

Texas Children's Health Plan Electronic Visit Verification

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 Consumer Directed Services (CDS) option is exempt from the HHSC EVV Initiative Provider Compliance Plan. Texas Children's Health Plan (MCO) will comply with all regulatory requirements for electronic visit verification as directed by the Health and Human Services Commission.

Implementation

The electronic visit verification (EVV) 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. Texas Children's Health Plan has selected two such vendors for providers to select from. 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 MCO is being billed.

While the HHSC EVV Initiative Provider Compliance Plan has common elements across HHSC, 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 Texas Children’s Health Plan prior authorization as defined in HHSC rule; Title 1 TAC §354.117.
EVV Transaction	One of the following transactions in an EVV system: <ol style="list-style-type: none"> 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.
MCO EVV 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.
MCO EVV 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.
MCO EVV 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.
MCO EVV Provider (Compliance Plan Score)	<p>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:</p> <ol style="list-style-type: none"> 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. <p>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.</p>

Payor	The Entity (MCO) provider contracted with to provide EVV targeted services;
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
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/MCO.
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 MCO EVV 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, MCO providers only receive a single grace period per contract. The MCO grace period will cover the period November 1, 2016 through December 31, 2016 if the provider was contracted with the MCO prior to November 1, 2016.
- Provider agencies should use the grace period to train their staff on how to use the EVV system and how to perform visit maintenance.

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- Provider 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 September 2017, 60 days after the end of for Quarter 1. Quarter 1 reviews will consist of visits between [April, May and June 2017; 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 new to the EVV Program with contracts effective on or after November 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.

Provider EVV Compliance Standards

- Provider agencies must adhere to requirements included in the MCO 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/MCO, 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:
 - MCO will review reason codes used by contracted provider agencies to ensure preferred reason codes are not misused.
 - If the 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.
 - MCO will review reason codes used by contracted provider agencies to ensure non preferred reason codes are not misused.

- 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 the 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.
 - Provider agencies currently are required to use EVV and have transition from Medically Dependent Children Program (MDCP). The EVV system must be used as the system of record by November 1, 2016. Any claim not supported by visits for dates of service November 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 MCO for payment 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 MCO.

MCO processes may include the following analysis to determine compliance for dates of service April 1, 2017 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/MCO.
- 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 for dates of service on or subsequent to April 1, 2017 all provider electronic visit verification (EVV) activity will be monitored for 90% HHSC EVV Provider Compliance Plan Score. The HHSC EVV 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 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 = April/May/June
- Q2 = July/August/September
- Q3 = October/November/December
- Q4 = January/February/March

When compliance measurement begins September 1, 2017, the first quarter to be reviewed for compliance will be Q1 (April, May and June 2017).

The September 1, 2017 measurement date allows for visit maintenance to be performed 60 days after end of quarter on June 30, 2017.

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 the MCO will use to determine compliance:

- EVV Compliance Plan Summary Snapshot (MCO & HHSC version)
- EVV Compliance Plan Daily Snapshot (MCO & HHSC version)

Corrective Action Plan

- Provider agencies may be required to specify the following information as part of a corrective action plan:
 - 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 -

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 the MCO 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 MCO.

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

Provider agencies may contact Texas Children's Health Plan for information about their administrative appeal processes.