

Health and Human Services Commission
Electronic Visit Verification Initiative
Provider Compliance Plan for Contracted Provider Agencies

Policy

Broad requirements for the use of electronic visit verification (EVV) in the Texas Medicaid program can be found in the Texas Administrative Code (15 TAC §354.1177). The Health and Human Services Commission (HHSC) implemented EVV statewide on the schedule which can be found in Appendix A. The Consumer Directed Services (CDS) option is exempt from the HHSC EVV Initiative Provider Compliance Plan.

Implementation

The HHSC electronic visit verification (EVV) initiative requires provider agencies to use an EVV system to record service delivery visit information. Information is recorded in a computer-based system that interfaces with either a telephone or a small alternative device (SAD) that generates a timestamp code. Providers may manually record or change service visit information, in accordance with policy, by performing visit maintenance in an HHSC-approved EVV system. Provider agencies that are subject to EVV requirements must use an EVV system to document service delivery visits performed in the home or in the community. The provider agency must complete the EVV record, including any visit maintenance, prior to submitting a claim associated with the EVV record. Claims that are not supported by an EVV entry into an EVV system may be denied or subject to recoupment.

Purpose

The EVV initiative:

- Establishes utilization standards for provider agencies to electronically verify visits; and
- Verifies that individuals/members receive the services authorized for their support and for which the state is being billed.

While the HHSC EVV Initiative Provider Compliance Plan has common elements across HHSC, the Department of Aging and Disability Services (DADS), and managed care organizations (MCOs) each of these entities may have other requirements for provider agencies and EVV vendors, according to their individual contracts.

Definitions

Term	Definition
Electronic Visit Verification (EVV)	Documentation and verification of service delivery through an EVV System.
EVV System	A telephone or computer-based system that allows confirmation services were provided to an eligible recipient according to an approved HHSC prior authorization or DADS Plan of Care as defined in HHSC rule; Title 1 TAC §354.117.
EVV Transaction	One of the following transactions in an EVV system: 1. call-in when service delivery begins, and 2. call-out when service delivery ends.
Exceptions	Visits that do not auto verify and require the use of one of more reason codes to clear in the EVV system.
HHSC EVV Initiative Provider Compliance Plan (Compliance Plan)	A set of requirements that establish a standard for EVV usage that must be adhered to by provider agencies under the HHSC EVV initiative.
HHSC EVV Initiative Provider Compliance Plan Grace Period (Grace Period)	A timeframe during which provider agencies must use an EVV system and may, for billing support purposes only, use paper timesheets as backup documentation. Provider agencies that are in a grace period are not subject to liquidated damages, contract actions, or corrective action plan requirements for failing to achieve a compliance plan score of at least 90 percent. However, claims may still be subject to denial or recoupment.
HHSC EVV Initiative Provider Compliance Plan Review Period (Review Period)	A period of time consisting of three consecutive calendar months prior to the review month that occurs at least once within a calendar year or more frequent as determined by the reviewer.
HHSC EVV Initiative Provider (Compliance Plan Score)	A percentage that indicates how often visits are verified through auto-verification and/or using only preferred reason codes for visits that are eligible to be billed during a particular period of time. Scores are calculated by: 1. Adding the number of visits auto-verified to the number of visits verified preferred for a particular period of time; 2. Dividing the sum by the total number of visits verified for the same period of time; and 3. Rounding the resulting number to the nearest whole percent. Compliance Plan Score = (Number of total visits auto-verified + Number of total visits verified preferred) ÷ (Number of total visits verified) rounded to the nearest whole percent.

Payor	Entity provider contracted with to provide EVV targeted services; HHSC, MCO, DADS
Non-Preferred Reason Code	A reason code that documents a change to an EVV visit record that is caused by a situation in which the provider agency staff did not document services in accordance with program and policy requirements.
Preferred Reason Code	A reason code that documents a change to an EVV visit record that is caused by a situation in which the provider agency staff documents services in accordance with program and policy requirements.
Provider/Provider Agency	Service providers that are under contract and are providing covered Medicaid services that are subject to EVV.
Reason Code	A standardized, HHSC-approved three-digit number and description used during visit maintenance to explain the specific reason for a change that was made to an EVV visit record.
Visit Maintenance	The process by which provider agencies can make adjustments in an EVV System to electronically document service delivery visit information as required by HHSC.
Visits Verified	The number of visits that have no exceptions or for which all exceptions have been resolved through visit maintenance in the EVV System. Visits that have been verified are eligible for billing. Visits verified = Number of visits auto-verified + Number of visits verified preferred + Number of visits verified non-preferred.
Visits Auto-Verified	The number of visits that have no exceptions and for which no visit maintenance was required.
Visit Maintenance Lockout	The inability for a provider to complete visit maintenance in an EVV system due to required accurate and complete information not entered into the EVV system
Visits Verified Preferred	The number of visits that have exceptions that were verified through visit maintenance using only preferred reason codes.
Visits Verified Non-Preferred	The number of visits that have exceptions that were verified through visit maintenance using at least one non-preferred reason code.

Grace Period

The HHSC EVV Initiative provides a grace period under the following conditions:

- Provider agencies only receive a single grace period. There is no additional grace period for provider agencies that transition from one EVV vendor to another. In addition, DADS providers only receive a single grace period per contract. Refer to Appendix B for historical grace period timeline.
- Provider agencies should use the grace period to train their staff on how to use the EVV system and how to perform visit maintenance.
- Provider agencies with contracts effective on or before January 1, 2015, through January 31, 2016:
 - Are entitled to an HHSC EVV Initiative Provider Compliance Plan grace period;

- Will be subject to the assessment of liquidated damages, the imposition of contract actions, and/or the corrective action plan process for failing to achieve and maintain a Compliance Plan score of at least 90 percent per review period beginning April 1, 2016; and
- May not request a vendor change before the end of the grace period. Provider agencies are required to submit a new Medicaid EVV Provider System Selection form 120 days before they begin to receive services from a different EVV vendor.
- Provider agencies with new contracts effective on or after February 1, 2016.
 - Managed care provider agencies:
 - Must research and select an EVV System according to timelines established by the respective MCO policy; and
 - MCOs will determine the appropriate grace periods for newly contracted provider agencies.
 - HHSC and DADS fee-for-service provider agencies:
 - Must research and select an EVV vendor no later than 30 calendar days after the effective date of the contract. The selection date for an EVV vendor is determined by the date on which the Provider Electronic Visit Verification Vendor System Selection Form was submitted to Texas Medicaid & Healthcare Partnership (TMHP)/Accenture.
 - The grace period for HHSC and DADS contracted providers ends the last day of the third calendar month after the effective date of the contract. Please see example in the table below:

Contract Effective Date	Grace Period End Date
February 1, 2016	April 30, 2016
March 1, 2016	May 31, 2016

- May no longer use paper timesheets to document service delivery beginning on the first day of the fourth calendar month after the effective date of the contract. If paper timesheets are used to document service delivery on or after this time, the visit may be subject to recoupment.
- Will be subject to the assessment of liquidated damages, the imposition of contract actions, and/or the corrective action plan process for failing to achieve and maintain a compliance plan score of at least 90 percent per review period beginning on the first day of the fourth calendar month after the effective date of the contract.
- May not request a vendor change before the end of the grace period. Provider agencies are required to submit new Medicaid EVV Provider System Selection Form 120 calendar days before they begin receiving services from a different EVV vendor.
- If a provider changing vendors requests a vendor technology change that causes extra programming to the new vendor (in addition to the established HHSC data elements layout), vendor may decline the transfer request.

Provider EVV Compliance Standards (HHSC/MCO/DADS)

- Provider agencies must adhere to requirements included in the compliance plan.
- Provider agencies that deliver services for which EVV is required must select and use an HHSC-approved EVV vendor.
 - The provider agency must ensure all required data elements, as determined by HHSC, are uploaded or entered into the EVV system completely and accurately to avoid visit maintenance lock out. Find complete list of EVV data elements at <http://www.dads.state.tx.us/evv/docs/IncorrectMissingDataElements-dec2015.pdf>
- Provider agencies must complete all required visit maintenance in EVV within 60 days of the day on which the service was delivered. Provider agencies cannot perform visit maintenance more than 60 days after the date of service.
- Provider agencies must achieve and maintain a compliance plan score of at least 90 percent per review period.
- Reason codes must be used each time a change is made to an EVV visit record in the EVV System.
- Provider agencies must use the reason code that most accurately explains why a change was made to a visit record in the EVV System.
- All exceptions identified in the EVV System must be addressed with one or more appropriate reason codes.
- Use of preferred reason codes:
 - HHSC, DADS, and MCOs will review reason code use by contracted provider agencies to ensure preferred reason codes are not misused.
 - If HHSC, DADS, or the appropriate MCO determines a provider agency has misused preferred reason codes per policy, the provider agency compliance plan score may be negatively impacted, and the provider agency may be subject to the assessment of liquidated damages, imposition of contract actions, implementation of the corrective action plan process, and/or referral for a fraud, waste, and abuse investigation. For example, providers use a preferred reason code 100 when there is no call in or call out.
- Use of Non-preferred Reason Codes:
 - Will lower the provider agency provider compliance plan score.
 - Failure to achieve and maintain a provider compliance plan score of at least 90 percent for each review period may result in the assessment of liquidated damages, the imposition of contract actions (including contract termination), and/or the corrective action plan process.
- **Additional Provider EVV Compliance Standards include:**
 - The provider agency must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
 - The provider agency must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
 - After notification to the appropriate vendor, providers must notify HHSC, and the appropriate MCO, within 48 hours of any ongoing issues with EVV vendors or issues with EVV Systems.

Claims

- Provider agencies must ensure claims for services are supported by service delivery records that have been verified by the provider agency and fully documented in an EVV System that has been approved by HHSC.
- Claims are subject to recoupment if they are submitted before all of the required visit maintenance has been completed in the EVV System.
- Claims that are not supported by the EVV system will be subject to denial or recoupment.
 - With the exception of displaced CM2000 providers identified by HHSC, all provider agencies must use the EVV system as the system of record by September 1, 2015. Any claim not supported by visits for dates of service April 1, 2016, or greater, entered into the EVV system may be denied or subject to recoupment.
 - Displaced CM 2000 providers identified by HHSC must use the EVV system as the system of record by February 1, 2016. Any claim not supported by visits for dates of service April 1, 2016, or greater, entered into the EVV System may be denied or subject to recoupment.

Note: If necessary visit maintenance is not completed on the transactions in the system or required elements are not included within the system, the transactions will not be submitted to the appropriate payor by the EVV vendor. Claims will be subject to recoupment, as the services are not supported by an EVV transaction. It's the Provider agency's responsibility to ensure all required data elements and visit maintenance is completed prior to billing the claim to the appropriate payor.

- MCO provider agencies only:
 - MCO processes may include the following analysis for dates of service April 1, 2016 forward:
 - Prepayment analysis of submitted claims against EVV transactions before payment so that unverified billed services can be identified and denied.
 - A retrospective analysis of submitted claims against completed EVV transactions after payment so that unverified billed services can be identified and recouped.
 - An alternate method for the prospective analysis of upfront claim denials that occur during processing when the EVV data is not present and validated. If the billed units exceed the completed EVV transactional units that have been verified by the EVV System, the claim is subject to denial or partial payment for the units billed.

Training

- A provider agency must ensure the staff who provides services for which EVV is required are trained and comply with all processes required to verify service delivery through the use of EVV.
 - Provider agencies must train attendants on the use of the EVV System to document the time at which service delivery begins and ends.
 - Provider agencies must train office and administrative staff members on the use of the EVV System to enter all of the required data elements, enter schedules (as applicable), and verify service delivery through visit maintenance and the use of reason codes.
- The provider agency must ensure their employees use the EVV system in a manner that is prescribed by HHSC.
- MCOs only – It is mandatory for all attendants to complete training before they begin to provide services to members. The provider agency is responsible for keeping track of the details of the training for all of their staff.

The training documentation must be retained for five years or until all litigation, audits, appeals, investigations, claims, or reviews have been completed, and it must be provided to the MCOs and HHSC upon request.

Equipment (Associated with EVV System use)

If an EVV vendor provides equipment to a provider agency (when applicable), it must be returned in good condition once it is no longer needed.

The provider agency is required to obtain the individual's/member's signature or an authorized representative's signature on the state-required Medicaid EVV Small Alternative Device Agreement Form before requesting a small alternative device. The Medicaid EVV Small Alternative Device Agreement Form should only be completed if the individual/member does not have a landline in the home or the individual/member refuses to allow a provider agency attendant to use the landline to document the visit.

Once the signed Medicaid EVV Small Alternative Device Agreement Form has been received, the provider agency must complete the provider agency portion of the agreement form (page 1) and the Medicaid EVV Small Alternative Device Order Form (page 2) in their entirety and submit the request to their HHSC approved EVV vendor for processing.

Small alternative devices are provided at no charge to the provider agency or individual/member by the EVV vendor as an approved exception to the use of the individual's/member's home landline phone. Provider agencies cannot pass through any charge to the individual/member for use of the EVV System.

Compliance Monitoring

Effective April 1, 2016, all provider electronic visit verification (EVV) activity will be monitored for 90% HHSC EVV Initiative Provider Compliance Plan Score. The HHSC EVV Initiative Provider Compliance Plan Score is a percentage that indicates how often visits are verified through auto-verification and/or using only preferred reason codes for visits that are eligible to be billed during a particular period of time. It is calculated by:

1. Adding the number of visits auto-verified to the number of visits verified preferred for a particular period of time.
2. Dividing that sum by the total number of visits verified for that same period of time.
3. Rounding the resulting number to the nearest whole percent.

HHSC EVV Initiative Provider Compliance Plan Score = (visits auto-verified + visits verified preferred) ÷ (total visits verified) rounded to the nearest whole percent

Compliance will be measured quarterly according to the calendar year:

- Q1 = January/February/March
- Q2 = April/May/June
- Q3 = July/August/September
- Q4 = October/November/December

When compliance measurement begins April 1, 2016, the first quarter to be reviewed for compliance will be Q2 (April, May and June 2016).

DADS EVV Compliance Schedule

DADS' provider contracts EVV is required for are randomly assigned to Groups 1, 2, or 3 for EVV Compliance reviews according to the last digit of the contract number.

The table below indicates the compliance reporting cycle for each of the three groups of contracts. DADS' intent in distributing the contracts subject to EVV into three groups is to smooth out workloads: DADS hopes this will benefit providers.

Last Digit of Contract Number	Group to which contract assigned	Compliance Review Months	The Months during which compliance reports will be run
Zero	1	April, May, June*	September
Three		July, August, September	December
Six		October, November, December	March
Nine		January, February, March	June
One	2	May, June, July*	October
Four		August, September, October	January
Seven		November, December, January	April
		February, March, April	July
Two	3	June, July, August*	November
Five		September, October, November	February
		December, January, February	May
Eight		March, April, May	August

* Each group will be evaluated at 75% for their first quarter review of EVV compliance in 2016.

The first time the EVV compliance reports will be run for groups 1, 2 and 3 will be in September, October and November 2016, respectively. Each time a three-month compliance report is run it will be evaluated. For example, the compliance report run in September 2016 will assess compliance data from April, May and June of 2016, the compliance report run in October 2016 will assess compliance data from May, June and July 2016 and the compliance report run in November 2016 will assess compliance data from June, July and August 2016.

Compliance Plan Reports

The EVV system allows for provider agencies to pull standardized and Ad hoc reports to analyze their own EVV compliance. Provider agencies are encouraged to use this function. Compliance Plan Reports will be published on the 5th of the month following the compliance quarter.

Below are the compliance reports your payor will use to determine compliance:

- EVV Compliance Plan Summary Snapshot (MCO & HHSC/DADS version)
- EVV Compliance Plan Daily Snapshot (MCO & HHSC/DADS version)
- EVV Compliance Plan Summary - Ad hoc version (UnitedHealthcare will also utilize)

Corrective Action Plan (MCOs Only)

- MCOs may develop a corrective action plan request to ask that provider agencies specify:
 - the reason the provider agency was not able to meet the compliance requirements for the quarter;
 - the actions the provider agencies will take to ensure they meet the compliance requirements in the future; and
 - the estimated date for completing those actions.
- The provider agency will have ten calendar days from the date of receipt to respond to the request for a corrective action plan:
 - If a response is received, the MCO will review the response and develop a formal corrective action plan to submit to the provider agency.
 - If no response is received, the MCO may assess liquidated damages or terminate the Provider Network Participation Agreement.

Liquidated Damages – DADS (MCOs may use or may Determine a Different per-visit Rate)

If a provider agency's Compliance Plan Score falls below 90 percent for a review period, the provider agency may be subject to the assessment of liquidated damages for each day in the review period the provider agency compliance plan score falls below 90 percent. A day on which this occurs is referred to as a "day below program expectations threshold."

Liquidated damages are assessed at a rate of \$3 per visit verified – Non-Preferred on a day below program expectations threshold. Liquidated damages are subject to a minimum assessment of \$10 to a maximum of \$500 per day below program expectations threshold. An example of calculations is shown in the table on the following page.

Day	Daily Compliance % **	# of Non-Preferred Visits	Calculation	Assessed Liquidated Damage
5/1	89%	2	2 x \$3 = \$6	\$10
5/6	80%	10	10 x \$3 = \$30	\$30
6/5	75%	15	15 x \$3 = \$45	\$45
6/8	52%	198	198 x \$3 = \$594	\$500
Total:				\$585
** less than 90% is a Day Below Program Expectations Threshold				

Informal Review

A provider agency may request an informal review if the provider agency seeks to demonstrate that the quarterly compliance score was due to a failure of the EVV System. The informal review request must:

- Be sent in the form of a letter;
- Be received by payor within 10 calendar days of the date on which provider agency received the quarterly compliance review findings.
- Describe the specific EVV System failures that caused the non-compliance; and
- Include all of the documentation that supports the provider's position.
- Date system issue was reported to the vendor and the contracted payors.

A request for an informal review that does not meet the above requirements will not be granted. The payor will notify the provider agency in writing of the results of the informal review. The payor's response will determine if the findings were substantiated, unsubstantiated or reduced based on the assessed corrective action plan and/or liquidated damages. Provider agencies that request an informal review may still request a formal administrative appeal.

Administrative Appeal – Right to State Office of Administrative Hearings Appeal (DADS Only)

Provider agencies have the right to request a formal appeal if the EVV compliance plan review results in liquidated damages. In accordance with Title 1 Texas Administrative Code (TAC), Section 357.484, Request for a Hearing, the request must be in writing, in the form of a petition or letter, and must state the basis of the appeal of the action. In addition, a legible copy of the notice must accompany the request.

In addition to providing a written appeal request to DADS, the request and notice must be received at the following address within 15 calendar days of the provider agency's receipt of the notice:

Texas Health and Human Services Commission
Attn: Director of Appeals
PO Box 149030 (MC- W-613)
Austin, Texas 78714-9030

Administrative Appeal – MCOs Only

Provider agencies may contact their respective MCOs for information about their administrative appeal processes.

Appendix A

Effective Date	Program	Services
June 1, 2015	STAR+PLUS Dual Eligible Integrated Care Demonstration	• Personal Assistance Services (PAS) • Personal Care Services (PCS) • In-home Respite Services • Community First Choice (CFC) – PAS and Habilitation (HAB)
June 1, 2015	STAR Health	• PCS • CFC (PAS/HAB)
June 1, 2015	Fee-for-Service	• Comprehensive Care Program – PCS • CFC (PAS/HAB)
June 1, 2015	Community Living Assistance and Support Services (CLASS)	• In-home respite services • CFC (PAS/HAB)
June 1, 2015	Medically Dependent Children Program (MDCP)	• In-home Respite Services • Flexible Family Support Services provided by an attendant
June 1, 2015	Community Attendant Services (CAS)	• PAS
June 1, 2015	Family Care (FC)	
June 1, 2015	Primary Home Care (PHC)	
November 1, 2016	STAR Kids	• PCS • In-home Respite Services • Flexible Family Support Services provided by an attendant • CFC (PAS/HAB)

Appendix B

Services	Action	Date
Personal Attendant Services/Personal Care Services (PAS/PCS)	Grace period	April 16–August 31, 2015
	Provider agencies learn reason codes	April 16–August 31, 2015
Medically Dependent Children Program (MDCP) - In-home respite services - Flexible family support services provided by an attendant	Provider agencies must be in full compliance (not using paper timesheets) with EVV requirements. EVV System must be used to record the clock-in and clock-out times of all attendants, and visit maintenance must be completed for all services.	September 1, 2015
	Displaced CM2000 System Users Identified by HHSC: Provider agencies must be in full compliance (not using paper timesheets) with EVV requirements. EVV System must be used to record the clock-in and clock-out times of all attendants.	February 1, 2016
Community Living Assistance and Support Services (CLASS) - In-home respite services - CFC (PAS/HAB)	All Provider agencies must be in compliance with EVV. Provider agencies must achieve and maintain a compliance plan score of at least 90 percent per review period. Provider agencies are subject to contract actions for failure to meet provider compliance plan requirements.	April 1, 2016
	All provider agencies must submit claims in accordance with their contracted entity claims submission policy. Any claim not supported by visits for dates of service April 1, 2016, or greater, entered into the EVV system may be denied or subject to recoupment.	April 1, 2016
Contracted with MCO For: - CFC (PAS/HAB) - In-home respite services	Grace period	June 1–August 31, 2015
	Provider agencies learn reason codes	June 1–August 31, 2015
	Provider agencies must be in full compliance (not using paper timesheets) with EVV requirements. EVV System must be used to record the clock-in and clock-out times of all attendants, and Visit Maintenance must be completed for all services.	September 1, 2015
	Displaced CM2000 System Users Identified by HHSC: Provider agencies must be in full compliance (not using paper timesheets) with EVV requirements. EVV system must be used to record the clock-in and clock-out times of all attendants.	February 1, 2016

	All Provider agencies must be in compliance with EVV. Provider agencies must achieve and maintain a Compliance Plan score of at least 90 percent per review period. Provider agencies are subject to contract actions for failure to meet provider compliance plan requirements.	April 1, 2016
	All provider agencies must submit claims in accordance with their contracted entity claims submission policy. Any claim not supported by visits for dates of service April 1, 2016 or greater, entered into the EVV system may be denied or subject to recoupment.	April 1, 2016