Electronic Visit Verification (EVV) Initiative: Provider Compliance Plan for Contracted Provider Agencies

Information posted May 22, 2015

***Note**: The Health and Human Services Commission (HHSC) has requested that TMHP publish the following information:*

The Health and Human Services Commission (HHSC) will implement an electronic visit verification (EVV) initiative statewide on the following schedule:

Effective	Implementation
No later than June 1, 2015	Personal attendant services (PAS) and personal care services (PCS)
June 1, 2015	Community first choice (CFC)
June 1, 2015	In-home respite for the STAR+PLUS managed care services

The Consumer Directed Services (CDS) option is exempt from the HHSC EVV Initiative Provider Compliance Plan.

Implementation

Implementation under the HHSC EVV initiative requires a provider agency to use an EVV system to record service delivery visit information. The information is recorded in a computer-based system that interfaces with either a telephone or a small alternative device which generates a time stamp code. Providers may manually record or change service visit information through performing visit maintenance in an HHSC-approved EVV system. Provider agencies providing services 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 necessary visit maintenance prior to submitting a claim. Claims not supported by an HHSC-approved EVV system entry may be denied or be subject to recoupment.

Purpose

- To establish a utilization standard for provider agencies in electronically verifying visits.
- To verify that individuals/members are receiving 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 managed care organizations (MCOs), HHSC, and Department of Aging and Disability Services (DADS), each of these organizations may have additional 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	Various home visit tracking systems that verify service visits occur in the home or in the community and document the precise time the provision of service begins and ends. The EVV System must be HHSC approved.
HHSC EVV Initiative Provider 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 time frame during which provider agencies must use an EVV system and may, for billing support purposes only, use paper timesheets as backup documentation. Provider agencies in a grace period are not subject to liquidated damages, contract actions, or corrective action plan requirements for failing to achieve an HHSC EVV Initiative Provider Compliance Plan score of at least 90 percent. However, claims may 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.
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. 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 the same particular period of time; and 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
Reason Code	A standardized HHSC-approved three digit number and description that is used during visit maintenance to explain the specific reason a change was made to an EVV visit record.
Non-preferred Reason Code	A reason code which documents a change to an EVV visit record that is caused by a situation in which the provider agency staff is **not** documenting services in accordance with program and policy requirements.
Preferred Reason Code	A reason code which documents a change to an EVV visit record that is caused by a situation in which the provider agency staff **is** documenting services in accordance with program and policy requirements.
Provider/Provider Agency	Service providers under contract that are providing covered Medicaid services which are subject to EVV.
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 equals the number of visits auto-verified plus visits verified preferred plus visits verified non-preferred. **Visits verified** = visits auto-verified + visits verified preferred + visits verified non-preferred
Visits Auto-Verified	The number of visits with no exceptions and for which no visit maintenance was required.

Visits Verified Preferred	The number of visits with exceptions which were verified through visit maintenance using only preferred reason codes.
Visits Verified Non-Preferred	The number of visits with exceptions which were verified through visit maintenance using at least one non-preferred reason code.

Grace Period

- Provider agencies only receive a single grace period under the HHSC EVV initiative, and there will be no additional grace period if a provider agency chooses to transition from one EVV vendor to another.
    - DADS providers only receive a single grace period per contract.
- 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:
    - Are not allowed to 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 receiving services from a different EVV vendor.
    - Are entitled to an HHSC EVV Initiative Provider Compliance Plan grace period:

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
	Provider agencies must be in compliance with EVV.	September 1, 2015
	Compliance - evaluation of provider agencies performance toward achieving the compliance plan score begins.	September 22, 2015

    - Will be subject to the assessment of liquidated damages, imposition of contract actions, and/or the corrective action plan process for failing to achieve and maintain an HHSC EVV Initiative Provider Compliance Plan score of at least 90 percent per review period beginning:
        - September 1, 2015, for PAS/PCS.

    - September 1, 2015, for CFC.
    - September 1, 2015, for in-home respite.
- Provider agencies with new contracts effective February 1, 2015:
    - Must research and select an EVV System according to policies established by the respective payer.
- Managed care provider agencies:
    - Must research and select an EVV System according to timelines established by the respective MCO policy.
    - The MCOs will determine appropriate grace periods for newly contracted provider agencies.
- DADS fee-for-service provider agencies with new contracts effective on or after February 1, 2015:
    - Must research and select an EVV vendor no later than 30 calendar days after the effective date of the contract. The date of selection of an EVV vendor is determined by the date the Medicaid EVV Provider System Selection Form was submitted to the selected EVV vendor and the Texas Medicaid & Healthcare Partnership (TMHP)/Accenture.
    - DADS grace period for DADS contracted providers:

Contract Effective Date	Grace Period End Date
February 1 - June 1, 2015	August 31, 2015.
July 1, 2015	September 30, 2015.
On or after August 1, 2015	The last day of the third calendar month after the effective date of the contract.

    - 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 or September 1, 2015, whichever is later. If paper timesheets are used to document service delivery on or after the first day of the fourth calendar month after the effective date of the contract or September 1, 2015, whichever is later, the visit may be subject to recoupment.
    - Are not allowed to 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 calendar days before they begin receiving services from a different EVV vendor.
    - Will be subject to the assessment of liquidated damages, imposition of contract actions, and/or the corrective action plan process for failing to achieve and maintain an HHSC EVV Initiative Provider 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 their contract.

Provider EVV Compliance Standards (MCO/DADS/HHSC)

- Provider agencies must adhere to the requirements of the HHSC EVV Initiative Provider Compliance Plan.
- Provider agencies delivering 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, accurately, and in a timely manner.
- Provider agencies must complete any and all required visit maintenance in EVV within 21 days beginning the day service was delivered. No visit maintenance will be allowed to be performed more than 20 days after the date of service.
- Provider agencies must achieve and maintain an HHSC EVV Initiative Provider 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.
- Use of preferred reason codes:
    - The MCOs, HHSC, and DADS will review reason code use by their contracted provider agencies to ensure that preferred reason code(s) are not misused.
    - If a provider agency is determined to have misused preferred reason codes as determined by the appropriate MCOs, HHSC, or DADS, the provider agency HHSC EVV Initiative Provider 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.
- Use of Non-preferred Reason Codes:
    - Will lower the provider agency HHSC EVV Initiative Provider Compliance Plan score.
    - Failure to achieve and maintain an HHSC EVV Initiative Provider Compliance Plan Score of at least 90 percent per review period may result in the assessment of liquidated damages, imposition of contract actions (including contract termination), and/or the corrective action plan process.

Additional MCO-Specific Provider EVV Compliance Standards (Not applicable to HHSC/DADS providers)

- 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.
- Providers should notify the appropriate MCO, or HHSC, within 48 hours of any ongoing issues with EVV vendors or issues with EVV Systems.
- Claims should not be submitted before the visit is entered into the EVV system and any necessary visit maintenance is completed.
- Any corrective action plan required by an MCO is required to be submitted to the MCO within ten calendar days of receipt of request.
- MCO provider agencies may be subject to termination from the MCO network for failure to submit a requested corrective action plan timely.

Claims

- Provider agencies must ensure that all required data elements, as determined by an MCO, HHSC, or DADS are entered in to an EVV System completely and accurately and in a timely manner (within 21 days beginning the day the service was delivered).
- Provider agencies must ensure that claims for services are supported by service delivery records that have been verified by the provider agency and fully documented in an EVV System before being submitted for payment.
- Any claims which are submitted prior to all required visit maintenance being completed in the EVV System are subject to recoupment.
- Claims not supported by the EVV system will be subject to denial or recoupment.
- MCO provider agencies ONLY:
    - MCO processes may include:
        - A retrospective analysis of submitted claims against completed EVV transactions after payment, for identification and recoupment of unverified billed services; and
        - An alternative method for prospective analysis for upfront claim denial during processing if the EVV data is not present and validated. If the billed units exceed the completed EVV transactional units verified by the EVV System, the claim is subject to denial or partial payment for the units billed.

Training

- A provider agency must ensure that staff providing 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 and nurses on the use of the EVV System to document the time service delivery begins and ends.
    - Provider agencies must train office and administrative staff members on the use of the EVV System to enter in all required data elements, enter in 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 prescribed by HHSC.
- **MCOs only**: Training is mandatory for all attendants and nurses prior to beginning services with members. The provider agency is responsible for keeping track of details of training for all their staff. The training documentation must be retained for five years, or until all litigation, audits, appeals, investigations, claims, or reviews are completed, and must be provided to the MCOs and HHSC when requested.

HHSC EVV Initiative Provider Compliance Plan Reports

The EVV system allows for standardized and ad hoc reports to be pulled by provider agencies to analyze their own EVV compliance. Provider agencies are encouraged to use this function.

Equipment

Equipment provided by an EVV vendor to a provider agency, if applicable, must be returned in good condition, when no longer needed. If equipment is lost, stolen, marked, altered, or damaged by the provider agency, the provider agency may be required to pay the replacement cost of the equipment.

The provider agency is required to obtain an individual/member or individual's/member's authorized representative signature on the state-required Medicaid EVV Small Alternative Device Agreement Form prior to 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** use of the landline for the provider agency attendant or nurse to document the visit.

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

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 landline phone. Provider agencies cannot pass through any charge to the individual/member for use of the EVV System.

Corrective Action Plan (MCOs only)

- A request for a corrective action plan may be developed requesting provider agencies to detail the reason they were not able to meet the compliance for the quarter, the actions they will take to ensure they can meet compliance going forward, and the estimated date for completion.
- 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 go forward with assessing liquidated damages.

Liquidated damages – DADS (MCOs may use or may determine a different per-visit rate)

If a provider agency's HHSC EVV Initiative Provider 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 that review period where the provider agency HHSC EVV Initiative Provider Compliance Plan Score falls below 90 percent, referred to as a day below program expectations threshold.

Liquidated damages are assessed at the rate of $3 per **visit verified – Non-Preferred** on a day below program expectations threshold, subject to a minimum assessment of $10 to a maximum of $500 per day below program expectations threshold.

Example of calculations:

Day	Daily Compliance % (less than 90% is a Day Below Program Expectations Threshold)	# 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

Informal Review – DADS

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 a letter;
- Received by DADS within ten **calendar days** after receipt of the "Notice of Finding of Non-Compliance and Assessment of Liquidated Damages" (Notice);
- Describe the specific EVV System failure(s) that caused the non-compliance; and
- Include all documentation supporting the provider's position.

A request for an informal review that does not meet the above requirements will not be granted. DADS will notify the provider agency in writing of the results of the informal

review. Requesting an informal review does not limit a provider agency from requesting a formal administrative appeal.

Informal Review - MCOs

- 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.
- A provider agency may request informal review for non-compliance finding by:
  - Submitting a letter;
  - Describe specific EVV System failure that prevented compliance;
  - Include all supporting documentation; and
  - Be received within ten calendar days after provider agency receives the written quarterly compliance review findings.
- A request for an informal review that does not meet the requirements will not be granted.
- The MCO will provide a written response to the informal review to the provider agency after information is reviewed. The response will detail the MCO's determination and due date for corrective action plan response or liquidated damages payment, if applicable.

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 of the Texas Administrative Code (TAC), Part 15, Chapter 357, Subchapter I, §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.
- The request and notice must be received at the following address within 15 calendar days of your receipt of the notice: Texas Health and Human Services Commission, Attn: Director of Appeals, P. O. Box 149030 (MC- W-613), Austin, Texas 78714-9030
- A copy of the written appeal request must also be provided to DADS.

Administrative Appeal - MCOs Only

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