State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 36 No. 09 **September 2026**

TO: Personal Care Assistance (PCA) and Home Health Services (HHS) provider agencies servicing Managed Care enrollees in the member's home- **For Action**
All Managed Care Organizations (MCOs) – **For Action**

SUBJECT: Electronic Visit Verification (EVV) compliance requirements for all Medicaid/NJ FamilyCare MCO Providers billing for PCA and HHS identified in the EVV mandate of the Federal 21st Century Cures Act.

EFFECTIVE: January 1, 2027

PURPOSE: To notify providers and MCOs regarding minimum EVV compliance requirements as of January 1, 2027.

BACKGROUND: Section 12006(a) of the 21st Century Cures Act for PCA and HHS requires that home health services that are paid by Medicaid/NJ FamilyCare comply with EVV requirements.

Beginning January 1, 2027, providers of PCA and HHS will be required to meet the minimum manual EVV compliance guidelines, as set forth below.

Refer to the DMAHS website https://www.nj.gov/humanservices/dmahs/providers-stakeholders/overview/evv.shtml for DMAHS Newsletters, Fact Sheets, and Provider Training documents.

Since the implementation of the EVV requirement, DMAHS has found that some providers have submitted EVV visits with a high volume of manual edits which raises program integrity concerns. To address these concerns, this Newsletter sets forth minimum requirements that providers must meet to contract with the NJ FamilyCare MCOs for PCA and HHS.

ACTION: Agency providers of PCA and HHS must electronically verify (with no manual edits) a minimum of 80% of the visits that require EVV. **Providers that manually edit or manually confirm over 20% of visits requiring EVV will be considered non-compliant with the 21st Century Cures Act**. Note: DMAHS has identified edit reasons that cannot be avoided when delivering personal care and home health services. These edit reasons will be excluded from the compliance calculation.

Providers will be given an initial three-month period (between October 1, 2026, and December 31, 2026) to comply with the updated requirements. Providers that manually confirm or manually edit more than 20% of visits after the three-month introductory period, on or after January 1, 2027, will be in violation of DMAHS EVV requirements and subject to the following:

1. After one (1) month of non-compliance, the MCOs will advise providers that they are non-compliant with the contract and must meet the minimum standard of less than 20% manual edits to avoid loss of new referrals and remain compliant with contract requirements.
2. After three (3) consecutive months of non-compliance, the MCOs shall stop sending new referrals for PCA and HHS to non-compliant providers.
3. After four (4) and (5) consecutive months of non-compliance, the MCOs may terminate the contracts of non-compliant providers, for cause, for repeated failure to use the EVV system as required in addition to stopping new referrals.
4. After (6) consecutive months the MCO must terminate the provider's contract for cause due to repeated failure to use the EVV system as required.

Providers that are terminated for not complying with EVV requirements will not be eligible for single case agreements or to join the MCO network **for a minimum of a year**. The individual MCOs will identify criteria to secure a contract after the one-year termination period.

Definition of Manual Edit:
There are six (6) elements required for EVV. When any of the six (6) elements below are altered or added, a **Manual Edit Reason** is required to document the edit.

The required EVV data elements for electronic verification are:

1. Type of service performed.
2. Individual receiving the service.
3. Date of the service.
4. Location of service delivery.
5. Individual providing the service; and
6. Time the service begins and ends.

Manual Edit Reason and the identified impact on Provider Compliance:
Providers are required to specify the reason for the manual editing each time one of the six (6) required data elements is modified or manually added to a visit confirmation. If one of the six (6) required data elements of a visit is edited but does not contain one of the reason codes below, the MCO must reject the claim, and the claim shall not be paid. Providers' payment will not be impacted if a Manual Edit reason is specified for the impacted visits and the provider does not exceed the maximum of 20% manual edits.

Edit reasons that DMAHS has identified that cannot be avoided when delivering home health services are noted below with the designation "N," which means that use of these codes does not impact the provider's EVV Compliance rate. Other edit reasons, which are designated with a "Y" in the table below, do impact the provider's EVV compliance rate. Please note all visits with manual edits are subject to further review by the MCOs and DMAHS.

Table 1: Manual Edit Reasons and Impact on Provider Compliance

REASON CODE	REASON	ADDITIONAL DESCRIPTION (IF APPLICABLE)	INCLUDED IN COMPLIANCE CALCULATION (Y/N)
200	Incorrect member phone number.	Phone number did not link to the Member.	Y
202	Members will not let attendant use phone, or member will not allow use of phone.	Member won't let attendant use phones, or member will not allow use of phone.	Y
205	Members' phone line not working (technical issues).	Member's phone line not working (technical issue or natural disaster).	Y
207	Address did not link to the Member (GPS).	Address did not link to the Member (GPS) - Visits where Geofencing errors are triggered based on the service location. For example, housing complexes, buildings, or schools where servicing address cannot be accurately captured.	N
208	Fail to call in.	Attendant failed to call in.	Y
209	Fail to call out.	Attendant failed to call out.	Y
210	Attendants failed to call in and out.	Attendant failed to call in and out - Confirmation received from family or members that services were provided.	Y
211	Attendants called in or out of the EVV system early or late.		Y
215	Fixed location device on order or pending placement in the home.		Y
216	Fixed location device malfunctioned.		Y
217	Attendant unable to use mobile device.		Y
218	Unable to connect to internet.	Caregiver not able to access internet.	Y
219	Data Entry Error		Y
221	Timesheet Received	Caregiver did not clock in but timesheet was used for back-up of manual edit	Y

222	Other	Scenario not captured in any other reason code. **Provider must specify reason in note field when "other" is the reason selected for manual edit. If a note is not specified, the visit will not be eligible for payment.**	Y
223	EPSDT PDN During the School Day	This is to be used only when a caregiver is servicing a member before/after and during school and a manual edit is needed for proper billing.	N
224	Retro- authorization for member issued – member had continuous Medicaid eligibility.	Members who require a retro-authorization- provider shall manually enter visit details until an authorization is received. (Provider must maintain documentation regarding reason for retro-authorization.)	N
225	Retro-authorization- Visits for members that may have a gap in eligibility.	Members who require retro-authorization- providers shall manually enter visit details until an authorization is received. (EMEVS must confirm gap in eligibility.)	N
226	Overlap visits	Visits that include overlaps based on DMAHS policy; however, an error is triggered and the provider must manually edit visit. For example, clock in and clock out results in additional unit and /or error for two staff.	N
227	Overnight visits	Visits that take place overnight (i.e. Shift begins on Sunday and ends on a Monday).	N
228	EVV System not accessible/available.	Attendant not able to access EVV System.	Y

Compliance Calculation:
Below are the details of the calculations that the MCOs will use to determine Provider EVV Compliance.

Description of Column Entries:

A. Provider Name
B. Provider 9 Digit Tax ID (reports will be by Tax ID not NPI)
C. Number of Members Served by Provider (Excluding Live-In)
D. Total Confirmed Visits
E. Total Confirmed visits with exempt manual edit
F. Total Visits to be included in EVV Compliance calculation
G. Number of visits without manual edits
H. EVV Compliance Calculation/Compliance Rate:
   % of Visits for EVV Mandated Services with Matching EVV Not Edited Manually (Column G/Column F)
I. Compliance Status (Y/N)
   Y-Provider meets the 80% compliance threshold
   N-Provider does not meet the 80% compliance threshold

Table 2: Monthly EVV Compliance Calculation Examples (based on date of service)

Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H**	Column I
Provider Name	Provider Tax ID	# of Members Served	Total Confirmed Visits	Total Confirmed Visits with exempt manual edit	Total visits to be included in Manual Edit calculation	Number of visits without manual edits	Manual Edit Calculation/ Compliance Rate	Compliance Status
Provider A	12345679	24	125	25	**100**	**85**	85%	Yes
Provider B	32390340	10	400	50	**350**	**200**	57%	No

Table 2 shows that Provider A is compliant and Provider B is not compliant. Please see detail below showing why Provider B is not compliant.

Provider B Calculation:
Provider B is not compliant with the EVV Compliance requirements because the calculation of manual edits for eligible services (Column G/Column F) is 57% and therefore less than the compliance level of 80%. See below for calculation details:

$$\underbrace{57\%}_{Compliance\ Rate} = \frac{\overbrace{200}^{Visits\ without\ Manual\ Edits}}{\underbrace{400}_{Total\ Visits} - \underbrace{50}_{Visits\ with\ Exempt\ Manual\ Edits}} < \underbrace{80\%}_{Compliance\ Threshold}$$

EVV Compliance will be measured **monthly**, all providers should have manual edits entered and documented for all visits for dates of service (DOS) in the previous (1) month, no later than 7 calendar days after the start of each subsequent month. (example, all visits for January should be finalized and shared no later than February 7th).

Electronic Data Interface (EDI) Providers, who are not using HHAx as their EVV solution should have all visits for DOS in the previous (1) month, shared with the corresponding EVV aggregator no later than 15 calendar days after the start of each subsequent month. (example, all visits for January should be finalized and shared no later than February 15th).

MCO Reporting of Provider EVV Compliance

MCOs will be required to report monthly to DMAHS the **Providers that manually edit or manually confirm that over 20% of visits requiring EVV.** The MCO will specify in their monthly reports the status of the provider based on the criteria below.

Table 3: Impact for providers who are not compliant with EVV requirements

Monthly Compliance Below 80%	Impact on Providers
1st Month	Provider receive notice they are non-compliant
2nd Month	Provider receive notice they are non-compliant for 2 months and will lose new referrals if they remain non-compliant
3rd Month	Stop new Referrals
4th Month	No new Referrals and/or Contract Termination
5th Month	No new Referrals and/or Contract Termination
6th Month	Contract Termination

Providers that are terminated for not complying with EVV requirements will not be eligible for single case agreements or to join the individual MCO network **for a minimum of a year.** The individual MCOs will identify conditions to secure a contract after the one-year termination period.

Bi-annual Service Unit Reconciliation:
On a bi-annual basis MCOs will submit to DMAHS a report outlining claims for service units for EVV-required services. Reimbursed services that do not have a corresponding confirmed visit recorded in the MCO aggregator (CareBridge or HHAeXchange) will be recouped.

Table 4: Paid Service Units comparison with Confirmed Visits Example

A. Provider Name
B. Provider 9 Digit Tax ID
C. Number of Members Served by Provider (Excluding Live-In)
D. Total Number of Service Units that require EVV
E. Total Billable Service Units with corresponding Confirmed Visit
F. Service Units without corresponding Confirmed Visit
G. Amount to be recouped from the Provider

Column A	Column B	Column C	Column D	Column E	Column F	Column G
Provider Name	Provider Tax ID	# of Members Served	Total Service Units that require EVV	Total Billable Service Units with corresponding Confirmed Visit	Service Units without corresponding Confirmed Visit	Amount to be recouped from Provider
Provider A	12345679	24	500	450	50	50 x the cost per unit of service billed
Provider B	23456789	13	180	180	0	0

Table 4 shows that Provider A will have funds recouped for not submitting confirmed visits to the required services. Provider B has submitted confirmed visits for all services and will not be impacted by the quarterly recoupment.

Providers are reminded that documentation to support services rendered and billed must be maintained in addition to EVV compliance.

Resources for Providers

Please visit the DMAHS EVV Website for additional information:
https://www.nj.gov/humanservices/dmahs/providers-stakeholders/overview/evv.shtml

To submit questions or concerns regarding Managed Care EVV, please email DMAHS Provider Relations at MAHS.Provider-Inquiries@dhs.nj.gov. Include copy of communication and/or claim denials from the MCO with your email.

To submit questions or concerns regarding FFS and PPP EVV, email New Jersey's EVV Mailbox at: MAHS.EVV@dhs.nj.gov.

For HHAeXchange provider information, please visit the New Jersey Home Health Information Center website at: https://hhaexchange.com/nj-home-health/.

For providers using a primary EVV system that is not HHAeXchange, refer to the link for the Application Program Interface, (API) specifications located at **API link** for additional details**.**

For CareBridge provider information, please visit the New Jersey specific site at http://resourcelibrary.carebridgehealth.com/njevv.

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