Aetna Better Health®
Electronic Visit Verification
Provider Compliance Plan

Policy

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

Applicability

Electronic visit verification is required for the STAR Kids program effective November 1, 2016 for the following services:

- Personal Care Services (PCS)
- In-home respite care
- Flexible Family Support Services
- Community First Choice (CFC) Services
  - Habilitation (HAB) and Personal Care Services (PCS) only

Implementation

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

Purpose

The EVV initiative:

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

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

Definitions

Term	Definition
Electronic Visit Verification (EVV)	Documentation and verification of service delivery through an EVV System.

EVV System	A telephone or computer-based system that allows confirmation services were provided to an eligible recipient according to an approved HHSC prior authorization or DADS Plan of Care as defined in HHSC rule; Title
EVV Transaction	One of the following transactions in an EVV system: 1. call-in when service delivery begins, and 2. call-out when service delivery ends.
Exceptions	Visits that do not auto verify and require the use of one of more reason codes to clear in the EVV system.
Aetna Better Health EVV Initiative Provider Compliance Plan (Compliance Plan)	A set of requirements that establish a standard for EVV usage that must be adhered to by provider agencies under the HHSC EVV initiative.
Aetna Better Health EVV Initiative Provider Compliance Plan Grace Period (Grace Period)	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.
Aetna Better Health EVV Initiative Provider Compliance Plan Review Period (Review Period)	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 A grace period of 5 months (November and December, 2016 and January through March, 2017) will apply to the implementation of EVV for the STAR Kids program. The compliance score for that period will be relaxed to 75% instead of the normal 90%. The first quarter to be reviewed for the 90% compliance score will be Q1 which will be run in September, 2017 following the end of the 60 day visit maintenance period for Q1.

Aetna Better Health EVV Initiative Provider Compliance Plan Score	A percentage that indicates how often visits are verified through auto-verification and/or using only preferred reason codes for visits that are eligible to be billed during a particular period of time. Scores are calculated by: 1. Adding the number of visits auto-verified to the number of visits verified preferred for a particular period of time; 2. Dividing the sum by the total number of visits verified for the same period of time; and 3. Rounding the resulting number to the nearest whole percent. Compliance Plan Score = (Number of total visits auto-verified + Number of total visits verified preferred) ÷ (Number of total visits verified) rounded to the nearest whole percent.
Payer	Entity provider contracted with to provide EVV targeted services; HHSC, MCO, DADS
Non-Preferred Reason Code	A reason code that documents a change to an EVV visit record that is caused by a situation in which the provider agency staff did not document services in accordance with program and policy requirements.
Preferred Reason Code	A reason code that documents a change to an EVV visit record that is caused by a situation in which the provider agency staff documents services in accordance with program and policy requirements.
Provider/Provider Agency	Service providers that are under contract and are providing covered Medicaid services that are subject to EVV.
Reason Code	A standardized, HHSC-approved three-digit number and description used during visit maintenance to explain the specific reason for a change that was made to an EVV visit record.
Visit Maintenance	The process by which provider agencies can make adjustments in an EVV System to electronically document service delivery visit information as required by HHSC.
Visits Verified	The number of visits that have no exceptions or for which all exceptions have been resolved through visit maintenance in the EVV System. Visits that have been verified are eligible for billing. Visits verified = Number of visits auto-verified + Number of visits verified preferred + Number of visits verified non-preferred.
Visits Auto-Verified	The number of visits that have no exceptions and for which no visit maintenance was required.
Visit Maintenance Lockout	The inability for a provider to complete visit maintenance in an EVV system due to required accurate and complete information not entered into the EVV system
Visits Verified Preferred	The number of visits that have exceptions that were verified through visit maintenance using only preferred reason codes.

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

Grace Period

Aetna Better Health will provide a grace period under the following guidelines:

- A grace period of 5 months (November and December, 2016, and January – March, 2017) will apply to the implementation of EVV for the STAR Kids program. The compliance score for that period will be relaxed to 75% instead of the normal 90%. The first quarter to be reviewed for the 90% compliance score will be Q1 2017 (April – June).
- Following the STAR Kids implementation, newly contracted providers who have not been previously required to submit EVV transactions with Aetna Better Health or any other Texas Managed Care Organization which requires EVV will receive a grace period of 2 months following their contract effective date where the compliance score requirement will be relaxed to 75%. Quarterly compliance measurement using the 90% minimum compliance score will begin following that grace period and may include a partial quarter for the first reporting period.
- No additional grace period will be granted for providers that change EVV vendors.
- Providers should use the grace period to train their staff on how to use the EVV system and how to perform visit maintenance. Claims submitted without a matching EVV transaction from the provider's vendor will be denied. Corrected claims may be submitted following the completion of EVV visit maintenance and must be received within the 95 day filing period from the date of service.

Provider EVV Compliance Standards (HHSC/MCO)

- Provider agencies must adhere to requirements included in the compliance plan.
- Provider agencies that deliver services for which EVV is required must select and use an HHSC- approved EVV vendor.
- The provider agency must ensure all required data elements, as determined by HHSC, are uploaded or entered into the EVV system completely and accurately to avoid visit maintenance lock out. Find complete list of EVV data elements at http://www.dads.state.tx.us/evv/docs/IncorrectMissingDataElements-dec2015.pdf
- Provider agencies must complete all required visit maintenance in EVV within 60 calendar days of the day on which the service was delivered. Provider agencies cannot perform visit maintenance more than 60 days after the date of service.
- Provider agencies must achieve and maintain a compliance plan score of at least 90 percent per review period.
- Reason codes must be used each time a change is made to an EVV visit record in the EVV System.
- Provider agencies must use the reason code that most accurately explains why a change was made to a visit record in the EVV System.
- All exceptions identified in the EVV System must be addressed with one or more appropriate reason codes.
- Use of preferred reason codes:
- HHSC and MCOs will review reason code use by contracted provider agencies to ensure preferred reason codes are not misused.
- If HHSC or the appropriate MCO determines a provider agency has misused preferred reason codes per policy, the provider agency compliance plan score may be negatively impacted, and the provider agency may be subject to the assessment of liquidated damages, imposition of contract actions, implementation of the corrective action plan process, and/or referral for a fraud, waste, and abuse investigation. For example, providers use a preferred reason code 100 when there is no call in or call out.

- Use of Non-preferred Reason Codes:
    - Will lower the provider agency provider compliance plan score.
    - Failure to achieve and maintain a provider compliance plan score of at least 90 percent for each review period may result in the assessment of liquidated damages, the imposition of contract actions (including contract termination), and/or the corrective action plan process.
- **Additional Provider EVV Compliance Standards include:**
    - The provider agency must ensure quality and appropriateness of care and services rendered by continuously monitoring for potential administrative quality issues.
    - The provider agency must systematically identify, investigate, and resolve compliance and quality of care issues through the corrective action plan process.
    - After notification to the appropriate vendor, providers must notify HHSC, and the appropriate MCO, within 48 hours of any ongoing issues with EVV vendors or issues with EVV Systems.

System Issues Notification

It is the provider agency's responsibility to notify Aetna Better Health within 48 hours when an EVV vendor system issue prevents the provider agency from accurately entering in electronic visit verification transactions. The provider agency may report this through the following options:

- Contacting their Provider Representative directly
- Calling our toll-free Provider Relations Hotline at 800-306-8612
- Email to EVVmailbox@aetna.com
- Fax to 866-510-3710.

The provider agency must report the issues directly to Aetna Better Health ensure the information is considered during the provider agency's compliance review. Without reporting the issue there is a risk that the issue will not be considered when Aetna Better Health determines the actions for non-compliance.

Compliance Monitoring

Aetna Better Health will monitor all provider agencies' EVV compliance quarterly using the EVV Compliance Plan Summary Report – MCO. Aetna Better Health will monitor the providers' compliance score at the provider's Tax Identification Number (TIN) and National Provider Identifier (NPI) level. All provider agencies that fall outside of the 75% for April 1, 2016 - March 31, 2017 and 90% minimum thereafter compliance level will receive a certified non-compliance letter from Aetna Better Health. The letter will outline any necessary action on the part of the provider agency along with a timeframe for improvement required. The following steps will be used in the process:

1. Education about correctly using the EVV system to document visits
2. A Corrective Action Plan (CAP)
3. Assessment of liquidated damages
4. Termination of the provider agency's network provider contract

Step 1 above will occur following the first quarter that the minimum compliance score is not achieved. If the minimum compliance score is not achieved after the second consecutive quarter, step 2 will be followed. If the minimum compliance score not achieved after the third consecutive quarter, step 3 will be followed. Finally, if the minimum compliance score is not achieved after the fourth consecutive quarter, step 4 will be followed. Once the provider agency has attained the minimum compliance score, repeated failure to achieve it may result in resuming the monitoring process at is not achieved after the second consecutive quarter, step 2 will be followed. If the minimum compliance score not achieved after the third consecutive quarter, step 3 will be followed. Finally, if the minimum compliance score is not achieved after the fourth consecutive quarter, step 4

will be followed. Once the provider agency has attained the minimum compliance score, repeated failure to achieve it may result in resuming the monitoring process at any of the above steps.

In addition to compliance score from the EVV State Standard reports, Aetna Better Health will also review the use of reason codes by the provider agencies to ensure preferred reason codes are not misused and to identify education needs for the provider agency on reason codes. If Aetna Better Health determines that a provider agency has misused preferred reason codes, the provider agency's HHSC EVV Initiative Provider Compliance Plan Score may be negatively impacted, and the provider agency may be subject to additional action including 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: If an attendant forgets to clock-in to the system and a preferred reason code is used during visit maintenance instead of the correct non-preferred reason code for when an attendant forgets to clock in/out, would be considered misuse of the preferred reason code.

Corrective Action Plan:

A Corrective Action Plan is a formal, signed document outlining specific actions, determined by the nature of non-compliance that is designed to improve the provider agency's compliance. Please note that CAPs include deadlines and consequences (to be determined) if compliance is not improved.

If it's determined that a Corrective Action Plan will be required; the plan will be submitted to the provider agency to request the following specifics:

- Reason the provider agency was not able to meet the compliance requirements for the quarter;
- Actions that they will take to ensure that they meet the compliance requirements in the future; and
- Estimated date for completing those actions.

The provider agency will have **10 calendar days** from the date of receipt to respond to the request for a corrective action plan:

- If a response is received, Aetna Better Health will review the response and develop a formal corrective action plan to submit to the provider agency.
- If no response is received, Aetna Better Health may assess liquidated damages or terminate the Aetna Better Health Provider Network Participation Agreement.

Liquidated Damages:

If it's determined that the non-compliance actions will include assessment of Liquidated damages, the certified letter will contain the compliance report results, the calculation of the liquidated damages, how to submit the liquidated damages and the due date for payment of liquidated damages.

The provider agency is subject to liquidated damages for each day the provider agency HHSC EVV Initiative Provider Compliance Plan Score falls below 90%. A day on which this occurs is 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.

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 payer 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 payers.

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

Provider agencies may contact Aetna Better Health for information about their administrative appeal processes.

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.

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

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

Training

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

Equipment (Associated with EVV System use)

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

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

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

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

EVV Compliance Monitoring

Effective November 1, 2016, all provider electronic visit verification (EVV) activity will be monitored for 75% HHSC EVV Initiative Provider Compliance Plan Score. This metric will change to 90% effective January 1, 2017.The HHSC EVV Initiative Provider Compliance Plan Score is a percentage that indicates how often visits are verified through auto-verification and/or using only preferred reason codes for visits that are eligible to be billed during a particular period of time. It is calculated by:

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

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

Compliance will be measured quarterly according to the calendar year:

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

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 fifth of the month following the compliance quarter.

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

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