

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

**INSPECTION OF
ELECTRONIC VISIT
VERIFICATION SYSTEM**



May 29, 2018
OIG Report No. INS-17-003



HHSC OIG

TEXAS HEALTH AND HUMAN
SERVICES COMMISSION

OFFICE OF
INSPECTOR GENERAL

WHY THE OIG CONDUCTED THIS INSPECTION

This inspection was conducted to determine how effective the EVV system is at verifying that home service visits for Medicaid clients occurred and at confirming that home services were provided. Objectives were to:

- Determine the percentage of Medicaid claim details that matched with EVV data.
- Determine the effectiveness of the HHSC EVV Provider Compliance Plan.

The EVV system was designed to deter fraud, waste, and abuse in personal care services in Texas Medicaid. Those services, performed by home health attendants who are not required to be licensed or certified, are provided in client homes to assist vulnerable, medically fragile clients to continue to live in the community. When used as intended, claim details matched to an EVV transaction can provide reasonable assurance that an attendant was present to provide services. In state fiscal year 2017, services subject to EVV totaled nearly \$2.6 billion in paid claims.

WHAT THE OIG RECOMMENDS

The Inspections Division recommends that Medicaid and CHIP Services (MCS) should:

1. Comply with 1 Tex. Admin. Code (TAC) §354.1177(g) and, as appropriate, recover dollars paid without EVV match
2. Require a prospective matching process and ensure claims without a matching EVV are not paid
3. Allow providers to only submit claims with a single date-of-service per detail for claims requiring EVV
4. Require vendors to develop and implement EVV edits and audits to help enforce reason code policy
5. Establish a standard for percentage of auto-verified EVV transactions that providers must achieve

View the report online

For more information, contact:

IG_Inspections_Division@hhsc.state.tx.us

ELECTRONIC VISIT VERIFICATION:

Inspection of Electronic Visit Verification (EVV) System

WHAT THE OIG FOUND

Texas Administrative Code 354.1177(g)(1) prohibits payment of a claim without a matching EVV transaction. In fiscal year 2017, both TMHP and MCOs paid Medicaid claims without a matching EVV transaction.

Payers can use a prospective or retrospective matching review to determine if a claim detail has a matching EVV transaction. A prospective matching means claims will be reviewed prior to payment and will not be paid without a matching EVV transaction.

A retrospective match means claims will be reviewed after

payment and TMHP or the MCO may have to recover funds after they are paid if there is no matching EVV transaction.

Based on the data available to OIG, more than \$117 million was paid for claims without matching EVV transactions, in violation of TAC.

Based on the data available to the OIG, in FY17 more than \$117 million was paid for claims without a matching EVV transaction.

HHSC also allows date span billing, where providers bill multiple consecutive dates of service in a single claim detail. An EVV transaction can only match to one single date of service. This leads to partial matches between claims and EVV transactions, where some dates will have a match and others will not. This allows some dates of service to be paid without a matching EVV transaction. Only allowing a single date of service in each claim detail would improve oversight by allowing systems to identify and only pay when there is a match.

The HHSC EVV Provider Compliance Plan establishes standards and rules for the collection and reporting of attendant visits. Inspectors found that the plan establishes a framework for monitoring and oversight. However, inspectors determined some components of the plan need improvement.

The plan includes a formula to measure the percentage of a provider's compliance with the established standards and rules. Information about visits can be auto-verified at the time of the visit or manually adjusted with reason codes provided for the adjustment. The auto-verified and manually entered information is used in the formula to judge a provider's performance. The inspection found that reason codes are not properly used and can lead to inflated provider compliance scores, which do not accurately reflect provider performance. The use of edits and audits to monitor the use of reason codes is not required. Further, there is no standard percentage of EVV transactions that should be auto-verified.

These observations led to five OIG recommendations listed to the left.

The management response provided by MCS acknowledges the concerns and indicates agreement with four of the recommendations. Regarding the fifth, related to edits and audits, the program proposed an alternate solution to address the concern.

Table of Contents

I. PURPOSE AND OBJECTIVES	1
II. BACKGROUND	2
III. INSPECTION RESULTS	7
Observation 1: TMHP and MCOs paid Medicaid claim details without a matching EVV transaction.	7
Recommendation 1.1	11
Recommendation 1.2	13
Observation 2: Submitting claim details with date spans, instead of a single date-of-service, leads to partial matches and allows some dates-of-service to be paid without a matching EVV transaction.	14
Recommendation 2	14
Observation 3: Preferred reason codes are misused, which can lead to inflated Provider Compliance Scores, and do not accurately reflect compliance.	15
Recommendation 3.1	19
Recommendation 3.2	20
V. CONCLUSION.....	22
VI. APPENDICES	23
Appendix A: Medicaid Program Services Enforcing Provider Use of EVV	23
Appendix B: EVV Legislative and Policy Milestones	24
Appendix C: EVV Data Flow	26
Appendix D: List of Reason Codes	27
Appendix E: Methodology.....	31
Appendix F: Report Team and Report Distribution	35
Appendix G: OIG Mission and Contact Information	36

I. PURPOSE AND OBJECTIVES

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Inspections Division conducted an inspection to determine how effective the Electronic Visit Verification (EVV) system is at verifying home service visits for Medicaid clients occurred and at confirming that home services were provided. The inspection focused on the following objectives:

- Determine the percentage of Medicaid claim details matched with EVV data.
- Determine the effectiveness of the HHSC EVV Provider Compliance Plan.

Why This Inspection Was Conducted

Loss of Medicaid funds nationwide through fraud, waste, and abuse (FWA) is a significant concern. Centers for Medicare & Medicaid Services estimated \$4.7 billion in improper payments for personal support services nationwide, which includes personal care services (PCS), for federal fiscal year 2016.¹ This was the estimate for fee-for-service personal support services. Texas Medicaid services are provided through a combination of fee-for-service (FFS) and managed care models.

The EVV system was designed to deter FWA in PCS in Texas Medicaid. Those services are provided by home health attendants who are not required to be licensed or certified care givers. Of all the complaints received by the Medicaid Program Integrity Division's Intake Unit in state fiscal year 2017, 45.9 percent were complaints about home health agencies.

In state fiscal year 2017, services subject to EVV totaled nearly \$2.6 billion in paid Texas Medicaid fee-for-service and managed care claims.²

Personal care services provided in the client's home assist vulnerable, often medically fragile, clients to continue to live in the community at an optimal level of well-being. Lack of critical daily living services could result in hospitalization or a client's need for institutional living, such as a group home or nursing facility which have the potential to increase Medicaid costs. When used as intended, claim details matched to an EVV transaction can provide reasonable assurance that an attendant was present to provide services to vulnerable clients.

¹ Centers for Medicare and Medicaid Services, Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services (November 2017), page 6, <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/vulnerabilities-mitigation-strategies.pdf>

² OIG Inspections Division from non-audited data self-reported by payers.

In December 2016, the 21st Century Cures Act was signed into law.³ Within this wide-ranging federal healthcare legislation, EVV will be required for PCS and home health services provided under Medicaid, including FFS and managed care. Under federal law, personal care services are required to be verified by January 1, 2019, and home health services by January 1, 2023. Each state is allowed to develop their own EVV program and oversight. HHSC has implemented and operationalized the PCS component of the EVV program.

Inspections are designed to be expeditious, targeted examinations into specific programmatic areas to identify systemic trends of FWA and result in recommendations to strengthen program effectiveness and efficiency. This report expresses the OIG's initial review of the integrity of the EVV system.

II. BACKGROUND

EVV Overview

EVV is a telephone and computer-based system intended to verify when home service visits for Medicaid clients occur by creating electronic documentation of when a service visit begins and ends. Texas implemented EVV to verify when clients receive select authorized services for which the state is billed and, as required by state rule, to adjudicate claims.

HHSC Medicaid and CHIP Services (MCS) administers EVV, which is required for certain home and community-based services.⁴ Texas Medicaid services are provided through a combination of fee-for-service (FFS) and managed care models. Texas Medicaid and Healthcare Partnership (TMHP), the Texas Medicaid claims administrator, pays FFS claims, while managed care organizations (MCOs) are contracted to administer and pay claims under the managed care model. Services that require EVV are paid through TMHP and 12 of the 20 contracted MCOs.⁵ These 12 MCOs are contracted to provide the select services that are subject to EVV.

In 2010, the Texas Legislature directed the Department of Disability and Aging Services (DADS) to identify cost savings.⁶ In response, DADS piloted EVV in March 2011 in the Midland/Odessa area. Senate Bill 7, 82nd Legislature, First Called Session, 2011, directed DADS to pilot EVV and, if cost effective, to implement it in a wider area.

³ 21st Century Cures Act, Public Law 114-225 (2016)

⁴ For a list of *Programs that Enforce Provider Use of EVV*, see Appendix A

⁵ The 12 MCOs are: Aetna, Amerigroup, Blue Cross Blue Shield, Children's Medical Center, Cigna-Health Spring, Community First, Cook Children's, Driscoll, Molina, Superior, Texas Children's, and UnitedHealthcare.

⁶ Texas Senate Committee on Health and Human Services, Interim Report to the 82nd Legislature, Page 203, <http://www.senate.state.tx.us/cmtes/81/c610/c610.InterimReport81.pdf>

In April 2014, DADS rules, 1 Tex. Admin. Code § 354.1177, were adopted requiring EVV for home skilled nursing, private duty nursing, and PCS. Incrementally EVV was expanded and was operational statewide by June 2015. In September 2016, as part of the Health and Human Services system transformation, administration of the EVV program transitioned from DADS to HHSC Medicaid and CHIP services. Currently, the requirement for EVV is only enforced for the programs listed in Appendix A.

PCS is also known as personal assistance services. These daily living services include bathing, cooking, feeding, personal hygiene, toileting, cleaning, and laundry. The services are provided to clients who have a physical, cognitive, or behavioral limitation related to a disability or chronic health condition.

State Guideline - Texas Administrative Code

The Texas Administrative Code sets forth the requirements for EVV in 1 Tex. Admin. Code § 354.1177 (2014). With regard to payment of claims, the rule states:

- (g) Use of EVV data for claims reimbursement.
- (1) HHSC will not pay a claim for reimbursement unless the data from the EVV system corresponds with the health care services for which reimbursement is claimed and is consistent with an approved HHSC prior authorization or DADS Plan of Care.
 - (2) Paid claims may be subject to retrospective review and recoupment, if appropriate.

Further, the Texas Medicaid Uniform Managed Care Manual states that every Medicaid-enrolled service provider who provides services subject to EVV must use an HHSC-approved EVV system to record service visits with the client.^{7,8}

Vendors

EVV is administered through an HHSC-approved system currently operated by two vendors: MEDsys and DataLogic. These vendors are required to provide and maintain electronic documentation of service delivery visits and provide daily data files to the payers: MCOs and TMHP. Each vendor is responsible to train its contracted providers on use of the EVV web-based system.

In December 2010 a contract was awarded to one vendor to pilot EVV. In November 2014, tentative awardee contracts were finalized with three additional vendors. In 2015, EVV transitioned from four vendors to two; DataLogic and MEDsys were the two remaining contracted vendors.

⁷ See Appendix B for a reference of guidance to providers and contractors when rolling out EVV.

⁸ Texas Medicaid and CHIP, Uniform Managed Care Manual, Chapter 3.3, Attachment N, page 51 (2017)

DataLogic and MEDsys experienced technical issues during their initial year of services and were placed on corrective action plans (CAP) in October 2015. DataLogic remained on a CAP until August 2016. MEDsys remained on the initial CAP until April 12, 2017. However, later that April MEDsys was placed on a new CAP, which currently remains in place.

Providers and Attendants⁹

Home health providers subject to EVV are required to contract with either MEDsys or DataLogic to ensure service activity is recorded. Providers employ attendants to deliver in-home services. Providers are responsible for training their attendants to use the EVV system when the attendant conducts service visits. During each home visit, using the client's landline, the attendant calls the EVV system toll-free phone number upon arrival to and departure from the Medicaid client's residence.

If a landline is not available, the provider is required to install a Small Alternative Device (SAD). The SAD, measuring about the size of credit card, is affixed to a permanent location in the residence with a zip tie. The SAD is specifically assigned to a client's residence and generates a code identifying the time and date, with the code changing approximately every minute. The attendant makes note of the code displayed at time of arrival and departure. Personal cell phones can be used to call in the SAD values, however attendants cannot use the client's personal cell. The codes are reported by providers to the EVV vendor, MEDsys or DataLogic, within seven days for entry into their system as reported service activity.

Through the provider's contracted EVV vendor, every call is documented as an EVV transaction that includes client, attendant, provider identification number, time and date of the visit, and other data elements. The call captures the transaction information in a client record, which can be reviewed in real-time by providers to determine if the attendant's time matches the client's scheduled time for visits. When the transaction is documented through the phone call to the vendor and no corrections or changes are made by the provider, transactions are considered *auto-verified*. Providers have the opportunity to make adjustments in the application for up to 60 days after the date-of-service. This is referred to as *visit maintenance*. Transactions are not considered auto-verified if visit maintenance is conducted.

Providers document reasons for visit maintenance to transactions by selecting one or more reason codes. Providers are required to use the reason code(s) with the most accurate description of why the adjustment is needed. The two types of codes are:

⁹ See Appendix C for the EVV Data Process Flow

- Preferred reason codes - These are codes that can be used for visit maintenance for a situation in which the provider staff is delivering and documenting services in accordance with HHSC expectations. An example is reason code 100, which documents a change in visit schedule.¹⁰
- Non-preferred reason codes - These are codes that can be used for visit maintenance for a situation in which the provider staff is not delivering and documenting services in accordance with HHSC expectations. An example is reason code 905, which documents the attendant failed to call out.

When a provider performs visit maintenance, the transaction becomes *verified preferred* or *verified non-preferred*, depending on the reason code(s) selected.

EVV Provider Compliance Plan and Score

The EVV Provider Compliance Plan establishes standards and rules for the electronic collection and reporting of visits by providers and vendors, which are used to support claims for services. A formula is used to measure the percentage of a provider's compliance with the established standards and rules. The Provider Compliance Score is calculated using the following equation:

$$\left(\begin{array}{c} \text{Visits} \\ \text{Auto} \\ \text{Verified} \end{array} + \begin{array}{c} \text{Visits} \\ \text{Verified} \\ \text{Preferred} \end{array} \right) \div \begin{array}{c} \text{Total Visits} \\ \text{Rounded to} \\ \text{the nearest} \\ \text{percent} \end{array} = \begin{array}{c} \text{Provider} \\ \text{Compliance} \\ \text{Score} \end{array}$$

EVV compliance scores are reviewed by HHSC and MCOs on a quarterly basis for monitoring and oversight. Failure to achieve and maintain a Provider Compliance Score of at least 90 percent per quarterly review period may result in providers receiving corrective action plans (CAP), the assessment of liquidated damages (LD), or the imposition of contract actions including contract termination.

EVV Transaction Data Files and Claims Processing

TMHP and MCOs process claims for payment. MEDsys and DataLogic submit a daily EVV transaction data file to those payers to compare with service claim details. EVV program policy does not specify criteria that payers must use to match a claim detail to an EVV transaction. Each payer has established their own criteria to match an EVV transaction to a claim detail. All payers consider: date-of-service, provider identification number, and recipient identification number. Six MCOs use up to six criteria, including procedure code and service units.

¹⁰ A list of EVV reason codes and explanation of each is in Appendix D.

When a payer attempts to match a claim detail to an EVV transaction, the result may be:

- Matched - claim detail had a matching EVV transaction
- Partially matched - only a portion of the claim detail had a matching EVV transaction
- Unmatched - claim detail did not have a matching EVV transaction

A claim detail may not match an EVV transaction for several reasons. The most common are: criteria missing or incorrect; the claim may have been submitted before the EVV transaction; the EVV transaction or claim may have been sent to the wrong payer; or the service may not have been performed. Unmatched does not conclusively indicate the service was, or was not, provided.

Data Issues Reported by the Program

MCS reported several data issues they believe may have impacted the unmatched rate in FY 2017, including:

- Implementation of STAR Kids reportedly resulted in EVV data being sent to the wrong payer.
- After submitting data to the OIG, one MCO, reported to MCS a problem calculating the unmatched rate. That MCO reported a high unmatched rate and low dollars paid for unmatched claims requiring EVV.
- After submitting data to the OIG, one MCO reported to MCS that registered nurse and licensed vocational nurse services were erroneously included in the data submitted to the OIG.

These data issues do not impact the structural programmatic issues identified in this report.

III. INSPECTION RESULTS

The inspection determined that TMHP and some MCOs are not in compliance with 1 Tex. Admin. Code § 354.1177, which specifies claims will not be paid without an EVV match. Claims without matching EVV transactions are paid by MCOs and TMHP.

Inspectors confirmed that the Provider Compliance Plan defines and establishes standards and rules for providers using EVV and contains multiple strategies designed to facilitate and support EVV operations. The plan discusses (a) compliance scoring, (b) compliance reporting, and (c) CAPs and LDs for instances where there is lack of compliance. The strategies establish a framework for monitoring and oversight.

In fiscal year 2017, MCOs and TMHP paid claims that did not have matching EVV transactions, in violation of TAC, totaling more than \$117 million.²

The inspection also determined some components of the Provider Compliance Plan need improvement. Interviews with program staff, providers, and MCOs, along with data and reports from one MCO confirm an awareness that some providers misuse reason codes, which can lead to inflated Provider Compliance Scores. Inspectors also found that some providers submit a span of service dates on one claim detail, but EVV matches to only a single date-of-service. This results in partially matched claim details making it difficult to determine which service date had a matching EVV.

The OIG Inspections Division makes the following observations and recommendations:

Observation 1: TMHP and MCOs paid Medicaid claim details without a matching EVV transaction.

Paid Claims

To determine the percentage of Medicaid claim details matched with EVV transaction data, the inspection team requested MCO and FFS claims and EVV match transaction data for fiscal year 2017. The results are shown in Table 1. For all 12 MCOs and TMHP, the table reflects the total number of claim details related to EVV. The percent of unmatched claim details that were paid by each payer ranged from 0 to 100 percent.

Table 1: Claim Details and EVV Transaction Match by Payer, 2017

Payers	Number of Claim Details	% of Matched Claim Details	% of Partially Matched Claim Details	% of Unmatched Claim Details
Driscoll Children's	12,672	0%	0%	100%
Aetna Better Health	6,000	35%	17%	48%
Texas Children's	147,981	39%	17%	45%
Cook Children's	29,063	65%	0%	35%
Children's Medical Center	30,070	69%	15%	16%
Community First	31,663	88%	1%	11%
Amerigroup	1,979,162	82%	8%	10%
Blue Cross Blue Shield	21,878	2%	88%	9%
TMHP	5,830,723	81%	12%	7%
United Healthcare	1,133,650	90%	5%	5%
Superior	12,965,281	97%	1%	3%
Cigna-Health Spring	2,299,958	97%	2%	2%
Molina Healthcare of TX	1,799,596	99%	1%	0%

Source: *OIG Inspections Division from non-audited data self-reported by payers*
Numbers have been rounded to the nearest whole percentage.

EVV Matching Processes

Inspectors reviewed the claim to EVV matching processes used by each MCO and TMHP to determine which processes allow payment of claims without an EVV match. Inspectors found two processes used to determine if a claim detail has a matching EVV transaction. Those are:

- Prospective matching review - This *pre-payment* process determines if there is a matching EVV transaction to the claim detail prior to claim payment. According to the Texas Administrative Code, the claim detail should not be paid if there is not a match. Using a prospective matching process, payers can deny payment of claim details that are not verified by a matching EVV transaction. Preventing payment when there is no EVV match ensures compliance with 1 Tex. Admin. Code § 354.1177(g)(1) and allows providers an opportunity to correct EVV data during the 60-day visit maintenance timeframe. This improves data integrity and helps ensure proper payment.

- Retrospective matching review** - This *post-payment* process determines if there is a matching EVV transaction to the claim detail after the claim is paid. If, during post payment review, it is determined there was not a match, recoupment of dollars paid may be possible. A retrospective review does not ensure compliance with 1 Tex. Admin. Code § 354.1177(g)(1) and may lead to a ‘pay and chase’ process, where a payer has a decreased chance to recoup dollars already paid.

‘Pay and chase’ refers to when a provider is paid and the payer chases provider for return of the payment.

HHSC directed TMHP to have a prospective matching process; however TMHP is not required to reprocess or make adjustments to claims if there is not a matching EVV transaction. The Provider Compliance Plan allows MCOs the flexibility to choose either a prospective or retrospective process. Inspectors sent questionnaires to the MCOs to determine which process they use. As Table 2 shows, those MCOs that indicated they conduct prospective reviews do not pay claim details without a matching EVV transaction.

Table 2 shows Aetna performed a prospective review for all fiscal year 2017 claims and has not paid or needed to recoup dollars for unmatched claim details. Superior and Molina have performed both prospective and retrospective reviews at different times during fiscal year 2017. When a retrospective review was done, claims were paid that were unmatched to EVV transaction detail.

Table 2: EVV Matching Process by Payer, 2017¹¹

Payer	Dollars Paid for Unmatched Claim Details	Prospective Matching Process or Retrospective Matching
TMHP	\$66,430,573	Prospective Matching
Amerigroup	\$28,456,851	Retrospective Matching
UnitedHealthcare	\$14,574,415	Retrospective Matching
Texas Children's	\$600,217	Retrospective Matching
Cigna-Health Spring	\$5,147,287	Retrospective Matching
Superior **	\$1,674,947	Retrospective Matching (Apr 2017 - Aug 2017)
Superior **	\$0	Prospective Matching (Sep 16 - Mar 17)
Children's Medical Center	\$148,077	Retrospective Matching
Cook Children's	\$121,518	Retrospective Matching
Driscoll	\$225,330	Retrospective Matching
Community First	\$57,480	Retrospective Matching
Blue Cross Blue Shield	\$96,962	Retrospective Matching
Molina ++	\$142,831	Retrospective Matching (Sep 2016 - May 2017)
Molina ++	\$0	Prospective Matching (Jun 2017 - Aug 2017)
Aetna	\$0	Prospective Matching (SFY 2017)
Total	\$117,676,488	

** Superior - switched from Prospective Matching to Retrospective Matching in April 2017
 ++ Molina - switched from a Retrospective Matching to Prospective Matching June 2017

Source: *OIG Inspections Division from non-audited data self-reported by payers*

¹¹ Dollars represent adjustments resulting from *Data Issues Report by the Program* section on page 6.

Recovery of Dollars Paid

Title 1, Section 354.1177(g) of the Texas Administrative Code has been in effect since April 13, 2014, and states HHSC will not pay a claim unless the data from the EVV system corresponds with the health care services for which reimbursement is claimed. The rule goes on to state recoupment of paid claims may occur. The inspection also reviewed processes for recoupment of dollars paid.

In November 2017, three MCOs reported managed care dollars identified for recoupment totaling \$12.5 million and are in the process of recouping the identified funds. For FFS claims, the HHSC Contracted Community Services (CCS) division within MCS handles recoupment of paid claims. The division conducts provider visits and reviews visit logs and EVV transactions. Dollars paid are recouped when there is no matching EVV transaction. However, visits to providers occur once every 2 years and only 30 client records for a 6 month period are reviewed, not the 2 years. The OIG requested the FFS amount recouped in fiscal year 2017. The CCS division recouped at least \$1 million, but the reasons for recoupment were not always due to unmatched EVV transactions.

Table 3 shows the total EVV dollars paid by each payer, as well as the dollars paid for matched, partially matched and unmatched claim details. Based on the data available to the OIG, it appears that more than \$117 million was paid for claim details without a matching EVV transaction.¹¹

Table 3: Dollars Paid for EVV Related Claims and EVV Match Status, 2017¹¹

Payers	Total Dollars Paid for EVV Related Claim Details	Dollars Paid for Matched Claim Details	Dollars Paid for Partially Matched Claim Details	Dollars Paid for Unmatched Claim Details
Amerigroup	\$339,495,646	\$282,416,983	\$28,621,812	\$28,456,851
UnitedHealthcare	\$342,583,117	\$298,726,192	\$29,282,510	\$14,574,415
Texas Children's	\$7,470,340	\$4,492,736	\$2,377,387	\$600,217
Cigna-Health Spring	\$260,377,163	\$253,483,628	\$1,746,248	\$5,147,287
Superior	\$713,438,889	\$711,171,541	\$592,402	\$1,674,947
Children's Medical Center	\$1,740,565	\$1,249,058	\$343,430	\$148,077
Cook Children's	\$1,263,891	\$1,134,501	\$7,872	\$121,518
Driscoll	\$226,684	\$1,354	\$0	\$225,330
Community First	\$1,608,509	\$1,538,909	\$12,119	\$57,480
Blue Cross Blue Shield	\$1,292,989	\$25,845	\$1,170,183	\$96,962
Molina	\$218,331,960	\$217,235,488	\$953,641	\$142,831
Aetna	\$189,020	\$162,364	\$26,656	\$0
Total for MCOs	\$1,888,018,774	\$1,771,638,599	\$65,134,260	\$51,245,916
TMHP	\$732,268,577	\$453,762,206	\$212,075,798	\$66,430,573
Total for All Payers	\$2,620,287,351	\$2,225,400,805	\$277,210,058	\$117,676,488

Source: OIG Inspections Division from non-audited data self-reported by payers
Rows may not total due to rounding to nearest whole dollar.

Payment of claim details without a matching EVV transaction violates 1 Tex. Admin. Code § 354.1177(g). Further, paying unmatched claim details allows providers to bypass the purpose of EVV implementation. Paying unmatched claim details does not deter fraud, waste, or abuse and fails to offer confidence that services were provided, which may result in patient harm.

Recommendation 1.1: HHSC MCS should comply with 1 Tex. Admin. Code § 354.1177(g) and recover dollars paid, as appropriate, for claims without a matching EVV transaction.

Management Response:

HHSC MCS acknowledges the need to ensure providers and payers comply with the requirements of the Texas Administrative Code (TAC) when matching claims to EVV visit transactions. HHSC MCS also agrees that, where appropriate, payers should recover dollars paid for claims without a matching EVV visit transaction. Based on the findings of our comprehensive review of the EVV systems and processes, which identified underlying data integrity issues in the EVV system, the appropriateness of the recovery, or recoupment, of funds from providers should be determined and restricted according to HHSC guidelines.

HHSC MCS recently completed a detailed review of current EVV processes and systems 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. The resulting legislative report, Electronic Visit Verification – Operational and Administrative Review, referred to here as the S.B. 894 report, recognizes weaknesses in the EVV systems, which affect data quality that limits the ability of payers to match EVV transactions to claims data.

While the IG Inspection Report mentions these data integrity issues briefly, the HHSC MCS review found that for the majority of claims the providers did document the visits in the EVV systems. However, as the S.B. 894 report indicates, the visit data used for claims matching was either not available to the payer or had errors which rendered the data unsuitable to match the EVV transaction to the claim. HHSC identified inadequate data validation in EVV systems to prevent data entry errors, issues introduced in EVV vendor software systems, and unreliable data exchanges with payers as root causes for these issues.

Therefore, given the high rate of data errors identified during research by payers and HHSC, payers took additional steps to determine the appropriateness of the denial or recoupment of claims. Because of the research, HHSC postponed the denial of fee-for-service claims associated with the match to EVV data. In addition, some MCOs have chosen not to recoup when a claim does not have a matching EVV transaction and have worked directly with providers and EVV vendors to verify the EVV data.

HHSC will direct the payers to pursue recovery of any dollars paid only if verified that the EVV visit data does not exist or is unusable for claims matching. Determination of an appropriate recovery will require payers to follow steps for research and documentation of the visit with providers and EVV vendors, as defined by HHSC requirements.

Responsible Party: Mine Epps, Director of Claims Management

Implementation Plan:

FFS Claims:

- HHSC and TMHP, the state's Medicaid claims administrator, will continue to work with EVV vendors to resolve data quality issues and ensure that the vendors successfully exchange EVV transactions for FFS providers to TMHP.
- As documented in the IG report, HHSC Contracted Community Services division within MCS has, and will continue to, recommend recoupments for FFS providers due to non-compliance.
- HHSC and TMHP will continue to monitor and research the primary causes of the unmatched FFS claims during fiscal year 2017. As part of this activity, HHSC will determine appropriate recoupment actions for unmatched EVV-related claims.

Managed Care Claims:

- MCOs are working closely with the EVV vendors to determine if visit data exists anywhere in the system prior to initiating recoupment.
- Where appropriate, MCOs are actively recouping claims paid with no matching EVV transaction and will continue to do so. As of November 2017, three MCOs have performed recoupment of EVV-related claims paid without an EVV visit transaction match.

HHSC will issue the following updated requirements to define appropriate recoupment of EVV-related claims.

FFS and MCO payers may only consider recoupment of claims without a matching EVV visit transaction back to April 2016, which is when HHSC first began enforcement of provider compliance. In doing so, all payers must adhere to the following actions to determine if the recoupment is appropriate:

- 1) Research provider visit data with the appropriate EVV vendor to determine if EVV visit data exists;
- 2) Perform outreach with the provider to confirm EVV; and,
- 3) Communicate an EVV appeals process in writing to the provider.

In addition, the S.B. 894 report documents short- and long-term activities by HHSC to address the underlying EVV data issues and ensure continuous improvement of the EVV processes and systems. HHSC must implement these improvements to ensure reliable EVV data to hold providers and payers accountable under the HHSC TAC rules.

Implementation Date:

- July 1, 2018 – Issue guidance related to recoupment
- September 2019 – Implementation of new EVV system capabilities

Recommendation 1.2: HHSC MCS should, through its contract oversight responsibility, require MCOs and TMHP to have a prospective (prepayment) matching process to ensure claim details without a matching EVV transaction are not paid.

Management Response:

HHSC MCS agrees with the IG recommendation and recognizes that the payers should perform a pre-payment review for EVV-related claims during claims adjudication. The current MCO claims adjudication rules in the HHSC Uniform Managed Care Manual (UMCM), which pre-date EVV implementation, give MCOs the flexibility to conduct either prospective (pre-payment) or retrospective (post-payment) reviews of any paid claims, whether EVV-related or not.

Issues identified during the S.B. 894 comprehensive review and research by payers, have deferred payer's adoption of the prospective review in order to determine if the match was unsuccessful due to underlying data integrity issues or the visit did not occur. Rather than deny the claim, given these known data issues, the payers have elected to recover dollars paid through recoupment when it has been determined it is appropriate.

Responsible Party: Mine Epps, Director of Claims Management

Implementation Plan:

HHSC will require each MCO to conduct prospective reviews and no longer conduct retrospective reviews on EVV claims. HHSC will also instruct TMHP to make the necessary changes to the state claims management system to enforce prospective reviews for FFS claims. If the claims adjudication process does not find a matching EVV transaction, payers will be required to send the provider agency a detailed EVV notice including a standardized Explanation of Benefit with detailed reasons for the claim denial.

Implementation Date:

- September 1, 2018 - UCMCM contract changes become effective and notification to providers
- September 1, 2019 - Implementation of FFS and MCO prospective claims adjudication process

Observation 2: Submitting claim details with date spans, instead of a single date-of-service, leads to partial matches and allows some dates-of-service to be paid without a matching EVV transaction.

HHSC allows TMHP and the MCOs to accept date span billing, where providers bill multiple consecutive dates-of-service in a single claim detail. However, an EVV transaction can only match to one single date-of-service. Allowing multiple dates-of-service on one detail creates partial matches. An example of a partial match is when a provider bills 14 days of service on one detail, but there are EVV transaction matches for only 10 of those days.

To accurately determine the total percentage of claim details and dollars paid without a matching EVV transaction, partially matched must also be considered. When reviewing Table 3, it is important to note that portion(s) of the partially matched claim details are unmatched. When that occurs, there is not an electronic process to identify which portion has a matching EVV transaction and which does not. To realize the actual percent of unmatched claim details, the unidentifiable portion of partially matched must be included with the unmatched.

When interviewed, TMHP claim experts explained that claims adjudication does not support paying a partial amount on a single claim detail. In FFS, when there is a partially matched claim detail, the entire detail will pay or deny. Denying partially matched claim details would delay reimbursement to providers if even one date-of-service does not have an EVV match. Paying a partial amount on a detail would cause confusion. Providers would not know which date in the span paid and which did not. Claim adjustments and oversight reviews would lack clarity and be complicated for providers and payers alike.

Allowing only a single date-of-service in each claim detail would enable payers and providers to accurately track dollars paid. Single dates-of-service would also allow systems to identify an EVV match for each date-of-service, improving oversight.

Recommendation 2: HHSC MCS should, through its contract oversight responsibility, direct TMHP and MCOs to allow providers to only submit claims with a single date-of-service per detail for claims that require EVV transactions.

Management Response:

HHSC MCS agrees with the IG recommendation to require providers to limit claim line item details to a single date-of-service for EVV related claims submissions. HHSC billing requirements currently allow providers to submit claims with either span date or a line item per date of service. Providers can avoid potential mismatches with EVV data by using a single date of service per line item on the claim. Several MCOs and providers already utilize this billing method.

Responsible Party: Mine Epps, Director of Claims Management

Implementation Plan:

HHSC MCS will issue new billing guidance to direct providers to submit claims with a single date-of-service per claim line item.

While some MCOs have put the single date of service per line item requirement in place, and it appears that payer claims adjudication systems handle both methods, HHSC will issue new guidance in the UMCM for MCOs and through written policy changes for FFS providers. Changes to the state claims management system to support this change will be included in the EVV continuous improvement project to standardize and centralize EVV capabilities at TMHP.

Implementation Date:

- September 2018 - Notification of billing policy changes to MCOs and providers
- March 1, 2019 - UMCM contract changes become effective
- September 2019 - Implementation of new EVV system capabilities

Observation 3: Preferred reason codes are misused, which can lead to inflated Provider Compliance Scores, and do not accurately reflect compliance.

The Provider Compliance Plan states, “If HHSC, DADS, or the appropriate MCO determines a provider agency has misused preferred reason codes per policy, the provider agency compliance plan score may be negatively impacted, and the provider agency may be subject to the assessment of liquidated damages, imposition of contract actions, implementation of the corrective action plan process, and/or referral for a fraud, waste, and abuse investigation.”

Inspectors found providers are not consistently following requirements of the Provider Compliance Plan. Interviews with program staff, providers, TMHP, and MCOs, as well as MCO responses to questionnaires and review of data, confirm the following:

- Preferred reason codes are misused.
- Provider Compliance Scores are inflated and do not accurately reflect provider performance.

Preferred Reason Code Misuse

Some providers misuse preferred reason codes. The Provider Compliance Plan states, “Providers must associate the **most appropriate** reason code with each change made in visit maintenance...” Providers have a choice of which reason code to use. By selecting a preferred reason code, providers can keep their compliance score higher than using a non-preferred reason code. Therefore, providers are unintentionally incentivized to select preferred reason codes.

Inspectors confirmed instances where reason codes used by providers did not match the EVV data recorded in corresponding transactions. Examples of the misuse of three preferred reason codes (Codes 100, 205, and 300) follow.

- **Preferred reason code 100 (Schedule Variation)** is intended to be used only when the attendant provided more or fewer hours of service, or service at a different time of day than was scheduled. The EVV Reason Code table shown in Appendix C states reason code 100 cannot be used when an attendant fails to clock in and/or clock out, unless the appropriate non-preferred reason code is also used: 900- attendant failed to call in, 905- attendant failed to call out, or 910- attendant failed to call in and out.

Preferred reason code 100 (Schedule Variation) is the most frequently used code and the most misused code overall.

Inspectors analyzed MCO and FFS visit data from across the state for January 2017. Table 4 shows results of analysis that indicated 15 percent of the time, when providers used reason code 100, there was no clocked time in or time out and no required accompanying 900 code.

Table 4: Reason Code 100 Transaction Summary, January 2017

Total Number of EVV Transactions Using Reason Code 100	Number Without the Appropriate Non-Preferred Reason Code	Number With the Appropriate Non-preferred Reason Code
1,032,091	151,099 (15%)	880,992 (85%)

Source: OIG DAT EVV data; run date 8/24/2017

Table 5 displays a sample of the misuse of reason code 100. Each row represents a visit by an attendant to a client. A blank indicates the attendant did not clock in or clock out. The provider entered only reason code 100 for each visit, when one of the appropriate non-preferred codes (900, 905, or 910) should have also been included.

Table 5: Example of Misuse of Preferred Reason Code 100

Scheduled Visit Date	Scheduled Visit Time In	Scheduled Visit Time Out	Number of Hours Scheduled	Attendant Entered Time In	Attendant Entered Time Out	Reason Code Entered For EVV Transaction
1/1/2017	12.00 PM	02.00 PM	2			100-Schedule Variation
1/4/2017	01.00 PM	04.30 PM	3.5		04-JAN-17 04.30 PM	100-Schedule Variation
1/5/2017	01.00 PM	04.30 PM	3.5	05-JAN-17 01.00 PM		100-Schedule Variation
1/7/2017	12.00 PM	03.00 PM	3		07-JAN-17 03.18 PM	100-Schedule Variation
1/8/2017	12.00 PM	02.00 PM	2		08-JAN-17 02.25 PM	100-Schedule Variation
1/12/2017	01.00 PM	04.30 PM	3.5	12-JAN-17 01.02 PM		100-Schedule Variation
1/15/2017	12.00 PM	02.00 PM	2			100-Schedule Variation
1/18/2017	01.00 PM	04.30 PM	3.5	18-JAN-17 01.11 PM		100-Schedule Variation
1/19/2017	01.00 PM	04.30 PM	3.5	19-JAN-17 01.03 PM		100-Schedule Variation
1/20/2017	01.00 PM	04.30 PM	3.5	20-JAN-17 12.59 PM		100-Schedule Variation
1/24/2017	01.00 PM	04.30 PM	3.5	24-JAN-17 01.08 PM		100-Schedule Variation
1/27/2017	01.00 PM	04.30 PM	3.5	27-JAN-17 12.59 PM		100-Schedule Variation
1/28/2017	12.00 PM	03.00 PM	3			100-Schedule Variation

Source: OIG DAT EVV Data; run date 8/24/2017

Preferred reason code 205 (Small Alternative Device Pending Installation) - This code is used when a small alternative device (SAD) is pending installation in a client’s home where a landline is not available. The published EVV Reason Code list states, “Use of RC [reason code] 205 for the same individual/member over a period greater than 14 calendar days may constitute misuse of this preferred reason code.”

Preferred Reason Code 300 (Phone not working - Not able to call) - The published EVV Reason Code list states this code, “is selected when call in or call out is not possible due to technical problems with landline phone (e.g., individual’s/member’s phone not working, phone line is disconnected or EVV vendor system issues). Continuous vendor system issues must be reported to your EVV vendor. Please notify payer(s) within 48 hours of unresolved vendor system issues.”

A report provided by one MCO shows examples of misuse of reason codes 205 and 300. Table 6 is derived from that report. The rows display the number of times the provider selected reason code 205 and reason code 300 for each of seven clients for each month of fiscal year 2017. For Client A, code 205 was selected by the provider 27 times in September and code 300 was selected 22 times in February.

The data shows a trend of the provider selecting reason code 205 for several months, more than the allowed length of time. The provider then switches to code 300 for the later part of the year to avoid detection without fixing the problem of installing a SAD in the home. This is one specific example, but was noted frequently in interviews with payers and providers.

If the SAD is pending installation for several months, there is not a way to verify the attendant was at the residence to provide services. During interviews with EVV vendors and home health providers, there was no indication of a delay in the supply of SADs when requested. The vendors have 10 days to ensure the SAD is delivered to the home health provider.

Table 6: Misuse of Reason Code 205 for One MCO Payer

Reason Codes Used		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Client A	205 - Small Alternative Device Pending Installation	27	29	25	29	27	4						
	300 - Phone Not Working Not Able To Call						22	31	30	31	4	26	1
Client B	205 - Small Alternative Device Pending Installation	24	29	25	31	28	18	6					
	300 - Phone Not Working Not Able To Call					1	8	22	30	30	29	31	1
Client C	205 - Small Alternative Device Pending Installation	24	29	25	31	30	15	3	1				
	300 - Phone Not Working Not Able To Call						7	27	29	31	28	28	1
Client D	205 - Small Alternative Device Pending Installation	24	29	17	31	16		2	5	1	15		
	300 - Phone Not Working Not Able To Call					13	22	31	14	2	5	7	1
Client E	205 - Small Alternative Device Pending Installation	24	28	25	31	9							
	300 - Phone Not Working Not Able To Call					8		11	9	31	28	29	1
Client F	205 - Small Alternative Device Pending Installation	24	29	24	31	28	3						
	300 - Phone Not Working Not Able To Call					5	23	31	24	3	1		
Client G	205 - Small Alternative Device Pending Installation	23	29	25	31	28							
	300 - Phone Not Working Not Able To Call					1	25	31	29	31	27	28	1

Source: OIG Inspections Division from non-audited data self-reported by an MCO

Provider Compliance Scores Are Inflated and Do Not Accurately Reflect Compliance

Inspectors found that the Provider Compliance Score does not accurately reflect provider performance. Two variables presently influence compliance scoring: misuse of preferred reason codes and how the score is calculated. The current compliance score equally values auto-verified and verified preferred visits. However, auto-verified offers more data integrity because:

- Auto-verified is an automated transaction that occurs when the attendant calls in or out to report a visit has occurred. Only the attendant enters the required data, which is then automatically time stamped. Transactions are considered auto-verified when documented through the phone call to the vendor and providers do not make corrections or changes.
- Verified preferred is a manual transaction that occurs when provider staff conducts visit maintenance and enters EVV data using reason codes. This could result in human error, thereby decreasing data integrity.

All three of the MCOs interviewed agreed that the auto-verified transactions percentage should be the standard for determining compliance scores. Presently, auto-verified transactions are approximately 40 percent of total transactions. The Provider Compliance Score would better reflect provider performance and policy adherence if the formula relied more heavily or solely on auto-verified transactions. Edits and audits are valuable tools that can prevent providers from misusing preferred reason codes during visit maintenance. They are rule-based software strategies that can aide in adherence to guidelines. For example:

- Edit for reason code 100 - Schedule Variation: This edit would set if code 100 was entered when an attendant failed to clock in or clock out, and code 900, 905, or 910 was not entered. The edit will not allow the entry.
- Audit for reason code 205 - Small Alternative Device Pending Installation: This audit would set if code 205 was entered more than 14 days. The audit will only allow an entry for a specified number of days.

EVV vendors are not required by HHSC to use reason code edits and audits. Vendor use of edits and audits could help ensure that payers receive EVV transactions that are in adherence with policy guidelines.

Recommendation 3.1: HHSC MCS should, through its contract oversight responsibility, require vendors to develop and implement EVV edits and audits to help enforce reason code policy.

Management Response:

HHSC MCS agrees with the IG observation that providers misuse preferred reason codes to clear exceptions during EVV maintenance when a non-preferred reason code is appropriate. However, HHSC MCS does not agree with the IG recommendation to have EVV vendors implement edit and audit capabilities to enforce reason code policy.

HHSC MCS has an initiative underway to review reason code usage with the goal of reducing the number of allowable reason codes and strengthening the policy for reason code usage. HHSC MCS will make changes to reason code policy in conjunction with the broader effort to address provider compliance. As necessary, HHSC will instruct EVV vendors to apply these policy changes to the EVV vendor system(s). EVV staff will review and coordinate proposed policy changes with the Contract Administration and Provider Monitoring (CAPM) and the Managed Care Compliance and Operations (MCCO) divisions as necessary.

Responsible Party: Mine Epps, Director of Claims Management

Implementation Plan:

HHSC MCS plans to align the reason code reduction and policy changes with the transition to the future EVV model and restructured technical environment. Prior to implementation of new reason code and compliance review policy, HHSC will:

- Develop new compliance guidelines for providers.
- Review proposed guidelines with payers, providers and EVV vendors.
- Codify policy changes in the EVV Providers Manual.
- Provide education on the revisions to reason code policy through provider stakeholder workgroups and training sessions.
- Provide payers with standardized reporting on reason code usage.

HHSC plans to include assessment of penalties, contract actions, liquidated damages, and potential contract termination in the new policies.

Implementation Date:

September 2019 - Implement new reason code policy and system modifications

Recommendation 3.2: HHSC MCS should establish a reasonable standard, in the Provider Compliance Plan, for the percentage of auto-verified EVV transactions that providers must achieve.

Management Response:

HHSC MCS agrees with the IG recommendation to establish standards for auto-verification of EVV transactions. The implementation of the future EVV model as well as policy changes already underway will improve auto-verification rates and may offer a better measure of provider compliance in the future.

Auto-verification of a visit occurs when the attendant call-in and call-out is successful and matches the visit schedule and data previously set up by the provider in the EVV system for a particular client service.

Several initiatives to reduce visit maintenance and increase auto-verified visits are underway. These include a pilot to reduce visit maintenance and a GPS mobile application pilot. HHSC MCS believes these efforts will lead to reduced visit maintenance, and improved provider performance, resulting in higher auto-verification rates.

Responsible Party: Mine Epps, Director of Claims Management

Implementation Plan:

HHSC MCS plans to implement solutions to reduce visit maintenance and expand the use of the GPS mobile application pilot this fiscal year. HHSC MCS will review the results of the ongoing pilot efforts and make appropriate changes to the EVV systems. Future data centralization will allow both providers and payers to better monitor auto-verification rates and provider compliance.

Implementation Date:

- May 1, 2018 - Expansion of GPS mobile application pilot
- July 1, 2018 - Visit Maintenance Reduction project implementation
- September 2019 - Implementation of new EVV system capabilities

IV. CONCLUSION

The OIG Inspections Division completed an inspection to determine the percentage of Medicaid claim details matched with EVV data and assess the effectiveness of the EVV Provider Compliance Plan.

The inspection found that the Provider Compliance Plan does define and establish standards and rules for providers using EVV. Through: 8 onsite visits with home health providers; more than 20 interviews with staff from the MCS EVV program, DataLogic, MEDsys, TMHP and MCOs; assessment of questionnaire responses; and review of payers' data for claim details to EVV transaction match, the OIG Inspections Division made the following observations:

- TMHP and MCOs paid Medicaid claim details without a matching EVV transaction.
- Submitting claim details with date spans, instead of a single date-of-service, leads to partial matches and allows some dates-of-service to be paid without a matching EVV transaction.
- Preferred reason codes are misused, which can lead to inflated Provider Compliance Scores, and do not accurately reflect compliance.

The OIG Inspections Division makes the following recommendations. HHSC MCS should:

1. Comply with 1 Tex. Admin. Code § 354.1177(g) and recover dollars paid, as appropriate, for claims without matching EVV transactions
2. Through its contract oversight responsibility, require MCOs and TMHP to have a prospective (prepayment) matching process and ensure claim details without matching EVV transactions are not paid
3. Through its contract oversight responsibility, direct TMHP and MCOs to allow providers to only submit claims with a single date-of-service per detail for claims that require EVV transactions
4. Through its contract oversight responsibility, require vendors to develop and implement EVV edits and audits to help enforce reason code policy
5. Establish a reasonable standard, in the Provider Compliance Plan, for the percentage of auto-verified EVV transactions that providers must achieve

As intended by the EVV system, implementation of these recommendations will further verify when service visits occur and will help ensure clients receive services for which the state is billed and claims are paid.

The OIG Inspections Division thanks HHSC MCS, TMHP, MCOs, and Texas Association for Home Care and Hospice for their cooperation and assistance during this inspection.

V. APPENDICES

Appendix A: Programs that Enforce Provider Use of EVV

Program	Services
STAR+PLUS Dual Eligible Integrated Care Demonstration	<ul style="list-style-type: none"> • Personal assistance services (PAS) • Personal care services (PCS) • In-home respite services • Community First Choice (CFC) - PAS and Habilitation (HAB)
STAR Health	<ul style="list-style-type: none"> • PCS • CFC (PAS/HAB)
STAR Kids (effective Nov. 1, 2016)	<ul style="list-style-type: none"> • PCS • In-home respite services • Flexible family support services • CFC (PAS/HAB)
Acute-care Fee for Service	<ul style="list-style-type: none"> • Comprehensive Care Program - PCS • CFC (PAS/HAB)
Community Living Assistance and Support Services (CLASS)	<ul style="list-style-type: none"> • In-home respite services • CFC (PAS/HAB) as of June 1, 2015
Medically Dependent Children Program (MDCP)	<ul style="list-style-type: none"> • In-home respite services provided by an attendant • Flexible family support services provided by an attendant
Community Attendant Services (CAS)	<ul style="list-style-type: none"> • PAS
Family Care (FC)	<ul style="list-style-type: none"> • PAS
Primary Home Care (PHC)	<ul style="list-style-type: none"> • PAS

Source: HHSC (<https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/electronic-visit-verification#which-providers-must-use-evv->)

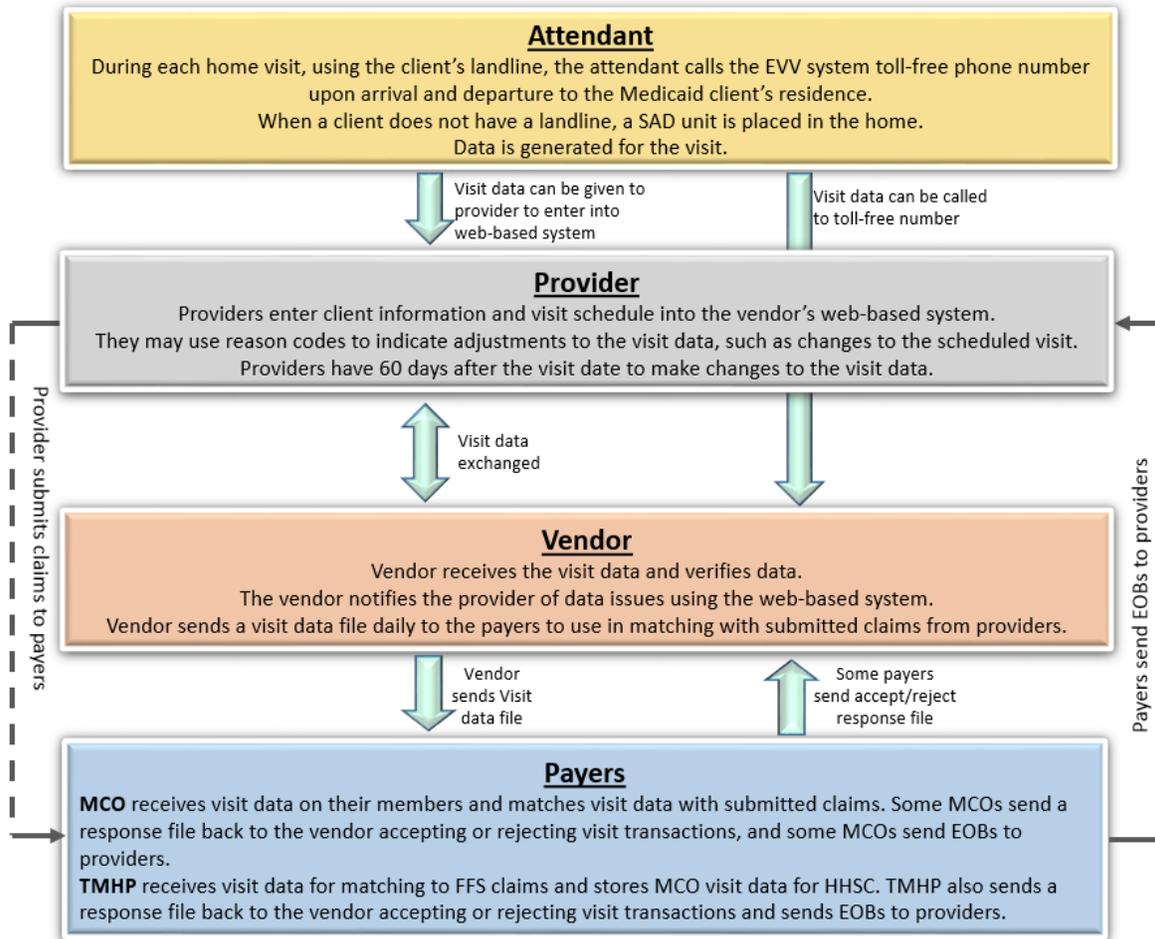
Note: EVV is optional for Consumer Directed Services, which is, therefore, not included in the scope of this inspection.

Appendix B: EVV Legislative and Policy Milestones

Date	Authority or Documentation	Event or Information Distributed
December 2010	Texas Senate Committee on Health and Human Services Interim Report to the 82 nd Legislature, December 2010	Expected EVV to impact personal attendant services, respite services, and comparable services in the Community Based Alternatives, Community Living Assistance and Support Services, Consolidated Waiver Program, Deaf Blind with Multiple Disabilities, and Medically Dependent Children's Program waiver programs, and the Primary Home Care and Community Attendant Services entitlement programs.
December 8, 2010	DADS Letter to Providers	Announced tentative contract award to vendor to pilot EVV
January 1, 2011	1 Tex. Admin. Code § 68.103(a)	Adopted rules confirming flexibility to implement and expand EVV
March 1, 2011	DADS	Implemented EVV pilot
September 28, 2011	Senate Bill 7, 82 nd Legislature, First Called Session, 2011	Directed DADS to pilot an EVV program and implement in a wider area if cost effective
September 30, 2011 October 2, 2012 December 17, 2012	DADS Letters to Providers	Announced expansion of EVV pilot into additional areas
April 13, 2014	1 Tex. Admin. Code § 354.1177	Adopted rules requiring EVV for home skilled nursing, private duty nursing (PDN), and PCS
June 1, 2015	DADS	Announced mandatory implementation date for all services required to use EVV. However, on May 15 DADS announced a "delay" for PDN Services; EVV has yet to include PDN
June 3, 2015	DADS Webpage	Announced reminder to ensure data integrity: payers may reject or recoup claims if data fields are not complete or are not accurate
September 1, 2015	DADS Webpage	Announced that penalties would not be imposed related to the Provider Compliance Plan and affiliated score
November 16, 2015	DADS Webpage	Announced reminder that missing, incomplete, or inaccurate data will result in partial EVV lockout on December 14, 2015, until all required data is entered in the system
April 1, 2016	DADS Webpage	Implemented a 75 percent minimum provider compliance score from April 2016 through March 2017. However, initial notice to providers stated a minimum of 90 percent would be required. The 90 percent requirement was placed on hold due to providers and vendors reporting data issues.
September 1, 2016	SB 200, 84 th Legislature Regular Session, 2015	Transitioned administration of the EVV program, along with many other programs, from DADS to HHSC

October 1, 2016	HHSC Webpage	Announced that providers will receive informational EOBs that indicate partial and no EVV match claims but indicated claims would not deny for these EOBs
February 2, 2017	HHSC Webpage	Announced that providers must ensure EVV data is accurate and complete. Missing or incorrect data may result in denied claims, recoupment during contract monitoring, contract actions, and/or inaccurate EVV reports. EVV vendors will lock visit maintenance until the provider enters missing data.
April 1, 2017	HHSC Webpage	Announced that HHSC implemented a minimum 90 percent Provider Compliance Plan Score.

Appendix C: EVV Data Flow



Appendix D: List of Reason Codes

Code	Reason Code Description	Instruction and Examples of Use	Type
100	Schedule Variation	RC 100 is selected when the attendant or assigned staff provides more or fewer hours of service than scheduled or provides services at a different time of day than scheduled, as requested by the individual/member. All situations that require documentation must be documented according to program policy. This reason code cannot be used when an attendant or assigned staff fails to clock in and/or clock out, unless the appropriate non-preferred reason code (RC 900, 905 or 910) is also saved to visit. Misuse of this preferred reason code may result in contract action(s).	Preferred
105	Services Provided Outside the Home Supported by Service Plan	RC 105 is selected when the attendant or assigned staff cannot call in and/or call out because some or all of the scheduled services were provided outside of the home in accordance with program policy.	Preferred
110	Fill-in for Regular Attendant or Assigned Staff	RC 110 is selected when someone other than the scheduled attendant or assigned staff provides services.	Preferred
115	Individual/Member Agreed or Requested Attendant Not Work Schedule.	RC 115 is selected when the attendant or assigned staff does not work and the individual/member was contacted and agreed, or the individual/member contacted the agency and requested the attendant or assigned staff not work. All situations that require documentation must be documented according to program policy.	Preferred
120	Invalid Attendant ID Entered - Verified Services Were Delivered	RC 120 is selected when an attendant or assigned staff does not accurately or completely enter his/her employee ID and/or the individual's/member's EVV ID into the EVV system.	Preferred
121	Attendant - No Call and No Show (New)	RC 121 is selected when there is a planned schedule entered in the EVV system and the attendant or assigned staff failed to report to work and did not inform the provider agency until after the missed scheduled visit. All situations that require documentation must be documented according to program policy.	Preferred
125	Multiple Calls for One Visit	RC 125 is selected when an attendant or assigned staff makes multiple calls for a single scheduled visit. RC 125 is not used if technical issues with the phone prevent the attendant or assigned staff from calling in. RC 300 should be used for technical problems with the phone.	Preferred
130	Disaster or Emergency	RC 130 is selected when an attendant or assigned staff is unable to provide all or part of the scheduled services to an individual/member due to a disaster (e.g., flood, tornado, ice storm, fire, etc.) or other emergency (e.g., EMS must be called). Free text is required in the comment field; the provider must document the nature of the disaster or emergency and the actual time service delivery begins and/or ends in the comment field.	Preferred

Code	Reason Code Description	Instruction and Examples of Use	Type
135	Confirm Visit with No Schedule (NEW)	RC 135 is selected when the attendant or assigned staff provides services, as requested by the individual/member, but there was no schedule in the EVV system. All situations that require documentation must be documented according to program policy.	Preferred
200	Small Alternative Device (SAD) has been Ordered - Initial or Replacement	RC 200 is selected when a small alternative device has been ordered, but the provider has not yet received the device. Misuse of this preferred reason code may result in contract action(s).	Preferred
205	Small Alternative Device (SAD) Pending Installation	RC 205 is selected when a small alternative device has been received by the provider, but the provider has not yet installed the device in the individual's/member's home. Use of RC 205 for the same individual/member over a period greater than 14 calendar days may constitute misuse of this preferred RC.	Preferred
210	Missing SAD	RC 210 is selected when the small alternative device cannot be located in the individual's/member's home. If the small alternative device is not located within 14 calendar days, the provider agency must request a replacement.	Preferred
215	Reversal of Call In/Out Times	RC 215 is selected when an attendant or assigned staff reverses a call in for a call out or a call out for a call in.	Preferred
300	Phone Lines Not Working - Attendant or Not Able to Call - Verified Services Were Delivered	RC 300 is selected when call in or call out is not possible due to technical problems with landline phone (e.g., individual's/member's phone not working, phone line is disconnected or EVV vendor system issues). Continuous vendor system issues must be reported to your EVV vendor. Please notify payor(s) within 48 hours of unresolved vendor system issues.	Preferred
305	Malfunctioning SAD	RC 305 is selected when a small alternative device malfunctions or provides invalid values. Free text is required in the comment field; the provider must document the actual time service delivery begins and ends. If RC 305 is used for the same individual/member over a period greater than 14 calendar days, a replacement small alternative device should be ordered.	Preferred
310	Malfunctioning Mobile Application	RC 310 is selected when the EVV mobile application malfunctions and prevents an attendant or assigned staff from documenting the time service delivery begins and/or ends in the EVV system. Free text is required in the comment field; the provider must document the nature of the problem with the mobile application AND the actual time service delivery begins and/or ends in the comment field.	Preferred

Code	Reason Code Description	Instruction and Examples of Use	Type
400	Individual/Member Does Not Have Home Phone - Verified Services Were Delivered	RC 400 is selected when an individual/member does not have a home landline phone and requires the use of a small alternative device, but one has not yet been requested by the individual/member. Provider has to submit a completed Medicaid EVV Small Alternative Device Agreement and Order form to the EVV vendor after learning and individual/member requires a small alternative device. Use of RC 400 or the same individual/member over a period of time greater than <u>14 calendar days</u> may constitute misuse of this preferred reason code.	Preferred
405	Phone Unavailable - Verified Services were Delivered	RC 405 is selected when the attendant or assigned staff cannot use the phone to call-in and/or call-out because the phone is in use when the service provision begins or ends (e.g., the individual/member is on the phone with his/her doctor) Use of RC 405 for the same individual/member over a period greater than 14 calendar days may constitute misuse of this preferred reason code. If this becomes a routine issue, a small alternative device should be ordered.	Preferred
410	Individual/Member Refused Attendant or Assigned Staff Use of Phone - Verified Services Were Delivered	RC 410 is selected when an attendant or assigned staff cannot use the phone to call in or call out of the EVV system because the individual/member refuses to allow the attendant or assigned staff to use the phone in this particular instance (e.g., the individual/member does not trust the fill-in attendant or assigned staff). Use of RC 410 for the same individual/member over a period of time greater than 14 calendar days may constitute misuse of this preferred reason code. If this becomes a routine issue, a small alternative device should be ordered.	Preferred
500	In-Home Respite Services	RC 500 is selected when unscheduled in-home respite services are provided.	Preferred
505	Consumer Directed Services (CDS) Employer Time Corrected	RC 505 is only selected by individual's/member's self-directing their services using the CDS option who need to correct an EVV entry. This reason code should only be used by CDS employers or Financial Management Services Agencies (FMSAs).	Preferred
600	Service Suspension	RC 600 is selected when the provider has suspended the individual's/member's services per program policy (e.g., the individual/member is in the hospital or temporarily in a nursing facility). All situations that require documentation must be documented according to program policy.	Preferred

Code	Reason Code Description	Instruction and Examples of Use	Type
700	Downward Adjustment to Billed Hours	RC 700 is selected when the time billed is adjusted downward to offset rounding. The EVV system applies rounding rules to the total actual hours for each visit. Each visit is rounded to the nearest quarter hour (0, 15, 30 or 45 minutes past the hour) based on the total actual hours. As a result of the rounding rules, providers must sometimes round hours down, causing an exception that must be cleared. MCO-Contracted provider agencies should contact their contracted MCOs for detailed information regarding MCO rounding policy. Misuse of this preferred reason code may result in contract action(s). Free text is not required.	Preferred
900	Attendant or Assigned Staff Failed to Call In - Verified Services Were Delivered	RC 900 is selected when an attendant or assigned staff fails to use the EVV system to call in. Free text is required in the comment field to document the actual "call in" time.	NON-Preferred
905	Attendant or Assigned Staff Failed to Call Out - Verified Services Were Delivered	RC 905 is selected when an attendant or assigned staff fails to use the EVV system to call out. Free text is required in the comment field to document the actual "call out" time.	NON-Preferred
910	Attendant or Assigned Staff Failed to Call In and Out - Verified Services Were Delivered	RC 910 is selected when attendant or assigned staff faults to use the EVV system to call in and call out (e.g., the attendant or assigned staff faults to call in and call out on the individual's/member's home landline, or the attendant assigned staff fails to enter the small alternative device values in the EVV system). Free text is required in the Comment field; the provider must record the actual time service delivery begins and ends in the Comment field.	NON-Preferred
915	Wrong Phone Number - Verified Services Were Delivered	RC 915 is selected when calls for a visit are received from a number that is not recognized by the EVV system.	NON-Preferred
999	Other	RC 999 is selected when a provider must address an EVV system exception that cannot be addressed using any of the other reason codes. Free text is required in the comment field explaining why use of this code was required.	NON-Preferred

Source: HHSC (<https://hhs.texas.gov/doing-business-hhs/provider-portals/resources/electronic-visit-verification/evv-reason-codes>)

Appendix E: Methodology

Scope

The inspection reviewed standards, policies, and practices of EVV, and analyzed claims data from September 1, 2016, through August 31, 2017.

All utilization reports were derived from periods within this time frame. Onsite visits to provider agencies were conducted from July 2017 to August 2017.

Data Collection and Analysis

The inspection focused on EVV claims in fiscal year 2017 and was conducted through analysis of data from seven primary sources:

- (1) HHSC policies and standards governing the maintenance and oversight of EVV operations, including:
 - a. Texas Administrative Code
 - b. Contracts and manuals, such as the Texas Medicaid Provider procedures Manual, Uniform Managed Care Manual and Uniform Managed Care Contract, vendor contracts, claims payment agreements
 - c. Provider information letters, announcements, and bulletins
- (2) Questionnaire responses from 12 MCOs assessing managed care policies, procedures, and practices for managing EVV claims and quality assurance
- (3) Provider auto-verification and visit maintenance utilization from both vendors (MEDsys and DataLogic)
- (4) Provider reason code utilization and patterns of EVV transactions compiled by the OIG Data and Technology Division (DAT)
- (5) Paid claims and EVV transaction data from all payers (12 MCOs and TMHP)
- (6) Interviews with the following stakeholders: MCS EVV program, contracted vendors (MEDsys and DataLogic), three MCOs (Amerigroup, Molina, and Superior), and TMHP
- (7) Onsite visits with eight Medicaid-enrolled home health providers to review policies and practices of providers with a range of compliance scores and EVV visit maintenance utilization patterns. Visits were conducted in Austin, Dallas, Houston, and McAllen.

In addition, the inspection team completed EVV training for MEDsys and DataLogic software operation and the HHSC EVV provider training.

Review of Managed Care EVV Policies

To learn about the administration of EVV, the inspection team created a questionnaire that the 12 MCOs completed. Responses were reviewed to identify policies, procedures, and practices for managing EVV transactions, claims payments, the claims matching process, overpayment recoupment, and provider compliance.

Review of Auto-verification and Visit Maintenance Utilization

MEDsys and DataLogic provided the OIG inspection team with EVV transaction utilization data and compliance score ratings for all providers. Utilization reports were analyzed to determine rates of auto-verified, preferred verified and non-preferred verified transactions. Auto-verification rates and compliance scores were also used as selection criteria for onsite provider visits.

Review of Reason Code Utilization

To further explore patterns of visit maintenance, the OIG DAT provided a details of a one-month snapshot of statewide reason code utilization. Data was reviewed to assess reason code use. Table 7 shows all reason codes, number of times each was used, and overall percentage it was used by providers across the state in January 2017. Cumulatively, non-preferred codes were used 4.69 percent of the time.

Table 7: Statewide Reason Code Utilization, January 2017

Reason Code	Reason Code Description	Number of times Reason Code Used	% of Reason Code Used	Reason Code Category
100	Schedule Variation	1,032,082	37.08%	Preferred
700	Downward Adjustment to Billed Hours	627,259	22.54%	Preferred
200	Small Alternative Device Has Been Ordered	157,858	5.67%	Preferred
120	Invalid Attendant or Nurse or Individual/Member ID Entered	120,973	4.35%	Preferred
115	Individual/Member Agreed or Requested Attendant or Nurse Not Work	117,371	4.22%	Preferred
125	Multiple Calls For One Visit	115,683	4.16%	Preferred
305	Malfunctioning Small Alternative Device and/or Invalid Small Alter	98,320	3.53%	Preferred
105	Services Provided Outside the Home	82,725	2.97%	Preferred
300	Phone Lines Not Working - Attendant or Nurse Not Able to Call	62,058	2.23%	Preferred
405	Phone Unavailable	53,783	1.93%	Preferred
905	Attendant or Nurse Failed to Call Out	50,798	1.83%	Non-Preferred
910	Attendant or Nurse Failed to Call In and Out	44,658	1.60%	Non-Preferred
205	Small Alternative Device Pending Installation	40,647	1.46%	Preferred
600	Service Suspension	30,350	1.09%	Preferred
110	Fill-in for Regular Attendant or Nurse	24,193	0.87%	Preferred
900	Attendant or Nurse Failed to Call In	24,076	0.87%	Non-Preferred
400	Individual/Member Does Not Have Home Phone	22,726	0.82%	Preferred
135	Confirm visits with no schedule	20,318	0.73%	Preferred
210	Missing Small Alternative Device	13,026	0.47%	Preferred
500	In-Home Respite Services	9,782	0.35%	Preferred
999	Other	8,483	0.30%	Non-Preferred
215	Reversal of Call In/Out Times	8,353	0.30%	Preferred
121	Attendant or Assigned Staff - No Call and No Show	8,041	0.29%	Preferred
310	Mobile Application Problems	3,240	0.12%	Preferred
915	Wrong Phone Number	2,467	0.09%	Non-Preferred
505	Consumer Directed Services (CDS) Employer Time Correction	2,107	0.08%	Preferred
410	Individual/Member Refused Attendant or Nurse Use of Phone	1,529	0.05%	Preferred
130	Disaster or Emergency	407	0.01%	Preferred
	Total	2,783,313	100.00%	

Source: Provided by OIG DAT

Review of Claim to EVV Matching Rates

The inspection team received claim details and EVV transaction data from all payers (TMHP and 12 MCOs) from fiscal year 2017. Payers reported on quantity of claim details and dollar amounts paid for matched, partially matched, and unmatched claims processed (See Table 3).

The data are dynamic due to a number of variables, including: 1) ongoing adjudication of claims, 2) ongoing EVV visit maintenance, and 3) payers recouping funds. Payers reported their claim details and matching rates as of a single date. Report dates selected by each of the payers vary, but were primarily in early November 2017. Some were as late as January 2018. All data were based on fiscal year 2017.

Interviews with EVV Stakeholders

During the course of the inspection, the team conducted interviews with HHSC EVV program operations staff, TMHP, MEDsys and DataLogic, and the three MCOs with the highest number of providers (Amerigroup, Molina, and Superior). The interviews focused on clarifying policies, procedures, and interrelationships between the key stakeholders, as well as discussion of concerns and opportunities for EVV administration improvement. Interview data was used to assess challenges from varying perspectives among the stakeholder groups and to prepare questions for the onsite visits.

Onsite Provider Visits

Onsite visits were conducted with eight provider agencies in Austin, Dallas, Houston, and McAllen to observe the implementation of EVV policies. Providers were selected through review of EVV transaction auto-verification and compliance scores. Specifically, providers with a range of the criteria scores were selected (i.e., high compliance score and high auto-verification; high compliance score and low auto-verification; low compliance score and high auto-verification; low compliance score and low auto-verification) to ensure the inspection teams could observe wide variation of provider practices for managing EVV operations.

During onsite visits, the inspection team conducted interviews with provider agency administrators, office staff, and designated EVV coordinators, when available. Topics covered in the interviews focused on learning day-to-day EVV operations, including:

- Knowledge of EVV program policies and procedures
- Provider agency EVV policies and procedures
- Procedures for collecting visit information
- Coordination among service providers, payers, and vendors
- Staff training on EVV
- Reason code utilization

- Specific challenges or concerns experienced while managing/using EVV
- Self-identified best practices that contributed to successful EVV management

Data gathered from provider interviews were analyzed to identify opportunities for program management improvement recommendations.

Limitations

As indicated in Appendix A, Consumer Directed Services are optional for EVV and are therefore out of scope for this inspection. Provider types and services which are not required to begin using EVV, but have elected to do so, are also not included.

MEDsys and DataLogic provided EVV transaction data. The MCOs and TMHP each self-reported claims data and matching EVV claim details. Although the focus is on claims during fiscal year 2017, the data is dynamic due to a number of variables, including: (1) adjudication of claims which may occur beyond the end of the fiscal year; (2) EVV visit maintenance that may occur and impact the rate of matching EVV to claim details; and (3) payers recouping funds.

Appendix F: Report Team and Report Distribution

Report Team

The OIG staff members who contributed to this OIG Inspections Division report include:

- Lisa Pietrzyk, CFE, CGAP, Director of Inspections
- Xavier Ortiz, Inspections Manager
- Deborah Wray, RN, BSN, Inspection Team Lead
- Jill Townsend, Inspector
- James Aldridge, Inspector
- Liviah Manning, PhD, Research Specialist
- Dawn Rehbein, Program Specialist
- Teklehaimanot Derseh, Data and Technology Statistical Analyst

Report Distribution

Texas Health and Human Services:

- Charles Smith, Executive Commissioner
- Kara Crawford, Chief of Staff
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Victoria Ford, Chief Policy Officer
- Karen Ray, Chief Counsel
- Stephanie Muth, Associate Commissioner, Medicaid and CHIP Services
- Katherine Scheib, Deputy Associate Commissioner, Operations, Medicaid and CHIP Services
- Karin Hill, Director of Internal Audit

Appendix G: OIG Mission and Contact Information

Inspector General Mission

The mission of the OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, review, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Anita D'Souza, OIG Chief Counsel and Chief of Staff
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Olga Rodriguez, Chief Strategy Officer
- Brian Klozik, Deputy IG for Medicaid Program Integrity
- David Griffith, Deputy IG for Audit
- Quinton Arnold, Deputy IG for Inspections
- Alan Scantlen, Deputy IG for Data and Technology
- Judy Knobloch, Assistant Deputy IG for Medical Services

To Obtain Copies of OIG Reports

- OIG website: <https://oig.hhsc.texas.gov/>

To Report Fraud, Waste, and Abuse in Texas HHS Programs

- Online: <https://oig.hhsc.texas.gov/report-fraud>
- Phone: 1-800-436-6184

To Contact the Inspector General

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services Commission
Inspector General
P.O. Box 85200
Austin, Texas 78708-5200
- Phone: (512) 491-2000