TITLE 1 ADMINISTRATION

PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 354 MEDICAID HEALTH SERVICES

SUBCHAPTER O ELECTRONIC VISIT VERIFICATION

§354.4001. Purpose and Authority.

(a) The purpose of this subchapter is to describerequirements related to electronic visit verification authorized by:

(1) Title XIX, Section 1903(l) of the Social Security Act (43 U.S.C. §1396b(l) ; and

(2) Texas Government Code §531.024172.

§354.4003. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

(1) CDS employer--Consumer Directed Services employer. A member or the member’s legally authorized representative who participates in the CDS option. A CDS employer is responsible for hiring and retaining a service provider who delivers a service described in §354.4005 of this subchapter (relating to Personal Care Services that Require the Use of EVV) or §354.4006 of this subchapter (relating to Home Health Care Services that Require the Use of EVV).

(2) CDS option--Consumer Directed Services option. A service delivery option in which a CDS employer employs and retains a service provider and directs the delivery of a service described in §354.4005 or §354.4006 of this subchapter.

(3) CFC--Community First Choice. A Medicaid state plan option governed by Code of Federal Regulations, Title 42, Part 441, Subpart K, Home and Community-Based Attendant Services and Supports State Plan Option (Community First Choice). CFC services include:

(A) CFC HAB--Community First Choice Habilitation. A Medicaid state plan service that provides habilitation through CFC as described in §354.1361 of this chapter (relating to Definitions).

(B) CFC PAS--Community First Choice Personal Assistance Services. A Medicaid state plan service that provides personal assistance services through CFC as described in §354.1361 of this chapter.

(C) CFC PAS/HAB--Community First Choice Personal Assistance Services/Habilitation. A Medicaid state plan service provided through CFC that provides both personal assistance services and habilitation.

(4) CLASS Program--Community Living Assistance and Support Services Program. A Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in 26 TAC Chapter 259 (relating to Community Living Assistance and Support Services (CLASS) and Community First Choice (CFC) Services).

(5) CMS--Centers for Medicare & Medicaid Services. The federal agency within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs.

(6) Community Attendant Services Program--A Medicaid state plan program operating under Title XIX of the Social Security Act, as described in 40 TAC Chapter 47 (relating to Primary Home Care, Community Attendant Services, and Family Care Programs).

(7) DBMD Program--Deaf Blind with Multiple Disabilities. The Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in 26 TAC Chapter 260 (relating to Deaf Blind with Multiple Disabilities (DBMD) Program and Community First Choice (CFC) Services).

(8) EVV--Electronic visit verification. The documentation and verification of service delivery through an EVV system.

(9) EVV aggregator--A centralized database that collects, validates, and stores statewide EVV visit data transmitted by an EVV system.

(10) EVV claim--A request for payment of a service described in §354.4005 and §354.4006 of this subchapter submitted to HHSC, HHSC’s designated contractor, or a managed care organization (MCO) in accordance with the EVV Policy Handbook.

(11) EVV Policy Handbook-- A handbook promulgated by HHSC that contains policies and requirements related to EVV .

(12) EVV portal--An online system established by HHSC that allows users to perform searches, view reports and view EVV claim match results associated with data in the EVV aggregator.

(13) EVV portal user--A person who is employed by or contracts with a program provider or financial management services agency (FMSA) and has access to the EVV portal.

(14) EVV proprietary system--An HHSC EVV system purchased or developed by a program provider or FMSA approved by HHSC in accordance with §354.4013 of this subchapter (relating to HHSC and MCO Compliance Reviews and Enforcement Actions) that a program provider uses instead of an EVV vendor system.

(15) EVV system--An EVV vendor system or an EVV proprietary system used to electronically document and verify the data elements described in §354.4009(a) of this subchapter (relating to EVV Visit and EVV Claim) for a visit conducted to provide a service described in §354.4005 and §354.4006of this subchapter.

(16) EVV system user--A person who has access to the EVV system, including a person employed by or contracting with a program provider, FMSA, or CDS employer.

(17) EVV vendor system--An EVV system developed and operated by a vendor that contracts with HHSC or HHSC’s designated contractor that a program provider or FMSA uses instead of an EVV proprietary system.

(18) EVV visit transaction--A record generated by an EVV system that contains the data elements described in §354.4009(a) of this subchapter for a visit conducted to provide a service described in §354.4005 or §354.4006 of this subchapter.

(19) FC Program--Family Care Program. A program funded under Title XX, Subtitle A of the Social Security Act, as described in 40 TAC Chapter 47.

(20) FMSA--Financial Management Services Agency. An entity that contracts with HHSC or an MCO to provide financial management services to a CDS employer as described in 40, TAC Chapter 41 (relating to Consumer Directed Services Option).

(21) HCBS-AMH Program--Home and Community-Based Services Adult Mental Health Program. A Medicaid state plan option approved by CMS under Title XIX, Section 1915(i) of the Social Security Act, as described in 26 TAC Chapter 307, Subchapter B (relating to Home and Community-Based Services--Adult Mental Health Program).

(22) HCS Program--Home and Community-based Services Program. A Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in 26 TAC Chapter 263 (relating to Home and Community-based Services (HCS) Program and Community First Choice (CFC)).

(23) HHSC--Texas Health and Human Services Commission.

(24) MCO--Managed care organization. Has the meaning set forth in Texas Government Code §536.001.

(25) MDCP--Medically Dependent Children Program. A Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in Chapter 353, Subchapter M of this title (relating to Home and Community Based Services in Managed Care).

(26) MDCP STAR Health covered service--Medically Dependent Children Program STAR Health covered service. A service provided to a member eligible to receive MDCP benefits under the STAR Health Program.

(27) MDCP STAR Kids covered service--Medically Dependent Children Program STAR Kids covered service. A service provided to a member eligible to receive MDCP benefits under the STAR Kids Program.

(28) Member--A person enrolled in one of the following:

(A) traditional Medicaid service model also referred to as fee-for-service;

(B) the CLASS Program;

(C) the Community Attendant Services Program;

(D) the DBMD Program;

(E) the FC Program;

(F) the HCBS-AMH Program;

(G) the HCS Program;

(H) the Primary Home Care Program;

(I) the STAR Program;

(J) the STAR Health Program;

(K) the STAR Kids Program;

(L) the STAR+PLUS Program;

(M) the STAR+PLUS Home and Community-Based Services Program;

(N) the STAR+PLUS Medicare-Medicaid Program;

(O) the Texas Home Living Program;

(P) Personal Care Services provided under the Texas Health Steps Comprehensive Care Program, a Medicaid state plan benefit as described in Chapter 363, Subchapter F of this title (relating to Personal Care Services); or

(Q) the Youth Empowerment Services Program.

(29) PCS--Personal Care Services.

(30) Primary Home Care Program--A Medicaid state plan program operating under Title XIX of the Social Security Act, as described in 40 TAC Chapter 47.

(31) Program provider--An entity that contracts with HHSC or an MCO to provide a service described in §354.4005 or §354.4006of this subchapter. A service provider described in paragraph (34)(B) of this section is both a program provider and a service provider.

(32) PSO--Proprietary system operator. A program provider or FMSA that uses an EVV proprietary system.

(33) Reason code--A standardized HHSC-approved code entered into an EVV system to explain the reason for completing visit maintenance.

(34) Service provider--A person who provides a service described in §354.4005 and §354.4006of this subchapter and who is employed or contracted by:

(A) who is employed by or contracting with:

(i) a program provider; or

(ii) a CDS employer; or

(B) who is contracting with:

(i) an MCO; or

(ii) HHSC.

(35) SRO--Service responsibility option. A service delivery option in which a member or legally authorized representative selects, trains, and provides daily management of a service provider, while the fiscal, personnel, and service back-up plan responsibilities remain with the program provider described in 40 TAC Chapter 43 (relating to Service Responsibility Option).

(36) STAR--State of Texas Access Reform.

(37) STAR Program--A Medicaid program operating under Title XIX, Section 1115 of the Social Security Act. The program provides services through a managed care delivery model to a member enrolled in STAR as described in Chapter 353, Subchapter I of this title (relating to STAR).

(38) STAR Health Program--A Medicaid program operating under Title XIX, Section 1915(a) of the Social Security Act and Texas Family Code, Chapter 266. The program provides services through a managed care delivery model to a member enrolled in STAR Health as described in Chapter 353, Subchapter H of this title (relating to STAR Health).

(39) STAR Kids Program--A Medicaid program operating under Title XIX, Section 1115 of the Social Security Act and Texas Government Code, Chapter 533. The program provides services through a managed care delivery model to a member enrolled in STAR Kids as described in Chapter 353, Subchapter N of this title (relating to STAR Kids).

(40) STAR+PLUS HCBS Program--STAR+PLUS Home and Community-Based Services Program. A Medicaid program operating through a federal waiver under Title XIX, Section 1115 of the Social Security Act. The program provides services to a member eligible to receive HCBS benefits under the STAR+PLUS Program, as described in Chapter 353, Subchapter M of this title (relating to Home and Community Based Services in Managed Care).

(41) STAR+PLUS MMP--STAR+PLUS Medicare-Medicaid Plan. A managed care program operating under Title XIX, Section 1115A of the Social Security Act that provides the authority to test and evaluate a fully integrated care model for clients who are dual eligible. The STAR+PLUS MMPs contract with CMS and HHSC to participate in the Dual Demonstration Program described in Chapter 353, Subchapter L of this title (relating to Texas Dual Eligibles Integrated Care Demonstration Project).

(42) STAR+PLUS Program--A Medicaid program operating under Title XIX, Section 1115 of the Social Security Act, and Texas Government Code, Chapter 533. The program provides services through a managed care delivery model to a member enrolled in STAR+PLUS as described in Chapter 353, Subchapter G of this title (relating to STAR+PLUS).

(43) TAC--Texas Administrative Code.

(44) Texas Health Steps Comprehensive Care Program--A Medicaid comprehensive program approved by CMS under Title XIX, Section 1905 of the Social Security Act, as described in Chapter 363, Subchapter F of this title (. This includes STAR members who receive these services through the traditional Medicaid service model also referred to as fee-for-service.

(45) TxHmL--Texas Home Living Program.A Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in 26 TAC Chapter 262 (relating to Texas Home Living (TxHmL) Program and Community First Choice (CFC)).

(46) Vendor hold--A temporary suspension of payments for claims that are due to a program provider or FMSA.

(47) Visit maintenance--As described in the EVV Policy Handbook, a process to:

(A) manually enter data elements described in §354.4009(a) of this subchapter in an EVV system;

(B) correct the data elements described in §354.4009(a) of this subchapter that are inaccurate in an EVV visit transaction; or

(C) include the data elements described in §354.4009(a) of this subchapter that are missing in an EVV visit transaction.

(48) YES Program--Youth Empowerment Services Program. A Medicaid waiver approved by CMS under Title XIX, Section 1915(c) of the Social Security Act as described in 26 TAC Chapter 307, Subchapter A (relating to Youth Empowerment Services (YES)).

§354.4005. Personal Care Services that Require the Use of EVV.

(a) A program provider must ensure a service provider uses EVV to document the provision of the following personal care services by the program provider:

(1) in the traditional Medicaid service model also referred to as fee-for-service:

(A) CFC PAS;

(B) CFC HAB; and

(C) PCS;

(2) in the CLASS Program:

(A) CFC PAS/HAB; and

(B) in-home respite;

(3) personal attendant services provided through the Community Attendant Services Program, including SRO;

(4) in the DBMD Program:

(A) CFC PAS/HAB; and

(B) in-home respite;

(5) personal attendant services provided through the FC Program, including SRO;

(6) in the HCBS-AMH Program:

(A) supported home living; and

(B) in-home respite;

(7) in the HCS Program:

(A) CFC PAS/HAB;

(B) in-home respite; and

(C) in-home individualized skills and socialization provided to members with the residential type of "own/family home";

(8) personal attendant services provided through the Primary Home Care Program;

(9) in the STAR Health Program:

(A) CFC PAS;

(B) CFC HAB;

(C) PCS; and

(D) for a member in STAR Health MDCP:

(i) in-home respite; and

(ii) flexible family support;

(10) in the STAR Kids Program:

(A) CFC PAS;

(B) CFC HAB;

(C) PCS; and

(D) for a member in STAR Kids MDCP:

(i) in-home respite; and

(ii) flexible family support;

(11) in the STAR+PLUS Program:

(A) personal assistance services, including SRO;

(B) CFC PAS, including SRO; and

(C) CFC HAB, including SRO;

(12) in the STAR+PLUS HCBS Program:

(A) in-home respite care, including SRO;

(B) protective supervision, including SRO;

(C) personal assistance services, including SRO;

(D) CFC PAS, including SRO; and

(E) CFC HAB, including SRO;

(13) in the STAR+PLUS MMP:

(A) in-home respite care, including SRO;

(B) protective supervision, including SRO;

(C) personal assistance services, including SRO;

(D) CFC PAS, including SRO; and

(E) CFC HAB, including SRO;

(14) PCS provided under the Texas Health Steps Comprehensive Care Program including STAR members who receive these services through the traditional Medicaid model;

(15) in the TxHmL Program:

(A) CFC PAS/HAB;

(B) in-home respite; and

(C) in-home individualized skills and socialization;

(16) in-home respite provided in the YES Program; and

(17) any other service required by federal or state mandates.

(b) A CDS employer must ensure a service provider uses EVV to document the provision of the following personal care services through the CDS option:

(1) in the traditional Medicaid service model also referred to as fee-for-service:

(A) CFC PAS;

(B) CFC HAB;

(C) PCS; and

(D) PCS-Behavioral Health

(2) in the CLASS Program:

(A) CFC PAS/HAB; and

(B) in-home respite;

(3) personal attendant services provided through the Community Attendant Services Program;

(4) in the DBMD Program:

(A) CFC PAS/HAB; and

(B) in-home respite;

(5) personal attendant services provided through the FC Program;

(6) in the HCS Program:

(A) CFC PAS/HAB;

(B) in-home respite; and

(C) in-home individualized skills and socialization provided to members with the residential type of "own/family home";

(7) personal attendant services provided through the Primary Home Care Program;

(8) in the STAR Health Program:

(A) CFC PAS;

(B) CFC HAB;

(C) PCS;

(D) PCS-Behavioral Health; and

(E) for a member in STAR Health MDCP:

(i) in-home respite, with and without registered nurse (RN) delegation; and

(ii) flexible family support, with and without RN delegation;

(9) in the STAR Kids Program:

(A) CFC PAS;

(B) CFC HAB;

(C) PCS;

(D) PCS-Behavioral Health; and

(E) for a member in STAR Kids MDCP:

(i) in-home respite, with and without RN delegation; and

(ii) flexible family support, with and without RN delegation;

(10) in the STAR+PLUS Program:

(A) personal assistance services;

(B) CFC PAS; and

(C) CFC HAB;

(11) in the STAR+PLUS HCBS Program:

(A) in-home respite care;

(B) protective supervision;

(C) personal assistance services;

(D) CFC PAS; and

(E) CFC HAB;

(12) in the STAR+PLUS MMP:

(A) in-home respite care;

(B) protective supervision;

(C) personal assistance services;

(D) CFC PAS; and

(E) CFC HAB;

(13) in the TxHmL Program:

(A) CFC PAS/HAB;

(B) in-home respite; and

(C) in-home individualized skills and socialization provided to members with the residential type of "own/family home".

§354.4006. Home Health Care Services that Require the Use of EVV.

(a) A program provider must ensure a service provider uses EVV to document the provision of the following home health care services by the program provider on and after January 1, 2024:

(1) in the traditional Medicaid service model also referred to as fee-for-service, the following services when provided in the residence of the member:

(A) any nursing service;

(B) occupational therapy; and

(C) physical therapy;

(2) in the CLASS Program, for a member who does not receive support family services or continued family services, the following services when provided in the residence of the member:

(A) any nursing service;

(B) occupational therapy; and

(C) physical therapy;

(3) in the DBMD Program, for a member who does not receive licensed assisted living or licensed home health assisted living, the following services when provided in the residence of the member:

(A) any nursing service;

(B) occupational therapy; and

(C) physical therapy;

(4) in the HCS Program, for a member whose residential type is "own/family home," the following services when provided in the residence of the member:

(A) any nursing service;

(B) occupational therapy; and

(C) physical therapy;

(5) in the HCBS-AMH Program, the following services when provided in the residence of the member:

(A) nursing - registered nurse (RN); and

(B) nursing - licensed vocational nurse (LVN);

(6) in the STAR Program, the following services when provided in the residence of the member:

(A) home health nursing;

(B) occupational therapy;

(C) physical therapy; and

(D) home health aide services as an extension of physical, occupational therapy, or nursing services;

(7) in the STAR Health Program, the following services when provided in the residence of the member:

(A) home health nursing;

(B) occupational therapy;

(C) physical therapy;

(D) home health aide services as an extension of physical, occupational therapy, or nursing services;

(E) nursing delegation and supervision of PCS and CFC tasks; and

(F) for a member in STAR Health MDCP, the following services when provided in the residence of the member:

(i) flexible family supports services performed by RN or an LVN; and

(ii) in-home respite performed by RN or an LVN;

(8) in the STAR Kids Program, the following services when provided in the residence of the member:

(A) home health nursing;

(B) occupational therapy;

(C) physical therapy;

(D) home health aide services as an extension of physical, occupational therapy, or nursing services;

(E) nursing delegation and supervision of PCS and CFC tasks; and

(F) for a member in STAR Kids MDCP, the following services when provided in the residence of the member:

(i) flexible family supports services performed by RN or an LVN; and

(ii) in-home respite performed by RN or an LVN;

(9) in the STAR+PLUS Program, the following services when provided in the residence of the member:

(A) home health nursing;

(B) occupational therapy;

(C) physical therapy; and

(D) home health aide services as an extension of physical, occupational therapy, or nursing services;

(10) in the STAR+PLUS HCBS Program, for members not receiving assisted living services the following services when provided in the residence of the member:

(A) home health nursing, including SRO;

(B) occupational therapy, including SRO;

(C) physical therapy, including SRO; and

(D) home health aide services as an extension of physical, occupational therapy, or nursing services, including SRO;

(11) in the STAR+PLUS MMP, the following services when provided in the residence of the member:

(A) home health nursing, including SRO;

(B) occupational therapy, including SRO;

(C) physical therapy, including SRO; and

(D) home health aide services as an extension of physical, occupational therapy, or nursing services, including SRO;

(12) in the TxHmL Program, the following services when provided in the residence of the member:

(A) any nursing service;

(B) occupational therapy; and

(C) physical therapy; and

(13) any other service required by federal or state mandates.

(b) A CDS employer must ensure a service provider uses EVV to document the provision of the following home health care services using the CDS option on and after January 1, 2024:

(1) in the CLASS Program, the following services when provided in the residence of the member:

(A) any nursing service;

(B) occupational therapy; and

(C) physical therapy;

(2) in the HCS Program, for a member whose residential type is "own/family home," the following services when provided in the residence of the member:

(A) any nursing service;

(B) occupational therapy; and

(C) physical therapy;

(3) in the STAR Health Program for a member in STAR Health MDCP, the following services when provided in the residence of the member:

(A) flexible family supports services performed by any RN or any LVN; and

(B) in-home respite performed by any RN or any LVN;

(4) in the STAR Kids Program for a member in STAR Kids MDCP, the following services when provided in the residence of the member:

(A) flexible family supports services performed by any RN or any LVN; and

(B) in-home respite performed by any RN or any LVN;

(5) in the STAR+PLUS Program, the following services when provided in the residence of the member:

(A) home health nursing;

(B) occupational therapy;

(C) physical therapy; and

(D) home health aide services as an extension of physical, occupational therapy, or nursing services;

(6) in the STAR+PLUS HCBS Program, the following services when provided in the residence of the member:

(A) home health nursing;

(B) occupational therapy;

(C) physical therapy; and

(D) home health aide services as an extension of physical, occupational therapy, or nursing services;

(7) in the STAR+PLUS MMP, the following services when provided in the residence of the member:

(A) home health nursing;

(B) occupational therapy;

(C) physical therapy; and

(D) home health aide services as an extension of physical, occupational therapy, or nursing services;

(8) in the TxHmL Program, the following services when provided in the residence of the member:

(A) any nursing service;

(B) occupational therapy; and

(C) physical therapy.

§354.4007. EVV System.

(a) A program provider or FMSA must use one of the following EVV systems to electronically document the provision of a service described in §354.4005 or §354.4006 of this subchapter (relating to Personal Care Services that Require the Use of EVV and Home Health Care Services that Require the use of EVV):

(1) an EVV vendor system; or

(2) an EVV proprietary system.

(b) A CDS employer must use the EVV system selected by their FMSA.

(c) Except as provided in subsection (d) of this section, a program provider, an FMSA, and a CDS employer must ensure that a service provider uses an EVV system to electronically document the provision of a service described in §354.4005 or §354.4006 of this subchapter as described in the EVV Policy Handbook.

(d) If a service provider fails to use an EVV system to document the provision of a service described in §354.4005 or §354.4006 of this subchapter or if a service provider cannot use an EVV system because the EVV system is unavailable:

(1) a program provider must:

(A) ensure that a service provider documents in writing:

(i) the name of the program provider;

(ii) the first name and last name of the member who received the service;

(iii) the type of service provided;

(iv) the date the service was provided;

(v) the time the service began and the time service ended;

(vi) the first name and last name of the service provider who provided the service; and

(vii) the location where the service was provided; and

(B) complete visit maintenance by manually entering the information described in subparagraph (A) of this paragraph into the EVV system; and

(2) an FMSA and a CDS employer must:

(A) ensure that a service provider documents in writing:

(i) the name of the FMSA and CDS employer; and

(ii) the information described in paragraph (1)(A)(ii) - (viii) of this subsection; and

(B) complete visit maintenance by manually entering the information described in subparagraph (A) of this paragraph into the EVV system.

(e) If a program provider or an FMSA does not comply with subsections (a), (c), or (d) of this section, HHSC or an MCO may do one or more of the following:

(1) deny payment for a service;

(2) take enforcement action including;

(A) requiring a program provider or FMSA to complete a corrective action plan; or

(B) propose to terminate the contract of the program provider or FMSA.

(f) If a CDS employer does not comply with subsections (b), (c), or (d) of this section, HHSC or an MCO may:

(1) require the CDS employer to complete a corrective action plan; or

(2) propose to terminate the member’s participation in the CDS option.

§354.4009. EVV Visit Transaction and EVV Claim.

(a) A program provider and an FMSA must:

(1) ensure that an EVV visit transaction contains the data elements required by the EVV system, including:

(A) the first and last name of the member who received the service;

(B) the type of service provided;

(C) the date the service was provided;

(D) the time the service began and the time the service ended;

(E) the first and last name of the service provider who provided the service; and

(F) the location, including the address or geolocation, where the service was provided.

(2) ensure the data elements required by paragraph (1) of this subsection are accurate.

(b) A CDS employer who elects to complete visit maintenance on the HHSC Employer's Selection for Electronic Visit Verification Responsibilities form must:

(1) ensure that an EVV visit transaction contains the data elements required by the EVV system, including those listed in subsection (a)(1) of this section; and

(2) ensure the data elements required by paragraph (1) of this subsection are accurate.

(c) A program provider and an FMSA must:

(1) before submitting an EVV claim:

(A) ensure that the EVV visit transaction is transmitted to and accepted by the EVV Portal; and

(B) ensure that the data elements on the EVV claim match the data elements in the accepted EVV visit transaction; and

(2) submit the EVV claim in accordance with HHSC or MCO billing requirements and the EVV Policy Handbook.

(d) HHSC or an MCO denies an EVV claim or recoups a payment made to a program provider or an FMSA if the EVV claim does not meet requirements described in the EVV Policy Handbook, including if:

(1) the EVV claim does not match the accepted EVV visit transaction; or

(2) there is no accepted EVV visit transaction that supports the EVV claim.

§354.4011. Visit Maintenance.

(a) A program provider and an FMSA must complete visit maintenance, including the visit maintenance described in §354.4007(d)(1)(B) and (2)(B) of this subchapter (relating to EVV System):

(1) in accordance with the EVV Policy Handbook; and

(2) within the visit maintenance time frame after the date a service was provided as described in the EVV Policy Handbook.

(b) If a CDS employer selects to complete visit maintenance on the HHSC Employer's Selection for Electronic Visit Verification Responsibilities form, the CDS employer must complete visit maintenance in accordance with subsection (a)(1) and (2) of this section.

(c) After the visit maintenance time frame has expired, the program provider, FMSA, or CDS employer may complete visit maintenance only if:

(1) the program provider, FMSA, or CDS employer submits a Visit Maintenance Unlock Request in accordance with the EVV Policy Handbook; and

(2) HHSC or an MCO approves the Visit Maintenance Unlock Request.

§354.4013. HHSC and MCO Compliance Reviews and Enforcement Actions.

(a) HHSC and an MCO conduct the following compliance reviews in accordance with the EVV Policy Handbook:

(1) an EVV Usage Review;

(2) an EVV Landline Phone Verification Review; and

(3) an EVV Required Free Text Review.

(b) If HHSC or an MCO determines from an EVV Usage Review that a program provider’s or FMSA’s EVV Usage score is less than 80% and such score is:

(1) the first occurrence within a 24-month period, HHSC or an MCO may require the program provider or FMSA to complete EVV policy, system, and portal trainings within a specific time frame;

(2) the second occurrence within a 24-month period, HHSC or an MCO may require the program provider or FMSA to complete a corrective action plan within 10 business days after the date the program provider or FMSA is notified that the EVV Usage score is less than 80%; and

(3) the third occurrence within a 24-month period, HHSC or an MCO may propose to terminate the contract of the program provider or FMSA.

(c) If HHSC or an MCO determines from an EVV Usage Review that a CDS Employer’s EVV Usage score is less than 80% and such score is:

(1) the first occurrence within a 24-month period, HHSC or an MCO may require the CDS employer to complete EVV policy and system trainings within a specific time frame;

(2) the second occurrence within a 24-month period, HHSC or an MCO may require the CDS employer to complete a corrective action plan within 10 business days after the date CDS employer is notified that the EVV Usage score is less than 80%; and

(3) the third occurrence within a 24-month period, HHSC or an MCO may propose to terminate the member’s participation in the CDS option.

(d) If a program provider or FMSA, or the CDS employer does not complete EVV trainings or a corrective action plan as required by subsections (b)(1) and (2) of this section, HHSC or the MCO may impose a vendor hold on the program provider or FMSA until the EVV trainings or a corrective action plan is completed.

(e) If a CDS employer does not complete EVV trainings required by subsection (c)(1) of this section, HHSC or the MCO may require the CDS employer to complete a corrective action plan within 10 business days.

(f) If a CDS employer does not complete a corrective action plan as required by subsections (c)(2) or (e) of this section, HHSC or the MCO may propose to terminate the member’s participation in the CDS option.

(g) If HHSC or an MCO determines from an EVV Landline Phone Verification Review that a service provider has used an unallowable phone type as described in the EVV Policy Handbook to clock in and clock out of the EVV system:

(1) HHSC or an MCO will provide written notification of such determination to the program provider or FMSA;

(2) within 20 business days after receipt of the written notification, the program provider or FMSA must provide the documentation described in the written notification to HHSC or the MCO; and

(3) if the program provider or FMSA does not provide the documentation described in the written notification to HHSC or the MCO, HHSC or the MCO may impose a vendor hold on the program provider or FMSA until the program provider or FMSA provides the documentation.

(h) If HHSC or an MCO determines from an EVV Required Free Text Review that a program provider, an FMSA, or a CDS employer who elects to complete visit maintenance on the HHSC Employer's Selection for Electronic Visit Verification Responsibilities form did not enter free text in the EVV system on an EVV visit transaction when using a reason code as required by the EVV Policy Handbook, HHSC or the MCO may recoup payment made to the program provider or the FMSA for the EVV claim associated with the EVV visit transaction.

§354.4015. EVV Training Requirements.

(a) A program provider and FMSA that uses an EVV vendor system must ensure that an EVV system user completes EVV System Training described in the EVV Policy Handbook and provided by the EVV vendor:

(1) before the EVV system user begins using the EVV system; and

(2) yearly thereafter.

(b) A PSO must ensure that an EVV system user completes EVV System Training described in the EVV Policy Handbook and provided by the PSO:

(1) before the EVV system user begins using the EVV system; and

(2) yearly thereafter.

(c) A program provider and FMSA must ensure an EVV system user completes EVV Policy Training described in the EVV Policy Handbook and provided by HHSC or the MCO with which the program provider or FMSA contracts:

(1) before the EVV system user begins using the EVV system; and

(2) yearly thereafter.

(d) A program provider and FMSA must ensure that an EVV portal user:

(1) completes EVV Portal Training described in the EVV Policy Handbook and provided by HHSC or its designated contractor:

(A) before the EVV portal user begins using the EVV portal; and

(B) yearly thereafter; and

(2) completes EVV Policy Training described in the EVV Policy Handbook provided by HHSC or the MCO with which the program provider or FMSA contracts:

(A) before the EVV portal user begins using the EVV portal; and

(B) yearly thereafter.

(e) A program provider or a CDS employer must train a service provider on the clock in and clock out portion of the EVV System Training described in subsections (a) and (b) of this section:

(1) before the service provider or CDS employee begins using the EVV system; and

(2) yearly thereafter.

(f) A program provider must document the following to demonstrate compliance with subsections (a) - (e) of this section:

(1) the name of the training;

(2) the name of the person who completed the training; and

(3) the date of the training.

(g) An FMSA must document the following to demonstrate compliance with subsections (a) - (d) of this section:

(1) the name of the training;

(2) the name of the person who completed the training; and

(3) the date of the training.

(h) A CDS employer must document the following to demonstrate compliance with subsections (a), (b), and (e) of this section:

(1) the name of the training;

(2) the name of the person who completed the training; and

(3) the date of the training.

(i) If a program provider or an FMSA does not comply with subsections (a), (c), or (d) of this section, HHSC or an MCO may require the program provider or FMSA to complete a corrective action plan.

(j) If a PSO does not comply with subsection (b) of this section, HHSC or an MCO may require the PSO to complete a corrective action plan.

(k) If a program provider or a CDS employer does not comply with subsection (e) of this section:

(1) HHSC or an MCO may require the program provider to complete a corrective action plan; and

(2) an FMSA may require the CDS employer to complete a corrective action plan.

§354.4017. Process to Request Approval of a Proposed EVV Proprietary System and Additional Requirements for a PSO.

(a) This section applies to a program provider or FMSA seeking HHSC’s approval of a proposed EVV proprietary system. To request HHSC’s approval of a proposed EVV proprietary system, a program provider or FMSA must comply with the onboarding process described in the EVV Policy Handbook, which includes:

(1) completing and submitting the EVV Proprietary System Request Form; and

(2) participating in an operational readiness review session.

(b) HHSC approves a proposed EVV proprietary system if a program provider or FMSA:

(1) demonstrates that the proposed EVV proprietary system is in compliance with:

(A) the EVV Policy Handbook, including the EVV Business Rules for Proprietary Systems set forth in the EVV Policy handbook; and

(B) state and federal laws governing EVV; and

(2) successfully completes the operational readiness review by receiving a score of 100% in the following methods, as described in the EVV Policy Handbook:

(A) certification;

(B) documentation;

(C) demonstration; and

(D) trading partner testing.

(c) A PSO must:

(1) ensure the EVV proprietary system is in compliance with the HHSC EVV Policy Handbook, including the EVV Business Rules for Proprietary Systems, and state and federal laws governing EVV;

(2) assume responsibility for the design, development, operation, and performance of the EVV proprietary system;

(3) cover all costs to develop, implement, operate, and maintain the EVV proprietary system;

(4) ensure the accuracy of EVV data collected, stored, and reported by the EVV proprietary system;

(5) assume all liability and risk for the use of the EVV proprietary system;

(6) maintain all data generated by the EVV proprietary system to demonstrate compliance with this subchapter and for general business purposes;

(7) develop training materials on the proprietary system and train HHSC staff and MCO staff;

(8) provide access to all HHSC-approved clock in and clock out methods offered by the PSO to a service provider at no cost to a member, HHSC, an MCO or HHSC’s designated contractor;

(9) ensure the functionality and accuracy of all clock in and clock out methods provided to a service provider;

(10) comply with the process in the HHSC EVV Policy Handbook if transferring EVV proprietary systems; and

(11) notify HHSC, in writing, if:

(A) the EVV proprietary system is not in compliance with the HHSC EVV Policy Handbook, including the EVV Business Rules for Proprietary Systems, and state and federal laws governing EVV; or

(B) if the PSO plans to make significant changes to the EVV system.

(d) HHSC may, at its discretion, audit an EVV proprietary system. Such audit may be conducted by a contractor of HHSC.

(e) If HHSC determines that a PSO is not in compliance with subsection (c) of this section, HHSC may, in accordance with the HHSC EVV Policy Handbook:

(1) require the PSO to correct the non-compliance within a time frame specified by HHSC;

(2) reject EVV visit transactions from the proprietary system until HHSC determines the non-compliance is corrected;

(3) cancel the use of the EVV proprietary system if:

(A) the PSO fails to correct the non-compliance within the time frame specified by HHSC; or

(B) the PSO does not respond to a written communication from HHSC about the non-compliance within the time frame specified by HHSC; and

(4) cancel the use of an EVV proprietary system without giving the PSO the opportunity to correct the non-compliance:

(A) if the non-compliance is egregious, as determined by HHSC; or

(B) because of a substantiated allegation of fraud, waste, or abuse by Office of Inspector General.

§354.4019. Access to EVV System and EVV Documentation.

A program provider and an FMSA must:

(1) allow HHSC and the MCO with which the program provider or FMSA has a contract immediate, direct, and on-site access to the EVV system the program provider or FMSA uses;

(2) at HHSC’s request, allow HHSC to review EVV system documentation or obtain a copy of that documentation at no charge to HHSC; and

(3) at the request of an MCO with which an EVV claim is filed, allow the MCO to review EVV system documentation related to the EVV claim or obtain a copy of that documentation at no charge to the MCO.

§354.4021. Additional Requirements.

A program provider, an FMSA, a CDS employer, a service provider, a member, and an MCO must comply with:

(1) applicable state and federal laws, rules, regulations, including the Health Insurance Portability Accountability Act of 1966 at 42 U.S.C. §1320d, et. seq., and regulations adopted under that act at 45 CFR Parts 160 and 164; and

(2) the EVV Policy Handbook.

§354.4023. Sanctions.

(a) HHSC or an MCO may propose to recoup funds paid to a program provider or FMSA as described in:

(1) §354.4009(d) of this subchapter (relating to EVV Visit Transaction and EVV Claim); and

(2) §354.4013(h) of this subchapter (relating to HHSC and MCO Compliance Reviews and Enforcement Actions.

(b) HHSC or an MCO may impose a vendor hold against a program provider or FMSA as described in §354.4013(d) and (g)(3) of this subchapter.

(c) HHSC or an MCO may propose to terminate the contract of program provider or FMSA as described in:

(1) §354.4007(e)(2)(B) of this subchapter (relating to EVV System); and

(2) §354.4013(b)(3) of this subchapter.

§354.4025. Administrative Hearing.

(a) If, as described in this subchapter, HHSC proposes to terminate the contract of a program provider or FMSA, proposes to recoup funds paid to a program provider or FMSA, or imposes a vendor hold on a program provider or FMSA, the program provider or FMSA may request an administrative hearing in accordance with §357.484 of this title (relating to Request for a Hearing).

(b) If, as described in this subchapter, an MCO proposes to terminate the contract of a program provider or FMSA, proposes to recoup funds paid to a program provider or FMSA, or imposes a vendor hold on a program provider or FMSA, the program provider or FMSA may appeal the proposed action in accordance with the MCO’s policy.