



# **All Provider Meeting – Topic: Program Integrity**

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March 19, 2021

# Tentative EVV Home Care Audit Plan

- Audit Period: January 1, 2021 through June 30, 2021
- All home care providers with any paid claims during that period will be audited to ensure compliance
- As in the past, PI will be transparent
- Purpose of audit is to ensure paid claims meet federal requirements for EVV (on next two slides)



## Federal requirement

There are six verification criteria of EVV to meet:

1. Service type.
2. Individual receiving the service.
3. Date of service.
4. Location of service delivery.
5. Individual providing the service.
6. Begin and end times of service.



SSA Section 1903(l)(1) specifies that the EVV requirement applies to “personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this title (or under a waiver of the plan)...”.

Similarly, section 1903(l)(5)(B) defines home health services for purposes of the EVV requirement to mean “services described in section 1905(a)(7) provided under a state plan under this title (or under a waiver of the plan).” Therefore, any home health services that the state has opted to cover under the state plan or under a waiver of the plan, and that require an in-home visit, would be subject to the EVV requirement.



It is important that agencies work with their caregivers to ensure visits are being verified automatically (meaning no manual corrections are needed to be performed by the agency post visit) vs the agency manually making corrections (meaning a manual corrections is needed to be performed by the agency post visit) after the visit has occurred. There will always be “human error” where someone may forget to log in or out, but this should be the exception, not the norm. There are some agencies that are very low in their manual verification and some agencies that are at 100% manual verification of their visits.

One of our CMS KPI’s is related to auto visit verification. We have discussed a starting target of 70% compliance of auto visit verification with continued improvement month over month.

The state will Monitor and identify providers who have not met the preliminary compliance benchmark for month-over-month trends. Complete targeted outreach to providers who are not meeting the manual visit verification rate beyond a two-month timespan to assist in identifying trends and/or assistance in moving to more auto verified visits.



- Final audit plan will be communicated to all providers prior to commencement of audit and no earlier than the first week in August
  - Parameters for claim sample will be contained in final audit plan
- For claims not processed through Sandata/ Aggregator, provider will need to supply documentation to PI in support of paid claims
  - records will be evaluated for consideration; it should not be assumed that all records will be deemed acceptable
- For claims processed through Sandata/Aggregator, PI does not anticipate needing to request records; however, there may be circumstances when it will be necessary



- After PI has concluded its initial review, each provider will receive their initial audit findings
  - PI will schedule a remote meeting to discuss the findings if a provider requests one
  - Providers will be allowed to ask questions
  - Providers may submit additional documentation for consideration; it should not be assumed that all additional documentation will be deemed acceptable
- Results *may* be extrapolated depending upon error rate once findings are finalized
- PI will advise providers of their appeal rights when final findings are sent to each provider

