample pricing is based on volume estimates pulled from the Kaiser Family Foundation Website and is for informational purposes only. Actual pricing will vary depending on program specifics and data provided by the Alaska DHSS.

Sample One Time Program Access Fee <sup>2</sup>				
Payer level	Average	Price Input	Quantity	Extended Price
Access Fee (with Agency Management)	\$150,000 - \$300,000	\$150,000	1	\$150,000
Santrax Jurisdictional View		\$50,000	1	\$ 50,000
Pricing Notes				
<b>Access Fee:</b> Fee for utilizing Sandata's SaaS (Software as a Service) solutions and does not include any custom development.				
<b>Technical Implementation:</b> The technical implementation fee includes business rule definition, data exchange configuration and testing, reporting, and system configuration and testing.				
<i>The initial access fee is payable in full upon contract execution.</i>				

Sample One Time Program Implementation Fees <sup>2</sup>				
Payer level	Average	Price Input	Quantity	Extended Price
Technical Implementation	\$150,000 - \$300,000 per program	\$200,000	1	\$200,000
Technical Implementation (Provider deployment per account)	\$330 per provider agency	\$330	100 <sup>3</sup>	\$33,000
Speaker Verification Enrollments (Optional)	\$3.00 per registered caregiver at each provider	\$3.00	TBD	-
Pricing Notes				
<b>Technical Implementation:</b> The technical implementation fee includes business rule definition, data exchange configuration and testing, reporting, and system configuration and testing.				
<b>Per Provider:</b> A per provider account implementation fee for provider Agency Management/EVV database deployment.				
<b>Speaker Verification:</b> One time set up of speaker verification recording.				
<i>All one-time fees are payable 25% at contract signing, 50% at project kick off date, and 25% at project go live.</i>				

<sup>2</sup> All stated numbers are samples; true pricing would be built as part of a proposal process

<sup>3</sup> Forecasted number of providers; true pricing would be built as part of a proposal process



Training				
Training Material Development	\$10,000 per program	\$10,000	1	\$10,000
Instructor-led Train-the-Trainer session	\$7,500 per session	\$7,500	1	\$7,500
Training system set up	\$16,000 per training environment	\$16,000	1	\$16,000
Pricing Notes				
To help ensure the Payer's project success, Sandata's experienced implementation team develops a custom training program to ensure program success. This includes all documentation creation and training environment configuration. Training can be handled a number of ways including: train-the-trainer, classroom sessions, and/or webinars.				

**Total Estimated One-time Fees \$466,500**

### **PRICING SAMPLE 1 –ANNUAL FEES (PCA ONLY) <sup>4</sup>**

The Annual fees are calculated based on total number of visits, and for purposes of this sample, we have forecasted 20 visits per member per month. There is also a yearly access fee.

~Recipients <sup>4</sup>	3,598
~Visits/Month <sup>5</sup>	20

Pricing Sample 1 Annual Fees <sup>1</sup>				
Yearly Service Fees		Price	Quantity	Ext. Price
Yearly Access Fee		\$ 40,000	1	\$40,000
EVV Transaction Fee- Base Fee		\$ 0.12	1,727,040	\$207,245
EVV Transaction Fee – Speaker Verification (Optional)		\$ 0.03	1,727,040	\$51,811

**Total Estimated Annual Fees \$299,056**

<sup>4</sup> All stated numbers are samples; true pricing would be built as part of a proposal process

<sup>4</sup> Kaiser Commission on Medicaid and the Uninsured: Medicaid Home and Community-Based Services Programs: 2012 Data Update

<sup>5</sup> Forecasted visits per month based on typical program volume

## PRICING SAMPLE 2 –ANNUAL FEES (ALL HCBS)<sup>7</sup>

The Annual fees are calculated based on total number of visits, and for purposes of this sample, we have forecasted 20 visits per member per month. There is also a yearly access fee.

PCA	3,598
Home Health	281
I/DD	1,624
Aged	1,819
PD	1,390
Children	270
<b>Totals:</b>	<b>8,982</b>

~ Recipients <sup>8</sup>	8,982
~Visits/Month <sup>9</sup>	20

Pricing Sample 2 Annual Fees				
Yearly Service Fees		Price	Quantity	Ext. Price
Yearly Access Fee		\$ 40,000	1	\$40,000
EVV Transaction Fee – Base Fee		\$ 0.12	4,311,360	\$517,363
EVV Transaction Fee – Speaker Verification (Optional)		\$ 0.03	4,311,360	\$129,341

**Total Estimated Annual Fees     \$686,704**

<sup>7</sup> All stated numbers are samples; true pricing would be built as part of a proposal process

<sup>8</sup> Kaiser Commission on Medicaid and the Uninsured: Medicaid Home and Community-Based Services Programs: 2012 Data Update

<sup>9</sup> Forecasted visits per month based on typical program volume

# Return on Investment

## ROI SAMPLE – PERSONAL CARE ATTENDANT<sup>6</sup>

This first example focuses on the potential savings Alaska DHSS could see using conservative savings calculations and factoring in the costs in Pricing Sample 1. You'll note the ~3,600 recipient population used in the pricing sample as well as the total expenditures for these recipients which is approximately \$92 million dollars.

	Recipients <sup>11</sup>	Expenditures
Personal Care Attendant program	3,598	\$91,921,000

The fees below come directly from Pricing Sample 1 and are first year costs only. Note that after the first year, the ROI increases as only the reoccurring fees continue. ***These fees can also be further reduced using Federal Medical Assistance Percentages at up to 90% for one time fees and up to 75% for reoccurring fees.***

SPM Fees (from Pricing)	
One Time Fees	\$466,500
Reoccurring Fees	\$299,056
<b>Total OTR + Year 1 Fees</b>	<b>\$ 765,556</b>

We have used conservative savings calculations starting off at 5% and netted the fees out of the gross savings to give a net savings and total ROI.

Percentage Savings	Cost Containment		
	5%	8%	12%
<b>Gross Savings</b>	\$ 4,596,050	\$ 7,353,680	\$ 11,030,520
<b>Sandata Fees</b>	\$ 765,556	\$ 765,556	\$ 765,556
<b>Net Savings:</b>	<b>\$ 3,830,494</b>	<b>\$ 6,588,124</b>	<b>\$ 10,264,964</b>
<b>ROI:</b>	5.00	8.61	13.41

As you can see, Alaska DHSS **could see savings from roughly \$4 million to over \$10 million dollars for a cost of roughly \$750,000 dollars** by implementing EVV. After the first year, those costs would drop to a little under \$300,000 dollars a year *before federal matching*.

<sup>6</sup> All stated numbers are samples; true pricing would be built as part of a proposal process

<sup>11</sup> Kaiser Commission on Medicaid and the Uninsured: Medicaid Home and Community-Based Services Programs: 2012 Data Update - Includes Personal Care Participants and Expenditures

## ROI SAMPLE – ALL HCBS<sup>12</sup>

This final example focuses on the potential savings Alaska DHSS could see if implemented for all HCBS populations using conservative savings calculations and factoring in the costs from Pricing Sample 2. You will note the ~9,000 recipient population used in the pricing sample as well as the total expenditures for these recipients which is just over \$300 million dollars.

	Recipients <sup>13</sup>	Expenditures
PCA	3,598	\$91,921,000
Home Health	281	\$319,000
I/DD	1,624	\$117,200,000
Aged	1,819	\$47,393,000
PD	1,390	\$36,365,000
Children	270	\$11,737,000
<b>TOTAL</b>	<b>8,982</b>	<b>\$304,935,000</b>

The fees below come directly from Pricing Sample 2 and are first year costs only. Note that after the first year, the ROI increases as only the reoccurring fees continue. ***These fees can also be further reduced using Federal Medical Assistance Percentages at up to 90% for one time fees and up to 75% for reoccurring fees.***

SPM Fees (from Pricing)	
One Time Fees	\$466,500
Reoccurring Fees	\$686,704
<b>Total OTR + Year 1 Fees</b>	<b>\$ 1,153,204</b>

We have again used conservative savings calculations starting off at 5% and netted the fees out of the gross savings to give a net savings and total ROI.

Percentage Savings	Cost Containment		
	5%	8%	12%
<b>Gross Savings</b>	\$ 15,246,750	\$ 24,394,800	\$ 36,592,200
<b>Sandata Fees</b>	\$ 1,153,204	\$ 1,153,204	\$ 1,153,204
<b>Net savings:</b>	<b>\$ 14,093,546</b>	<b>\$ 23,241,596</b>	<b>\$ 35,438,996</b>
<b>ROI:</b>	12.22	20.15	30.73

<sup>12</sup> All stated numbers are samples; true pricing would be built as part of a proposal process

<sup>13</sup> Kaiser Commission on Medicaid and the Uninsured: Medicaid Home and Community-Based Services Programs: 2012 Data Update - Includes Personal Care, Home Health, and Waiver Participants and Expenditures

As you can see, Alaska DHSS **could see savings from roughly \$14 million to over \$35 million dollars for a cost of roughly \$1.15 million dollars** by implementing EVV. After the first year, those costs would drop to under \$700,000 dollars a year *before federal matching*.

Thank you for the opportunity to provide an overview of our solution as well as sample pricing and ROI information. We look forward to demonstrating our EVV capabilities for you and assisting you with anything you might need as you go through your process!

Sincerely,

A handwritten signature in black ink, appearing to read 'Brian Lawson', with a long horizontal line extending to the right.

Brian Lawson  
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