Electronic Visit Verification -- Operational and Administrative Review

Medicaid and CHIP Services

Medical and Social Services Division

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Executive Summary

Electronic Visit Verification (EVV) is a set of computer-based tracking systems that electronically verify the occurrence of personal attendant service visits by documenting the precise time a service delivery begins and ends. In Texas, EVV is required for certain Medicaid-funded home and community-based services provided through the Health and Human Services Commission (HHSC) and managed care organizations (MCOs). EVV helps ensure that Medicaid members receive services authorized for their care and to prevent fraud, waste, and abuse.

Texas was one of the earliest adopters of EVV in the country. In 2011, the Legislature directed the use of EVV if it was cost-effective and feasible. As a result, the Texas Department of Aging and Disability Services (DADS) initiated an EVV pilot program. In 2013, the Legislature expanded their direction for EVV to include other community care and home health services. To see a full listing of Medicaid services covered by EVV rules, see Appendix A.

As required by the 2018-19 General Appropriations Act, Senate Bill (S.B.) 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 222) and S.B. 894, 85th Legislature, Regular Session, 2017, HHSC performed a review of EVV processes and systems in place within the state. This report is the result of that review and provides an overview of current EVV system functions, identifies business process and technology issues, and proposes actions to improve the system.

As one of the early adopters of EVV, Texas did not have the benefit of learning from other states' experiences. Rather, today, other states are using Texas' experiences to help shape their developing EVV systems. This review considers the historic issues that HHSC has experienced and discusses steps the agency has taken to remedy these issues, and evaluates the current state of EVV processes and systems and provides next steps to continuously improve this system.

HHSC implemented the EVV initiative statewide on June 1, 2015. There were some challenges during the initial statewide implementation, including delays related to the setup of twelve MCOs, training several thousand providers on the use of EVV, the roll out of the STAR Kids program, and MCO contracts with HHSC-approved EVV vendors. A thorough analysis of provider adoption of EVV, MCO feedback, and data accuracy trends revealed that by early 2017, the EVV system had improved. However, HHSC's review identified several remaining issues. One of the weaknesses

in the current system is that payers have limited ability to successfully match claims against confirmed visits, in part due to issues with data collection and transfer. This results in additional costs for MCOs and provider agencies, causes significant manual data maintenance for service providers, and requires increased operational oversight interventions by HHSC staff.

HHSC is pursuing short- and long-term activities to improve EVV processes and systems. HHSC has initiated a continuous innovation project with the Texas Medicaid and Healthcare Partnership (TMHP) to centralize the visit verification and claims matching processes. TMHP is Texas' Medicaid claims administrator and operates the state's Medicaid Management Information System (MMIS) as part of this contract. HHSC plans to shift several EVV system functions to TMHP to take advantage of their existing administrative oversight, claims processing expertise, and online portal capabilities. The planned project will maximize the use of the existing MMIS to improve the overall data integrity of the EVV statewide system.

HHSC continues to identify and correct issues with the EVV system. The upgrades and improvements to the system, as detailed in this report, will address feedback from stakeholders and recent reviews of the system, as well as introduce cost savings and efficiencies. As EVV is not intended to create an impediment to service delivery, HHSC will continue to ensure members receive and providers are paid for appropriate services while these improvements are made.

These modernization efforts to fully incorporate EVV into the Texas MMIS, along with other HHSC projects, will prepare the state for further EVV adoption required by the federal 21st Century Cures Act, Section 12006, in 2019 and 2023.

1. Introduction

EVV is a telephone and computer-based system that electronically verifies and documents basic information relating to the delivery of certain Medicaid attendant-based services. Visit data collected include:

- Type of service performed;
- Individual receiving the service;
- Date of the service;
- Location of service delivery;
- Individual providing the service; and,
- Time the service begins and ends.

EVV helps ensure that Medicaid members receive services authorized for their care and to prevent fraud, waste, and abuse. EVV systems verify that services billed are for actual visits, and that a caregiver is physically present with the individual or completes allowed services outside the home. Attendants are required to document the precise time the service begins and ends by clocking in and out. Below are three methods for recording a visit:

- The individual's home landline telephone;
- A small alternative device (SAD) installed in the individual's home with an EVV vendor-supplied zip tie; or,
- Global Positioning System (GPS) mobile application downloaded on the individual providing the service's (attendant) smart phone.

EVV does not replace existing program rules or requirements related to service delivery or service-delivery documentation. Providers are required to continue documenting service delivery as outlined in existing program rules. EVV also does not change the method and location in which providers deliver Medicaid services. Members continue to receive services in accordance with their service authorization and plan of care.

Recognizing the need to make improvements to EVV, S.B. 894 and Rider 222 instructed HHSC to conduct a review of the EVV system in use by HHSC and its health care partners. In addition, S.B. 894 required the following:

- HHSC and MCOs to inform Medicaid recipients of EVV requirements;
- HHSC to adopt compliance standards for health care providers and MCOs that contract with HHSC;
- HHSC to ensure standardized processes are put in place by MCOs to retrospectively correct data and to ensure MCOs provide timely service authorizations;
- HHSC to adopt compliance standards that take into account any added administrative burdens placed on health care providers; and
- HHSC to consider potential benefits of emerging technologies to ensure compliance with EVV requirements.

Rider 222, Operational and Administrative Efficiencies Related to Technology and Electronic Visit Verification, requires the state to identify the following:

- Programmatic and administrative areas where HHSC can:
    - maximize current investments in technology and automation to achieve operational efficiencies,
    - generate cost savings and cost avoidance, and
    - create opportunities to share services within the health and human services system;
- Strategies to improve the collection and maintenance of current and accurate contact information for individuals receiving health and human services benefits;
- Operational efficiencies and cost savings achieved by HHSC through improvements in collection and maintenance of current and accurate contact information for individuals receiving health and human services benefits; and
- Strategies to streamline the administrative requirements imposed on health care providers that are required to use EVV, including a review of:
    - Minimum state and federal statutory requirements relating to EVV;
    - State program and policy requirements requiring health care providers to make unnecessary visits or incur unnecessary costs; and
    - Differences in compliance requirements between fee-for-service and managed care.

Accordingly, HHSC has identified issues and recommended improvements as part of the review. This report identifies issues related to administrative and operational

requirements of the EVV system, the effectiveness of the EVV system components, technical problems affecting providers, and challenges with claims matching. It discusses short-term improvements and future EVV technology changes to address EVV data integrity, reduce provider visit maintenance, and maximize use of the state's existing MMIS. In addition, this report will describe strategies for streamlining EVV administrative requirements, such as changes to state policy and MCO requirements to improve standardization and reduce administrative burdens. The report will also outline the impact of the Cures Act and discuss a timeline for required EVV changes.

2. Background

State Requirement for EVV System

In 2011, Texas Government Code Section 531.024172, as amended by S.B. 894, required HHSC to establish an electronic visit verification system. In 2013, the Legislature recommended expanding EVV to other community care and home health services. The state's EVV system has evolved significantly in the seven years since it was created.

DADS Implementation of EVV

As a result of legislative direction by the 82nd Legislature, in March 2011, DADS initiated a pilot EVV program covering a subset of individuals in fee-for-service (FFS) Medicaid. The pilot was limited to FFS because DADS had no existing contracts with MCOs.

DADS executive management exempted nursing services in all programs as well as services in the Home and Community-based Services waiver, Texas Home Living waiver, and the Deaf Blind Multiple Disabilities waiver from using EVV. They also made EVV optional for Financial Management Services Agencies (FMSAs) and Consumer Directed Services employers for the following services:

- Personal assistance services and in-home respite services in the Community Based Alternatives program;
- Residential habilitation and in-home respite services in the Community Living Assistance and Support Services program;
- In-home respite services and family flexible support services in the Medically Dependent Children Program (MDCP);
- Primary Home Care program as described in 40 TAC Section 47.3(20);
- Community Attendant Services as described in Section 47.3(3); and
- Family Care services as described in Section 47.3(11).

Providers continued to use the DADS EVV system until the system's transition to HHSC in June 2015.

HHSC Implementation of EVV

HHSC replaced the DADS EVV pilot with the HHSC EVV initiative on June 1, 2015. This initiative expanded requirements for the use of EVV statewide and integrated the MCOs into the EVV process for the first time. See Appendix A for a complete list of the EVV-related programs.

HHSC, DADS, and MCOs recognized system challenges faced by providers in the initial implementation of the new EVV system, and agreed to delay enforcement of EVV compliance until April 1, 2016.

By August 2016, TMHP, the state's contracted Medicaid claims adjudicator, completed the state's FFS EVV implementation. In November 2016, HHSC implemented the STAR Kids managed care program and created the need for STAR Kids MCOs to contract with HHSC-approved EVV vendors. Providers who contracted with a STAR Kids MCO had to adjust to data elements in the EVV system.

Twelve of twenty managed care organizations (MCOs) contracted with HHSC are managing services required to use EVV. The MCOs each have contracts with the HHSC-approved EVV vendors and with provider agencies to cover various geographical areas of the state. The MCOs and TMHP serve approximately 6,200 providers of attendant-based services subject to the use of EVV. Each provider must select one of the state authorized EVV vendors for the selected services. These provider agencies currently serve over 251,000 Medicaid members and employ as many as 306,360 caregivers.

3. HHSC EVV Review Findings

EVV is an evolving, complex system made up of multiple technologies with roles and responsibilities distributed among multiple entities and personnel. The EVV process is dependent on the existing Medicaid business processes between payers (MCOs and TMHP), providers, and the state for the eligibility verification, authorization of services and claims adjudication. These business processes must be working well in order for the EVV process to function effectively. The EVV business process overlaid onto existing business processes and systems represents an additional layer of complexity. For a full description of EVV components and business processes, see Appendix B.

In 2015, HHSC established a provider workgroup and a MCO stakeholder workgroup that provides HHSC with information on the ongoing operations of the EVV operational process and system. The provider workgroup meets quarterly and the MCO workgroup meets monthly. More recently, as directed by S.B. 894, HHSC established a stakeholder workgroup comprised of representatives of healthcare providers, MCOs, and Medicaid recipients. HHSC will periodically solicit input from this new workgroup regarding the ongoing operations of the EVV system.

Through feedback from workgroups and business process analyses of the EVV system, HHSC identified several challenges within the existing operational model that limit the ability of payers to match claims to verified EVV visit data. Together, these challenges cause additional work for providers, increase the potential for claim denials and recoupments of previously paid claims. Challenges include:

- Data integrity errors in visit data;
- Errors with data collection devices;
- Errors in data exchange;
- Errors in service authorization data; and,
- Errors in claims matching.

Data Integrity Errors in Visit Data

The EVV operational model depends upon the accurate collection, storage, and transmission of electronic visit data when a provider delivers services to an individual. Payers use this electronic visit data during the claims adjudication process to ensure that the visit actually occurred and matches the claim submitted by the provider for Medicaid reimbursement of services rendered.

Providers and payers have identified several high priority issues regarding the accuracy of the electronic visit data. HHSC's review revealed data entry errors by providers caused by a lack of adequate upfront data validations in the EVV vendor software, as well as cases of incorrect manual entry by providers of individuals' service authorizations into the EVV vendor system. Several cases of missing EVV visit data caused by data errors or because of programs transitioning from fee-for-service to managed care have also been reported.

In addition, the use of multiple identification numbers by provider agencies in the EVV vendor system (National Provider Identifier [NPI], Alternate Provider Identifier [API], Tax Identification Number [TIN], and Texas Provider Identifier [TPI]), complicates management and assignment of provider identification within the visit data, adding to the potential for data errors. Lastly, the rate of auto-confirmed visit data in the EVV vendor system is low, with only 40-50 percent of visits auto-confirmed by the EVV vendor system and the remainder requiring verification by providers during visit maintenance.

To correct issues with the electronic visit data, the providers must make adjustments and assign HHSC-established reason codes to describe the exception. This process, called visit maintenance, allows providers up to 60 days following the visit to make adjustments. If visit maintenance is required beyond 60 days, authorization by the payer is required to allow for the adjustment.

Due to the visit data integrity challenges listed above, there is a high volume of visit maintenance required by providers and they often occur beyond the 60-day limit.

Errors with Data Collection Devices

To meet program policy requirements, the technology most often used in the client's home is a landline telephone or small alternative device (SAD). Some of the technical issues associated with the use of SAD included data entry errors because

caregivers must enter the client and employee identification numbers or time codes generated by SADs. Furthermore, the limited display size of SAD screens contribute to reading errors. Additionally, SADs do not support services delivered outside the home, as providers must affix these devices at the home location. Errors associated with the EVV data collection technology require visit maintenance by the providers to correct.

Errors in Data Exchange

EVV vendors transmit over six million transactions of visit data to payers each month. Payers match the visit data against claims submitted by the providers for reimbursement by Medicaid. Currently, only six of the twelve MCOs send response files back to the EVV vendors to indicate the acceptance or rejection of daily visit data transactions. Without a transaction response, providers do not know if the transaction contained errors. TMHP analyzed visit data sent by EVV vendors to TMHP and MCOs and found a potential rejection rate of up to 15 percent by payers due to fatal errors. Given delays in identifying data errors, providers may not be able to perform data corrections in a timely manner to support claims submissions. Incorrect visit data that remains uncorrected results in a high rate of mismatched claims when submitted.

Because of these errors in the EVV data exchange process, payers may deny claims or send recoupment notices for paid claims, requiring additional provider visit maintenance to ensure EVV visits match claims submitted. These issues are time-consuming to resolve and create the need for more monitoring by MCOs, more visit maintenance by the providers, and increased state oversight of issue resolution.

Errors in Service Authorization Data

All EVV relevant Medicaid services require a service authorization from the payer prior to service delivery. Currently, EVV vendor systems require providers to manually key in service authorizations received from the payer to set up the visit schedules for each individual.

However, manual entry of service authorizations by providers can introduce errors into the EVV vendor system. Providers report frequent time delays in receiving service authorizations and the occasional receipt of incorrect service authorizations from the MCOs. In addition, with minimal systematic validation of visits against the

service authorization, the provider may or may not receive an error or warning message if the service authorization is incorrect or out of date.

Errors in Claims Matching

Each claim submitted by a provider to a payer for an EVV-related service must have matching EVV visit data. Initial review of data from fiscal year 2017 suggested that a large number of paid claims did not have a matching EVV visit. Further investigation and discussions with payers revealed that most mismatches are the result of data errors, rather than claims submitted by the provider without an EVV transaction. Without this match, the payers may deny a claim during a pre-review process or recoup a claim after a retrospective review process.

MCOs report that missing visit data is frequently due to the provider incorrectly assigning a payer on the record. It is clear from such reports that EVV vendors do not effectively perform checks against the HHSC master provider files to validate provider identifiers, or use the HHSC eligibility data to validate the payer prior to sending the visit data to payers. If the EVV system does not catch the data error, and the incorrect payer does not reject the record back to the EVV system upon receipt, then the provider may not realize there was an error until after a claim is submitted. This is one of the frequent reasons for claims mismatches and payer recoupments.

In addition, most payers perform retrospective reviews of paid claims. With no current limit on the timeframe for the reviews, payers may notify providers of EVV mismatches and potential recoupment of the claim well after making the payment. This delay limits the provider's ability to perform necessary visit maintenance to correct transaction errors within the 60-day window.

Mismatching also occurs because providers typically submit claims based on date spans for the delivery of the service instead of submitting a claim line item for each date of service. This practice by providers creates partially matched claims against the visit data, particularly if a date of service is missing for a date span. This can happen due to holidays or schedule changes.

Together, challenges, in the overall EVV process create additional costs for MCOs and provider agencies, and they require increased operational oversight interventions by HHSC staff.

4. Strategies to Improve Data Integrity and Improve Administrative Efficiency

HHSC is pursuing short- and long-term technology and operational solutions to improve the EVV process. HHSC has initiated a continuous innovation project to integrate the EVV process into the state's existing MMIS technology environment.

HHSC has identified strategies to produce cost savings to providers, MCOs, and the agency. The strategies also will address the legislative direction and many of the findings from the HHSC review, such as:

- Reducing the EVV administrative burden for providers;
- Implementing advanced EVV visit capture technology;
- Streamlining and standardizing EVV requirements;
- Maximizing HHSC existing technology investments; and
- Introducing cost savings for EVV participants.

Quality Improvement Initiatives

The initiatives discussed below are short-term actions to reduce the administrative burden for providers using the EVV system, ensure provider services comply with a current service authorization, expand the use of smart-phone technology to capture visits, and introduce efficiencies to reduce costs.

Improve Visit Data Integrity

Improvements in the integrity of the EVV visit transaction data will have a direct impact on reducing administrative burden to providers. HHSC identified several possible verification and validation improvements.

HHSC has begun working with MCOs, providers, and TMHP to systematically address and correct mismatched visit data to payers. Some mismatch errors are due to lack of provider updates in the EVV vendor system, such as the November 2016 transition of STAR Kids services to managed care or member transfers.

To address visit data rejection, HHSC will require MCOs to validate daily visit transaction data and promptly send back rejection response files to EVV vendors. The vendors will then alert providers of any errors that require corrections. MCOs that have sent back response files have a higher claims match rate due to timely provider visit maintenance.

Greater use of existing state-maintained member and provider data can also cut down on provider data entry, decrease errors in visit data transactions, and streamline provider visit maintenance. Therefore, HHSC will instruct EVV vendors to expand their use of provider enrollment files, Texas Integrated Eligibility Redesign System (TIERS) member eligibility files, and county records in EVV data validation.

To further improve EVV processes and systems, HHSC has requested several small software enhancements to the TMHP EVV system, including improved reporting of validation error trends across all payers, updates to eligibility file sharing, changes to data capture and data warehousing, and changes to the explanation of benefits messages for claims.

Upgrade Visit Data Capture Technology and Auto-Confirmation

Improvements in the data collection technology will reduce provider visit maintenance caused by failures and increase the percentage of auto-confirmed visits to 75 percent.

For example, HHSC has implemented a pilot project for attendants to use a Global Positioning System (GPS) mobile application downloaded on their smart phone to perform visit check in and check out. This technology automatically confirms the location of the attendant, whether it be at the member's home or another known service location. This will reduce the number of SADs in use; reducing device errors and improper use of the device outside the home. It also will decrease errors associated with attendant data entry, increase auto-confirmed visits, and reduce provider visit maintenance.

Additionally, TMHP is implementing a software change to accept the GPS coordinates in the visit transaction record for reporting purposes. EVV vendors are putting into effect an online SAD request capability so that providers can log initial and replacement SAD requests in the EVV system. This will reduce the need for paper forms and eliminate home visits by the provider to obtain members' signatures on the forms.

HHSC also will explore the usefulness and cost-effectiveness of emerging EVV visit capture technologies, such as biometric recognition.

Standardize EVV Visit Data Verification

TMHP currently receives a copy of all EVV visit data for all individuals whether FFS or managed care. In the future environment, TMHP will provide validation services that EVV vendor systems can access. In the new environment, TMHP will continue to accept EVV visit data from vendors, and EVV vendors will no longer transmit visit data to the MCOs.

The MMIS will provide a centralized repository to aggregate visit data to improve data integrity through standardized data validation and business edits. These standardized data processes will provide timely error notifications to providers, and reduce data exchange requirements for MCOs.

Improve Verification of Service Authorizations

Improvements within the EVV vendor system to accept electronic service authorizations will assist in the reduction of administrative burden on the providers.

MCO submission of electronic service authorizations to EVV vendors for use by the providers is currently in a pilot phase. However, the electronic service authorization interface will give providers access to the most current authorization from the MCO, ensure services adhere to the service authorization, and reduce the need for the providers to key enter authorizations.

In addition, the EVV system will notify providers of service authorization changes and allow providers to accept these changes. The system will produce reports for use by HHSC in monitoring expired service authorizations to guarantee that MCOs are issuing valid service authorizations. The EVV system will also validate visit schedules and transactions against the electronic service authorizations and notify providers of mismatches.

The future environment in the MMIS will accept and store both FFS and MCO service authorizations for visit data validation. TMHP will implement standards for MCO service authorization submission and visit data verification. The system will compare visit data to current service dates and authorized service codes and units.

Maximize Existing Technology to Improve the Claims Matching Process

In addition to efforts underway to streamline EVV technology, HHSC has initiated a continuous innovation project to centralize EVV visit data validation and claims matching to maximize the use of the state's existing MMIS. HHSC will shift several EVV system functions under the umbrella of the Medicaid claims administrator contract (TMHP), taking advantage of administrative oversight, claims processing expertise, and online portal capabilities already in place. Expansion of the MMIS capabilities provides several advantages, including:

- Confirm client care is occurring through comprehensive online monitoring of the EVV program;
- Improve EVV transaction data integrity with standardized, reliable, accurate, and timely verification and validation;
- Improve payer claims processing by providing a matching service against the centralized EVV transaction data;
- Increase provider visibility and access to EVV visit data validation and claims matching through online reporting in an effort to reduce provider administrative burden;
- Simplify the state's administration of EVV vendor contracts by the transfer of the contracts to TMHP; and
- Improve the state's ability to detect fraud, waste and abuse for EVV relevant service delivery.

Centralized EVV Software and Services

Shifting some functions to TMHP will allow HHSC to implement standardized and centralized verification of visit data, centralized storage of visit data, a claims matching service for MCOs, and reporting through a portal dashboard system accessible by providers, MCOs and HHSC.

The future environment in the MMIS will improve EVV management reporting through the implementation of an online portal dashboard system. The portal dashboard will be accessible to provider staff, HHSC state staff, and MCO staff. The

portal dashboard will provide online reporting of the verified EVV visit data, display payer's service authorization data, and claims matching results.

The future environment in the MMIS will also include a claims-matching service accessible by the payers to verify the visit occurred during the EVV review process. Using the claims data submitted by the provider, the payer will make a web-based inquiry to the MMIS and attempt to match a validated visit. The MMIS will provide a response indicating a match or a mismatch back to the payer along with a detailed rejection code if a mismatch occurs.

The centralization and standardization of visit data and claims matching will ensure providers are subject to standard validation and processing. The system will use existing standards already applied within the MMIS for EVV visit rejection and expand these standards for MCOs. In addition, standard explanation of benefits specific to EVV will be required when adjudicating claims, both in FFS and for MCOs processing during either a pre-review or post-review process.

Allow the Use of Provider Proprietary EVV Systems

The future environment within the MMIS would allow for the use of EVV systems put in place by the providers as opposed to the HHSC approved EVV vendors. TMHP already has extensive experience with third party software agreements to allow vendors to interact safely and securely with the MMIS. TMHP will establish data submission standards that meet all statutory and programmatic requirements for use by provider EVV systems as necessary to accept and exchange visit data and validate provider EVV systems.

Any proprietary EVV systems would have to comply with all necessary data submission, exchange, and reporting requirements established within the MMIS, as well as meet all other standards and requirements established within the MMIS. Each potential provider EVV system would go through extensive system testing protocols to verify data exchange standards and ensure data accuracy.

Collection of Individual Contact Information

Although relevant legislation calls for the EVV system to improve the collection of individual contact information, it is important to note that EVV is not a source for this information. The HHSC TIERS system is the source of information for individual contact information used by the EVV vendor systems. Data transmitted to the EVV vendor systems occurs through existing interfaces with TMHP and TIERS. The EVV

processes and systems have no impact on the data validations occurring within TIERS and it is therefore, outside the scope of identified improvements.

Potential Cost Savings

HHSC cannot estimate cost savings at this time due to the number of data integrity issues described in the previous sections. As HHSC remediates data processing issues, valid data will be available for use in comparing the cost efficiencies of the EVV system.

Currently, manual processes employed in the EVV systems by providers and MCOs require a substantial administrative cost to operate. These costs are in addition to the costs of business prior to the implementation of EVV.

Strategies proposed by HHSC will reduce or eliminate manual data entry, provide upfront validation of data, allow the use of proprietary systems in the exchange of EVV visit data, and allow visibility into EVV visit data and related data prior to the submission of claims. These improvements will lower the administrative burden on providers and MCOs and will improve the ability of HHSC to oversee the EVV program.

4. Improvements in Administrative Requirements

HHSC has identified and begun implementing several changes in administrative requirements to streamline the EVV process. HHSC plans to update rules and policies in fiscal years 2018 and 2019, enhance education and training, and strengthen MCO policies and guidelines to help address EVV review findings.

These strategies will also address issues such as:

- Ensuring case managers and service coordinators inform members of EVV requirements;
- Standardizing MCO processes and make policies publicly accessible;
- Standardizing requirements between fee-for-service and managed care;
- Ensuring timely delivery of member service authorizations; and
- Streamlining administrative requirements to achieve operational efficiencies, reduce costs, and reduce unnecessary EVV related visits.

Improvements in State Program and Policy Requirements

Several improvements to existing program and policy requirements are currently underway to address problems such as the efficacy of phone category EVV data, the inappropriate use of SADs, and more.

The move from landlines to cellular telephones has led to inconsistencies in data reports and has brought into question the accuracy of phone category EVV data (cell, landline, Voice Over IP [VOIP] fixed vs. VOIP unfixed, etc.). This has resulted in some inappropriate recoupment of claims. HHSC developed a standardized guideline for acceptable telephonic EVV and recoupment of claims for telephonic EVV, and has issued the revised guidelines to MCOs and provider agencies to lay out a fair process for all parties with a notification and claims appeal process.

Inappropriate use of SADs, such as SADS carried with attendants rather than permanently affixed in a person's home, result in inaccurate data on services rendered. On December 22, 2017, HHSC reissued policy guidance to all parties to

reinforce the message that the provider must permanently affix the SAD in the member's home.

In addition, implementation of an online SAD request form will replace the paper form and eliminate the provider home visit solely to have the paper form signed by the member, reducing provider administrative burden.

Providers must use HHSC-defined reason codes to clear visit exceptions when a call is not auto-verified by the EVV system. Currently, providers must select from 28 reason codes. HHSC and MCOs are working together to reduce the number of codes to avoid misuse and minimize confusion.

Enhanced Communication and Education

HHSC is continually updating information available to members, providers and MCOs regarding EVV rules, guidelines, and best practices through a variety of educational tools.

The agency has created a new form, the EVV Rights and Responsibilities form, for use by case managers and services coordinators during initial and annual visits. The member (or legally authorized representative) must sign and date the form acknowledging that they understand the state and federal EVV mandate and how it affects them. HHSC has also created a new information brochure for use by MCOs and HHSC as part of the enrollment packages mailed to individuals requesting information for EVV-related services.

In addition, HHSC organizes a variety of statewide trainings. Throughout 2017, HHSC traveled across the state to give additional EVV training to providers. Along with HHSC's presentation of EVV requirements, MCOs and EVV vendors also attended to answer provider questions. HHSC provider trainings will continue through 2019. MCOs will also train all of their provider agencies in the EVV requirements, including using the most appropriate reason codes and claims adjudication policies related to EVV.

HHSC plans to implement computer-based trainings (CBTs) for provider agencies prior to execution of a FFS contract. These CBTs will introduce the provider agencies to EVV requirements, including using the most appropriate reason codes. HHSC will expand CBTs in the future for providers to use in training new personnel or to review new or existing guidelines. The CBTs will supplement HHSC provider trainings conducted throughout the state.

Improvements to MCO Guidance

HHSC is making significant updates to the HHSC Uniform Managed Care Manual minimum requirements for standardized processes and policies. These changes will strengthen MCO contractual requirements to enforce the improvements identified in this report. For example, MCOs will soon be required to share standardized electronic service authorizations with EVV systems (currently under pilot). HHSC will also require MCOs to standardize and expand explanation of benefits for claims denials during pre-payment reviews and retrospective reviews.

5. Impact of 21st Century Cures Act

The 21st Century Cures Act (Cures Act) is a federal law enacted on December 13, 2016, and amends Section 1903 of the Social Security Act (42 USC 1396b). Section 12006 of the Cures Act describes EVV requirements and federal financial matching participation to support the development of EVV systems. The CURES Act requires states to implement an EVV system by January 1, 2019 for in-home personal care services (PCS) and January 1, 2023, for home health care services. States that do not comply with the Cures Act by the applicable deadlines may have their Federal Medical Assistance Percentage (FMAP) reduced; with reductions increasing with a maximum reduction of 1 percent of FMAP.

An HHSC interdisciplinary committee is currently reviewing all aspects of the federal law to determine impacts to Texas Medicaid programs. Early evaluation of expansion requirements include several of the technology changes described previously in this report. Additional technology modernization projects to facilitate the addition of EVV relevant services (e.g., Community First Choice, Texas Home Living waiver, Home and Community-based Services waiver, and Consumer Directed Services) within the Cures Act are in the planning phase.

Although the Cures Act did not provide states with direct funding to implement these new requirements, it does allow enhanced federal matching (up to 90 percent) for the development of EVV information technology systems. HHSC plans to pursue this funding to implement the future EVV environment within the MMIS.

The Centers for Medicare and Medicaid Services is in the process of providing more detailed guidance about the implementation of EVV under the Cures Act. HHSC will review the guidance and make adjustments as needed, as well as share with stakeholders as appropriate.

6. Conclusion

Texas recognized early on the importance of minimizing fraud, waste, and abuse in attendant services and the importance of ensuring Medicaid recipients receive care that is authorized for them. As one of the earliest adopters of this technology, Texas experienced challenges with its implementation due to factors such as integrating multiple systems, expansion of populations in Medicaid managed care, and varied technologies (i.e., landlines and cellular telephones).

HHSC is committed to a system that is efficient and effective for provider agencies, caregivers, Medicaid members, and MCOs. Regular reviews of internal processes are critical to ensure programs are operating as intended. HHSC continues to identify and correct issues with the EVV system and continues to learn from stakeholder feedback. The upgrades and improvements to the system will address these issues as well as introduce cost savings and efficiencies. These activities, along with other HHSC projects, will prepare the state for further EVV adoption as required by the federal 21st Century Cures Act, Section 12006.

Appendix A. Current Programs Using EVV

Program	Services
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)
STAR Health	• PCS • CFC (PAS/HAB)
STAR Kids (effective Nov. 1, 2016)	• PCS • In-home respite services • Flexible family support services • CFC (PAS/HAB)
Acute-care Fee for Service	• Comprehensive Care Program - PCS • CFC (PAS/HAB)
Community Living Assistance and Support Services (CLASS)	• In-home respite services • CFC (PAS/HAB) as of June 1, 2015
Medically Dependent Children Program (MDCP)	• In-home respite services provided by an attendant • Flexible family support services provided by an attendant

Community Attendant Services (CAS)	• PAS
Family Care (FC)	• PAS
Primary Home Care (PHC)	• PAS

Appendix B. Current EVV System Operations

The sections below document the business process and the roles and responsibilities of each of the involved entities.

EVV Business Process

HHSC implemented the EVV initiative in order to change from a paper-based attendant timesheet process, which is difficult to monitor and regulate, to an automated, verifiable check-in and checkout system that could ensure providers deliver prescribed services to individuals.

EVV Roles and Responsibilities

HHSC and TMHP

HHSC provides program oversight of the EVV process and system including EVV vendor selection and contract management, MCO oversight for EVV services, and provider compliance plan monitoring.

TMHP serves as the state's Medicaid claims administrator under HHSC's contract with Accenture, LLC. In this role, TMHP is responsible for development and maintenance of the state's MMIS, including components for EVV administration and claims adjudication. TMHP must receive electronic visit data from the EVV vendor system to use in claims adjudication.

Managed Care Organizations

Each MCO is responsible for ensuring contracted providers are using EVV. MCOs must contract directly with HHSC-selected EVV vendors for EVV services, must ensure that providers of EVV-related services have registered with an EVV vendor and are using the system appropriately. The MCO is also responsible for educating its members about EVV requirements.

MCOs contract with the HHSC-approved EVV vendors based on standard rates negotiated by HHSC. Additionally, each MCO must provide oversight and conduct compliance reviews of the EVV contractors to ensure delivery of EVV services follows minimum HHSC standard requirements. MCOs must receive electronic visit data from the EVV vendor system to use in claims adjudication.

Provider Agencies Using EVV

Contracted 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. Each provider delivering EVV-related services must register to use one of two state-contracted EVV vendors to collect and process visit data. The home health attendants (employed by providers) must interact with the EVV systems to indicate the delivery of the scheduled service. The provider agency must complete the EVV record, including any visit maintenance, prior to submitting a claim associated with the EVV record. Payers may deny or recoup claims not supported by a confirmed EVV record in their selected EVV system. Under the HHSC EVV utilization standards, provider agencies must electronically verify visits, and certify that i.e., members receive the services authorized and billed to the state. Medicaid providers may be associated with one or more MCOs for applicable managed care services or with the TMHP for services categorized as FFS.

All providers providing the mandated services must use the EVV system and must maintain compliance with the following requirements:

- Providers must enter member information, provider information, and service schedules (scheduled or non-scheduled) into the EVV system for validation either through an automated system or a manual system.

- Providers must train attendants to ensure they are providing services applicable to EVV and complying with all EVV-related processes required to verify service delivery.

- Providers must achieve and maintain an HHSC EVV provider compliance plan score of at least 90 percent per quarterly review period. The purpose of the compliance plan is to ensure required provider agency staff use an HHSC-approved EVV vendor system to document the precise time services begin and end. In addition, EVV provider administrators must use reason codes when performing maintenance on EVV visit records in the EVV System.

Providers must complete all required visit maintenance in the EVV system within 60 days of the visit (date of service). Visit maintenance not completed prior to claim submission is subject to claim denial or recoupment. Provider agencies must submit claims in accordance with their contracted entity claim submission policy. The provider may not perform visit maintenance more than 60 days after the date of service unless the payer grants an exception.

Each provider is subject to a HHSC compliance plan review period consisting of three consecutive calendar months prior to the review month to occur at least once per calendar year. The compliance plan score is a percentage that indicates how often visits are verified through auto-verification or are using only preferred reason codes for visits that are eligible to be billed during a particular period of time.

Technology in Use

EVV Vendor Systems

HHSC currently has two EVV software vendors under contract to manage EVV visit data for service providers. The EVV vendors administer online capabilities for collection of visit information, and to providers for online maintenance. Providers must register with one of the vendors and utilize the system to record the EVV attendant visits. The EVV vendors must make data within the EVV system available to an associated payer prior to the provider's submission of a claim.

The provider must receive training from their selected EVV vendor. After training is completed and the required data entered, the provider may begin using the EVV system. The EVV system documents as visit data, the individual or member receiving services, the attendant providing services, the provider agency information, and the precise time the attendant begins and end service delivery.

The attendant must use the individual or member home landline telephone to document the time services begin and services end. Currently, an attendant may not use an individual or member cell phone in place of his or her home landline. If the home landline is unavailable, the individual or member must complete, sign, and date the EVV SAD form to request small alternative device installation in the individual or member's home. The SAD documents the time the service begins and ends. When the attendant uses a SAD, it generates unique numbers on the screen that represents a specific date and time. This SAD information expires seven days from the date of the visit.

If the EVV system cannot automatically verify an attendant visit against the schedule in the system, the provider must accurately reflect the visit data through visit maintenance. Visit maintenance allows designated staff in a provider agency to edit records of EVV visits by reviewing, modifying and correcting visit information. The provider must use an appropriate reason code to record exceptions. For a single visit, there may be more than one exception. Correcting exceptions in visit maintenance is similar to correcting an attendant or private duty nurse's paper time

sheet. Providers must enter the most appropriate reason codes and any required free text in the comment field in order to explain and clear each exception.

The provider must document all situations according to program policy and clear all exceptions before billing. The EVV system transmits to visit data via the daily EVV transaction file to each payer for their claims adjudication process.

In-Home Visit Data Collection

Each EVV vendor system must provide a means to capture visit data and verify that visits occurred as part of services provided. There are multiple types of technology to capture the attendant check-in and checkout times, which are critical to the authentication of the visit (see descriptions below).

Telephony

The attendant can use a landline phone if available at the member's address allowing the attendant to call in to the EVV system and record the visit check-in and checkout times. In order to use the EVV system, a provider must input the individual's home telephone number into the EVV system when setting up the initial records for an individual. Once entered, the system will validate that the EVV call made by an attendant is from the specified telephone line or from a different number. If the phone number matches the phone number in the EVV system, and the visit check-in or checkout time match the schedule, the EVV system will automatically confirm the visit data. In instances where the phone numbers do not match or the time does not match the schedule, the system will flag the visit for additional system administrator attention. Administrators will then contact the home care attendant or client to investigate the discrepancy and perform visit maintenance.

Early in the deployment of EVV vendor systems, there were frequent problems with recording and recognizing landline phones, but those problems were resolved and are now a reliable means of recording visits. However, based on a recent National Health Interview Survey[1], researchers report that a majority of U.S. homes now rely on cell phones alone for their telephone connection, without a landline. In addition, many "landline" phones are now set up using voice over internet protocol

[1] Center for Disease Control (CDC) National Center for Health Statistics, National Health interview Survey (NHIS), *Wireless Substitution: Estimates from the NHIS,* May 4, 2017.

(VOIP) technology. The EVV systems do not recognize these VOIP phones as "landlines" but instead record the call as a cell phone call. In some instances, clients do not know if their phones are landlines or VOIP technology. The type of phones must be determined prior to visit call-ins. If a landline is using VOIP technology, or if a member does not allow the attendant to use the member's phone, then the provider must set up a different means of recording each visit.

Small Alternative Device (SAD)

As an alternative to landlines, a SAD, or time clock token, may be used. The provider must request a SAD from the EVV vendor, and then affix the SAD at the individual's home for use by the attendant. Similar to a pager, the SAD uses a formula based on the time, date and client identification number to provide a digital code to the attendant, who then calls an automated system to enter the generated code.

While the SAD avoids the problems presented by telephones, or lack thereof, attendants must write down and type in a long series of numbers for each call-in and call-out. This requirement to re-enter numbers often can contribute to data entry errors in the call-in and call-out process. In addition, the permanently mounted SAD at a member's home and does not allow an attendant to check-in or check-out when the member is receiving services outside the home. In addition, there have been an increasing number of reported cases where, the SAD can generate incorrect date-time combinations that affect rounding of service units. The SAD values expire seven calendar days after the visit.

Global Positioning System Mobile Applications

Smart phone applications using Global Positioning System (GPS) technology are available from EVV vendors to facilitate an easier check-in and checkout process and a more accurate validation of an attendant's location. HHSC has piloted the use of a GPS mobile application with one of the EVV vendors to determine the feasibility, accuracy and limitations related to the use of the GPS location in recording attendant service delivery. HHSC plans to implement this capability statewide for all providers during calendar year 2018.

The GPS mobile application makes use of an attendant's personal cell phone and records the location of the phone at the time of check-in and checkout. The GPS mobile application will associate the calculated location to a standard street address, if possible. This process can improve the capture of visit data and make

location data easier to verify. If a member frequently receives services at an alternate location, the GPS mobile application can store this additional information as a "learned location" that can be quickly verified during attendant check-in and checkout.

The drawbacks of the GPS mobile application include the need for the attendant to have, and be willing to use, their own smart phone without reimbursement from the provider, MCO, or HHSC. In addition, the GPS mobile app may not identify a particular location in some rural areas of the state or within an apartment complex, that share the same single street address.

EVV Data Exchange with Payers

Once service delivery has occurred in either the home or community, and the visit data has been auto-confirmed by the EVV system or manually confirmed by provider administrative personnel, the EVV system sends the daily visit data to the appropriate payer. The payer may choose at that time to review the visit data to verify that the identification data (member number, NPI/API, TIN, service group/code, visit hours, etc.) matches the payer internal records and the prior authorization for services. Payers may return errors found to the EVV vendor, who can notify the provider of rejections and the need for required data maintenance.

Regardless of whether the payers review and reject records upon receipt, or at claims submission, EVV visit transaction records must exist for each date of service on claims submitted by providers. Payers must match the claim to an associated EVV visit transaction, either before or after paying the claim.

Appendix C. List of Acronyms

Acronym	Full Name
API	Alternate Provider Identifier
CBT	computer based training
CDS	Consumer Directed Services
CFC	Community First Choice
CLASS	Community Living Assistance and Support Services
CMS	Centers for Medicare and Medicaid Services
DADS	Department of Aging and Disability Services
EVV	electronic visit verification
FC	Family Care
FFS	fee-for-service
HAB	Habilitation services

HHSC	Health and Human Services Commission
MCO	managed care organization
MDCP	Medically Dependent Children's Program
MMIS	Medicaid Management Information System
NPI	National Provider Identifier
PAS	personal assistance services
PCS	personal care services
PHC	Primary Home Care
SAD	small alternative device
TIERS	Texas Integrated Eligibility Redesign System
TIN	Tax Identification Number
TMHP	Texas Medicaid and Healthcare Partnership
TPI	Texas Provider Identifier

VOIP	voice over internet protocol