Cecile E. Young, Executive Commissioner

Request for Offers (RFO)

For

Electronic Visit Verification (EVV) System Management Services

Solicitation No. HHS0011055

Date of Release: April 26, 2022

Responses Due: June 7, 2022, by 10:30 a.m. Central Time

NIGP Class/Item Codes:

208-11 Application Software, (Not Otherwise Classified), Microcomputer
915-20 Call Center Service
920-64 System Implementation and Engineering Services
962-69 Personnel Services, Temporary
948-43 Health Information Services
958-77 Project Management Services
961-30 Employment Agency and Search Firm Service, Including Background Investigations and Drug Testing for Employment

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ARTICLE I. EXECUTIVE SUMMARY, DEFINITIONS, AND AUTHORITY

1.1 EXECUTIVE SUMMARY

The State of Texas, by and through the Texas Health and Human Services Commission (HHSC), issues this Request for Offer (RFO) to solicit an entity to deliver Electronic Visit Verification (EVV) system management services to support the Title XIX Texas Medical Assistance Program (Medicaid) and other State and federally funded programs in accordance with the Scope of Work (SOW). The Contractor will be responsible for the management and oversight of Proprietary EVV Systems, and management, oversight and operation of the State Pool System. **The Respondent awarded the Contract resulting from this Solicitation must provide a State Pool System which is not owned by Respondent**.

The SOW requires an aggressive Transition timeline of five (5) months for Contractor to become operational. To meet this timeline, it is critical that the Respondent contract with their State Pool System Operator (SPSO) no later than two (2) Calendar Days after the Contract Effective Date. This will provide maximum time for the State Pool System to be configured in accordance with the SOW.

The SOW includes extensive performance standards and technical requirements that the Contractor must meet, as well as HHSC's right to monitor the Contractor's performance. The SOW in **Article II - Scope of Work, Article VII - Cost Proposal**, and all Attachments and Exhibits set forth herein will become part of any Contract awarded under this Solicitation.

Respondents are advised that this Solicitation does not anticipate or include time or funding for a software design, development, and implementation (DDI) phase. The Contract timelines assume minimal time and effort to configure the Contractor Solution and establishing full operational readiness of the Contractor Solution. All risks for cost overruns and additional development efforts discovered after the Contract Effective Date shall be borne exclusively by the Contractor and may be grounds for termination for cause.

To be considered for Award, Respondents must execute **Exhibit A, HHS Solicitation Affirmations Acceptance V2.2** and federal assurances and certifications—**Exhibit D, Federal Assurances – Non-Construction Programs** and **Exhibit E, Certification Regarding Lobbying** of this Solicitation and provide all other required information and documentation identified in this Solicitation.

HHSC PCS will administer the procurement process for this Solicitation, which includes RFO publication, handling of communications from Respondents, as well as managing the receipt of responses for review and evaluation.

Information regarding HHSC and its programs is available online and can currently be accessed at https://hhs.texas.gov.

1.2 DEFINITIONS

Refer to **Exhibit B, HHS Uniform Terms and Conditions Vendor V3.2**, for additional definitions.

Additionally, as used in this Solicitation, unless the context clearly indicates otherwise, the following terms and conditions have the meanings assigned below:

"Addendum" means a written clarification or revision to this Solicitation issued by HHSC PCS and posted to the ESBD.

"Advancement Criteria" means the published criteria for Respondent to advance to the next phase of evaluation if multiple evaluation methods are utilized.

"Award Consideration (AC) Documents" means documents Respondent must submit as part of the Solicitation Response to be considered for negotiations or award.

"Base Contract Term" is a period of four (4) years from the Contract Effective Date.

"Business Day" is any day of the week except a Saturday, a Sunday, or a national or State holiday as listed in Texas Government Code, Section 662.003(a) or (b).

"Business Operations and Business Integration" The services to be provided by the Business Operations and Business Integration service provider include the business integration effort and staff managing projects to ensure effective functioning of the Medicaid ecosystem when divided across multiple vendors.

"Calendar Day" is each day shown on the calendar beginning at 12:00 AM Midnight, including Saturdays, Sundays, and holidays.

"Centers for Medicare & Medicaid Services" or "CMS" is the agency that is part of the U.S. Department of Health and Human Services, which oversees many federal healthcare programs, including Medicaid and those that involve health information technology.

"CMS Conditions and Standards" means the conditions and standards required by CMS that must be met by state Medicaid Information Technology systems to qualify for enhanced federal funding for Medicaid eligibility, enrollment, and delivery systems. Originally a set of seven conditions and standards as documented in the CMS Enhanced Funding Requirements: Seven Conditions and Standards; Medicaid IT Supplement (MITS-11-01-v1.0) dated April 2011, the list was expanded to twelve conditions and standards based on the CMS state Medicaid Directors' letter, number SMD #16-009, titled "Re: Mechanized Claims Processing and Information Retrieval Systems - APD Requirements", dated June 27, 2016.

"Central Time" or "CT" is the standard time in a zone that includes the central states of the US and parts of central Canada.

"Code of Federal Regulations" or "CFR" means the codified general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the federal government of the United States.

"Competitive Range" has the same meaning as the definition under **Title 1 of the Texas Administrative Code Part 15, Chapter 391, Subchapter A, Rule §391.107(3)**.

"Confidential Information" shall have the meaning assigned in **Exhibit H, Data Use Agreement (DUA)**

"Consumer Directed Services" or "CDS" means a Medicaid service delivery option that allows people who receive services to hire and manage the Direct Service Providers who provide their services.

"CDS Employer" means a person who hires and manages the Direct Service Providers who provide their services.

"Contract Term" is the duration of the Contract, including the Base Contract Term of the Contract and all Contract renewals and extensions.

"Contractor Solution" refers to the Contractor's combined business and technology managed services approach for addressing the SOW requirements and any other specifications, terms, or conditions contained in this Solicitation. As part of the Contractor Solution, the Contractor must provide all Services to the State of Texas pursuant to the terms in this SOW.

"Critical Application" means a State Pool System application or business process that provides one or more of the following functions: the ability for a Direct Service Provider to clock in and clock out when delivering Medicaid services; and the ability for a Program Provider or FMSA to submit EVV visit transactions to the EVV Aggregator.

"Demonstration" refers to a secondary evaluation method following the evaluation of the written responses and is utilized for the purpose of distinguishing between Respondents by scoring them on a demonstration of use cases typically aimed at verifying the functionality of a Respondent's software. Although most often used in information technology (IT) procurements, the method can be used in RFOs where software is a smaller component of the overall procurement but needs to be verified.

"Direct Service Provider" means a person who delivers Medicaid services directly to a Member. Service Providers include but are not limited to: personal attendants, nurses, therapists, and home health aides.

"Disaster" means a sudden, unplanned catastrophic event that compromises an organization's ability to provide critical business functions, processes, or services for some unacceptable period of time.

"Domain" means the functional groupings of the requirements for this Solicitation.

"ESBD" means the Electronic State Business Daily, the electronic marketplace where State of Texas bid opportunities over $25,000 are posted. The ESBD may currently be accessed at http://www.txsmartbuy.com/esbd.

"Electronic Protected Health Information" or "ePHI" means any Protected Health Information (PHI) that is created, stored, transmitted, or received in any electronic format or media.

"Electronic Visit Verification" or "EVV" is a systematic method to capture and verify data with respect to personal care services or home healthcare services, including type of service performed; individual receiving the service; date of service; location of service delivery; individual providing the service; and time the service begins and ends.

"EVV Aggregator" is a centralized system that collects, validates, and stores statewide EVV visit data transmitted by the EVV System(s) and performs a match of EVV visit transaction data to claims submitted by Program Providers and FMSAs. EVV Systems submit EVV visit transactions in a defined custom file format. The EVV Aggregator performs edits and validations on the files, sends responses to the EVV Systems and stores EVV visit transaction data where it is used in reporting and available for view through the EVV Portal.

"EVV Systems" refers collectively to the State Pool System and Proprietary Systems.

"EVV System Selection Table" means the HHSC-approved table housed within the EVV Aggregator that identifies the EVV System selected by or assigned to each Program Provider and FMSA, including: the begin and end date of current and previous EVV System selection(s) or assignment(s), provider identifiers (e.g., national provider identifier, atypical provider identifier, contract number) and other HHSC-approved data elements.

"EVV Users" means any person or entity that uses an EVV system. This includes but is not limited to state staff, MCO staff, Program Providers, FMSAs, CDS Employers, CDS Employees, Direct Service Providers, and other HHSC-approved users.

"Evaluator" means a State staff resource who is charged with judging the quality, importance or value of the Solicitation Responses.

"Fee-For-Service" or "FFS" means a delivery system where healthcare providers are paid for each service provided to a patient.

"Final Written Response Score" refers to the final scoring of the written response as documented in the Solicitation.

"Financial Management Services Agency" or "FMSA" means an entity that contracts with HHSC or an MCO to provide financial management services, such as payroll services, to a CDS employer as described in 40, TAC Chapter 41 (relating to Consumer Directed Services option).

"Health Insurance Portability and Accountability Act" or "HIPAA" means the federal statute that protects health insurance coverage for workers and their families when they change or lose their jobs (via Title I) and requires the establishment of national standards for electronic healthcare transactions and national identifiers for providers, health insurance plans, and employers (via Title II, the Administrative Simplification provision).

"HHSC" means the Health and Human Services Commission.

"HHSC PCS" means Procurement and Contracting Services (PCS), a division of HHSC.

"HUB" means Historically Underutilized Business, as defined by Chapter 2161 of the Texas Government Code.

"HUB Subcontracting Plan" or "HSP" means written documentation regarding the use of subcontractors, which is required to be submitted with all responses to state agency Solicitations with an expected value of $100,000 or more where the state agency has determined subcontracting opportunities are probable. The HSP subsequently becomes a provision of the awarded Contract and shall be monitored for compliance by the state agency during the term of the Contract.

"Incident" means an unplanned interruption or failure of a service, or reduction in the quality of a service, as well as the failure of a configuration item that has not yet affected service but has the potential to cause a service interruption.

"Key Performance Measures" or "KPM" means measurable value that demonstrates how effectively the Contractor is achieving key business objectives.

"Managed Care Organization" or "MCO" means an entity that contracts with the State to provide health benefits and additional services and accepts a set capitation payment per Member, per month, for such services.

"Managed Services" are services performed by an entity that utilizes its proprietary or licensed software and infrastructure to provide business or data management processes to customers. Managed Services do NOT include software or infrastructure owned by HHSC.

"Medicaid Enterprise Systems" or "MES" means the State's systems which enable efficient operations of Medicaid and non-Medicaid programs by supporting beneficiary eligibility, enrollment, care management, and other beneficiary-facing tools. These systems also serve provider enrollment and payment, benefits managements, data analytics and reporting, fraud and abuse detection, and provider electronic health record incentive payments.

"Medicaid Information Technology Architecture" or "MITA" is a national framework to support improved systems development and health care management for the Medicaid enterprise. MITA has several goals, including development of seamless and integrated systems that communicate effectively through interoperability and common standards and processes

"Medicaid Management Information System" or "MMIS" is a mechanized claims processing and information retrieval system that State Medicaid programs must have to be eligible for Federal funding. The system controls Medicaid business functions, such as: administrative program and cost control; beneficiary and provider inquiries and services; operations of claims control and computer capabilities; and management reporting for planning and control.

"Member" means a person who receives Medicaid services.

"Off-Shore" means located outside of the continental United States.

"Operations Start Date" means the date Operations start.

"Operations" means the Contract activities that begin immediately after Transition activities are completed and approved by the State and continue throughout any Contract renewals and extensions and Turnover activities.

"Personal Identifiable Information" or "PII" means any representation of information that permits the identity of an individual to whom the information applies to be reasonably inferred by either direct or indirect means.

"Procurement Library" means the repository of additional information that is made available to Respondents subject to the terms and conditions of this Solicitation.

"Program" means collectively HHSC's healthcare programs, that will be utilizing the services provided by any resulting contract of this Solicitation to fulfill their programmatic objectives.

"Program Provider" is an entity contracted with the HHSC Fee-For-Service (FFS) program or an MCO that delivers services subject to HHSC EVV requirements. EVV Program Providers include, but are not limited to:

a. Provider Agencies;
b. Long-Term Support Services (LTSS) Providers;
c. Local Intellectual and Developmental Disability Authorities (LIDDAs);
d. Local Mental Health Authorities (LMHA); and
e. Independent Direct Service Providers

"Proprietary System" is an EVV System that a Program Provider or FMSA may opt to use instead of the State Pool System that:

a. is purchased or developed by a Program Provider or an FMSA;
b. is used to exchange information with the EVV Aggregator;
c. is approved by HHSC or it's designee (*i.e.*, Contractor) for use;
d. complies with HHSC EVV requirements; and,
e. complies with the requirements of Texas Government Code §531.024172 or its successors.

"Proprietary System Operator" or "PSO" is a Program Provider or FMSA that uses a Proprietary System to comply with HHSC EVV requirements.

"Protected Health Information" or "PHI" means all individually identifiable health information 'held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. See also, "ePHI" above.

"Respondent" means the individual or entity responding to this Solicitation.

"Solicitation" means this RFO including all exhibits, attachments, forms, and Addenda, if any.

"Solicitation Consideration (SC) Documents" means documents that must be submitted by Respondent with the Solicitation Response in order to be considered for evaluation and cannot be resubmitted or have errors remedied after the submission due date and time in the Schedule of Events has passed.

"State" means the State of Texas and its instrumentalities, including HHSC, the System Agency, and any other state agency, its officers, employees, or authorized agents.

"State Pool System" an EVV System that is provided by Contractor to be available to all Program Providers or FMSA free of charge.

"State Pool System Operator" or "SPSO" is an entity that is subcontracted with Contractor to operate a State Pool System.

"Texas EVV Program" means all components of the EVV process with respect to Texas Medicaid.

"Total Score" means the Final Written Response Score plus any additional points for secondary evaluation activities, as outlined by this Solicitation.

"Trading Partner" is a person or entity that sends, receives, and exchanges information in an ongoing business relationship.

"Turnover" means the Contractor's administrative and operational activities under the Contract to transition Operations either to HHSC or an HHSC designated service provider at the direction of the State.

"VPTS" means Vendor Performance Tracking System, as defined under Section 2262.055 of the Texas Government Code and Title 34 of the Texas Administrative Code Part 1, Chapter 20, Subchapter B, Division 2, Rule §20.115 and Subchapter F, Division 2, Rule §20.509.

"Weekday Call Center Hours" means 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday.

"Weekend Call Center Hours" means 9:00 a.m. to 1:00 p.m. Central Time, Saturday and Sunday excluding HHSC-approved holidays, unless otherwise approved by HHSC.

1.3 AUTHORITY

HHSC is soliciting the services listed herein under Tex. Gov't Code § 2157.068 (e-2) and 2157.006 (a)(2); and Tex. Admin. Code, Title 34, Part 1, Chapter 20, Subchapter H, Section 20.391. The governing authorities for EVV are: Tex. Gov't Code § 531.024172; Tex. Admin. Code Title 1, Part 15, Chapter 354, Subchapter O; and 42 U.S. Code § 1396b (l).

ARTICLE II. SCOPE OF WORK

2.1 DESCRIPTION OF SERVICES/STATEMENT OF WORK/SPECIFICATIONS

The Contractor must take a collaborative, innovative, cooperative, flexible, and customer-oriented approach to the Contractor Solution and must work with HHSC as necessary, to achieve successful outcomes in completing the requirements under this SOW. The SOW includes the Services, requirements, Deliverables, and Key Performance Measures to be performed by the Contractor during the Contract Term, subject to the terms and conditions set forth in this Solicitation. For additional specifications and clarification, refer to the Addenda, Exhibits, and other documents expressly designated by the State as part of this Solicitation.

The Contractor must provide a comprehensive Contractor Solution, comprised of business and technology managed services. As a part of its Contractor Solution, the Contractor must provide a State Pool System for use by Program Providers, Financial Management Services Agencies (FMSAs) and CDS employers to comply with Texas EVV requirements. As part of the Contractor Solution, the Contractor must provide management services to evaluate, approve, and oversee the use of Proprietary Systems by Program Providers, FMSAs and CDS employers to comply with Texas EVV requirements. The Contractor must facilitate onboarding, operational readiness review and deployment activities to incorporate approved Proprietary Systems into the operational environment of the Texas EVV open/hybrid model. The Contractor must onboard, implement and manage the Contractor Solution awarded through this Solicitation. The Contractor services include the following:

a. Securing, onboarding, and managing a State Pool System that meets all requirements in **Exhibit Q, HHSC EVV Business Rules** and **Exhibit R, HHSC EVV Policies**;
b. Reviewing, approving, and onboarding Proprietary Systems that meet all requirements in **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** and **Exhibit R, HHSC EVV Policies**;
c. Coordinating State Pool System and Proprietary System integration with the Texas EVV Aggregator;
d. Facilitating onboarding and training for EVV Users of the State Pool System; and
e. Providing operational and technical support for the Contractor Solution for Program Providers, FMSAs, CDS Employers, MCOs, HHSC staff, and other HHSC-approved Trading Partners.

The State of Texas fully implemented the use of EVV for Medicaid personal care services on January 1, 2021. The State of Texas, with Contractor's assistance, will expand the use of EVV to include Medicaid home health care services in compliance with federal law.

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Texas EVV Open Model

MCO Claim Adjudication Results

Program Providers & Financial Management Services Agencies (FMSAs)

Service Providers

CDS Employers

Visit Data

Program Providers and FMSAs choose their preferred EVV System

Managed Care Organizations (MCOs)

Forwarded MCO Claim w/Match Result

EVV Systems to be managed by Contractor

Proprietary Systems

State Pool System

Visit Data

Acceptance Results

EVV Aggregator & Portal

Match Results

Claims Matching

Match Results

FFS Claim Adjudication & Match Results

All EVV Claims

Claims Systems

The use of EVV is required for Medicaid personal care services and will be required for home health care services within these programs in accordance with the federal 21st Century Cures Act requirements. Many Medicaid programs include a CDS option in addition to the traditional provider agency service delivery model. Refer to the **Attachment A-2, Procurement Library** for the Programs, Services and Service Delivery Options Required to Use EVV for Personal Care Services and Programs, Services and Service Delivery Options Required to Use EVV for Home Health Care Services.

Respondents are advised that HHSC's home health care services expansion efforts may occur during the Transition Phase and continue after the Operations Start Date. Contractor shall support HHSC's home health care services expansion efforts by providing all training, onboarding and other services required by this Solicitation, including, but not limited to, activities described in Contractor's HHSC-approved Home Health Care Services Expansion Plan. Refer to Table 8 – Deliverables Requirements. HHSC, at its sole discretion, may require Contractor to provide the above referenced services in support of HHSC's home health care services expansion efforts on or before the Operations Start Date.

HHSC may, at any time throughout the Contract Term, commence modernization activities that could result in HHSC decoupling or replacing business functions or functionality within the Contractor Solution with updated business and technology components. The

Contractor must work with HHSC through the approved change management process to update, integrate, and implement the transition of any business or technology components at the request of HHSC.

HHSC, at its sole discretion, reserves the option to request early Contract termination, pursuant to Article IX of **Exhibit B, HHS Uniform Terms and Conditions Vendor V3.2**, in order to separate or disengage functionality, or to remove business functions from the Contractor, if it is in the best interest of HHSC. The Contractor will commence Turnover activities for any in-scope functionality at the request of HHSC.

2.1.1 Project Phases

The Contractor shall provide services, as described in this SOW, within three (3) phases: (1) Transition Phase, (2) Operations Phase, and (3) Turnover Phase, as defined in the following subsections.

2.1.1.1 *Transition Phase*

The primary objectives for the Transition Phase are for the Contractor to oversee and validate that all necessary set-up and operational readiness activities are completed to enable the Contractor to take over performance of Services from the incumbent service provider with no adverse impact on the performance of EVV operations, Members, and EVV Users. Transition activities occur between the Contract Effective Date and the Operations Start Date.

Transition activities include, but are not limited to, setup of the Contractor's Project Management Office (PMO), onboarding, and orientation of Contractor's staff; timely completion of all Transition Key Milestones; configuration and implementation of the Contractor Solution; data migration and conversion oversight for the State Pool System; implementation of HHSC EVV processes, procedures, and policies; and implementation of **Exhibit R, HHSC EVV Business Rules** in the State Pool System.

2.1.1.2 *Operations Phase*

The Operations Phase begins after HHSC provides written approval and notification to the Contractor that the operational readiness activities have been completed. During the Operations Phase, the Contractor will perform all Services in accordance with the requirements of this Solicitation, and State and federal law and regulation.

2.1.1.3 *Turnover Phase*

The Turnover Phase is anticipated to begin twelve (12) months prior to the end of the Contract Term, which includes any optional renewal periods. The Turnover Phase is the Contract phase in which the Contractor performs administrative and operational activities sufficient to transition Operations either to HHSC or an HHSC designated service provider at the direction of the State.

Turnover Phase tasks will be planned and coordinated with HHSC and the HHSC designated successor service provider to ensure that stakeholders and Members do not experience any adverse impact from the transfer of Services (see **Table 19 – Turnover Requirements**).

All Turnover activities will be completed according to the Contractor's HHSC-approved Turnover Plan.

The Contractor will be responsible for any defects that existed prior to the Turnover Phase or that were caused by the Contractor's lack of support, coordination, or cooperation during the Turnover Phase.

2.1.2 Contractor Requirements

The Contractor Solution requirements for this Solicitation have been organized as Domains in the following sections. Key Performance Measures and Liquidated Damages requirements with a 'K' suffix in the requirement identification (Req ID) column appear in sub-sections following the Domain requirements where applicable.

The list below contains the Domains and associated acronyms used to organize the Contractor Solution requirements.

a. Domain: Transition = TRA

b. Domain: General Operations = GOP

   1. Subdomain: Project Management = PMO
   2. Subdomain: Staffing = STF
   3. Subdomain: Contractor Facility = FAC
   4. Subdomain: Deliverable = DEL
   5. Subdomain: Business Continuity and Disaster Recovery = BCD
   6. Subdomain: Communications = COM
   7. Subdomain: Support Services = SUP
   8. Subdomain: Litigation Support = LIT
   9. Subdomain: Security = SEC
   10. Subdomain: Testing = TST
   11. Subdomain: Training = TNG
   12. Subdomain: Turnover = TUN

c. Domain: State Pool Management and Oversight = SPS

d. Domain: State Pool System Operations = SPO

   1. Subdomain: Customer Support = CUS

2. Subdomain: Call Center = CAC
3. Subdomain: State Pool System Training = SPT
4. Subdomain: System = SYS
5. Subdomain: CMS Certification = CMS
6. Subdomain: MITA = MIT
7. Subdomain: Alternative Device Management = ALT

e. Domain: Proprietary System Management and Oversight = PSM

The requirements stated in **Exhibit R, HHSC EVV Business Rules**, **Exhibit S, HHSC EVV Business Rules for Proprietary Systems**, **Exhibit Q, HHSC EVV Policies, Exhibit T, EVV Standard Language Guide**, and **Exhibit U, EVV Service Bill Codes Table** are living rules, policies, and data and will be revised throughout the Contract Term as a result of State and federal mandates, new business needs, and from audit findings. The Contractor Solution shall comply with **Exhibit R, HHSC EVV Business Rules**, **Exhibit S, HHSC EVV Business Rules for Proprietary Systems**, **Exhibit Q, HHSC EVV Policies**, **Exhibit T, EVV Standard Language Guide**, and **Exhibit U, EVV Service Bill Codes Table**, in their current versions and as amended, throughout the Contract Term. The **HHSC EVV Business Rules, HHSC EVV Business Rules for Proprietary Systems, HHSC EVV Policies, EVV Standard Language Guide,** and **EVV Service Bill Codes Table** will be maintained by the HHSC EVV Program. HHSC will provide the most current version of the foregoing documents identified in this paragraph to the awarded Contractor upon the Contract Effective Date or as otherwise agreed between the Parties.

2.1.3 Transition Requirements (TRAR)

The Contractor shall work with HHSC and the outgoing services provider to transition the EVV functions in the Contract on a schedule approved by HHSC.

HHSC places great emphasis on operational readiness and will be evaluating the Contractor's capabilities and performance during the Transition Phase. Periodic assessments will be performed before a formal operational readiness assessment is conducted. HHSC intends to include EVV Users in the operational readiness assessment. EVV User participation could include providing sample EVV visit records and live testing of the State Pool System.

The requirements for Transition listed in **Table 1 - Transition Requirements** below describe the tasks and activities that must be performed by the Contractor during the Contract Term.

Table 1 – Transition Requirements

Transition Requirements	
Req ID	**Detailed Requirements**
TRAR-001	Complete all Transition Phase milestones as defined in the Contractor's HHSC-approved **Project Work Schedule** within HHSC-approved timeframes. Refer to **Table 8 – Deliverable Requirements**.
TRAR-002	Provide a State Pool System no later than two (2) Calendar Days after Contract Effective Date.
TRAR-003	Facilitate the transfer of all EVV Users from the incumbent State Pool Systems to Contractor's State Pool System in accordance with Contractor's HHSC-approved **Project Work Schedule.** Refer to **Table 8 – Deliverable Requirements**.
TRAR-004	Complete the transfer of all EVV Users from the incumbent State Pool Systems to Contractor's State Pool System no later than fifteen (15) Calendar Days prior to the Operations Start Date unless otherwise approved by HHSC.
TRAR-005	Conduct a kickoff meeting no later than ten (10) Calendar Days following the Contract Effective Date.
TRAR-006	Deliver final data conversion test results to HHSC no later than fifteen (15) Calendar Days prior to Operations Start Date demonstrating that all data has been successfully converted.
TRAR-007	Establish Contractor's operational site in the Austin, Texas area within twenty-five (25) miles of HHSC's designated office at 701 W. 51st Street, Austin, TX 78751 no later than two (2) Calendar Days following the Contract Effective Date.
TRAR-008	Provide and facilitate an HHSC on-site review of Contractor's operational site in accordance with Contractor's HHSC-approved **Operational Readiness Review Plan**. Refer to **Table 8– Deliverable Requirements**.
TRAR-009	Develop and maintain throughout the Contract Term a detailed requirements traceability matrix that tracks the technical and operational requirements implemented by the State Pool System to meet the requirements of **Exhibit R, HHSC EVV Business Rules**, **Exhibit Q, HHSC EVV Policies** and other HHSC requirements in accordance with Contractor's HHSC-approved **State Pool System Onboarding Plan.** Refer to **Table 8 – Deliverable Requirements.** Refer to **Exhibit R, HHSC EVV Business Rules** and **Exhibit Q, HHSC EVV Policies**.
TRAR-010	Complete a gap analysis as directed by HHSC and document any gaps between the Contractor Solution and the business requirements in a requirements management tool. Gaps must show bi-directional traceability with applicable business requirement(s), design, test cases, test results, and certification artifacts.
TRAR-011	Accept and convert five (5) years of data into the State Pool System including, but not limited to: Program Provider and FMSA demographic data (e.g., contract information), CDS Employer information, Member information, Direct Service

	Provider information and Service Authorization information, in accordance with Contactor's HHSC-approved **Data Conversion Plan**. Refer to **Table 8 – Deliverable Requirements**.
TRAR-012	Provide authorized HHSC or other designated individuals access to validate any converted data needed to support continuity of Services and provide support for the data validation effort.
TRAR-013	Begin operational readiness review activities for the Contractor Solution no later than ninety (90) Calendar Days prior to the Operations Start Date or as otherwise approved by HHSC. Refer to **Operational Readiness Review Plan** in **Table 8 – Deliverable Requirements**.
TRAR-014	Complete operational readiness activities with HHSC and Trading Partners in accordance with the Contractor's HHSC-approved **Operational Readiness Review Plan.** Refer to **Table 8 – Deliverable Requirements**.
TRAR-015	Submit the final operational readiness review checklist(s) demonstrating that Contractor Solution meets all readiness criteria no later than fifteen (15) Calendar Days prior to the Operations Start Date, unless otherwise approved by HHSC.
TRAR-016	Submit a weekly operational readiness results report to HHSC in accordance with the Contractor's HHSC-approved **Operational Readiness Review Plan**. Refer to **Table 8 – Deliverable Requirements**.
TRAR-017	Complete all testing prior to implementation in accordance with the Contractor's HHSC-approved **Test Plan**. Refer to **Table 8 – Deliverable Requirements**.
TRAR-018	Conduct full end-to-end testing of the State Pool System in coordination with HHSC and Trading Partners in accordance with the Contractor's HHSC-approved **State Pool System Onboarding Plan**. Contractor must provide all documentation, including, but not limited to, use cases, test cases, test data, scenarios used, and report results to HHSC. Refer to **Table 8 – Deliverable Requirements**.
TRAR-019	Submit to HHSC the final training materials for the initial training for EVV Users of the State Pool System no later than seventy-five (75) Calendar Days prior to the Operations Start Date unless otherwise approved by HHSC.

2.1.3.1 *Transition Key Performance Measures (TRAK)*

The requirements listed in **Table 2-Transition Key Performance Measures** below describe the level of performance required by the Contractor for Transition.

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Table 2 – Transition Key Performance Measures

Transition Key Performance Measures		
Req ID	**Key Performance Measures**	**Liquidated Damages**
TRAK-001	Begin training EVV Users on the use of the State Pool System no later than sixty (60) Calendar Days prior to the Operations Start Date.	HHSC will assess $2,000 for each Calendar Day past the sixtieth (60th) Calendar Day prior to Operations Start Date training for EVV Users has not started.
TRAK-002	The Contractor must complete all activities on the critical path for the Transition Phase as outlined in the HHSC-approved **Project Work Schedule** no later than the Operations Start Date, unless otherwise approved by HHSC. Refer to requirement DELR-006 in **Table 8 Deliverable Requirements.**	HHSC will assess $25,000 for each Business Day beyond the Operations Start Date for any incomplete activities on the critical path for the Transition Phase.

2.1.4 General Operations (GOP)

The General Operations Domain encompasses the requirements the Contractor will perform throughout the Contract Term to deliver the Contractor Solution.

2.1.4.1 *Project Management Requirements (PMOR)*

The Contractor shall perform, manage, and control all tasks and activities according to an industry-recognized methodology like, or similar to Project Management Institute (PMI®) System Development Life Cycle (SDLC).

The Project Management requirements listed in **Table 3 – Project Management Requirements** below describe the tasks and activities that must be performed by the Contractor during the Contract Term.

Table 3 – Project Management Requirements

Project Management	
Req ID	**Detailed Requirements**
PMOR-001	Provide a monthly **Key Performance Measure Report** detailing Contractor's performance for the prior service month no later than the twenty-fifth (25th) Calendar Day of each month in accordance with Contractor's HHSC-approved **Key Performance Measure Plan**. Refer to **Table 8 – Deliverable Requirements**.

Project Management	
Req ID	**Detailed Requirements**
PMOR-002	Provide HHSC-approved web-based conferencing software and HHSC-approved toll-free teleconferencing capabilities to support Contract activities (e.g., facilitating meetings with HHSC and HHSC-approved Trading Partners).
PMOR-003	Complete a project management template for HHSC approval at least five (5) Business Days prior to initiating a Project in accordance with the Contractor's HHSC-approved **Project Management Plan**. Refer to **Table 8 - Deliverable Requirements.**
PMOR-004	Work collaboratively with any HHSC-approved Trading Partners and independent verification and validation service providers.
PMOR-005	Utilize only project management tool(s) which are capable of capturing and generating the information required by HHSC. The tool(s) must be capable of capturing notes including dates, action items, next steps, and decisions made with corresponding due dates. The functionality included in the tool(s) must ensure standardization and traceability of work products throughout the Contract Term.
PMOR-006	Conduct a project initiation kickoff meeting with key stakeholders and the HHSC Project team at least five (5) Business Days prior to the start of any enhancement or modification project.
PMOR-007	Utilize the document and deliverable and acceptance process agreed upon by HHSC that incorporates the following: a. Review cycles, which will be conducted and scaled to the size and complexity of the Deliverables. b. Deliverables must reflect coordination with the MES service providers that will follow agreed upon change control processes; and c. Informal reviews and walkthroughs of draft and final Deliverables are encouraged.
PMOR-008	Conduct weekly meetings to discuss Project tasks, Project activities (e.g., Deliverables, critical path, milestones, Key Performance Measures, issues, risks, progress of current Projects, solution changes, resource changes, and other areas specific to the Contract.
PMOR-009	Contribute to HHSC's integration collaboration activities; technical and non-technical Project artifacts for the Contractor Solution components including requirements, use cases, user stories, storyboards, supplemental specifications, test cases, test scripts, test results, and user and training documentation at HHSC's direction.
PMOR-010	Participate in ad hoc and permanent work groups consisting of: Program Providers, FMSAs, CDS employers, Members, HHSC, MCOs and other stakeholders as directed by HHSC.
PMOR-011	Report, upon discovery, any potential Contract compliance deficiencies, and operational issues to HHSC that impact Service delivery to Members, EVV Users, HHSC and/or HHSC-approved Trading Partners.

Project Management	
Req ID	**Detailed Requirements**
PMOR-012	Submit root cause analyses and corrective action plans (CAP), to resolve State Pool System operational deficiencies, discrepancies, and issues no later than five (5) Business Days of request or as otherwise directed by HHSC.
PMOR-013	Provide a Contractor Solution, including a State Pool System, that is compliant with the HIPAA, Public Law 104-1919 requirements in effect as of the date of release for the Solicitation and with any changes that subsequently occur, unless otherwise noted.
PMOR-014	Provide Services, Work Products and Deliverables that are compliant with pertinent State and federal statutes, **Exhibit Q, HHSC EVV Policies**, HHSC program policies, rules, and standards for and development tools and processes, and operational procedures. Refer to **Exhibit Q, HHSC EVV Policies**. Contractor shall comply with all laws, regulations, requirements, and guidelines applicable to the Services provided under the Contract as these laws, regulations, requirements, and guidelines currently exist and as they are amended throughout the Contract Term.
PMOR-015	Disclose no information in the possession of the Contractor about any individual without prior written consent from HHSC, except as provided by the Contract.
PMOR-016	Evaluate all Projects under the Contract for operational, procedural and policy changes for impacts to each HHSC Program required to use EVV. Report potential impacts and recommendations during the Project planning process. Coordinate implementation efforts with all associated programs.
PMOR-017	Maintain online access to historical versions of **Exhibit R, HHSC EVV Business Rules**, and **Exhibit S, HHSC EVV Business Rules for Proprietary Systems**. All versions must be available in the Contractor's electronic repository for audit purposes in accordance with HHSC Retention Schedule. Refer to **Exhibit R, HHSC EVV Business Rules**, and **Exhibit S, HHSC EVV Business Rules for Proprietary Systems**.
PMOR-018	Maintain a cross-reference of the State Pool System process and procedure with the corresponding HHSC EVV policy, business rules and/or requirements and make the information available to HHSC as requested.
PMOR-019	Identify and propose revisions to EVV communications, training, and publications related to EVV business process changes. Coordinate with and obtain approval from HHSC for proposed changes at least thirty (30) Calendar Days prior to implementation or another HHSC-approved timeframe.

PMOR-020	Obtain HHSC approval for any non-HHSC initiated change prior to the Contractor approving any change to a State Pool System in accordance with Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 - Deliverable Requirements**
PMOR-021	Participate in a post Project implementation review meeting upon request by HHSC by the date specified following the implementation of each Project. The Contractor shall ensure that Contractor staff have knowledge of the applicable Project; and participate in post Project implementation review meetings.
PMOR-022	Provide a warranty that the Contractor Solution will meet and maintain the CMS certification requirements, SOW requirements, and HHSC-approved functionality. The Contractor shall modify or correct all deficiencies developed during the Contract Term at no additional cost to HHSC.
PMOR-023	Retain and maintain all e-mails in accordance with the HHSC-designated records retention policies. This includes all e-mails turned over by previous service providers and all e-mail of Subcontractors.
PMOR-024	Track information regarding communication with stakeholders (e.g., name and number, date, nature of the call, documented detailed response given, and staff member responding) and make available to HHSC upon request with content and format approved by HHSC.
PMOR-025	Coordinate with and respond to inquiries from the Business Operations and Business Integration service provider call center and other MES service providers to coordinate resolution for EVV-related questions and issues in accordance with Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 - Deliverable Requirements.**
PMOR-026	Work collaboratively with HHSC to gather, analyze, and report findings to the United States Office for Civil Rights (OCR) for any HIPAA or Health Information Technology for Economic and Clinical Health Act (HITECH) Incident involving Contractor that affects a population of five hundred (500) Members or more. Sufficient technical evaluation will be completed by the Contractor to verify the number of Members potentially affected.
PMOR-027	Prepare and distribute agendas for each scheduled meeting at least five (5) Business Days prior to a scheduled meeting.
PMOR-028	Submit invoices containing **no** billing errors.
PMOR-029	Work with all HHSC-approved Trading Partners and provide timely support in integrating solutions within HHSC's Medicaid enterprise. Timely means scheduling a meeting no later than five (5) Business Days after receipt of the request by HHSC, review of applicable documentation no later than five (5) Business Days of receipt, scheduling of testing no later than five (5) Business Days of request or ensuring the appropriate Contractor staff are participating.
PMOR-030	Provide and maintain a searchable customer relationship management (CRM) application that tracks and reports information and associated documentation, including, but not limited to, calls, complaints, problems, issues, Incidents, resolutions, and role-based permissions for Contractor and SPSO activities.
PMOR-031	Provide a State Pool System solution that has achieved CMS certification in at least one (1) State to provide EVV Services.

PMOR-032	Coordinate and validate that all system changes to the State Pool System are completed as outlined in the Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 - Deliverable Requirements.**
PMOR-033	Communicate HHSC-approved planned changes to the maintenance schedule to Providers, Trading Partners, and HHSC staff at least ten (10) Business Days in advance of implementing the change.
PMOR-034	Submit all requests for unscheduled State Pool System maintenance and considerations to waive the minimum ten (10) Business Days notification period to HHSC for approval. Complete all system changes to the State Pool System as outlined in the Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 - Deliverable Requirements.**
PMOR-035	Provide HHSC detailed supporting information monthly for all Key Performance Measures in accordance with processes and timeframes in the Contractor's HHSC-approved **Key Performance Measure Plan**. Refer to **Table 8 - Deliverable Requirements.**
PMOR-036	Manage all aspects of the **Project Management Plan** throughout the Contract Term using a Project Management Information System (PMIS), (i.e., SharePoint) or any other HHSC-approved PMIS. Refer to **Table 8 - Deliverable Requirements.**
PMOR-037	Lead the development and documentation of project management and support processes for HHSC review and approval.
PMOR-038	Coordinate with HHSC and Trading Partners to determine business directions, review ongoing Projects, and improve project management.
PMOR-039	Coordinate the Contractor's **Project Management Plan** with the project management processes of HHSC and Trading Partners. Refer to **Table 8 - Deliverable Requirements.**
PMOR-040	Assist HHSC in planning, preparing, and implementing any transition or changes related to Services, resulting from a business addition, merger, or other reorganization by Contractor or HHSC (e.g., divestiture, acquisition, consolidation, and relocation).
PMOR-041	Identify, monitor, resolve and escalate risks and issues in accordance with the Contractor's HHSC-approved **Risk and Issue Management Plan**. Refer to **Table 8 - Deliverable Requirements.**
PMOR-042	Facilitate and participate with HHSC and Trading Partners for all Projects and initiatives, kick-off and status meetings, and any training as directed by HHSC.
PMOR-043	Provide role-based access to the CRM application as directed by HHSC.
PMOR-044	Provide all documentation relating to the Contractor Solution, including results of Contractor performance and the performance profile used for testing, system security audits, schematics, architecture, procedures, processes, policies, strategies, and services delivery methodology.

PMOR-045	Establish and manage an HHSC-approved project management tool that includes a time-keeping system, which tracks all Contractor personnel time for all Work performed under the Contract.
PMOR-046	Deliver post-meeting materials (e.g., agendas, minutes, action items, etc.) to HHSC for approval and within timeframes in accordance with the Contractor's HHSC-approved **Communications Plan**. HHSC-approved post-meeting materials must be stored in the HHSC electronic document repository and retained in accordance with the HHSC Retention Schedule. Refer to **Table 8 - Deliverable Requirements.**
PMOR-047	Provide and maintain all technology, equipment, and software necessary for Contractor staff to support and complete the SOW, including enabling access to HHSC and HHSC-authorized systems and data.
PMOR-048	Support EVV program expansion efforts as defined by HHSC.
PMOR-049	Provide ongoing operation support to HHSC-approved Trading Partners to promote successful submission of data. Work one-on-one with HHSC-approved Trading Partners to resolve data submission issues.
PMOR-050	Provide technical and subject matter expertise on EVV Systems to support the development of and modifications to **Exhibit R, HHSC EVV Business Rules** and **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** as directed by HHSC. Refer to **Exhibit R, HHSC EVV Business Rules** and **Exhibit S, HHSC EVV Business Rules for Proprietary Systems**.
PMOR-051	Maintain the EVV System Selection Table in coordination with the MES service providers.
PMOR-052	Update the EVV System Selection Table in accordance with HHSC-approved timeframes and procedures.

2.1.4.2 *Staffing Requirements (STFR)*

The Contractor shall provide all personnel resources necessary to perform the Services described in this SOW unless specifically stated as the responsibility of HHSC or another entity. This section does not identify all required staff. Rather, this section identifies the Contractor's key personnel and certain other staff where specific requirements must be met. The requirements below include providing qualified, knowledgeable, trained, professional staff to install, configure, manage, and maintain the Contractor Solution.

Table 4 – Key Personnel Descriptions and Qualifications below includes a comprehensive list of key personnel and the minimum qualifications required.

Table 4 – Key Personnel Descriptions and Qualifications

Key Personnel Descriptions and Qualifications		
Role	**Description**	**Qualifications**
Project Director	Represents Contractor and oversees the day-to-day activities of Contractor Solution. This individual shall serve as HHSC's primary point of contact (POC) for matters relating to the Contractor Solution and collaborating with other MES service providers, and stakeholders.	The Project Director must meet the following qualifications: a. A minimum of seven (7) years project management experience managing projects of size and scope similar to the Contract Work, preferably in Medicaid or the healthcare industry. Relevant experience must have occurred within the three (3) years immediately preceding the issuance date of this Solicitation. b. Project management experience must include each phase of the software development life cycle. c. Project management certification through the Project Management Institute (PMI) is preferred.
Transition Project Manager	Serves as the project manager and single POC for HHSC regarding Contractor's Transition activities. Responsible for the successful transition of the Contract to Contractor. Administers and executes Contractor's HHSC-approved Transition Plan. Responsible for Contractor's adherence to Transition timelines and requirements.	The Transition Project Manager must meet the following qualifications: a. A minimum of five (5) years project management experience managing Projects of size and scope similar to the Contract, preferably in Medicaid or the healthcare industry. Relevant experience must have occurred within the three (3) years immediately preceding the issuance date of this Solicitation. b. A minimum of three (3) years of experience managing operational transition Project(s) similar in scope and size to the transition for this Contract. c. Experience must involve managing projects with both technical and operational components. d. Knowledge of EVV technology and operation is strongly preferred.

Key Personnel Descriptions and Qualifications		
Role	**Description**	**Qualifications**
		e. Project management certification is required, preferably through the Project Management Institute (PMI).
Contract Manager	Serves as the single POC for HHSC for matters concerning the Contractor's performance under the Contract. This person shall have the authority to make decisions that are binding to the Contractor, shall be responsible for timely completion of the Contractor SOW, and shall be responsible for meeting all Contract obligations.	The Contract Manager must have a minimum of five (5) years contract management experience managing contracts for related services with similar budgets, preferably in Medicaid or the healthcare industry, and for projects similar in size and scope to the Contract Work.
State Pool System Operations Manager	Serves as the primary POC for HHSC for matters concerning State Pool System performance and operations. The State Pool System Operations Manager is responsible for the successful CMS certification and operation of the State Pool System from a technology and operations perspective.	The State Pool System Operations Manager must meet the following qualifications: a. A minimum of three (3) years of experience working with EVV Systems is preferred. b. A minimum of five (5) years project management experience managing projects of size and scope similar to the Contract Work, preferably in Medicaid or the healthcare industry. c. Project management certification. through the Project Management Institute (PMI) is preferred.
Proprietary Systems Manager	Serves as the primary POC for HHSC for matters concerning Proprietary Systems. The Proprietary Systems manager is responsible for reviewing and approving Proprietary Systems for use in Texas and executing Contractor's responsibilities with respect to Proprietary Systems.	The Proprietary Systems Manager must meet the following qualifications: a. A minimum of three (3) years of experience working with EVV Systems is preferred. b. A minimum of five (5) years project management experience managing projects of size and scope similar to the Contract, preferably in Medicaid or the healthcare industry.

Key Personnel Descriptions and Qualifications		
Role	**Description**	**Qualifications**
		c. Project management certification is required, preferably through the Project Management Institute (PMI).
Privacy Compliance Manager	Serves as the primary POC for HHSC staff for the development, implementation, and maintenance of the policies and procedures of a covered entity as required by HIPAA and all applicable State and federal laws, rules, regulations, and guidelines.	Knowledge of State and federal privacy laws including, but not limited to, HIPAA privacy, security and breach response requirements, and pertinent management experience including the ability to effectively communicate orally and in writing in a professional manner. The Privacy Compliance Manager must have at least five (5) years of experience overseeing privacy policies and procedures.
Information Security Manager	Serves as the primary POC for HHSC staff for information security matters including potential electronic or system information compromise.	Knowledge of National Institute of Standards and Technology (NIST) security requirements, Federal Risk and Authorization Management Program (FedRAMP) requirements, HIPAA security requirements, and pertinent management experience including the ability to effectively communicate orally and in writing in a professional manner. The Information Security Manager must have at least five (5) years of experience overseeing information security policies, procedures, and training.
Systems Lead	Serves as the primary POC for HHSC regarding system testing, change management, integration, modification, and maintenance activities. The Systems Lead is responsible for scheduling and reporting all	The System Lead must meet the following qualifications: a. Minimum of three (3) years of experience leading system operations for a project similar in size and scope to the Contract Work.

Key Personnel Descriptions and Qualifications		
Role	**Description**	**Qualifications**
	maintenance and modification activities, coordinating use of modification task personnel resources, facilitating implementation of modifications, maintaining all interfaces, and maintaining the ability for all appropriate users to access the Contractor Solution.	b. Minimum of five (5) years executing change management processes for system projects similar in size and scope to the Contract Work. Experience must involve directing multi-discipline technical teams. c. In-depth understanding of the software development lifecycle and testing lifecycle and all artifacts required to successfully validate the Contractor Solution. d. Project management certification is required, preferably through the Project Management Institute (PMI).
Turnover Project Lead	Primary POC for HHSC for Turnover. The Turnover Project Lead is responsible for oversight and coordination of all Turnover activities.	The Turnover Project Lead must meet the following qualifications: a. A minimum of five (5) years project management experience managing Projects of size and scope similar to the Contract, preferably in Medicaid or the healthcare industry. b. A minimum of three (3) years of experience managing operational transition/turnover Project(s) similar in scope and size to the Turnover for this Contract. c. Experience must involve managing projects with both technical and operational components. d. A minimum of two (2) years of experience working on this Contract is preferred. e. Knowledge of EVV technology and operation is required. f. Project management certification is required, preferably through the Project Management Institute (PMI).

During the Contract Term, Contractor must provide staffing services in accordance with the requirements specified in **Table 5-Staffing Requirements.**

Table 5 – Staffing Requirements

Staffing Requirements	
Req ID	**Detailed Requirements**
STFR-001	Provide HHSC-approved key personnel (with the exception of the Turnover Project Lead) no later than two (2) Calendar Days following the Contract Effective Date. These key personnel must be available during all configuration and certification activities. Key personnel must not hold more than one key role unless otherwise approved by HHSC.
STFR-002	Fill a vacant key personnel position with a substitute that meets key personnel qualifications no later than five (5) Business Days of staff separation date, unless an extension is approved by HHSC, until a permanent replacement fills the vacancy.
STFR-003	Fill a vacant key personnel position with an HHSC-approved permanent replacement no later than thirty (30) Calendar Days from the vacancy date (a position is considered vacant even with the substitute replacement serving in that role) unless an extension is approved by HHSC.
STFR-004	Submit proposed key personnel permanent replacements and qualification information for HHSC approval within ten (10) Business Days of staff separation date unless an extension is approved by HHSC. Provide the following information for each key personnel permanent replacement demonstrating how the candidate meets the key personnel qualifications: a. Candidate profile b. Résumé c. Two (2) external written references The profile, résumé and references must depict relevant and current experience as described in **Table 4 – Key Personnel Descriptions and Qualifications**.
STFR-005	Provide "on call" access to at least one key personnel or their HHSC-approved designee outside of normal business hours, including weekends and State holidays, in accordance with Contractor's HHSC-approved **Staffing Management Plan**. Refer to **Table 8 - Deliverable Requirements.**
STFR-006	Key personnel are required to attend all in-person meetings in Austin, Texas as requested at no cost to HHSC, with five (5) Business Days' notice. HHSC may choose to designate online meetings in place of any face-to-face meeting.

Staffing Requirements	
Req ID	**Detailed Requirements**
STFR-007	Key personnel must be full-time personnel that are knowledgeable, experienced, and qualified to perform the responsibilities of the position under the Contract. Contractor staff are subject to the following requirements: a. HHSC will approve key personnel (including replacement key personnel) assigned to the Contract; and b. HHSC reserves the right to request removal of any Contractor staff or Subcontractor staff, if applicable, assigned to the Project, and the Contractor must comply with any such request within two (2) Business Days.
STFR-008	Provide an organizational chart identifying key personnel for HHSC approval no later than two (2) Calendar Days of the Contract Effective Date and no later than ten (10) Business Days of any change to key personnel or re-organization of functional groups during the Contract Term.
STFR-009	Provide HHSC with written notice, ten (10) Business Days prior to any changes in key personnel as soon as Contractor becomes aware of the need for a change during the Contract Term and any Contract renewal (s) or extension(s) thereof.
STFR-010	Obtain HHSC's prior written approval before any reduction of the staffing levels or replacement of any key personnel identified in the Contractor's HHSC-approved **Staffing Management Plan**. Refer to **Table 8 Deliverable Requirements.**
STFR-011	Investigate the matters forming the basis for HHSCs request to remove key personnel and correct any deficient Contract performance within thirty (30) Calendar Days of request.
STFR-012	Remove and replace key personnel found deficient by HHSC and submit all replacement key personnel résumés within ten (10) Business Days of request for HHSC review and approval.
STFR-013	Ensure the key personnel are one hundred percent (100%) allocated to the Contract.
STFR-014	Provide staff resources and information to assist with HHSC's activities to support the to-be vision of the CMS Standards and Conditions and the MITA framework as directed by HHSC.
STFR-015	Provide qualified, professional staff knowledgeable of Texas Medicaid, the Texas EVV Program, Contractor Solution, and EVV Systems to participate in internal and external meetings including public stakeholder meetings, workgroups, training, HHSC meetings related to EVV, meetings with HHSC-approved Trading Partners and Texas provider association meetings as directed by HHSC.
STFR-016	Provide designated reporting/data specialists to assist HHSC and HHSC-approved Trading Partners with the development and analysis of data requests.
STFR-017	Any staff working remotely, must be available to work in HHSC's offices at HHSC's request at no cost to HHSC, with five (5) Business Days' notice for functions necessary to support the Contract Work.

Staffing Requirements	
Req ID	**Detailed Requirements**
STFR-018	Provide a written attestation document, "Personnel Background Check Attestation", of a completed background check for Contractor personnel who might reasonably be expected to access sensitive and confidential Member data contained in any system accessed during the Contract Term, as requested by HHSC. Contractor must describe its process for performing background checks for non-US citizens or Lawful Permanent Resident Card holders in compliance with the U.S. Department of Homeland Security's E-Verify requirements.
STFR-019	The Contractor staff must clearly identify themselves as Contractor staff and not as employees or representatives of HHSC, unless and solely to the extent specifically authorized in writing in advance by HHSC, including in all communications, whether oral, written, or electronic.

2.1.4.2.1 Staffing Performance Measures (STFK)

The requirements listed in **Table 6 – Staffing Key Performance Measures** below describe the level of performance required for Staffing that must be performed by the Contractor during the Contract Term.

Table 6 – Staffing Key Performance Measures

Staffing Key Performance Measures		
Req ID	**Key Performance Measures**	**Liquidated Damages**
STFK-001	Contractor key personnel positions (with the exception of the Turnover Project Lead) must be staffed, located in Austin, and trained to provide Contract Services no later than two (2) Calendar Days following the Contract Effective Date or as negotiated and approved by HHSC.	If any Contractor key personnel positions are not staffed, located in Austin, and trained to provide Services no later than two (2) Calendar Days following the Contract Effective Date or as negotiated and approved by HHSC, HHSC will assess $10,000 per Calendar Day of delay.

2.1.4.3 *Contractor Facility Requirements (FACR)*

During the Contract Term, Contractor must maintain an operational site in Austin, Texas in accordance with the requirements specified in **Table 7-Contractor Facility Requirements.**

Table 7 – Contractor Facility Requirements

Contractor Facility	
Req ID	**Detailed Requirements**
FACR-001	Maintain an operational site in the Austin, Texas area within twenty-five (25) miles of HHSC's designated office at 701 W. 51st Street, Austin, TX 78751 throughout the life of the Contract Term.
FACR-002	Provide HHSC access to Contractor facilities and operations as requested by HHSC for on-site visits and internal and external audits.

2.1.4.4 *Deliverables Requirements (DELR)*

All Deliverables included in the tables below will be developed, implemented, and maintained in a HHSC-approved format. Each Deliverable will be submitted to HHSC for approval, and written approval must be obtained from HHSC for all versions. Each Deliverable must be submitted within timeframes approved by HHSC and may be subject to applicable liquidated damages.

Deliverables include the plans and documentation necessary to prepare for, implement, manage, and maintain the requirements of the Contract during the Contract Term.

The Deliverable review cycle consists of:

a. Initial Contractor submission;

    1. First HHSC review: five (5) Business Days to accept or reject the initial submission;

b. Second Contractor submission (if initial submission is rejected);

    1. Contractor resubmission within five (5) Business Days of HHSC's rejection notification; and

    2. Second HHSC review for final approval within three (3) Business Days of receipt of the Contractor resubmission.

The Contractor's submission of the same Deliverable that does not conform with HHSC-approved acceptance criteria three (3) or more times shall constitute a material breach of the Contract.

The requirements for Deliverables listed in **Table 8-Deliverables Requirements** below describes the tasks and activities that must be performed by the Contractor during the Contract Term.

Table 8 – Deliverables Requirements

<table>
<tr><th colspan="2">Deliverables</th></tr>
<tr><th>Req ID</th><th>Detailed Requirements</th></tr>
<tr><td>DELR-001</td><td>Project Management Plan

Develop and maintain a Project Management Plan and project management template that Contractor will follow when managing Projects throughout the Contract Term.

The completed Project Management Plan and template must be submitted no later than ten (10) Calendar Days after the Contract Effective Date and maintained during the Contract Term. The project management template will be completed by Contractor prior to starting each Project.

The Project Management Plan and template will define how Projects are executed, monitored, and controlled. The Project Management Plan and template should correlate with the following related Deliverables: Risk and Issue Management Plan, Staffing Management Plan, Change Management Plan, and Quality Management Plan.

The Project Management Plan template must include, at minimum:

a. Project Overview
1. Project Description
2. Project Scope
3. Assumptions
4. Constraints
b. Project Organization
1. Project Structure
2. External stakeholders
3. Roles and Responsibilities
c. Project Lifecycle
1. Methods, Tools and Techniques
2. Status Reporting Frequency and Method</td></tr>
<tr><td>DELR-002</td><td>Risk and Issue Management Plan

Develop, maintain, and adhere to a Risk and Issue Management Plan.

The completed Risk and Issue Management Plan must be submitted no later than ten (10) Calendar Days after the Contract Effective Date and maintained during the Contract Term.

At a minimum, the Risk and Issue Management Plan must include the following:

a. Contractor’s approach to monitoring, tracking, communicating, reporting risk and issue status including procedures for documenting, resolving, and</td></tr>
</table>

Deliverables	
Req ID	**Detailed Requirements**
	reporting issues and risks identified by the Contractor, HHSC or other Project service providers; b. Contractor’s approach to identifying risks and issues associated with integrated systems or processes managed by HHSC or HHSC-approved trading partners; c. Contractor’s risk and issue avoidance, transfer, mitigation, or management strategies; and d. Contractor’s approach to root cause analysis and impact analysis and Description of how risks and issues will be quantified and qualified.
DELR-003	**Staffing Management Plan** Submit and maintain a **Staffing Management Plan** as part of the **Project Management Plan**. The completed **Staffing Management Plan** must be submitted no later than ten (10) Calendar Days after the Contract Effective Date and maintained during the Contract Term. The **Staffing Management Plan** must include the following: a. Identification of the roles and responsibilities by resource type during all activities of the Contract, including identifying key personnel and functional groups within the organization; b. Staffing levels by resource type and by phase for the duration of the Project; c. Detail how the Staffing Levels will achieve consistent, dependable service regardless of changes that may influence work volume; d. Work locations of all functional groups within the organization; e. Contractor’s approach to providing appropriate personnel for live, in-person meetings in Austin, Texas; f. Staff training requirements to maintain appropriate privacy and security protocols; g. Expectations regarding onsite time for Contractor resources; h. Process for temporarily and permanently replacing vacancies in key personnel positions consistent with staffing Key Performance Measures; i. Contractor’s telework policies and procedures including protocols for safeguarding sensitive information such as PHI and PII and Contractor’s approach to maintaining contract performance with a telework/hybrid workforce; j. Contractor’s approach to providing "on call" access to at least one (1) key personnel or their HHSC-approved designee outside of normal business hours, including weekends and State holidays; and k. Contractor’s approach to providing appropriate technical staffing to resolve State Pool System issues outside of Weekday Call Center Hours and Weekend Call Center Hours.

Deliverables	
Req ID	**Detailed Requirements**
DELR-004	**Change Management Plan** Develop, maintain, and adhere to a **Change Management Plan** for the State Pool System and Proprietary Systems. The completed **Change Management Plan** must be submitted ten (10) Calendar Days after the Contract Effective Date and maintained during the Contract Term. The **Change Management Plan** must include: a. Contractor's approach to providing demonstrations and walkthroughs of system changes to HHSC prior to implementation; b. Written, trackable and diagrammatic representation of the processes and procedures to be used to initiate, evaluate, review, and resolve any change requests that occur both before and after the solution is implemented; c. Adherence to HHSC change management policies; d. Contractor's approach to completing and validating changes to the State Pool System when HHSC updates **Exhibit R, HHSC EVV Business Rules**; e. Contractor's approach to communicating required changes, completing, and validating that changes have been made to Proprietary Systems when HHSC updates **Exhibit S, HHSC EVV Business Rules for Proprietary Systems**; f. How Contractor will work with HHSC and HHSC-approved Trading Partners to coordinate changes that impact integrated systems; g. Contractor's process for maintaining the public-facing change history log for all system changes and updates to the State Pool System; h. Contractor's process for providing cost estimates for proposed changes; and i. Contractor's approach to managing reference data updates in coordination with HHSC and HHSC-approved Trading Partners.
DELR-005	**Quality Management Plan** Develop, maintain, and adhere to a comprehensive **Quality Management Plan**. The completed **Quality Management Plan** must be submitted ten (10) Calendar Days after the Contract Effective Date and maintained during the Contract Term. At a minimum, the **Quality Management Plan** must include: a. Contractor's approach to measuring and maintaining quality for all functional areas of the Contract such as system changes, customer support, data management, communications and training, State Pool System oversight, and Proprietary System oversight; b. The process steps and quality tools that will be used (e.g., templates, standards, and checklists); c. A detailed description of the software development life cycle to be used by the Contractor, and controls for measuring quality; and

Deliverables	
Req ID	**Detailed Requirements**
	d. Contractor's approach to providing quantitative results and qualitative analysis of quality metrics in the **Monthly Status Report**.
DELR-006	**Project Work Schedule** Develop, maintain, and adhere to a detailed **Project Work Schedule** that is aligned with the SOW. The completed **Project Work Schedule** must be provided in Microsoft Project within two (2) Calendar Days after the Contract Effective Date and updated regularly throughout the Contract Term. At a minimum, the **Project Work Schedule** must include: a. detailed project task description; b. accurate FTE hours for each task; c. the sequence of tasks and activities including duration necessary to meet Deliverable and milestone dates for each phase; d. baselined start and completion dates for every task and milestone; e. actual start and completion date for every task and milestone; f. identification of the critical path; g. resources assignment by task and milestone, by name or resource if name is unknown; h. predecessors tied to every task; i. permanent tracking number for each task; j. completion percentage for every task; and k. organized phase level Milestones. Once approved, the baselined dates and hours in the **Project Work Schedule** will only be modified with approval from HHSC. The baselined **Project Work Schedule** will be retained for HHSC's own Project reporting.
DELR-007	**System Security Plan** Develop, execute, maintain, and deliver for HHSC approval, a **System Security Plan** to document the current level of security controls within the Contractor Solution that protects the confidentiality, integrity, and availability (CIA) of the solution and its information. The initial **System Security Plan** must be submitted for HHSC approval no more than fifteen (15) Calendar Days after the Contract Effective Date. The **System Security Plan** must address the following topics: a. adherence to HHSC's "Security and Privacy Control requirements" document, included in **Exhibit N, HHS Information Security and Privacy Requirements**, and further guidance located on the HHSC Vendor Resources site (https://www.hhs.texas.gov/doing-business-hhs/contracting-hhs/vendor-resources#risk-assessment-report-and-system-security-plan); b. compliance with CMS;

Deliverables	
Req ID	**Detailed Requirements**
	c. acceptable risk safeguards to assess CIA and NIST SP 800-53 Revision 4 at a "moderate" control level; d. physical security; e. network segmentation, access controls, and forensics; f. application security and data sensitivity classification, including Protected Health Information and Personally Identifiable Information; g. end-point protections such as multiple redundant firewalls and host-based intrusion detection systems; h. identification and prevention of the use of prohibited functions, ports, protocols, and services; i. network, firewall, server, and other security-related configurations and changes; j. intrusion detection and prevention; k. network scanning tools; l. host hardening; m. internet filtering; n. remote access; o. encryption of data at rest and in transit; p. user authentication and directory services; q. interfaces and exchange of data with external entities; r. system penetration testing; s. management of operating system and security patches; t. anti-virus and malware detection and e-mail gateways; u. assessment and testing of system and code modifications; and v. allowable internal and external communication protocols. The **System Security Plan** is a living document and updates will be submitted annually by October 1st to HHSC for approval, as part of the vendor's risk assessment.
DELR-008	**CMS Certification Plan** Develop and maintain a **CMS Certification Plan** that defines the Contractor's approach to achieving and maintaining CMS certification. The completed **CMS Certification Plan** must be submitted sixty (60) Calendar Days after the Contract Effective Date and maintained throughout the Contract Term. At a minimum, the **CMS Certification Plan** must include: a. The processes and procedures that will be used to manage Certification requirements; b. How Contractor will adhere to the most current CMS certification processes; c. Contractor's approach to tracking Project status throughout the CMS certification process;

Deliverables	
Req ID	**Detailed Requirements**
	d. Contractor's approach to working collaboratively with HHSC and other MES service providers to provide data and reporting on CMS key performance indicators; and e. Perform all activities necessary to achieve and maintain final CMS certification within specified timeframes, with content and format as directed by HHSC.
DELR-009	**Test Plan** Provide, submit, and maintain a **Test Plan** that describes the Contractor's plan for all testing activities, processes, types, and levels. Testing must be as automated and self-documenting as possible (e.g., continuous unit testing). The **Test Plan** must be submitted fifteen (15) Calendar Days after the Contract Effective Date and maintained throughout the Contract Term. At a minimum, the **Test Plan** must address the following: a. Overall testing strategy; b. Approach to planning and preparing the test; c. Maintain a testing environment with functions, database tables and files, and data elements in accordance with State-approved processes and procedures; d. Approach to conducting each test level: performance/load/stress testing; system testing; parallel testing; regression testing; integration testing; and Trading Partner testing; e. Approach for supporting user acceptance testing (UAT) (including State tester access); f. Approach for testing nonfunctional requirements; g. Approach to test documentation (e.g., test cases, test scripts, test case matrices added as design progresses); h. Approach to quality control/quality assurance; i. Approach to bi-directional traceability to requirements and design; j. Tools, techniques, and methods; k. Reporting mechanisms, traceability, and metrics; effects and defects resolution; l. Entrance and exit criteria for each test level including alignment with industry standards; m. Configuration management for each test level; and n. Testing roles and responsibilities. Acceptance criteria shall include, but is not limited to, no high or critical defects in code released to production and production releases will not be promoted if more than five percent (5%) of requirements have an open defect.
DELR-010	**Training Plan**

Deliverables	
Req ID	**Detailed Requirements**
	Develop, submit and maintain a **Training Plan** which must be submitted for HHSC approval fifteen (15) Calendar Days after the Contract Effective Date and maintained during the Contract Term. At a minimum, the **Training Plan** must include: a. Summary of training approach, objectives, and desired outcomes; b. Contractor's process to ensure training content is aligned with and supports **Exhibit R, HHSC EVV Policies**; c. Contractor's process for conducting initial and annual training needs analyses, including an assessment of the target audience and their knowledge and skills; d. Recommendations on type of training and delivery approach based on training needs analysis; e. Summary of proposed training content; f. Contractor's approach to training all EVV Users on the State Pool System prior to the Operations Start Date, including a schedule of training opportunities that will accommodate the large volume of training needed during Transition; g. Contractor's approach to delivering final materials for the initial training for the State Pool System no later than seventy-five (75) Calendar Days prior to Operations Start Date; h. Contractor's approach to tracking all State Pool System training activities for EVV Users (e.g., initial system training, annual system training, etc.) i. Proposed annual training schedule for live-in person training and webinars, including locations; j. Listing of all training opportunities and resources including on-demand training, job aids, manuals, computer-based training, webinars, and other training resources; k. Approach to keeping training content current with respect to system changes, implementations and EVV Program changes; l. Approach to providing training and updating content to support new functionality and software releases; m. Approach to training other MES service providers on Contractor Solution with a focus on the train-the-trainer methodology; n. Approach to coordinating with other MES service providers to provide or receive feedback when training content involves Contractor Solution or services/technology provided by other MES service providers; o. Approach to obtaining and incorporating feedback from trainees to improve training effectiveness throughout the Contract Term; p. Approach to receiving and incorporating HHSC feedback on content, including review cycle timeframes; q. Approach to providing live in-person training to CDS Employers and designated representatives at least quarterly; and

Deliverables	
Req ID	**Detailed Requirements**
	r. Approach to developing and submitting all CMS and MITA training materials to support the Contractor.
DELR-011	**Business Continuity and Contingency Plan** Develop, submit, and maintain a comprehensive **Business Continuity and Contingency Plan**. The completed **Business Continuity and Contingency Plan** must be submitted for HHSC approval sixty (60) Calendar Days after the Contract Effective Date and maintained during the Contract Term. Contractor shall review the **Business Continuity and Contingency Plan** no less than annually, update the BCCP as needed, and request HHSC approval of all changes. The **Business Continuity and Contingency Plan** must adhere to industry best practices and standards and include, at a minimum, the following: a. Identification of the core business processes involved in Contractor Solution. For each core business process include: 1. Identification of potential failures for the process; 2. Risk analysis; 3. Impact analysis; and 4. Definition of minimum acceptable levels of service/output. b. Definition of triggers for activating contingency plans; c. Procedures for activating any special teams for business continuity; d. A plan for continuation of business functions, units, processes, human resources, technology infrastructure; e. Communication protocols and timelines for conducting operations on a backup or remote site in a timely manner; f. Back up protocols for each electronic verification method; and g. Notification timelines to HHSC if Contractor activates components of this plan.
DELR-012	**Disaster Recovery Plan** Develop, submit, and maintain a **Disaster Recovery Plan**. The completed **Disaster Recovery Plan** must be submitted for HHSC approval sixty (60) Calendar Days after the Contract Effective Date and maintained during the Contract Term. Contractor shall review the Plan no less than annually, update the Plan as needed, and request HHSC approval of all changes. At a minimum, the **Disaster Recovery Plan** must address the following: a. Contractor's processes and schedule for conducting an annual Disaster Recovery exercise to test all components of the **Disaster Recovery Plan**; b. Retention and storage of backup files and software; c. Hardware backup for critical solution components; d. Facility backup;

Deliverables	
Req ID	**Detailed Requirements**
	e. Backup for any telecommunications links and networks; f. Backup procedures and support to accommodate the loss of any online communications; g. A detailed file backup plan, procedures, and schedules, including rotation to an off-site storage facility. The off-site storage facility must provide security of the data stored there, including protections against unauthorized access or disclosure of the information, fire, sabotage, and environmental considerations; h. An enumeration of the prioritized order of restoration for Contractor's proposed solution; i. Provide a short-term uninterruptible power supply to facilitate an orderly shutdown of the information system in the event of a primary power source loss; and j. Notification timelines to HHSC, if Contractor experiences a disaster.
DELR-013	**Transition Plan** Develop, maintain, and administer a HHSC-approved **Transition Plan**. The completed **Transition Plan** must be submitted for HHSC approval two (2) Calendar Days after the Contract Effective Date and maintained during Transition period. The **Transition Plan** shall detail the activities and milestones that Contractor will complete to establish the Contractor Solution. The plan shall also include Contractor's approach to migrating existing EVV Users who are using the incumbent State Pool System to Contractor's State Pool System or Proprietary Systems. At a minimum, the **Transition Plan** must include: a. Contractor's approach and timeline for establishing the Contractor Solution in alignment with HHSC's Transition timeline; b. Identification of the Transition Project Manager and the Contractor's Transition Phase project management team that will be based in Austin, Texas; c. Identification of key transition dates, activities, and milestones as documented in the **Project Work Schedule**; d. Contractor's approach and timeline for assuming oversight and administration of Proprietary System onboarding activities in accordance with the **Proprietary System Onboarding Plan;** and e. Contractor's approach and timeline for transitioning all EVV System users from the incumbent State Pool Systems to Contractor's State Pool System.

DELR-014	**Data Conversion Plan** Develop, submit, and maintain a **Data Conversion Plan**. The objectives must align with the operational readiness and pre-production testing. The plan must describe Contractor's approach to accepting and converting data from incumbent State Pool Systems to Contractor's State Pool System to minimize the need for EVV Users to create new information in Contractor's State Pool System. The completed **Data Conversion Plan** must be submitted for HHSC approval forty-five (45) Calendar Days after the Contract Effective Date. The **Data Conversion Plan** must include the following: a. Approach to conversion, cleansing, and migration; b. Approach to risk management for data conversion effort; c. Approach for testing migration or converted data; d. Approach to reporting the number of records successfully converted vs. errors or exceptions; e. Approach for cleansing data to prepare it for loading to the Contractor Solution; f. Approach to resolving data conversion errors and issues; g. Approach for supporting HHSC validation of converted data; h. Approach for delivering comparative reports for all converted data; i. Tasks, timelines, and responsible resources for all conversion and migration tasks; j. Data conversion test results template that will be used to demonstrate that data conversion has been successfully completed; and k. Entrance and exit criteria for each phase of the plan.
DELR-015	**State Pool System Change Plan** In the event of a change or termination of the selected State Pool System, Contractor must provide a **State Pool System Change Plan** to the State at least one-hundred and eighty (180) Calendar Days prior to the effective date of the change or termination that addresses how the change or termination will be operationalized. At a minimum, the **State Pool System Change Plan** must address: a. Transition timeline and tasks; b. Approach to stakeholder communications and education; c. Stakeholder impact assessment of the proposed transition; and d. Data transfer approach.
DELR-016	**Operational Readiness Review Plan** Coordinate with HHSC to develop a comprehensive **Operational Readiness Review Plan** and timeline to verify that Contractor is ready to assume all business operations and technology functions. The plan should describe an approach to ensure successful transition from the current service provider to the Contractor with periodic reviews with HHSC. The completed **Operational Readiness Review Plan** must be submitted forty-five (45) Calendar Days after the Contract Effective Date; with operational

	readiness results reports due on a weekly basis once operational readiness review begins. At a minimum, the **Operational Readiness Review Plan** must include the following: a. Identification of critical milestones for operational readiness as documented in the **Project Work Schedule**; b. Contractor and HHSC roles and responsibilities; c. Operational Readiness Checklist(s) that define the tasks or milestones that determines the go/no-go decision for all aspects of the Contractor Solution; d. A detailed work plan that describes the processes and procedures to meet and maintain compliance with accessibility standards outlined in Section 508 of the Rehabilitation Act for all components of the Contractor Solution; e. Contractor's approach to providing weekly operational readiness status reports to HHSC to track progress toward readiness for each component of Contractor Solution; f. Contractor's proposed template for the weekly operational readiness status report; g. All critical tasks that are required for cutover; h. Contractor's approach for post cutover monitoring: i. The onsite and offsite user support provided by the Contractor and HHSC during the initial solution implementation; and j. Contractor's process to provide and facilitate an HHSC on-site review of Contractor's operational site and data center upon HHSC request.
DELR-017	**Interface Control Document** Develop, submit, and maintain an online searchable electronic **Interface Control Document** for each interface which will include data layout documentation, data mapping crosswalk, inbound/outbound capability, and frequency of all interfaces. The completed **Interface Control Document** must be submitted thirty (30) Calendar Days after the Contract Effective Date. Complete updates to the **Interface Control Document** no more than ten (10) Business Days after any change. The **Interface Control Document** must: a. Be provided in an HHSC-approved format; b. Include documentation of the HHSC Program owner, the name and phone number of the Contractor's POC responsible for the interface, the distribution frequency of interface, the interface layout including field definitions and descriptions, response file requirements, the purpose for the interface, and a change log; c. Identify the priority level of each interface; d. Be updated upon implementation of any change that affects any **Interface Control Document** item; e. Be accessible by HHSC-approved staff and Trading Partners and f. Be reviewed with HHSC Program owner stakeholders prior to publication of any updates.

DELR-018	**Privacy Plan** Develop, submit, and maintain an HHSC-approved **Privacy Plan** which meets all applicable federal and state statutes, regulations, rules, and guidelines for handling of personal information. The **Privacy Plan** must be submitted for HHSC approval thirty (30) Calendar Days after the Contract Effective Date and maintained during the Contract Term.
DELR-019	**Customer Support Plan** Provide and maintain a **Customer Support Plan**. The completed **Customer Support Plan** must be submitted thirty (30) Calendar Days after the Contract Effective Date and maintained throughout the Contract Term. At a minimum, the plan must include the following: a. Contractor's tiered escalation process for customer support inquiries, including resolution timeframes; b. Contractor's approach to assigning tracking numbers to customer support inquiries and recording customer support calls; c. Complaint handling and resolution processes, including timeframes; d. Contractor's approach to maintaining a technical and operational knowledge base to ensure consistent and accurate customer service; e. Contractor's approach to coordinating with and responding to inquiries from the Business Operations and Business Integration service provider call center and other MES service providers to coordinate resolution for EVV-related questions and issues; f. Contractor's approach to receiving and resolving State Pool System issues outside of Weekday Call Center Hours and Weekend Call Center Hours; g. Contractor's code of conduct policy to ensure Contractor and SPSO staff provide accurate information and interact with customers in a professional manner; h. A listing of customer support avenues available to EVV Users and HHSC staff; i. Contractor's approach to performing stakeholder outreach and outbound communication; j. Contractor's timeframes and processes for responding to and resolving inquiries received through the Contractor's and SPSO's customer service email addresses; k. Contractor's approach to providing customer service in languages other than English and l. Contractor's approach to providing customer service in an accessible manner in accordance with the HHS Accessibility Policy.
DELR-020	**Communications Plan** Develop, submit, and maintain a HHSC-approved **Communications Plan**

	The HHSC-approved **Communications Plan** must be submitted forty-five (45) Calendar Days after the Contract Effective Date and maintained throughout the Contract Term. The **Communications Plan** must include: a. Contractor's process and timeline for providing comprehensive and accurate responses to all correspondence regarding Contractor's Services and its State Pool System; b. Contractor's process for developing, maintaining, and coordinating the publication of public-facing website content about the EVV program including State Pool System information, Proprietary System information, and other information as directed by HHSC; c. Contractor's process for documenting, tracking, and retaining correspondence received by Contractor or SPSO; d. Process for developing and transmitting all HHSC-approved physical and electronic correspondence (e.g., letters and emails) and e. Processes for posting all notices, banners, alerts and emails for planned and unplanned system outages, implementations, and other notifications as directed by HHSC.
DELR-021	**Monthly Status Report** Develop and deliver an HHSC-approved **Monthly Status Report.** The initial **Monthly Status Report** must be submitted ninety (90) Calendar Days after the Contract Effective Date and delivered monthly throughout the Contract Term. The **Monthly Status Report** must include, at a minimum: a. Reporting on Contractor's compliance with the requirements of the Contract; b. Reporting on the compliance of the State Pool System with **Exhibit R, HHSC EVV Business Rules** and **Exhibit Q, HHSC EVV Policies**, and the requirements of the Contract. c. Reporting on the performance, compliance, and deficiencies of Proprietary Systems with respect to **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** and **Exhibit Q, HHSC EVV Policies**, and the requirements of the Contract. d. Reporting on Contractor's monthly quality management results, including quantitative results and qualitative analysis, in alignment with the Contractor's HHSC-approved **Quality Management Plan**. e. Monthly results and quantitative analysis of the post-call customer satisfaction survey; f. Metrics regarding the number of accepted and rejected EVV visits from each EVV System; g. Customer service and call center metrics; h. Reporting on the number of alternative devices issued and in use and i. Other metrics and reporting as requested by HHSC.

DELR-022	**State Pool System Onboarding Plan**. Develop, maintain, and administer an HHSC-approved **State Pool System Onboarding Plan**. The completed **State Pool System Onboarding Plan** must be submitted two (2) Calendar Days after the Contract Effective Date and maintained throughout the Contract Term. The **State Pool System Onboarding Plan** details the processes, activities, and validation methods that Contractor will complete to validate that the State Pool System is compliant with **Exhibit R, HHSC EVV Business Rules**, **Exhibit Q, HHSC EVV Policies** and the requirements of this Contract, and is ready for use by EVV Users. Refer to **Exhibit R, HHSC EVV Business Rules** and **Exhibit Q, HHSC EVV Policies**. At a minimum, the **State Pool System Onboarding Plan** must include: a. Contractor's approach to implementing **Exhibit R, HHSC EVV Business Rules** in the State Pool System, including updated home health care services business rules and requirements provided by HHSC; b. Contractor's approach to communicating requirements to the SPSO and involving HHSC to explain business needs; c. Contractor's approach to performing readiness reviews of its State Pool System prior to initial go-live; d. Contractor's validation procedures for each requirement to ensure that its State Pool System has accurately implemented the requirement before go-live; e. Contractor's process to maintain a detailed requirements traceability matrix that tracks the technical and operational requirements implemented by its State Pool System to meet the requirements of **Exhibit R, HHSC EVV Business Rules, Exhibit Q, HHSC EVV Policies** and other HHSC requirements throughout the Contract Term; f. Contractor's approach to demonstrating compliance with the HHS Accessibility Policy and accessibility standards outlined in Section 508 of the Rehabilitation Act; g. Contractor's go/no-go criteria for approving its State Pool System for go-live; h. Contractor's approach to communicating State Pool System readiness status and progress to HHSC; i. Contractor's test approach, including the approach to full end-to-end testing of its State Pool System in coordination with HHSC and Trading Partners and j. Contractor's approach to documenting use cases, test cases, test data, scenarios used, and providing results to HHSC.
DELR-023	**Proprietary System Onboarding Plan**. Develop, maintain, and administer an HHSC-approved **Proprietary System Onboarding Plan**.

	The completed **Proprietary System Onboarding Plan** must be submitted sixty (60) Calendar Days after the Contract Effective Date and maintained throughout the Contract Term. The **Proprietary System Onboarding Plan** details the processes, activities, and validation methods that Contractor will complete to validate that a Proprietary System is compliant with **Exhibit S, HHSC EVV Business Rules for Proprietary Systems, Exhibit Q, HHSC EVV Policies** and the requirements of this Contract, and is ready for use by EVV Users. Refer to **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** and **Exhibit Q, HHSC EVV Policies**. At a minimum, the **Proprietary System Onboarding Plan** must include: a. A listing of roles and responsibilities, including Contractor's responsibilities for overall project management, technical orientation, Trading Partner testing, operational readiness review and ongoing operational support; b. Contractor’s processes for managing readiness reviews of new Proprietary Systems; c. Contractor’s processes for managing expedited Proprietary System readiness reviews; d. The process for prospective PSOs to request approval of their Proprietary System and how Contractor will manage requests; e. The process for providing technical, business, and policy requirements to prospective PSOs; f. The process for measuring and reporting Proprietary Systems compliance with **Exhibit Q, HHSC EVV Policies, Exhibit S, HHSC EVV Business Rules for Proprietary Systems**, and other business and technical requirements; g. The process for facilitating and scoring Trading Partner testing with relevant systems (e.g., the EVV Aggregator); h. The process for facilitating and scoring operational readiness review of the Proprietary System; i. The process for provisioning access to test and production environments for relevant systems (e.g., the EVV Aggregator); j. The process for providing ongoing technical and operational support to PSOs; k. The process for notifying HHSC of changes in PSO status, such as a PSO that no longer wishes to participate and l. The process for reviewing and validating Proprietary Systems changes after HHSC publishes updates to **Exhibit S, HHSC EVV Business Rules for Proprietary Systems**.
DELR-024	**Production Control Plan**. Develop, maintain, and administer a HHSC-approved **Production Control Plan**. The completed **Production Control Plan** must be submitted forty-five (45) Calendar Days after the Contract Effective Date and maintained throughout the Contract Term. The **Production Control Plan** details the processes, timelines, and communication processes for managing the EVV Systems in production.

	At a minimum, the **Production Control Plan** must address: a. Defect management, including: 1. Approach to reporting, documenting, tracking, and resolving defects; 2. Timelines for resolution based on severity level; 3. The identification and definition of said severity levels; and 4. Approach to defect severity categorization using an industry standard methodology (See **Exhibit O, Information Technology Infrastructure Library (ITIL) Severity Levels**). b. Contractor's processes for system maintenance management; c. Contractor's processes for system Incident management, including timelines for resolution based on severity level; d. Contractor's process and timeline for submitting and maintaining the annual State Pool System maintenance schedule to HHSC for approval; e. Contractor's approach to scheduling releases and unplanned outages; f. Contractor's approach to enhancement integration; g. Contractor's defined acceptance criteria for releasing State Pool System changes into production. Acceptance criteria must include but are not limited to: 1. no high or critical defects; and 2. production releases will not be promoted if more than five percent (5%) of requirements have an open defect. h. Contractor's approach to coordinating with HHSC and HHSC-approved trading partners for production control matters and i. Communication processes to keep HHSC informed of production control matters and receive necessary HHSC approvals.
DELR-025	**Provider Onboarding Plan**. Develop, submit, maintain, and administer a HHSC-approved **Provider Onboarding Plan**. The completed **Provider Onboarding Plan** must be submitted thirty (30) Calendar Days after the Contract Effective Date and maintained during the Contract Term. At a minimum the **Provider Onboarding Plan** must include: a. Processes and procedures for processing and validating system onboarding and system transfer requests; b. Processes, procedures, and proposed timelines that will be administered and overseen by Contractor that allow a Program Provider or FMSA to select and onboard with an EVV System; c. Processes, procedures, and proposed timelines for updating and maintaining the EVV System Selection Table; and d. Processes, procedures, proposed timelines, and data transfer approach that will be administered and overseen by Contractor to transfer a Program Provider or FMSA from one EVV System to another for each transition type (i.e., State Pool System to Proprietary System, Proprietary System to Proprietary System,

	and Proprietary System to State Pool System) in accordance with **Exhibit Q, HHSC EVV Policies**.
DELR-026	**Home Health Care Services Expansion Plan** Develop, maintain, and implement an HHSC-approved **Home Health Care Services Expansion Plan.** The **Home Health Care Services Expansion Plan** must be submitted thirty (30) Calendar Days after the Contract Effective Date and maintained throughout the Contract Term. At a minimum the **Home Health Care Services Expansion Plan** must include: a. Approach to collaborating with HHSC and other MES service providers to identify and onboard new Program Providers, FMSAs, and CDS Employers, including tracking of onboarding status; b. Approach for performing stakeholder outreach and outbound communication; c. Training approach for new EVV Users and HHSC-approved Trading Partners; d. Approach to conduct marketing demonstrations to ensure Program Providers and FMSAs are aware of their system options and can make an informed decision; e. Approach to coordinating with HHSC and other stakeholders to track implementation status and f. Approach to providing customer support throughout the implementation, with focus on support during and after the go-live period.
DELR-027	**Key Performance Measure Plan**. Develop, maintain, and adhere to an HHSC-approved **Key Performance Measure Plan**. The completed **Key Performance Measure Plan** must be submitted ninety (90) Calendar Days after the Contract Effective Date and maintained throughout the Contract Term. The **Key Performance Measure Plan** provides written processes and methodologies used to calculate Key Performance Measure outcomes. At a minimum, the **Key Performance Measure Plan** must include the following details for each Key Performance Measure: a. Contractor's approach for reporting Key Performance Measure performance on a monthly basis including required data elements and report templates; b. Mutually agreed upon calculation methodologies; c. Definition of key terms; d. Supporting information allowing HHSC to reproduce the calculations made by Contractor to validate the results reported; e. Instructions on how to access supporting Key Performance Measure and liquidated damage information online and in real-time; f. Quality assurance reviews and verification procedures; g. Automated measurement process and

	h. Documented, verifiable, and auditable manually entered data collection steps. All changes must be documented and provided to HHSC for approval within HHSC-approved timeframes.
DELR-028	**Project Kick-off Presentation** Develop and submit an HHSC-approved **Project Kick-off Presentation** to familiarize Project team members with the Project and ensure there is a baseline level of understanding between all parties. The completed **Project Kick-off Presentation** must be submitted no later than three (3) Calendar Days after the Contract Effective Date." The **Project Kick-off Presentation** includes the following topics: a. Project overview; b. Project schedule (high level); c. Objectives and definitions; d. Processes and methodologies; e. Deliverables; f. Roles and responsibilities; g. Impact to business, including organizational considerations; h. State resources needed to achieve Project objectives; i. Keys to success; j. Next steps; k. Questions and answers (Q&A), and **l.** Contractor resources.
DELR-029	**Turnover Plan** Provide a **Turnover Plan** to HHSC no more than sixty (60) Calendar Days after the Operations Start Date and annually on October 1st (including option years that have been exercised). The **Turnover Plan** must include the following: a. Proposed approach to Turnover; b. Tasks and subtasks for Turnover; c. Schedule for Turnover; d. Resource plan that ensures adequate staffing is maintained to support turnover activities and operations throughout the Turnover Phase; e. Updated operational tasks and procedures during Turnover; f. Description of Contractor coordination activities that will occur during the Turnover Phase and implementation of the activities to ensure continued system operations and Services as deemed necessary by HHSC; g. List of incomplete tasks, such as defects, modifications or enhancements, mass adjustments, and reference updates; h. A detailed description of the Services that would be required by another service provider to fully take over all Work identified in the Contract. The description shall also include an estimate of the number and type of staff resources required to perform the supporting Services and

	i. Contractor's proposed format for organizing the artifacts.
DELR-032	Coordinate Contract Deliverable and milestone walkthroughs with stakeholders and Trading Partners and participate in other MES service provider walkthroughs as required by HHSC.
DELR-033	Submit all Deliverables to HHSC for approval within the specified timeframe, format and content as directed by HHSC.
DELR-034	Correct any Deliverable(s) deemed unsatisfactory by HHSC within five (5) Business Days.
DELR-035	Submit for HHSC approval all electronic documentation on every system modification regarding the State Pool System as described in the Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 – Deliverables Requirements**.

2.1.4.5 *Business Continuity and Disaster Recovery Requirements (BCDR)*

The requirements below will help the state determine if the Contractor is prepared to take all the steps necessary to fully recover the state's data from the effects of a Disaster and to achieve complete recovery from such disaster within HHSC-specified timeframes. Complete recovery from a Disaster is defined as being back in full operational production mode with respect to all aspects of the system. Disasters may include natural disasters, human error, crime, intentional torts, hackers, terrorism, computer virus, malfunctioning hardware, electrical supply and/or other similar events.

Business Continuity and Disaster Recovery Requirements listed in **Table 9-Business Continuity and Disaster Recovery Requirements** below, describe the functionality, features and capabilities that shall be part of the Contractor Solution during the Contract Term.

Table 9 – Business Continuity and Disaster Recovery Requirements

Business Continuity and Disaster Recovery Requirements	
Req ID	**Detailed Requirements**
BCDR-001	Conduct an annual disaster recovery exercise to test all components of the HHSC-approved **Disaster Recovery Plan** in accordance with processes and within timeframes as directed by the Contractor's HHSC-approved **Disaster Recovery Plan**. Refer to **Table 8 – Deliverables Requirements**.
BCDR-002	Coordinate disaster recovery activities with HHSC-approved Trading Partners to restore system availability in accordance with the Contractor's HHSC-approved **Disaster Recovery Plan.** Refer to **Table 8 – Deliverables Requirements.**
BCDR-003	Coordinate with and demonstrate to HHSC the **Business Continuity and Contingency Plan** on the HHSC-approved schedule in conjunction with the annual disaster recovery exercise and report any identified deficiencies with appropriate corrective actions. Refer to **Table 8 – Deliverables Requirements**.
BCDR-004	Provide an alternate business site or telework protocols if Contractor's primary business site becomes unsafe or inoperable. The alternate business site or telework

	protocols must be fully operational no later than one (1) Business Day of the primary business site becoming unsafe or inoperable.
BCDR-005	Notify HHSC of a disruption of service(s) no later than fifteen (15) minutes of discovery.

2.1.4.5.1 Business Continuity and Disaster Recovery Key Performance Measures (BCDK)

The requirements listed in **Table 10-Business Continuity and Disaster Recovery Key Performance Measures** below describe the level of performance required by the Contractor for Disaster Recovery and Business Continuity.

Table 10 - Business Continuity and Disaster Recovery Key Performance Measures

Business Continuity and Disaster Recovery Key Performance Measures		
Req ID	**Key Performance Measures**	**Liquidated Damages**
BCDK-001	Provide backup processing and/or data replication capabilities at a remote site, located at least one hundred (100) miles from the primary site for State Pool System processing functions, such that normal EVV data processing can continue in the event that the primary site for State Pool System processing functions becomes inoperable. Normal EVV data processing must resume no later than one (1) Calendar Day of the primary site becoming inoperable. Normal EVV data processing is defined as the ability for EVV Users to clock in and clock out, run reports, perform visit maintenance, and submit EVV visit transactions to the EVV Aggregator.	a. If normal EVV data processing does not resume following one (1) Calendar Day after the primary site becomes inoperable, HHSC will assess $10,000 per day for the first two (2) Calendar Days; b. If normal EVV data processing does not resume between three (3) and five (5) Calendar Days, HHSC will assess $25,000 per Calendar Day; and c. If normal EVV data processing does not resume for more than five (5) Calendar Days, HHSC will assess $50,000 per Calendar Day until normal EVV data processing resumes.

BCDK-002	Restore Services to full functionality in the event the State Pool System becomes unavailable, in accordance with HHSC-approved standards and timeframes specified below or an alternate timeframe with HHSC approval: a. Tier 1: Emergency – critical application(s) no longer function. Correct within one (1) hour of discovery; b. Tier 2: System Disabled – business function or components of the business function do not work as required and no workaround is available. Correct within twenty-four (24) hours of discovery. Only applies to functionality that does not impact critical application(s); c. Tier 3: System Disabled – business function or components of the business function do not work as required, but a workaround that is acceptable to HHSC is available until the problem is resolved. Correct within three (3) Business Days of discovery; d. Tier 4: Minor system deficiency – minimal or no direct impact on the business function. Correct within five (5) Business Days of discovery; and e. Tier 5: Minimal cosmetic problem. Correct within ten (10) Business Days of discovery Discovery shall mean the point in time when either HHSC or Contractor identifies and confirms that the State Pool System is unavailable or not providing full functionality.	a. HHSC will assess $500 per hour for failure to restore Services related to a Tier 1 Incident within one (1) hour or an alternate HHSC-approved timeframe. b. HHSC will assess $500 per hour for failure to restore Services related to a Tier 2 Incident within twenty-four (24) hours or an alternate HHSC-approved timeframe. c. HHSC will assess $1,000 per day for failure to restore Services related to a Tier 3 Incident within three (3) Business Days or an alternate HHSC-approved timeframe.

2.1.4.6 *Communication Requirements (COMR)*

Communications tasks and activities are designed to promote clear, comprehensive and effective communication between Trading Partners, Members, Program Providers, and HHSC.

The requirements for Communications listed in **Table 11 – Communication Requirements** describe the tasks and activities that must be performed by the Contractor during the Contract Term.

Table 11 – Communication Requirements

Communication Requirements	
Req ID	**Detailed Requirements**
COMR-001	Provide customer support for Contractor's Solution (including State Pool System call centers) in English and Spanish.
COMR-002	Provide interpreter services for customer support for Contractor's Solution (including State Pool System call centers) including, but not limited to, a language line and Relay Texas (relay services for persons with speech or hearing loss) to support languages other than English and Spanish. Services must be provided at no cost to callers.
COMR-003	Assign a uniform tracking number in the CRM application to each inquiry, call, complaint, and customer support interaction received or handled by Contractor and SPSO.
COMR-004	Track the status and history of each inquiry, call, complaint, and customer support interaction received or handled by Contractor and SPSO within the CRM application.
COMR-005	Provide the uniform tracking number assigned to each inquiry, call, complaint, and customer support interaction received or handled by Contractor and SPSO to the customer when the customer service interaction is initiated.
COMR-006	Create materials for a culturally diverse population in a language or format (e.g., Braille, large-fonts, recordings) preferred by the intended recipient (e.g., Member and Program Provider) as defined by HHSC.
COMR-007	Comply with all sections of the Americans with Disabilities Act (ADA), Web Content Accessibility Guidelines (WCAG) 2.0 Level AA (or most current version), Section 508 of the Rehabilitation Act, and ensure user interface standards account for the various forms of colorblindness.
COMR-008	Develop and transmit HHSC-approved hardcopy and electronic correspondence (e.g., letters and emails) in accordance with Contractor's HHSC-approved **Communications Plan**. Refer to **Table 8 – Deliverables Requirements**.
COMR-009	Generate applicable notices to Program Providers, FMSAs, CDS employers and other entities as directed by HHSC.

Communication Requirements	
Req ID	**Detailed Requirements**
COMR-010	Document, track and retain correspondence received by Contractor or the SPSO in accordance with Contractor's HHSC-approved **Communications Plan**. Refer to **Table 8 – Deliverables Requirements.**
COMR-011	Compose public facing materials in plain language, following person-first principles, and adhere to HHSC-approved writing style as outlined in the current Texas Health and Human Services Brand Guide.
COMR-012	Comply with relevant State and federal accessibility requirements, including the HHS Accessibility Policy.
COMR-013	Communicate HHSC-approved changes to the maintenance schedule to Program Providers, HHSC-approved business partners and HHSC via the web, e-mail, and banner messages no less than forty-five (45) Calendar Days in advance of implementing the change or as otherwise approved by HHSC.
COMR-014	Notify EVV Users and HHSC-approved Trading Partners of planned and unplanned State Pool System events (e.g., system implementations and system outages) in accordance with Contractor's HHSC-approved **Communications Plan**. Refer to **Table 8 – Deliverables Requirements**.
COMR-015	Accommodate Program Provider, FMSA and CDS employer preferences for communications by e-mail, written correspondence, and phone.
COMR-016	Provide comprehensive and accurate responses to all correspondence regarding Contractor's Services and the State Pool System, within timeframes in the Contractor's HHSC-approved **Communications Plan**. Refer to **Table 8 – Deliverables Requirements.**
COMR-017	Utilize HHSC-approved terminology as defined in **Exhibit T, EVV Standard Language Guide** for all public-facing Contractor and the State Pool System technology, communications, educational services and materials, websites, and publications unless otherwise directed by HHSC. Refer to **Exhibit T, EVV Standard Language Guide**.
COMR-018	Forward all correspondence and inquiries pertaining to issues outside the purview of the Contractor to the appropriate entity and HHSC, no more than two (2) Business Days after receipt of correspondence or inquiry, or as directed by HHSC.
COMR-019	Respond to all complaints and inquiries submitted by HHSC by the due date requested.
COMR-020	Request and receive written approval by HHSC prior to releasing any public announcement concerning the Contract, including, but not limited to, notices, information pamphlets, press releases, research, reports, signs, and similar public notices prepared by or for Contractor.
COMR-021	Notify the appropriate user community, as defined by HHSC, of unplanned State Pool System events (e.g., system outages) via HHSC-approved communication methods for all the systems for which the Contractor is responsible.
COMR-022	Develop, maintain, and coordinate the publication of public-facing website content about the EVV program including the State Pool System information, Proprietary System information, and other information as directed by HHSC.

Communication Requirements	
Req ID	**Detailed Requirements**
COMR-023	Comply with federal (45 CFR 164.316), State, and program Records Management Policy and HHSC Retention Schedule(s) for all data and documentation, except where a different retention period is specified.
COMR-024	Develop, administer, and maintain HHSC-approved processes for documentation management, including defined timeframes and processes for HHSC review and approval of Contractor-maintained documentation.
COMR-025	Maintain version control and version history for all Contractor-maintained documents.
COMR-026	Establish and maintain an HHSC-approved electronic document repository, accessible to HHSC, to store all Contractor-maintained documents (e.g., publicly shared, or published documents, correspondence, CMS certification artifacts and reports) with built in filtering and search functionalities.
COMR-027	Perform stakeholder outreach and outbound communication in accordance with the Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements**,
COMR-028	Provide a customer service email address for HHSC-approved Trading Partners and stakeholders to send comments, complaints, and inquiries about Contractor's Services, including management and oversight of the State Pool System and Proprietary Systems, in accordance with the **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements**.
COMR-029	Conduct and deliver to HHSC an annual EVV User satisfaction survey with HHSC-approved content and format within forty-five (45) Calendar Days following the end of the State Fiscal Year (SFY).
COMR-030	Resolve complaints about Contractor Solution in accordance with procedures outlined in Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements**.
COMR-031	Respond to, but not necessarily resolve, one hundred percent (100%) of complaints and inquiries related to Contractor Solution no later than two (2) Business Days from receipt of the complaint or inquiry, or as directed by HHSC.
COMR-032	Establish and maintain a process to track and resolve EVV User complaints as part of Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements.**
COMR-033	Record all inbound and outbound customer support calls conducted by Contractor and SPSO and store in an HHSC-approved retrievable format.
COMR-034	Link customer support call recordings to each customer support call by the uniform tracking number in the CRM.
COMR-035	Provide access to call recordings to HHSC-approved entities as directed by HHSC.
COMR-036	Return all customer support voice messages received by the SPSO within one (1) Business Day.
COMR-037	Provide all call recordings, in an HHSC-approved format, within five (5) Business Days of HHSC's request.

Communication Requirements	
Req ID	**Detailed Requirements**
COMR-038	Provide customer support for the Contractor Solution (including State Pool System call centers) in additional languages within thirty (30) Calendar Days as directed by HHSC.
COMR-039	Develop and maintain all correspondence templates necessary to support HHSC requirements related to the Contract.

2.1.4.6.1 Communication Key Performance Measures (COMK)

The requirements listed in **Table 12 - Communication Key Performance Measures** below describe the level of performance required by the Contractor for Communication.

Table 12 – Communication Key Performance Measures

Communication Key Performance Measures		
Req ID	**Key Performance Measures**	**Liquidated Damages**
COMK-001	Resolve ninety-eight percent (98%) of email inquiries received through the Contractor's customer service email address within two (2) Business Days. Performance will be measured on a monthly basis. Resolved means the customer service ticket has been closed as a result of Contractor providing an accurate response to the inquiry in accordance with processes and procedures outlined in Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements**.	HHSC will assess $1,000 for each percentage point, or portion thereof, below the ninety-eight percent (98%) standard.
COMK-002	Resolve ninety percent (90%) of complaints related to Contractor Solution or the SPSO no later than five (5) Business Days from receipt of complaint. Resolve the remaining ten percent (10%) no later than ten (10) Business Days from receipt of complaint. Performance will be measured on a monthly basis. Resolved means Contractor has provided a final response to the complainant	a. HHSC will assess $500 for each percentage point, or portion thereof, below the ninety percent (90%) standard. b. HHSC will assess $1,000 for each percentage point, or portion thereof, below the one hundred percent (100%) standard.

Communication Key Performance Measures		
Req ID	**Key Performance Measures**	**Liquidated Damages**
	addressing their complaint, and the customer service ticket has been closed as a result of Contractor providing an accurate response to the inquiry in accordance with processes and procedures outlined in Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements.**	

2.1.4.7 *Support Services Requirements (SUPR)*

The Contractor shall provide the support and documentation identified in **Table 13-Support Services Requirements**. The Support Services tasks and activities shall be conducted by qualified, knowledgeable personnel, in an environment of confidentiality, timeliness and accuracy.

Table 13 – Support Services Requirements

	Support Services Requirements
Req ID	**Detailed Requirements**
SUPR-001	Cooperate with and assist HHSC in responding to all open records, law enforcement, federal and State audit, and review requests. Provide audit support (e.g., random sample generation, data extracts, hard-copy documents), and provide any requested data or information within HHSC-approved timeframes.
SUPR-002	Comply with all State and federal entities performing inspections, audits, and reviews and provide assistance as requested, including access to or copies of necessary records and information.
SUPR-003	Refer all known instances of possible or suspected fraud, waste, and abuse directly to HHSC. Notify HHSC in writing no later than five (5) Business Days following initial detection of suspected fraud, waste, or abuse and provide supporting documentation.
SUPR-004	Develop and maintain procedures for making referrals for suspected fraud, waste, and abuse directly to HHSC. The procedures must be submitted to HHSC for approval prior to implementation. The procedures must include: a. Educating Contractor staff at all levels, on ways to recognize possible fraud, waste, and abuse; b. Providing the ability for Contractor staff, at all levels, to freely and directly refer all instances of possible or suspected fraud, waste, and abuse to HHSC without interference, or required approval from the Contractor's management; and c. Educating Contractor staff on how to make a direct referral to HHSC.

	Support Services Requirements
Req ID	**Detailed Requirements**
SUPR-005	Post notice of the HHSC toll-free fraud hotline and other HHSC mediums available to employees for reporting fraud, waste, or abuse in HHSC Programs in the Contractor's common work and break areas (e.g., conference rooms, reception area, restrooms, elevators, break rooms, hallways, etc.).
SUPR-006	Cooperate with and assist the Texas Office of the Attorney General's (OAG) Civil Medicaid Fraud Division or any State or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting individuals or entities allegedly involved in fraud, waste, and abuse in relation to the scope of the Contract.
SUPR-007	Provide documents or records relating to the Contract, for an investigation into or litigation of allegations of fraud, waste, and abuse, upon receipt of a Civil Investigative Demand or a litigation hold from OAG Civil Medicaid Fraud Division, or any other request from a State or federal agency.
SUPR-008	Provide knowledgeable staff to ensure the requested information provided by Contractor is accurate and relevant, and provided within the timeframes established by the requesting entity.
SUPR-009	Maintain any documents, records, or data that the Contractor creates in the course of business for Work performed under the Contract and within the HHS Retention Schedule incorporated into the Contract, until the conclusion of the investigation or litigation to which the requested documents, records, or data relate.
SUPR-010	Provide a designated person to respond to specific requests outlined in each request by the State or federal agency submitted to the Contractor regarding the investigation and prosecution of fraud, waste, or abuse in the Contractor Solution that relate to the SOW of the Contract.
SUPR-011	Update the State or federal agency with new contact information upon receipt of a litigation hold or notice of investigation for any designated points of contacts or back-up personnel, as necessary, within ten (10) Calendar Days of the change.
SUPR-012	Ensure the Contractor staff and the SPSO maintain the confidentiality, including internal confidentiality, of all matters under investigation or litigation by the State or federal agency.
SUPR-013	Supply all reports, files, copies, and other documentation requested by the State or federal agencies as the reports, files, copies, and other documentation relate to a litigation hold or investigation into fraud, waste, and abuse related to the SOW of the Contract.
SUPR-014	Provide results of ad hoc data requests to HHSC within ten (10) Business Days of request by HHSC unless otherwise approved by HHSC.

2.1.4.8 *Litigation Support Requirements (LITR)*

The Contractor provides litigation support, HHSC enforcement proceedings, State administrative hearings and other legal proceedings administrative hearing activity support and documentation as required in the following requirements. The Litigation Support tasks and activities are conducted by qualified, knowledgeable personnel, in an environment of confidentiality, timeliness and accuracy.

Litigation Requirements listed in

Table 14 – Litigation Support Requirements below, describe the functionality, features and capabilities that must be part of the Contractor Solution during the Contract Term.

Table 14 – Litigation Support Requirements

Litigation Support Requirements	
Req ID	**Detailed Requirements**
LITR-001	Participate in and support HHSC enforcement proceedings, State administrative hearings, and other legal proceedings including providing testimony on relevant aspects of the State Pool System, Proprietary Systems, or EVV data when compliance issues regarding EVV result in contested actions or cases as directed by HHSC.
LITR-002	Provide all document retrieval, copying, preparation, and travel costs for Contractor and SPSO staff called as witnesses to HHSC enforcement proceedings, State administrative hearings, and other legal proceedings, at no additional cost to HHSC. The number of hearings and proceedings varies from year to year.
LITR-003	Retain all supporting documentation related to an active dispute until the dispute is resolved and HHSC has approved either storage or destruction of the supporting documentation.
LITR-004	Store, archive, and make accessible all records, including e-mail, involved in any litigation until HHSC requests the destruction, return of the records, or lifting of the litigation hold.
LITR-005	Supply all reports, files, copies, and other documentation requested by HHSC or the OAG, Department of Justice (DOJ) or other federal entities to support their prosecution or defense of lawsuits.
LITR-006	In support of pending litigation, and as requested by HHSC or the OAG, analyze the data and provide the initial and final results to HHSC or its designee.
LITR-007	Assist HHSC or the OAG in due diligence required for paper and/or electronic discovery obligations that arise in litigation. Assist HHSC or the OAG in litigation document retention holds, as instructed by HHSC and/or OAG.
LITR-008	Strictly comply with all litigation holds issued by HHSC or OAG.

2.1.4.9 *Security Requirements (SECR)*

The Contractor is responsible for controlling access to State data which includes sensitive data. The Contractor Solution must therefore include a certain amount of protection for such data and must in turn control access to those parts of the system that administer this protection.

Security Requirements listed in **Table 15 – Security Requirements** below, describe the functionality, features and capabilities that must be part of the Contractor Solution during the Contract Term.

Table 15 – Security Requirements

Security Requirements	
Req ID	**Detailed Requirements**
SECR-001	The Contractor must coordinate security management across all Contractor business and technical functions of the Contractor Solution including, but not limited to, the following: a. Participate and collaborate with HHSC in evaluation and risk assessment for impact to security vulnerabilities of HHSC-approved Contractor Solution software and third-party software and to: 1. provide updates and security patches in accordance with the Contractor's HHSC-approved **System Security Plan**; and 2. remediate moderate to critical issues of the **security evaluation and assessment**, as approved by HHSC. b. Perform security audits, provide incident investigation support, including reports, and initiate corrective actions to minimize and prevent data and security breaches in accordance with the Contractor's HHSC-approved **System Security Plan**. Refer to **Table 8 – Deliverables Requirements**.
SECR-002	Coordinate with HHSC to complete a **Privacy Threshold Analysis and Privacy Impact Assessment** for each module or module component. The contractor must also coordinate with HHSC to update the **Privacy Threshold Analysis and Privacy Impact Assessment** as required.
SECR-003	Track disclosures of ePHI; provide authorized users access to and reports on the disclosures.
SECR-004	Provide logical segregation of the Contractor Solution, components, and network connections with other entities and prevent any unauthorized disclosure of the states' data.
SECR-005	Provide training to Contractor and Subcontractor personnel providing Services under the Contract on **Exhibit H, Data Use Agreement (DUA)** and **Exhibit H-1, Attachment 2 to the DUA, Security and Privacy Inquiry (SPI)** and the privacy and security policies included in the Contract.
SECR-006	Comply with the OASIS Web Services Security - Simple Object Access Protocol (SOAP) Message Security Version 1.1 Specifications as required by CMS to build secure web services to implement message content integrity and confidentiality.
SECR-007	Provide scalable Services to integrate other solutions for security and regulatory purposes in the future.
SECR-008	Comply with the Harmonized Security and Privacy Framework - Exchange Reference Architecture Supplement Version 1.0 and as required by CMS.
SECR-009	Provide to HHSC, upon request, a listing of all users having access to the Contractor Solution components and/or data with details regarding the access granted to each user.
SECR-010	Provide monitoring Services to prevent and detect intrusion, hacking, unusual activity, or compromise of the Contractor Solution. The Contractor must immediately report any Incidents of such, regardless of the outcome to HHSC,

Security Requirements	
Req ID	**Detailed Requirements**
	activate an HHSC-approved communication strategy, perform mitigation activities, and provide continuous status updates to HHSC until the issues are resolved to HHSC's satisfaction.
SECR-011	Complete risk assessments and security audit reports on an annual basis and when additions or changes to functionality impact the security framework, architecture or when a new vulnerability exists.
SECR-012	Adhere to recognized best practices during the execution of the SOW including the latest version of the NIST Special Publication (SP) 800 series related to cyber security.
SECR-013	Deliver a Security Assessment Report in accordance with the Security Assessment Report and Attestation Guideline. Refer to security control baseline and relevant overlays identified in **Table 1 - Transition Requirements**, **Exhibit N, HHS Information Security and Privacy Requirements** for frequency.

2.1.4.9.1 Security Key Performance Measures (SECK)

The requirements listed in **Table 16 – Security Key Performance Measures** below describe the level of performance required for Security that must be performed by the Contractor during the Contract Term.

Table 16 – Security Key Performance Measures

Security Key Performance Measures		
Req ID	**Key Performance Measures**	**Liquidated Damages**
SECK-001	Provide coverage to respond to security Incidents within timeframes identified in **Exhibit H, Data Use Agreement (DUA)**.	$500 per Calendar Day when response failures are identified by Contractor or HHSC.

2.1.4.10 *Testing Requirements (TSTR)*

The Testing Requirements below describe the procedures to be used to perform and complete all testing of the Contractor Solution to attain all required system functionality and HHSC approval prior to initial deployment and any subsequent change. Testing must include at a minimum, testing for compatibility, operational and system functionality with HHSC and HHSC-approved Business Partners. HHSC reserves the right to conduct independent testing of the solution at any time.

The Testing Requirements listed in **Table 17 – Testing Requirements** below, describe the functionality, features and capabilities that must be part of the Contractor Solution during the Contract Term.

Table 17 – Testing Requirements

Testing Requirements	
Req ID	**Detailed Requirements**
TSTR-001	Test all current and future HIPAA transaction processing according to federal transaction guidelines as defined by HHSC (e.g., compliance testing; application, operations, and interface testing; business to business testing).
TSTR-002	Coordinate and conduct Trading Partner testing and operational readiness activities with HHSC-approved Trading Partners as directed by HHSC.
TSTR-003	Provide testing environments, including but not limited to, system integration testing, user acceptance testing and load and stress testing (LaST) testing in accordance with the Contractor's HHSC-approved **Test Plan**. Refer to **Table 8 – Deliverables Requirements**
TSTR-004	Provide a testing environment available to HHSC-authorized users and approved Trading Partners for UAT training and other purposes as defined by HHSC.
TSTR-005	Provide HHSC with online access to test database tables and files which allows HHSC to independently prepare test data, run tests, and review test results.
TSTR-006	Cooperate with HHSC or HHSC-authorized service providers, and provide environments, data, and technical support for independent testing. HHSC reserves the right to conduct independent testing of the State Pool System at any time.
TSTR-007	Plan and execute testing for all inbound and outbound interfaces, ensure accurate and secure data transmission between the Contractor Solution components, and coordinate with external entities as appropriate.
TSTR-008	Participate in Trading Partner testing and operational readiness activities when implementing the State Pool System.
TSTR-009	Identify and request a representative sample of Program Provider, FMSA, CDS employer, Member and EVV transaction records for use in testing based on individual program business requirements and coordinate the testing with other MES service providers. The samples must allow users to perform "what if testing" and compare the before and after outcomes.
TSTR-010	Assist in preparing test data, conducting tests, and reviewing test results, as required by HHSC.
TSTR-011	Conduct UAT for all system modifications (e.g., configuration, development, defects, maintenance, enhancement and mass adjustment activities and requests).
TSTR-012	Work with HHSC's designated testing resources to review test results and provide the necessary operational and functional information to create verification procedures and user acceptance test cases.
TSTR-013	Perform testing of the State Pool System, document the results, and provide the results to HHSC upon request in accordance with Contractor's HHSC-approved **Test Plan**, for each of the following test levels: a. Performance test results; b. System test results; c. Parallel test results;

Testing Requirements	
Req ID	**Detailed Requirements**
	d. Regression test results; and e. Integration test (including Trading Partner Testing) results. Test results must be traced to the use case/user story, and design documentation being tested, and integration and regression testing must meet or exceed national industry standards, such as NIST or Software Engineering Institute for all changes before changes are promoted to the production environment, in accordance with Contractor's HHSC-approved **Test Plan**. Refer to **Table 8 – Deliverables Requirements**.
TSTR-014	Make system test results available for HHSC review and submit, as necessary, to other HHSC-approved Trading Partners for evaluation.
TSTR-015	Coordinate with HHSC and other HHSC-approved Trading Partners to conduct integration testing.
TSTR-016	Identify and resolve interdependencies that restrict or impede required testing of the Contractor Solution, other MES service providers, or MES service provider components from performing required testing.
TSTR-017	Test all operational and system functionality (e.g., patches, upgrades, and releases) in a timely manner and in coordination with other MES service providers, prior to implementing changes into the production environment.
TSTR-018	Release code changes into production when the acceptance criteria are met as documented in the **Production Control Plan**. Refer to **Table 8 – Deliverables Requirements.**

2.1.4.11 *Training Requirements (TNGR)*

Training Requirements in this section include training documentation and "Train-the-Trainer" training for other MES service providers. The Contractor will provide initial and ongoing training, documentation, and educational Services to MES service providers and EVV Users regarding the Contractor Solution.

Training Requirements listed in **Table 18 – Training Requirements** below, describe the functionality, features, and capabilities that must be part of the Contractor Solution during the Contract Term.

Table 18 – Training Requirements

Training Requirements	
Req ID	**Detailed Requirements**
TNGR-001	Provide training, documentation, and educational Services to EVV Users regarding the Contractor Solution and the State Pool System that complies with the HHSC Accessibility Policy and Section 508 of the Rehabilitation Act.

Training Requirements	
Req ID	**Detailed Requirements**
TNGR-002	Train and educate all employees, Subcontractors and workforce, and provide annual refresher or retraining on confidentiality, privacy, security and the importance of promptly reporting any event or breach as defined in **Exhibit H, Data Use Agreement (DUA)**, and of the consequences of failing to do so, including without limitation: employment disciplinary action, employer sanctions or enforcement actions for legal noncompliance, potential loss of State federal financial participation (FFP), and risks to third-party agreements.
TNGR-003	Provide face-to-face training, marketing, system demonstrations, and other educational events in accordance with Contractor's HHSC-approved **Home Health Care Services Expansion Plan** or as otherwise directed by HHSC. Refer to **Table 8 – Deliverables Requirements.**
TNGR-004	Coordinate with other MES service providers to develop training content that involves Contractor Solution and services/technology provided by other MES service providers in accordance with Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.**
TNGR-005	Obtain and incorporate feedback from trainees to improve training effectiveness in accordance with Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.**
TNGR-006	Conduct initial and annual assessments of training needs for EVV Users and other MES service providers regarding Contractor Solution and the State Pool System in accordance with Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.**
TNGR-007	Maintain accurate, current, and complete training, user documentation, and educational Services for the State Pool System and Contractor Solution.
TNGR-008	Coordinate with HHSC and HHSC-approved Trading Partners to produce and maintain accurate and comprehensive educational materials, including but not limited to, training, job aids, computer-based training, user guides, and publications according to HHSC-approved content, format, and schedules. Update training materials when changes occur.
TNGR-009	Respond to requests for training needs no later than three (3) Business Days after HHSC's request.
TNGR-010	Provide technical training to HHSC staff and designated MES service providers for monitoring the Contractor Solution using available tools and dashboards.
TNGR-011	Collaborate with HHSC to finalize a training schedule. A training schedule must be submitted to HHSC at least annually for approval.
TNGR-012	Utilize a variety of delivery methods to best meet the training objectives. Examples include online self-paced training presentations, in-person classroom setting, written material, and demonstrations.

2.1.4.12 *Turnover Requirements (TUNR)*

The performance of the Turnover Phase activities as defined in this SOW is to the mutual benefit of HHSC and Contractor. The primary objective for Turnover activities is to

ensure no interruption of Services to EVV Users. The Contractor must cooperate with the successor service provider(s) while performing Turnover activities defined in this SOW.

Turnover Requirements listed in **Table 19 – Turnover Requirements** below, describe the functionality, features and capabilities that must be part of the Contractor Solution during the Contract Term.

Table 19 – Turnover Requirements

Turnover Requirements	
Req ID	**Detailed Requirements**
TUNR-001	Submit all modifications to the Contractor's HHSC-approved **Turnover Plan** in writing to HHSC for approval. Refer to **Table 8 – Deliverables Requirements.**
TUNR-002	Submit an updated **Turnover Plan** within ninety (90) Calendar Days from notification of Contract termination or as directed by HHSC. Refer to **Table 8 – Deliverables Requirements.**
TUNR-003	Maintain all key personnel and required Contractor staff during the Turnover Phase in accordance with the Contractor's HHSC-approved **Turnover Plan**. Refer to **Table 8 – Deliverables Requirements.**
TUNR-004	Collaborate with HHSC and successor to interpret and analyze test results and resolve all identified issues from Turnover Phase activities as outlined in the Contractor's HHSC-approved **Turnover Plan**. Refer to **Table 8 – Deliverables Requirements.**
TUNR-005	Conduct and document knowledge transfer sessions with HHSC-designated staff, successor, and Trading Partners for all current Contractor Solution functionality and Services as outlined in the Contractor's HHSC-approved **Turnover Plan**. Refer to **Table 8 – Deliverables Requirements.**
TUNR-006	Obtain HHSC approval prior to reducing staffing levels during the Turnover period. The Contractor will not restrict or prevent Contractor staff from accepting employment with any successor service provider.
TUNR-007	Coordinate with HHSC and Trading Partners to successfully plan and transfer the management and operations of the Contractor Solution and HHSC's assets including data, Contractor Solution process documentation, all work products delivered by Contractor, and related business and technical functions in a format, media, content, and within timeframes approved by HHSC to its successor or to HHSC.
TUNR-008	Deliver all work products for in-flight Projects and transfer to HHSC and Trading Partners in a format, media, content, and within timeframes approved by HHSC in an HHSC-approved commercially consumable form.
TUNR-009	Prepare, deliver and facilitate the transfer of five (5) years of data and data attributes (including meta data necessary to interpret the data) from the State Pool System to HHSC or successor including, but not limited to: Program Provider and FMSA demographic data (e.g. contract information), CDS Employer information,

	Member information, Direct Service Provider information, Service Authorization information and other information HHSC deems necessary to support Turnover activities as directed by HHSC.
TUNR-010	Report on Turnover progress and status in an HHSC-approved format at least weekly throughout the Turnover Phase.
TUNR-011	Provide authorized HHSC or other designated individuals access to validate any converted data needed to support continuity of Services and provide support for the data validation effort.
TUNR-012	Coordinate with HHSC and successor to facilitate the transfer of all EVV Users from the State Pool System to successor's State Pool System in accordance with Contractor's HHSC-approved **Turnover Plan.** Refer to **Table 8 Deliverables Requirements.**
TUNR-013	Submit the final Turnover progress and status report demonstrating that Contractor has completed all Turnover tasks no later than thirty (30) Calendar Days prior to the Contract end date or as otherwise approved by HHSC.
TUNR-014	Deliver Turnover artifacts to the HHSC-designated knowledge sharing repository in an HHSC-approved format.

2.1.5 State Pool System Management and Oversight Requirements (SPSR)

The requirements listed in **Table 20 – State Pool System Management and Oversight Requirements** below describe the tasks and activities that must be performed by the Contractor during the Contract Term.

Table 20 – State Pool System Management and Oversight Requirements

State Pool System Management and Oversight	
Req ID	**Detailed Requirements**
SPSR-001	Publish a public-facing monthly report of all outages, defects, and Incidents that could adversely impact Program Provider, FMSA and CDS employer compliance with HHSC requirements in an HHSC-approved format.
SPSR-002	Report on SPSO compliance with HHSC-defined performance objectives in the **Monthly Status Report**. Refer to **Table 8 – Deliverables Requirements.**
SPSR-003	Report and resolve all State Pool System Incidents in accordance with processes and within timeframes outlined in the Contractor's HHSC-approved **Production Control Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPSR-004	Validate and report the State Pool System is utilizing current reference table data in accordance with processes and within timeframes in the Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPSR-005	Report and remediate one hundred percent (100%) of State Pool System defects at no additional cost to HHSC and within timeframes outlined in the Contractor's HHSC-approved **Production Control Plan**. Refer to **Table 8 – Deliverables Requirements.**

State Pool System Management and Oversight	
Req ID	**Detailed Requirements**
SPSR-006	Prohibit the SPSO from offering cash or cash-equivalent incentives to EVV Users.
SPSR-007	Prohibit the SPSO from automatically opting EVV Users in to paid Services.
SPSR-008	Provide one (1) State Pool System that delivers EVV Services in accordance with **Exhibit R, HHSC EVV Business Rules, Exhibit Q, HHSC EVV Policies**, and the requirements of this Contract free of charge to EVV Users and Members Additional software and functionality may be offered but cannot be required for the use of the free EVV component. Refer to **Exhibit R, HHSC EVV Business Rules** and **Exhibit Q, HHSC EVV Policies**.
SPSR-009	Define and publish the format and standards for exchanging data between the State Pool System and third-party systems in accordance with Contractor's HHSC-approved **Interface Control Document**. Refer to **Table 8 – Deliverables Requirements.**
SPSR-010	Coordinate and validate the compliance of the State Pool System with **Exhibit R, HHSC EVV Business Rules** and **Exhibit Q, HHSC EVV Policies**, and the requirements of this Contract. Refer to **Exhibit R, HHSC EVV Business Rules** and **Exhibit Q, HHSC EVV Policies**.
SPSR-011	Report on performance, compliance, and deficiencies of the State Pool System with respect to the **Exhibit R, HHSC EVV Business Rules and Exhibit Q, HHSC EVV Policies**, and the requirements of the Contract. Report this information in the HHSC-approved **Monthly Status Report** or as otherwise directed by HHSC. Refer to **Table 8 – Deliverables Requirements.** Refer to **Exhibit R, HHSC EVV Business Rules** and **Exhibit Q, HHSC EVV Policies**.
SPSR-012	Notify HHSC of any planned changes to or terminations of the SPSO participation in the State Pool at least one hundred fifty (150) Calendar Days prior to the effective date of the change or termination in accordance with the Contractor's HHSC-approved **State Pool System Change Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPSR-013	Coordinate, validate, and report that Trading Partner testing and operational readiness activities with Trading Partners are successfully completed by the SPSO in accordance with processes and timeframes in the Contractor’s HHSC-approved **Test Plan** or as directed by HHSC. Refer to **Table 8 – Deliverables Requirements.**
SPSR-014	Disallow policies which require EVV Program Providers to remain with the State Pool System for a specific length of time.
SPSR-015	Develop, administer, and maintain a code of conduct policy to ensure Contractor and SPSO staff provide accurate information and interact with customers in a professional manner as part of the HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements.**

State Pool System Management and Oversight	
Req ID	**Detailed Requirements**
SPSR-016	Monitor, validate, and report that SPSO customer support calls are compliant with quality standards in accordance with the HHSC-approved **Quality Management Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPSR-017	Notify Trading Partners and HHSC-approved users when the State Pool System is unavailable due to HHSC-approved maintenance windows or an unscheduled outage in accordance with the Contractor's HHSC-approved **Communications Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPSR-018	Track and report on all State Pool System training activities for each user in accordance with the Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPSR-019	Provide educational Services for the State Pool System that support **Exhibit Q, HHSC EVV Policies** and business objectives in accordance with the Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.** Refer to **Exhibit Q, HHSC EVV Policies**.
SPSR-020	Update the State Pool System to utilize the current version of **Exhibit U, EVV Service Bill Codes Table** in accordance with processes and within timeframes in the Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 – Deliverables Requirements** and **Exhibit U, EVV Service Bill Codes Table**.
SPSR-021	Validate and report the State Pool System is utilizing the current version of the **Exhibit U, EVV Service Bill Codes Table** in accordance with processes and within timeframes in the Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 – Deliverables Requirements.** Refer to **Exhibit U, EVV Service Bill Codes Table**.
SPSR-022	Provide standard reports from the State Pool System within specified timeframes, with content and format as defined in **Exhibit R, HHSC EVV Business Rules** or as otherwise directed by HHSC. Refer to **Exhibit R, HHSC EVV Business Rules**.
SPSR-023	Provide a State Pool System that is accessible through multiple web browsers (browser agnostic) and supports HHSC-approved web browsers including, but not limited to, browsers on tablets, smartphones, laptops, and other mobile devices.
SPSR-024	Provide role-based access to the State Pool System for EVV Users as directed by HHSC.
SPSR-025	Provide a State Pool System that can submit Texas Medicaid claims via electronic data interchange (EDI) to the Texas Medicaid claims administrator and offer this functionality to EVV Users for free or as a paid additional service.
SPSR-026	Obtain and maintain status of the State Pool System as an approved third-party submitter for Texas Medicaid claims via EDI, whereby EVV Users can use the State Pool System to submit a Texas Medicaid claim for payment based on an EVV visit transaction.
SPSR-027	Provide electronic verification methods for the State Pool System that allow EVV Users to clock in and clock out in English and Spanish.

State Pool System Management and Oversight	
Req ID	**Detailed Requirements**
SPSR-028	Provide electronic verification methods for the State Pool System that allow EVV Users to clock in and clock out in languages other than English and Spanish within thirty (30) Calendar Days of HHSC's request.
SPSR-029	Provide a State Pool System that complies with the relevant State and federal accessibility requirements, including the HHS Accessibility Policy.
SPSR-030	Conduct an annual assessment of Contractor's Services and capabilities, including the State Pool System capabilities, measured against EVV industry best practices to identify areas of improvement as directed by HHSC.
SPSR-031	Deliver the results of the Contractor's annual EVV industry best practice assessment with content and within timeframes approved by HHSC.
SPSR-032	Provide technical coordination between the SPSO, PSOs, and HHSC-approved Trading Partners for topics including, but not limited to, connectivity with the EVV Aggregator, EVV web services, and EVV visit transaction rejections, and other EVV data exchanges.

2.1.6 State Pool System Operations Requirements (SPOR)

The requirements listed in **Table 21 – State Pool System Operations Requirements** below describe the tasks and activities that must be performed by the Contractor during the Contract Term.

Table 21 – State Pool System Operations Requirements

State Pool System Operations Management	
Req ID	**Detailed Requirements**
SPOR-001	Demonstrate the free EVV component first when demonstrating the State Pool System to EVV Users.
SPOR-002	Clearly communicate that the purchase of optional Services is not required to access the free EVV components of the State Pool System when onboarding or registering EVV Users.
SPOR-003	Use **Exhibit U, EVV Service Bill Codes Table** to identify EVV-required Services, unit types, claims matching effective dates, and other key details regarding EVV-required Services as defined by HHSC. Refer to the **Exhibit U, EVV Service Bill Codes Table**.
SPOR-004	Provide concurrent role-based access to the State Pool System for all authorized users to support HHSC EVV business operations for EVV Program Providers, HHSC, MCOs, and other HHSC-approved entities.
SPOR-005	Process visit maintenance unlock requests for the State Pool System within ten (10) Business Days in accordance with **Exhibit Q, HHSC EVV Policies**. Refer to **Exhibit Q, HHSC EVV Policies**.

State Pool System Operations Management	
Req ID	**Detailed Requirements**
SPOR-006	Maintain the State Pool System compliance with **Exhibit R, HHSC EVV Business Rules, Exhibit Q, HHSC EVV Policies**, and the requirements of this Contract. Refer to **Exhibit R, HHSC EVV Business Rules** and **Exhibit Q, HHSC EVV Policies**.
SPOR-007	Provide a State Pool System that does not impose a limit on the number of user accounts for Contractor, HHSC, MCOs, Program Providers, FMSAs, and other HHSC-approved entities in accordance with the **State Pool System Onboarding Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPOR-008	Provide a State Pool System that supports integration with third-party systems for functions including but not limited to, payroll, scheduling, and client/case management in accordance with **Exhibit R, HHSC EVV Business Rules**. Refer to **Exhibit R, HHSC EVV Business Rules**.

2.1.6.1 *Customer Support Requirements (CUSR)*

The requirements listed in **Table 22 - Customer Support Requirements** below describe the tasks and activities that must be performed by the Contractor during the Contract Term.

Table 22 - Customer Support Requirements

Customer Support Requirements	
Req ID	**Detailed Requirements**
CUSR-001	Respond to and resolve one hundred percent (100%) of legislative inquiries no later than eight (8) business hours from receipt of the inquiry or provide a plan to obtain the information with an estimated time of completion agreed to by HHSC.
CUSR-002	Provide a customer service email address for stakeholders to send comments, complaints, and inquiries about the SPSO's Services.
CUSR-003	Respond to email inquiries received through the SPSO customer service email address by live person (not an automated response) within one (1) Business Day after receipt of the email inquiry.
CUSR-004	Resolve email inquiries received through the SPSO customer service email address in accordance with processes and procedures outlined in the Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements.**

2.1.6.1.1 Customer Support Key Performance Measures (CUSK)

The requirements listed in

Table 23 – Customer Support Key Performance Measures below describe the level of performance required by the Contractor for Communication.

Table 23 – Customer Support Key Performance Measures

Customer Support Key Performance Measures		
Req ID	**Key Performance Measures**	**Liquidated Damages**
CUSK-001	Resolve ninety-eight percent (98%) of email inquiries received through the SPSO's customer service email address within two (2) Business Days. Performance will be measured on a monthly basis. Resolved means the customer service ticket has been closed as a result of Contractor or SPSO providing an accurate response to the inquiry in accordance with processes and procedures outlined in Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements**.	HHSC will assess $500 for each percentage point, or portion thereof, below the 98% standard.
CUSK-002	Resolve one hundred percent (100%) of email inquiries received through the SPSO's customer service email address within ten (10) Business Days. Performance will be measured on a monthly basis. Resolved means the customer service ticket has been closed as a result of Contractor or SPSO providing an accurate response to the inquiry in accordance with processes and procedures outlined in Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements.**	HHSC will assess $1,000 for each percentage point, or portion thereof, below the 100% standard.

2.1.6.2 *Call Center Requirements (CACR)*

The Call Center Requirements include the daily tasks and activities related to staff, equipment, and Services related to the operation, maintenance and enhancement of the call center which handles all inquiries related to the State Pool System.

The Call Center Requirements listed in **Table 24 – Call Center Requirements** below, describe the functionality, features and capabilities that must be part of the Contractor Solution during the Contract Term.

Table 24 – Call Center Requirements

Call Center Requirements	
Req ID	**Detailed Requirements**
CACR-001	Record all inbound and outbound customer support calls conducted by Contractor and SPSO and store in an HHSC-approved retrievable format. Refer to the

Call Center Requirements	
Req ID	**Detailed Requirements**
	Attachment A-2, Procurement Library for the EVV Program Metrics workbook.
CACR-002	Link customer support call recordings to each customer support call by the uniform tracking number in the CRM.
CACR-003	Provide access to call recordings to HHSC-approved entities as directed by HHSC.
CACR-004	Develop, administer, and maintain a process for handling incoming and outgoing customer support calls for the State Pool System if the primary telephony system is not operational as part of the Contractor's HHSC-approved **Business Continuity and Contingency Plan**. Refer to **Table 8 – Deliverables Requirements.**
CACR-005	Retain call recordings for six (6) years after the date of the telephone call unless otherwise specified by HHSC.
CACR-006	Obtain HHSC approval before limiting the number of topics or inquiries that may be addressed during SPSO customer support calls **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements.**
CACR-007	Provide the data used to calculate the State Pool System call center performance metrics to HHSC upon request.
CACR-008	Provide accessibility Services for SPSO customer support lines in accordance with the HHS Accessibility Policy
CACR-009	Obtain HHSC approval of any policies related to the SPSO clearing call queues or removing callers from a call queue.
CACR-010	Develop, administer, and maintain a call resolution and escalation process as part of the HHSC-approved **Customer Support Plan**. Refer to in **Table 8 – Deliverables Requirements.**
CACR-011	Provide an automated system to answer SPSO customer support lines outside of Weekday Call Center Hours and Weekend Call Center Hours that provides operating hour information in English and Spanish and the functionality to allow callers to leave a message for call back. Set holiday and operating hour messages as the primary message.
CACR-012	Receive and resolve critical State Pool System issues outside of Weekday Call Center Hours and Weekend Call Center Hours in accordance with processes and timeframes in the Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements**.
CACR-013	Train call center staff to be able to perform all functions available to EVV Users in accordance with processes and procedures outlined in the Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements.**
CACR-014	Provide real time functionality for call center staff to assist EVV Users with EVV inquiries in accordance with processes and procedures.
CACR-015	Answer at least ninety-eight percent (98%) of calls from the call center queue within two (2) minutes by a live call center agent during Weekend Call Center Hours in accordance with the processes and procedures outlined in the

Call Center Requirements	
Req ID	**Detailed Requirements**
	Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements.**
CACR-016	Provide the functionality for all callers to complete an HHSC-approved post-call customer satisfaction survey, and store and make survey results available to HHSC upon request.
CACR-017	Maintain call blockage at a rate of less than five percent (5%) for all calls during Weekend Call Center Hours.
CACR-018	Maintain a call abandonment rate of less than ten percent (10%) during Weekend Call Center Hours. Calls which are abandoned within 10 seconds or less shall not be considered "abandoned" for this calculation.
CACR-019	Maintain a zero percent (0%) call deflection rate for all call lines. Call deflection includes calls that have connected to the call tree at the trunk level however are unable to connect to a State-approved recorded message, queue, or agent.
CACR-020	Respond to all call center messages within one (1) Business Day upon receipt of message.
CACR-021	Allow outbound calls from SPSO call centers.
CACR-022	Provide monthly results and quantitative analysis of the post-call customer satisfaction survey within the **Monthly Status Report** to measure caller satisfaction drivers, trend analysis, and service improvement priorities in accordance with the Contractor's HHSC-approved **Quality Management Plan**. Refer to **Monthly Status Report** and **Quality Management Plan** in **Table 8 – Deliverables Requirements.**
CACR-023	Update automated scripts to notify callers of non-standard Weekday Call Center Hours, Weekend Call Center Hours, and holiday messages in accordance with the State holiday schedule or as directed by HHSC.
CACR-024	Staff all call centers from 7:00 a.m. to 7:00 p.m. Central Time, Monday through Friday ("Weekday Call Center Hours") excluding HHSC-approved holidays, unless otherwise approved by HHSC.
CACR-025	Staff all call centers from 9:00 a.m. to 1:00 p.m. Central Time, Saturday, and Sunday ("Weekend Call Center Hours") excluding HHSC-approved holidays, unless otherwise approved by HHSC.

2.1.6.2.1 Call Center Key Performance Measures (CACK)

The requirements listed in **Table 25 – Call Center Key Performance Measures** below describe the level of performance required by the Contractor for Communication.

Table 25 – Call Center Key Performance Measures

Call Center Performance Measures		
Req ID	**Key Performance Measures**	**Liquidated Damages**
CACK-001	Maintain call blockage at a rate of less than two percent (2%) for all calls during Weekday Call Center Hours. Performance will be measured on a monthly basis. Call blockage means the number of calls that were unable to connect to the call center trunk.	HHSC will assess $5,000 per toll-free telephone line for each percentage point, or portion thereof, exceeding the two percent (2%) standard for call blockage.
CACK-002	Answer at least ninety-eight percent (98%) of calls from the call center queue within two (2) minutes by a live call center agent during Weekday Call Center Hours in accordance with the processes and procedures outlined in the Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements**. Performance will be measured on a monthly basis. Time of answering shall be calculated as follows: The number of seconds from when a caller selects their final desired option in the automated call queue (if applicable) to when a live call center agent answers the call.	HHSC will assess $5,000 per toll-free telephone line for each percentage point, or portion thereof, not meeting a ninety-eight percent (98%) standard for Calls answered by a live agent within two (2) minutes.
CACK-003	Maintain a call abandonment rate of less than five percent (5%) during Weekday Call Center Hours. Calls which are abandoned within ten (10) seconds or less shall not be considered abandoned for this calculation. Performance will be measured on a monthly basis. An abandoned call is a call where the caller hangs up while waiting for the call to be answered by a live agent or the call queue.	HHSC will assess $5,000 per toll-free telephone line for each percentage point, or portion thereof, exceeding the five percent (5%).

Call Center Performance Measures		
Req ID	**Key Performance Measures**	**Liquidated Damages**
CACK-004	Answer at least ninety-nine percent (99%) of all calls on or before the fourth (4th) ring by a live agent or the call center queue in accordance with the processes and procedures outlined in the Contractor's HHSC-approved **Customer Support Plan**. Refer to **Table 8 – Deliverables Requirements**. Performance will be measured on a monthly basis.	HHSC will assess $5,000 per toll-free telephone line for each percentage point, or portion thereof, not meeting a ninety-nine percent (99%) standard for calls answered on or before the fourth (4th) ring.

2.1.6.3 *State Pool System Training Requirements (SPTR)*

Training Requirements in this section include training documentation for EVV Users for use of the State Pool System. Contractor and the SPSO will provide initial and ongoing training, documentation, and educational Services to EVV Users for the State Pool System.

Training Requirements listed in **Table 26 – State Pool System Training Requirements** below, describe the functionality, features, and capabilities that must be part of the Contractor Solution during the Contract Term.

Table 26 – State Pool System Training Requirements

State Pool System Training Requirements	
Req ID	**Detailed Requirements**
SPTR-001	Conduct live in-person training for use of the State Pool System to CDS Employers and designated representatives at least quarterly in accordance with the Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPTR-002	Provide initial and ongoing training, documentation, and educational Services to EVV Users for the State Pool System in accordance with the Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPTR-003	Provide educational Services for the State Pool System that are tailored to the appropriate audience based on their role in the Texas EVV Program in accordance with the Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPTR-004	Maintain training materials and content for the State Pool System that are current and accurately reflect **Exhibit Q, HHSC EVV Policies** and system functionality in accordance with Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPTR-005	Provide draft training materials for the Contractor Solution and the State Pool System to HHSC for review in accordance with Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.**

SPTR-006	Provide initial and ongoing training, documentation, and educational Services to EVV Users and other MES service providers regarding the Contractor Solution in accordance with the Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPTR-007	Develop and maintain electronic training guides and materials for use by Program Providers and CDS Employers to train Direct Service Providers on the use of the State Pool System and electronic verification methods.
SPTR-008	Train one hundred percent (100%) of identified system/component users on the system relative to their use initially and on updated functionality prior to the initial production deployment and each major release into the production environment.
SPTR-009	Verify and document the completion of mandatory system training for EVV Users prior to using the State Pool System, in accordance with the Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements**.
SPTR-010	Verify and document the completion of mandatory annual system training for EVV Users of the State Pool System in accordance with the Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPTR-011	Track and report on all State Pool System training activities for each user in accordance with the Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.**
SPTR-012	Provide educational Services for the State Pool System that support **Exhibit Q, HHSC EVV Policies** and business objectives in accordance with the Contractor's HHSC-approved **Training Plan**. Refer to **Table 8 – Deliverables Requirements.** Refer to **Exhibit Q, HHSC EVV Policies**.

2.1.6.4 *System Requirements (SYSR)*

System requirements encompass the tasks and activities the Contractor will manage and oversee to manage data, manage Incidents, provide technical coordination, provide system issue resolution, provide internal controls, and perform routine backup of systems, tables, and files for the State Pool System.

System Requirements listed in **Table 27 – System Requirements** below, describe the functionality, features and capabilities that must be part of the State Pool System during the Contract Term.

Table 27 – System Requirements

System Requirements	
Req ID	**Detailed Requirements**
SYSR-001	Implement and utilize the current reference table data in the State Pool System in accordance with the Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 – Deliverables Requirements.**
SYSR-002	Maintain a public-facing change history log for all system changes and updates made to the State Pool System.

System Requirements	
Req ID	**Detailed Requirements**
SYSR-003	Implement changes to the State Pool System no later than one hundred and twenty (120) Calendar Days, or another mutually agreed upon timeframe after HHSC notifies Contractor in writing of updates to the **Exhibit R, HHSC EVV Business Rules**.
SYSR-004	State Pool System must support extract transform and load (ETL) processes from real-time web services or batch processes associated with the EVV Aggregator.
SYSR-005	Support the exchange of data between the State Pool System and the MES to facilitate business functions that meet the requirements of State policy, and federal and State laws, rules, and regulations.
SYSR-006	Support retrieval and presentation of data associated with geographic indicators such as by state, by county, by zip code, by peer group, or other geographical indicators specified by HHSC.
SYSR-007	Process interfaces for the State Pool System in accordance with the **Interface Control Document**. Refer to **Table 8 – Deliverables Requirements.**
SYSR-008	Process one hundred percent (100%) of inbound files and interfaces within four (4) clock hours of receipt.
SYSR-009	Process one hundred percent (100%) of both inbound and outbound files for the State Pool System accurately in accordance with the HHSC-approved **Interface Control Document**. Refer to **Table 8 – Deliverables Requirements.**
SYSR-010	Develop and maintain a data management strategy. The Data management strategy at a minimum must contain: a. Data integrity (data cannot be modified undetectably); b. Data availability (access is not inappropriately blocked or denied); c. Data authenticity (validation of transactions); d. Data security (encryption and HHSC-approved security protocols) and e. Non-repudiation of data (parties to a transaction cannot deny their participation in the transaction).
SYSR-011	Maintain and update all HHSC-approved data sets and reference files (e.g., rates, reimbursement data, national code set), data elements and functions required for all programs within a HHSC-approved timeline.
SYSR-012	Receive, store, and utilize **Exhibit U, EVV Service Bill Codes Table** to identify EVV-relevant Services, service unit types, and other key details regarding EVV-relevant Services as defined by the State. Refer to **Exhibit U, EVV Service Bill Codes Table**.
SYSR-013	Maintain data currency using date parameters (e.g., effective date, beginning and end date, change date) for each occurrence of all reference data.
SYSR-014	Maintain and provide all narrative descriptions of codes and abbreviations for reporting.

System Requirements	
Req ID	**Detailed Requirements**
SYSR-015	Provide the flexibility to accept new and incremental data items from MES systems/applications as required for system integration.
SYSR-016	Participate in State activities around policy changes to ensure reference tables are up to date and all changes are identified.
SYSR-017	Maintain data integrity across all Contractor supported systems in accordance with HHSC directives. Provide timely and consistent feedback to HHSC and MES service providers on error rates, issues, and problems with data quality.
SYSR-018	Notify HHSC immediately upon identification of any corrupt or lost data or software.
SYSR-019	Develop a root cause analysis and a corrective action plan no more than twenty-four (24) hours after identification of corrupt or lost data or software for HHSC approval.
SYSR-020	Restore and recover lost or corrupted data or software in accordance with the CAP.
SYSR-021	Participate and present, as needed, in the data stewardship workgroup(s) of the HHS data governance council.
SYSR-022	Update and submit metadata, data quality reporting results, and status of remediation efforts, in timeframes determined by HHS data governance council, its functional data stewardship workgroups, or information technology (IT) governance processes as directed by HHSC.
SYSR-023	All data within the scope of the Contract must be delivered to HHSC and Trading Partners in a non-proprietary, secure, accessible format.
SYSR-024	Retain all records for Members under the age of twenty-one (21) for all Medicaid programs in accordance with the *Frew v. Smith,* Civil Action No. 3:93CV65 litigation hold.
SYSR-025	Maintain a ninety-nine and nine tenths of a percent (99.9%) accuracy rate for all reference file updates.
SYSR-026	Execute all data exchanges (real-time, near real-time, and batch) with HHSC and Trading Partners in a manner that is secure, timely, accurate, and in full compliance with State and federal laws, rules, regulations, and guidelines.
SYSR-027	Provide EVV mobile applications for the State Pool System that are compatible with Android and iOS as approved by HHSC.
SYSR-028	Provide technical support for Trading Partners via a dedicated email box or toll-free telephone line in accordance with processes and procedures.

System Requirements	
Req ID	**Detailed Requirements**
SYSR-029	Provide operational support, maintenance, and ongoing configuration of the State Pool System during the Contract Term. This includes providing Trading Partner support and Operations support as described in the SOW as well as providing maintenance and enhancements to the provided State Pool System to meet the business needs of the State. HHSC defines maintenance for each module as follows: a. Making updates as necessary to comply with new business rules, including new **Exhibit R, HHSC EVV Business Rules**; b. Correcting deficiencies (defects) found in the solution(s) based on detailed requirements described in the SOW and published test results; c. Correcting deficiencies (defects) found in the solution(s) based on a failure to meet the requirements in completed enhancement, configuration, or maintenance requests; d. Conducting research requested by HHSC or required to support the State. For example: 1. Solution behavior and results; 2. New healthcare initiatives; 3. Best practices research across states and industry; and 4. Impacts of new State and federal legislation; e. Performing regular maintenance as required to support the State's healthcare programs. Examples of maintenance include but are not limited to: 1. Database management; 2. Interface, report, and correspondence changes; and 3. Making corrections or changes to maintain the integrity of the system or the data within it (e.g., backing out changes, correcting duplicate records, cleansing corrupt data, adding security measures, adding redundancy); f. Using appropriate testing, configuration, and change control procedures and g. Updating user, and training documentation and online help to reflect changes that have been made to the solution. Refer to **Exhibit R, HHSC EVV Business Rules**.
SYSR-030	Provide a State Pool System that can be adapted to changes in business practices and policies within the agreed timeframes. The Contractor is required to cover the cost of such systems modifications during the Contract Term.
SYSR-031	Submit an annual maintenance schedule of planned downtime of the State Pool System by September 1st of each year for that SFY for HHSC review and approval. All changes must be submitted to HHSC for approval.
SYSR-032	Submit all requests for unscheduled and emergency maintenance to HHSC for approval and consideration to waive the forty-five (45) Business Days communication notification period.
SYSR-033	Provide a web page that displays notification when the State Pool System is unavailable for scheduled maintenance or unscheduled outages.

System Requirements	
Req ID	**Detailed Requirements**
SYSR-034	Provide electronic notification for all updates and fixes deployed to the State Pool System that could impact HHSC's delivery of services to Members or Program Providers or as directed by HHSC.
SYSR-035	Resolve all Incidents and problems impacting the State Pool System, using HHSC-approved ITIL guidelines (see **Exhibit O, Information Technology Infrastructure Library (ITIL) Severity Levels**) based on the severity levels defined by HHSC.
SYSR-036	Notify HHSC at least forty-five (45) Calendar Days prior to the installation or implementation of any changes that affect the State Pool System.
SYSR-037	Perform a demonstration or walk-through of system changes, as defined in Contractor's HHSC-approved **Change Management Plan** for each modification to the State Pool System as directed by HHSC. Refer to **Table 8 – Deliverables Requirements**.
SYSR-038	Deploy any modification to the State Pool System only after receiving approval from HHSC.
SYSR-039	Verify State Pool System modification implementation results through monitoring of the production process and correct and document any problems found within HHSC-approved timeframes.
SYSR-040	Provide confirmation that State Pool System modifications have been deployed to production and the Contractor has completed three (3) Calendar Days of Operations without significant operational issues defined as no critical or high defects.
SYSR-041	Notify HHSC in writing of all deficiencies or processing errors within HHSC-approved timeframes.
SYSR-042	Provide technical 24/7/365 monitoring to support per HHSC service level requirements within the Contract to resolve problems with EVV transaction processing, portals, and all related interfaces.
SYSR-043	Provide initial and ongoing technical coordination and support to MCOs, Program Providers, FMSAs, SPSO, approved PSO and the State with content, format and delivery method defined by HHSC.
SYSR-044	Request approval from HHSC prior to scheduling non-emergency system downtime or maintenance during hours of operation no later than five (5) Business Days prior to downtime.
SYSR-045	Complete and implement one hundred percent (100%) of all critical priority tickets, (enhancements, deficiencies, maintenance, research, and configuration) by the HHSC-approved Implementation date. HHSC will establish the Priority and the required implementation date for each ticket based on the business need (e.g., federal law, State law, or regulation).
SYSR-046	Notify HHSC of any Severity Level 1 deficiencies, as defined by **Exhibit O, Information Technology Infrastructure Library (ITIL) Severity Levels**, within one (1) hour of the initial deficiency or within thirty (30) minutes of becoming aware of the issue. Contractor shall provide its plan for resolution within four (4) hours of

System Requirements	
Req ID	**Detailed Requirements**
	the notification of the deficiency to HHSC and resolve the deficiency within twenty-four (24) hours of the notification of the deficiency to HHSC. The Contractor will remediate defects at no additional cost to HHSC.
SYSR-047	Notify HHSC of any Severity Level 2 deficiencies, as defined **Exhibit O, Information Technology Infrastructure Library (ITIL) Severity Levels**, within one (1) hour of becoming aware of the issue. Contractor shall provide its plan for resolution no later than four (4) hours of the notification of the deficiency to HHSC and resolve the deficiency no later than thirty-six (36) hours of the notification of the deficiency to HHSC. The Contractor will remediate defects at no additional cost to HHSC.
SYSR-048	Notify HHSC of any Severity Level 3 or Severity Level 4 deficiency, as defined by **Exhibit O, Information Technology Infrastructure Library (ITIL) Severity Levels**, no less than twenty-four (24) hours of becoming aware of the issue. The Contractor will remediate defects at no additional cost to HHSC.
SYSR-049	Develop and administer HHSC-approved processes for providing access to the State Pool System to authorized users.
SYSR-050	The State Pool System must provide web-based interactive portals **<u>that</u>**: a. Adhere to HHSC-approved accessibility and security, as outlined at https://hhs.texas.gov/policies-practices-privacy; b. Utilize HHSC-approved terminology as defined in **Exhibit T, EVV Standard Language Guide**; c. Write in plain language and follow person-first principles; d. Comply with HHSC-approved version of Web Content Accessibility Guidelines (WCAG) for accessibility standards: https://www.access-board.gov/guidelines-and-standards/communications-and-it/about-the-ict-refresh/final-rule/text-of-the-standards-and-guidelines; e. Support multiple web browsers (browser agnostic); f. Use administrative tools to identify usage/analytics and broken links; and g. Include a test environment for usability testing. Refer to **Exhibit T, EVV Standard Language Guide**.
SYSR-051	Identify and propose enhancements, modifications, and technical solutions for HHSC review and consideration to assist HHSC's ongoing modernization and efficiency efforts.
SYSR-052	Submit updates to the maintenance schedule within ten (10) Business Days of any change in accordance with the Contractor's HHSC-approved **Production Control Plan**. Refer to **Table 8 – Deliverables Requirements**.
SYSR-053	Provide documentation to HHSC for any test results in accordance with the Contractor's HHSC-approved **Test Plan**. Refer to **Table 8 – Deliverables Requirements**.

System Requirements	
Req ID	**Detailed Requirements**
SYSR-054	Interface successfully with MES service providers and Trading Partners in accordance with the Contractor's HHSC-approved **Interface Control Document**. Refer to **Table 8 – Deliverables Requirements**.
SYSR-055	Perform and track all routine maintenance as specified in the Contractor's HHSC-approved **Production Control Plan**. Refer to **Table 8 – Deliverables Requirements**.
SYSR-056	Notify HHSC and Trading Partners of the State Pool System downtimes and outages as outlined in the Contractor's HHSC-approved **Communications Plan**. Refer to **Table 8 – Deliverables Requirements**.
SYSR-057	The State Pool System must be available for transaction processing 24/7/365, except for HHSC-approved planned downtime or maintenance windows as specified in the Contractor's HHSC-approved **Production Control Plan**. Refer to **Table 8 – Deliverables Requirements**.
SYSR-058	Provide a test environment that adequately represents the production environment to allow HHSC staff to Review and approve changes prior to moving the changes to production in accordance with the Contractor's HHSC-approved **Test Plan**. Refer to **Table 8 – Deliverables Requirements**.
SYSR-059	Test all State Pool System modifications before moving into production and maintain environments for all UAT (i.e., walkthroughs) and report test results in accordance with the Contractor's HHSC-approved **Test Plan**. Refer to **Table 8 – Deliverables Requirements**.
SYSR-060	Provide a State Pool System that allows EVV Users to request, download, and export EVV data, EVV standard reports, and ad hoc reports on demand.
SYSR-061	Provide a State Pool System that allows EVV Users to correct and update an EVV visit transaction (i.e., visit maintenance).
SYSR-062	Provide a State Pool System that supports and allows for the creation of the following user profile types: Direct Service Provider, Member, Program Provider, FMSA, CDS Employer and other profile types as directed by HHSC.
SYSR-063	Provide a State Pool System that maintains an audit trail of all changes made to an EVV visit transaction.
SYSR-064	Provide a State Pool System that allows EVV Users to clock in and clock out using a landline telephone.
SYSR-065	Provide a State Pool System that allows EVV Users to clock in and clock out using an EVV mobile application (i.e., smart phone application).
SYSR-066	Provide a State Pool System that allows EVV Users to manually create an EVV visit transaction if the Direct Service Provider fails to clock in or clock out using an electronic verification method.

2.1.6.4.1 System Key Performance Measures (SYSK)

The requirements listed in **Table 28 – System Solution Key Performance Measures** below describe the level of performance required for Processing that must be performed by the Contractor during the Contract Term.

Table 28 – System Solution Key Performance Measures

System Solution Key Performance Measures		
Req ID	**Key Performance Measures**	**Liquidated Damages**
SYSK-001	Maintain ninety-nine and five tenths of a percent (99.5%) availability for the State Pool System, except for planned HHSC-approved downtime. Performance will be measured on a monthly basis.	HHSC will assess $500 for each tenth of a percentage point, or portion thereof, below the ninety-nine and five tenths of a percent (99.5%) standard.
SYSK-002	Correct all data extract delivery and content problems within five (5) Business Days of problem identification, or another timeframe as mutually agreed within the five (5) Business Days of problem identification and notify HHSC of correction. Data extracts are documented in the Contractor's HHSC-approved **Interface Control Document**. Performance will be measured on a monthly basis. A data extract delivery or content problem shall be considered corrected when the originally intended data or content is provided, extracted, or delivered to the appropriate entity as documented in the **Interface Control Document**. Refer to **Table 8 – Deliverables Requirements**.	HHSC will assess $1,000 per day for failure to meet the timeliness standard.
SYSK-003	Remediate State Pool System defects at no additional cost to the State as documented in the HHSC-approved Maintenance Level Table Description Definition, within the following timeframes or an alternate date with HHSC approval:	HHSC will assess $5,000 per day for failure to correct each Standard 1: Emergency defect within one (1) Business Day of discovery or an HHSC-approved alternate date. HHSC will assess $3,000 per day for failure to correct each Standard 2: System Disabled

System Solution Key Performance Measures		
Req ID	**Key Performance Measures**	**Liquidated Damages**
	a. Standard 1: Emergency- System no longer functions. Correct within one (1) Business Day of discovery; b. Standard 2: System Disabled- Business function or components of the business function do not work as required and no workaround is available. Correct within three (3) Business Days of discovery; c. Standard 3: System Disabled -business function or components of the business function do not work as required, but a workaround that is acceptable to HHSC is available until the problem is resolved. Correct within ten (10) Business Days of discovery; d. Standard 4: Minor Non-critical problem. Correct within twenty (20) Business Days of discovery; and e. Standard 5: Minimal Cosmetic. Correct within forty (40) Business Days of discovery. Performance will be measured on a monthly basis. Discovery shall mean the point in time when either party identifies; and confirms that the State Pool System functionality is defective.	defect within three (3) Business Days of discovery or an HHSC-approved alternate date. HHSC will assess $1,000 per day for failure to correct each Standard 3: System Disabled defect within ten (10) Business Days of discovery or an HHSC-approved alternate date. HHSC will assess $500 per day for failure to correct each Standard 4: Minor Non-critical problem defect within twenty (20) Business Days. HHSC will assess $500 per day for failure to correct each Standard 5: Minimal Cosmetic defect within forty (40) Business Days.
SYSK-004	Process and deliver at least ninety-nine percent (99%) of all interfaces within the timeframes defined in the Contractor's HHSC-approved **Interface Control Document**. Performance will be measured on a monthly basis. Refer to **Table 8 – Deliverables Requirements**.	HHSC will assess $1,000 for each percentage point, or portion thereof, below the ninety-nine percent (99%) standard.

2.1.6.5 *CMS Certification Requirements (CMSR)*

CMS has begun to transition its systems certification process to one that evaluates how well Medicaid information technology systems support desired business outcomes while reducing the burden on states. This streamlined, outcomes-based approach, or "Outcomes-Based Certification (OBC)," is designed to ensure that systems that receive federal financial participation are meeting the business needs of the State and of CMS. The

requirements in this section are for the purpose of obtaining federal certification and rely on the cooperation of HHSC and its Trading Partners, including all Contractors and Sub-Contractors whose products and/or ancillary Services interface with the modernized MES.

Certification Requirements listed in **Table 29 – CMS Certification Requirements** below, describe the functionality, features and capabilities that must be part of the Contractor Solution during the Contract Term.

Table 29 – CMS Certification Requirements

Certification Requirements	
Req ID	**Detailed Requirements**
CMSR-001	Perform all activities necessary to achieve final CMS certification within specified timeframes, with content and format as directed by HHSC.
CMSR-002	Maintain CMS certification during the Contract Term.
CMSR-003	Contractor must maintain the **CMS Certification Plan** and all associated documentation during the Contract Term. Refer to **CMS Certification Plan** in **Table 8 – Deliverables Requirements.**
CMSR-004	Coordinate with HHSC to develop CMS certification documentation for each applicable review criteria.
CMSR-005	Provide support by running reports, analyzing samples, facilitating walkthroughs and demonstrations, and delivering completed system documentation to HHSC and CMS as directed by HHSC.
CMSR-006	Provide a State Pool System that meets all current CMS certification requirements (https://www.medicaid.gov/medicaid/data-systems/outcomes-based-certification/electronic-visit-verification-certification/index.html) in accordance with Contractor's HHSC-approved **CMS Certification Plan**. Refer to **CMS Certification Plan** in **Table 8 – Deliverables Requirements.**
CMSR-007	Provide staff resources experienced with EVV CMS certification activities, to participate in planning activities, meetings, and other CMS certification activities.
CMSR-008	Participate in and support CMS certification activities of the other MES service provider solutions as directed by HHSC.
CMSR-009	Assist HHSC in preparing certification artifacts, evidence, and presentation materials (e.g., requirements, user stories, or use cases) for functional and non-functional requirements) in accordance with the Contractor's HHSC-approved **CMS Certification Plan**. Refer to **Table 8 – Deliverables Requirements.**
CMSR-010	Follow the most current CMS process to report on CMS key performance indicators to achieve and maintain CMS certification in accordance with Contractor's HHSC-approved **CMS Certification Plan**. Refer to **Table 8 – Deliverables Requirements.**
CMSR-011	Work collaboratively with HHSC and other MES service providers to provide data and reporting to HHSC in support of reporting CMS key performance indicators in accordance with Contractor's HHSC-approved **CMS Certification Plan**. Refer to **Table 8 – Deliverables Requirements.**

Certification Requirements	
Req ID	**Detailed Requirements**
CMSR-012	Provide required security assessments of the State Pool System, completed by an independent third-party vendor, at no additional cost to HHSC.
CMSR-013	Provide detailed test reports to demonstrate the State Pool System compliance with Section 508 of the Rehabilitation Act and current ADA requirements at no additional cost to HHSC in accordance with Contractor's HHSC-approved **CMS Certification Plan**. Refer to **Table 8 – Deliverables Requirements.**

2.1.6.6 *MITA Requirements (MITR)*

CMS requires MES service providers to meet all applicable CMS Conditions and Standards, and states must strive to continually improve the MES' MITA maturity level. As part of the Texas MMIS modernization, the State's goal is to gain measurable improvements in supporting Medicaid business processes and information and demonstrate the progress to CMS during the Contract Term.

CMS Conditions and Standards for modularity and interoperability require acquisition of loosely coupled solutions with open, documented interfaces. MITA includes a well-documented set of open interfaces that allow for vendor's independent integration of solutions into an overall EVV solution.

The MITA requirements listed in **Table 30 – MITA Requirements** below describe the tasks and activities that must be performed by the Contractor during the Contract Term.

Table 30 – MITA Requirements

MITA	
Req ID	**Detailed Requirements**
MITR-001	Provide a Contractor Solution that is fully integrated with the MITA initiative.
MITR-002	Provide a requirements management tool that has the ability to manage requirements traceability by the MITA business area, MITA business process, and CMS or HHSC-defined checklists.
MITR-003	Assess MITA maturity impacts related to the Contractor Solution as directed by HHSC.
MITR-004	Provide Contractor staff and information as requested by HHSC to assist with CMS requirements for the MITA State Self-Assessment and MITA Roadmap activities. Information must be provided in a format, content, and within timeframes approved by HHSC.
MITR-005	Provide staff resources and information to assist with HHSC's activities to support the "to-be" vision of the CMS Standards and Conditions and the MITA framework as directed by HHSC.
MITR-006	Provide MITA framework training for Contractor staff with responsibility for business analysis or systems analysis.
MITR-007	Update and provide the MITA training materials to HHSC for review and approval at the Operations Start Date and annually thereafter.

MITA	
Req ID	**Detailed Requirements**
MITR-008	Meet future MITA requirements as required by State or federal laws, rules, and guidelines.

2.1.6.7 *Alternative Device Management Requirements (ALTR)*

Alternative devices allow Direct Service Providers to clock in and clock out when the Member doesn't have a landline phone (or won't allow it to be used for EVV) or when the Direct Service Provider doesn't have a smart phone. Strategically, HHSC is looking to reduce reliance on alternative devices to increase program integrity and reduce ongoing operations costs for the State Pool System.

Alternative Device Management Requirements listed in **Table 31 – Alternative Device Management Requirements** below, describe the functionality, features and capabilities that must be part of the State Pool System during the Contract Term.

Table 31 – Alternative Device Management Requirements

Alternative Device Management	
Req ID	**Detailed Requirements**
ALTR-001	Provide alternative devices to Program Providers, CDS employers, and FMSAs that allow Direct Service Providers to clock in and clock out of the State Pool System without an internet or telephone connection at the time of clock in and clock out in accordance with **Exhibit R, HHSC EVV Business Rules and Exhibit Q, HHSC EVV Policies**. Refer to **Exhibit R, HHSC EVV Business Rules** and **Exhibit Q, HHSC EVV Policies**.
ALTR-002	Ship alternative devices to Program Providers, CDS employers, and FMSAs using the State Pool System within five (5) Business Days of a complete and accurate request at no cost to the requestor.
ALTR-003	Provide an electronic process for Program Providers, CDS employers, and FMSAs using the State Pool System to request an alternative device.
ALTR-004	Work with HHSC to reduce the use of alternative devices.

2.1.7 Proprietary System Management and Oversight Requirements (PSMR)

Contractor will be responsible for reviewing, approving, and monitoring Proprietary Systems. Contractor will perform readiness reviews of Proprietary Systems on an ongoing basis to determine if the system meets HHSC requirements for use in Texas. Contractor will collaborate with other MES service providers to facilitate Trading Partner testing with Proprietary Systems as part of the readiness review process.

Program Providers and FMSAs may opt to use a Proprietary System and apply for their system to be approved. Program Providers, FMSAs and their software vendors are not directly reimbursed by HHSC for the use of a Proprietary System. Program Providers, FMSAs and their software vendors will not have a contractual relationship with Contractor.

Proprietary System Management and Oversight listed in **Table 32-Proprietary System Management and Oversight Requirements** below describe the Contractor's responsibilities for Proprietary Systems.

Table 32 – Proprietary System Management and Oversight Requirements

Proprietary System Management and Oversight	
Req ID	**Detailed Requirements**
PSMR-001	Notify PSOs that they must implement and utilize the current version of the HHSC-approved **Exhibit U, EVV Service Bill Codes Table** in their Proprietary System, in accordance with the Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 – Deliverables Requirements**.
PSMR-002	Develop and administer HHSC-approved processes for providing access to the Proprietary System to authorized users.
PSMR-003	Validate and report that Proprietary Systems are utilizing current **Exhibit U, EVV Service Bill Codes Table** in accordance with processes and within timeframes in the Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 – Deliverables Requirements**.
PSMR-004	Notify PSOs that they must implement and utilize the current reference table data in their Proprietary Systems, in accordance with the Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 – Deliverables Requirements**.
PSMR-005	Validate and report that Proprietary Systems are utilizing current reference table data in accordance with processes and within timeframes in the Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 – Deliverables Requirements**.
PSMR-006	Notify PSOs that they must implement and utilize the current version of the **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** in their Proprietary System, in accordance with the Contractor's HHSC-approved **Change Management Plan**. Refer to **Table 8 – Deliverables Requirements**. Refer to **Exhibit S, HHSC EVV Business Rules for Proprietary Systems**.
PSMR-007	Report on performance, compliance, and deficiencies of Proprietary Systems with respect to **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** and **Exhibit Q, HHSC EVV Policies**, and the requirements of this Contract. Report this information in the HHSC-approved **Monthly Status Report** or as otherwise directed by HHSC. Refer to **Table 8 – Deliverables Requirements.** Refer to **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** and **Exhibit Q, HHSC EVV Policies**.
PSMR-008	Validate and report that PSOs have a process to require the completion of mandatory system training for EVV Users prior to using a Proprietary System in accordance with the Contractor's HHSC-approved **Proprietary System Onboarding Plan.** Refer to **Table 8 – Deliverables Requirements.**
PSMR-009	Validate and report that PSOs have a process to require the completion of mandatory annual system training for EVV Users of a Proprietary System in accordance with the Contractor's HHSC-approved **Proprietary System Onboarding Plan**. Refer to **Table 8 – Deliverables Requirements**.

Proprietary System Management and Oversight	
Req ID	**Detailed Requirements**
PSMR-010	Validate and report that PSOs assign and provide role-based system access to HHSC-authorized users as defined in the **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** in accordance with Contractor's HHSC-approved **Proprietary System Onboarding Plan**. Refer to **Table 8 – Deliverables Requirements**.
PSMR-011	Coordinate the exchange of data between the Proprietary Systems, HHSC, and HHSC-approved Trading Partners to transmit data in accordance with format, content, and timeframes outlined in the Contractor's HHSC-approved **Interface Control Document** Refer to **Table 8 – Deliverables Requirements**.
PSMR-012	Validate that electronic verification methods provided by a Proprietary System comply with **Exhibit Q, HHSC EVV Policies** and **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** as outlined in the Contractor's HHSC-approved **Proprietary System Onboarding Plan**. Refer to **Table 8 – Deliverables Requirements.** Refer to **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** and **Exhibit Q, HHSC EVV Policies**.
PSMR-013	Validate that a Proprietary System does not impose a limit on the number of user accounts for Contractor, HHSC, MCOs, and other HHSC-approved entities prior to approving the Proprietary System.
PSMR-014	Develop, administer, and maintain an HHSC-approved **Proprietary System Onboarding Plan**. Refer to **Table 8 – Deliverables Requirements**.
PSMR-015	Develop and maintain HHSC-approved website content regarding PSOs that includes general information, the process for onboarding, the form/application to start the onboarding process, technical resources, contact information for approved PSOs, and other information as directed by HHSC.
PSMR-016	Coordinate the publication of updated HHSC-approved PSO website content with the MES service provider responsible for public-facing communications.
PSMR-017	Coordinate, validate, and report that testing is successfully completed between PSOs and HHSC-approved Trading Partners in accordance with processes and timeframes in the Contractor's HHSC-approved **Test Plan** or as directed by HHSC. Refer to **Table 8 – Deliverables Requirements**.
PSMR-018	Conduct readiness reviews to determine if a Proprietary System complies with **Exhibit S, HHSC EVV Business Rules for Proprietary Systems, Exhibit Q, HHSC EVV Policies** and other HHSC-defined requirements. Refer to **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** and **Exhibit Q, HHSC EVV Policies**.
PSMR-019	Approve Proprietary Systems for use in Texas if the PSO complies with **Exhibit S, HHSC-EVV Business Rules for Proprietary Systems**, **Exhibit Q, HHSC EVV Policies** and other HHSC-defined requirements. Refer to **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** and **Exhibit Q, HHSC EVV Policies**.
PSMR-020	Provide capacity to conduct at least twenty (20) readiness reviews of new Proprietary Systems each Contract Year.
PSMR-021	Provide capacity to conduct at least fifty (50) expedited Proprietary System readiness reviews each Contract Year. An expedited Proprietary System readiness

Proprietary System Management and Oversight	
Req ID	**Detailed Requirements**
	review can occur when a Program Provider or FMSA applies to use a Proprietary System which has been previously approved for use by another Program Provider or FMSA.
PSMR-022	Provide an annual schedule of Proprietary System readiness review opportunities for HHSC approval.
PSMR-023	Validate and report that all approved Proprietary Systems have implemented the current version of **Exhibit S, HHSC EVV Business Rules for Proprietary Systems** within one hundred and twenty (120) Calendar Days, or another mutually agreed upon timeframe, after HHSC notifies Contractor in writing of updates to **Exhibit S, HHSC EVV Business Rules for Proprietary Systems**. Refer to **Exhibit S, HHSC EVV Business Rules for Proprietary Systems**.
PSMR-024	Establish a HHSC-approved process for Program Providers and FMSAs to apply for Proprietary System approval.
PSMR-025	Track and report Proprietary System approval status to HHSC.

2.1.7.1 *Proprietary System Management Key Performance Measures (PSMK)*

The requirements listed in **Table 33 – Proprietary System Management Key Performance Measures** below describe the level of performance required by the Contractor for Project Management.

Table 33 – Proprietary System Management Key Performance Measures

Proprietary System Management		
Req ID	**Key Performance Measures**	**Liquidated Damages**
PSMK-001	Complete ninety-eight percent (98%) of Contractor's assigned tasks related to Proprietary System Onboarding in accordance with timeframes in Contractor's HHSC-approved Proprietary System Onboarding Plan.	HHSC will assess $1,000 for each percentage point, or portion thereof, below the ninety-eight percent (98%) standard.

2.2 CONTRACT AWARD, TERM, AND HISTORICAL COMPENSATION

2.2.1 Contract Award and Execution

HHSC intends to award one (1) Contract as a result of this Solicitation. Any Award is contingent upon approval of the Executive Commissioner or their designee.

If, for any reason, a Contract cannot be negotiated with a Respondent selected for Award on terms HHSC determines reasonable within forty (40) Calendar Days of HHSC's determination to seek to contract with that Respondent, HHSC may avail itself of any option permissible under applicable law including, but not limited to, negotiate a Contract

with the next highest scoring Respondent, make a partial award, or withdraw the Solicitation.

2.2.2 Contract Term

HHSC anticipates that the Base Contract Term of any Contract resulting from this Solicitation will be for a period of four (4) years (Base Contract Term). HHSC, at its sole discretion, may renew or extend the Contract. However, in no event may the Contract term, including all renewals, exceed seven (7) years. Notwithstanding the limitation in the preceding sentence, HHSC, at its sole discretion, also may extend the Contract beyond seven (7) years as necessary to ensure continuity of service, for purposes of transition, to address immediate operational or service delivery needs, or as otherwise determined by System Agency to serve the best interest of the State.

Table 34 – Project Schedule

Project Schedule		
Milestone	**Duration (Calendar)**	**Anticipated Start Date**
Transition Phase	Five (5) months	3/1/2023
Operations Phase	Three (3) years seven (7) months	8/1/2023
Optional Contract Renewal(s)	Up to three (3) additional years	3/1/2027
Turnover Phase	Twelve (12) months prior to end of Contract Term	3/1/2026

2.2.3 Historical Compensation

Historically, the estimated contract cost attributable to EVV Services is $31,045,337.13 million dollars for SFY 2020. Contracted cost for SFY 2021 attributable for EVV Services was $27,119,778.57. Notwithstanding **Section 2.2.3 Historical Compensation**, HHSC reserves the right to adjust any projected amount based on State funding during the term of a resulting Contract.

2.3 Data Use Agreement and Security Privacy Inquiry

By entering into a Contract with HHSC as a result of this Solicitation, Respondent agrees to be bound by the terms of the Data Use Agreement attached as **Exhibit H, Data Use Agreement (DUA).**

Respondents must complete and return with their Solicitation Response **Exhibit H-1, Attachment 2 to the DUA, Security and Privacy Inquiry (SPI)**.

2.4 NO GUARANTEE OF VOLUME, USAGE, OR COMPENSATION

HHSC makes no guarantee of volume, usage, or total compensation to be paid to any Respondent under any awarded Contract, if any, resulting from this Solicitation. Any awarded Contract is subject to appropriations and the continuing availability of state funds.

HHSC reserves the right to cancel, make partial Award, or decline to award a Contract under this Solicitation at any time at its sole discretion.

ARTICLE III. ADMINISTRATIVE INFORMATION

3.1 SCHEDULE OF EVENTS

EVENT	DATE/TIME
Solicitation Posting Date to ESBD	APRIL 26, 2022
Pre-proposal Conference and HSP Training Attendance is Optional	MAY 4, 2022, at 11:00 AM CT
Deadline for Submitting Questions or Requests for Clarification	MAY 5, 2022, at 4:30 PM CT
Tentative Date Responses to Questions or Requests for Clarification Posted on ESBD	MAY 23, 2022
Submission deadline for courtesy HSP review	MAY 23, 2022, at 10:30 AM CT
Deadline for Submission of Solicitation Responses ***[NOTE: Responses must be RECEIVED by HHSC by the deadline.]***	JUNE 7, 2022, **at 10:30 AM** CT
Evaluation Period	JUNE 2022 – AUGUST 2022
Demonstrations	AUGUST 2022
Anticipated Notice of Award	MARCH 2023
Anticipated Contract Start Date	MARCH 2023

Respondents must submit their Solicitation Responses to HHSC in accordance with the due date and time indicated in this Schedule of Events or as changed via an Addendum posted to the ESBD.

NOTE: All dates are tentative and HHSC reserves the right to modify these dates at any time. At the sole discretion of HHSC, events listed in the Schedule of Events are subject to scheduling changes and cancellation. Scheduling changes or cancellation determinations made prior to the deadline for submission will be published by posting an Addendum to the ESBD. After the deadline for submission, if there are delays that significantly impact the anticipated award date, HHSC, at its sole discretion, may post updates regarding the anticipated award date to the Procurement Forecast on the HHS Procurement Opportunities web page. Each Respondent is responsible for checking the ESBD and Procurement Forecast for updates.

By submitting a Solicitation Response, Respondent represents and warrants that any individual submitting the Solicitation Response and any related documents on behalf of the Respondent is authorized to do so and to bind the Respondent under any Contract that may result from this Solicitation.

3.2 AMBIGUITY, CONFLICT, OR DISCREPANCY

Respondent must notify the Sole Point of Contact listed in **Section 3.3.1** of any ambiguity, conflict, discrepancy, exclusionary specification, omission, or other error in the Solicitation in the manner and by the deadline described in **Section 3.3.4, Solicitation Questions**.

Respondent submits a Solicitation Response at its own risk.

If Respondent fails to properly and timely notify the Sole Point of Contact listed in **Section 3.3.1** of any ambiguity, conflict, discrepancy, exclusionary specification, omission, or other error in the Solicitation, Respondent, whether awarded a Contract or not:

a. Waives any claim of error or ambiguity in the Solicitation and any resulting Contract;
b. Must not contest the interpretation by HHSC of such provision(s); and
c. Is not entitled to additional compensation, relief, or time by reason of ambiguity, conflict, discrepancy, exclusionary specification, omission, or other error or its later correction.

3.3 INQUIRIES

3.3.1 Sole Point of Contact

All requests, questions, or other communication about this Solicitation shall be made in writing to HHSC PCS, addressed to the person listed below (Sole Point of Contact).

Name	Andrick Reese, CTCD, CTCM
Title	Contract Specialist V
Phone	Phone #: 512/406-2606
Email	Andrick.Reese@hhs.texas.gov

See also, **Section 3.3.3, Exception to Sole Point of Contact** below.

3.3.2 Prohibited Communication

Except as provided in **Section 3.3.1, Sole Point of Contact** and **Section 3.3.3, Exception to Sole Point of Contact**, potential Respondents and Respondents are prohibited from any communication with HHSC regarding the Solicitation. HHSC its representative(s), and partners will not answer any questions or otherwise discuss the contents of this Solicitation with any potential Respondent or its representative(s). Attempts to ask questions by phone or in person will not be allowed or recognized as valid. Respondent shall rely only on written statements issued by or through HHSC designated staff as provided by **Section 3.3, Inquiries**. This restriction does not preclude discussions between affected parties for the purposes of conducting business unrelated to this Solicitation. **Failure to comply with these restrictions may result in disqualification of Respondent's Solicitation Response.**

3.3.3 Exception to Sole Point of Contact

Exceptions to **Section 3.3.1** are as follows:

a. Respondents with questions relating to the HUB Subcontracting Plan are permitted to direct those questions to the HUB coordinator at Cheryl.Bradley@hhs.texas.gov.

b. Where it is expressly directed by the Sole Point of Contact that another designated HHSC representative may speak to the Respondent, such as during Contract negotiations. Respondents are required to ensure that communications have been authorized by the Sole Point of Contact before engaging in such communication. Failure to comply with this requirement may result in the disqualification of a Respondent's Solicitation Response.

3.3.4 Solicitation Questions

HHSC will allow written questions and requests for clarification regarding this Solicitation. Questions must be submitted by e-mail to the Sole Point of Contact listed in **Section 3.3.1** by the deadline established in **Section 3.1, Schedule of Events.** Responses to questions or other written requests for clarification will be consolidated and posted to the ESBD and will not be provided individually to requestors.

HHSC reserves the right to amend answers previously posted, prior to the Solicitation response deadline listed in **Section 3.1**, **Schedule of Events**. Amended answers will be posted on the ESBD. It is the Respondent's responsibility to check the ESBD. HHSC also reserves the right to provide a single consolidated response to all similar questions at the agency's sole discretion.

a. All questions and requests for clarification must include the following information:

1. Solicitation number;
2. Solicitation package reference (page number, section, and exhibit or attachment, if applicable; may also reference **Attachment A-2, Procurement Library** documents in this manner, if applicable);
3. Question topic (e.g., "Schedule of Events," or "**Attachment A-1, Pricing Workbook**"); and
4. Question for HHSC.

b. Requestor contact information below must be included in the body of the e-mail and submitted with the question(s):

  1. Company name;
  2. Company representative name;
  3. Phone number; and
  4. E-Mail address.

Questions or requests for clarification received after the deadline in **Section 3.1, Schedule of Events**, may be reviewed by HHSC but may not be answered. Only answers to questions submitted to the Sole Point of Contact in writing, in accordance with this section, are binding.

3.4 PRE-PROPOSAL CONFERENCE

3.4.1 Attendance

HHSC PCS will conduct a pre-proposal conference and HSP webinar. Attendance is optional but highly recommended.

Attendees to virtual pre-proposal conferences are required to send an email to the Sole Point of Contact listed in **Section 3.3.1**, advising of participation in the pre-proposal conference and HSP training. Attendees must provide their name, phone number, and name of the company they are representing regardless of whether the pre-proposal conference is in-person or virtual.

3.4.2 Conference Logistical Information

HHSC PCS will hold the pre-proposal conference and HSP webinar on the date and time set out in **Section 3.1, Schedule of Events.**

People with disabilities who wish to attend the meeting and require auxiliary aids or services should contact the Sole Point of Contact identified in **Section 3.3.1, Sole Point of Contact**, at least seventy-two (72) hours before the meeting in order to have reasonable accommodations made by HHSC.

Participants must register for the webinar conference prior to the event. After registration, participants will receive another email with the actual link to the webinar.

Webinar Information:

Webinar Link: https://attendee.gotowebinar.com/register/7581081416981877518

Audio Only: 1 (631) 992-3221

At prompt enter passcode: 622-636-360

3.4.3 Questions at Pre-Proposal Conference

a. Reference **Section 3.3.4, Solicitation Questions** for the required format and information to be provided for submission of questions and requests for clarification.

b. Attendees may submit questions at the conference. All questions must be in the required format and include the information as referenced in **Section 3.3.4, Solicitation Questions**.

c. During the conference, HHSC may provide responses to questions and requests for clarification, but only written responses posted by HHSC PCS as an Addendum to the Solicitation on the ESBD will be considered an official, binding update to the Solicitation.

d. HHSC reserves the right to amend, prior to the Solicitation Response Deadline, answers previously posted. Amended answers will be posted on the ESBD. Notification of posting will be in accordance with **Section 3.1, Schedule of Events**.

e. Conversations with HHSC program area staff **before or after the pre-proposal conference and HSP training** are prohibited.

3.5 PROCUREMENT LIBRARY

HHSC will maintain a **Procurement Library** for this Solicitation containing certain reference information that will be located on the ESBD. HHSC will update, add, or remove documents in the **Attachment A-2, Procurement Library** as needed, and it is the Respondent's responsibility to check the ESBD for any updates that will be posted via an Addenda.

3.6 SOLICITATION RESPONSE COMPOSITION

3.6.1 General Information

Failure to submit all required Solicitation Response documents in the required format(s) may result in disqualification of the Solicitation Response without further consideration **Section 3.7.3, Submission Checklist.** Respondent shall prepare a Solicitation Response that clearly and concisely represents its qualifications and capabilities. Expensive bindings, colored displays, promotional materials, etc. are not necessary or desired. Respondent should focus on the instructions and requirements of the Solicitation.

3.6.2 Page Limit and Supporting Documentation

The Narrative Proposal, described in Article V, must not exceed three hundred (300) pages in length, not including supporting documentation provided as appendices or attachments to the Narrative Proposal. A Narrative Proposal may be submitted with supporting documentation if (1) complete and concise responses cannot be provided within the Narrative Proposal without referencing the supporting documentation, (2) the Narrative Proposal clearly specifies the location (e.g., file, page, section, and/or paragraph) where the supporting information can be found, and (3) such supporting documentation is submitted as part of the Solicitation Response.

The Narrative Proposal must be properly paginated, formatted as an 8 ½" x 11" page with 1-inch margins, and use a 12 point or larger font, except that a smaller font may be used for page headers and footers, footnotes, and illustrations such as tables, charts, diagrams, figures, graphs and other visual aids. If a font smaller than 12 point is used, the text when printed on 8 ½" x 11" paper must not require magnification to be legible. Times New Roman font is preferred.

The Narrative Proposal must not include other documents embedded as electronic files within the text. The Narrative Proposal, including supporting documentation, submitted as an electronic file should be pre-formatted for printing on 8 ½" x 11" paper.

3.6.3 Discrepancies

In the event of any discrepancies or variations between copies, HHSC is under no obligation to resolve the inconsistencies and may make its scoring and selection decisions, accordingly, including the decision to potentially disqualify a Solicitation Response. If Respondent is required to designate an "Original" Solicitation Response but fails to do so, HHSC, in its sole discretion, will determine the version to be used as the original or may disqualify the Solicitation Response. If the Respondent submits a redacted Solicitation Response as the "Original," HHSC will disqualify the Solicitation Response and it will not be evaluated. HHSC will not accept submissions after the "Deadline for Submission of Solicitation Responses" in the **Schedule of Events, Section 3.1** to remedy discrepancies or variations in Solicitation Response submissions.

3.6.4 Exceptions

Respondents are highly encouraged, in lieu of including exceptions in their Solicitation Responses, to address all issues that might be advanced by way of exception by submitting such issues as questions or requests for clarification pursuant to **Section 3.3.4, Solicitation Questions**.

Any exception included in a Solicitation Response may result in a Respondent not being awarded a Contract. If a Respondent includes exceptions in its Solicitation Response, Respondent is required to use the **Exceptions Form** included as **Exhibit F** to this Solicitation and provide all information requested on the form. Any exception that does not provide all required information in the format set forth in **Exhibit F** may be rejected without consideration.

No exception, nor any other term, condition, or provision in a Solicitation Response that differs, varies from, or contradicts this Solicitation will be considered to be part of any Contract resulting from this Solicitation unless expressly made a part of the Contract in writing by HHSC.

3.6.5 Assumptions

Respondent must identify on the **Exhibit G, Assumptions Form** any business, economic, legal, programmatic, or practical assumptions that underlie the Respondent's response to the Solicitation. HHSC reserves the right to accept or reject any assumptions. All assumptions not expressly identified and incorporated into any Contract resulting from this RFO are deemed rejected by HHSC.

3.6.6 Binding Offer

A Solicitation Response should be responsive to the Solicitation as worded and without any assumption that any or all terms, conditions, or provisions of the Solicitation will be negotiated. Furthermore, all Solicitation Responses constitute binding offers. **Any Solicitation Response that includes any type of disclaimer or other statement indicating that the response does not constitute a binding offer may be disqualified.**

If a Respondent's ability to enter into a Contract is contingent upon any exception or assumption provided in accordance with **Section 3.6.4, Exceptions** or **Section 3.6.5,**

Assumptions, the Respondent may be disqualified from further consideration for Contract award.

3.7 Solicitation Response Submission and Delivery

3.7.1 Deadline

Solicitation Responses must be received at the address in **Section 3.7.4, Labeling and Delivery for USB Submission and Other Materials** and time stamped by HHSC PCS no later than the date and time specified in **Section 3.1, Schedule of Events**.

Solicitation Responses received after the deadline specified in Section 3.1, Schedule of Events will be rejected and not considered for Contract award.

3.7.2 Submission Option

a. Submission Option #1**:** Respondent shall submit two USB drives—one (1) labeled "Original Proposal" and one (1) labeled "Copy"—containing the following documents:

1. Each USB must contain one file named "Original" that contains the Respondent's entire Solicitation Response (except the cost proposal and HUB Subcontracting Plan) in searchable portable document format (PDF), unless otherwise specified for a particular attachment or exhibit.
2. If applicable in accordance with **Section 9.1.5**, **Public Information Act – Respondent Requirement Regarding Disclosure,** each USB must contain one file named "Public Information Act Copy" that contains the Respondent's entire Solicitation Response, including all exhibits and attachments, in searchable PDF.
3. In accordance with **Section 7.1, Cost Proposal**, one (1) file named "Pricing Narrative" that contains the Respondent's cost proposal in searchable PDF.
4. In accordance with **Section 7.1, Cost Proposal**, one (1) file named "Pricing Workbook" that includes the completed Exhibit in MS Excel format with active formulas (compatible with Microsoft Office 2016).
5. In accordance with **Section 6.8**, **HUB Subcontracting Plan,** each USB must contain one file named "HUB Subcontracting Plan" in searchable PDF, that contains the Respondent's HUB Subcontracting Plan and all supporting documentation.

b. Submission Option #2: Respondent shall submit the following through the Online Bid Room utilizing the procedures in **Exhibit K, Online Bid Room Instructions**:

1. One file named "Original" that contains the Respondent's entire Solicitation Response (except the cost proposal and HUB Subcontracting Plan) in searchable portable document format (PDF), unless otherwise specified for a particular attachment or exhibit.

2. If applicable in accordance with **Section 9.1.5, Public Information Act – Respondent Requirements Regarding Disclosure**, one file named "Public Information Act Copy" that contains the Respondent's entire Solicitation Response, including all exhibits and attachments, in searchable PDF.
3. In accordance with **Section 7.1, Cost Proposal**, one (1) file named "Pricing Narrative" that contains the Respondent's cost proposal in searchable PDF.
4. In accordance with **Section 7.1, Cost Proposal**, one (1) file named "Pricing Workbook" that includes the completed Exhibit in MS Excel format with active formulas (compatible with Microsoft Office 2016).
5. In accordance with **Section 6.8**, **HUB Subcontracting Plan**, one (1) file named "HUB Subcontracting Plan" in searchable PDF, that contains the Respondent's HUB Subcontracting Plan and all supporting documentation.

3.7.3 Submission Checklist

Solicitation Consideration and Award Consideration Documents, reference **Section 1.2, Definitions** must be submitted by the deadline for Solicitation Response submissions, reference **Section 3.1, Schedule of Events**. Solicitation Consideration Documents will be reviewed as received, and Respondent will not have an opportunity to remedy missed requirements. At its sole discretion, HHSC may request some or all of the Respondents to remedy missing elements of Award Consideration Documents. Those marked "SC" are Solicitation Consideration Documents and those marked "AC" are Award Consideration Documents.

The Solicitation Response must be submitted using one of the approved methods identified in **Section 3.7, Solicitation Response Submission and Delivery**. Below are the documents required to be submitted with the Solicitation Response. Where searchable PDF files are required, submission of non-searchable (image only) PDF files may result in disqualification from further consideration for Contract award.

A.	**Proposal and Respondent Information**			
1.	Narrative Proposal	(Section 5.1)	SC	____
2.	Company Information	(Section 6.1)	SC	____
3.	Franchise Tax – Right to Transact Business in Texas	(Section 6.2)	AC	____
4.	References	(Section 6.3)	AC	____
5.	Major Subcontractor Information	(Section 6.4)	SC	____
6.	HHS Solicitation Affirmations V 2.2	(Section 6.5, Exhibit A)	SC	____
7.	Federal Assurances – Non-Construction Programs	(Section 6.5, Exhibit D)	AC	____

8.	Certification Regarding Lobbying	(Section 6.5, Exhibit E)	AC	____
9.	Exceptions (if applicable)	(Section 3.6.4, Exhibit F)	AC	____
10.	Assumptions (if applicable)	(Section 3.6.5, Exhibit G)	AC	____
11.	Dun and Bradstreet Report	(Section 6.7.1)	AC	____
12.	Financial Statements and Financial Solvency	(Section 6.7.2)	AC	____
13.	Corporate Guarantee	(Section 6.8)	AC	____
14.	Data Use Agreement and Security Privacy Inquiry	(Section 2.3, Exhibit H-1)	AC	____
15.	Secretary of State Certification	(Section 6.10)	AC	____
16.	Insurance	(Section 9.2., Exhibit J)	AC	____
B.	**Cost Proposal**			
17.	Pricing Narrative	(Article VII)	SC	____
18.	Pricing Workbook	(Article VII, Attachment A-1)	SC	____
C.	**HUB Subcontracting Plan and Submittal Requirements**	(Section 6.9 and Exhibit I)	SC	____

3.7.4 Labeling and Delivery for USB Submission and Other Materials

Respondent must deliver Solicitation Responses submitted via USB by one of the methods below.

Overnight/Express/Priority Mail	Hand Delivery
Health and Human Services Commission ATTN: Response Coordinator Tower Building, Room 108 1100 W. 49th St., MC 2020 Austin, Texas 78756	Health and Human Services Commission ATTN: Response Coordinator 1100 W. 49th St., MC 2020 Austin, Texas 78756

BE ADVISED, all Solicitation Responses become the property of HHSC after submission and will not be returned to the Respondent. It is the Respondent's responsibility to appropriately mark and deliver the Solicitation Response to HHSC PCS by the specified date. A U.S. Postal Service (USPS) postmark or round validation stamp; a mail receipt with the date of mailing, stamped by the USPS; a dated shipping label, invoice of receipt from a commercial carrier; or any other documentation in lieu of the on-site time stamp WILL NOT be accepted.

Each Respondent is solely responsible for ensuring its Solicitation Response is submitted in accordance with all Solicitation requirements, including, but not limited to, proper labeling of packages, sufficient postage, or delivery fees, and ensuring timely receipt by HHSC. **In no event will HHSC be responsible or liable for any delay or error in delivery. Solicitation Response must be RECEIVED by HHSC PCS by the Solicitation Response Deadline identified in Section 3.1, Schedule of Events.**

Solicitation Responses submitted via USB by mail or hand delivery shall be placed in a sealed package. The sealed package and the USB drives shall be clearly labeled on the outside as follows:

SOLICITATION NO:	HHS0011055
SOLICITATION NAME	EVV System Management Services
SOLICITATION RESPONSE DEADLINE	June 7, 2022 @ 10:30 AM Central Time
PURCHASER NAME:	Andrick Reese, CTCD, CTCM
RESPONDENT NAME:	

It is Respondent's sole responsibility to ensure that packaging is sufficient to prevent damage to contents. HHSC will not be responsible or liable for any damage, and damaged Solicitation Responses will not be considered at HHSC sole discretion.

HHSC will not be held responsible for any Solicitation Response that is mishandled prior to receipt by HHSC PCS. It is the Respondent's sole responsibility to mark appropriately and deliver the Solicitation Response to HHSC PCS by the specified date and time. HHSC will not be responsible for late delivery, inappropriately identified documents, or other submission errors that may lead to disqualification or nonreceipt of the Respondent's Solicitation Response.

3.7.5 Modifications and Withdrawals

Prior to the Solicitation Response submission deadline in **Section 3.1, Schedule of Events**, Respondent may: (1) withdraw its Solicitation Response by submitting a written request to the Sole Point of Contact identified in **Section 3.3.1, Sole Point of Contact**; or (2) modify its Solicitation Response by submitting a written amendment to the Sole Point of Contact identified in **Section 3.3.1, Sole Point of Contact**. When modifying its Solicitation Response, Respondent must include in writing the section(s) of its submission that will be replaced or removed by the amendment.

ARTICLE IV. SOLICITATION RESPONSE EVALUATION AND AWARD PROCESS

4.1 CONFORMANCE WITH STATE LAW

Solicitation Responses shall be evaluated in accordance with Texas Government Code §2157.003. HHSC shall not be obligated to accept the lowest priced Solicitation Response

but shall make an Award to the Respondent that provides the best value to the State of Texas.

4.2 BEST VALUE DETERMINATION

4.2.1 Selection Methodology

Solicitation Responses that meet the minimum qualifications will be submitted to the evaluation team for review and scoring. Each member of the evaluation team will receive a copy of each responsive Solicitation Response. The evaluators will review the Solicitation Responses considering the criteria listed in **Section 4.2.5, Written Response Evaluation Criteria**.

Evaluators will individually score the Solicitation Responses. This procurement will utilize an aggregated individual evaluation methodology as outlined by this section. Demonstrations will be used to make a selection for Contract award, as outlined by this section.

The following subsections describe the evaluation process, including any criteria for advancement to the various phases of evaluation, if applicable.

4.2.2 Minimum Qualifications

Respondents must meet the minimum qualifications listed below. Failure to meet any of the minimum qualifications below will result in disqualification without the opportunity to remedy any discrepancies. Respondents should ensure they are providing adequate documentation to meet the requirements below upon submission of the Solicitation.

a. **THE RESPONDENT MUST AFFIRM THE FOLLOWING IN ITS RESPONSE:**

   "<LEGAL NAME OF RESPONDENT> HAS THE ABILITY TO CONTRACT WITH AN SPSO TO OPERATE A STATE POOL SYSTEM IN COMPLIANCE WITH THE REQUIREMENTS STATED IN THIS SOLICITATION NO LATER THAN TWO (2) CALENDAR DAYS FOLLOWING THE CONTRACT EFFECTIVE DATE;

b. Respondents must have a minimum of five (5) years of experience operating, providing, and maintaining EVV Systems and Services or the Principals/Owners must have five (5) years of recent ownership or executive management experience in a company that provided Services for projects of similar size and scope, see **Section 6.1.1, Company Narrative;**
c. Respondents must submit at least three (3) references from projects performed within the last five (5) years that demonstrate the Respondent's ability to perform the SOW described in the Solicitation see **Section 6.1.2, References**; and
d. Respondents must provide documentation that the systems being considered for the State Pool System is/has been CMS certified in at least one (1) state in the United States; must include accessibility disclosure information. This can be in the form of a Voluntary Product Accessibility Template® VPAT® or another method that provides substantially the same information. Refer to **Exhibit L, Voluntary Product Accessibility Template® (VPAT)®.**

4.2.3 Initial Compliance Screening

HHSC will review Solicitation Responses for compliance with **Section 3.7.3**, **Submission Checklist** and for demonstrated ability to meet the minimum qualifications listed in **Section 4.2.2, Minimum Qualifications** required to advance to evaluations. Failure to meet the minimum qualifications listed in **Section 4.2.2, Minimum Qualifications** will result in the disqualification of the Solicitation Response.

HHSC will automatically disqualify any Solicitation Response that does not include one or more of the completed and signed (as applicable) Solicitation Consideration Documents listed in **Section 3.7.3, Submission Checklist**.

At its sole discretion, HHSC may disqualify any Solicitation Response that does not include all required Award Consideration Documents. Refer to **Section 3.7.3, Submission Checklist.**

HHSC may contact references provided in response to this Solicitation. HHSC may contact Respondent's clients, or solicit information from any available source, including the Comptroller's VPTS. Any information received may be grounds for disqualification if that information, in HHSC's sole discretion, suggests that the Respondent may perform poorly if selected.

4.2.4 Written Solicitation Response Evaluation

Each member of the evaluation team will read the Solicitation Responses in preparation for evaluation. The evaluation team will score all Solicitation Responses that pass initial screening described in **Section 4.2.3, Initial Compliance Screening.** Solicitation Responses will be scored against the criteria in **Section 4.2.5, Written Response Evaluation Criteria.**

Solicitation Responses will be evaluated utilizing aggregated individual scoring and any other methods outlined in **Article IV, Solicitation Response Evaluation and Award Process**. The individual evaluators' scores will be aggregated and weighted, resulting in the Final Written Response Scores, unless BAFOs are conducted.

4.2.5 Written Response Evaluation Criteria

Solicitation Responses shall be consistently evaluated and scored in accordance with the following criteria. See also, **Exhibit M, Evaluation Tool**.

1. Project Work Plan (50%)
2. Relevant Qualifications, Past Performance and Experience (10 %)
3. Personnel, Organization and Qualifications (10 %)
4. Cost and Comprehensiveness of Pricing Schedule (30 %)

4.2.6 Advancement Criteria

After the written Solicitation Response evaluation, Respondents may be selected for invitation to Demonstrations using the Advancement Criteria specified by this section. Advancement to Demonstrations will be determined by the Competitive Range.

HHSC will limit advancement to secondary evaluation activities, and further award consideration, to Respondents that meet the specified Advancement Criteria.

The Competitive Range will consist of the Solicitation Responses that receive the highest scores or most satisfactory ratings, based on the published evaluation criteria and

procedures governing this procurement. Cutoff for the Competitive Range will be based on the "natural break" in scores and on reasoned judgment that Solicitation Responses below the cutoff cannot be made successful through clarification and negotiation. By way of example, in a scenario where initial evaluation scores are 97, 93, 82, 81, 79 and 68, the Competitive Range may include only the top two Respondents. HHSC is not obligated to enforce a natural break in scores and reserves the right to advance as many or as few Proposals as qualified under this criteria.

4.2.7 Demonstrations

To further identify the Respondent providing best value, Demonstrations may be requested. The Advancement Criteria, as described by **Section 4.2.6, Advancement Criteria**, will be utilized to determine which Respondents will advance to Demonstrations.

Respondents selected for Demonstrations will be the final group of Respondents eligible for award. Demonstrations will allow for points to be added to Final Written Response Score in accordance with **Section 4.2.8, Demonstration Criteria.**

Respondents will be provided with advance notice of any such Demonstration and are responsible for their own presentation equipment. Advance notice will include an agenda and specific scenarios or use cases for each category or criteria listed in **Section 4.2.8, Demonstration Criteria.** Failure to participate in the requested Demonstration may eliminate a Respondent from further consideration. HHSC is not responsible for any costs incurred by the Respondent in preparation for any Demonstration. All costs incurred by Respondent are the responsibility of Respondent.

4.2.8 Demonstration Criteria

Demonstrations may add up to a possible ten (10) additional points to a Respondent's Final Written Solicitation Response Score.

The opportunity to participate in **Demonstration** will be given in accordance with **Section 4.2.1 Selection Methodology**.

Demonstrations will be scored based on Respondent's performance under the categories included in **Table 35 – Demonstration Use Cases** below. Specific Use Cases will be provided only to those respondents who meet the advancement criteria listed in **Section 4.2.6, Advancement Criteria.**

Table 35 – Demonstration Use Cases provides a description of the categories of Use Cases that the Respondent will be expected to demonstrate.

Table 35 – Demonstration Use Cases

#	Use Case Category
1	Clock-in and Clock-out Methods
2	Visit Maintenance
3	Profile Setup
4	Reporting

When considering the success of each scenario, Evaluators may refer to the following table and may consider some or all of the usability guidelines listed below and will score the categories in accordance with **Exhibit P, Demonstration Consensus Scoring Rubric**.

(Remainder of this page intentionally left blank)

Table 36 – Guidelines for Use Case Evaluation

Guidelines for Use Case Evaluation		
#	**Guideline**	**Explanation**
1	Visibility of system status	The system shall keep users informed about what is going on, through appropriate feedback within reasonable time.
2	Match between system and the real world	The system shall speak the user's language with words, phrases, and concepts familiar to the user, rather than system-oriented terms. Follow real-world conventions and make information appear in natural order.
3	User control and freedom	Users often choose system functions by mistake and will need a clearly marked "emergency exit" to leave the unwanted state without having to go through an extended dialogue. Support undo and redo.
4	Consistency and standards	Users shall not have to wonder whether different words, situations, or actions mean the same thing. Follow platform conventions.
5	Error prevention	Even better than good error messages, is a careful design which prevents a problem from occurring in the first place. Eliminate error-prone conditions or handle them gracefully.
6	Recognition rather than recall	Minimize the user's memory load by making objects, actions, and options visible. The user shall not have to remember information form one part of the dialogue to another.
7	Flexibility and efficiency of use	Accelerators – unseen by the novice user – may often speed up interaction for the expert user such that the system can cater to both inexperienced and experienced users.
8	Help users recognize, diagnose, and recover from errors	Error messages shall be expressed in plain language (no codes), precisely indicate the problem, and constructively suggest a solution.
9	Avoid hard mental Operations and lower workload	Do not force the user into hard mental operation and keep the user's workload at a minimum.
10	Avoid forcing the user to premature commitment	Do not force the user to perform a particular task or decision until it is needed. Will the user know why something must be done?
11	Provide functions that are of utility to the user	Consider whether the functionality described is likely to be useful to users and whether functions/data are missing.

Source: Kasper Hornbæk, University of Copenhagen, Dept. of Computer Science; Rune Thaarup Høegh, Aalborg University, Dept. of Computer Science; Michael Bach Pedersen, ETI A/S, Bouet Moellevej; and Jan Stage, University of Copenhagen, Dept. of Computer Science (2007), Use Case Evaluation (UCE): A Method for Early Usability Evaluation in Software Development.

4.2.9 Best and Final Offer (BAFO)

HHSC may, at its sole discretion, following the execution of **Section 4.2.1, Selection Methodology** request BAFOs from all Respondents or, if applicable, only those

Respondents whose Solicitation Responses meet the Advancement Criteria listed in **Section 4.2.6, Advancement Criteria**. The request for a BAFO will allow a Respondent the opportunity to revise its original Solicitation Response, including pricing, or leave its Solicitation Responses originally submitted. Revisions must be submitted in the manner and form prescribed by the BAFO request. Requests will be sent to the point of contact provided by the Respondent. HHSC is not responsible for a Respondent's failure to timely receive the BAFO request.

HHSC reserves the right to request more than one BAFO from each of the selected Respondents. If a response is submitted to a request for a BAFO, the Final Written Response Scores or Total Score as outlined by **Section 4.2.10, Final Written Response Score and Total Score** will be revised in accordance with the stated criteria in **Section 4.2.5, Written Response Evaluation Criteria** as to any changes made to the Respondent's original Solicitation Response. A request for a BAFO does not guarantee an award or further negotiations.

If BAFOs are requested by HHSC and submitted by the Respondent, they will be evaluated using the criteria stated in the BAFO invitation, scored, and ranked by the evaluation committee. The award will then be granted to the highest scoring Respondent. However, a Respondent should provide its best offer in its original Solicitation Response. Respondents should not expect or assume that HHSC will request a BAFO.

4.2.10 Final Written Response Score and Total Score

A Respondent that does not meet the Advancement Criteria listed in **Section 4.2.6, Advancement Criteria** will not be asked to Demonstrations, will receive no points for the Demonstrations added to their Final Written Response Score, their Final Written Response Score will be considered their Total Score, and the Respondent will not be further considered for Contract award. For Respondents meeting the Advancement Criteria and who are invited to Demonstrations, up to ten (10) additional points may be added to the Final Written Response Score. The Total Score will be the Final Written Response Score plus any additional points received. If BAFOs are conducted, the Total Score may be adjusted in accordance with **Section 4.2.9, Best and Final Offer**. Total Score may not always determine best value or selection for negotiation and award, see **Section 4.2.11, Summary of Best Value Determination** for more information.

4.2.11 Summary of Best Value Determination

The final selection for award will be based on best value, as determined by this section. This includes any scoring adjustments for outliers, interviews, best and final offers, oral presentations, demonstrations, site visits, or other additional considerations as specified by this solicitation. Respondents are encouraged to thoroughly review the processes outlined in this section, as it documents the best value considerations to be made by HHSC when selecting a Respondent for negotiation and Contract award.

4.3 QUESTIONS OR REQUESTS FOR CLARIFICATION

By submitting a Solicitation Response, Respondent grants HHSC the right to ask questions, request clarifications and to obtain any information from any lawful source regarding the past history, practices, conduct, ability, and eligibility of the Respondent to supply Goods or Services and to fulfill requirements under this RFO, and the past history, practices, conduct, ability, and eligibility of any director, officer, or key employee of the Respondent.

By submitting a Solicitation Response, the Respondent generally releases from liability and waives all claims against any party providing information about the Respondent at the request of HHSC. Such information may be taken into consideration in evaluating the Solicitation Response.

ARTICLE V. NARRATIVE PROPOSAL

5.1 NARRATIVE PROPOSAL

5.1.1 Transmittal Letter (Section 1)

The Respondent will provide a transmittal letter, signed by an individual authorized to legally bind the Respondent to the terms and conditions of this Solicitation and identifying the individuals authorized to negotiate on behalf of the Respondent. This letter will also include contact information for these individual(s).

5.1.2 Executive Summary (Section 2)

The Respondent must provide a high-level overview of the Respondent's approach to meeting the requirements contained in **Article II**, **Scope of Work**. The summary must demonstrate an understanding of HHSC's goals and objectives for this Solicitation. The Executive Summary must not exceed five (5) pages and must represent a full and concise summary of the Solicitation Response for the Contractor EVV System Management Services.

5.1.3 Project Work Plan (Section 3)

The Respondent must describe the Respondent's proposed processes and methodologies for providing all components described in **Article II**, **Scope of Work,** including the Respondent's approach to meeting the Project Work Schedule. Respondent must identify all tasks to be performed, including all Project activities, materials and other products, Services, and reports to be generated during the Contract Term and relate them to the stated purpose(s) and specifications described in this Solicitation.

The Respondent’s Project Work Plan must reflect a clear understanding of the nature of the Work to be undertaken and must include detailed descriptions of how the Respondent intends to meet each Work requirement within the proposed solution. Responses which simply repeat the requirement or include marketing materials will be considered non-responsive.

The Respondent's proposal for the Project Work Plan must be submitted in the following structure, and include a description of the following business and service components:

a. Project Management - see **Section 5.1.3.1, Project Management Proposal** for description;
b. Transition and Conversion - see **Section 5.1.3.2, Transition and Conversion** for description;
c. State Pool System - see **Section 5.1.3.3, State Pool System** for description;
d. Application Services - see **Section 5.1.3.4, Application Services** for description;
e. Business Services - see **Section 5.1.3.5, Business Services** for description;
f. Certification - see **Section 5.1.3.6, Certification** for description;
g. Turnover - see **Section 5.1.3.7, Turnover** for description; and

h. Appendices - see **Section 5.1.3.8, Appendices** for description.

5.1.3.1 Project Management Proposal

The Respondent must provide a detailed description of how the Respondent proposes to meet each requirement under **Section 2.1.4.1**, **Project Management Requirements**; **Section 2.1.4.2, Staffing Requirements**; **Section 2.1.4.3, Contractor Facility Requirements**; **Section 2.1.4.4, Deliverables Requirements**; and **Section 2.1.4.6, Communication Requirements**.

5.1.3.2 Transition and Conversion

The Respondent must provide a detailed description on how the Respondent proposes to meet each requirement under **Section 2.1.3, Transition Requirements**. The Respondent is responsible for demonstrating an in-depth knowledge of conversion tasks necessary to move data from a legacy system to a service provider.

5.1.3.3 State Pool Systems

The Respondent must provide a detailed description on how the Respondent proposes to meet each requirement under **Section 2.1.5, State Pool System Management and Oversight Requirements**, **Section 2.1.6, State Pool System Operations Requirements**, **Section 2.1.6.1, Customer Support Requirements**, **Section 2.1.6.2, Call Center Requirements**, **Section 2.1.6.3, State Pool System Training Requirements**, and **Section 2.1.6.7, Alternative Device Management Requirements**.

Respondent must provide a detailed description on the Respondent's approach and timeline for onboarding the proposed State Pool System in accordance with the **State Pool System Onboarding Plan**.

Respondent must provide a detailed Project Work Schedule to execute the contract with the proposed SPSO to meet transition milestones as of the Contract Effective Date.

5.1.3.4 Application Services

The Respondent must provide a detailed description on how the Respondent proposes to meet each requirement under **Section 2.1.4.5, Business Continuity and Disaster Recovery Requirements**; **Section 2.1.4.9, Security Requirements**; **Section 2.1.4.10, Testing Requirements**; **Section 2.1.6.4, System Requirements;** and **Section 2.1.6.6, MITA Requirements**.

The Respondent is responsible for providing a service which minimizes the frequency and impact of system failures, reduces downtime, and minimizes recovery time in the event of catastrophic failure. In this section, provide details on the Respondent's approach to meeting those responsibilities.

The Respondent must describe the Respondent's approach to security architecture, including measures that provide security and protection for the States data.

The Respondent must detail the proposed approach to system support, including the levels of support offered and the process for requesting support.

The Respondent must describe the Respondent's approach to facilitating integration efforts for the proposed system with other information systems.

5.1.3.5 Business Services

The Respondent must provide a detailed description on how the Respondent proposes to meet each requirement under **Section 2.1.4.7, Support Services Requirements**; **Section 2.1.4.8, Litigation Support Requirements**; **Section 2.1.4.11, Training Requirements**; and **Section 2.1.7, Proprietary System Management and Oversight Requirements**.

5.1.3.6 Certification

The Respondent must provide a detailed description of how the Respondent proposes to meet each requirement under **Section 2.1.6.5, CMS Certification Requirements**. The Respondent is responsible for providing a Response which shows a thorough understanding of CMS certification processes and the Respondent's part in attaining CMS certification.

5.1.3.7 Turnover

The Respondent must provide a detailed description of how the Respondent proposes to meet each requirement under **Section 2.1.4.12, Turnover Requirements**. Responses must demonstrate total agreement for timeframes and data Turnover requirements.

5.1.3.8 Appendices

Respondent must include as part of the Respondent's proposed solution the following documents as part of the Solicitation response:

a. Project Work Schedule;
b. High Level Transition Plan; and
c. Training Plan.

The Deliverables and plans must demonstrate how the Respondent proposes to meet the requirements and transition timeline of this Solicitation: Plans and Transition timeline must clearly articulate strategies Respondent will use to meet the proposed go-live date of **August 1, 2023**.

In addition, Respondent must complete the following if applicable:

a. **Exhibit F, Exceptions Form;** and
b. **Exhibit G, Assumptions Form**.

5.1.4 Organization Structure and Key Personnel Profile (Section 4)

Respondent must provide the proposed organizational structure to deliver the Services requested under this Solicitation with key personnel positions identified.

Respondent must provide the following for key personnel that will be responsible for the performance of the Services requested under this Solicitation:

a. Candidate profile;
b. Resume; and
c. Two (2) external written references.

The profile, resume, and references must depict relevant and current experience no more than seven (7) years prior to the date of the issuance date of the Solicitation.

ARTICLE VI. REQUIRED RESPONDENT INFORMATION

6.1 COMPANY INFORMATION

In accordance with **Article III, Administrative Information**, Respondents must include the following information with their responses:

6.1.1 Company Narrative

Respondents must provide a detailed narrative explaining why they are qualified to provide the Services enumerated in **Article II, Scope of Work,** focusing on their key strengths and competitive advantages.

6.1.2 Company Profile

Respondents must provide a company profile, including:

a. Their ownership structure (e.g., corporation, partnership, LLC, or sole proprietorship), including any wholly owned subsidiaries, affiliated companies, or joint ventures. (*Please provide this information in a narrative and as a graphical representation.*) If Respondent is an affiliate of, or has a joint venture or strategic alliance with, another company, Respondent must identify the percentage of ownership of each joint venture member or affiliate and the percentage of the parent's ownership. The entity performing the majority of the Work under any Contract resulting from this RFO, throughout the duration of the Contract, must be the primary bidder. Finally, Respondents must provide their proposed operating structure for the Services requested under this Solicitation and which entities (i.e., parent company, affiliate, joint venture, subcontractor) will be performing them;

b. The year the company was founded and/or incorporated. If incorporated, please indicate the state where the company is incorporated and the date of incorporation;

c. The location of company headquarters and any field office(s) that may provide Services for any resulting Contract under this Solicitation;

d. The number of employees in the company, both locally and nationally, and the location(s) from which employees will be assigned;

e. The name, address, and telephone number of Respondent's point of contact for any resulting Contract under this Solicitation;

f. The name, address, and telephone number of Respondent's point of contact for any questions regarding the Solicitation Response;

g. Indicate whether the company has ever been in contract with any Texas state agency. If "Yes," specify the contract term, for what duties, and for which agency; and

h. Respondents must provide documentation that the systems being considered for the State Pool System is/has been CMS certified in at least one (1) State in the United States.

6.2 Franchise Tax – Right to Transact Business in Texas

The Texas franchise tax is imposed on each taxable entity formed or organized in Texas or doing business in Texas. Respondent must provide their 11-digit Comptroller's Taxpayer Number or the 9-digit Federal Employer's Identification Number.

Respondent must be set up in the Texas franchise tax system prior to Contract award. Texas franchise tax information can be accessed at https://comptroller.texas.gov/taxes/franchise/.

6.3 References

Respondents shall provide a minimum of three (3) references from similar contracts or projects performed, preferably for state and/or local government, within the last five (5) years. Respondents must verify current contracts and provide the following information:

a. Client name;

b. Contract/Project description;

c. Total dollar amount of contract/Project;

d. Key staff assigned to the referenced contract/Project who will be designated for Work under any Contract resulting from this Solicitation; and

e. Client contract/Project manager name, telephone number, fax number, and email address.

6.4 Major Subcontractor Information

Respondents must identify any major subcontractors who will perform fifteen percent (15%) or more of the Work under any Contract resulting from this Solicitation. Respondents must indicate whether or not they hold any financial interest in any major subcontractor. As a condition of award, an authorized officer or agent of each proposed major subcontractor may be required to sign a statement to the effect that the Subcontractor has read, and will agree to abide by, Respondent's obligations under any Contract awarded pursuant to this Solicitation.

6.5 Affirmations and Certifications

Respondents must complete and return with their Solicitation Response all of the following affirmations and certifications:

a. **Exhibit A, HHS Solicitation Affirmations V2.2;**

b. **Federal Assurances and Certifications:**

   1. **Exhibit D, Federal Assurances – Non-Construction Programs;**

   2. **Exhibit E, Certification Regarding Lobbying; and**

c. **Exhibit H-1, Attachment 2 to the DUA, Security and Privacy Inquiry (SPI).**

6.6 Sample Contract Signature Document and Contract Affirmations V.2.1

A **Sample Contract Signature Document** is attached and incorporated into the Solicitation as **Exhibit V** and **Contract Affirmations V.2.1** is attached and incorporated into the Solicitation as **Exhibit A**. Please be advised that a Contract Signature Document and the Contract Affirmations V.2.1 will be incorporated into the Contract that results from the Solicitation. The Contract Signature Document is provided only as an example and is subject to revision based upon negotiations between the parties to the resultant Contract.

Please be advised that **Exhibit B, HHS Uniform Terms and Conditions V.3.2** and **Exhibit C, HHS Additional Provisions V.1.0**, will be incorporated into the Contract that results from this Solicitation.

6.7 Other Reports

6.7.1 Dun and Bradstreet Reports

Respondents with a Dun and Bradstreet number must include a Comprehensive Insight Plus Report, Business Information Report, or Credit eValuator Report (collectively referred to as "Dunn and Bradstreet Reports") with their Solicitation Response.

6.7.2 Financial Statements and Financial Solvency

a. Respondents must submit electronically in a searchable PDF an annual report, which must include:

   1. Last three (3) years of audited financial statements, including all supplements, management discussion and analysis, and actuarial opinions;
   2. If applicable, last three (3) years of consolidated statements for any holding companies or affiliates and
   3. A full disclosure of any events, liabilities, or contingent liabilities that could affect Respondent's financial ability to perform this Contract.

   At a minimum, financial statements must include:

   i. Balance sheet;

   ii. Income statement;

   iii. Statement of changes in financial position;

   iv. Statement of cash flows; and

   v. Capital expenditures.

b. If the Respondent is a corporation that is required to report to the Securities and Exchange Commission (SEC), Respondent must submit its three (3) most recent SEC Form 10K, Annual Reports, pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934, Title 15 of the United States Code Chapter 2B, Sections 78m or 78o(d). Financial materials must be submitted electronically as a word searchable PDF;

c. If audited financial statements are not available, Respondent must submit unaudited financial information and any other information the Respondent believes meets the requirements of this section. Reference **Section 6.6.3, Alternate Report**. If the submitted documents do not provide adequate assurance of financial stability or

solvency, HHSC reserves the right to request additional information or to disqualify the Respondent;

d. If the Respondent is either substantially or wholly owned by another corporate (or legal) entity, the Respondent must include the information required in this section for each such entity, including the most recent detailed financial report for each such entity; and

e. If HHSC determines that an entity does not have sufficient financial resources to guarantee the Respondent's performance, HHSC may require the Respondent to obtain another acceptable financial instrument or resource from such entity, or to obtain an acceptable guarantee from another entity with sufficient financial resources to guarantee Respondent's performance.

6.7.3 Alternate Report

If any Respondent(s) is unable to provide the annual report specified above, the Respondent(s) may, at the discretion of HHSC, provide the following alternate report:

a. Last three (3) years of unaudited financial statements, including all supplements, management discussion and analysis, and actuarial opinions;

b. An unaudited financial statement of the most recent quarter of operation; and

c. A full disclosure of any events, liabilities, or contingent liabilities that could affect Respondent's financial ability to perform this Contract.

d. At a minimum, such financial statements must include:

   i. Balance sheet;

   ii. Income statement;

   iii. Statement of changes in financial position;

   iv. Statement of cash flows; and

   v. Capital expenditures.

6.8 CORPORATE GUARANTEE

If the Respondent is substantially or wholly owned by another corporate (or other) entity, HHSC reserves the right to request that such entity unconditionally guarantee performance by the Respondent in each and every obligation, warranty, term, covenant, and condition of any Contract resulting from this Solicitation.

6.9 HUB SUBCONTRACTING PLAN

Respondents must submit the HUB Subcontracting Plan in accordance with **Section 3.7, Solicitation Response Submission and Delivery.** The HSP should be labeled: "HUB Subcontracting Plan (HSP)," and include all supporting documentation in accordance with **Exhibit I, HUB Subcontracting Plan and Submittal Requirements**.

A courtesy review of a Respondent's completed HSP is optional and is available upon request to assist in providing a compliant and responsive HSP. This courtesy review may only identify possible deficiencies, but a final compliant determination cannot be provided until the Solicitation Response is submitted.

To request a courtesy review, submit the completed HSP including all supporting documentation in a PDF format by e-mail to the HHSC HUB Program Office by or before the Courtesy Review of HUB Subcontracting Plan Deadline in **Section 3.1**, **Schedule of Events.**

E-Mail for Courtesy Review: Cheryl.Bradley@hhs.texas.gov

E-mail Subject Line: HSP Courtesy Review, No. HHS0011055

Due Date: May 23, 2022, at 10:30 AM CT

HSPs received after the courtesy review deadline in the **Schedule of Events (Section 3.1)**, will not be processed. A response regarding the HSP will be provided at least eight (8) business days prior to the Solicitation Response deadline in **Section 3.1, Schedule of Events** from the HUB Office, allowing enough time to rectify any potential deficiencies for the final HSP submission.

The final HSP must be submitted with the Solicitation Response by the deadline in **Section 3.1, Schedule of Events**. Solicitation Responses that do not include a completed HUB Subcontracting Plan shall be rejected due to material failure to comply with Texas Government Code Section 2161.252(b).

6.10 Secretary of State Certification

The Respondent must be currently authorized to do business in the State of Texas as evidenced by Certificate of Authority from the Texas Secretary of State submitted prior to contract execution.

ARTICLE VII. COST PROPOSAL

7.1 Cost Proposal

As noted above in **Section 3.6, Solicitation Response Composition,** cost information must be included as a separate document/file, the cost proposal, with the Respondent's Solicitation Response for the services listed in **Article II, Scope of Work** and **Article VIII, Financial Approach - Business Terms**.

Respondents must state their pricing for all Goods and Services rendered during the course of any Contract resulting from this Solicitation, including any and all costs involved that are to be paid or reimbursed by HHSC. The pricing for the required Goods and Services is to be presented only in the format set forth in **Attachment A-1, Pricing Workbook** of the RFO. Pricing information shall include all costs associated with providing the required Goods and Services and must be submitted and labeled as specified in **Section 3.7, Solicitation Response Submission and Delivery**. No reimbursement is available to the successful Respondent beyond the amount agreed to be paid for the Goods and Services provided. Pricing agreed to in any resulting Contract shall be firm and remain constant through the life of the Contract.

Cost Proposal Submission is addressed in **Section 3.7.2, Submission Option**.

All Respondents must submit a comprehensive and complete Cost Proposal that meets all the requirements specified within this Solicitation. Cost Proposal consists of two (2) main components - pricing narrative and Pricing workbook. The complete Cost Proposal must contain the following:

Pricing Narrative

Section 1 - Cover Letter;

Section 2 - Cost Proposal, Assumptions and Exceptions, if applicable - **Exhibit F, Exceptions Form** and **Exhibit G, Assumptions Form;**

Section 3 - Transition Phase FTE and Pricing Narrative;

Section 4 - Operations Phase FTE and Pricing Narrative;

Section 5 - Response to Financial Requirements;

Section 6 - Financial Statements;

Section 7 - Financial Security Requirements;

Section 8 - Initial Accounting Policy Manual;

Section 9 - Federal Disclosure Statement; and

Section 10 - Pricing Workbook **- Attachment A-1, Pricing Workbook.**

Note: Respondents must base their Cost Proposal on the requirements stated in this Solicitation. A Respondent must submit a single proposal with pricing for all of the Service Domains provided in Section 7.2 Cost Proposal Instructions.

Respondents must state their pricing for all Goods and Services rendered during the course of any Contract resulting from this Solicitation, including any and all costs involved that are to be paid or reimbursed by HHSC. The pricing for the required Goods and Services is to be presented only in the format set forth in **Attachment A-1, Pricing Workbook**. Pricing information shall include all costs associated with providing the required Goods and Services and must be submitted and labeled as specified in **Section 3.7, Solicitation Response Submission and Delivery**. No reimbursement is available to the Contractor beyond the amount agreed to be paid for the Goods and Services provided. Pricing agreed to in the Contract shall be firm and remain constant through the Contract Term.

Assumptions made by the Respondent responding to this Solicitation do not obligate HHSC in any way. Additionally, Respondent must not make assumptions that result in a conditional offer. If HHSC determines that an offer is conditional, the Solicitation Response may, in HHSC's sole discretion, be rejected.

HHSC will have the right to accept or reject any assumptions. All assumptions not expressly identified and incorporated into the Contract are deemed rejected by HHSC.

Respondent must separately identify any cost-savings and cost-avoidance methods and measures, and the effect of such methods on the Cost Proposal and Scope of Work.

The Respondent will identify and clearly document in its Cost Proposal any overlaps or inconsistencies with any Solicitation requirements, any material assumptions employed by the Respondent in developing its Cost Proposal, and how the Respondent's specific Cost Proposal resolves the issues identified. Additionally, the Cost Proposal must clearly identify where efficiencies would be realized and how HHSC will benefit from these efficiencies.

Cost Proposals should be fully responsive to the requirements in **Article VIII**, **Financial Approach – Business Terms,** and all the Worksheets in **Attachment A-1, Pricing Workbook**. Respondents that do not comply with the requirements and instructions included in this Solicitation may be deemed non-responsive.

7.2 Cost Proposal Instructions

The Respondent shall include all fixed price fees in the Respondent's Cost Proposal. Total fees are required by HHSC for evaluation and budget purposes, while additional detail of rates and costs is required for HHSC's understanding of the proposed price. Pricing shall be based on the Requirements of the Solicitation and not the Respondent's exceptions to the Solicitation. The Respondent is required to state all other assumptions upon which its pricing is being determined in Solicitation **Exhibit F, Exceptions Form** and **Exhibit G, Assumptions Form**, Pricing Workbook, Worksheet Pricing Assumptions. Assumptions that conflict with mandatory requirements of this Solicitation may be cause for disqualification.

The components to be priced in the Respondent's proposal include the following five (5) Service Domains:

1. Fixed Price approach includes the four (4) Service Domains:
    a. Transition (TRA);
    b. General Operations (GOP);
    c. State Pool System Management and Oversight (SPS); and
    d. Proprietary System Management and Oversight (PSM).

In general, the above four (4) Service Domains shall be stated as fixed price with payments based on Deliverables or other payment milestones (e.g., monthly payments).

2. Variable Price approach includes one (1) Service Domain, State Pool System Operations (SPO)

7.2.1 Section 1 – Cover Letter

A Cover Letter referencing the Cost Proposal and Price Summary Sheets will be included in the Respondent's separate, sealed package. This letter will be signed by an individual authorized to legally bind the Respondent for the Cost Proposal and price summary sheet(s) submitted. This individual will complete, sign, and date the Cost Proposal verifying that the enclosed information is valid for two hundred forty (240) Calendar Days from date of submission. The Cover Letter will also separately identify cost-savings and cost-avoidance methods and measures, and the effect of such methods on the Cost Proposal and Scope of Work.

7.2.2 Section 2 – Cost Proposal Assumptions and Exceptions

Pricing shall conform to the Solicitation requirements, including Exhibits, appendices, and HHSC-provided contract terms and conditions. The Respondent is required to state all pricing assumptions upon which pricing is determined. Pricing shall not be based upon the Respondent's assumptions or exceptions to the terms and conditions.

The Respondent's Cost Proposal must include any business, economic, legal, programmatic, or practical assumptions that underlie its Cost Proposal. The Respondent is

required to state all pricing assumptions upon which pricing is determined using **Exhibit F, Exceptions Form** and **Exhibit G, Assumptions Form**.

Assumptions made by the Respondent do not obligate HHSC in any way. Additionally, Respondent must not make assumptions that result in a conditional offer. If HHSC determines that an offer is conditional, the Solicitation Response may, in HHSC's sole discretion, be rejected.

HHSC will have the right to accept or reject any assumptions. All assumptions not expressly identified and incorporated into the Contract are deemed rejected by HHSC.

7.2.3 Section 3 – Transition Phase Full-Time Equivalent (FTE) and Pricing Narrative

Respondent must provide a written narrative justifying the proposed FTEs depicted on **Attachment A-1, Pricing Workbook, TRA_A Worksheet** for the Transition Phase of the Contract by Key Milestone. This information must contain sufficient detail to give HHSC a complete understanding of each FTE. This narrative should include, but not be limited to, the following information:

1. The Transition deliverables to be performed;
2. The number of proposed FTEs for each function;
3. The anticipated start date;
4. The number of weeks necessary to train staff for the respective duties;
5. How proposed staffing levels will support readiness reviews with HHSC program staff; and
6. Any other relevant information that would allow HHSC to better understand the FTEs proposed by the Respondent.

7.2.4 Section 4 – Operations Phase FTE and Pricing Narrative

Respondents must provide a written narrative justifying the proposed FTEs depicted on **Attachment A-1, Pricing Workbook**, **GOP_B Worksheet**, **SPS_B Worksheet**, **PSM_B Worksheet**, and **Variable SPO Fees Worksheet** for the Operations phase of the Contract by each domain, task, and year. This information must contain sufficient detail to give HHSC a complete understanding of each FTE. The following Operations Domains should be covered:

a. General Operations (GOP);
b. State Pool System Management and Oversight (SPS);
c. Proprietary System Management and Oversight (PSM); and
d. Variable State Pool System Operations Fees (SPO).

This narrative should include, but not be limited to, the following information:

1. The operational tasks to be performed;
2. The number of proposed FTEs for each function;
3. The anticipated start date;
4. The number of weeks necessary to train staff for the respective duties;
5. How proposed staffing levels will support readiness reviews with HHSC program staff; and
6. Any other relevant information that would allow HHSC to better understand the FTEs proposed by the Respondent.

7.2.5 Section 5 – Response to Financial Requirements

Respondents must provide a detailed description of the proposed financial services, which must support all financial accounting and reporting requirements described in Article VIII. The Respondent must reflect a clear understanding of the nature of the work undertaken and must include detailed descriptions of the proposed services.

7.2.6 Section 6 - Financial Statements

Refer to **Section 6.6, Other Reports** for all the financial statements and reports required to be submitted along with the Cost Proposal.

7.2.7 Section 7 – Financial Security Requirements

If required and within ten (10) Business Days after written notification of award of the Contract, the selected Respondent shall deliver to HHSC, insurance certificates, duly executed performance bond or an irrevocable Stand-by Letter of Credit, or other documentation required for execution of Contract.

7.2.8 Section 8 – Initial Accounting Policy Manual

The Respondent must submit in its Cost Proposal an initial Accounting Policy Manual forty-five (45) Calendar Days after the Contract Effective Date that includes all proposed accounting policies and procedures (including cost allocations) utilized to calculate the Fixed Fees, Variable Fees, and all-inclusive hourly labor rates included in this Cost Proposal.

Following are examples of topics that may be included in an Accounting Policy Manual:

1. Accounting system structure;
2. Cost reporting standards;
3. Expense management;
4. Labor recording;
5. Travel policy;
6. Cost allowability;
7. Access to accounting records; and
8. Contract-specific expenses.

7.2.9 Section 9 – Disclosure Statement

The Respondent must submit with its Cost Proposal a copy of the Respondent's Cost Accounting Standards Board Disclosure Statement (form CASB DS-1) as approved by the federal government's Code of Federal Regulations. (See, Title 48 CFR Chapter 99, Subchapter B, Part 9903, Section 9903.202.)

1. Respondents that already have a federal Disclosure Statement in use by one or more federal agencies would need to submit a copy of the current federal Disclosure Statement with their Proposals.
2. Respondents that do not currently do business with the federal government or are not required to have a federal Disclosure Statement will not be required to create / submit one to HHSC with their Cost Proposal.

Note: A Disclosure Statement could be required to be completed by the Respondent if a Respondent's total amount of business with one or more federal entities, including the annual values of the final Contract, exceeds the thresholds contained in Title 48 CFR Chapter 99, Subchapter B, Part 9903, Section 9903.202.

As required in **Attachment A-1, Pricing Workbook** instructions, all Respondents must fully complete and provide a detailed analysis of all Fringe Benefit Rates, Indirect Rates, Administrative Services Rates, and Variable Unit Fee Rates developed specifically for and utilized in the Respondent's Cost Proposal.

7.2.10 Section 10 – Pricing Workbook

To document the EVV Services purchase price, HHSC requires Respondents to complete the Pricing Workbook. The Pricing Workbook is in an Excel format and can be found in **Attachment A-1, Pricing Workbook**.

Respondent must ensure that a complete set of pricing sheets (**Attachment A-1, Pricing Workbook**) are submitted for **every Major Subcontractor** along with the with the Respondent's Cost Proposal.

The Pricing Workbook contains Excel Worksheets, as outlined below:

1. **Table of Contents Worksheet** - This Worksheet provides the contents of the workbook and hyperlinks to all other worksheets.
2. **Instructions Worksheet** - This Worksheet includes general instructions for completing the Workbook.
3. **Total Price Summary Worksheet -** This Worksheet provides a summary of total purchase price. The Total Price Summary Table is automatically populated with information from all other Worksheets in the Pricing Workbook. This Worksheet provides a summary of total purchase price by Domain and by year. The Total Price Summary Table is automatically populated with information from all other Worksheets in the Pricing Workbook.
4. **Budget Detail Summary Worksheet** – This Worksheet contains the summary of costs by expense type and year for all service domains.
5. **Transition Milestones Worksheet (TRA Milestones)** – This Worksheets lists the Transition Key Milestones along with the due dates for the Key Milestones.
6. **Transition Services Domain Pricing Worksheet (TRA_A)** - This worksheet provides Transition Phase pricing for EVV Services and Project Management Office Services for the five (5) months of transition. Transition services shall be proposed on a fixed price basis. See **Section 2.1.3, Transition Requirements (TRAR)**.
7. **General Operations Services Pricing Worksheet (GOP_B)** — This Worksheet provides pricing for General Operations Services. These Services shall be proposed as a fixed price based on the performance requirements and/or the specified results within the level of effort defined by HHSC. See section **2.1.4, General Operations (GOP)**.
8. **State Pool System Management Services Pricing Worksheet (SPS_B)** - This Worksheet provides pricing for State Pool System Management Service Domain.

Included in these services are the State Pool System Management and Oversight. Pricing for these services shall be proposed as a fixed monthly price based on the performance requirements and/or the specified results within the level of effort defined by HHSC. See **Section 2.1.5, State Pool System Management and Oversight Requirements (SPSR)**.

9. **Proprietary System Management Services Pricing Worksheet (PSM_B)** - This Worksheet provides pricing for the Proprietary System Management Services. The services in this worksheet shall be proposed as a fixed monthly price. See **Section 2.1.7, Proprietary System Management and Oversight (PSMR)**.

10. **Variable State Pool Systems Operations Fees Worksheet (Variable_SPO_Fees)** – This Worksheet provides pricing for Respondent proposed State Pool System Operations Fees and Variable Unit Transaction Fees for State Pool System Operations and for various transaction tiers, for the Operations Phase by year. A tier is a band with a minimum to a maximum transaction volume. Pricing should be based on the performance requirements and/or the specified results within the level of effort defined by HHSC. The Variable Unit Transaction Fee for the baseline and other transaction tiers must be provided in Attachment A1 – Pricing workbook, Variable State Pool System Operations Fees **(Variable_SPO_Fees)**. See **Section 2.1.6, State Pool System Operations (SPOR)**.

11. **Non-SaaS Nonexpendable Capital Items Listing Worksheet** – This Worksheet shows the quantity and cost, amortization and depreciation of all proposed Non-SaaS Nonexpendable Capital Acquisitions and Leases by equipment category, equipment type, and month of acquisition during the Base Term of the Contract. Refer to **Section 8.4.3.1, Ownership of Non-SaaS Nonexpendable Capital Items at Termination of the Contract** for definition of Non-SaaS Nonexpendable Capital Items.

12. **Direct and Indirect Rate(s) Worksheet** - This Worksheet includes the following information necessary to comply with the Prospective Price Re-determination provisions of the contract:
    a. Indirect Rate (expressed as a percentage);
    b. Fringe Benefit rate (expressed as a percentage of salaries); and
    c. Administrative Service Fees (expressed as a percentage).

    The Respondent must include a detailed explanation of each rate as to allow HHSC to fully understand their basis for calculation

13. **Proposed State and Local Taxes Worksheet** - This Worksheet shows the Respondent's proposed State and local taxes, including Texas franchise taxes, to be paid in Texas by the Contractor and all proposed subcontractors for all months of Operations during the Base Term of the Contract and optional renewal/extension years.

14. **All Inclusive Hourly Labor Rates Worksheet** - This Worksheet provides the information for specification of Respondent staff classification and associated all-inclusive hourly labor rates for the Electronic Visit Verification Services for all IT and Non-IT classification of staff. The Respondent must commit to these rates for unanticipated tasks, changes to existing services.

15. **Non-IT Staffing Descriptions Worksheet** – Non-IT Staffing Category Descriptions provided by Respondent.
16. **DIR NTE Rates Worksheet** – This Sheet contains the DIR published IT Staff Augmentation Contracts (ITSAC) not to exceed rates as of June 15, 2021, for each of the IT categories. **Detailed description of the ITSAC categories are available in the Attachment A-2, Procurement Library**. Refer to **Section 3.5, Procurement Library** for details on how to access the **Attachment A-2, Procurement Library**.

Note: Each of the Operations Service Domains has their own payment schedule tables embedded in their respective worksheets.

7.2.10.1 Pricing Worksheets

The Respondent is responsible for entering price and rates data in the green cells using the format prescribed by the Pricing Workbook. Formulas have been inserted in the appropriate cells of the worksheets to automatically calculate summary numbers and Payment Schedules and shall not be altered unless errors are discovered or to accommodate additional rows or columns of data. Further instructions for entering price and rates data are included in the worksheets. Respondents must complete the worksheets and maintain the integrity of the data and formulas in the Pricing Workbook. Completion of the Pricing Workbook and worksheets is mandatory. Applicable purchase, delivery, tax, services, safety, license, travel, per diem, staff training, and any other allowable expenses associated with the delivery and implementation of the proposed items must be included in the Respondent's fixed price and/or Hourly Rates.

7.2.10.2 Total Price Summary Worksheet

The Total Price Summary worksheet will calculate the total purchase price of the EVV Services for the Base Term and the optional renewal or extension periods of the Contract.

7.2.10.3 Budget Detail Summary Worksheet

Respondents must include in the Budget Detail Summary Worksheet, the Respondent's proposed Transition and Operational costs by expense type and year for all service domains. Fringe Benefits, Indirect and Administrative Service Fee Rates included in this schedule will match those proposed by the Respondent in the "Direct and Indirect Rate(s)" Worksheet in the Pricing Workbook. Totals by year in this Worksheet must agree to totals by year in the Total Price Summary, for the Base Term and each of the optional renewal or extension years. This Worksheet should also include all Pass-through costs if any.

7.2.10.4 Transition Services Pricing Worksheet (TRA_A)

The Respondent Transition Phase Pricing Worksheet shall reflect all Transition Phase pricing for EVV Services for the five (5) months of transition for all the Transition Milestones. All mandatory Solicitation deliverables have been incorporated into the worksheet. The Respondents will define the roles and level of effort (hours) associated with each Milestone (i.e., number of FTEs, hours, and hourly rate by deliverable). Deliverables and associated fees will be incorporated within the Payment Schedule table in this worksheet.

NOTE: Any expenses or costs incurred by the Contractor after the commencement of the service delivery phase of any contract resulting from this Solicitation to complete transition activities or correct any defects from the Transition Phase will not be considered an allowable expense and will not be paid by HHSC.

7.2.10.5 General Operations Services Pricing Services Pricing Worksheet (GOP_B)

The General Operations Services Pricing Worksheet include fixed monthly fees, based on an estimated average level of effort for this domain, through the Base Term, renewal period one (1), renewal period two (2), and renewal period three (3) of the Contract. These fees will be incorporated within the Payment Schedules table in this worksheet. Refer to GOP_B Worksheet for instructions to complete the sheet.

The following subdomains will be priced separately:

a. Business Continuity and Disaster Recovery (BCD) Support
b. Other GOP Services

7.2.10.6 State Pool System Management Services Pricing Worksheet (SPS_B)

The State Pool System Management Services will be included in the Pricing Worksheet as a fixed monthly price based on the Solicitation requirements through the Base Term, renewal period one, renewal period two and renewal period three. Respondents are required to identify the total number of staff resources to perform support and oversight Services activities. The Total Price for these services will be fixed price, with the service quality defined by Key Performance Measures and Deliverables.

The worksheet shall contain the ongoing SMS subcategories listed below for cost evaluation purposes through the Base Term, renewal period one, renewal period two and renewal period three. All fees will be incorporated within the Payment Schedule table in this worksheet.

7.2.10.7 Proprietary System Management Services Pricing Worksheet (PSM_B)

This Worksheet provides pricing for the Proprietary System Management Services. The services in this worksheet shall be proposed as a fixed monthly price.

The Respondent's Proprietary System Management Services Pricing Worksheet shall reflect all services and will be paid on a fixed monthly price basis. Respondent shall incorporate all Proprietary System Management services and oversight within this worksheet and define the level of effort associated with these services (i.e., Number of FTEs, Hours and Hourly Rate) during the Base Term, renewal period one, renewal period two, and renewal period three of the Contract. Deliverables and associated fees will be incorporated within the Payment Schedule table in this worksheet.

7.2.10.8 Variable State Pool System Operations Fees Worksheet (Variable_SPO_Fees)

The Variable State Pool System Operations Fees Worksheet will be included in the Pricing Worksheet as a variable monthly price by Tier based on the Solicitation requirements through the Base Term, renewal period one, renewal

period two and renewal period three. The following subdomains will be priced separately:

a. Call Center Support (CAC);
b. Training Support (TNG);
c. Alternative Device Management (ALT); and
d. Other SPO Services.

Respondent must complete the transaction fees by Tier in this Worksheet with their proposed Variable Fee for State Pool Operations for various transaction Tiers, for the Operations Phase by year. HHSC anticipates that over time the use of Proprietary Systems will increase, which in turn will decrease State Pool System usage. HHSC expects Respondent to provide pricing that reflects reduced operating costs for State Pool System transaction Tiers below the baseline. Respondents are required to complete the pricing for various transaction Tiers as described in the **Attachment A-1, Pricing workbook.**

7.2.10.9 Non-SaaS Nonexpendable Capital Items Listing Worksheet (Nonexpendable capital items)

This Worksheet shows the quantity of all proposed Non-SaaS Contract Specific capital equipment acquisitions and leases by equipment category, equipment type, quantity and the total acquisition costs and month of acquisition during the Base Term of the Contract and the optional renewal years.

The term capital equipment includes, but is not limited to, office furniture, office equipment, telephone equipment, scanning equipment, computer furniture, computer equipment, computer software, the cost of initial installation (excluding in-house labor), and leasehold improvements.

All capital equipment acquisitions (including purchases, leases, and leasehold improvements) will be recorded in the month they are acquired/leased.

1. Software will be listed by manufacturer, product name, and version. Different products will be listed on separate lines, even if they are from the same suite of products (e.g., Microsoft Office).

2. Equipment types shown are examples only. Use appropriate categories and descriptions as necessary to include all capital items acquired (define categories clearly to help identify if the Proposal includes ramping up capital item acquisition by Key Milestone). Show capital equipment acquisitions in the month required. If more equipment types are needed, add rows and link appropriately.

The Respondent will include all costs related to the proposed acquisitions and leases of capital equipment it will incur during the **Transition Phase**, including capital equipment requiring refresh. The Respondent will show the acquisitions and leases of all capital equipment grouped by category and type within each category. Each equipment category will be sub-totaled for each month. Transition phase costs should be updated in the Table – "Transition - Total Quantity and Cost of Capital Equipment Listing by Type and Month of Acquisition". Operations phase costs should be updated in the table – "Operations

- Total Quantity and Cost of Capital Equipment Listing by Type and Month of Acquisition".

All capital equipment acquisitions, including purchases, leases, and leasehold improvements, will be recorded in the month they are acquired/leased, as indicated in the Worksheet "Capital Costs". Each equipment category costs will be sub-totaled for each month.

Example: Assume that 120 computers costing $500 each are purchased, leased, or refreshed and put into use during the 1st month of Transition. The number 120 and the cost of the cost for all 120 computers (120*500 = $60,000) will be recorded in the appropriate cell in the column for Month 1 on the schedule. If an additional 50 computers are purchased, leased, or refreshed (50*500 = $25,000) and put into use during the 9th month of Transition, the number 50, and the cost for all 50 computers (50*500 = $25,000) will be recorded in the appropriate cell in the column for Month 9. In this example, only months 1 and 9 on the schedule would include entries related to the acquisition of these computers.

The Lease Amortization /Depreciation Expenses table in the Capital Costs Worksheet shows the Respondent's proposed lease expenses, amortization expenses, and depreciation of capital equipment for the Base Term of the Contract. The Respondent will show the expenses and depreciation of all capital equipment grouped by equipment category and month.

The expenses, depreciation, and amortization of leasehold improvements shown in this schedule will agree with the capital expenses, depreciation, and amortization.

All capital expenses that will be incurred during the Base Term of the Contract are to be expensed in the month they are incurred.

Example: In the scenario above, $60,000 in computer equipment was acquired during the 1st month of Transition, and an additional $25,000 in computer equipment was acquired during the 9th month of Transition. Since all capital expenses will be expensed in the month incurred, $60,000 will be recorded in the appropriate cell in the column for Month 1 on the schedule and $25,000 will be recorded in the appropriate cell in the column for Month 9. As was the case previously, only months one (1) and nine (9) would include expenses related to the acquisition of these computers.

7.2.10.10 Direct and Indirect Rate(s) Worksheet

This Worksheet will include the following information necessary to comply with the Prospective Price Re-determination provisions of the contract:

1. Indirect Rate (expressed as a percentage).

   Respondents may include one or more indirect rates in their Cost Proposal to capture general and administrative expenses and/or overhead expenses that are not readily identified with a specific Project or organizational activity but are incurred for the joint benefit of projects and other activities.

Respondents to provide a detailed analysis of any proposed indirect rate(s) including, but is not limited to:

a. A detailed explanation of each indirect rate proposed;
b. The actual calculation and calculation methodology for each rate;
c. The source of the costs included in each indirect rate;
d. The methodology of allocating the costs included in each indirect rate;
e. The Respondent's internal lines of business and business segments included in each indirect rate;
f. The total amount for each indirect rate proposed for each year of the contract, including the amount(s) applicable for the Transition period and Operations period;
g. An analysis of the impact the award would have on the Respondent's current indirect rate(s).
h. A detailed listing of the types of operational support Services included in each applicable Indirect Rate that will be provided by the Respondent's home office;
i. A detailed listing of the types of support expenses included in each applicable Indirect Rate that will be paid by the Respondent's home office; and
j. Proposed indirect rates will be applied as a "mark-up" to applicable Direct Expenses.

2. Fringe Benefit rate (expressed as a percentage).

Respondent to provide a detailed analysis of the Respondent's employee benefits, fringe benefits, and bonus percentage(s). The analysis must contain sufficient detail to provide HHSC a complete understanding of the Respondent's fringe benefit rate, including but not limited to the following:

a. The fringe benefit rate(s) proposed by the Respondent for each year of the contract, including the rate(s) applicable for the Transition period and Operations period. The actual calculation and calculation methodology for the proposed fringe benefit rate(s) must also be included in the analysis;
b. The fringe benefit rate(s) applicable for any parent, affiliate, or subsidiary organization providing Services associated with this procurement;
c. Materials describing the employee benefits as given to each employee, or a detailed description of the type of employee benefit, fringe benefit, and bonus arrangement offered to the Respondent's employees;
d. A description of how these benefits and bonuses would be directly or indirectly charged and included in the amounts (Salaries of Respondent-employed FTEs) and in the Respondent's total Cost Proposal; and

e. A description of any other type of expenses that are included in the employee benefits, fringe benefits, and bonus calculation(s) that would not normally appear in the materials provided to each employee describing employee benefits (i.e., are staff turnover elements included in this calculation; are non-productive staff time included in this calculation; etc.).

The analysis must also clearly indicate whether holidays, vacation, and sick leave are included as part of an employee's base salary or as part of the proposed fringe benefit rate.

With respect to any and all Change Orders or Contract Amendments for Services and Deliverables contracted after the Effective Date of the Contract, the Respondent's fees and pricing shall be based upon the Respondent's actual fringe benefits and fringe benefit rates at the time those Services and Deliverables are contracted.

3. Administrative Service Fees (expressed as a percentage)

The Administrative Service Fee percentage shall be calculated as a percent of total allowable expenses. In its Cost Proposal narrative, the Respondent must provide an explanation and justification of how the proposed Administrative Service Fee percentage used correlates with risk(s) assumed by the Respondent in the performance of the Contract. This explanation should consider the following factors:

a. Contractor effort and complexity of work;
b. Contract cost risk;
c. The Respondent's initiative in supporting federal socioeconomic programs;
d. Capital investments by the Respondent to improve contract efficiency and performance;
e. Cost-control measures and other past accomplishments; and
f. Independent development efforts relevant to the Contract.

The Administrative Service Fee is intended to represent a (profit) percentage that will be applied as a "mark-up" to Allowable Costs.

a. The Administrative Service Fee percentage utilized to calculate the final fixed pricing included in the Contract resulting from this Solicitation will also be effective for any and all contract amendments during the term of the Contract including any renewals or extensions. TRA Domain;
b. GOP Domain;
c. SPS Domain; and
d. PSM Domain.

The Labor Rates Worksheet shall include the Respondent's Not-To-Exceed all-inclusive hourly rates (inclusive of travel, per diem, and other expenses) for all the staff working on this Contract. Staff classifications should be based on the Texas

DIR IT Service Role Classifications for IT staff and Non-IT staff. For Non-IT staffing classification, Respondent must complete the **Attachment A-1, Pricing Workbook**, Non-IT-Staffing-Descriptions Worksheet. All the roles for IT and Non-IT staff must match the roles defined in **Section 5.1.5 Key Staffing Profile** of the Solicitation.

Based on the Respondent's estimated staffing model for the service delivery phase, the percentage of total level of effort (hours) associated with specific role/rate classifications will automatically calculate the composite rate within the worksheet based on the component rates and number of staff in each role classification, regardless of the mix of staff classifications required to perform the work for future change orders, or unanticipated tasks.

The proposed fixed rates shall apply throughout the term of the Transition Phase and Base Term, renewal period one, renewal period two, and renewal period three. The Respondent may apply an inflator/deflator only once, beginning of renewal period one.

HHSC may request that the Respondent provide additional services for unanticipated tasks that were not originally envisioned and are out-of-scope of this agreement. These service requests will be handled via change requests, based on level of effort (hours) estimates to meet the performance requirements and/or specified results included in the change order requested by HHSC and either the actual rates of staff performing the work or the composite rate.

7.2.10.13 Non-IT Staffing Descriptions Worksheet

Respondent must include the detailed description of all the Non-IT staffing classification used in the Solicitation response along with all the categories, in the Non-IT-Staffing-Descriptions Worksheet.

ARTICLE VIII. FINANCIAL APPROACH – BUSINESS TERMS

8.1 OVERVIEW OF FINANCIAL APPROACH

This section presents the rights, requirements, and responsibilities of HHSC and the Contractor for monitoring, recording, and reporting of financial transactions during the Contract Term. All costs and expenses incurred by the Contractor or any of its Subcontractors for the completion of any contractual requirement will be included in the Cost Proposal submitted by the Respondent. Additional costs or expenses not contained in the Cost Proposal will not be allowed under the Contract, unless approved in advance by HHSC. Approval shall be limited to matters falling under **Sections 8.4.2.5, Supplemental Services** and **8.4.2.7, Periodic Activities** for the Service Provider Labor Rates for Changes to Services and Task of the Contract.

HHSC will determine cost allowability in accordance with Generally Accepted Accounting Principles (GAAP); Title 48 CFR, Chapter 1, Parts 30 and 31, and Chapter 99; federal guidelines, rules, and regulations applicable to programs within the scope of this

Solicitation; and HHSC guidelines, rules, regulations, and provisions applicable to programs within scope of the procurement.

Any expenses incurred by the Respondent or any of the Respondents Subcontractors for the completion of any contractual requirement deemed by HHSC or any State, federal, or HHSC auditors to be inefficient or uneconomical will be deemed unallowable under the Contract resulting from this Solicitation. HHSC reserves the right to reduce the Respondent's administrative payments for the duration of the Contract for any contractual requirement deemed to be inefficient and/or is not being provided economically.

The reduction of a Respondent's payments from HHSC for any contractual requirement deemed to be inefficient and/or is not being provided economically will be determined based on facts related to each specific circumstance. The basis for determining the efficiency or economic value will be based on numerous elements including, but not limited to, specific audit findings, additional research performed by the State after an audit finding, and discussions with the Respondent related to the finding. The Respondent has the right to review, challenge, and dispute any audit findings. Any such dispute will be managed through the Dispute Resolution process contained in the Contract.

8.2 Business Objective

The objective of the Financial Approach is to describe the financial components that will enable HHSC, and other State programs included in this Solicitation to achieve the objectives of this Solicitation and to ensure that all Services required of the Contractor are provided as efficiently and effectively as possible to assist HHSC in its responsibility for the efficient and effective administration of federal awards through the application of sound management practices.

8.3 Financial: Accounting and Reporting Requirements

8.3.1 Overview of Financial Accounting and Reporting Requirements

This section describes the various respective responsibilities of HHSC and the Contractor for recording and reporting Contract transactions. Any costs or expenses incurred by the Contractor or any of its Subcontractors for the completion of any contractual requirement will be included in the Cost Proposal. Additional costs or expenses will not be allowed under the Contract, unless approved in advance by HHSC.

The need for greater public and financial accountability in the administration of critical taxpayer-funded programs has led to a demand for more information regarding government programs and services. Public officials, legislators, and citizens want and need to know whether government funds are handled properly and in compliance with laws and regulations. These stakeholders also want and need to know whether government organizations, programs, services, and contractors (including any Subcontractors) retained to provide contracted services are achieving their purposes and whether these organizations, programs, services, and contractors (including any Subcontractors) are operating economically and efficiently.

Any expenses incurred by the Contractor or any of its Subcontractors for the completion of any contractual requirement that are deemed by HHSC or any auditors to be inefficient or uneconomical will be deemed unallowable under the Contract. HHSC reserves the right to reduce a Contractor's administrative payments for the duration of the Contract

for any contractual requirement that is deemed to be inefficient and/or is not being provided economically.

It is HHSC's intention to determine cost allowability in accordance with Generally Accepted Accounting Principles (GAAP); Title 48 CFR, Chapter 1, Parts 30 and 31, and Chapter 99; federal guidelines, rules, and regulations applicable to programs within the scope of this Solicitation; and HHSC guidelines, rules, regulations, and provisions applicable to programs within scope of this Solicitation.

The reduction of a Contractor's administrative payments for any contractual requirement that is deemed to be inefficient and/or is not being provided economically will be determined based on facts related to each specific circumstance. The basis for determining the efficiency or economic value will be based on numerous elements including, but not limited to, specific audit findings, additional research performed by HHSC after an audit finding and discussions with the Contractor related to the finding. The Contractor has the right to review, challenge and dispute any audit findings. Any such dispute will be managed through the Dispute Resolution process contained in the Contract.

8.3.2 Business Objectives

The business objectives relating to accounting and reporting requirements include:

1. Accumulating and reporting accounting data in accordance with the following standards (which may be amended during the Contract Term):
    a. Generally Accepted Accounting Principles (GAAP);
    b. Title 48 CFR, Subchapter E, Chapter 1, Parts 30 and 31, and Title 48 CFR, Chapter 99 Federal Acquisition Regulation (FAR);
    c. Federal and State regulations, rules, and guidelines, applicable to programs within the scope of this Solicitation;
    d. HHSC guidelines, rules, regulations, and provisions applicable to programs within scope of this Solicitation; and
    e. Providing authorized representatives of HHSC and the federal government full access to all information needed to conduct financial reviews and audits required by law or by the Contract in accordance with applicable standards.

    NOTE: Where HHSC guidelines, rules, regulations, and provisions of this Solicitation set a stricter or more demanding standard than GAAP; Title 48 CFR Chapter 1, Subchapter E, Part 30; Title 48 CFR Chapter 1, Subchapter E, Part 31; or Title 48 CFR, Chapter 99; then the HHSC guidelines, rules and provisions of the Contract will prevail.

2. Effectively regulating costs. Allowable costs are costs that are:
    a. Necessary and reasonable for the proper and efficient performance and administration of applicable State and federal awards;
    b. Allocable to applicable federal awards under the provisions of the federal standards or any other accounting provisions included in the Contract;
    c. Authorized or not prohibited under State laws, State regulations or any provision included in the Contract;

d. In conformity with any limitations or exclusions set forth in applicable accounting principles, current and future State and federal laws, terms, and conditions of HHSC and federal award(s) to HHSC, or the Contract;
e. Consistent with policies, regulations and procedures that apply uniformly to State and federal awards impacting the Contract;
f. Determined in accordance with GAAP;
g. Adequately documented; and
h. Consistent with a Respondent's normal treatment of the expense.

8.3.3 Financial Accounting Requirements

The Contractor's accounting records and procedures are subject to HHSC approval. Accruals of expenses or liabilities are subject to HHSC review and approval. HHSC will not recognize as valid costs, any accruals that it deems inappropriate. For example, lease agreement costs beyond the effective date of termination or completion of the Contract, or lease cancellation expenses resulting from termination or completion of the Contract, are not valid costs. HHSC will not recognize as valid costs any excessive charges or fees from the Contractor or from any of the Contractor's Subcontractors that HHSC deems inappropriate.

Allowable and non-allowable direct and indirect costs, wherever applicable to any payments to the Contractor, will be governed by the FAR principles set forth in the following regulations (as may be amended during the Contract Term) and documents:

a. Title 48 CFR, Chapter 1, Subchapter E, Part 30: Cost Accounting Standards Administration;
b. Title 48 CFR, Chapter 1, Subchapter E, Part 31: Contract Cost Principles and Procedures; and
c. Title 48 CFR, Chapter 99: Cost Accounting Standards Board, Office of Federal Procurement Policy, Office of Management and Budget.

In addition to costs that are unallowable pursuant to the above accounting principles, HHSC has deemed certain items within the allowable costs to be specifically unallowable for the Contract. The list of additional unallowable costs is as follows:

a. Local and State taxes paid to local or state governments outside of Texas (other than hotel, airline, and sales taxes expended specifically for the Contract);
b. Federal taxes (other than hotel and airline taxes expended specifically for the Contract resulting from this Solicitation);
c. Bid and Proposal costs of any type;
d. Employee bonuses in excess of **ten percent (10%)** of the employee's base pay;
e. Public relations and selling costs;
f. Actual costs, remedies, or damages due to HHSC for the Contractor not meeting HHSC performance requirements;
g. Any monies owed to the federal government due to the Contractor not meeting federal performance requirements;
h. Dispute resolution and arbitration costs, including legal fees and expert witness expenses;

i. Contingency funding costs;
j. Pre-Contract costs;
k. Indirect expenses (overhead, general and administrative charges,) and administrative service fees related to pass-through items;
l. As indicated in Title 48 CFR, Chapter 1, Subchapter E, Part 31, Section 31.203, any indirect costs, and associated profit applicable to Subcontract costs where the Contractor does not provide "added value" (e.g., Subcontract management functions) are considered excessive pass-through costs which are unallowable; and
m. Inter-company profits and margins related to all transactions with any parent, affiliate, or subsidiary organization, including inter-company profits and margins related to all transactions the Contractor or the Contractor's subsidiary has with any parent, affiliate, or subsidiary organization.

NOTE: A cost may not be assigned to a federal award or the Contract as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to a federal award or a different contract with HHSC as an indirect cost.

8.3.4 General Access to Accounting Records

The Contractor must provide authorized representatives of HHSC full access to all financial and accounting records related to the performance of the Contract, including all requested Subcontractor financial and accounting records. The financial and accounting records will be provided to the authorized representatives of HHSC in an electronic format when requested.

8.3.4.1 Contractor Responsibilities

In addition to the requirements stated above, the Contractor and its Subcontractor(s) must comply with providing access to accounting records stipulated in **Table 37 - Contractor Responsibilities for Access to Accounting Records,** below:

Table 37 - Contractor Responsibilities for Access to Accounting Records

Req. Id	Contractor Responsibilities for Access to Accounting Records
EFRC-1	Cooperate with HHSC and authorized representatives in their inspections, audits, and reviews, and provide all necessary records and information. As required by Title 48 CFR, Chapter 1, Subchapter E, Part 30; Title 48 CFR, Chapter 1, Subchapter E, Part 31; and Title 48 CFR, Chapter 99; it is the responsibility of the Contractor to provide adequate documentation and justification to the authorized representatives of HHSC during the inspection, audit, or review process for all expenses included in the Contractor's accounting records.
EFRC-2	Permit authorized representatives of HHSC full access, both online (on a read-only basis) and in person, during normal Business Hours, to the accounting records that HHSC or its authorized representatives determine are relevant to the Contract. Such access is guaranteed at all times during the performance and retention period of any Contract resulting from this Solicitation, and will include both announced and unannounced inspections, on-site audits, and the review, analysis, or reproduction of reports produced by the Contractor. If any report cannot be accessed online then Contractor will deliver to HHSC any reports or records that cannot be accessed online

Req. Id	Contractor Responsibilities for Access to Accounting Records
	by HHSC personnel in a format, media, content, and within timeframes approved by HHSC. The Contractor shall support audits past the end of the Contact as long as required to complete any outstanding audit and meet any appropriate agency's retention policies.
EFRC-3	Make accounting records or supporting documentation relevant to the Contract available to HHSC or its agents within **ten (10)** Business Days of receiving a written request from HHSC for specified records or information.
EFRC-4	Pay all additional costs, including any applicable professional fees, incurred by HHSC resulting from the Contractor's failure to provide the requested accounting records or financial information within the specified **ten (10)** Business Days of receiving a written request from HHSC for specified accounting records or information.
EFRC-5	Deliver to HHSC any reports or records that cannot be accessed online by HHSC personnel.
EFRC-6	Provide authorized representatives of HHSC with access to accounting and financial records of all Subcontractors, suppliers, or other parties the Contractor hires, retains, or otherwise employs or pays for Goods or Services related to the performance of the Contract. This requirement is limited to those records that relate to the performance of any applicable functions of the Contract. The Contractor must include this requirement in any Contract(s) it enters with such Subcontractors, suppliers, or other parties related to this Solicitation.
EFRC-7	Provide authorized representatives of HHSC with access to the accounting and financial records of the Contractor's parent company, Contractor's affiliates, Contractor's subsidiaries, and to any individual, partnership, firm, or corporation of the Contractor or parent company of the Contractor that transacts business with any department, board, commission, institution, or other HHSC or federal agency connected with the Contract. This requirement is limited to those records that relate to the performance of the Contract.

8.3.4.2 State Responsibilities

HHSC will monitor all Contractor responsibilities to ensure compliance, assess performance and determine satisfaction related to Financial Reporting Requirements. HHSC reserves the right to waive the review and approval of Contractor work products or processes. In addition, HHSC approval of Contractor work products or processes will not relieve the Contractor of liability for errors and omissions in the work products or processes.

8.3.5 Financial Reporting Requirements

HHSC will require the Contractor to provide financial reports to support Contract monitoring and support any HHSC, State, and federal reporting requirements.

8.3.5.1 Contractor Responsibilities

The Contractor is responsible for providing financial reports to satisfy the requirements stipulated in **Table 38 - Contractor Responsibilities for Financial Reporting,** below.

Table 38 - Contractor Responsibilities for Financial Reporting

Req. Id	Detailed Requirements
ERRC-01	Provide monthly financial statements, including but not limited to, an Income Statement outlining the Contractor's operation under the Contract no later than the **twenty-fifth (25th)** Calendar Day following the end of the previous month. HHSC reserves the right to request financial information in a format that will allow HHSC to most efficiently comply with its State and federal financial reporting requirements.
ERRC-02	Provide a separate monthly expense summary, detailing operations under the Contract for each of the business functional areas and program types of the Contract, no later than the **twenty-fifth (25th)** Calendar Day after the end of each reporting month period. Each summary will include accounts contained in **Article II, Scope of Work** in conformance with GAAP and the FAR. In addition to an expense account listing, the report will also identify total expenditures by business functional area and program type. Each expense summary will fully disclose the financial impact of all transactions with any parent, affiliated, or subsidiary organization either under a formal or informal arrangement that would relate to the performance under the Contract. These transactions must be reported in a manner such that inter-company profits or margins are eliminated. The methodologies and assumptions supporting cost allocations must be disclosed, including cost allocations from home and/or central offices. HHSC reserves the right to request modifications to monthly financial reports if, in HHSC's sole determination, such changes are in HHSC's best interest. Requested modifications to content and format of the monthly financial reports will be completed by the Contractor with no additional charges due from HHSC.
ERRC-03	Provide annual financial statements for the preceding State Fiscal Year no later than **ninety (90)** Calendar Days after the end of each State Fiscal Year or after the termination of the Contract. These annual financial statements must depict the financial position of the Contractor and the result of operations (including administrative service fees) for each applicable business functional area and program type under the Contract. HHSC will consider this financial statement (report of Allowable Costs) as "FINAL" for the applicable Operational Contract period and will not recognize any additional direct expense(s) not included in the financial report as allowable for the Prospective Price Re-Determination provision described in **Section 8.4.3.4, Prospective Price Re-Determination**.
ERRC-04	Provide a separate expense summary, detailing operations under the Contract no later than **ninety (90)** Calendar Days after the end of each Contract Year or after the termination of the Contract. Each summary will include accounts in conformance with GAAP and any applicable provisions included in this Solicitation. The Contractor will identify and eliminate any expenses not allowed by State or federal laws and regulations and any applicable provisions included in this Solicitation. HHSC reserves the right to request modifications to annual financial reports if, in HHSC's sole determination, such changes are in HHSC's best interest. Requested

Req. Id	Detailed Requirements
	modifications to annual financial reports will be completed by the Contractor with no additional fees due from HHSC. The expense summary will fully disclose the financial impact of all transactions with any parent, affiliated, or subsidiary organization either under a formal or informal arrangement that relates to the performance under the Contract. These transactions will be reported in a manner such that inter-company profits and margins are eliminated. The methodologies and assumptions supporting cost allocations will be disclosed, including cost allocations from home or central offices; and will follow the prescribed methodologies included in the Accounting Policy Manual approved by HHSC.
ERRC-05	Submit an initial Accounting Policy Manual with the Contractor's Cost Proposal that includes all proposed accounting policies and procedures (including cost allocations) the Contractor utilized to calculate the Contractor's Fixed and Variable Fees and the All-inclusive Hourly Labor Rates that are included in the Contractor's Cost Proposal.
ERRC-06	Submit a final accounting policy manual and Disclosure Statement (Cost Accounting Practices Statement Title 48 CFR, Chapter 99, Subchapter B Part 9903 Section 9903.101) within forty-five (45) Calendar Days of the Contract Effective Date, which includes any modifications necessary due to contract negotiations and all of the proposed accounting policies and procedures the Contractor must follow during the Contract Term. Any modifications included in the final accounting policy manual submitted within forty-five (45) Calendar Days of the Contract Effective Date must be approved in writing by HHSC prior to implementation of any change. Any modifications to the final accounting policy manual approved by HHSC must be approved in writing by HHSC prior to implementation of any change.

8.4 Financial Payment Structure and Provisions

The following sections further describe the components of each pricing structure to be utilized by HHSC and the major variables affecting each component.

8.4.1 Electronic Visit Verification Services Payment Structures

Payment for the contractual services described in this Solicitation will be based on several pricing structures, depending on the specific service domain and/or deliverable required. The Contractor will be responsible for performing the responsibilities stipulated in **Article II, Scope of Work** and **Article VIII, Financial: Section 8.3, Accounting and Reporting Requirements**. The Respondent will receive payments monthly as compensation for correctly and appropriately performing the services and deliverables required in the Contract or will receive payment based on deliverable milestones and acceptance as defined in **Attachment A-1, Pricing Workbook**.

The methods by which the Respondent will be paid for services under the Contract include:

a. Administrative Costs - Costs for administrative Services provided by the Contractor

will be based on variable fee formulas for the State Pool System Operations Services (SPO). The costs for administrative Services for the other domains (GOP, SPS, PSM) will be based on fixed fee(s) only. The fixed administrative fee(s) and the variable administrative fee(s) will be competitively determined. The operational costs for administrative Services will be subject to the Prospective Price Re-determination provisions documented in **Section. 8.4.3.4, Prospective Price Re-Determination**;

b. Additional Periodic Activities - The costs associated with systems modifications and additional periodic activities to be performed by the Contractor will, in part, be based on explicit fixed prices competitively proposed by the Contractor;

c. Additional Recurring Activities - The costs associated with Additional Recurring Activities will be negotiated between the Contractor and HHSC after HHSC determines that the Contractor has submitted all of the detailed cost information necessary (including detailed metrics deemed acceptable by HHSC) to accurately modify the fixed and/or variable fees. Once a total cost for the Additional Recurring Activities is agreed upon, HHSC will make the determination as to whether the fixed fee formula(s) are modified, one or more of the variable formula(s) are modified, or all appropriate administrative payment components are modified and

d. Transition (TRA) - Transition costs to meet Solicitation requirements will be paid on a fixed fee basis. Transition costs in excess of the final fixed price amount(s) included in the Contract will not be paid by HHSC. Transition costs will not be paid as an element of Operational administrative costs. Transition costs will be paid to the Respondent retrospectively. Any expenses incurred by the Respondent after the Operational start date of a specific Deliverable to complete Transition activities or correct any defects from the Transition Phase of that specific Deliverable must not be recorded as an Operational expense and will not be considered an allowable expense for the Prospective Price Re-determination element of the Contract.

8.4.2 Payment for Administrative Services

The Operations phase of the Contract is forty-three (43) months in length, and it begins in month six (6) of the Contract. The Operations pricing schedules consist of the following four (4) operational periods:

a. Operational Contract Year 1: Contract months 6-12 (7 months);
b. Operational Contract Year 2: Contract months 13-24 (12 months);
c. Operational Contract Year 3: Contract months 25-36 (12 months) and
d. Operational Contract Year 4: Contract months 37-48 (12 months).

In the event HHSC exercises an available renewal or extension term under the Contract, the fixed and variable administrative fees will be determined by the application of an inflator/deflator proposed by the Contractor.

Payment to the Contractor for Administrative Services will be based either on a fixed administrative fee basis only, or a combination of fixed administrative fees plus one (1) or more variable administrative fees as depicted below:

a. For the State Pool System Operations Services (SPO) variable payment methodologies will be proposed; and

b. For the Domains (GOP, SPS, PSM), only separate fixed monthly payment methodologies will be proposed.

HHSC will reduce the fixed and/or variable administrative payments for any services that become obsolete or no longer necessary during the Contract Term through negotiations and Amendments as necessary.

HHSC will not recognize as valid costs, any excessive charges or fees from the Contractor or any of the Contractor's Subcontractors that HHSC deems inappropriate.

HHSC will reduce the fixed and/or variable administrative payments in any option year exercised by HHSC for any expenses that will not be applicable during the option year, such as, but not limited to, depreciation and amortization expenses for capital items fully expensed during the Base Term of the Contract.

The Contractor must acknowledge and agree that HHSC will not be invoiced for fees for Services or Deliverables that have not been provided by the Contractor or any of its Subcontractors and will not be invoiced for fees for capital items that have not been incurred by the Contractor or any of its Subcontractors.

HHSC reserves the right to modify the fixed and variable fee payment methodologies to include fewer variable payment elements and/or additional variable payment elements in the administrative payment structure at any time during the Contract Term through negotiations and Amendments as necessary.

The Contractor's **Attachment A-1, Pricing Workbook** Worksheets related to this Solicitation must be based on the Contractor's proposed costs and an administrative service fee that will be included as part of each proposed fixed or variable fee and each proposed periodic activity fee applicable to the Contract. The final Administrative Service Fee that is included in the Contract will remain unchanged and be applicable for all Fixed Fees, Variable Fees, Periodic Activity Fees, recurring activity fees and any change orders executed during the Contract Term.

HHSC, at its sole discretion, may choose to process only a portion of an administrative fee invoice (Fixed and Variable) and a Transition Key Milestones transition invoice if only a portion of an invoice can be verified and validated by the information submitted. If HHSC decides to process an invoice in this manner, an adjustment will be made by HHSC, if only that portion of the fee invoice can be verified and validated by the information submitted. This is applicable to the subsections below.

8.4.2.1 Fixed Administrative Fees

Separate annual fixed administrative fees will be proposed for each operational Contract year of the Base Term and any optional Contract renewals or extensions for each domain. The final annual fixed administrative fees included in the Contract will be paid in equal monthly payments based on the number of months in each respective operational Contract year for each program type.

The Contractor must submit monthly invoices following the month in which the Contractor provides administrative services. HHSC will process and pay monthly fixed administrative fees in accordance with Texas Government Code Title 10, Subtitle F, Chapter 2251. Separate invoices for each program type must be

submitted by the Contractor to HHSC in the format specified by HHSC. Each invoice will be processed and paid separately.

Each invoice must show separate lines for each appropriations strategy, and Federal Financial Participation rate. The Contractor must also provide supporting documentation for fixed administrative costs invoices, in an electronic format, subject to approval by HHSC, by Program, appropriations strategy, and Federal Financial Participation rate.

HHSC, at its sole discretion, may choose to process only a portion of a fixed administrative fee invoice, if only a portion of an invoice can be verified and validated by the information submitted. If HHSC decides to process an invoice in this manner, an adjustment will be made by HHSC and only that portion of a fixed administrative invoice that can be verified and validated will be paid.

To be paid for the fixed administrative fees previously denied or not processed by HHSC, the Contractor must submit supplemental invoice(s) along with all corrections necessary. If any discrepancies are determined in the supporting documentation and invoice provided by the Contractor, HHSC will notify the Contractor of the discrepancies as soon as practicable and will not process the invoice until all information is reconciled.

HHSC will process and pay fixed administrative fees billed on supplemental invoices in accordance with Texas Government Code Title 10, Subtitle F, Chapter 2251. Each invoice will be processed and paid separately.

8.4.2.2 Variable Administrative Fees

Separate variable administrative fees will be proposed for each operational Contract year of the Base Term and any of the three (3) optional contract renewals for the State Pool System Operations (SPO). The other Domains, General Operations (GOP), State Pool System Management and Oversight (SPS), and Proprietary System Management and Oversight (PSM) will not have a variable fee component. HHSC reserves the right to modify the payment structure to including one or more additional variable administrative fees that will be negotiated with the Contractor.

The Contractor must submit monthly variable administrative cost invoices based on the determination of the costs as stated in **Sections 8.4.2.3, Determination of the Variable State Pool System Operations Fees** for State Pool System Operations Services. HHSC will process and pay monthly variable administrative fee(s) in accordance with Texas Government Code Title 10, Subtitle F, Chapter 2251. Separate variable payment invoices for each Program must be submitted by the Contractor to HHSC in the format specified by HHSC. Each invoice will be processed and paid separately.

Each invoice must show separate lines for each appropriations strategy and Federal Financial Participation rate. The Contractor must also provide supporting documentation for variable units included for each variable invoice, in an electronic format, subject to approval by HHSC, by Program, appropriations strategy and the Federal Financial Participation rate.

HHSC, at its sole discretion, may choose to process only a portion of a variable administrative fee invoice, if only a portion of an invoice can be verified and validated by the information submitted. If HHSC decides to process an invoice in this manner, an adjustment will be made by HHSC and only that portion of a variable administrative invoice that can be verified and validated will be paid.

To be paid for the variable administrative fees previously denied or not processed by HHSC, the Contractor must submit supplemental invoice(s) along with all corrections necessary. HHSC will process and pay variable administrative fees billed on supplemental invoices in accordance with Texas Government Code Title 10, Subtitle F, Chapter 2251. Each invoice will be processed and paid separately.

8.4.2.3 Determination of the Variable State Pool System Operations Fees

Payment for State Pool System Operations Services will be variable administrative fees will be based upon the number of transactions processed by the State Pool System during a month. These variable administrative fees will be based on a tiered structure. The baseline tier was established using historical transaction volumes and considers factors that may increase or decrease State Pool System transaction volumes. The number of "accepted transactions" in the service month shall determine the tier and corresponding variable administrative fee to be paid.

An "accepted transaction" is an EVV visit transaction that meets the following criteria:

a. has been successfully transmitted from the State Pool System to HHSC's EVV Aggregator;
b. has received an "accepted" status from HHSC's EVV Aggregator;
c. is invoiced within twelve (12) months of acceptance into HHSC's EVV Aggregator;
d. has not been previously paid for by HHSC;
e. does not update, cancel, or void a previously accepted EVV visit transaction; and
f. is not a duplicate of a previously accepted EVV visit transaction.

For avoidance of doubt, transactions transmitted from Proprietary Systems to HHSC's EVV Aggregator will not be counted for determination of the State Pool System Operations Fees.

If the number of "accepted transactions" is within the Reprice tier below Tier 1, HHSC shall pay Contractor the variable fee for Tier 1 until such time as the Parties mutually agree upon a price for the reduced volume. Upon agreement, Contractor shall refund to HHSC any difference between the variable fee for Tier 1 and the new price.

If the number of "accepted transactions" is within the Reprice tier above Tier 7, HHSC shall pay Contractor the variable fee for Tier 7 until such time as the Parties mutually agree upon a price for the increased volume. Upon agreement, Contractor shall invoice HHSC any difference between the variable fee for Tier 7 and the new price.

The tier pricing for each month's specific volume will be applicable as described in **Attachment A-1, Pricing Workbook, Variable State Pool System Operations Fees Worksheet.**

8.4.2.4 Transition Costs

During the Transition Phase, the Contractor will submit an invoice for up to **eighty-five (85%) percent** of the total fee for each Transition Key Milestones related to transition. HHSC will pay up to **eighty-five (85%) percent** of each completed Transition phase Key Milestone, less any assessed deductions for failure to provide an approved required Deliverable or for Service Level remedy. Once**,** the final transition milestone (Transition Milestone 8) is completed, the Contractor will submit an invoice for the final **fifteen (15%) percent** fee balance from all **eight (8)** transition milestones to HHSC. Once HHSC has provided formal acceptance and acknowledgement of completion of a fully operational Contractor Solution to the Contractor, then the final invoice for the remaining **fifteen (15%) percent** fee will be paid to the Contractor in accordance with the Prompt Payment Act, Title 10, Subtitle F Chapter 2251, Texas Government Code.

The fee structure for the respective Transition Key Milestones are capped as a percentage of the entire Transition Cost in **Table 39 – Transition Key Milestones with Percentage of Total Fee** as follows:

Table 39 – Transition Key Milestones with Percentage of Total Fee

Key Milestones	Maximum Percent of Key Milestone Total Fee Allowed	Payment After Transition Acceptance (Remainder Balance)	Total
Transition Milestone 1	85%	15%	100%
Transition Milestone 2	85%	15%	100%
Transition Milestone 3	85%	15%	100%
Transition Milestone 4	85%	15%	100%
Transition Milestone 5	85%	15%	100%
Transition Milestone 6	85%	15%	100%
Transition Milestone 7	85%	15%	100%
Transition Milestone 8	85%	15%	100%

HHSC will process and pay the transition costs in accordance with Texas Government Code Title 10, Subtitle F, Chapter 2251. Separate invoices for each Key Milestone must be submitted by the Contractor to HHSC in the format specified by HHSC. Each invoice will be processed and paid separately. As directed by HHSC, the Contractor will separate the invoices according to the various State and federal funding sources

that support the applicable Program that have responsibilities for specific Transition Key Milestones and/or segments of the respective Service.

HHSC, at its sole discretion, may choose to process only a portion of a Key Milestone invoice, if only a portion of the invoice can be verified and validated by the information submitted. If HHSC decides to process an invoice in this manner, an adjustment will be made by HHSC and only that portion of the Key Milestone invoice that can be verified and validated will be paid.

The Contractor must submit supplemental invoice(s) along with all necessary corrections to be paid for the Transition Key Milestones transition fees previously denied or not processed by HHSC. HHSC will process and pay Transition Key Milestones transition fee(s) billed on supplemental invoices in accordance with Texas Government Code Title 10, Subtitle F, Chapter 2251. Each invoice will be processed and paid separately.

Proposed transition costs will be included in the pricing evaluation for each Key Milestone. Actual transition costs in excess of the amount included in the Contract for each Transition Key Milestones will not be paid by HHSC. Transition requirements for each Transition Key Milestones will be subjected to one or more performance measurement(s). Performance remedies, either liquidated damages and/or actual damages, may apply to each Transition Key Milestones if the Contractor is not able to provide all of the necessary Services and/or Deliverables on the specified date for the specific Key Milestone(s) included in the Contract.

8.4.2.5 Supplemental Services

In order to accommodate future business objectives, which may be a result of implementation of federal and State mandates and other State initiatives, that are aligned with the original purpose of the Contract and reasonably related to the scope of the Solicitation, HHSC may require the Contractor to perform Supplemental Services during the Contract Term.

HHSC will initiate the request for Supplemental Services using the Change Order Request (COR) process. HHSC will provide such information as the Contractor reasonably requests in order to prepare a Supplemental Services Plan to address the performance of the requested services within the required timeline.

Unless otherwise agreed by the Parties, the Contractor will respond to HHSC’s Supplemental Services request on or before the thirtieth (30th) Business Day following the date of receipt of HHSC's request. In the case of a pressing need or an emergency, the Contractor will respond more quickly to HHSC’s Supplemental Services request.

In response to HHSC’s Supplemental Services request, the Contractor shall provide a Supplemental Services Plan that will include, at a minimum, the following information, properly itemized and supported by sufficient substantiating data (e.g., documentation by Subcontractors performing the work), to permit evaluation by HHSC:

a. A Project plan and fixed price or price estimate for the additional service;
b. A detailed breakdown of such price or estimate;

c. The estimated level of effort (service hours);
d. A description of the Service Levels to be associated with the additional service;
e. A schedule for commencing and completing the additional service;
f. A description and justification of the new hardware or software to be provided by the Contractor in connection with the additional service;
g. A description of the software, hardware, and other resources necessary to provide the additional service;
h. Any risks associated with the additional service and/or the integration of the additional service into the existing environment;
i. In the case of any developed materials to be created through the provision of the additional service, any ownership rights therein that differs from the provisions already included in the Contract; and
j. An analysis and estimate of the operational impacts related to the additional service.

The Contractor must provide, in the supplemental services cost proposal, cost information, including detailed supporting metrics and detailed supporting costs deemed acceptable by HHSC, in sufficient detail to accurately modify the applicable Fixed Fee and Variable Fee formulas. Once a total cost for the supplemental services is agreed upon, HHSC will make the determination as to which Fixed Fee and/or Variable Fee formula(s) are to be modified.

Notwithstanding any provision to the contrary:

a. The Contractor will act reasonably and in good faith in formulating the Supplemental Services pricing proposal;
b. The Contractor will identify potential means of reducing the cost to HHSC, including utilizing Subcontractors as and to the extent appropriate;
c. The Supplemental Services pricing proposal will be no less favorable to HHSC than the pricing and labor rates set forth in the Contract for comparable services;
d. The Supplemental Services pricing proposal will account for the existing and future volume of business between HHSC and the Contractor; and
e. The Contractor shall not be entitled to an increase in the Contract amount or a renewal or extension of the Base Contract Term with respect to any work performed that is not required by the Contract as amended, modified, and supplemented in a fully executed contract amendment.

HHSC may accept or reject any Supplemental Services Plan. Upon HHSC's acceptance of the Contractor's Supplemental Services Plan, the Contract will be amended to include the addition of such Supplemental Services. The Contractor shall not invoice and HHSC shall not pay for any charges related to the investigation of any proposed change to existing services or the development of Supplemental Services Plan(s). In addition, the Contractor shall not invoice and HHSC shall not pay for Supplemental Services that:

(1) deviate from the HHSC-approved Supplemental Services Plan;
(2) commence prior to the date of the applicable Contract amendment; and

(3) exceed the fees specified in the applicable Contract amendment.

8.4.2.6 Reduced Services

In the event of the occurrence of an Extraordinary Event or Unanticipated Change, HHSC may, at its option, request modifications to the Scope of Work to address each such occurrence.

For the purpose of this clause, the term "Extraordinary Event" means a circumstance in which an event or discrete set of events has occurred or is planned with respect to the operations of HHSC that results or will result in a reduction in the nature or volume of the Services that HHSC will require from the Contractor.

For the purpose of this clause, the term "Unanticipated Change" refers to a material change in the technologies or processes available to provide all or any portion of the Services which is outside the normal evolution of technology experienced by the Services, that was not generally available as of the Contract Effective Date and that would materially reduce the Contractor's cost of providing the Services.

If an Extraordinary Event or Unanticipated Change occurs, and if HHSC requests a modification to the Scope of Work to address such an occurrence, the Parties will use the Change Order Request (COR) process to equitably adjust the fees and other relevant provisions of the Contract to take the changed circumstance into account.

As part of the COR process, the Contractor and HHSC will mutually determine the efficiencies, economies, savings, and resource utilization reductions, if any, resulting from the Extraordinary Event and/or Unanticipated Change. Following the contract amendment memorializing the reduction of Services and the associated pricing adjustments, the Contractor will then proceed to implement such efficiencies, economies, savings, and resource utilization reductions as quickly as practicable and in accordance with the agreed upon schedule. As the efficiencies, economies, savings or resource utilization reductions are realized, the applicable Fixed Fee and/or Variable Fee specified in the Contract will be promptly and equitably adjusted to pass through to HHSC the net benefit of such efficiencies, economies, savings and resource utilization reductions; provided, that HHSC will reimburse the Contractor for any net costs or expenses incurred to realize such efficiencies, economies, savings or resource utilization reductions if and to the extent the Contractor:

a) Notifies HHSC of such additional costs and obtains HHSC's approval prior to incurring such costs;
b) Provides documented efforts to identify and consider practical alternatives, and reasonably determines that there is no other more practical or cost-effective way to obtain such savings without incurring such expenses; and
c) Provides documented efforts to minimize the additional costs to be reimbursed by HHSC.

An Extraordinary Event or Unanticipated Change will not result in Fixed Fee and/or Variable Fee to HHSC being higher than such Fixed Fee and/or Variable Fee in the Contract at the time of the applicable Extraordinary Event or Unanticipated

Change. The Contractor shall not invoice and HHSC shall not pay for any charges related to the investigation of any proposed change to existing services.

8.4.2.7 Periodic Activities

HHSC anticipates that, during the Contract Term, implementation of State and/or federal mandates and other State initiatives will require additions or changes to the activities performed under the Contract. Payment for costs associated with changes to Services and/or Deliverables required after the Effective Date of the Contract will be negotiated with the Contractor. The Contractor will develop not to exceed fixed price Change Orders based on the performance requirements and the specified results included in any potential change order requested by HHSC. The not to exceed Change Order will utilize the explicit fixed all-inclusive hourly labor rates proposed by the Contractor as described in **Attachment A-1, Pricing Workbook All-Inclusive Hourly Labor Rates Worksheet**. The invoices submitted to HHSC will be based on the actual number of hours worked on the specific modification by the Contractor's staff or the staff of the Contractor's Subcontractor multiplied by the explicit fixed all-inclusive hourly labor rates included in the Contract and proposed in the Change Order. The invoices for such changes will also be based on the actual costs for hardware, hardware maintenance, software license fees and software maintenance necessary to complete the Services and/or Deliverables.

A Contractor will employ the all-inclusive hourly labor rates for all staff working on this Project. **Attachment A-1, Pricing Workbook, All-Inclusive Hourly Labor Rates Worksheet,** contains definitions, classifications, and detailed information for all ITSAC defined IT related staffing roles and the all-inclusive labor rates for all IT and Non-IT staffing roles. **Attachment A-1, Pricing Workbook, All-Inclusive Hourly Labor Rates Worksheet** relates to both IT staffing and Non-IT staffing resources labor rates under this Contract. The Respondent must insert additional rows, classification types, definitions, and detailed information similar to the information that is included in **Attachment A-1, Pricing Workbook, All-Inclusive Hourly Labor Rates Worksheet** for all additional staff that would be utilized by the Contractor during the Contract Term. For consistency, the staffing Services roles defined in **Attachment A-1, Pricing Workbook, All-Inclusive Hourly Labor Rates Worksheet** are to be utilized for specifying all-inclusive hourly labor rates.

Attachment A-1, Pricing Workbook, Non-IT-Staffing-Descriptions must be completed with all the definitions, classifications, and detailed information for all Non-IT staffing roles.

The Contractor will employ the all-inclusive hourly labor rates proposed in developing pricing proposals for the performance of new or modified Services and Deliverables that are required after the Contract Effective Date.

No additional costs related to the all-inclusive hourly labor rates will be paid for any other items unless HHSC, in its sole discretion, determines that any additional cost(s) requested by the Contractor are unique to the specific Project and that the Contractor should not have otherwise included those additional costs as part of the required all-inclusive hourly labor rates.

HHSC will process and pay these fee(s) in accordance with Texas Government Code Title 10, Subtitle F, Chapter 2251. If HHSC identifies any discrepancies in the information provided by the Contractor, HHSC will notify the Contractor of the discrepancies as soon as is practicable and will not process the invoice until all information is reconciled.

To be paid for the fixed service delivery fees previously denied or not processed by HHSC, the Contractor will submit supplemental invoice(s) along with all necessary corrections. HHSC will process and pay service delivery fees billed on supplemental invoices in accordance with Texas Government Code Title 10, Subtitle F, Chapter 2251. Contractor will submit separate invoices for each specific program type and each specific Change Order to HHSC in the format specified by HHSC. HHSC will process and pay each invoice separately.

The costs for such non-recurring modifications will be subject to the Prospective Price Re-determination provisions.

The Contractor will employ the Periodic Activity All-Inclusive Hourly Labor Rates proposed in developing pricing proposals for the performance of additional periodic activities required after the Contract Effective Date. Additional periodic activities are defined as the provision of any service(s), Deliverable(s) or product(s) that will not be performed on a regular recurring basis.

The all-inclusive hourly labor rates will be proposed for the first forty-eight (48) months of the resulting Contract. Periodic Activity All-Inclusive Hourly Labor Rates for the subsequent twelve (12) month of the optional renewal or extension periods will be determined by the application of a onetime fixed annual price inflator/deflator on renewal year one (1) proposed by the Contractor and accepted by HHSC.

The Periodic Activity All-Inclusive Hourly Labor Rates proposed by the Contractor must contain all costs related to performing the required functions; including, but not limited to, local travel, long-distance travel, long-distance telephone communications, computer depreciation and/or computer usage costs, salaries, fringe benefits, indirect overhead charges, and the allowable administrative service fee. No additional costs will be paid for any other items unless HHSC, in its sole discretion, determines that any additional cost(s) requested by the Contractor are extremely unique to the specific Project and that the Contractor should not have otherwise included those additional costs as part of the required all-inclusive hourly labor rates.

The State intends to process and pay the modifications fee(s) in accordance with Texas Government Code Title 10, Subtitle F, Chapter 2251. If any discrepancies are determined in the information provided by the Contractor, HHSC will notify the Contractor of the discrepancies as soon as is practicable and will not process the invoice until all information is reconciled.

The Contractor must submit supplemental invoice(s) along with all corrections necessary to be paid for the modifications fee(s) previously denied or not processed by HHSC. HHSC will process and pay modifications fee(s) billed on supplemental

invoices in accordance with Texas Government Code Title 10, Subtitle F, Chapter 2251. Each invoice will be processed and paid separately.

8.4.2.8 Recurring Activities

HHSC anticipates that, during the Contract Term, implementation of State and federal mandates and other State initiatives will require additions or changes to the normal activities performed under the Contract. For purposes of this section, Recurring Activities means those additions or changes to normal activities that will be needed to be performed on an ongoing basis. All such changes will be negotiated between HHSC and Contractor. The pricing associated with additional Recurring Activities will be negotiated between the Contractor and HHSC after HHSC determines that the Contractor has submitted all the detailed cost information and proper justification necessary (including detailed metrics deemed acceptable by HHSC) to accurately modify the fixed and/or Variable fees. Once a total cost for the additional recurring activities is agreed upon, HHSC will make the determination as to whether the fixed fee formula(s) are modified, one or more of the Variable formula(s) are modified, or all appropriate administrative payment components are modified. If the Parties fail to reach an agreement regarding either the change or the associated cost, HHSC may exercise its right to terminate the Contract.

The fixed annual inflation/deflation factor(s) (if applicable) and the allowable Administrative Service Fee included in the Contract will be applicable for any of the proposed expenses submitted by the Contractor and reviewed by HHSC to determine the appropriate Fixed and/or Variable fee adjustments included in any amendment executed to include the Additional Recurring Activities in the Contract.

8.4.3 Additional Financial Components

8.4.3.1 Ownership of Non-SaaS Nonexpendable Capital Items at Termination of the Contract

This **Section 8.4.3.1, Ownership of Non-SaaS Nonexpendable Capital Items at Termination of the Contract,** relates to Contract specific capital items needed to support the Services and Deliverables included in this Solicitation such as desktop/laptop computers purchased for use by the EVV Contractor staff.

Ownership of all Non-SaaS Nonexpendable Capital Items, including leased capital items, funded by the Contract will pass to HHSC at the expiration or earlier termination of the Contract.

Non-SaaS Nonexpendable Capital Items are defined as tangible and personal property of a non-consumable nature that have an acquisition cost of $500.00 or more per unit and an expected useful life of at least **one (1)** year. The term nonexpendable capital item includes, but is not limited to, office furniture, office equipment, telephone equipment, computer furniture, computer equipment, computer software (including COTS software) and computer leases.

Computer software and software license(s) that fall under this definition are limited to those that transfer with equipment to HHSC upon termination of the Contract and do not require any monthly or annual fees to continue to be operational.

All Non-SaaS Nonexpendable Capital Items, including Non-SaaS Nonexpendable Capital Items that are leased, will either be expensed at the time of purchase and implementation or will be depreciated / amortized monthly during the Contract Term. HHSC will determine the methodology for expensing or depreciating / amortizing any nonexpendable capital item and inform the Contractor of its decision prior to the Contractor purchasing the items. The cost of installation (excluding in-house labor) of equipment, furniture, workstations, and other leasehold improvements required to make the space useable to meet the requirements of the Contract will also be treated in the same manner as the capital item; the cost will either be expensed at the time of purchase and implementation or will be depreciated during the Contract Term.

If the Contract terminates before the end of the Base Contract Term, HHSC will have the option to take ownership of all, some, or none of the Non-SaaS Nonexpendable Capital Items.

All capital lease(s) will include the ability for the Contractor to purchase the capital items included in the lease for $1.00 at the expiration of the Contract Term. If the Contract terminates before the end of the Base Term, HHSC will have the option to take ownership of all, some, or none of the Non-SaaS Nonexpendable Capital Items. If HHSC chooses to take ownership of a Non-SaaS Nonexpendable Capital Items, HHSC will (subject to the other limitations set forth in the Contract), reimburse the Contractor for the remaining months of any Non-SaaS Nonexpendable Capital Items (depreciation), amortized capitalized lease costs, amortized operating lease costs, costs related to lease purchase options and/or installation costs related to equipment, furniture, workstations, or other leasehold improvements (capital items) acquired under the Contract. These costs are limited to the Contract Term.

In exercising its options under the foregoing paragraph, HHSC will have the right to offset against any such reimbursements any remedies and/or damages that HHSC is entitled to assess against the Contractor.

If HHSC elects to take ownership of any Non-SaaS Nonexpendable Capital Items, the Contractor will ship all Non-SaaS Nonexpendable Capital Items purchased and third-party software licensed pursuant to the Contract, freight prepaid, freight on board (FOB) HHSC's destination. The method of shipment will be consistent with the nature of the Non-SaaS Nonexpendable Capital Items and hazards of transportation. Regardless of FOB point, the Contractor must agree to bear all risks of loss, damage, or destruction of Deliverables, in whole or in part, ordered hereunder that occurs prior to acceptance by HHSC, except loss or damage attributable to HHSC's fault or negligence; and such loss, damage, or destruction will not release the Contractor from any obligation hereunder. After acceptance by HHSC, the risk of loss or damage will be borne by HHSC, except loss or damage attributable to the Contractor's fault or negligence.

If HHSC does not choose to take ownership of a Non-SaaS Nonexpendable Capital Items, then all costs associated with that item remain the responsibility of the Contractor without any recourse to HHSC.

The Contractor is advised not to enter into any leases that extend beyond the base term of the Contract. In no event will HHSC reimburse the Contractor for the portion of

any lease that is allocable beyond the base term of the Contract. The Contractor will be responsible to pay any costs related to exercising any purchase option to provide HHSC with a clear title to any capital items HHSC chooses to retain. The Contractor will be responsible to pay any such costs on or before the date the Contract expires or is terminated.

At the end of the Contract, the Contractor will transfer ownership and possession of all hardware and software related to the Non-SaaS Nonexpendable Capital Items described in this section (including but not limited to software purchased under the Contract) that was funded through the respective Contract and any other materials or property deemed to be a product of the Contract to HHSC, or a new service provider as designated by HHSC, within the timelines specified by HHSC. The Contractor will be responsible for all costs related to transferring the assets to HHSC or HHSC's designee. All transferred data must be compliant with HIPAA requirements. Refer to Title 45 CFR, Subtitle A, Subchapter A, Part 95, Subpart F, Section 95.617 for ownership rights related to nonexpendable capital items specifically related to the EVV SaaS solution.

The funds budgeted for capital equipment cannot be used for any expenditures other than for capital items (capital equipment purchases, capital equipment leases or installation costs related to equipment, furniture, workstations, or other leasehold improvements) necessary to meet the requirements of the Contract.

All Non-SaaS Nonexpendable Capital Items acquired under the Contract will be recorded and a list will be provided to HHSC at the end of each State fiscal quarter. The Contractor will use an asset tracking system, processes, procedures, and asset tracking software approved by HHSC to record all Non-SaaS Nonexpendable Capital Items on the required asset list. The list of the Non-SaaS Nonexpendable Capital Items must include, at a minimum:

a. A description of each capital item;
b. Model number;
c. Manufacturer's serial number where applicable;
d. Funding source;
e. Information needed to calculate the federal and State share of the acquisition cost;
f. Date of acquisition;
g. Unit cost; and
h. Information on the specific location of the capital item. HHSC will have the right to modify the detailed information necessary that is related to this asset listing requirement.

At HHSC's option and subject to its prior written approval and acceptance, ownership of all Non-SaaS Nonexpendable Capital Items acquired during the term of the Contract will vest in HHSC at the earliest of:

1) The date the nonexpendable capital item is no longer needed to fulfill any requirements of the Contract;

2) The date the item is turned over to HHSC; or
3) Upon expiration or termination of the Contract.

At no time will the Contractor dispose of Non-SaaS Nonexpendable Capital Items purchased for the Contract without prior approval from HHSC. Within ten (10) Business Days after the earliest of the events stated above, the Contractor will provide HHSC with all documentation reasonably necessary to evidence HHSC's ownership of the items. The Contractor will obtain prior approval from HHSC before purchasing any Non-SaaS Nonexpendable Capital Items and/or any commercially off the shelf software for the Contract.

8.4.3.2 Payment for Pass-Through Items

Actual expenditures for Pass-Through Items made on HHSC's behalf will be paid without allocation of any indirect charges (general and administrative expenses, overhead, etc.) or administrative service fees. The Contractor must utilize the detailed pricing schedules included in **Attachment A-1, Pricing Workbook,** to depict the amount of pass-through expenses that will be paid without indirect charges or administrative service fees. Items designated as Pass-Through Items include the following:

a. Capital expenditures (with sales taxes) including lease or rental payments on capital equipment;
b. All postage expenses/delivery expenses directly related to the operation of the Contract;
c. Software license and maintenance fees;
d. Office rent (including leasehold improvements and lease pass-through expenses);
e. All printing costs including Provider Manuals, Handbooks, Bulletins, and similar; and
f. All telecommunication lines, including local lines, toll-free lines, electronic communications lines, fiber optic lines, cell phones, Internet connections, etc.

Actual expenditures for Pass-Through Items made on HHSC's behalf will be paid without allocation of any indirect charges (general and administrative expenses, overhead, etc.) or the allowable administrative service fee for any proposed expenses submitted by the Contractor and reviewed by HHSC to determine the appropriate Fixed Fee and/or Variable Fee adjustments included in any amendment to the Contract.

Pass-Through Items will not be paid separately by HHSC. Contractors must include expenses related to Pass-Through Items in with the Fixed Fee and/or Variable Fee proposed by the Contractor. As such, since Pass-Through Items are included as an element of the fixed and/or variable fees that will be paid to the Contractor, they are included in the "Fee Ceiling" explained in **Section 8.4.3.3, Administrative Fees**.

Actual allowable expenses related to Pass-Through Items incurred by the Contractor will be included as part of the total allowable costs incurred by the Contractor plus the

allowable Administrative Service Fee in calculating any Payment Disparities for the Prospective Price Re-determination.

8.4.3.3 Administrative Fees

Administrative Fees paid to the Contractor during each Operational Contract Year will consist of:

1. the Fixed Administrative Fees;
2. the Variable Administrative Fees:
3. the Administrative Fees for the Additional Periodic Activities; and
4. the Administrative Fees for the Additional Recurring Activities.

The sum of the above four Fee components will be referred to as the "Fee Ceiling". The total maximum cost of the Services and Deliverables, separated by each program type, supplied by the Contractor to HHSC during each Operational Contract Year will not exceed the lesser of

a. the Contractor's fees (Fee Ceiling); or

b. the sum of the Allowable Costs incurred by the Contractor plus the allowable administrative service fee during the subject Operational Contract Year.

The sum of Allowable Costs incurred by the Contractor will potentially include adjustments necessary as a result of the determination of Allowable Costs for the Contractor. HHSC will solely determine the specific Subcontractors that will be considered Major Subcontractors for this Prospective Price Re-determination provisions. Major Subcontractors will normally be limited to Contractor's Subcontractors whose costs exceed 15% of the annual projected value of the Fee Ceiling or whose primary business function is to provide staffing. HHSC reserves the right to designate any of the Contractor's Subcontractors as a Major Subcontractor.

8.4.3.4 Prospective Price Re-Determination

HHSC is procuring a fixed-price re-determinable prospective Contract that will allow the total fees paid during a specified time period to be lowered during a succeeding time period if the actual profits earned by the Contractor during a specified time period are at least 20% greater than the allowed profit percentage included in the negotiated fixed fees at the beginning of the Contract. For example: if the agreed upon profit percentage is 10%, then actual profits above 12% would meet the criteria for the Prospective Price Re-determination provisions. Specified time periods designated by HHSC for this provision are as follows:

1. PPR Audit #1: Operational Contract Year 1 and Operational Contract Year 2 (i.e., the initial nineteen (19) months of Operations) of the Base Term of the Contract.

2. PPR Audit #2: Operational Contract Year 3 and Operational Contract Year 4, (i.e., the remaining twenty-four (24) months of Operations) of the Base Term of the Contract.

The first Prospective Price Re-determination audit would include the initial nineteen (19) months of operations. The PPR Audit #1 may be conducted during

the Operational Contract Year three (3). Modifications, if necessary, would be applied to Operational Contract Year 4 and each applicable option year (Operational Contract Years 5, 6 and 7) if the Contract is extended.

A second Prospective Price Re-determination audit may be conducted and would include Operational Contract Years 3 and 4 of the base term of the Contract. The PPR audit #2 may be conducted during the Operational Contract Year 5. Modifications, if necessary, would be applied to each applicable option year during the second (Operational Contract Year 6) and third (Operational Contract Year 7) option periods. Any contract resulting from this Solicitation shall include the Prospective Price Re-determination provisions. See Figure 1 - Prospective Price Re-Determination (PPR) Audit Timeline.

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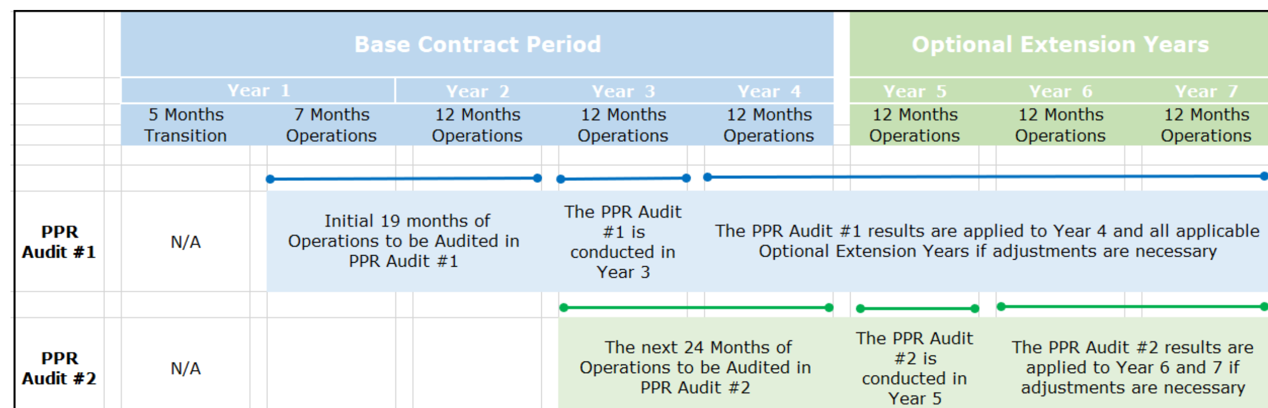
Figure 1 - *Prospective Price Re-Determination (PPR) Audit Timeline*



The following three (3) scenarios depict how HHSC will apply the prospective price re-determination provisions to hypothetical results attained by a Contractor.

Table 40 – PPR Scenario 1: actual profit is greater than allowed profit and greater than proposed profit.

Table 40 – PPR Scenario 1

Cost Items	Rates	Proposed Expenses and Profit for Initial 20 Operational Months	Actual Expenses and Profit for Initial 20 Operational Months	
Cost Analysis				
Salaries (including Fringe Benefits)		$1,000,000	$950,000	A
Direct Expenses		$2,000,000	$1,900,000	B
Subtotal: Salaries and Direct Expenses		$3,000,000	$2,850,000	C = A + B
Indirect Expenses: (Overhead and General and Administrative)	8.00%	$240,000	$228,000	D = 8% x C
Subtotal: Salaries, Direct Expense, and Indirect Expenses		$3,240,000	$3,078,000	E = C + D
Proposed Profit	10.00%	$324,000		

Total Fixed and Variable Ceiling Amount		$3,564,000		
Total Fixed and Variable Fees Paid to Contractor		$3,564,000	$3,564,000	F
Profit Analysis				
Proposed Profits	10.00%	$324,000		
Actual Profits (= G / E)	15.79%		$486,000	G = F - E
Allowed Profit	12.00%		$369,360	H = 12% x E
Difference (Excess Profits)			$116,640	I = G - H
Monthly Average of Excess Profits (Amount / 20 months)			$5,832	J = I / 20
Annualized Excess Profits (12 Months)			$69,984	K = J x 12
Reduction to future Fixed Fees			$69,984	K

Table 41 – PPR Scenario 2: actual profit is less than allowed profit but greater than proposed profit.

Table 41 – PPR Scenario 2

Cost Items	Rates	Proposed Expenses and Profit for Initial 20 Operational Months	Actual Expenses and Profit for Initial 20 Operational Months	
Cost Analysis				
Salaries (including Fringe Benefits)		$1,000,000	$990,000	A
Direct Expenses		$2,000,000	$1,980,000	B

Cost Items	Rates	Proposed Expenses and Profit for Initial 20 Operational Months	Actual Expenses and Profit for Initial 20 Operational Months	
Subtotal: Salaries and Direct Expenses		$3,000,000	$2,970,000	C = A + B
Indirect Expenses: (Overhead and General and Administrative)	8.00%	$240,000	$237,600	D = 8% x C
Subtotal: Salaries, Direct Expense, and Indirect Expenses		$3,240,000	$3,207,600	E = C + D
Proposed Profit	10.00%	$324,000		
Total Fixed and Variable Ceiling Amount		$3,564,000		
Total Fixed and Variable Fees Paid to Contractor		$3,564,000	$3,564,000	F
Profit Analysis				
Proposed Profits	10.00%	$324,000		
Actual Profits (= G / E)	11.11%		$356,400	G = F - E
Allowed Profit	12.00%		$384,912	H = 12% x E
Difference (Excess Profits)			None	I = G - H
Monthly Average of Excess Profits (Amount / 20 months)			N/A	J = I / 20
Annualized Excess Profits (12 Months)			N/A	K = J x 12
Reduction to future Fixed Fees			N/A	K

Table 42 - PPR Scenario 3: actual profit is less than allowed profit and less than proposed profit.

Table 42 – PPR Scenario 3

Cost Items	Rates		Proposed Expenses and Profit for Initial 20 Operational Months	Actual Expenses and Profit for Initial 20 Operational Months	
	Cost Analysis				
Salaries (including Fringe Benefits)			$1,000,000	$1,020,000	A
Direct Expenses			$2,000,000	$2,040,000	B
Subtotal: Salaries and Direct Expenses			$3,000,000	$3,060,000	C = A + B
Indirect Expenses: (Overhead and General and Administrative)	8.00%		$240,000	$244,800	D = 8% x C
Subtotal: Salaries, Direct Expense, and Indirect Expenses			$3,240,000	$3,304,800	E = C + D
Proposed Profit	10.00%		$324,000		
Total Fixed and Variable Ceiling Amount			$3,564,000		
Total Fixed and Variable Fees Paid to Contractor			$3,564,000	$3,564,000	F
	Profit Analysis				
Proposed Profits	10.00%		$324,000		

Actual Profits (= G / E)	7.84%			$259,200	G = F - E
Allowed Profit	12.00%			$396,576	H = 12% x E
Difference (Excess Profits)				None	I = G - H
Monthly Average of Excess Profits (Amount / 20 months)				N/A	J = I / 20
Annualized Excess Profits (12 Months)				N/A	K = J x 12
Reduction to future Fixed Fees				N/A	K

ARTICLE IX. GENERAL TERMS AND CONDITIONS

9.1 GENERAL CONDITIONS

9.1.1 Changes, Modifications, and Cancellation

HHSC reserves the right to make changes to and/or cancel this RFO and will post all changes and modifications, whether made as a result of a potential Respondent's written inquiries or otherwise, and cancellation notices on the ESBD. It is the responsibility of the Respondent to check the ESBD regularly for any additional information regarding this RFO. If the Respondent fails to monitor the ESBD for any changes or modifications to the RFO, such failure will not relieve the Respondent of its obligation to fulfill the requirements as posted.

9.1.2 Offer Period

Solicitation Responses shall be binding for a period of 240 days after the submission due date. A Respondent may extend the time for which its Solicitation Response will be honored. Upon Contract execution, prices agreed upon by the successful Respondent(s) are an irrevocable offer for the term of the Contract and any Contract renewals or extension(s). No other costs, rates, or fees shall be payable to the successful Respondent unless expressly agreed upon in writing by HHSC.

9.1.3 Costs Incurred

Respondents understand that issuance of this Solicitation in no way constitutes a commitment by HHSC to award a Contract or to pay any costs incurred by a Respondent in the preparation of a response to this Solicitation. HHSC is not liable for any costs incurred by a Respondent. Costs of developing Solicitation Responses, preparing for or

participating in Oral Presentations, Demonstrations, and Site Visits, or any other similar expenses incurred by a Respondent are entirely the responsibility of the Respondent, and will not be reimbursed in any manner by the State of Texas.

9.1.4 Contract Responsibility

HHSC will look solely to the successful Respondent for the performance of all contractual obligations that may result from an award based on this Solicitation. The successful Respondent shall not be relieved of its obligations for any nonperformance by its Subcontractors.

9.1.5 Public Information Act - Respondent Requirements Regarding Disclosure

Proposals and contracts are subject to the Texas Public Information Act (PIA), Texas Government Code Chapter 552, and may be disclosed to the public upon request. Other legal authority also requires HHSC to post contracts and proposals on its public website and to provide such information to the Legislative Budget Board for posting on its public website.

Under the PIA, certain information is protected from public release. If Respondent asserts that information provided in its Solicitation Response is exempt from disclosure under the PIA, Respondent must:

a. Mark Original Solicitation Response:

1. Mark the Original Solicitation Response, on the top of the front page, with the words "CONTAINS CONFIDENTIAL INFORMATION" in large, bold, capitalized letters (the size of, or equivalent to, 12-point Times New Roman font or larger);
2. Mark the bottom of each page on the Solicitation Response that contains information that Respondent claims is exempt from public disclosure with the words "CONTAINS CONFIDENTIAL INFORMATION";
3. Identify, adjacent to each portion of the Solicitation Response that Respondent claims is exempt from public disclosure, the claimed exemption from disclosure *(**NOTE**: no redactions are to be made in the Original Solicitation Response)*;

b. Certify in Original Solicitation Response – HHS Solicitation Affirmations V2.2 (attached as <u>Exhibit A</u> to this Solicitation):

Certify, in the designated section of the HHS Solicitation Affirmations Version 2.2, Respondent's confidential information assertion and the filing of its Public Information Act Copy; and

c. Submit Public Information Act Copy of Solicitation Response:

Submit a separate "Public Information Act Copy" of the Original Solicitation Response (in addition to the original and all copies otherwise required under the provisions of this Solicitation). The Public Information Act Copy must meet the following requirements:

1. The copy must be clearly marked as "Public Information Act Copy" on the front page in large, bold, capitalized letters (the size of, or equivalent to, 12-point Times New Roman font or larger);

2. Each portion Respondent claims is exempt from public disclosure must be redacted (blacked out); and
3. Respondent must identify, adjacent to each redaction, the claimed exemption from disclosure. Each identification provided as required in Subsection (c) of this section must be identical to those set forth in the Original Solicitation Response as required in Subsection (a)(2), above. The only difference in required markings and information between the Original Solicitation Response and the "Public Information Act Copy" of the Solicitation Response will be redactions - which can only be included in the "Public Information Act Copy." There must be no redactions in the Original Solicitation Response.

By submitting a response to this Solicitation, Respondent agrees that, if Respondent does not mark the Original Solicitation Response, provide the required certification in the HHS Solicitation Affirmations Version 2.2, and submit the Public Information Act Copy, Respondent's Solicitation Response will be considered to be public information that may be released to the public without notice to the Respondent in any manner including, but not limited to, in accordance with the Public Information Act, posted on HHSC' public website, and posted on the Legislative Budget Board's public website.

If any or all Respondents submit partial, but not complete, information suggesting inclusion of confidential information and failure to comply with the requirements set forth in this section, HHSC, in its sole discretion and in any Solicitation, reserves the right to (1) disqualify all Respondents that fail to fully comply with the requirements set forth in this section, or (2) to offer all Respondents that fail to fully comply with the requirements set forth in this section additional time to comply.

Respondent should not submit a Public Information Act Copy indicating that the entire Solicitation Response is exempt from disclosure. Merely making a blanket claim that the entire response is protected from disclosure because it contains any amount of confidential, proprietary, trade secret, or privileged information is not acceptable.

A Solicitation Response should not be marked or asserted as copyrighted material. If Respondent asserts a copyright to any portion of its response, by submitting a response, Respondent agrees to reproduction and posting on public websites by the State of Texas, including all other State agencies, without cost or liability and, additionally, agrees to allow the State of Texas to provide a copy of the Solicitation Response to individuals making a PIA request for the response.

HHSC will strictly adhere to the requirements of the PIA regarding the disclosure of public information. As a result, by participating in this Solicitation process, Respondent acknowledges that all information, documentation, and other materials submitted in the Solicitation Response in response to this Solicitation may be subject to public disclosure under the PIA. HHSC does not have authority to agree that any information submitted will not be subject to disclosure. Disclosure is governed by the PIA and by rulings of the Office of the Texas Attorney General. Respondents are advised to consult with their legal counsel concerning disclosure issues resulting from this process and to take precautions to safeguard trade secrets and proprietary or otherwise confidential information. HHSC

assumes no obligation or responsibility relating to the disclosure or nondisclosure of information submitted by Respondents.

For more information concerning the types of information that may be withheld under the PIA or questions about the PIA, please refer to the Public Information Act Handbook published by the Office of the Texas Attorney General or contact the attorney general's Open Government Hotline at (512) 478-OPEN (6736) or toll-free at (877) 673-6839 (877-OPEN TEX). To access the Public Information Act Handbook, please visit the attorney general's website at http://www.texasattorneygeneral.gov.

9.1.6 Respondent Waiver – Intellectual Property

SUBMISSION OF ANY DOCUMENT TO HHSC IN RESPONSE TO THIS SOLICITATION CONSTITUTES AN IRREVOCABLE WAIVER AND AGREEMENT BY RESPONDENT TO FULLY INDEMNIFY THE STATE OF TEXAS, HHSC FROM ANY CLAIM OF INFRINGEMENT BY HHSC REGARDING THE INTELLECTUAL PROPERTY RIGHTS OF RESPONDENT OR ANY THIRD PARTY FOR ANY MATERIALS SUBMITTED TO HHSC BY RESPONDENT.

9.1.7 Standards of Conduct for Vendors

Pursuant to Title 1 of the Texas Administrative Code (TAC), Part 15, Chapter 391, Subchapter D, Rule §391.405(a), contractors, Respondents, and vendors interested in working with [HHSC are required to implement standards of conduct to apply to all matters involving, or related to, those solicitations and contract(s) between themselves and HHS. These standards must adhere to ethics requirements adopted in rule, in addition to any ethics policy, or code of ethics approved by the HHSC executive commissioner and must be at least as restrictive as those applicable to HHSC personnel in the applicable ethics law and policy provisions.

The standards of conduct must include the ten standards of ethical conduct set forth in Section I of the HHS Ethics Policy and requirements to comply with ethical standards set forth in federal and State law (including, but not limited to, 1 TAC pt. 15, ch. 391, subch. D).

The standards of conduct, together with the responsibilities and restrictions incorporated herein, also apply to Subcontractors of Contractors, Respondents, and vendors.

Standards of conduct of any Contractor, Respondent, or vendor may be reviewed and/or audited by the State Auditor and HHSC. Additionally, pursuant to Title 1 of the TAC Part 15, Chapter 391, Subchapter D, Rule §391.405(a), HHSC may examine a Respondent's standards of conduct in the evaluation of a bid, offer, proposal, quote, or other applicable expression of interest in a proposed purchase of Goods or Services.

Any vendor or contractor that violates a provision of Title 1 of the TAC Part 15, Chapter 391, Subchapter D may be barred from receiving future contracts or have an existing contract canceled. Additionally, HHSC may report the vendor's actions to the Comptroller of Public Accounts for statewide debarment, or law enforcement.

9.1.8 Disclosure of Interested Parties

Pursuant to Section 2252.908 of the Texas Government Code, a successful Respondent to be awarded a Contract with a value of $1 million or more or awarded a Contract that would

require the successful Respondent to register as a lobbyist under Texas Government Code Chapter 305 must submit a disclosure of interested parties form to HHSC at the time the Respondent submits the signed Contract. Rules and filing instructions may be found on the Texas Ethics Commission's public website and additional instructions will be given by HHSC to the successful Respondent.

9.2 INSURANCE

9.2.1 Required Coverage

For the duration of the Contract Term, Contractor shall acquire insurance, bonds, or both with financially sound and reputable independent insurers, in the type and amount listed on **Exhibit J, Contractor Insurance**. Failure to maintain insurance coverage or acceptable alternative methods of insurance shall be deemed a breach of contract.

Contractor shall carry insurance in the types and amounts indicated in **Exhibit J, Contractor Insurance** for the duration of the Contract. The insurance shall be evidenced by delivery to System Agency of certificates of insurance executed by the insurer or its authorized agent stating coverages, limits, expiration dates and compliance with all applicable required provisions. Upon request, Owner, or its agents, shall be entitled to receive without expense, copies of the policies and all endorsements.

Contractor shall update all expired policies prior to submission for monthly payment. Failure to update policies shall be reason for withholding of payment until renewal is provided to System Agency.

Contractor shall provide and maintain all insurance coverage with the minimum amounts described throughout the life of the Contract.

Failure to maintain insurance coverage, as required, is grounds for suspension of Work for cause.

Contractor shall deliver to System Agency true and complete copies of certificates and corresponding policy endorsements upon Award.

Failure of System Agency to demand such certificates or other evidence of Contractor's full compliance with these insurance requirements or failure of System Agency to identify a deficiency in compliance from the evidence provided shall not be construed as a waiver of Contractor's obligation to maintain such insurance.

The insurance and insurance limits required herein shall not be deemed as a limitation on Contractor's liability under the indemnities granted to System Agency in the Contract.

The insurance coverage and limits established below shall not be interpreted as any representation or warranty that the insurance coverage and limits necessarily will be adequate to protect Contractor.

Coverage shall be written on an occurrence basis by companies authorized and admitted to do business in the State of Texas and rated A or better by A.M. Best Company or similar rating company or otherwise acceptable to System Agency.

9.2.2 Alternative Insurability

Notwithstanding the preceding, HHSC reserves the right to consider reasonable alternative methods of ensuring the Contract in lieu of the insurance policies customarily required. It

will be the Respondent's responsibility to recommend to HHSC alternative methods of insuring the Contract. Any alternatives proposed by Respondent should be accompanied by a detailed explanation regarding Respondent's inability to obtain the required insurance and/or bonds. HHSC shall be the sole and final judge as to the adequacy of any substitute form of insurance coverage.

9.3 PROTEST

Any protest shall be governed by the rules published by HHSC in the TAC, Title 1, Part 15, Chapter 391, Subchapter C, Protests.

(Remainder of this page intentionally left blank)

ARTICLE X. LIST OF EXHIBITS AND ATTACHMENTS

ATTACHMENT A -1	PRICING WORKBOOK
ATTACHMENT A -2	PROCUREMENT LIBRARY
EXHIBIT A	HHS SOLICITATION AFFIRMATIONS V2.2
EXHIBIT B	HHS UNIFORM TERMS AND CONDITIONS – VENDOR V3.2
EXHIBIT C	HHS ADDITIONAL PROVISIONS, V1.0
EXHIBIT D	FEDERAL ASSURANCES – NON-CONSTRUCTION PROGRAMS
EXHIBIT E	CERTIFICATION REGARDING LOBBYING
EXHIBIT F	EXCEPTIONS FORM
EXHIBIT G	ASSUMPTIONS FORM
EXHIBIT H	DATA USE AGREEMENT (DUA)
EXHIBIT H-1	ATTACHMENT 2 TO THE DUA, SECURITY AND PRIVACY INQUIRY (SPI)
EXHIBIT I	HUB SUBCONTRACTING PLAN AND SUBMITTAL REQUIREMENTS
EXHIBIT J	CONTRACTOR INSURANCE
EXHIBIT K	ONLINE BID ROOM INSTRUCTIONS
EXHIBIT L	VOLUNTARY PRODUCT ACCESSIBILITY TEMPLATE® (VPAT®)
EXHIBIT M	EVALUATION TOOL
EXHIBIT N	HHS INFORMATION SECURITY AND PRIVACY REQUIREMENTS
EXHIBIT O	INFORMATION TECHNOLOGY INFRASTRUCTURE LIBRARY (ITIL) SEVERITY LEVELS
EXHIBIT P	DEMONSTRATION CONSENSUS SCORING RUBRIC
EXHIBIT Q	HHSC EVV POLICIES
EXHIBIT R	HHSC EVV BUSINESS RULES
EXHIBIT S	HHSC EVV BUSINESS RULES FOR PROPRIETARY SYSTEMS
EXHIBIT T	EVV STANDARD LANGUAGE GUIDE
EXHIBIT U	EVV SERVICE BILL CODES TABLE
EXHIBIT V	SAMPLE CONTRACT SIGNATURE DOCUMENT
EXHIBIT W	CONTRACT AFFIRMATIONS V2.1

Solicitation Number ______________________________

Exhibit A. HHS SOLICITATION AFFIRMATIONS

In this document, HHS includes both the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS). System Agency refers to HHSC, DSHS, or both, that will be a party to any contract resulting from the Solicitation. In this document, the terms Respondent, Contractor, Applicant, and Vendor, when referring to the following affirmations (whether framed as certifications, representations, warranties, or in other terms) refer to Respondent, and the affirmations apply to all Respondents regardless of their business form (e.g., individual, partnership, corporation). To the extent applicable for DFPS solicitations, the definition of System Agency includes DFPS.

Respondent must provide information, as applicable, and affirms, without exception, as follows:

1. Respondent represents and warrants that all certifications, representations, warranties, and other provisions in this Affirmations and Solicitation Acceptance apply to Respondent and all of Respondent's principals, officers, directors, shareholders, partners, owners, agents, employees, subcontractors, independent contractors, and any other representatives who may provide services under, who have a financial interest in, or otherwise are interested in this Solicitation or any contract resulting from this Solicitation.

2. **Complete and Accurate Information.** Respondent represents and warrants that all statements and information provided to HHS are current, complete, and accurate. This includes all statements and information in this Solicitation Response.

3. **Public Information Act.** Respondent understands that HHS will comply with the Texas Public Information Act (Chapter 552 of the Texas Government Code) as interpreted by judicial rulings and opinions of the Attorney General of the State of Texas. Information, documentation, and other material prepared and submitted in connection with this Solicitation or any resulting contract may be subject to public disclosure pursuant to the Texas Public Information Act. In accordance with Section 2252.907 of the Texas Government Code, Respondent is required to make any information created or exchanged with the State pursuant to the contract, and not otherwise excepted from disclosure under the Texas Public Information Act, available in a format that is accessible by the public at no additional charge to the State.

4. **Contracting Information Requirements.** Respondent represents and warrants that it will comply with the requirements of Section 552.372(a) of the Texas Government Code. Except as provided by Section 552.374(c) of the Texas Government Code, the requirements of Subchapter J (Additional Provisions Related to Contracting Information), Chapter 552 of the Government Code, may apply to the contract and the Respondent agrees that the contract can be terminated if the Respondent knowingly or intentionally fails to comply with a requirement of that subchapter.

5. **Confidential or Proprietary Information.** Respondent acknowledges its obligation to specifically identify information it contends to be confidential or proprietary and, if Respondent designated substantial portions of its Solicitation Response or its entire Solicitation Response as confidential or proprietary, the Solicitation Response is subject to being disqualified.

6. **Binding Offer.** Respondent's Solicitation Response will remain a firm and binding offer for 240 days from the date the Solicitation Response is due.

7. **Assignment.** Respondent shall not assign its rights under the contract or delegate the performance of its duties under the contract without prior written approval from System Agency. Any attempted assignment in violation of this provision is void and without effect.

8. **Terms and Conditions.** Respondent accepts the Solicitation terms and conditions unless specifically noted by exceptions advanced in the form and manner directed in the Solicitation. No exceptions, terms, or conditions will be considered if not advanced in the form and manner directed in the Solicitation. Respondent agrees that all exceptions to the Solicitation as well as terms and conditions advanced by Respondent that differ in any manner from HHS' terms and conditions are rejected unless expressly accepted by System Agency in writing in a fully executed contract.

9. **HHS Right to Use.** Respondent agrees that HHS has the right to use, produce, and distribute copies of and to disclose to HHS employees, agents, and contractors and other governmental entities all or part of Respondent's Solicitation Response as HHS deems necessary to complete the procurement process or comply with state or federal laws.

10. **Release from Liability.** Respondent generally releases from liability and waives all claims against any party providing information about the Respondent at the request of HHS.

11. **Addenda and Amendments to Solicitation.** Respondent acknowledges all addenda and amendments to the Solicitation.

12. **Texas Bidder.** Respondent certifies that if a Texas address is shown as the address of Respondent on this Response, Respondent qualifies as a Texas Bidder as defined in Section 2155.444(c) of the Texas Government Code.

13. **Preferences.** Respondent represents and warrants that it qualifies for all preferences claimed under 34 Texas Administrative Code, Section 20.306 or Chapter 2155, Subchapter H of the Texas Government Code as indicated below (check applicable boxes):

    - ☐ Goods produced or offered by a Texas bidder that is owned by a Texas resident service-disabled veteran
    - ☐ Goods produced in Texas or offered by a Texas bidder that is not owned by a Texas resident service-disabled veteran
    - ☐ Agricultural products grown in Texas
    - ☐ Agricultural products offered by a Texas bidder
    - ☐ Services offered by a Texas bidder that is owned by a Texas resident service-disabled veteran
    - ☐ Services offered by a Texas bidder that is not owned by a Texas resident service-disabled veteran
    - ☐ Texas Vegetation Native to the Region
    - ☐ USA-produced supplies, materials or equipment
    - ☐ Products of persons with mental or physical disabilities

- ☐ Products made of recycled, remanufactured, or environmentally sensitive materials including recycled steel
- ☐ Energy efficient products
- ☐ Rubberized asphalt paving material
- ☐ Recycled motor oil and lubricants
- ☐ Products produced at facilities located on formerly contaminated property
- ☐ Products and services from economically depressed or blighted areas
- ☐ Vendors that meet or exceed air quality standards
- ☐ Recycled or reused computer equipment of other manufacturers
- ☐ Foods of higher nutritional value
- ☐ Commercial production company or advertising agency located in Texas

14. **Dealings with Public Servants.** Respondent has not given, has not offered to give, and does not intend to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with this Solicitation Response, this Solicitation, or any contract resulting from this Solicitation.

15. **Financial Participation Prohibited.** Under Section 2155.004, Texas Government Code (relating to financial participation in preparing solicitations), Respondent certifies that the individual or business entity named in this Response or contract is not ineligible to receive the specified contract and acknowledges that this contract may be terminated and payment withheld if this certification is inaccurate.

16. **Prior Disaster Relief Contract Violation.** Under Sections 2155.006 and 2261.053 of the Texas Government Code (relating to convictions and penalties regarding Hurricane Rita, Hurricane Katrina, and other disasters), the Respondent certifies that the individual or business entity named in this bid or contract is not ineligible to receive the specified contract and acknowledges that this contract may be terminated and payment withheld if this certification is inaccurate.

17. **Child Support Obligation.** Under Section 231.006(d) of the Texas Family Code regarding child support, Respondent certifies that the individual or business entity named in this Response is not ineligible to receive the specified payment and acknowledges that the contract may be terminated and payment may be withheld if this certification is inaccurate. Furthermore, any Respondent subject to Section 231.006 of the Texas Family Code must include in the Response the names and social security numbers (SSNs) of each person with at least 25% ownership of the business entity submitting the Response:

Name: ______________________________ SSN: ____________________

Name: ______________________________ SSN: ____________________

Name: ______________________________ SSN: ____________________

Name: ______________________________ SSN: ____________________

FEDERAL PRIVACY ACT NOTICE: This notice is given pursuant to the Federal Privacy Act. Disclosure of requested SSNs is required under Section 231.006(c) and Section 231.302(c)(2), Texas Family Code. The SSNs will be used to identify persons

that may owe child support. The SSNs will be kept confidential to the fullest extent permitted by law.

If submitted by email, Responses containing SSNs must be encrypted. Failure by a Respondent to provide or encrypt the SSNs as required may result in disqualification of the Respondent's Response.

18. **Suspension and Debarment.** Respondent certifies that it and its principals are not suspended or debarred from doing business with the state or federal government as listed on the *State of Texas Debarred Vendor List* maintained by the Texas Comptroller of Public Accounts and the *System for Award Management (SAM*) maintained by the General Services Administration. This certification is made pursuant to the regulations implementing Executive Order 12549 and Executive Order 12689, Debarment and Suspension, 2 C.F.R. Part 376, and any relevant regulations promulgated by the Department or Agency funding this project. This provision shall be included in its entirety in Respondent's subcontracts, if any, if payment in whole or in part is from federal funds.

19. **Excluded Parties.** Respondent certifies that it is not listed in the prohibited vendors list authorized by Executive Order 13224, *"Blocking Property and Prohibiting Transactions with Persons Who Commit, Threaten to Commit, or Support Terrorism,"* published by the United States Department of the Treasury, Office of Foreign Assets Control.

20. **Foreign Terrorist Organizations.** Respondent represents and warrants that it is not engaged in business with Iran, Sudan, or a foreign terrorist organization, as prohibited by Section 2252.152 of the Texas Government Code.

21. **Executive Head of a State Agency.** In accordance with Section 669.003 of the Texas Government Code, relating to contracting with the executive head of a state agency, Respondent certifies that it is not (1) the executive head of an HHS agency, (2) a person who at any time during the four years before the date of the contract was the executive head of an HHS agency, or (3) a person who employs a current or former executive head of an HHS agency.

22. **Human Trafficking Prohibition.** Under Section 2155.0061 of the Texas Government Code, the Respondent certifies that the individual or business entity named in this Response or contract is not ineligible to receive the specified contract and acknowledges that this contract may be terminated and payment withheld if this certification is inaccurate.

23. **Franchise Tax Status.** Respondent represents and warrants that it is not currently delinquent in the payment of any franchise taxes owed the State of Texas under Chapter 171 of the Texas Tax Code.

24. **Debts and Delinquencies.** Respondent agrees that any payments due under any contract resulting from this Solicitation shall be applied towards any debt or delinquency that is owed to the State of Texas.

25. **Lobbying Prohibition.** Respondent represents and warrants that payments to Respondent and Respondent's receipt of appropriated or other funds under any contract resulting from this Solicitation are not prohibited by Sections 556.005, 556.0055, or 556.008 of the Texas Government Code (relating to use of appropriated money or state funds to employ or pay lobbyists, lobbying expenses, or influence legislation).

26. **Buy Texas.** Respondent agrees to comply with Section 2155.4441 of the Texas Government Code, requiring the purchase of products and materials produced in the State of Texas in performing service contracts.

27. **Disaster Recovery Plan.** Respondent agrees that upon request of HHS, Respondent shall provide copies of its most recent business continuity and disaster recovery plans.

28. **Computer Equipment Recycling Program.** If Respondent is submitting a Response for the purchase or lease of computer equipment, then Respondent certifies that it is in compliance with Subchapter Y, Chapter 361 of the Texas Health and Safety Code related to the Computer Equipment Recycling Program and the Texas Commission on Environmental Quality rules in 30 TAC Chapter 328.

29. **Television Equipment Recycling Program.** If Respondent is submitting a Response for the purchase or lease of covered television equipment, then Respondent certifies that it is compliance with Subchapter Z, Chapter 361 of the Texas Health and Safety Code related to the Television Equipment Recycling Program.

30. **Cybersecurity Training.** Respondent represents and warrants that it will comply with the requirements of Section 2054.5192 of the Texas Government Code relating to cybersecurity training and required verification of completion of the training program.

31. **Restricted Employment for Certain State Personnel.** Respondent acknowledges that, pursuant to Section 572.069 of the Texas Government Code, a former state officer or employee of a state agency who during the period of state service or employment participated on behalf of a state agency in a procurement or contract negotiation involving Respondent may not accept employment from Respondent before the second anniversary of the date the contract is signed or the procurement is terminated or withdrawn.

32. **No Conflicts of Interest.** Respondent represents and warrants that it has no actual or potential conflicts of interest in providing the requested goods or services to System Agency under this Solicitation and any resulting contract and that Respondent's provision of the requested goods and/or services under this Solicitation and any resulting contract will not constitute an actual or potential conflict of interest or reasonably create an appearance of impropriety.

33. **Fraud, Waste, and Abuse.** Respondent understands that HHS does not tolerate any type of fraud, waste, or abuse. Violations of law, agency policies, or standards of ethical conduct will be investigated, and appropriate actions will be taken. Pursuant to Texas Government Code, Section 321.022, if the administrative head of a department or entity that is subject to audit by the state auditor has reasonable cause to believe that money received from the state by the department or entity or by a client or contractor of the department or entity may have been lost, misappropriated, or misused, or that other fraudulent or unlawful conduct has occurred in relation to the operation of the department or entity, the administrative head shall report the reason and basis for the belief to the Texas State Auditor's Office (SAO). All employees or contractors who have reasonable cause to believe that fraud, waste, or abuse has occurred (including misconduct by any HHS employee, Grantee officer, agent, employee, or subcontractor that would constitute fraud, waste, or abuse) are required to immediately report the questionable activity to the Health and Human Services Commission's Office of Inspector General. Respondent agrees to comply with all applicable laws, rules, regulations, and System Agency policies regarding fraud, waste, and abuse including, but not limited to, HHS Circular C-027.

A report to the SAO must be made through one of the following avenues:

- SAO Toll Free Hotline: 1-800-TX-AUDIT
- SAO website: http://sao.fraud.state.tx.us/

All reports made to the OIG must be made through one of the following avenues:

- OIG Toll Free Hotline 1-800-436-6184
- OIG Website: ReportTexasFraud.com
- Internal Affairs Email: InternalAffairsReferral@hhsc.state.tx.us
- OIG Hotline Email: OIGFraudHotline@hhsc.state.tx.us.
- OIG Mailing Address: Office of Inspector General
  Attn: Fraud Hotline
  MC 1300
  P.O. Box 85200
  Austin, Texas 78708-5200

34. **Antitrust.** The undersigned affirms under penalty of perjury of the laws of the State of Texas that (a) in connection with this Response, neither I nor any representative of the Respondent has violated any provision of the Texas Free Enterprise and Antitrust Act, Tex. Bus. & Comm. Code Chapter 15; (b) in connection with this Response, neither I nor any representative of the Respondent has violated any federal antitrust law; and (c) neither I nor any representative of the Respondent has directly or indirectly communicated any of the contents of this Response to a competitor of the Respondent or any other company, corporation, firm, partnership or individual engaged in the same line of business as the Respondent.

35. **Legal and Regulatory Actions.** Respondent represents and warrants that it is not aware of and has received no notice of any court or governmental agency proceeding, investigation, or other action pending or threatened against Respondent or any of the individuals or entities included in numbered paragraph 1 of this Affirmations and Solicitation Acceptance within the five (5) calendar years immediately preceding the submission of this Solicitation response that would or could impair Respondent's performance under any contract resulting from this Solicitation, relate to the contracted or similar goods or services, or otherwise be relevant to System Agency's consideration of entering into a contract. If Respondent is unable to make the preceding representation and warranty, then Respondent instead represents and warrants that it has included as a detailed attachment to this Solicitation Affirmations document a complete, detailed disclosure of any such court or governmental agency proceeding, investigation, or other action that would or could impair Respondent's performance under a contract awarded as a result of this Solicitation, relate to the contracted or similar goods or services, or otherwise be relevant to System Agency's consideration of entering into a contract. Respondent must identify here how many pages, if any, are attached: _____. Respondent acknowledges this is a continuing disclosure requirement. In addition, Respondent represents and warrants that, if awarded a contract as a result of this Solicitation, Respondent shall notify System Agency in writing within five (5) business days of any changes to the representations or warranties in this clause and understands that failure to so timely update System Agency shall constitute breach of contract and may result in immediate contract termination.

36. **E-Verify.** Respondent certifies that for contracts for services, Respondent shall utilize the U.S. Department of Homeland Security's E-Verify system during the term of the contract to determine the eligibility of:

A. all persons employed by Respondent to perform duties within Texas; and
B. all persons, including subcontractors, assigned by Respondent to perform work pursuant to the contract within the United States of America.

37. Former Agency Employees – Certain Contracts. If this Solicitation is for an employment contract, a professional services contract under Chapter 2254 of the Texas Government Code, or a consulting services contract under Chapter 2254 of the Texas Government Code, Respondent represents and warrants that neither Respondent nor any of Respondent's employees including, but not limited to, those authorized to provide services under the contract, were former employees of an HHS Agency during the twelve (12) month period immediately prior to the date of the execution of the contract.

38. Disclosure of Prior State Employment – Consulting Services. If this Solicitation is for consulting services,

A. In accordance with Section 2254.033 of the Texas Government Code, a Respondent offering to provide consulting services in response to this solicitation who has been employed by, or employs an individual who has been employed by, System Agency or another State of Texas agency at any time during the two years preceding the submission of Respondent's Solicitation Response must disclose the following information in its Solicitation Response and hereby certifies that this information is true, correct, and complete:

(1) Name of individual(s) (Respondent or employee(s)):

____

(2) Status (check one): ☐ Respondent ☐ Employee

(3) The nature of the previous employment with System Agency or the other State of Texas agency:

____

(4) The date the employment was terminated and the reason for the termination:

____

(5) The annual rate of compensation for the employment at the time of its termination: ____

If more than one individual is identified in A(1) above, Respondent must provide responses to A(2)-(5) as to each identified individual. To satisfy this requirement, Respondent must attach a separate page or pages, as necessary, and include the information required in Section A, including subsections (1)-(5). Respondent must identify here how many pages, if any, are attached: ____. Respondent acknowledges, agrees, and certifies that all information provided is true, correct, and complete on this and all attached pages.

B. If no information is provided in response to Section A above, Respondent certifies that neither Respondent nor any individual employed by Respondent was employed by System Agency or any other State of Texas agency at any time during the two years preceding the submission of Respondent's Solicitation Response.

39. **Entities that Boycott Israel.** Pursuant to Section 2271.002 of the Texas Government Code, Respondent certifies that either (1) it meets an exemption criteria under Section 2271.002; or (2) it does not boycott Israel and will not boycott Israel during the term of the contract resulting from this Solicitation. If Respondent refuses to make that certification, Respondent shall state here any facts that make it exempt from the boycott certification:

____

40. **Abortion Funding Limitation.** Respondent understands, acknowledges, and agrees that, pursuant to Article IX of the General Appropriations Act (the Act), to the extent allowed by federal and state law, money appropriated by the Texas Legislature may not be distributed to any individual or entity that, during the period for which funds are appropriated under the Act: (1) performs an abortion procedure that is not reimbursable under the state's Medicaid program; (2) is commonly owned, managed, or controlled by an entity that performs an abortion procedure that is not reimbursable under the state's Medicaid program; or (3) is a franchise or affiliate of an entity that performs an abortion procedure that is not reimbursable under the state's Medicaid program. The provision does not apply to a hospital licensed under Chapter 241, Health and Safety Code, or an office exempt under Section 245.004(2), Health and Safety Code. Respondent represents and warrants that it is not ineligible, nor will it be ineligible during the term of the contract resulting from this Solicitation, to receive appropriated funding pursuant to Article IX.

41. **Funding Eligibility.** Respondent understands, acknowledges, and agrees that, pursuant to Chapter 2272 (eff. Sept. 1, 2021, Ch. 2273) of the Texas Government Code, except as exempted under that Chapter, System Agency cannot contract with an abortion provider or an affiliate of an abortion provider. Respondent certifies that it is not ineligible to contract with System Agency under the terms of Chapter 2272 (eff. Sept. 1, 2021, Ch. 2273) of the Texas Government Code. If Respondent refuses to make that certification, Respondent shall state here any facts that make it exempt from the certification:

____

42. **Prohibition on Certain Telecommunications and Video Surveillance Services or Equipment (2 CFR 200.216).** Respondent certifies that the individual or business entity

named in this Response or contract is not ineligible to receive the specified contract or funding pursuant to 2 CFR 200.216.

43. **COVID-19 Vaccine Passports.** Pursuant to Texas Health and Safety Code, Section 161.0085(c), Respondent certifies that it does not require its customers to provide any documentation certifying the customer's COVID-19 vaccination or post-transmission recovery on entry to, to gain access to, or to receive service from the Respondent's business. Respondent acknowledges that such a vaccine or recovery requirement would make Respondent ineligible for a state-funded contract.

44. **Entities that Boycott Energy Companies.** In accordance with Senate Bill 13, Acts 2021, 87th Leg., R.S., if Respondent is required to make a verification pursuant to Section 2274.002 of the Texas Government Code (relating to prohibition on contracts with companies boycotting certain energy companies), Respondent verifies that Respondent does not boycott energy companies and will not boycott energy companies during the term of the Contract. If Respondent does not make that verification, Respondent must state here why the verification is not required:

____

45. **Entities that Discriminate Against Firearm and Ammunition Industries**. In accordance with Senate Bill 19, Acts 2021, 87th Leg., R.S., if Respondent is required to make a verification pursuant to Section 2274.002 of the Texas Government Code (relating to prohibition on contracts with companies that discriminate against firearm and ammunition industries), Respondent verifies that it (1) does not have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association and (2) will not discriminate during the term of the contract against a firearm entity or firearm trade association. If Respondent does not make that verification, Respondent must state here why the verification is not required:

____

46. **Security Controls for State Agency Data**. In accordance with Senate Bill 475, Acts 2021, 87th Leg., R.S., pursuant to Texas Government Code, Section 2054.138, Respondent understands, acknowledges, and agrees that if awarded a contract pursuant to this Solicitation and under which Respondent will be authorized to access, transmit, use, or store data for System Agency, Respondent is required to meet the security controls the System Agency determines are proportionate with System Agency's risk under the contract based on the sensitivity of System Agency's data and that Respondent must periodically provide to System Agency evidence that Respondent meets the security controls required under the contract.

47. **Cloud Computing State Risk and Authorization Management Program**. In accordance with Senate Bill 475, Acts 2021, 87th Leg., R.S., pursuant to Texas Government Code, Section 2054.0593, Respondent acknowledges and agrees that, if providing cloud computing services for System Agency, Respondent must comply with

the requirements of the state risk and authorization management program and that System Agency may not enter or renew a contract with a vendor to purchase cloud computing services for the agency that are subject to the state risk and authorization management program unless the vendor demonstrates compliance with program requirements. If providing cloud computing services for System Agency that are subject to the state risk and authorization management program, Respondent certifies it will maintain program compliance and certification throughout the term of the Contract.

48. **Foreign-Owned Companies in Connection with Critical Infrastructure.** If Texas Government Code, Section 2274.0102(a)(1) (relating to prohibition on contracts with certain foreign-owned companies in connection with critical infrastructure) is applicable to a contract resulting from this Solicitation, pursuant to Government Code Section 2274.0102, Respondent certifies that neither it nor its parent company, nor any affiliate of Respondent or its parent company, is: (1) majority owned or controlled by citizens or governmental entities of China, Iran, North Korea, Russia, or any other country designated by the Governor under Government Code Section 2274.0103, or (2) headquartered in any of those countries.

49. **Critical Infrastructure Subcontracts.** For purposes of this Paragraph, the designated countries are China, Iran, North Korea, Russia, and any countries lawfully designated by the Governor as a threat to critical infrastructure. Pursuant to Section 113.002 of the Business and Commerce Code, Respondent shall not enter into a subcontract that will provide direct or remote access to or control of critical infrastructure, as defined by Section 113.001 of the Texas Business and Commerce Code, in this state, other than access specifically allowed for product warranty and support purposes to any subcontractor unless (i) neither the subcontractor nor its parent company, nor any affiliate of the subcontractor or its parent company, is majority owned or controlled by citizens or governmental entities of a designated country; and (ii) neither the subcontractor nor its parent company, nor any affiliate of the subcontractor or its parent company, is headquartered in a designated country. Respondent will notify the System Agency before entering into any subcontract that will provide direct or remote access to or control of critical infrastructure, as defined by Section 113.001 of the Texas Business & Commerce Code, in this state.

50. **Enforcement of Certain Federal Firearms Laws Prohibited**. In accordance with House Bill 957, Acts 2021, 87th Leg., R.S., if Texas Government Code, Section 2.101 is applicable to Respondent, Respondent certifies that it is not ineligible to receive state grant funds pursuant to Texas Government Code, Section 2.103.

51. **Prohibition on Abortions.** Respondent understands, acknowledges, and agrees that, pursuant to Article II of the General Appropriations Act, (1) no funds shall be used to pay the direct or indirect costs (including marketing, overhead, rent, phones, and utilities) of abortion procedures provided by contractors of HHSC; and (2) no funds appropriated for Medicaid Family Planning, Healthy Texas Women Program, or the Family Planning Program shall be distributed to individuals or entities that perform elective abortion procedures or that contract with or provide funds to individuals or entities for the performance of elective abortion procedures. Respondent represents and warrants that it is not ineligible, nor will it be ineligible during the term of the contract resulting from this Solicitation, to receive appropriated funding pursuant to Article II.

52. **Public Information Act Copy.** Respondent understands, acknowledges, and agrees, that solicitation responses and contracts are subject to the Texas Public Information Act (PIA), Texas Government Code Chapter 552, and may be disclosed to the public upon request or through posting on the System Agency's website, the LBB's website, or as otherwise required by law. Respondent certifies that it:

- ☐ asserts that information provided in its response is exempt from disclosure under the PIA, and Respondent, therefore, has submitted a "Public Information Act Copy" as required under the solicitation; or
- ☐ asserts that there is no information provided in its response that is exempt from disclosure under the PIA, and Respondent, therefore, has not submitted a "Public Information Act Copy."

53. **No Felony Criminal Convictions.** Respondent represents that neither Respondent nor any of its employees, agents, or representatives, including any subcontractors and employees, agents, or representative of such subcontractors, have been convicted of a felony criminal offense or that if such a conviction has occurred Respondent has fully advised System Agency in writing of the facts and circumstances surrounding the convictions.

54. **Unfair Business Practices.** Respondent represents and warrants that it has not been the subject of allegations of Deceptive Trade Practices violations under Chapter 17 of the Texas Business and Commerce Code, or allegations of any unfair business practice in any administrative hearing or court suit and that Respondent has not been found to be liable for such practices in such proceedings. Respondent certifies that it has no officers who have served as officers of other entities who have been the subject of allegations of Deceptive Trade Practices violations or allegations of any unfair business practices in an administrative hearing or court suit and that such officers have not been found to be liable for such practices in such proceedings.

55. **False Representation.** Respondent understands, acknowledges, and agrees that any false representation or any failure to comply with a representation, warranty, or certification made by Respondent is subject to all civil and criminal consequences provided at law or in equity including, but not limited to, immediate termination of any contract resulting from this Solicitation.

56. **Permits and Licenses.** Respondent represents and warrants that it will comply with all applicable laws and maintain all permits and licenses required by applicable city, county, state, and federal rules, regulations, statutes, codes, and other laws that pertain to any contract resulting from this Solicitation.

57. **False Statements.** Respondent represents and warrants that all statements and information prepared and submitted in this document are current, complete, true, and accurate. Submitting a Response with a false statement or material misrepresentations made during the performance of a contract is a material breach of contract and may void the submitted Response and any resulting contract.

58. **Signature Authority.** By submitting this Response, Respondent represents and warrants that the individual submitting this document and the documents made part of this Response is authorized to sign such documents on behalf of the Respondent and to bind the Respondent under any contract that may result from the submission of this Response.

Signature Page Follows

Authorized representative on behalf of Respondent must complete and sign the following:

Legal Name of Respondent

Assumed Business Name of Respondent, if applicable (d/b/a or 'doing business as')

Texas County(s) for Assumed Business Name (d/b/a or 'doing business as')
Attach Assumed Name Certificate(s) filed with the Texas Secretary of State and Assumed Name Certificate(s), if any, for each Texas County Where Assumed Name Certificate(s) has been filed.

Signature of Authorized Representative	**Date Signed**
Printed Name of Authorized Representative **First, Middle Name or Initial, and Last Name**	**Title of Authorized Representative**
Physical Street Address	**City, State, Zip Code**
Mailing Address, if different	**City, State, Zip Code**
Phone Number	**Fax Number**
Email Address	**DUNS Number**
Federal Employer Identification Number	**Texas Identification Number (TIN)**
Texas Franchise Tax Number	**Texas Secretary of State Filing Number**
SAM.gov Unique Entity Identifier (UEI)	

Exhibit B, Health and Human Services (HHS) Uniform Terms and Conditions - Vendor

Version 3.2

Effective: April 2021

Responsible Office: Chief Counsel

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ARTICLE I. DEFINITIONS AND INTERPRETIVE PROVISIONS

1.1 DEFINITIONS

As used in this Contract, unless the context clearly indicates otherwise, the following terms and conditions have the meanings assigned below:

"Amendment" means a written agreement, signed by the Parties, which documents changes to the Contract other than those permitted by Work Orders.

"Attachment" means documents, terms, conditions, or information added to this Contract following the Signature Document or included by reference and made a part of this Contract.

"Contract" means the Signature Document, these Uniform Terms and Conditions, along with any Attachments, and any Amendments, purchase orders, or Work Orders that may be issued by the System Agency, to be incorporated by reference for all purposes.

"Contractor" means the Party selected to provide the goods or Services to the State under this Contract.

"Deliverable" means a Work Product(s), including all reports and project documentation, prepared, developed, or procured by Contractor as part of the Services under the Contract for the use or benefit of the System Agency or the State of Texas.

"Effective Date" means the date agreed to by the Parties as the date on which the Contract takes effect.

"Federal Fiscal Year" means the period beginning October 1 and ending September 30 each year, which is the annual accounting period for the United States government.

"GAAP" means Generally Accepted Accounting Principles.

"GASB" means the Governmental Accounting Standards Board.

"Goods" means supplies, materials, or equipment.

"Health and Human Services Commission" or "HHSC" means the administrative agency established under Chapter 531, Texas Government Code, or its designee.

"Health and Human Services" or "HHS" includes the Department of State Health Services (DSHS), in addition to the Health and Human Services Commission.

"HUB" means Historically Underutilized Business, as defined by Chapter 2161 of the Texas Government Code.

"Intellectual Property Rights" means the worldwide proprietary rights or interests, including patent, copyright, trade secret, and trademark rights, as such rights may be evidenced by or embodied in:

i. any idea, design, concept, personality right, method, process, technique, apparatus, invention, discovery, or improvement;

ii. any work of authorship, including any compilation, computer code, website or web page design, literary work, pictorial work, or graphic work;
iii. any trademark, service mark, trade dress, trade name, branding, or other indicia of source or origin;
iv. domain name registrations; and
v. any other proprietary or similar rights. The Intellectual Property Rights of a Party include all worldwide proprietary rights or interests that the Party may have acquired by assignment, by exclusive license, or by license with the right to grant sublicenses.

"Parties" means the System Agency and Contractor, collectively.

"Party" means either the System Agency or Contractor, individually.

"Project" means the goods or Services described in the Signature Document or a Work Order of this Contract.

"Scope of Work" means the description of Services and Deliverables specified in the Contract and as may be amended.

"Services" means the tasks, functions, and responsibilities assigned and delegated to Contractor under the Contract.

"Signature Document" means the document executed by both Parties that specifically sets forth all of the documents that constitute the Contract.

"Solicitation" means the document issued by the System Agency (including any published addenda, exhibits, and Attachments) under which the goods or Services provided under the Contract were initially requested, which is incorporated by reference for all purposes in its entirety.

"Solicitation Response" means Contractor's full and complete response (including any Attachments and addenda) to the Solicitation, which is incorporated by reference for all purposes in its entirety.

"State Fiscal Year" means the period beginning September 1 and ending August 31 each year, which is the annual accounting period for the State of Texas.

"State of Texas *Textravel*" means the State Travel Management Program through the Texas Comptroller of Public Accounts website and Texas Administrative Code, Title 34, Part 1, Chapter 5, Subchapter C, Section 5.22, relative to travel reimbursements under this Contract, if any.

"Subcontract" means any written agreement between Contractor and a third party to fulfill the requirements of the Contract. All Subcontracts are required to be in writing.

"Subcontractor" means any individual or entity that enters a contract with the Contractor to perform part or all of the obligations of Contractor under this Contract.

"System Agency" means HHSC or any of the agencies of the State of Texas that are overseen by HHSC under authority granted under state law and the officers, employees, authorized representatives, and designees of those agencies. These agencies include: HHSC and the Department of State Health Services.

"Third Party IP" means the Intellectual Property Rights of any third party that is not a party to this Contract, and that is not a Subcontractor.

"Work" means all Services to be performed, goods to be delivered, and any appurtenant actions performed, and items produced, conceived, or developed, including Deliverables.

"Work Order" means an individually negotiated document that is executed by both Parties and which authorizes a Project, if any, in an indefinite quantity Contract.

"Work Product" means any and all works, including work papers, notes, materials, approaches, designs, specifications, systems, innovations, improvements, inventions, software, programs, source code, documentation, training materials, audio or audiovisual recordings, methodologies, concepts, studies, reports, whether finished or unfinished, and whether or not included in the Deliverables, that are developed, produced, generated, or provided by Contractor in connection with Contractor's performance of its duties under the Contract or through use of any funding provided under this Contract.

1.2 Interpretive Provisions

A. The meanings of defined terms include the singular and plural forms.
B. The words "hereof," "herein," "hereunder," and similar words refer to this Contract as a whole and not to any particular provision, section, Attachment, or schedule of this Contract unless otherwise specified.
C. The term "including" is not limiting and means "including without limitation" and, unless otherwise expressly provided in this Contract, (i) references to contracts (including this Contract) and other contractual instruments shall be deemed to include all subsequent Amendments and other modifications, but only to the extent that such Amendments and other modifications are not prohibited by the terms of this Contract, and (ii) references to any statute or regulation are to be construed as including all statutory and regulatory provisions consolidating, amending, replacing, supplementing, or interpreting the statute or regulation.
D. Any references to "sections," "appendices," or "attachments" are references to sections, appendices, or attachments of the Contract.
E. Any references to agreements, contracts, statutes, or administrative rules or regulations in the Contract are references to these documents as amended, modified, or supplemented from time to time during the term of the Contract.
F. The captions and headings of this Contract are for convenience of reference only and do not affect the interpretation of this Contract.
G. All Attachments, including those incorporated by reference, and any Amendments are considered part of the terms of this Contract.
H. This Contract may use several different limitations, regulations, or policies to regulate the same or similar matters. All such limitations, regulations, and policies are cumulative, and each will be performed in accordance with its terms.
I. Unless otherwise expressly provided, reference to any action of the System Agency or by the System Agency by way of consent, approval, or waiver will be deemed modified by the phrase "in its sole discretion."
J. Time is of the essence in this Contract.

ARTICLE II. PAYMENT PROVISIONS

2.1 PROMPT PAYMENT

Payment shall be made in accordance with Chapter 2251 of the Texas Government Code, commonly known as the Texas Prompt Payment Act. Chapter 2251 of the Texas Government Code shall govern remittance of payment and remedies for late payment and non-payment.

2.2 ANCILLARY AND TRAVEL EXPENSES

A. Except as otherwise provided in the Contract, no ancillary expenses incurred by the Contractor in connection with its provision of the Services or Deliverables will be reimbursed by the System Agency. Ancillary expenses include, but are not limited to costs associated with transportation, delivery, and insurance for each Deliverable.
B. When the reimbursement of travel expenses is authorized by the Contract, all such expenses will be reimbursed in accordance with the rates set by the State of Texas *Textravel* available at the Texas Comptroller of Public Accounts State Travel Management Program website.

2.3 NO QUANTITY GUARANTEES

The System Agency makes no guarantee of volume or usage of work under this Contract. All Work requested may be on an irregular and as needed basis throughout the Contract term.

2.4 TAXES

Purchases made for State of Texas use are exempt from the State Sales Tax and Federal Excise Tax. Contractor represents and warrants that it shall pay all taxes or similar amounts resulting from the Contract, including, but not limited to, any federal, State, or local income, sales or excise taxes of Contractor or its employees. System Agency shall not be liable for any taxes resulting from the contract.

ARTICLE III. STATE AND FEDERAL FUNDING

3.1 EXCESS OBLIGATIONS PROHIBITED

The Contract is subject to termination or cancellation, without penalty to the System Agency, either in whole or in part, subject to the availability of state funds. System Agency is a state agency whose authority and appropriations are subject to actions of the Texas Legislature. If System Agency becomes subject to a legislative change, revocation of statutory authority, or lack of appropriated funds that would render either System Agency's or Contractor's delivery or performance under the Contract impossible or unnecessary, the Contract will be terminated or cancelled and be deemed null and void. In the event of a termination or cancellation under this Section, System Agency will not be liable to Contractor for any damages that are caused or associated with such termination, or cancellation, and System Agency will not be required to give prior notice.

3.2 NO DEBT AGAINST THE STATE

This Contract will not be construed as creating any debt by or on behalf of the State of Texas.

3.3 DEBT AND DELINQUENCIES

Contractor agrees that any payments due under the Contract shall be directly applied towards eliminating any debt or delinquency it has to the State of Texas including, but not limited to, delinquent taxes, delinquent student loan payments, and delinquent child support.

3.4 REFUNDS AND OVERPAYMENTS

A. At its sole discretion, the System Agency may:
   i. withhold all or part of any payments to Contractor to offset overpayments, unallowable or ineligible costs made to the Contractor, or if any required financial status report(s) is not submitted by the due date(s); or,
   ii. require Contractor to promptly refund or credit - within thirty (30) calendar days of written notice - any funds erroneously paid by System Agency which are not expressly authorized under the Contract.

B. "Overpayments," as used in this Section, include payments:
   i. made by the System Agency that exceed the maximum allowablerates;
   ii. that are not allowed under applicable laws, rules, or regulations; or,
   iii. that are otherwise inconsistent with this Contract, including any unapproved expenditures. Contractor understands and agrees that it will be liable to the System Agency for any costs disallowed pursuant to financial and compliance audit(s) of funds received under this Contract. Contractor further understands and agrees that reimbursement of such disallowed costs shall be paid by Contractor from funds which were not provided or otherwise made available to Contractor under this Contract.

ARTICLE IV. WARRANTY, AFFIRMATIONS, ASSURANCES, AND CERTIFICATIONS

4.1 WARRANTY

Contractor warrants that all Work under this Contract shall be completed in a manner consistent with standards under the terms of this Contract, in the applicable trade, profession, or industry; shall conform to or exceed the specifications set forth in the Contract; and all Deliverables shall be fit for ordinary use, of good quality, and with no material defects. If System Agency, in its sole discretion, determines Contractor has failed to complete Work timely or to perform satisfactorily under conditions required by this Contract, the System Agency may require Contractor, at its sole expense, to:

   i. Repair or replace all defective or damaged Work;
   ii. Refund any payment Contractor received from System Agency for all defective or damaged Work and, in conjunction therewith, require Contractor to accept the return of such Work; and,
   iii. Take necessary action to ensure that Contractor's future performance and Work conform to the Contract requirements.

4.2 GENERAL AFFIRMATIONS

Contractor certifies that, to the extent General Affirmations are incorporated into the Contract under the Signature Document, the Contractor has reviewed the General Affirmations and that Contractor is in compliance with allrequirements.

4.3 FEDERAL ASSURANCES

Contractor certifies that, to the extent federal assurances are incorporated into the Contract under the Signature Document, the Contractor has reviewed the federal assurances and that Contractor is in compliance with all requirements.

4.4 FEDERAL CERTIFICATIONS

Contractor certifies that, to the extent federal certifications are incorporated into the Contract under the Signature Document, the Contractor has reviewed the federal certifications and that Contractor is in compliance with all requirements. In addition, Contractor certifies that it is and shall remain in compliance with all applicable federal laws, rules, and regulations, as they may pertain to this Contract.

ARTICLE V. INTELLECTUAL PROPERTY

5.1 OWNERSHIP OF WORK PRODUCT

A. All right, title, and interest in the Work Product, including all Intellectual Property Rights therein, is exclusively owned by System Agency. Contractor and Contractor's employees will have no rights in or ownership of the Work Product or any other property of System Agency.

B. Any and all Work Product that is copyrightable under United States copyright law is deemed to be "work made for hire" owned by System Agency, as provided by Title 17 of the United States Code. To the extent that Work Product does not qualify as a "work made for hire" under applicable federal law, Contractor hereby irrevocably assigns and transfers to System Agency, its successors and assigns, the entire right, title, and interest in and to the Work Product, including any and all Intellectual Property Rights embodied therein or associated therewith, and in and to all works based upon, derived from, or incorporating the Work Product, and in and to all income, royalties, damages, claims and payments now or hereafter due or payable with respect thereto, and in and to all causes of action, either in law or in equity for past, present or future infringement based on the copyrights, and in and to all rights corresponding to the foregoing.

C. Contractor agrees to execute all papers and to perform such other acts as System Agency may deem necessary to secure for System Agency or its designee the rights herein assigned.

D. In the event that Contractor has any rights in and to the Work Product that cannot be assigned to System Agency, Contractor hereby grants to System Agency an exclusive, worldwide, royalty-free, transferable, irrevocable, and perpetual license, with the right to sublicense, to reproduce, distribute, modify, create derivative works of, publicly perform and publicly display, make, have made, use, sell and offer for sale the Work Product and any products developed by practicing such rights.

E. The foregoing does not apply to Incorporated Pre-existing Works or Third-Party IP that are incorporated in the Work Product by Contractor. Contractor shall provide System Agency access during normal business hours to all Vendor materials, premises, and computer files containing the Work Product.

5.2 Contractor's Pre-existing Works

A. To the extent that Contractor incorporates into the Work Product any works of Contractor that were created by Contractor or that Contractor acquired rights in prior to the Effective Date of this Contract ("**Incorporated Pre-existing Works**"), Contractor retains ownership of such Incorporated Pre-existing Works.

B. Contractor hereby grants to System Agency an irrevocable, perpetual, non-exclusive, royalty-free, transferable, worldwide right and license, with the right to sublicense, to use, reproduce, modify, copy, create derivative works of, publish, publicly perform and display, sell, offer to sell, make and have made, the Incorporated Pre-existing Works, in any medium, with or without the associated Work Product.

C. Contractor represents, warrants, and covenants to System Agency that Contractor has all necessary right and authority to grant the foregoing license in the Incorporated Pre-existing Works to System Agency.

5.3 Third Party IP

A. To the extent that any Third Party IP is included or incorporated in the Work Product by Contractor, Contractor hereby grants to System Agency, or shall obtain from the applicable third party for System Agency's benefit, the irrevocable, perpetual, non-exclusive, worldwide, royalty-free right and license, for System Agency's internal business purposes only,

  i. to use, reproduce, display, perform, distribute copies of, and prepare derivative works based upon such Third-Party IP and any derivative works thereof embodied in or delivered to System Agency in conjunction with the Work Product, and

  ii. to authorize others to do any or all of the foregoing.

B. Contractor shall obtain System Agency's advance written approval prior to incorporating any Third-Party IP into the Work Product, and Contractor shall notify System Agency on delivery of the Work Product if such materials include any Third Party IP.

C. Contractor shall provide System Agency all supporting documentation demonstrating Contractor's compliance with this **Section 5.3**, including without limitation documentation indicating a third party's written approval for Contractor to use any Third Party IP that may be incorporated in the Work Product.

5.4 Agreements With Employees and Subcontractors

Contractor shall have written, binding agreements with its employees and subcontractors that include provisions sufficient to give effect to and enable Contractor's compliance with Contractor's obligations under this **Article V**.

5.5 Delivery Upon Termination or Expiration

No later than the first calendar day after the termination or expiration of the Contract or upon System Agency's request, Contractor shall deliver to System Agency all completed, or partially completed, Work Product, including any Incorporated Pre-existing Works, and any and all versions thereof. Contractor's failure to timely deliver such Work Product is a material breach of the Contract. Contractor will not retain any copies of the Work Product or any documentation or other products or results of Contractor's activities under the Contract without the prior written consent of System Agency.

5.6 SURVIVAL

The provisions and obligations of this **Article V** survive any termination or expiration of the Contract.

5.7 SYSTEM AGENCY DATA

A. As between the Parties, all data and information acquired, accessed, or made available to Contractor by, through, or on behalf of System Agency or System Agency contractors, including all electronic data generated, processed, transmitted, or stored by Contractor in the course of providing data processing services in connection with Contractor's performance hereunder (the "**System Agency Data**"), is owned solely by System Agency.

B. Contractor has no right or license to use, analyze, aggregate, transmit, create derivatives of, copy, disclose, or process the System Agency Data except as required for Contractor to fulfill its obligations under the Contract or as authorized in advance in writing by System Agency.

C. For the avoidance of doubt, Contractor is expressly prohibited from using, and from permitting any third party to use, System Agency Data for marketing, research, or other non-governmental or commercial purposes, without the prior written consent of System Agency.

D. Contractor shall make System Agency Data available to System Agency, including to System Agency's designated vendors, as directed in writing by System Agency. The foregoing shall be at no cost to System Agency.

E. Furthermore, the proprietary nature of Contractor's systems that process, store, collect, and/or transmit the System Agency Data shall not excuse Contractor's performance of its obligations hereunder.

ARTICLE VI. PROPERTY

6.1 USE OF STATE PROPERTY

A. Contractor is prohibited from using State Property for any purpose other than performing Services authorized under the Contract.

B. State Property includes, but is not limited to, System Agency's office space, identification badges, System Agency information technology equipment and networks (*e.g.,* laptops, portable printers, cell phones, iPads or tablets, external hard drives, data storage devices, any System Agency-issued software, and the System Agency Virtual Private Network (VPN client)), and any other resources of System Agency.

C. Contractor shall not remove State Property from the continental United States. In addition, Contractor may not use any computing device to access System Agency's network or e- mail while outside of the continental United States.

D. Contractor shall not perform any maintenance services on State Property unless the Contract expressly authorizes such Services.

E. During the time that State Property is in the possession of Contractor, Contractor shall be responsible for:

   i. all repair and replacement charges incurred by State Agency that are associated with loss of State Property or damage beyond normal wear and tear, and

ii. all charges attributable to Contractor's use of State Property that exceeds the Contract scope. Contractor shall fully reimburse such charges to System Agency within ten (10) calendar days of Contractor's receipt of System Agency's notice of amount due. Use of State Property for a purpose not authorized by the Contract shall constitute breach of contract and may result in termination of the Contract and the pursuit of other remedies available to System Agency under contract, at law, or in equity.

6.2 Damage to Government Property

A. In the event of loss, destruction, or damage to any System Agency or State of Texas owned, leased, or occupied property or equipment by Contractor or Contractor's employees, agents, Subcontractors, and suppliers, Contractor shall be liable to System Agency and the State of Texas for the full cost of repair, reconstruction, or replacement of the lost, destroyed, or damaged property.

B. Contractor shall notify System Agency of the loss, destruction, or damage of equipment or property within one (1) business day. Contractor shall reimburse System Agency and the State of Texas for such property damage within 10 calendar days after Contractor's receipt of System Agency's notice of amount due.

6.3 Property Rights upon Termination or Expiration of Contract

In the event the Contract is terminated for any reason, or upon its expiration State Property remains the property of the System Agency and must be returned to the System Agency by the end date of the Contract or upon System Agency's request.

ARTICLE VII. Work Orders

7.1 Work Orders

If the Contract is for indefinite quantities of Services, as specified in the Signature Document, all Work will be performed in accordance with properly executed Work Orders.

7.2 Proposals

For Work Order contracts, the Contractor shall submit to System Agency separate proposals, including pricing and a project plan, for each Project.

7.3 Responsibility

For each approved Project, the Contractor shall be responsible for all Work assigned under the Work Order. Multiple Work Orders may be issued during the term of this Contract, all of which will be in writing and signed by the Parties. Each Work Order will include a scope of Services; a list of tasks required; a time schedule; a list of Deliverables, if any; a detailed Project budget; and any other information or special conditions as may be necessary for the Work assigned.

7.4 Termination

If this Work Order is in effect on the day the Contract would otherwise expire, the Contract will remain in effect until this Work Order is terminated or expires; and the Contract and this Work Order may be amended after such termination or expiration to

extend the performance period or add ancillary deliverables or services, only to the extent necessary.

ARTICLE VIII. Record Retention, Audit, and Confidentiality

8.1 Record Maintenance and Retention

A. Contractor shall keep and maintain under GAAP or GASB, as applicable, full, true, and complete records necessary to fully disclose to the System Agency, the Texas State Auditor's Office, the United States Government, and their authorized representatives sufficient information to determine compliance with the terms and conditions of this Contract and all state and federal rules, regulations, and statutes.
B. Contractor shall maintain and retain legible copies of this Contract and all records relating to the performance of the Contract including supporting fiscal documents adequate to ensure that claims for contract funds are in accordance with applicable State of Texas requirements. These records shall be maintained and retained by Contractor for a minimum of seven (7) years after the Contract expiration date or seven (7) years after the completion of all audit, claim, litigation, or dispute matters involving the Contract are resolved, whichever is later.

8.2 Agency's Right to Audit

A. Contractor shall make available at reasonable times and upon reasonable notice, and for reasonable periods, work papers, reports, books, records, supporting documents kept current by Contractor pertaining to the Contract for purposes of inspecting, monitoring, auditing, or evaluating by System Agency and the State of Texas.
B. In addition to any right of access arising by operation of law, Contractor and any of Contractor's affiliate or subsidiary organizations, or Subcontractors shall permit the System Agency or any of its duly authorized representatives, as well as duly authorized federal, state or local authorities, unrestricted access to and the right to examine any site where business is conducted or Services are performed, and all records, which includes but is not limited to financial, client and patient records, books, papers or documents related to this Contract. If the Contract includes federal funds, federal agencies that shall have a right of access to records as described in this section include: the federal agency providing the funds, the Comptroller General of the United States, the General Accounting Office, the Office of the Inspector General, and any of their authorized representatives. In addition, agencies of the State of Texas that shall have a right of access to records as described in this section include: the System Agency, HHSC, HHSC's contracted examiners, the State Auditor's Office, the Texas Attorney General's Office, and any successor agencies. Each of these entities may be a duly authorized authority.
C. If deemed necessary by the System Agency or any duly authorized authority, for the purpose of investigation or hearing, Contractor shall produce original documents related to this Contract.
D. The System Agency and any duly authorized authority shall have the right to audit billings both before and after payment, and all documentation that substantiates the billings.

E. Contractor shall include this provision concerning the right of access to, and examination of, sites and information related to this Contract in any Subcontract it awards.

8.3 Response/Compliance with Audit or Inspection Findings

A. Contractor must act to ensure its and its Subcontractors' compliance with all corrections necessary to address any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle, or any other deficiency identified in any audit, review, or inspection of the Contract and the Services and Deliverables provided. Any such correction will be at Contractor's or its Subcontractor's sole expense. Whether Contractor's action corrects the noncompliance shall be solely the decision ofthe System Agency.
B. As part of the Services, Contractor must provide to System Agency upon request a copy of those portions of Contractor's and its Subcontractors' internal audit reports relating to the Services and Deliverables provided to the State under the Contract.

8.4 State Auditor's Right to Audit

A. The state auditor may conduct an audit or investigation of any entity receiving funds from the state directly under the Contract or indirectly through a subcontract under the Contract. The acceptance of funds directly under the Contract or indirectly through a subcontract under the Contract acts as acceptance of the authority of the state auditor, under the direction of the legislative audit committee, to conduct an audit or investigation in connection with those funds. Under the direction of the legislative audit committee, an entity that is the subject of an audit or investigation by the state auditor must provide the state auditor with access to any information the state auditor considers relevant to the investigation or audit.
B. The Contractor shall comply with any rules and procedures of the state auditor in the implementation and enforcement of Section 2262.154 of the Texas Government Code.

8.5 Confidentiality

Contractor shall maintain as confidential and shall not disclose to third parties without System Agency's prior written consent, any System Agency information including but not limited to System Agency Data, System Agency's business activities, practices, systems, conditionsand services. This section will survive termination or expiration of this Contract. The obligations of Contractor under this section will survive termination or expiration of this Contract. This requirement must be included in all subcontracts awarded by Contractor.

ARTICLE IX. Contract Remedies and Early Termination

9.1 Contract Remedies

To ensure Contractor's full performance of the Contract and compliance with applicable law, the System Agency reserves the right to hold Contractor accountable for breach of contract or substandard performance and may take remedial or corrective actions, including, but not limited to:

i. suspending all or part of theContract;
ii. requiring the Contractor to take specific actions in order to remain in compliance with the Contract;

iii. recouping payments made by the System Agency to the Contractor found to be in error;
iv. suspending, limiting, or placing conditions on the Contractor's continued performance of Work; or
v. imposing any other remedies, sanctions, or penalties authorized under this Contract or permitted by federal or statelaw.

9.2 TERMINATION FOR CONVENIENCE

The System Agency may terminate the Contract, in whole or in part, at any time when, in its sole discretion, the System Agency determines that termination is in the best interests of the State of Texas. The termination will be effective on the date specified in the System Agency's notice of termination.

9.3 TERMINATION FOR CAUSE

Except as otherwise provided by the U.S. Bankruptcy Code, or any successor law, the System Agency may terminate the Contract, in whole or in part, upon either of the following conditions:

i. **Material Breach**
The System Agency will have the right to terminate the Contract in whole or in part if the System Agency determines, in its sole discretion, that Contractor has materially breached the Contract or has failed to adhere to any laws, ordinances, rules, regulations or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of Contractor's duties under the Contract. Contractor's misrepresentation in any aspect of Contractor's Solicitation Response, if any, or Contractor's addition to the System for Award Management (SAM) exclusion list will also constitute a material breach of the Contract.

ii. **Failure to Maintain Financial Viability**
The System Agency may terminate the Contract if, in its sole discretion, the System Agency has a good faith belief that Contractor no longer maintains the financial viability required to complete the Work, or otherwise fully perform its responsibilities under the Contract.

9.4 CONTRACTOR RESPONSIBILITY FOR SYSTEM AGENCY'S TERMINATION COSTS

If the System Agency terminates the Contract for cause, the Contractor shall be responsibleto the System Agency for all costs incurred by the System Agency and the State of Texas to replace the Contractor. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation attributable to Contractor's failure to perform any Work in accordance with the terms of the Contract.

ARTICLE X. INDEMNITY

10.1 GENERAL INDEMNITY

A. **CONTRACTOR SHALL DEFEND, INDEMNIFY AND HOLD HARMLESS THE STATE OF TEXAS AND SYSTEM AGENCY, AND/OR THEIR OFFICERS, AGENTS, EMPLOYEES, REPRESENTATIVES, CONTRACTORS, ASSIGNEES, AND/OR DESIGNEES FROM ANY AND ALL LIABILITY, ACTIONS, CLAIMS, DEMANDS, OR SUITS, AND ALL**

RELATED COSTS, ATTORNEY FEES, AND EXPENSES ARISING OUT OF OR RESULTING FROM ANY ACTS OR OMISSIONS OF CONTRACTOR OR ITS AGENTS, EMPLOYEES, SUBCONTRACTORS, ORDER FULFILLERS, OR SUPPLIERS OF SUBCONTRACTORS IN THE EXECUTION OR PERFORMANCE OF THE CONTRACT AND ANY PURCHASE ORDERS ISSUED UNDER THE CONTRACT.

B. THIS PARAGRAPH IS NOT INTENDED TO AND WILL NOT BE CONSTRUED TO REQUIRE CONTRACTOR TO INDEMNIFY OR HOLD HARMLESS THE STATE OR THE SYSTEM AGENCY FOR ANY CLAIMS OR LIABILITIESRESULTING FROM THE NEGLIGENT ACTS OF OMISSIONS OF THE SYSTEM AGENCY OR ITS EMPLOYEES.

C. For the avoidance of doubt, System Agency shall not indemnify Contractor or any other entity under the Contract.

10.2 Intellectual Property

CONTRACTOR SHALL DEFEND, INDEMNIFY, AND HOLD HARMLESS THE SYSTEM AGENCY AND THE STATE OF TEXAS FROM AND AGAINST ANY AND ALL CLAIMS, VIOLATIONS, MISAPPROPRIATIONS, OR INFRINGEMENT OF ANY PATENT, TRADEMARK, COPYRIGHT, TRADE SECRET, OR OTHER INTELLECTUAL PROPERTY RIGHTS AND/OR OTHER INTANGIBLE PROPERTY, PUBLICITY OR PRIVACY RIGHTS, AND/OR IN CONNECTION WITH OR ARISING FROM:

i. THE PERFORMANCE OR ACTIONS OF CONTRACTOR PURSUANT TO THIS CONTRACT;

ii. ANY DELIVERABLE, WORK PRODUCT, CONFIGURED SERVICE OR OTHER SERVICE PROVIDED HEREUNDER; AND/OR

iii. SYSTEM AGENCY'S AND/OR CONTRACTOR'S USE OF OR ACQUISITION OF ANY REQUESTED SERVICES OR OTHER ITEMS PROVIDED TO SYSTEM AGENCY BY CONTRACTOR OR OTHERWISE TO WHICH SYSTEM AGENCY HAS ACCESS AS A RESULT OF CONTRACTOR'S PERFORMANCE UNDER THE CONTRACT.

10.3 Additional Indemnity Provisions

A. CONTRACTOR AND SYSTEM AGENCY AGREE TO FURNISH TIMELY WRITTEN NOTICE TO EACH OTHER OF ANY INDEMNITY CLAIM. CONTRACTOR SHALL BE LIABLE TO PAY ALL COSTS OF DEFENSE, INCLUDING ATTORNEYS' FEES.

B. THE DEFENSE SHALL BE COORDINATED BY THE CONTRACTOR WITH THE OFFICE OF THE TEXAS ATTORNEY GENERAL WHEN TEXAS STATE AGENCIES ARE NAMED DEFENDANTS IN ANY LAWSUIT AND CONTRACTOR MAY NOT AGREE TO ANY SETTLEMENT WITHOUT FIRST OBTAINING THE CONCURRENCE FROM THE OFFICE OF THE TEXAS ATTORNEY GENERAL.

C. CONTRACTOR SHALL REIMBURSE SYSTEM AGENCY AND THE STATE OF TEXAS FOR ANY CLAIMS, DAMAGES, COSTS, EXPENSES OR OTHER AMOUNTS, INCLUDING, BUT NOT LIMITED TO, ATTORNEYS'

FEES AND COURT COSTS, ARISING FROM ANY SUCH CLAIM. IF THE SYSTEM AGENCY DETERMINES THAT A CONFLICT EXISTS BETWEEN ITS INTERESTS AND THOSE OF CONTRACTOR OR IF SYSTEM AGENCY IS REQUIRED BY APPLICABLE LAW TO SELECT SEPARATE COUNSEL, SYSTEM AGENCY WILL BE PERMITTED TO SELECT SEPARATECOUNSEL AND CONTRACTOR SHALL PAY ALL REASONABLE COSTS OF SYSTEM AGENCY'S COUNSEL.

ARTICLE XI. GENERAL PROVISIONS

11.1 AMENDMENT

The Contract may only be amended by an Amendment executed by both Parties.

11.2 INSURANCE

A. Unless otherwise specified in this Contract, Contractor shall acquire and maintain, for the duration of this Contract, insurance coverage necessary to ensure proper fulfillment of this Contract and potential liabilities thereunder with financially sound and reputable insurers licensed by the Texas Department of Insurance, in the type and amount customarily carried within the industry as determined by the System Agency. Contractor shall provide evidence of insurance as required under this Contract, including a schedule of coverage or underwriter's schedules establishing to the satisfaction of the System Agency the nature and extent of coverage granted by each such policy, upon request by the System Agency. In the event that any policy is determined by the System Agency to be deficient to comply with the terms of this Contract, Contractor shall secure such additional policies or coverage as the System Agency may reasonably request or that are required by law or regulation. If coverage expires during the term of this Contract, Contractor must produce renewal certificates for each type of coverage.

B. These and all other insurance requirements under the Contract apply to both Contractor and its Subcontractors, if any. Contractor is responsible for ensuring its Subcontractors' compliance with all requirements.

11.3 LIMITATION ON AUTHORITY

A. The authority granted to Contractor by the System Agency is limited to the terms of the Contract.

B. Contractor shall not have any authority to act for or on behalf of the System Agency or the State of Texas except as expressly provided for in the Contract; no other authority, power, or use is granted or implied. Contractor may not incur any debt, obligation, expense, or liability of any kind on behalf of System Agency or the State of Texas.

C. Contractor may not rely upon implied authority and is not granted authority under the Contract to:

   i. Make public policy on behalf of the System Agency;
   ii. Promulgate, amend, or disregard administrative regulations or program policy decisions made by State and federal agencies responsible for administration of a System Agency program; or
   iii. Unilaterally communicate or negotiate with any federal or state agency or the Texas Legislature on behalf of the System Agency regarding System Agency

programs or the Contract. However, upon System Agency request and with reasonable notice from System Agency to the Contractor, the Contractor shall assist the System Agency in communications and negotiations regarding the Work under the Contract with state and federal governments.

11.4 Legal Obligations

Contractor shall comply with all applicable federal, state, and local laws, ordinances, and regulations, including all federal and state accessibility laws relating to direct and indirect use of information and communication technology. Contractor shall be deemed to have knowledge of all applicable laws and regulations and be deemed to understand them.

11.5 Change in Laws and Compliance with Laws

Contractor shall comply with all laws, regulations, requirements and guidelines applicable to a vendor providing services and products required by the Contract to the State of Texas, as these laws, regulations, requirements and guidelines currently exist and as amended throughout the term of the Contract. System Agency reserves the right, in its sole discretion, to unilaterally amend the Contract to incorporate any modifications necessary for System Agency's compliance, as an agency of the State of Texas, with all applicable state and federal laws, regulations, requirements and guidelines.

11.6 E-Verify Program

Contractor certifies that for Contracts for Services, Contractor shall utilize the U.S. Department of Homeland Security's E-Verify system during the term of the Contract to determine the eligibility of:

i. all persons employed by Contractor to perform duties within Texas; and
ii. all persons, including subcontractors, assigned by the Contractor to perform Work pursuant to the Contract within the United States of America.

11.7 Permitting and Licensure

At Contractor's sole expense, Contractor shall procure and maintain for the duration of this Contract any state, county, city, or federal license, authorization, insurance, waiver, permit, qualification or certification required by statute, ordinance, law, or regulation to be held by Contractor to provide the goods or Services required by this Contract.

Contractor shall be responsible for payment of all taxes, assessments, fees, premiums, permits, and licenses required by law. Contractor shall be responsible for payment of any such government obligations not paid by its Subcontractors during performance of this Contract.

11.8 Subcontractors

Contractor may not subcontract any or all of the Work and/or obligations under the Contract without prior written approval of the System Agency. Subcontracts, if any, entered into by the Contractor shall be in writing and be subject to the requirements of the Contract. Should Contractor Subcontract any of the services required in the Contract, Contractor expressly understands and acknowledges that in entering into such Subcontract(s), System Agency is in no manner liable to any subcontractor(s) of Contractor. In no event shall this provision relieve Contractor of the responsibility for

ensuring that the services performed under all Subcontracts are rendered in compliance with the Contract.

11.9 INDEPENDENT CONTRACTOR

Contractor and Contractor's employees, representatives, agents, Subcontractors, suppliers, and third-party service providers shall serve as independent contractors in providing the services under the Contract. Neither Contractor nor System Agency is an agent of the other and neither may make any commitments on the other party's behalf. Contractor shall have no claim against System Agency for vacation pay, sick leave, retirement benefits, social security, worker's compensation, health or disability benefits, unemployment insurance benefits, or employee benefits of any kind. The Contract shall not create any joint venture, partnership, agency, or employment relationship between Contractor and System Agency.

11.10 GOVERNING LAW AND VENUE

This Contract shall be governed by and construed in accordance with the laws of the State of Texas, without regard to the conflicts of law provisions. The venue of any suit arising under the Contract is fixed in any court of competent jurisdiction of Travis County, Texas, unless the specific venue is otherwise identified in a statute which directly names or otherwise identifies its applicability to the System Agency.

11.11 SEVERABILITY

If any provision of the Contract is held to be illegal, invalid or unenforceable by a court of law or equity, such construction will not affect the legality, validity or enforceability of any other provision or provisions of this Contract. It is the intent and agreement of the Parties this Contract shall be deemed amended by modifying such provision to the extent necessary to render it valid, legal and enforceable while preserving its intent or, if such modification is not possible, by substituting another provision that is valid, legal and enforceable and that achieves the same objective. All other provisions of this Contract will continue in full force and effect.

11.12 SURVIVABILITY

Expiration or termination of the Contract for any reason does not release Contractor from any liability or obligation set forth in the Contract that is expressly stated to survive any such expiration or termination, that by its nature would be intended to be applicable following any such expiration or termination, or that is necessary to fulfill the essential purpose of the Contract, including without limitation the provisions regarding warranty, indemnification, confidentiality, and rights and remedies upon termination.

11.13 FORCE MAJEURE

Neither Contractor nor System Agency shall be liable to the other for any delay in, or failure of performance of, any requirement included in the Contract caused by force majeure. The existence of such causes of delay or failure shall extend the period of performance until after the causes of delay or failure have been removed provided the non-performing party exercises all reasonable due diligence to perform. Force majeure is defined as acts of God, war, fires, explosions, hurricanes, floods, failure of transportation, or other causes that are beyond the reasonable control of either party and that by exercise of due foresight such party could not reasonably have been expected to

avoid, and which, by the exercise of all reasonable due diligence, such party is unable to overcome.

11.14 Dispute Resolution

A. The dispute resolution process provided for in Chapter 2260 of the Texas Government Code must be used to attempt to resolve any dispute arising under the Contract. If the Contractor's claim for breach of contract cannot be resolved informally with the System Agency, the claim shall be submitted to the negotiation process provided in Chapter2260. To initiate the process, the Contractor shall submit written notice, as required by Chapter 2260, to the individual identified in the Contract for receipt of notices. Any informal resolution efforts shall in no way modify the requirements or toll the timing of the formal written notice of a claim for breach of contract required under §2260.051 of the Texas Government Code. Compliance by the Contractor with Chapter 2260 is a condition precedent to the filing of a contested case proceeding under Chapter 2260.

B. The contested case process provided in Chapter 2260 is the Contractor's sole and exclusive process for seeking a remedy for an alleged breach of contract by the System Agency ifthe Parties are unable to resolve their disputes as described above.

C. Notwithstanding any other provision of the Contract to the contrary, unless otherwise requested or approved in writing by the System Agency, the Contractor shall continue performance and shall not be excused from performance during the period of any breach of contract claim or while the dispute is pending. However, the Contractor may suspend performance during the pendency of such claim or dispute if the Contractor has complied with all provisions of Section 2251.051, Texas Government Code, and such suspension of performance is expressly applicable and authorized under that law.

11.15 No Implied Waiver of Provisions

The failure of the System Agency to object to or to take affirmative action with respect to any conduct of the Contractor which is in violation or breach of the terms of the Contract shall not be construed as a waiver of the violation or breach, or of any future violation or breach.

11.16 Media Releases

A. Contractor shall not use System Agency's name, logo, or other likeness in any press release, marketing material, or other announcement without System Agency's prior written approval. System Agency does not endorse any vendor, commodity, or service. Contractor is not authorized to make or participate in any media releases or public announcements pertaining to this Contract or the Services to which they relate without System Agency's prior written consent, and then only in accordance with explicit written instruction from System Agency.

B. Contractor may publish, at its sole expense, results of Contractor performance under the Contract with the System Agency's prior review and approval, which the System Agency may exercise at its sole discretion. Any publication (written, visual, or sound) will acknowledge the support received from the System Agency and any Federal agency, as appropriate.

11.17 No Marketing Activities

Contractor is prohibited from using the Work for any Contractor or third-party marketing, advertising, or promotional activities, without the prior written consent of System Agency. The foregoing prohibition includes, without limitation, the placement of banners, pop-up ads, or other advertisements promoting Contractor's or a third party's products, services, workshops, trainings, or other commercial offerings on any website portal or internet-based service or software application hosted or managed by Contractor as part of the Work.

11.18 Prohibition on Non-compete Restrictions

Contractor shall not require any employees or Subcontractors to agree to any conditions, such as non-compete clauses or other contractual arrangements that would limit or restrict such persons or entities from employment or contracting with the State of Texas.

11.19 Sovereign Immunity

Nothing in the Contract shall be construed as a waiver of the System Agency's or the State's sovereign immunity. This Contract shall not constitute or be construed as a waiver of any of the privileges, rights, defenses, remedies, or immunities available to the System Agency or the State of Texas. The failure to enforce, or any delay in the enforcement of, any privileges, rights, defenses, remedies, or immunities available to the System Agencyor the State of Texas under the Contract or under applicable law shall not constitute a waiver of such privileges, rights, defenses, remedies, or immunities or be considered as a basis for estoppel. System Agency does not waive any privileges, rights, defenses, or immunities available to System Agency by entering into the Contract or by its conduct prior to or subsequent to entering into the Contract.

11.20 Entire Contract and Modification

This Contract constitutes the entire agreement of the Parties and is intended as a complete and exclusive statement of the promises, representations, negotiations, discussions, and other agreements that may have been made in connection with the subject matter hereof. Any additional or conflicting terms in any future document incorporated into the Contract will be harmonized with this Contract to the extent possible.

11.21 Counterparts

This Contract may be executed in any number of counterparts, each of which will be an original, and all such counterparts will together constitute but one and the same Contract.

11.22 Civil Rights

A. Contractor agrees to comply with state and federal anti-discrimination laws, including:
   - i. Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d et seq.);
   - ii. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
   - iii. Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);
   - iv. Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
   - v. Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
   - vi. Food and Nutrition Act of 2008 (7 U.S.C. §2011 et seq.); and
   - vii. The System Agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Contract.

B. Contractor agrees to comply with all amendments to the above-referenced laws, and all requirements imposed by the regulations issued pursuant to these laws. These laws provide in part that no persons in the United States may, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service or other benefits provided by Federal or State funding, or otherwise be subjected to discrimination.

C. Contractor agrees to comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 C.F.R. Part 80 or 7 C.F.R. Part 15, prohibiting a contractor from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of clients in its programs, benefits, or activities on the basis of national origin. State and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. Contractor agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

D. Contractor agrees to post applicable civil rights posters in areas open to the public informing clients of their civil rights and including contact information for the HHS Civil Rights Office. The posters are available on the HHS website at: https://hhs.texas.gov/about-hhs/your-rights/civil-rights-office/civil-rights-posters

E. Contractor agrees to comply with Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16. These provide in part that any organization that participates in programs funded by direct financial assistance from the United States Department of Agriculture or the United States Department of Health and Human Services shall not discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.

F. Upon request, Contractor shall provide HHSC's Civil Rights Office with copies of the Contractor's civil rights policies and procedures.

G. Contractor must notify HHSC's Civil Rights Office of any complaints of discrimination received relating to its performance under this Contract. This notice must be delivered no more than ten (10) calendar days after receipt of a complaint. Notice provided pursuant to this section must be directed to:
HHSC Civil Rights Office
701 W. 51st Street, Mail CodeW206
Austin, Texas 78751
Phone Toll Free: (888) 388-6332
Phone: (512) 438-4313
Fax: (512) 438-5885
Email: HHSCivilRightsOffice@hhsc.state.tx.us

11.23 ENTERPRISE INFORMATION MANAGEMENT STANDARDS

Contractor shall conform to HHS standards for data management as described by the policies of the HHS Chief Data and Analytics Officer. These include, but are not limited to, standards for documentation and communication of data models, metadata, and other data definition methods that are required by HHS for ongoing data governance, strategic portfolio analysis, interoperability planning, and valuation of HHS System data assets.

11.24 DISCLOSURE OF LITIGATION

A. The Contractor must disclose in writing to the contract manager assigned to this Contract any material civil or criminal litigation or indictment either threatened or pending involving the Contractor. "Threatened litigation" as used herein shall include governmental investigations and civil investigative demands. "Litigation" as used herein shall include administrative enforcement actions brought by governmental agencies. The Contractor must also disclose any material litigation threatened or pending involving Subcontractors, consultants, and/or lobbyists. For purposes of this section, "material" refers, but is not limited, to any action or pending action that a reasonable person knowledgeable in the applicable industry would consider relevant to the Work under the Contract or any development such a person would want to be aware of in order to stay fully apprised of the total mix of information relevant to the Work, together with any litigation threatened or pending that may result in a substantial change in the Contractor's financial condition.

B. This is a continuing disclosure requirement; any litigation commencing after Contract Award must be disclosed in a written statement to the assigned contract manager within seven calendar days of its occurrence.

11.25 NO THIRD-PARTY BENEFICIARIES

The Contract is made solely and specifically among and for the benefit of the Parties named herein and their respective successors and assigns, and no other person shall have any right, interest, or claims hereunder or be entitled to any benefits pursuant to or on account of the Contract as a third-party beneficiary or otherwise.

11.26 BINDING EFFECT

The Contract shall inure to the benefit of, be binding upon, and be enforceable against, each Party and their respective permitted successors, assigns, transferees, and delegates.

Exhibit C
Health and Human Services (HHS)
Additional Provisions
Version 1.0
Effective: November 7, 2019

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ADDITIONAL PROVISIONS

The terms and conditions of these Additional Provisions are incorporated into and made a part of the Contract. Capitalized items used in these Additional Provisons and not otherwise defined have the meanings assigned to them in HHSC Uniform Terms and Conditions.

1. HHSC Vendor Access

At HHSC's request, Contractor will allow parties interested in responding to other HHSC solicitations to have reasonable access during normal business hours to the Work, software, systems documentation, and site visits to the Contractor's facilities. Contractor may elect to have such parties inspecting the Work, facilities, software or systems documentation to agree to use the information so obtained only in the State of Texas and only for the purpose of responding to the relevant HHSC solicitation.

2. HHSC Approval of Staffing

A. Contractor shall not employ or contract with or permit the employment of unfit or unqualified persons or persons not skilled in the tasks assigned to them. The Contractor shall at all times employ sufficient labor to carry out functions and services in the manner and time prescribed by the Contract. The Contractor shall be responsible to HHSC for the acts and omissions of the Contractor's employees, agents (including, but not limited to, lobbyists) and Subcontractors and the Contractor shall enforce strict discipline among the Contractor's employees, agents (including, but not limited to, lobbyists) and Subcontractors performing the services under the Contract.

B. Any person employed by the Contractor shall, at the written request of HHSC, and within HHSC's sole discretion, be removed immediately by the Contractor from work relating to the Contract.

3. Turnover Plan

HHSC, in its sole discretion, may require Contractor to develop and submit a Turnover Plan at any time during the term of the Contract. Contractor must submit the Turnover Plan to HHSC for review and approval. The Turnover Plan must describe Contractor's policies and procedures that will ensure:

i. The least disruption in the delivery of the Work during Turnover to HHSC or its designee; and

ii. Full cooperation with HHSC or its designee in transferring the Work and the obligations of the Contract.

4. Turnover Assistance

Contractor will provide any assistance and actions reasonably necessary to enable HHSC or its designee to effectively close out the Contract and transfer the Work and the obligations of the Contract to another vendor or to perform the Work by itself. Contractor agrees that this obligation survives the termination, regardless of whether for cause or convenience, or the expiration of the Contract and remains in effect until completed to the satisfaction of HHSC.

5. Discounts

If Contractor at any time during the term of the Contract provides a discount on the final contract costs, Contractor will notify HHSC in writing at least ten (10) calendar days prior to the effective date of the discount. HHSC will generate a Purchase Order Change Notice and send a revised Purchase Order to Contractor.

6. Notice of Criminal Activity and Disciplinary Actions

A. Contractor shall immediately report in writing to its assigned HHSC contract manager when Contractor learns of or has any reason to believe it or any person with ownership or controlling interest in Contractor, or their agent, employee, subcontractor or volunteer who is providing services under this Contract has:

   i. Engaged in any activity that could constitute a criminal offense equal to or greater than a Class A misdemeanor or grounds for disciplinary action by a state or federal regulatory authority; or

   ii. Been placed on community supervision, received deferred adjudication, or been indicted for or convicted of a criminal offense relating to involvement in any financial matter, federal or state program or felony sex crime.

B. Contractor shall not permit any person who engaged, or was alleged to have engaged, in any activity subject to reporting under this section to perform direct client services or have direct contact with clients, unless otherwise directed in writing by the System Agency.

7. Notice of IRS or TWC Insolvency

Contractor shall notify in writing its assigned HHSC contract manager of any insolvency, incapacity or outstanding unpaid obligations of Contractor owed to the Internal Revenue Service or the State of Texas, or any agency or political subdivision of the State of Texas within five days of the date of Contractor's becoming aware of such.

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Exhibit H, DATA USE AGREEMENT
BETWEEN THE
TEXAS HEALTH AND HUMAN SERVICES SYSTEM
AND
CONTRACTOR

This Data Use Agreement ("DUA") is effective as of the date of the Base Contract into which it is incorporated ("Effective Date"), by and between the Texas Health and Human Services System, which includes the Texas Health and Human Services Commission and the Department of State Health Services ("HHS") and Contractor (the "Base Contract").

ARTICLE 1. PURPOSE; APPLICABILITY; ORDER OF PRECEDENCE

The purpose of this DUA is to facilitate access to, creation, receipt, maintenance, use, disclosure or transmission of Confidential Information with Contractor, and describe Contractor's rights and obligations with respect to the Confidential Information and the limited purposes for which the Contractor may create, receive, maintain, use, disclose or have access to Confidential Information. This DUA also describes HHS's remedies in the event of Contractor's noncompliance with its obligations under this DUA. This DUA applies to both HHS business associates, as "business associate" is defined in the Health Insurance Portability and Accountability Act (HIPAA), and contractors who are not business associates, who create, receive, maintain, use, disclose or have access to Confidential Information on behalf of HHS, its programs or clients as described in the Base Contract. As a best practice, HHS requires its contractors to comply with the terms of this DUA to safeguard all types of Confidential Information.

As of the Effective Date of this DUA, if any provision of the Base Contract conflicts with this DUA, this DUA controls.

ARTICLE 2. DEFINITIONS

For the purposes of this DUA, capitalized, underlined terms have the following meanings:

"Authorized Purpose" means the specific purpose or purposes described in the Base Contract for Contractor to fulfill its obligations under the Base Contract, or any other purpose expressly authorized by HHS in writing in advance.

"Authorized User" means a person:

(1) Who is authorized to create, receive, maintain, have access to, process, view, handle, examine, interpret, or analyze Confidential Information pursuant to this DUA;

(2) For whom Contractor warrants and represents has a demonstrable need to create, receive, maintain, use, disclose or have access to the Confidential Information; and

(3) Who has agreed in writing to be bound by the disclosure and use limitations pertaining to the Confidential Information as required by this DUA.

"Breach" means an impermissible use or disclosure of electronic or non-electronic sensitive personal information by an unauthorized person or for an unauthorized purpose that compromises the security or privacy of Confidential Information such that the use or disclosure poses a risk of reputational harm, theft of financial information, identity theft, or medical identity theft. Any acquisition, access, use, disclosure or loss of Confidential Information other than as permitted by this

DUA shall be presumed to be a Breach unless Contractor demonstrates, based on a risk assessment, that there is a low probability that the Confidential Information has been compromised.

"Confidential Information" means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to Contractor or that Contractor may create, receive, maintain, use, disclose or have access to on behalf of HHS that consists of or includes any or all of the following:

(1) Education records as defined in the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g; 34 C.F.R. Part 99

(2) Federal Tax Information as defined in Internal Revenue Code §6103 and Internal Revenue Service Publication 1075;

(3) Personal Identifying Information (PII) as defined in Texas Business and Commerce Code, Chapter 521;

(4) Protected Health Information (PHI) in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information as defined in 45 C.F.R. §160.103;

(5) Sensitive Personal Information (SPI) as defined in Texas Business and Commerce Code, Chapter 521;

(6) Social Security Administration Data, including, without limitation, Medicaid information means disclosures of information made by the Social Security Administration or the Centers for Medicare and Medicaid Services from a federal system of records for administration of federally funded benefit programs under the Social Security Act, 42 U.S.C., Chapter 7;

(7) All privileged work product;

(8) All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

"Destroy", **"Destruction"**, for Confidential Information, means:

(1) Paper, film, or other hard copy media have been shredded or destroyed such that the Confidential Information cannot be read or otherwise cannot be reconstructed. Redaction is specifically excluded as a means of data destruction.

(2) Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publication 800-88, "Guidelines for Media Sanitization," such that the Confidential Information cannot be retrieved.

"Discover, Discovery" means the first day on which a Breach becomes known to Contractor, or, by exercising reasonable diligence would have been known to Contractor.

"Legally Authorized Representative" of an individual, including as provided in 45 CFR 435.923 (authorized representative); 45 CFR 164.502(g)(1) (personal representative); Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164 (medical power of attorney); and Texas Estates Code § 22.031 (representative).

"Required by Law" means a mandate contained in law that compels an entity to use or disclose Confidential Information that is enforceable in a court of law, including court orders, warrants, subpoenas or investigative demands.

"Subcontractor" means a person who contracts with a prime contractor to work, to supply commodities, or to contribute toward completing work for a governmental entity.

"Workforce" means employees, volunteers, trainees or other persons whose performance of work is under the direct control of a party, whether or not they are paid by that party.

ARTICLE 3. CONTRACTOR'S DUTIES REGARDING CONFIDENTIAL INFORMATION

Section 3.01 Obligations of Contractor

Contractor agrees that:

(A) With respect to PHI, Contractor shall:

(1) Make PHI available in a designated record set if requested by HHS, if Contractor maintains PHI in a designated record set, as defined in HIPAA.

(2) Provide to HHS data aggregation services related to the healthcare operations Contractor performs for HHS pursuant to the Base Contract, if requested by HHS, if Contractor provides data aggregation services as defined in HIPAA.

(3) Provide access to PHI to an individual who is requesting his or her own PHI, or such individual's Legally Authorized Representative, in compliance with the requirements of HIPAA.

(4) Make PHI available to HHS for amendment, and incorporate any amendments to PHI that HHS directs, in compliance with HIPAA.

(5) Document and make available to HHS, an accounting of disclosures in compliance with the requirements of HIPAA.

(6) If Contractor receives a request for access, amendment or accounting of PHI by any individual, promptly forward the request to HHS or, if forwarding the request would violate HIPAA, promptly notify HHS of the request and of Contractor's response. HHS will respond to all such requests, unless Contractor is Required by Law to respond or HHS has given prior written consent for Contractor to respond to and account for all such requests.

(B) With respect to ALL Confidential Information, Contractor shall:

(1) Exercise reasonable care and no less than the same degree of care Contractor uses to protect its own confidential, proprietary and trade secret information to prevent Confidential Information from being used in a manner that is not expressly an Authorized Purpose or as Required by Law. Contractor will access, create, maintain, receive, use, disclose, transmit or Destroy Confidential Information in a secure fashion that protects against any reasonably anticipated threats or hazards to the security or integrity of such information or unauthorized uses.

(2) Establish, implement and maintain appropriate procedural, administrative, physical and technical safeguards to preserve and maintain the confidentiality, integrity, and availability of the Confidential Information, in accordance with applicable laws or regulations relating to Confidential Information, to prevent any unauthorized use or disclosure of Confidential Information as long as Contractor has such Confidential Information in its actual or constructive possession.

(3) Implement, update as necessary, and document privacy, security and Breach notice policies and procedures and an incident response plan to address a Breach, to comply with the privacy, security and breach notice requirements of this DUA prior to conducting work under the Base Contract. Contractor

shall produce, within three business days of a request by HHS, copies of its policies and procedures and records relating to the use or disclosure of Confidential Information.

(4) Obtain HHS's prior written consent to disclose or allow access to any portion of the Confidential Information to any person, other than Authorized Users, Workforce or Subcontractors of Contractor who have completed training in confidentiality, privacy, security and the importance of promptly reporting any Breach to Contractor's management and as permitted in Section 3.01(A)(3), above. Contractor shall produce evidence of completed training to HHS upon request. HHS, at its election, may assist Contractor in training and education on specific or unique HHS processes, systems and/or requirements. All of Contractor's Authorized Users, Workforce and Subcontractors with access to a state computer system or database will complete a cybersecurity training program certified under Texas Government Code Section 2054.519 by the Texas Department of Information Resources.

(5) Establish, implement and maintain appropriate sanctions against any member of its Workforce or Subcontractor who fails to comply with this DUA, the Base Contract or applicable law. Contractor shall maintain evidence of sanctions and produce it to HHS upon request.

(6) Obtain prior written approval of HHS, to disclose or provide access to any Confidential Information on the basis that such act is Required by Law, so that HHS may have the opportunity to object to the disclosure or access and seek appropriate relief. If HHS objects to such disclosure or access, Contractor shall refrain from disclosing or providing access to the Confidential Information until HHS has exhausted all alternatives for relief.

(7) Certify that its Authorized Users each have a demonstrated need to know and have access to Confidential Information solely to the minimum extent necessary to accomplish the Authorized Purpose and that each has agreed in writing to be bound by the disclosure and use limitations pertaining to the Confidential Information contained in this DUA. Contractor and its Subcontractors shall maintain at all times an updated, complete, accurate list of Authorized Users and supply it to HHS upon request.

(8) Provide, and shall cause its Subcontractors and agents to provide, to HHS periodic written confirmation of compliance with controls and the terms and conditions of this DUA.

(9) Return to HHS or Destroy, at HHS's election and at Contractor's expense, all Confidential Information received from HHS or created or maintained by Contractor or any of Contractor's agents or Subcontractors on HHS's behalf upon the termination or expiration of this DUA, if reasonably feasible and permitted by law. Contractor shall certify in writing to HHS that all such Confidential Information has been Destroyed or returned to HHS, and that Contractor and its agents and Subcontractors have retained no copies thereof. Notwithstanding the foregoing, Contractor acknowledges and agrees that it may not Destroy any Confidential Information if federal or state law, or HHS record retention policy or a litigation hold notice prohibits such Destruction. If such return or Destruction is not reasonably feasible, or is impermissible by law, Contractor shall immediately notify HHS of the reasons such return or Destruction is not feasible and agree to extend the protections of this DUA to the Confidential Information for as long as Contractor maintains such Confidential Information.

(10) Complete and return with the Base Contract to HHS, attached as Attachment 2 to this DUA, the HHS Security and Privacy Initial Inquiry (SPI) at https://hhs.texas.gov/laws-regulations/forms/miscellaneous/hhs-information-security-privacy-initial-inquiry-spi. The SPI identifies basic privacy and security controls with which Contractor must comply to protect Confidential Information. Contractor shall comply with periodic security controls compliance assessment and monitoring by HHS as required by state and federal law, based on the type of Confidential Information Contractor creates, receives, maintains, uses, discloses or has access to and the Authorized Purpose and level of risk. Contractor's

security controls shall be based on the National Institute of Standards and Technology (NIST) Special Publication 800-53. Contractor shall update its security controls assessment whenever there are significant changes in security controls for HHS Confidential Information and shall provide the updated document to HHS. HHS also reserves the right to request updates as needed to satisfy state and federal monitoring requirements.

(11) Comply with the HHS Acceptable Use Policy (AUP) and require each Subcontractor and Workforce member who has direct access to HHS Information Resources, as defined in the AUP, to execute an HHS Acceptable Use Agreement.

(12) Only conduct secure transmissions of Confidential Information whether in paper, oral or electronic form. A secure transmission of electronic Confidential Information *in motion* includes secure File Transfer Protocol (SFTP) or encryption at an appropriate level as required by rule, regulation or law. Confidential Information *at rest* requires encryption unless there is adequate administrative, technical, and physical security as required by rule, regulation or law. All electronic data transfer and communications of Confidential Information shall be through secure systems. Contractor shall provide proof of system, media or device security and/or encryption to HHS no later than 48 hours after HHS's written request in response to a compliance investigation, audit, or the Discovery of a Breach. HHS may also request production of proof of security at other times as necessary to satisfy state and federal monitoring requirements. Deidentification of Confidential Information in accordance with HIPAA de-identification standards is deemed secure.

(13) Designate and identify a person or persons, as Privacy Official and Information Security Official, each of whom is authorized to act on behalf of Contractor and is responsible for the development and implementation of the privacy and security requirements in this DUA. Contractor shall provide name and current address, phone number and e-mail address for such designated officials to HHS upon execution of this DUA and prior to any change. Upon written notice from HHS, Contractor shall promptly remove and replace such official(s) if such official(s) is not performing the required functions.

(14) Make available to HHS any information HHS requires to fulfill HHS's obligations to provide access to, or copies of, Confidential Information in accordance with applicable laws, regulations or demands of a regulatory authority relating to Confidential Information. Contractor shall provide such information in a time and manner reasonably agreed upon or as designated by the applicable law or regulatory authority.

(15) Comply with the following laws and standards ***if applicable to the type of Confidential Information and Contractor's Authorized Purpose***:

- Title 1, Part 10, Chapter 202, Subchapter B, Texas Administrative Code;
- The Privacy Act of 1974;
- OMB Memorandum 17-12;
- The Federal Information Security Management Act of 2002 (FISMA);
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Internal Revenue Publication 1075 – Tax Information Security Guidelines for Federal, State and Local Agencies;
- National Institute of Standards and Technology (NIST) Special Publication 800-66 Revision 1 – An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule;

- NIST Special Publications 800-53 and 800-53A – Recommended Security Controls for Federal Information Systems and Organizations, as currently revised;
- NIST Special Publication 800-47 – Security Guide for Interconnecting Information Technology Systems;
- NIST Special Publication 800-88, Guidelines for Media Sanitization;
- NIST Special Publication 800-111, Guide to Storage of Encryption Technologies for End User Devices containing PHI;
- Family Educational Rights and Privacy Act
- Texas Business and Commerce Code, Chapter 521;
- Any other State or Federal law, regulation, or administrative rule relating to the specific HHS program area that Contractor supports on behalf of HHS.

(16) Be permitted to use or disclose Confidential Information for the proper management and administration of Contractor or to carry out Contractor's legal responsibilities, except as otherwise limited by this DUA, the Base Contract, or law applicable to the Confidential Information, if:

(a) Disclosure is Required by Law;

(b) Contractor obtains reasonable assurances from the person to whom the information is disclosed that the person shall:

1. Maintain the confidentiality of the Confidential Information in accordance with this DUA;

2. Use or further disclose the information only as Required by Law or for the Authorized Purpose for which it was disclosed to the person; and

3. Notify Contractor in accordance with Section 4.01 of a Breach of Confidential Information that the person Discovers or should have Discovered with the exercise of reasonable diligence.

(C) With respect to ALL Confidential Information, Contractor shall NOT:

(1) Attempt to re-identify or further identify Confidential Information that has been deidentified, or attempt to contact any persons whose records are contained in the Confidential Information, except for an Authorized Purpose, without express written authorization from HHS.

(2) Engage in prohibited marketing or sale of Confidential Information.

(3) Permit, or enter into any agreement with a Subcontractor to, create, receive, maintain, use, disclose, have access to or transmit Confidential Information, on behalf of HHS without requiring that Subcontractor first execute either the Form Subcontractor Agreement, Attachment 1, or Contractor's own Subcontractor agreement that ensures that the Subcontractor shall comply with the same safeguards and restrictions contained in this DUA for Confidential Information. Contractor is directly responsible for its Subcontractors' compliance with, and enforcement of, this DUA.

ARTICLE 4. BREACH NOTICE, REPORTING AND CORRECTION REQUIREMENTS

Section 4.01. Cooperation and Financial Responsibility.

(A) Contractor shall, at Contractor's expense, cooperate fully with HHS in investigating, mitigating to the extent practicable, and issuing notifications as directed by HHS, for any Breach of Confidential Information.

(B) Contractor shall make Confidential Information in Contractor's possession available pursuant to the requirements of HIPAA or other applicable law upon a determination of a Breach.

(C) Contractor's obligation begins at the Discovery of a Breach and continues as long as related activity continues, until all effects of the Breach are mitigated to HHS's satisfaction (the "incident response period").

Section 4.02. Initial Breach Notice.

For federal information ***obtained from a federal system of records***, including Federal Tax Information and Social Security Administration Data (which includes Medicaid and other governmental benefit program Confidential Information), Contractor shall notify HHS of the Breach within the first consecutive clock hour of Discovery. The Base Contract shall specify whether Confidential Information is obtained from a federal system of records. For all other types of Confidential Information Contractor shall notify HHS of the Breach not more than 24 hours after Discovery, ***or in a timeframe otherwise approved by HHS in writing.*** Contractor shall initially report to HHS's Privacy and Security Officers via email at: privacy@HHSC.state.tx.us and to the HHS division responsible for the Base Contract.

Contractor shall report all information reasonably available to Contractor about the Breach.

Contractor shall provide contact information to HHS for Contractor's single point of contact who will communicate with HHS both on and off business hours during the incident response period.

Section 4.03 Third Business Day Notice: No later than 5 p.m. on the third business day after Discovery, or a time within which Discovery reasonably should have been made by Contractor of a Breach of Confidential Information, Contractor shall provide written notification to HHS of all reasonably available information about the Breach, and Contractor's investigation, including, to the extent known to Contractor***:***
a. The date the Breach occurred;

b. The date of Contractor's and, if applicable, Subcontractor's Discovery;

c. A brief description of the Breach, including how it occurred and who is responsible (or hypotheses, if not yet determined);

d. A brief description of Contractor's investigation and the status of the investigation;

e. A description of the types and amount of Confidential Information involved;

f. Identification of and number of all individuals reasonably believed to be affected, including first and last name of the individual and if applicable, the Legally authorized representative, last known address, age, telephone number, and email address if it is a preferred contact method;

g. Contractor's initial risk assessment of the Breach demonstrating whether individual or other notices are required by applicable law or this DUA for HHS approval, including an analysis of whether there is a low probability of compromise of the Confidential Information or whether any legal exceptions to notification apply;

h. Contractor's recommendation for HHS's approval as to the steps individuals and/or Contractor on behalf of individuals, should take to protect the individuals from potential harm, including

Contractor's provision of notifications, credit protection, claims monitoring, and any specific protections for a Legally Authorized Representative to take on behalf of an individual with special capacity or circumstances;

i. The steps Contractor has taken to mitigate the harm or potential harm caused (including without limitation the provision of sufficient resources to mitigate);

j. The steps Contractor has taken, or will take, to prevent or reduce the likelihood of recurrence of a similar Breach;

k. Identify, describe or estimate of the persons, Workforce, Subcontractor, or individuals and any law enforcement that may be involved in the Breach;

l. A reasonable schedule for Contractor to provide regular updates regarding response to the Breach, but no less than every three (3) business days, or as otherwise directed by HHS in writing, including information about risk estimations, reporting, notification, if any, mitigation, corrective action, root cause analysis and when such activities are expected to be completed; and

m. Any reasonably available, pertinent information, documents or reports related to a Breach that HHS requests following Discovery.

Section 4.04. Investigation, Response and Mitigation.

(A) Contractor shall immediately conduct a full and complete investigation, respond to the Breach, commit necessary and appropriate staff and resources to expeditiously respond, and report as required to HHS for incident response purposes and for purposes of HHS's compliance with report and notification requirements, to the satisfaction of HHS.

(B) Contractor shall complete or participate in a risk assessment as directed by HHS following a Breach, and provide the final assessment, corrective actions and mitigations to HHS for review and approval.

(C) Contractor shall fully cooperate with HHS to respond to inquiries and/or proceedings by state and federal authorities, persons and/or individuals about the Breach.

(D) Contractor shall fully cooperate with HHS's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such Breach, or to recover or protect any Confidential Information, including complying with reasonable corrective action or measures, as specified by HHS in a Corrective Action Plan if directed by HHS under the Base Contract.

Section 4.05. Breach Notification to Individuals and Reporting to Authorities.

(A) HHS may direct Contractor to provide Breach notification to individuals, regulators or third-parties, as specified by HHS following a Breach.

(B) Contractor must comply with all applicable legal and regulatory requirements in the time, manner and content of any notification to individuals, regulators or third-parties, or any notice required by other state or federal authorities, including without limitation, notifications required by Texas Business and Commerce Code, Chapter 521.053(b) and HIPAA. Notice letters will be in Contractor's name and on Contractor's letterhead, unless otherwise directed by HHS, and will contain contact information, including the name and title of Contractor's representative, an email address and a toll-free telephone number, for the individual to obtain additional information.

(C) Contractor shall provide HHS with draft notifications for HHS approval prior to distribution and copies of distributed and approved communications.

(D) Contractor shall have the burden of demonstrating to the satisfaction of HHS that any required notification was timely made. If there are delays outside of Contractor's control, Contractor shall provide written documentation to HHS of the reasons for the delay.

(E) If HHS directs Contractor to provide notifications, HHS shall, in the time and manner reasonably requested by Contractor, cooperate and assist with Contractor's information requests in order to make such notifications.

ARTICLE 5. GENERAL PROVISIONS

Section 5.01 Ownership of Confidential Information

Contractor acknowledges and agrees that the Confidential Information is and shall remain the property of HHS. Contractor agrees it acquires no title or rights to the Confidential Information.

Section 5.02 HHS Commitment and Obligations

HHS will not request Contractor to create, maintain, transmit, use or disclose PHI in any manner that would not be permissible under applicable law if done by HHS.

Section 5.03 HHS Right to Inspection

At any time upon reasonable notice to Contractor, or if HHS determines that Contractor has violated this DUA, HHS, directly or through its agent, will have the right to inspect the facilities, systems, books and records of Contractor to monitor compliance with this DUA. For purposes of this subsection, HHS's agent(s) include, without limitation, the HHS Office of the Inspector General, the Office of the Attorney General of Texas, the State Auditor's Office, outside consultants, legal counsel or other designee.

Section 5.04 Term; Termination of DUA; Survival

This DUA will be effective on the date on which Contractor executes the Base Contract and will terminate upon termination of the Base Contract and as set forth herein. If the Base Contract is extended, this DUA is extended to run concurrent with the Base Contract.

(A) If HHS determines that Contractor has violated a material term of this DUA; HHS may in its sole discretion:

(1) Exercise any of its rights including but not limited to reports, access and inspection under this DUA and/or the Base Contract; or

(2) Require Contractor to submit to a corrective action plan, including a plan for monitoring and plan for reporting as HHS may determine necessary to maintain compliance with this DUA; or

(3) Provide Contractor with a reasonable period to cure the violation as determined by HHS; or

(4) Terminate the DUA and Base Contract immediately and seek relief in a court of competent jurisdiction in Travis County, Texas.

Before exercising any of these options, HHS will provide written notice to Contractor describing the violation and the action it intends to take.

(B) If neither termination nor cure is feasible, HHS shall report the violation to the applicable regulatory authorities.

(C) The duties of Contractor or its Subcontractor under this DUA survive the expiration or termination of this DUA until all the Confidential Information is Destroyed or returned to HHS, as required by this DUA.

Section 5.05 Injunctive Relief

(A) Contractor acknowledges and agrees that HHS may suffer irreparable injury if Contractor or its Subcontractor fails to comply with any of the terms of this DUA with respect to the Confidential Information or a provision of HIPAA or other laws or regulations applicable to Confidential Information.

(B) Contractor further agrees that monetary damages may be inadequate to compensate HHS for Contractor's or its Subcontractor's failure to comply. Accordingly, Contractor agrees that HHS will, in addition to any other remedies available to it at law or in equity, be entitled to seek injunctive relief without posting a bond and without the necessity of demonstrating actual damages, to enforce the terms of this DUA.

Section 5.06 Indemnification

Contractor shall indemnify, defend and hold harmless HHS and its respective Executive Commissioner, employees, Subcontractors, agents (including other state agencies acting on behalf of HHS) or other members of HHS' Workforce (each of the foregoing hereinafter referred to as "Indemnified Party") against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this DUA or from any acts or omissions related to this DUA by Contractor or its employees, directors, officers, Subcontractors, or agents or other members of Contractor's Workforce. The duty to indemnify, defend and hold harmless is independent of the duty to insure. Upon demand, Contractor shall reimburse HHS for any and all losses, liabilities, lost profits, fines, penalties, costs or expenses (including costs of required notices, investigation, and mitigation of a Breach, fines or penalties imposed on an Indemnified Party by a regulatory authority, and reasonable attorneys' fees) which may be imposed upon any Indemnified Party to the extent caused by and which results from the Contractor's failure to meet any of its obligations under this DUA. Contractor's obligation to defend, indemnify and hold harmless any Indemnified Party will survive the expiration or termination of this DUA.

Section 5.07 Insurance

(A) In addition to any insurance required in the Base Contract, at HHS's option, HHS may require Contractor to maintain, at its expense, the special and/or custom first- and third-party insurance coverages, including without limitation data breach, cyber liability, crime theft and notification expense coverages, with policy limits sufficient to cover any liability arising under this DUA, naming the State of Texas, acting through HHS, as an additional named insured and loss payee, with primary and noncontributory status.

(B) Contractor shall provide HHS with written proof that required insurance coverage is in effect, at the request of HHS.

Section 5.08 Entirety of the Contract

This DUA is incorporated by reference into the Base Contract and, together with the Base Contract, constitutes the entire agreement between the parties. No change, waiver, or discharge of obligations arising under those documents will be valid unless in writing and executed by the party against whom such change, waiver, or discharge is sought to be enforced.

Section 5.09 Automatic Amendment and Interpretation

Upon the effective date of any amendment or issuance of additional regulations to any law applicable to Confidential Information, this DUA will automatically be amended so that the obligations imposed on HHS and/or Contractor remain in compliance with such requirements. Any ambiguity in this DUA will be resolved in favor of a meaning that permits HHS and Contractor to comply with laws applicable to Confidential Information.

Section 5.10 Notices; Requests for Approval

All notices and requests for approval related to this DUA must be directed to the HHS Chief Privacy Officer at privacy@hhsc.state.tx.us.

ATTACHMENT 1. SUBCONTRACTOR AGREEMENT FORM

HHS CONTRACT NUMBER

____

The DUA between HHS and Contractor establishes the permitted and required uses and disclosures of Confidential Information by Contractor.

Contractor has subcontracted with_____________________________________ (Subcontractor) for performance of duties on behalf of CONTRACTOR which are subject to the DUA. Subcontractor acknowledges, understands and agrees to be bound by the same terms and conditions applicable to Contractor under the DUA, incorporated by reference in this Agreement, with respect to HHS Confidential Information. Contractor and Subcontractor agree that HHS is a third-party beneficiary to applicable provisions of the subcontract.

HHS has the right, but not the obligation, to review or approve the terms and conditions of the subcontract by virtue of this Subcontractor Agreement Form.

Contractor and Subcontractor assure HHS that any Breach as defined by the DUA that Subcontractor Discovers shall be reported to HHS by Contractor in the time, manner and content required by the DUA.

If Contractor knows or should have known in the exercise of reasonable diligence of a pattern of activity or practice by Subcontractor that constitutes a material breach or violation of the DUA or the Subcontractor's obligations, Contractor shall:

1. Take reasonable steps to cure the violation or end the violation, as applicable;
2. If the steps are unsuccessful, terminate the contract or arrangement with Subcontractor, if feasible;
3. Notify HHS immediately upon Discovery of the pattern of activity or practice of Subcontractor that constitutes a material breach or violation of the DUA and keep HHS reasonably and regularly informed about steps Contractor is taking to cure or end the violation or terminate Subcontractor's contract or arrangement.

This Subcontractor Agreement Form is executed by the parties in their capacities indicated below.

CONTRACTOR		SUBCONTRACTOR	
BY:	________________________________	BY:	________________________________
NAME:	________________________________	NAME:	________________________________
TITLE:	________________________________	TITLE:	________________________________
DATE	________________________, 202 .	DATE:	________________________________

HHS Data Use Agreement v. 8.5

Attachment 2-
Security and Privacy Initial Inquiry
[Attach Completed SPI Here]

Historically Underutilized Business (HUB) Plan (HSP) Requirements

Health and Human Services (HHS/agency) is committed to promoting full and equal business opportunities for businesses in state contracting by contracting directly and indirectly (subcontracting) with HUBs. HHS strongly encourages the use of HUBs through race, ethnic, and gender-means in accordance with Texas Government Code (TGC) Chapter 2161 and Texas Administrative Code (TAC), Title 34, Part 1, Chapter 20, Subchapter D, Division 1.

1.1 HHS Administrative Rules

Pursuant to TGC Section 2161.002 and Section 2161.003, HHS adopted the rules of the Texas Comptroller of Public Accounts (CPA) as its own rules (see TAC, Title 1, Part 15, Chapter 391, Subchapter E, Rule §391.501). If there are any discrepancies between the CPA's administrative rules and this Solicitation, the rules will take priority.

1.2 Statewide Annual HUB Utilization Goal

HHS adopted the CPA's Statewide Annual HUB Goals based on the 2009 State of Texas Disparity Study as its own agency-specific goals (TAC, Title 34, Part 1, Chapter 20, Subchapter D, Division 1, Rules §20.284). The HHS policy is to promote full inclusion of HUBs in all of its procurement opportunities in a direct and indirect (subcontracting) capacity to achieve or exceed the goals specified by each procurement category reflected in the disparity study.

This Solicitation is classified as an **Other Services Contract** under the above CPA rule and therefore the HHS HUB utilization goal is **26%.**

1.3 Determination of HSP Requirement

TGC Chapter 2161 and TAC, Title 34, Part 1, Chapter 20, Subchapter D, Division 1, Rules §20.284 and §20.285, requires the agency to consider whether there will be probable subcontracting opportunities for all contracts, with an expected value of $100,000 or more (including renewals and amendments), before the agency solicits bids, proposals, offers, or other applicable expressions of interest for the contract. Subcontracting opportunities are

considered to be equipment, materials, goods, contracted labor,[1] and services the Respondent cannot fulfill with its own internal resources.

If the agency determines that there is a probability of subcontracting opportunities, the agency **must** require that each bid, proposal, offer, or other applicable expression of interest for the contract include a completed HSP. If the response does not include a completed HSP and/or HHS determines that the HSP was not developed in good faith, the response will be deemed non-responsive, and it cannot be evaluated for a contract award.

HHS has examined the Scope of Work under the proposed Contract to determine if it is likely to be performed by a Subcontractor; researched the Centralized Master Bidders List (CMBL) for HUBs that may be available to perform the Contract Work; reviewed the past history of similar agency procurements; and has **determined that subcontracting opportunities are probable for this Solicitation.**

Therefore, all Respondents regardless of HUB status (HUB or non-HUB) must develop an HSP in good faith and submit a completed HSP with their response. Failure to comply with this requirement will deem the bid, proposal, offer, or other applicable expression of interest non-responsive, and it will be rejected without further evaluation due to material failure.

1.3.1 Probable Subcontracting Opportunities

HHS has determined that probable subcontracting opportunities exist within the following National Institute of Governmental Purchasing (NIGP) Class/Item Code(s):

Class	Item	Item Description
915	**20**	**Call Center Services**
948	**43**	**Health Information Services**
961	**30**	**Employment Agency and Search Firm Service, Including Background Investigations and Drug Testing for Employment**
962	**69**	**Personnel Services, Temporary**

The above identified items do not represent all of the possible subcontracting opportunities that may be available through this Solicitation. The Respondent is not required to use, nor

[1] Contracted labor means individuals that are not "regular" employees of the company/organization, see also guidance available from the Internal Revenue Service (IRS) regarding contracted labor vs. employees (IRS 1099 publications). Contracted labor is a subcontractor.

limited to using any of the above class and item code(s). However, the Respondent is required to include HUBs in any opportunity the Respondent will not be performing with their internal resources (materials, equipment, supplies, and employees[2]).

1.4 Compliance Resources

1.4.1 Solicitation's HUB Coordinator

In an effort to assist Respondents to comply with the HUB requirements, HHS assigns a HUB Coordinator as a sole point of contact for HUB inquiries, HSP training, and to provide HSP Courtesy Reviews (upon request – see Section 1.4.2 of this exhibit). The assigned HUB Coordinator for this Solicitation is:

Cheryl Bradley
512-406-2529
cheryl.bradley@hhs.texas.gov

1.4.2 HSP Courtesy Reviews

A courtesy review of a Respondent's completed HSP is optional and is available to assist Respondents in providing a compliant and responsive HSP. This courtesy review may only identify possible deficiencies. The final HSP determination may only be provided at the time of the final submission of the HSP with the Solicitation Response.

To request a courtesy review, submit the completed HSP including all supporting documentation in portable document format (PDF) by e-mail to the HUB Coordinator listed in Section 1.4.1 of this exhibit prior to the "Courtesy Review of HSP" deadline in the Solicitation's Schedule of Events.

Identify the request in the e-mail "Subject" field as "HSP Courtesy Review, Solicitation No. HHS0011055, Courtesy Review May 25, 2022, at 10:30 AM CT."

HSPs received after the "Courtesy Review of HSP" deadline in the Solicitation's Schedule of Events or deadlines established in subsequent Addenda, will not be reviewed and will be returned to the requestor.

[2] Employee means an individual that receives a Wage and Tax Statement (W-2 Form) from the Respondent.

The final HSP must be submitted by the Solicitation Response Deadline identified in the Solicitation's Schedule of Events or deadline established in subsequent Addenda. Responses received without a properly completed and compliant HSP will be disqualified.

1.4.3 **HSP Training Resources**

HHS encourages Respondents to take advantage of the HSP training offered specifically for this Solicitation (if applicable) and noted in the Solicitation's Schedule of Events. In addition, a pre-recorded Webinar HSP training providing general information for developing an HSP in good faith is available at:

https://attendee.gotowebinar.com/register/866041748445661451

HHS also recommends that Respondents review training resources provided in Section 1.7, Post-Award HSP Requirements, and Section 1.8, HSP Most Common Errors, of this exhibit.

1.4.4 **CMBL/HUB Directory**

The CPA is responsible for HUB certification as well as maintaining the CMBL/HUB Directory to satisfy the good-faith effort requirements. Note, only HUB vendors that are included in the CPA's database that are actively HUB certified at the time of the Solicitation may be used to satisfy the Respondent's requirement for developing the HSP in good faith.

Below are instructions for identifying the State of Texas Certified HUBs on the CMBL/HUB Directory:

1. Access the CMBL and HUB Directory at https://mycpa.cpa.state.tx.us/tpasscmblsearch/tpasscmblsearch.do.
2. CMBL page will default to certain fields already checked – using the "HUBs Only" and "HUBs On CMBL" radio buttons will help to provide a current list of Texas certified HUBs. Ensure the vendor's HUB status code is "A" for currently active HUBs.
3. Under the "Multiple Vendor Search" tab enter the NIGP code that correlates to the products or services in the "NIGP Class Code" and "Items" fields. A complete list of NIGP codes may be found at: https://mycpa.cpa.state.tx.us/commbook/.
4. Enter "Highway District(s)" number to select specific geographical location or leave blank for a statewide search. Start with a specific geographical search; and if unable to locate HUBs, expand the geographical search.
5. Under the "Selected Fields for Output" tab, the detail list page will default to certain fields. In addition to these defaulted fields, add "HUB Eligibility," "HUB Gender," and "Business Description" fields to the search.
6. The "Output Options" tab provides users with the ability to choose the format of the data. For better data sorting, "Excel" is recommended as the output option. Data

manipulations are easier to perform in an Excel spreadsheet to find the appropriate HUB vendors for effective HUB outreach.

7. The CPA is responsible for certifying vendors that meet the legal criteria for HUB certification. More information regarding HUB certification may be accessed at https://comptroller.texas.gov/purchasing/vendor/hub/certification-process.php.
8. Respondent may contact the assigned HUB Coordinator in Section 1.4.1 of this exhibit for assistance if needed.

Note, HHS does not endorse, qualify, or guarantee any of the vendors listed in the CMBL or HUB directory.

1.4.5 HUB Trade Organizations and Business Development Centers

Outreach resources to identify HUB trade organizations or business development centers that predominantly serve members of economically disadvantage groups (e.g., Asian-Pacific Americans, Black Americans, Hispanic Americans, Native Americans, American Women, and service-disabled veterans as defined by 38 U.S.C. § 101(2)) to assist with good-faith effort requirements may be accessed on the CPA's website at https://mycpa.cpa.state.tx.us/tpasscmblsearch/tpasscmblsearch.do.

1.5 HUB Subcontracting Plan Procedures - If Respondent Intends to Subcontract

An HSP must demonstrate that the Respondent made a good-faith effort to comply with the HHS HUB policies and procedures. The following subparts outline the items that HHS will review in determining whether an HSP meets the good-faith effort standard. A Respondent that intends to Subcontract must complete the HSP to document its good-faith efforts.

1.5.1 Identify Subcontracting Areas and Divide Them into Reasonable Lots

A Respondent should first identify each area of the Contract Work it intends to Subcontract. Then, to maximize HUB participation, it should divide the Contract Work into reasonable lots or portions to the extent consistent with prudent industry practices.

1.5.2 Notify Potential HUB Subcontractors

The HSP must demonstrate that the Respondent made a good-faith effort to Subcontract with HUBs. The Respondent's good-faith efforts shall be shown through utilization of all methods in conformance with the development and submission of the HSP and by complying with the following steps:

1. Divide the Contract Work into reasonable lots or portions to the extent consistent with

prudent industry practices. The Respondent must determine which portions of Work, including Goods and Services, will be Subcontracted.

2. Use the appropriate method(s) to demonstrate good-faith effort. The Respondent must use one of the method(s) I, II, III, or IV

   as set out below when subcontracting:

1.5.2.1 **Method I: Using Only HUBs;**

Respondent only intends to utilize HUB Subcontractors. No non-HUB Subcontractors may be use for this method. The Respondent must identify in the HSP the active and certified HUBs that will be utilized and submit written documentation that confirms 100% of all available subcontracting opportunities will be performed by one or more HUBs. Note, this method is not time sensitive.

Please complete the following sections and provide the following documents for "Method I":

- ☐ HSP, Page 1, Section 1 - Respondent and Requisition Information;
- ☐ HSP, Page 2, Section 2 - Respondent's Subcontracting Intentions;
- ☐ HSP, Page 3, Section 4 – Affirmation;
- ☐ Submit an "Attachment A" for each subcontracting item listed in HSP, Section 2; and
- ☐ Submit supporting documentation to substantiate each HUB selected is an actively certified HUB vendor (include a copy of the profile located in the CPA's CMBL/HUB Directory);

or

1.5.2.2 **Method II: Mentor-Protégé Program;**

Respondent (Mentor) intends to subcontract directly with their HUB Protégé. HHS will accept a Mentor-Protégé Agreement that has been entered into by a Respondent (Mentor) and a certified HUB (Protégé) in accordance with TGC Section 2161.065. When a Respondent proposes to subcontract with their Protégé(s), it does not need to provide additional notices to three (3) HUB vendors for the subcontracted item(s) provided by Protégé(s).

The Respondent must identify the subcontracting item(s) that the Protégé(s) will be providing as well as the subcontracting value. However, if the Respondent intends to utilize additional Subcontractors other than the Protégé(s), the Respondent is required to utilize Method IV: Solicitation, Section 1.5.2.4 below, for all other subcontracting items to comply fully with the HSP requirements – see all applicable requirements for Section 1.5.2.4, Method IV: Solicitation.

Participation in the Mentor-Protégé Program, along with the submission of a Protégé as a

Subcontractor in an HSP, constitutes a good-faith effort only for the particular area subcontracted to the Protégé.

Please complete the following sections and provide the following documents for "Method II":

- ☐ HSP, Page 1, Section 1 - Respondent and Requisition Information;
- ☐ HSP, Page 2, Section 2 - Respondent's Subcontracting Intentions;
- ☐ HSP, Page 3, Section 4 – Affirmation;
- ☐ Submit an "Attachment B" for each subcontracting item listed in HSP, Section 2; and
- ☐ Submit supporting documentation from the CPA's Mentor-Protégé Program Webpage https://mycpa.cpa.state.tx.us/mentorprotege/ctg/menproPairs/ that confirms the Mentor- Protégé Agreement is registered with CPA;

or

1.5.2.3 **Method III: Meeting or Exceeding the HUB Contract Goal;**

The Respondent intends to subcontract with both HUBs and non-HUBs and the expected aggregated percentage of the Contract will be meeting or exceeding the HHS HUB utilization goal listed in Section 1.2, Statewide Annual HUB Utilization Goal of this exhibit. The Respondent must identify in the HSP and submit written documentation that one or more HUB Subcontractors will be utilized and that the aggregate expected percentage of Subcontracts with HUBs will meet or exceed the HHS HUB utilization goal. When utilizing this method HUBs that have had a continuous contract[3] in place with the Respondent a period of more than five (5) years cannot be used to satisfy this requirement.

When the aggregate expected percentage of Subcontracts with HUBs meets or exceeds the goal specified in this exhibit, Respondents may also use non-HUB Subcontractors. All Subcontractors (HUB and non-HUB) to be utilized must be stated within the HSP. Note, this method is not time sensitive.

Please complete the following sections and provide the following documents for "Method III":

- ☐ HSP, Page 1, Section 1 - Respondent and Requisition Information;

---

[3] **Continuous Contract (excerpt from the HSP): Any existing written agreement (including any renewals that are exercised) between a prime contractor and a HUB vendor, where the HUB vendor provides the prime contractor with goods or service under the same contract for a specified period of time. The frequency the HUB vendor is utilized or paid during the term of the contract is not relevant to whether the contract is considered continuous. Two or more contracts that run concurrently or overlap one another for different periods of time are considered by CPA to be individual contracts rather than renewals or extensions to the original contract. In such situations the prime contractor and HUB vendor are entering (have entered) into "new" contracts*

- ☐ HSP, Page 2, Section 2 - Respondent's Subcontracting Intentions;
- ☐ HSP, Page 3, Section 4 - Affirmation;
- ☐ Submit an "Attachment A" for each subcontracting item listed in HSP, Section 2; and
- ☐ Submit supporting documentation to substantiate each HUB selected is an actively certified HUB vendor (include a copy of the profile located in the CPA's CMBL/HUB Directory).

or

1.5.2.4 **Method IV: Solicitation;**

The Respondent will NOT be utilizing all HUBs and will NOT be meeting the HHS HUB utilization goal on the Contract. ALL of the following requirements apply and requires written supporting documentation:

1. Written notifications to a minimum of two (2) HUB trade organizations and/or business development centers that predominantly serve members of economically disadvantage groups (e.g., Asian-Pacific Americans, Black Americans, Hispanic Americans, Native Americans, American Women, and service-disabled veterans as defined by 38 U.S.C. § 101(2)) to assist in identifying and marketing to potential HUBs by disseminating the subcontracting solicitations to their respective membership/participants. A list of HUB trade organizations, and/or business development centers is available on the CPA's website as noted in Section 1.4.5 of this exhibit and (https://mycpa.cpa.state.tx.us/tpasscmblsearch/tpasscmblsearch.do).

2. Provide written notifications to a minimum of three (3) HUB vendors per subcontracting opportunity item listed on the HSP, Page 2, "Section 2 Respondent's Subcontracting Intentions."

3. The above written notices to the HUB trade organizations/business development centers AND HUB vendors must contain the following information:
   a. A description of the scope of work to be subcontracted and all of the pertinent information to submit a response;
   b. Information regarding the location to review the plans or specifications;
   c. Information regarding insurance and bonding requirements (if applicable);
   d. Required qualifications and other pertinent contract requirements;
   e. The Respondent's point of contact and how to respond to the subcontracting solicitation; and
   f. The time and date the subcontracting response is due to the Respondent (note, must be due prior to the Solicitation deadline identified in the Solicitation's Schedule of Events or deadlines established in a subsequent

Addendum).

Note, the CPA's "HUB Subcontracting Opportunity Notification" form is an optional form that may also be used to comply with the above requirements. It is not a mandatory form but may assist Respondents in providing all of the required information.

4. Respondent must provide HUB trade organizations/business development centers AND HUB vendors a reasonable amount of time to respond to the written notice but not less than a minimum of seven (7) working days. The date the notification is sent is considered day "zero" and cannot be used to satisfy the seven (7) working days' requirement. In accordance with [TAC, Title 34, Part 1, Chapter 20, Subchapter D, Division 1, Rule §20.282(35)](), a working day is a "[n]ormal business day of a state agency, not including weekends, federal or state holidays, or days the state agency is declared closed by its executive officer." To further clarify what days are considered non-working days due to federal or state holidays, a link to the state's holiday schedule is provided at http://www.hr.sao.texas.gov/Holidays/.

   Note, Method IV: Solicitation **is time sensitive** and failure to provide the required seven (7) working days as noted as well as all of the other requirements noted in Section 1.5.6 of this exhibit will result in disqualification, and the HSP will be deemed non-responsive for material failure to comply with advertised specifications.

5. In addition, a Respondent must provide written justification of its selection process if it chooses a non-HUB Subcontractor. The justification should demonstrate that the Respondent negotiated in good faith with qualified HUB bidders and did not reject qualified HUBs who were the best value responsive bidders.

Please complete the following sections and provide the following documents for "Method IV":

- ☐ HSP, Page 1, Section 1 - Respondent and Requisition Information;
- ☐ HSP, Page 2, Section 2 - Respondent's Subcontracting Intentions;
- ☐ HSP, Page 3, Section 4 - Affirmation;
- ☐ Submit an "Attachment B" for each item listed in HSP, Page 2, Section 2
- ☐ Submit supporting documentation to substantiate that each HUB notified or selected is an actively certified HUB vendor (include a copy of the profile located in the CPA's CMBL/HUB Directory); and
- ☐ Submit written supporting documentation (emails, faxes, or certified letters) to substantiate compliance with Section 1.5.2.4, Method IV.

1.6 HUB Subcontracting Plan Procedures - Respondent Does Not Intend to Subcontract

1.6.1 Method V: Self-Performance;

When the Respondent does not intend to subcontract any portion of the Contract, but instead is able to provide all Work with the Respondent's own equipment, supplies, materials, and/or

employees (see Footnote 2), the Respondent is still required to submit a completed HSP.

The Respondent must complete the HSP, Page 3, "Section 3: Self Performing Justification" and attest that it does not intend to subcontract for any Goods or Services, including the class and item codes identified in Section 1.3.1, Probable Subcontracting Opportunities of this exhibit. In addition, the Respondent must identify the sections of the proposal that describe how it will complete the Scope of Work using its own resources (including employees, see Footnote 2) or provide a statement explaining how it will complete the entire Scope of Work using its own internal resources (including employees, see Footnote 2). The Respondent must agree to comply with the following upon HHS request:

1. Provide evidence of sufficient Respondent staffing to meet the Contract objectives;
2. Provide monthly payroll records showing the Respondent staff fully engaged in the Contract;
3. Allow HHS to conduct an on-site review of company headquarters or work site where Services are to be performed; and
4. Provide documentation proving employment of qualified personnel holding the necessary licenses and certificates required to perform the Scope of Work.

Note, for purposes of this exhibit, TAC, Title 34, Part 1, Chapter 20, Subchapter D, Division 1, Rule §20.282(27), defines Subcontractor "[a]s defined by Government Code, §2251.001, this is a person who contracts with a prime contractor to work or contribute toward completing work for a governmental entity." Subcontracting includes outsourcing of supplies, materials, equipment, and/or services. In addition to provide further clarity, contracting staffing (see Footnote 1) is also considered subcontracting and if the Respondent intends to fulfill any portion of the Contract utilizing contracted staffing (see Footnote 1), then the Method V: Self-Performance is not an option for complying with the good-faith effort requirements. The Respondent must utilize any one of the four other methods listed above to submit a responsive HSP.

1.7 Post-Award HSP Requirements

Once the Contract has been awarded, the HSP submitted with the response becomes a Contract provision and must be implemented in good faith. To assist the Contractor in understanding the HUB Contract requirements post award, a pre-recorded Webinar-based training has been provided for review and may be accessed at:

https://attendee.gotowebinar.com/register/4975984327235320076

Immediately after the Contract award, a HUB Coordinator will be assigned to coordinate a HUB Post-Contract-Award meeting with the Contractor and the program area. The following items will be addressed during this meeting:

1. Solidifying the HSP prior to the start of the Contract. Please note, to make any updates to the HSP, the Contractor must have proper justification. Pricing is not an acceptable justification **after** the Contract is awarded.

2. As a condition of award, the Contractor is required to send notification to all selected Subcontractors as identified in the accepted/approved HSP. In addition, a copy of the notification(s) must be provided to the HHS contract manager and/or HUB Program Office within ten (10) working days of the Contract award.
3. Discuss procedure for any HSP change requirements should a need arise during the life of the Contract to replace or add any new Subcontractors onto the HSP. Contractor is required to make changes in good faith by utilizing any of the good-faith methods stated in Section 1.5, HUB Subcontracting Plan Procedures – If Respondent Intends to Subcontract, of this exhibit. In addition, it requires the HHS HUB Program Office to provide prior approval before the Contractor may engage any new Subcontractors.
4. Failure to meet the HSP and post-contract-award requirements will constitute a breach of Contract and will be subject to remedial actions.
5. HHS may also report noncompliance to the CPA in accordance with the administrative rule governing the Vendor Performance and Debarment Program. Note, the CPA Debarment Program may result in being debarred from state contracting for a period of up to five (5) years.

1.8 HSP Most Common Errors

1. **Methods I through V:** Failure to submit a completed HSP with the Solicitation Response when the agency determined probability of subcontracting opportunities (see Section 1.3.1, Probable Subcontracting Opportunities of this exhibit). Completion requires responses with supporting documentation reflected by respective HSP Method, see Section 1.5. through Section 1.6.1 of this exhibit.

2. **HUB Respondent's failure to provide a completed HSP or incorrectly incorporating their company's participation into the HSP towards meeting the HUB goal.** Please note, being a certified Texas HUB **does not** exclude HUB Respondent from complying with the good-faith effort requirements reflected in this Solicitation, nor is the Respondent able to use their company's participation towards meeting the HUB Utilization Goal. All Respondents regardless of HUB status responding to the Solicitation must fully adhere to the good-faith effort requirements in developing the HSP.

3. **Method IV: Solicitation -** Failure to provide seven (7) working days for HUB trade organizations/business development centers and HUB vendors to respond. Note, in accordance with TAC, Title 34, Part 1, Chapter 20, Subchapter D, Division 1, Rule §20.282(35), "working day" means a "[n]ormal business day of a state agency, not including weekends, federal or state holidays, or days the state agency is declared closed by its executive officer." To further clarify what days are considered federal or state holidays, a link to the state's holiday schedule is provided: http://www.hr.sao.texas.gov/Holidays/. In addition, the day the Solicitation notification document is sent to the HUB trade organizations/business development centers and HUB vendors is considered day zero (0) and cannot be used to satisfy the seven (7) working days' requirement (i.e., the notices were sent out on a Friday and the following Monday was a holiday, then Tuesday would be day one (1)).

4. **Method IV: Solicitation -** Soliciting a trade organization that is not considered a HUB trade organization or a trade organization not located in the State of Texas. Contact information for HUB trade organizations is available on the CPA's website: https://comptroller.texas.gov/purchasing/vendor/hub/resources.php.

5. **Method IV: Solicitation - Solicitation Method IV:** Failure to provide sufficient information in the subcontractor solicitation(s) for HUB vendors and HUB trade organizations/business development centers to be able to respond to a solicitation or determine the Solicitation's Scope of Work (see Section1.5.2.4, Method IV: Solicitation, and the HSP form, Attachment B, "Section B-3: Notification of Subcontracting Opportunity).

6. **Method IV: Solicitation –** Soliciting to HUB businesses whose NIGP Class and Item Codes or business description is unrelated to the subcontracting solicitation or soliciting HUB businesses for services outside of the geographical area, when HUBs are available in the immediate area (i.e., the physical work is located in Houston, Texas, but Respondent choose to solicit HUBs in El Paso, Texas). Start with a specific geographical search; and if unable to locate HUBs, expand the geographical search area until HUBs are located. If unable to locate HUBs to solicit, contact the HUB Coordinator in Section 1.4.1 for guidance.

7. **Methods I through IV:** Indicating "TBD" in any of the required HSP fields. When a solicitation contains unknown variables for determining dollar amounts or percentages, contact the HUB Coordinator for guidance. Leaving these fields blank or documenting as "TBD" may result in a non-responsive HSP determination.

8. **Methods I through IV:** Documenting a non-certified vendor as a HUB vendor used to satisfy the good-faith effort requirements. Respondent should always confirm the vendor's HUB status in the CPA's CMBL/HUB Directory profile (https://mycpa.cpa.state.tx.us/tpasscmblsearch/tpasscmblsearch.do) to ensure the vendor HUB certification is "A" active on the date the Solicitation was sent to the vendor. Furthermore, it is recommended that a printed copy of the HUB vendor's profile be include with the HSP as supporting documentation to avoid any issues.

9. **Methods I through V:** Including contracting staffing (see Footnote 1) as employees in the proposal and/or HSP and does not perform a good-faith effort requirement to include HUBs in the services performed by the contracted staffing (see Footnote 1) - note, only employees (see Footnote 2) may be considered as employees.

10. **Methods I through V:** Failure to document all subcontracting activity reflected within the proposal on the HSP documents. At the time of the HSP evaluation, a comparison is performed of the submitted proposal and the HSP to ensure the HSP is a true representation of any subcontracting that will be needed to fulfill all portions of an awarded contract. Any discrepancies may result in a non-responsive HSP and cannot be considered for a contract award.

11. **Methods I through IV:** Calculating the subcontracting percentages incorrectly. The correct method for calculating subcontracting percentages is: (subcontracting amount divided by (÷) total contract amount).

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HUB Subcontracting Plan (HSP) Quick Checklist

While this HSP Quick Checklist is being provided to merely assist you in readily identifying the sections of the HSP form that you will need to complete, it is very important that you adhere to the instructions in the HSP form and instructions provided by the contracting agency.

1. **If you will be awarding all of the subcontracting work you have to offer under the contract to only Texas certified HUB vendors, complete**:
   - ❒ Section 1 - Respondent and Requisition Information
   - ❒ Section 2 a. – Yes, I will be subcontracting portions of the contract
   - ❒ Section 2 b. – List all the portions of work you will subcontract, and indicate the percentage of the contract you expect to award to Texas certified HUB vendors.
   - ❒ Section 2 c. – Yes
   - ❒ Section 4 – Affirmation
   - ❒ GFE Method A (Attachment A) – Complete an Attachment A for each of the subcontracting opportunities you listed in Section 2b.

2. **If any of your subcontracting opportunities will be performed using HUB protégés, complete:**
   - ❒ Section 1 - Respondent and Requisition Information
   - ❒ Section 2 a. – Yes, I will be subcontracting portions of the contract
   - ❒ Section 2 b. – List all the portions of work you will subcontract, and indicated the percentage of the contract you expect to award to HUB protégés (Skip Section 2c and 2d)
   - ❒ Section 4 – Affirmation
   - ❒ HSP GFE Method B (Attachment B) - Complete Section B-1, Section B-2, and B-4 only for each HUB Protégé

3. **If any of your subcontracting any portion of the contract to Texas certified HUB vendors and Non-HUB vendors, and the aggregated percentage of all the subcontracting work you will be awarding to the Texas certified HUB vendors with which you do not have a continuous contract* in place for more than five (5) years meets or exceeds the HUB Goal the contracting Agency identified in the "Agency Special Instructions/Additional Requirements", complete :**
   - ❒ Section 1 - Respondent and Requisition Information
   - ❒ Section 2 a. – Yes, I will be subcontracting portions of the contract
   - ❒ Section 2 b. – List all the portions of work you will subcontract, and indicate the percentage of the contract you expect to award to Texas certified HUB vendors and Non-HUB vendors.
   - ❒ Section 2 c. – No
   - ❒ Section 2 d. – Yes
   - ❒ Section 4 – Affirmation
   - ❒ GFE Method A (Attachment A) – Complete an Attachment A for each of the subcontracting opportunities you listed in Section 2b.

4. **If you are subcontracting any portion of the contract to Texas certified HUB vendors and Non-HUB vendors or only to Non-HUB vendors, and the aggregate percentage of all the subcontracting work you will be awarding to the Texas certified HUB vendors with which you do not have a continuous contract * in place for more than five (5) years does not meet or exceed the HUB Goal the contracting agency identified in the "Agency Special Instructions/Additional Requirements", complete:**
   - ❒ Section 1 - Respondent and Requisition Information
   - ❒ Section 2 a. – Yes, I will be subcontracting portions of the contract
   - ❒ Section 2 b. – List all the portions of work you will subcontract, and indicated the percentage of the contract you expect to award to Texas certified HUB vendors and Non HUB vendors.

HUB Subcontracting Plan (HSP) Quick Checklist

- ❒ Section 2 c. – No
- ❒ Section 2 d. – No
- ❒ Section 4 – Affirmation
- ❒ HSP GFE Method B (Attachment B) – Complete an Attachment B for each of the subcontracting opportunities you listed in Section 2b.

5. **If you will not be subcontracting any portion of the contract and will be fulfilling the entire contract with your own resources (i.e., employees, supplies, materials and/or equipment, including transportation and delivery, complete:**
   - ❒ Section 1 – Respondent and Requisition Information
   - ❒ Section 2 a. – No, I will not be subcontracting any portion of the contract, and I will be fulfilling the entire contract with my own resources
   - ❒ Section 3 – Self Performing Justification
   - ❒ Section 4 – Affirmation

***Continuous Contract**: Any existing written agreement (including any renewals that are exercised) between a prime contractor and a HUB vendor, where the HUB vendor provides contractor with goods or services, to include under the same contract for a specified period of time. The frequency the HUB vendor is utilized or paid during the term of the contract is not relevant to whether the contract is considered continuous. Two or more contracts that run concurrently or overlap one another for different periods of time are considered by CPA to be individual contracts rather than renewals or extensions to the original contract. In such situations the prime contractor and HUB vendor are entering (have entered) into "new" contracts.*

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HUB Subcontracting Plan (HSP)

In accordance with Texas Gov't Code §2161.252, the contracting agency has determined that subcontracting opportunities are probable under this contract. Therefore, all respondents, including State of Texas certified Historically Underutilized Businesses (HUBs) must complete and submit this State of Texas HUB Subcontracting Plan (HSP) with their response to the bid requisition (solicitation).

NOTE: Responses that do not include a completed HSP shall be rejected pursuant to Texas Gov't Code §2161.252(b).

The HUB Program promotes equal business opportunities for economically disadvantaged persons to contract with the State of Texas in accordance with the goals specified in the 2009 State of Texas Disparity Study. The statewide HUB goals defined in 34 Texas Administrative Code (TAC) §20.284 are:

- ***11.2 percent for heavy construction other than building contracts,***
- ***21.1 percent for all building construction, including general contractors and operative builders' contracts,***
- ***32.9 percent for all special trade construction contracts,***
- ***23.7 percent for professional services contracts,***
- ***26.0 percent for all other services contracts, and***
- ***21.1 percent for commodities contracts.***

- - Agency Special Instructions/Additional Requirements - -

In accordance with 34 TAC §20.285(d)(1)(D)(iii), a respondent (prime contractor) may demonstrate good faith effort to utilize Texas certified HUBs for its subcontracting opportunities if the total value of the respondent's subcontracts with Texas certified HUBs meets or exceeds the statewide HUB goal or the agency specific HUB goal, whichever is higher. When a respondent uses this method to demonstrate good faith effort, the respondent must identify the HUBs with which it will subcontract. If using existing contracts with Texas certified HUBs to satisfy this requirement, only the aggregate percentage of the contracts expected to be subcontracted to HUBs with which the respondent ***does not*** *have a* ***continuous contract**** *in place for* ***more than five (5) years*** *shall qualify for meeting the HUB goal. This limitation is designed to encourage vendor rotation as recommended by the 2009 Texas Disparity Study.*

SECTION 1: RESPONDENT AND REQUISITION INFORMATION

a. Respondent (Company) Name: ______________________ State of Texas VID #: __________

Point of Contact: ______________________ Phone #: __________

E-mail Address: ______________________ Fax #: __________

b. Is your company a State of Texas certified HUB? ☐ **- Yes** ☐ **- No**

c. Requisition #: ______________________ Bid Open Date: __________
(mm/dd/yyyy)

Enter your company's name here: ______________________ Requisition #: ______________

SECTION 2: RESPONDENT's SUBCONTRACTING INTENTIONS

After dividing the contract work into reasonable lots or portions to the extent consistent with prudent industry practices, and taking into consideration the scope of work to be performed under the proposed contract, including all potential subcontracting opportunities, the respondent must determine what portions of work, **including contracted staffing, goods and services will be subcontracted**. Note: In accordance with 34 TAC §20.282, a "Subcontractor" means a person who contracts with a prime contractor to work, to supply commodities, or to contribute toward completing work for a governmental entity.

a. Check the appropriate box (Yes or No) that identifies your subcontracting intentions:

☐ - *Yes*, I will be subcontracting portions of the contract. (If *Yes*, complete Item b of this SECTION and continue to Item c of this SECTION.)

☐ - *No*, I will not be subcontracting any portion of the contract, and I will be fulfilling the entire contract with my own resources, including employees, goods and services. (If *No*, continue to SECTION 3 and SECTION 4.)

b. List all the portions of work (subcontracting opportunities) you will subcontract. Also, based on the total value of the contract, identify the percentages of the contract you expect to award to Texas certified HUBs, and the percentage of the contract you expect to award to vendors that are not a Texas certified HUB (i.e., Non-HUB).

Item #	Subcontracting Opportunity Description	HUBs		Non-HUBs
		Percentage of the contract expected to be subcontracted to HUBs with which you do not have a continuous contract* in place for more than five (5) years.	**Percentage of the contract expected to be subcontracted to HUBs with which you have a continuous contract* in place for more than five (5) years.**	Percentage of the contract expected to be subcontracted to non-HUBs.
1		%	%	%
2		%	%	%
3		%	%	%
4		%	%	%
5		%	%	%
6		%	%	%
7		%	%	%
8		%	%	%
9		%	%	%
10		%	%	%
11		%	%	%
12		%	%	%
13		%	%	%
14		%	%	%
15		%	%	%
	Aggregate percentages of the contract expected to be subcontracted:	**%**	**%**	**%**

(Note: If you have more than fifteen subcontracting opportunities, a continuation sheet is available online at https://www.comptroller.texas.gov/purchasing/vendor/hub/forms.php).

c. Check the appropriate box (Yes or No) that indicates whether you will be using **only** Texas certified HUBs to perform **all** of the subcontracting opportunities you listed in SECTION 2, Item b.

- *Yes* (If *Yes*, continue to SECTION 4 and complete an "HSP Good Faith Effort - Method A (Attachment A)" for **each** of the subcontracting opportunities you listed.)
- *No* (If *No*, continue to Item d, of this SECTION.)

d. Check the appropriate box (Yes or No) that indicates whether the aggregate expected percentage of the contract you will subcontract **with Texas certified HUBs** with which you **do not** have a **continuous contract*** in place with for **more than five (5) years**, **meets or exceeds** the HUB goal the contracting agency identified on page 1 in the "**Agency Special Instructions/Additional Requirements**."

- *Yes* (If *Yes*, continue to SECTION 4 and complete an "HSP Good Faith Effort - Method A (Attachment A)" for **each** of the subcontracting opportunities you listed.)
- *No* (If *No*, continue to SECTION 4 and complete an "HSP Good Faith Effort - Method B (Attachment B)" for **each** of the subcontracting opportunities you listed.)

***Continuous Contract**: Any existing written agreement (including any renewals that are exercised) between a prime contractor and a HUB vendor, where the HUB vendor provides the prime contractor with goods or service under the same contract for a specified period of time. The frequency the HUB vendor is utilized or paid during the term of the contract is not relevant to whether the contract is considered continuous. Two or more contracts that run concurrently or overlap one another for different periods of time are considered by CPA to be individual contracts rather than renewals or extensions to the original contract. In such situations the prime contractor and HUB vendor are entering (have entered) into "new" contracts.*

Enter your company's name here: ______________________ Requisition #: ______________

SECTION 2: RESPONDENT's SUBCONTRACTING INTENTIONS (CONTINUATION SHEET)

This page can be used as a continuation sheet to the HSP Form's page 2, Section 2, Item b. Continue listing the portions of work (subcontracting opportunities) you will subcontract. Also, based on the total value of the contract, identify the percentages of the contract you expect to award to Texas certified HUBs, and the percentage of the contract you expect to award to vendors that are not a Texas certified HUB (i.e., Non-HUB).

Item #	Subcontracting Opportunity Description	HUBs		Non-HUBs
		Percentage of the contract expected to be subcontracted to HUBs with which you do not have a continuous contract* in place for more than five (5) years.	Percentage of the contract expected to be subcontracted to HUBs with which you have a continuous contract* in place for more than five (5) years.	Percentage of the contract expected to be subcontracted to non-HUBs.
16		%	%	%
17		%	%	%
18		%	%	%
19		%	%	%
20		%	%	%
21		%	%	%
22		%	%	%
23		%	%	%
24		%	%	%
25		%	%	%
26		%	%	%
27		%	%	%
28		%	%	%
29		%	%	%
30		%	%	%
31		%	%	%
32		%	%	%
33		%	%	%
34		%	%	%
35		%	%	%
36		%	%	%
37		%	%	%
38		%	%	%
39		%	%	%
40		%	%	%
41		%	%	%
42		%	%	%
43		%	%	%
Aggregate percentages of the contract expected to be subcontracted:		**%**	**%**	**%**

****Continuous Contract*: Any existing written agreement (including any renewals that are exercised) between a prime contractor and a HUB vendor, where the HUB vendor provides the prime contractor with goods or service under the same contract for a specified period of time. The frequency the HUB vendor is utilized or paid during the term of the contract is not relevant to whether the contract is considered continuous. Two or more contracts that run concurrently or overlap one another for different periods of time are considered by CPA to be individual contracts rather than renewals or extensions to the original contract. In such situations the prime contractor and HUB vendor are entering (have entered) into "new" contracts.**

Enter your company's name here: ______________________________ Requisition #: ______________

SECTION 3: SELF PERFORMING JUSTIFICATION **(If you responded "No" to SECTION 2, Item a, you must complete this SECTION and continue to SECTION 4.)** If you responded "No" to SECTION 2, Item a, in the space provided below **explain how** your company will perform the entire contract with its own employees, supplies, materials and/or equipment.

SECTION 4: AFFIRMATION

As evidenced by my signature below, I affirm that I am an authorized representative of the respondent listed in SECTION 1, and that the information and supporting documentation submitted with the HSP is true and correct. Respondent understands and agrees that, if awarded any portion of the requisition:

- The respondent will provide notice as soon as practical to all the subcontractors (HUBs and Non-HUBs) of their selection as a subcontractor for the awarded contract. The notice must specify at a minimum the contracting agency's name and its point of contact for the contract, the contract award number, the subcontracting opportunity they (the subcontractor) will perform, the approximate dollar value of the subcontracting opportunity and the expected percentage of the total contract that the subcontracting opportunity represents. A copy of the notice required by this section must also be provided to the contracting agency's point of contact for the contract no later than ten (10) working days after the contract is awarded.
- The respondent must submit monthly compliance reports (Prime Contractor Progress Assessment Report – PAR) to the contracting agency, verifying its compliance with the HSP, including the use of and expenditures made to its subcontractors (HUBs and Non-HUBs). (The PAR is available at https://www.comptroller.texas.gov/purchasing/docs/hub-forms/ProgressAssessmentReportForm.xls).
- The respondent must seek approval from the contracting agency prior to making any modifications to its HSP, including the hiring of additional or different subcontractors and the termination of a subcontractor the respondent identified in its HSP. If the HSP is modified without the contracting agency's prior approval, respondent may be subject to any and all enforcement remedies available under the contract or otherwise available by law, up to and including debarment from all state contracting.
- The respondent must, upon request, allow the contracting agency to perform on-site reviews of the company's headquarters and/or work-site where services are being performed and must provide documentation regarding staffing and other resources.

Signature	Printed Name	Title	Date (mm/dd/yyyy)

Reminder:

- If you responded "Yes" to SECTION 2, Items c or d, you must complete an "HSP Good Faith Effort - Method A (Attachment A)" for each of the subcontracting opportunities you listed in SECTION 2, Item b.
- If you responded "No" SECTION 2, Items c and d, you must complete an "HSP Good Faith Effort - Method B (Attachment B)" for each of the subcontracting opportunities you listed in SECTION 2, Item b.

HSP Good Faith Effort - Method A (Attachment A)

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Enter your company's name here: ______________________ Requisition #: ______________

IMPORTANT: If you responded "*Yes*" to **SECTION 2, Items c** or **d** of the completed HSP form, you must submit a completed "HSP Good Faith Effort - Method A (Attachment A)" for each of the subcontracting opportunities you listed in **SECTION 2, Item b** of the completed HSP form. You may photo-copy this page or download the form at https://www.comptroller.texas.gov/purchasing/docs/hub-forms/hub-sbcont-plan-gfe-achm-a.pdf

SECTION A-1: SUBCONTRACTING OPPORTUNITY

Enter the item number and description of the subcontracting opportunity you listed in SECTION 2, Item b, of the completed HSP form for which you are completing the attachment.

Item Number: Description:

SECTION A-2: SUBCONTRACTOR SELECTION

List the subcontractor(s) you selected to perform the subcontracting opportunity you listed above in SECTION A-1. Also identify whether they are a Texas certified HUB and their Texas Vendor Identification (VID) Number or federal Employer Identification Number (EIN), the approximate dollar value of the work to be subcontracted, and the expected percentage of work to be subcontracted. When searching for Texas certified HUBs and verifying their HUB status, ensure that you use the State of Texas' Centralized Master Bidders List (CMBL) - Historically Underutilized Business (HUB) Directory Search located at http://mycpa.cpa.state.tx.us/tpasscmblsearch/index.jsp. HUB status code "**A**" signifies that the company is a Texas certified HUB.

Company Name	Texas certified HUB	Texas VID or federal EIN Do not enter Social Security Numbers. If you do not know their VID / EIN, leave their VID / EIN field blank.	Approximate Dollar Amount	Expected Percentage of Contract
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%

REMINDER: As specified in SECTION 4 of the completed HSP form, if you (respondent) are awarded any portion of the requisition, you are required to provide notice as soon as practical to all the subcontractors (HUBs and Non-HUBs) of their selection as a subcontractor. The notice must specify at a minimum the contracting agency's name and its point of contact for the contract, the contract award number, the subcontracting opportunity they (the subcontractor) will perform, the approximate dollar value of the subcontracting opportunity and the expected percentage of the total contract that the subcontracting opportunity represents. A copy of the notice required by this section must also be provided to the contracting agency's point of contact for the contract no later than ten (10) working days after the contract is awarded.

HSP Good Faith Effort - Method B (Attachment B)

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Enter your company's name here: ______________________ Requisition #: ____________

IMPORTANT*:** If you responded "No***" to **SECTION 2, Items c** and **d** of the completed HSP form, you must submit a completed "HSP Good Faith Effort - Method B (Attachment B)" for **each** of the subcontracting opportunities you listed in **SECTION 2, Item b** of the completed HSP form. You may photo-copy this page or download the form at https://www.comptroller.texas.gov/purchasing/docs/hub-forms/hub-sbcont-plan-gfe-achm-b.pdf..

SECTION B-1: SUBCONTRACTING OPPORTUNITY

Enter the item number and description of the subcontracting opportunity you listed in SECTION 2, Item b, of the completed HSP form for which you are completing the attachment.

Item Number: Description:

SECTION B-2: MENTOR PROTÉGÉ PROGRAM

If respondent is participating as a Mentor in a State of Texas Mentor Protégé Program, submitting its Protégé (Protégé must be a State of Texas certified HUB) as a subcontractor to perform the subcontracting opportunity listed in **SECTION B-1**, constitutes a good faith effort to subcontract with a Texas certified HUB towards that specific portion of work.

Check the appropriate box (Yes or No) that indicates whether you will be subcontracting the portion of work you listed in SECTION B-1 to your Protégé.

- Yes (If *Yes*, continue to SECTION B-4.)
- No / Not Applicable (If *No* or *Not Applicable*, continue to SECTION B-3 and SECTION B-4.)

SECTION B-3: NOTIFICATION OF SUBCONTRACTING OPPORTUNITY

When completing this section you MUST comply with items a, b, c and d, thereby demonstrating your Good Faith Effort of having notified Texas certified HUBs and trade organizations or development centers about the subcontracting opportunity you listed in SECTION B-1. Your notice should include the scope of work, information regarding the location to review plans and specifications, bonding and insurance requirements, required qualifications, and identify a contact person. When sending notice of your subcontracting opportunity, you are encouraged to use the attached HUB Subcontracting Opportunity Notice form, which is also available online at https://www.comptroller.texas.gov/purchasing/docs/hub-forms/HUBSubcontractingOpportunityNotificationForm.pdf.

Retain supporting documentation (i.e., certified letter, fax, e-mail) demonstrating evidence of your good faith effort to notify the Texas certified HUBs and trade organizations or development centers. Also, be mindful that a working day is considered a normal business day of a state agency, not including weekends, federal or state holidays, or days the agency is declared closed by its executive officer. The initial day the subcontracting opportunity notice is sent/provided to the HUBs and to the trade organizations or development centers is considered to be "day zero" and does not count as one of the seven (7) working days.

a. Provide written notification of the subcontracting opportunity you listed in SECTION B-1, to three (3) or more Texas certified HUBs. Unless the contracting agency specified a different time period, you must allow the HUBs at least seven (7) working days to respond to the notice prior to you submitting your bid response to the contracting agency. When searching for Texas certified HUBs and verifying their HUB status, ensure that you use the State of Texas' Centralized Master Bidders List (CMBL) - Historically Underutilized Business (HUB) Directory Search located at http://mycpa.cpa.state.tx.us/tpasscmblsearch/index.jsp. HUB status code "**A**" signifies that the company is a Texas certified HUB.

b. List the **three (3) Texas certified HUBs** you notified regarding the subcontracting opportunity you listed in SECTION B-1. Include the company's Texas Vendor Identification (VID) Number, the date you sent notice to that company, and indicate whether it was responsive or non-responsive to your subcontracting opportunity notice.

Company Name	Texas VID (Do not enter Social Security Numbers.)	Date Notice Sent (mm/dd/yyyy)	Did the HUB Respond?
			- Yes - No
			- Yes - No
			- Yes - No

c. Provide written notification of the subcontracting opportunity you listed in SECTION B-1 to two (2) or more trade organizations or development centers in Texas to assist in identifying potential HUBs by disseminating the subcontracting opportunity to their members/participants. Unless the contracting agency specified a different time period, you must provide your subcontracting opportunity notice to trade organizations or development centers at least seven (7) working days prior to submitting your bid response to the contracting agency. A list of trade organizations and development centers that have expressed an interest in receiving notices of subcontracting opportunities is available on the Statewide HUB Program's webpage at https://www.comptroller.texas.gov/purchasing/vendor/hub/resources.php.

d. List **two (2) trade organizations or development centers** you notified regarding the subcontracting opportunity you listed in SECTION B-1. Include the date when you sent notice to it and indicate if it accepted or rejected your notice.

Trade Organizations or Development Centers	Date Notice Sent (mm/dd/yyyy)	Was the Notice Accepted?
		- Yes - No
		- Yes - No

HSP Good Faith Effort - Method B (Attachment B) Cont.

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Enter your company's name here: ______________________ Requisition #: ____________

SECTION B-4: SUBCONTRACTOR SELECTION

Enter the item number and description of the subcontracting opportunity you listed in **SECTION 2, Item b,** of the completed HSP form for which you are completing the attachment.

a. Enter the item number and description of the subcontracting opportunity for which you are completing this Attachment B continuation page.

Item Number: Description:

b. List the subcontractor(s) you selected to perform the subcontracting opportunity you listed in **SECTION B-1**. Also identify whether they are a Texas certified HUB and their Texas Vendor Identification (VID) Number or federal Employer Identification Number (EIN), the approximate dollar value of the work to be subcontracted, and the expected percentage of work to be subcontracted. When searching for Texas certified HUBs and verifying their HUB status, ensure that you use the State of Texas' Centralized Master Bidders List (CMBL) - Historically Underutilized Business (HUB) Directory Search located at http://mycpa.cpa.state.tx.us/tpasscmblsearch/index.jsp. HUB status code "**A**" signifies that the company is a Texas certified HUB.

Company Name	Texas certified HUB	Texas VID or federal EIN Do not enter Social Security Numbers. If you do not know their VID / EIN, leave their VID / EIN field blank.	Approximate Dollar Amount	Expected Percentage of Contract
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%
	- Yes - No		$	%

c. If any of the subcontractors you have selected to perform the subcontracting opportunity you listed in **SECTION B-1** is **not** a Texas certified HUB, provide written justification for your selection process (attach additional page if necessary):

REMINDER: As specified in SECTION 4 of the completed HSP form, if you (respondent) are awarded any portion of the requisition, you are required to provide notice as soon as practical to **all** the subcontractors (HUBs and Non-HUBs) of their selection as a subcontractor. The notice must specify at a minimum the contracting agency's name and its point of contact for the contract, the contract award number, the subcontracting opportunity it (the subcontractor) will perform, the approximate dollar value of the subcontracting opportunity and the expected percentage of the total contract that the subcontracting opportunity represents. A copy of the notice required by this section must also be provided to the contracting agency's point of contact for the contract no later than ten (10) working days after the contract is awarded.

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HUB Subcontracting Opportunity Notification Form

In accordance with Texas Gov't Code, Chapter 2161, each state agency that considers entering into a contract with an expected value of $100,000 or more shall, before the agency solicits bids, proposals, offers, or other applicable expressions of interest, determine whether subcontracting opportunities are probable under the contract. The state agency I have identified below in **Section B** has determined that subcontracting opportunities are probable under the requisition to which my company will be responding.

34 Texas Administrative Code, §20.285 requires all respondents (prime contractors) bidding on the contract to provide notice of each of their subcontracting opportunities to at least three (3) Texas certified HUBs (who work within the respective industry applicable to the subcontracting opportunity), and allow the HUBs at least seven (7) working days to respond to the notice prior to the respondent submitting its bid response to the contracting agency. In addition, at least seven (7) working days prior to submitting its bid response to the contracting agency, the respondent must provide notice of each of its subcontracting opportunities to two (2) or more trade organizations or development centers (in Texas) that serves members of groups (i.e., Asian Pacific American, Black American, Hispanic American, Native American, Woman, Service Disabled Veteran) identified in Texas Administrative Code §20.282(19)(C).

We respectfully request that vendors interested in bidding on the subcontracting opportunity scope of work identified in **Section C, Item 2**, reply no later than the date and time identified in **Section C, Item 1**. Submit your response to the point-of-contact referenced in **Section A**.

SECTION A: PRIME CONTRACTOR'S INFORMATION

Company Name: ____________________ State of Texas VID #: ____________

Point-of-Contact: ____________________ Phone #: ____________

E-mail Address: ____________________ Fax #: ____________

SECTION B: CONTRACTING STATE AGENCY AND REQUISITION INFORMATION

Agency Name: ____________________

Point-of-Contact: ____________________ Phone #: ____________

Requisition #: ____________________ Bid Open Date: ____________ (mm/dd/yyyy)

SECTION C: SUBCONTRACTING OPPORTUNITY RESPONSE DUE DATE, DESCRIPTION, REQUIREMENTS AND RELATED INFORMATION

1. Potential Subcontractor's Bid Response Due Date:

If you would like for our company to consider your company's bid for the subcontracting opportunity identified below in Item 2,

we must receive your bid response no later than ____________ (Central Time) on ____________ (Date (mm/dd/yyyy)).

In accordance with 34 TAC §20.285, each notice of subcontracting opportunity shall be provided to at least three (3) Texas certified HUBs, and allow the HUBs at least seven (7) working days to respond to the notice prior to submitting our bid response to the contracting agency. In addition, at least seven (7) working days prior to us submitting our bid response to the contracting agency, we must provide notice of each of our subcontracting opportunities to two (2) or more trade organizations or development centers (in Texas) that serves members of groups (i.e., Asian Pacific American, Black American, Hispanic American, Native American, Woman, Service Disabled Veteran) identified in Texas Administrative Code, §20.282(19)(C).

(A working day is considered a normal business day of a state agency, not including weekends, federal or state holidays, or days the agency is declared closed by its executive officer. The initial day the subcontracting opportunity notice is sent/provided to the HUBs and to the trade organizations or development centers is considered to be "day zero" and does not count as one of the seven (7) working days.)

2. Subcontracting Opportunity Scope of Work:

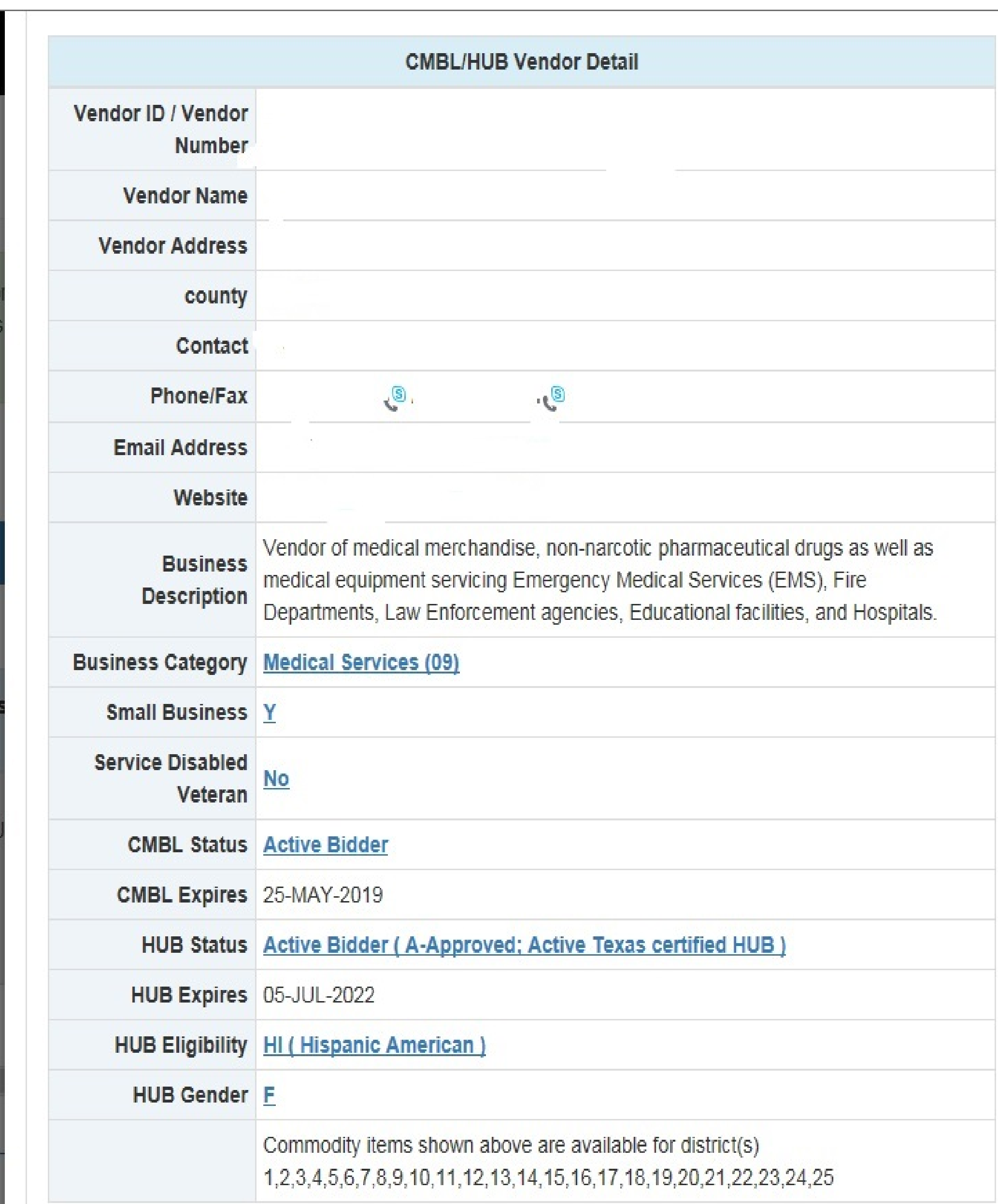
3. Required Qualifications: - Not Applicable

4. Bonding/Insurance Requirements: - Not Applicable

5. Location to review plans/specifications: - Not Applicable

Sample CMBL - HUB Vendor Detail

Note: The CMBL/HUB Vendor Detail page must be attached with all of the required documentation for the submittal of the HSP Plan.



CMBL/HUB Vendor Detail	
Vendor ID / Vendor Number	
Vendor Name	
Vendor Address	
county	
Contact	
Phone/Fax	
Email Address	
Website	
Business Description	Vendor of medical merchandise, non-narcotic pharmaceutical drugs as well as medical equipment servicing Emergency Medical Services (EMS), Fire Departments, Law Enforcement agencies, Educational facilities, and Hospitals.
Business Category	Medical Services (09)
Small Business	Y
Service Disabled Veteran	No
CMBL Status	Active Bidder
CMBL Expires	25-MAY-2019
HUB Status	Active Bidder (A-Approved: Active Texas certified HUB)
HUB Expires	05-JUL-2022
HUB Eligibility	HI (Hispanic American)
HUB Gender	F
	Commodity items shown above are available for district(s) 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25

Exhibit J:
Contractor Insurance

Electronic Visit Verification (EVV) System Management Services
Health and Human Services Commission (HHSC)

A. Specific Insurance Coverage Required.

1. **Workers' Compensation.** Insurance with limits as required by the Texas Workers' Compensation Act, with the policy endorsed to provide a waiver of subrogation in favor of Health and Human Services Commission, employer's liability insurance of not less than:

    a. $1,000,000 each accident;

    b. $1,000,000 disease each employee; and

    c. $1,000,000 disease policy limit.

    Workers' compensation insurance coverage must be provided for all workers at all tier levels and meet the statutory requirements of Texas Labor Code.

2. **Commercial General Liability Insurance**. Including premises, operations, independent Respondent's liability, products and completed operations and contractual liability, covering, but not limited to, the liability assumed under the indemnification provisions of this Contract, fully insuring Respondent's liability for bodily injury (including death) and property damage with a minimum limit of:

    a. $1,000,000 per occurrence;

    b. $2,000,000 general aggregate;

    c. $5,000 Medical Expense each person;

    d. $1,000,000 Personal Injury and Advertising Liability;

    e. $2,000,000 products and completed operations aggregate;

    f. $50,000 Damage to Premises Rented to You; and Coverage shall be on an "occurrence" basis.

    The term "You" as referenced in Subsection above, means the Respondent.

3. **Comprehensive Automobile Liability Insurance**, covering owned, hired, and non-owned vehicles, with a minimum combined single limit for bodily injury (including death) and property damage of $1,000,000 per accident. No aggregate shall be permitted for this type of coverage.

4. **Umbrella Liability Insurance.** Respondent shall obtain, pay for and maintain umbrella liability insurance during the Contract term, insuring Respondent for an amount of not less than amount $5,000,000 that provides coverage at least as broad as and applies in excess and follows form of the primary liability coverages required hereinabove.

    a. The policy shall provide "drop down" coverage where underlying primary insurance coverage limits are insufficient or exhausted.

5. **Cyber/Privacy Liability Insurance Policy**. Respondent shall provide Cyber/Privacy Liability Insurance to cover risk of loss to electronic data. The policy must include coverage for electronic vandalism to electronic data, including coverage for a third party's willful electronic alteration of data, introduction of viruses which impact electronic data, unauthorized use of electronic data, or denial of service to web site or email destinations.

    a. Cyber Liability Insurance $5,000,000 Claim/$5,000,000 Aggregate.

6. **Professional Liability Insurance.** Respondent shall obtain, pay for and maintain professional liability errors and omissions insurance during the Contract term, insuring Respondent for an amount of not less than $5,000,000.

B. Required Policy Clauses

Policies must include the following clauses, as applicable:

1. This insurance shall not be canceled, materially changed, or non-renewed except after thirty (30) days written notice has been given to HHSC.
2. It is agreed that Respondent's insurance shall be deemed primary with respect to any insurance or self-insurance carried by HHSC for liability arising out of operations under the Contract with HHSC. Health and Human Services Commission, its officials, directors, employees, representatives, and volunteers are added as additional insureds as respects operations and activities of, or on behalf of the named insured performed under Contract with HHSC. The additional insured status must cover completed operations as well. This is not applicable to workers' compensation policies.
3. A waiver of subrogation in favor of Health and Human Services Commission shall be provided in all policies.
4. Without limiting any of the other obligations or liabilities of Respondent, Respondent shall require each Sub Respondent performing work under the Contract, at Sub Respondent's own expense, to maintain during the term of the Contract, the same stipulated minimum insurance including the required provisions and additional policy conditions as shown above.
5. As an alternative, Respondent may include its Sub Respondent's as additional insureds on its own coverage as prescribed under these requirements. Respondent's certificate of insurance shall note in such event that Sub Respondents are included as additional insureds and that Respondent agrees to provide workers' compensation for Sub Respondents and their employees. Respondent shall obtain and monitor the certificates of insurance from each Sub Respondent in order to assure compliance with the insurance requirements. Respondent must retain the certificates of insurance for the duration of the Contract plus seven (7) years and shall have the responsibility of enforcing these insurance requirements among its Sub Respondents. Owner shall be entitled, upon request and without expense, to receive copies of these certificates.

C. Alternative Insurability

Notwithstanding the preceding, HHSC reserves the right to consider reasonable alternative methods of insuring the Contract in lieu of the insurance policies customarily required. It will be the Respondent's responsibility to recommend to HHSC alternative methods of insuring the Contract. Any alternatives proposed by Respondent should be accompanied by a detailed explanation regarding Respondent's inability to obtain the required insurance and/or bonds. HHSC shall be the sole and final judge as to the adequacy of any substitute form of insurance coverage.

Exhibit K, Online Bid Room Instructions

Request for Offers
HHS0011055

Responses for this Request for Offers may be submitted electronically using the HHS Online Bid Room or any other method identified in the solicitation. *Use of the HHS Online Bid Room is optional and is subject to all terms and conditions, affirmations, and other requirements of the solicitation as any other method of submission.*

> **Read and review** the solicitation package and all associated documents carefully before completing and submitting a response in the form and manner described in the solicitation package. ***Exhibits requiring signatures must be signed and included with the response by the solicitation response deadline.***
>
> **Questions** regarding the solicitation must be addressed to the Point of Contact in the solicitation package. The Point of Contact is identified in the solicitation package.
>
> **Submit** the solicitation response in the form and manner described in the solicitation package on or before the response due date and time.

IMPORTANT: The solicitation package will identify the specific form and method of delivery. Failure to adhere to the requirements in the solicitation package may result in disqualification.

Access to the HHS Online Bid Room is a two-step process.

> Step 1: Register for the Enterprise Portal using the **Enterprise Portal Link**. It can take up to five business days to receive your user name and password. If you do not receive this information within five days, email pcsbids@hhsc.state.tx.us.
>
> Step 2: Using the Enterprise Portal login credentials you will receive via email, you can request the necessary HHS Online Bid Room user name and password to enter the HHS Online Bid Room to submit your response to the solicitation electronically.

See our resources page for a tutorial, guidebook, and other resources to help you use the HHS Online Bid Room.

IMPORTANT: Allow enough time for the registration process to submit your response by the response due date. **Late solicitation responses are not accepted.**

The optional use of the HHS Online Bid Room and any resulting technical difficulties which may prevent a successful, responsive electronic submission of a solicitation response shall not be sufficient basis for a protest of a contract award.

Exhibit L, Voluntary Product Accessibility Template® (VPAT®)

Revised Section 508 Edition

Version 2.4

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Essential Requirements and Best Practices for Information & Communications Technology (ICT) Vendors 4

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About This Document

The VPAT is provided in four editions based on the standards/guidelines being evaluated. The editions are WCAG, Revised 508, EN 301 549 and International, which includes all of the standards.

This is the Revised Section 508 edition of the VPAT. It includes the following standards/guidelines:

- Web Content Accessibility Guidelines 2.0
- Revised Section 508 standards published January 18, 2017 and corrected January 22, 2018

If you need a different combination of standards/guidelines then use the appropriate alternate edition of the VPAT found on the ITI Accessibility web page.

This document is broken into two main sections:

- Essential Requirements and Best Practices for using the VPAT® to complete an Accessibility Conformance Report (the instructions)

- The VPAT

Please carefully review the Essential Requirements and Best Practices sections before using the VPAT to create an Accessibility Conformance Report.

The purpose of these instructions is to promote accurate and consistent reporting of product accessibility information.

The VPAT is a template used to document a product's conformance with accessibility standards and guidelines. The purpose of the Accessibility Conformance Report is to assist customers and buyers in making preliminary assessments regarding the availability of commercial "Electronic and Information Technology," also referred to as “Information and Communication Technology” (ICT) products and services with features that support accessibility.

The Information Technology Industry Council (ITI) provides the VPAT. Use of the template and service mark does not require membership in ITI.

Essential Requirements and Best Practices for Information & Communications Technology (ICT) Vendors

This section provides guidance for reporting product conformance for major accessibility standards and guidelines using the VPAT® to produce the Accessibility Conformance Report. Deviating from these guidelines precludes vendors from referencing the template by name and/or the VPAT acronym.

Getting Started

1. Before creating a report, read all of the materials provided in this document.
2. Determine which accessibility standards/guidelines will be included in the Accessibility Conformance Report and use the appropriate VPAT file.
3. It is the vendor's responsibility to maintain the integrity of the data in the report.

Essential Requirements for Authors

The following are the minimum requirements to produce an Accessibility Conformance Report based on the VPAT®.

1. The VPAT name and template are registered service marks of ITI. Use of the VPAT template and name requires the inclusion of the registered service mark (i.e., "VPAT®"). Users of the VPAT agree not to deviate from the Essential Requirements for Authors.
2. The template file can be used as is or replicated in a different delivery format, for example as HTML or PDF. The final conformance report must be accessible.
3. A report must contain the following content at a minimum:
    - **Report Title** – In the heading format of "[Company Name] Accessibility Conformance Report"
    - **VPAT Heading Information** – Template version
    - **Name of Product/Version** – Name of Product being reported, including product version identifier if necessary

- **Report Date** – Date of report publication. At a minimum, provide the month and year of the report publication. For example, “May 2016”. If date is included, ensure it is clear “4 May 2016” or “May 4, 2016”.
- **Product Description** – A brief description of the product
- **Contact Information** – Contact Information for follow-up questions. Listing an email is sufficient.
- **Notes** – Any details or further explanation about the product or the report. This section may be left blank.
- **Evaluation Methods Used** – Include a description of evaluation methods used to complete the VPAT for the product under test.
- **Applicable Standards/Guidelines** – A clear indication of which Standards/Guidelines this Conformance Report covers.
    - The list must include only the Standards/Guidelines used to evaluate the product.
    - The applicable Standards/Guidelines that are included in this VPAT edition are:
        - Web Content Accessibility Guidelines 2.0 or WCAG 2.0 (ISO/IEC 40500)
        - Revised Section 508 standards – the U.S. Federal accessibility standard for ICT Products, published by the U.S. Access Board in the Federal Register on January 18, 2017 and corrected on January 22, 2018
    - If other Standards/Guidelines are reported, then use the appropriate VPAT edition.
    - This information can be in a table format at the top of the report with the table heading ‘Standards/Guidelines’ and the reported Standards/Guidelines identified. This information can alternatively be supplied in the introductory text of the report. In the VPAT we have used a table as an example and listed “(yes / no)” for each standard/guideline. To indicate what the report covers leave the appropriate yes or no on each standard/guideline.
    - If multiple Standards or Guideline tables are included, each table must identify the Standard or Guideline that the criteria in that table represent.
- **Terms** – The report must list the definition of the terms used in the Conformance Level column. ITI recommends the following terms. If a vendor

deviates from the ITI definitions, the vendor shall reference this change in the heading Notes section. If a term is not used it can be removed from the list. The ITI definitions are: This can only be used in WCAG 2.x Level AAA

- **Supports**: The functionality of the product has at least one method that meets the criterion without known defects or meets with equivalent facilitation.
- **Partially Supports**: Some functionality of the product does not meet the criterion.
- **Does Not Support**: The majority of product functionality does not meet the criterion.
- **Not Applicable**: The criterion is not relevant to the product.

Note: When filling in the WCAG tables, a response may use 'Supports' where one might otherwise be inclined to use 'Not Applicable'. This is in keeping with WCAG 2.0 Understanding Conformance: This means that if there is no content to which a success criterion applies, the success criterion is satisfied.

- **Not Evaluated**: The product has not been evaluated against the criterion. This can only be used in WCAG 2.x Level AAA.

- **Tables for Each Standard or Guideline** – Tables showing the responses to the criteria.

4. WCAG Conformance Information – The answers in the WCAG success criteria are based on the level of conformance being reported (Level A, AA or AAA).

- These tables are used to answer:
  - Revised Section 508:
    - Chapter 5 Software
    - Chapter 6 Support Documentation
  - The selected levels of WCAG 2.0 Guidelines.
- If using a summary table, due to answers applying to multiple criteria, when answering for the Revised Section 508, the answers need to be clear about which individual criteria the answer applies to. It is possible to either use a summary, selecting the worst case for the criteria, or to have separate answers or even tables for software, support documentation, authoring tools, etc., so long as the methodology used is made clear.

5. Remarks and Explanations – Detailed remarks should be provided in the Remarks and Explanations column to justify your answer in the Conformance Level column.

- When the conformance level is ‘Partially Supports’ or ‘Does Not Support’, the remarks should identify:
    1. The functions or features with issues
    2. How they do not fully support
- If the criterion does not apply, explain why.
- If an accessible alternative is used, describe it.

6. In the Section 508 tables, when subsections of criteria do not apply to the product, the section may be summarized or removed as long as an explanation is provided explaining why a criterion does not apply. Another alternative is to leave the table and add a summary why the section does not apply. For example, in Chapter 5 the criteria in 502 and 503 will not apply to a web only application, thus those sections can be removed with a summary in the notes for the chapter, or a row in the table.

Best Practices for Authors

ITI suggests that authors adopt the following best practices when using the VPAT® to create an Accessibility Conformance Report.

- **Branding Header:** Company logo or branding information
- **Report Date Changes:** If a report is revised, change the report date and explain the revision in the Notes section. Alternately, create a new report and explain in the Notes section that it supersedes an earlier version of the report.
- **Notes:** Add any notes applicable to product or the report
    - Additional information about the product version that the document references
    - Any revisions to the document
    - Links to any related documents
    - Additional information describing the product
    - Additional information about what the document does or does not cover
    - Information suggested by the WCAG 2.0 Conformance Claim
    - Information needed to satisfy ISO/IEC 17050-1:2004, Supplier’s Declaration of Conformity
- **Evaluation Methods Used –** Information to enter may include the following:

    - Testing is based on general product knowledge
    - Similar to another evaluated product
    - Testing with assistive technologies
    - Published test method (provide name, publisher, URL link)
    - Vendor proprietary test method
    - Other test method
- **Remarks and Explanations:** This section may include:
    - Information regarding the testing of a given criteria.
    - Information on application dependencies to support accessibility (e.g. OS, app frameworks, browsers recommended).
    - How the customer can find more information about accessibility issues. One method can be to include the bug ID where customers can call the company's customer support to get additional information.
    - Known workarounds for accessibility issues.
- **Legal Disclaimer:** Area for any legal disclaimer text required by your organization.
- **Report Size:** To reduce the size of the report it is acceptable to remove sections. Individual criteria cannot be removed, only sections at a time. Section removal is acceptable in four situations:
    - When an entire section is not being reported on because it does not apply to the product, for example:
        - Chapter 4: Hardware. Information should be included in the notes for that section why it has been removed.
        - A card reader that doesn't have sound could remove the criteria in section 413 Closed Caption Processing Technologies and just note the why the criteria doesn't apply.
    - If the product is not being evaluated for a level of the criteria (for example Level AAA) then that table may be deleted.
    - If a requesting customer has identified that a section of the standard does not apply, information should be included in the notes that the section has been removed.
- **WCAG 2.0 Tables:** The WCAG 2.0 criteria are shown in three tables, Level A, Level AA, and Level AAA.
    - If desired, these tables can be combined into one table.

    - When reporting on a level (A, AA or AAA) all criteria for that level must be answered.

- **Language:** Translation to other languages is permitted.
- **Multiple Reports:** When using the VPAT to create an Accessibility Conformance Report for complex products it may be helpful to separate answers into multiple reports. For example, when a product is an Authoring Tool that also has web content and documentation. When multiple reports are used for a complex product, it is required to explain this and how to reach the other reports in the Notes section of each report.
- **Criteria Text:** To help conserve space in the ITI template only the criteria ID number and a short title have been included. Where possible, links have been included to the standard/guideline.
    - It is acceptable to add the full text of the criteria into the cell if desired to help with understanding.
    - The links to the standards/guidelines can be removed.
- **Ordering of Tables:** The order that the standard and guideline tables appear may be changed to facilitate reading. The current order is WCAG then Section 508. You can change this order to insert the WCAG criteria into the Section 508 tables.
- **Guideline Section Heading Rows in Tables:** The tables include heading rows to facilitate understanding the context of the criteria.
    - The cells in these rows do not require answers as indicated by "Heading cell – no response required."
    - It is optional to add a response if desired.
    - The shading of the row is also optional.
    - If removing the heading rows, edit the criteria titles so it's clear where they apply.

Posting the Final Document

- When publishing your Accessibility Conformance Report, be sure to remove the entire first 9 pages of this document, including the table of contents, introductory information and instructions.
- Check for each required item in the VPAT® document:
    - **[Company Name] Accessibility Conformance Report** (report title)

- **(Based on VPAT® Version 2.4)**
- **Name of Product/Version**
- **Report Date**
- **Product Description**
- **Contact Information**
- **Notes**
- **Evaluation Methods Used**
- **Applicable Standards/Guidelines**
- **Terms**
- **Tables for Each Standard or Guideline**
  - Check that there is a response for each criterion for ‘Conformance Level’ and ‘Remarks and Explanations.’

- Verify that the final document is accessible.
- Post your final document on your company’s web site, or make the document available to customers upon request.

Table Information for VPAT® Readers

For each of the standards, the criteria are listed by chapter in a table. The structures of the tables are: the first column contains the criteria being evaluated, the second column describes the level of conformance of the product regarding the criteria and the third column contains any additional remarks and explanations regarding the product.

- When sections of criteria do not apply, or are deemed by the customer as not applicable, the section is noted as such and the rest of that table may be removed for that section.
- When multiple standards are being recorded in this document, the duplicative sections are noted and responded to only one time. The duplicate entry will note the cross reference to the data.

[Company] Accessibility Conformance Report

Revised Section 508 Edition

(Based on VPAT® Version 2.4)

Name of Product/Version:

Report Date:

Product Description:

Contact Information:

Notes:

Evaluation Methods Used:

Applicable Standards/Guidelines

This report covers the degree of conformance for the following accessibility standard/guidelines:

Standard/Guideline	Included In Report
Web Content Accessibility Guidelines 2.0	Level A (Yes) Level AA (Yes) Level AAA (No)
Revised Section 508 standards published January 18, 2017 and corrected January 22, 2018	(Yes)

"Voluntary Product Accessibility Template" and "VPAT" are registered
service marks of the Information Technology Industry Council (ITI)

Terms

The terms used in the Conformance Level information are defined as follows:

- **Supports**: The functionality of the product has at least one method that meets the criterion without known defects or meets with equivalent facilitation.
- **Partially Supports**: Some functionality of the product does not meet the criterion.
- **Does Not Support**: The majority of product functionality does not meet the criterion.
- **Not Applicable**: The criterion is not relevant to the product.
- **Not Evaluated**: The product has not been evaluated against the criterion. This can be used only in WCAG 2.0 Level AAA.

WCAG 2.0 Report

Tables 1 and 2 also document conformance with Revised Section 508:

- Chapter 5 – 501.1 Scope, 504.2 Content Creation or Editing
- Chapter 6 – 602.3 Electronic Support Documentation

Note: When reporting on conformance with the WCAG 2.0 Success Criteria, they are scoped for full pages, complete processes, and accessibility-supported ways of using technology as documented in the WCAG 2.0 Conformance Requirements.

Table 1: Success Criteria, Level A

Notes:

Criteria	Conformance Level	Remarks and Explanations
1.1.1 Non-text Content (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
1.2.1 Audio-only and Video-only (Prerecorded) (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
1.2.2 Captions (Prerecorded) (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
1.2.3 Audio Description or Media Alternative (Prerecorded) (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
1.3.1 Info and Relationships (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:

Criteria	Conformance Level	Remarks and Explanations
• 602.3 (Support Docs)		
[1.3.2 Meaningful Sequence] (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
[1.3.3 Sensory Characteristics] (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
[1.4.1 Use of Color] (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
[1.4.2 Audio Control] (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
[2.1.1 Keyboard] (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
[2.1.2 No Keyboard Trap] (Level A)	Web:	Web:

Criteria	Conformance Level	Remarks and Explanations
Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Electronic Docs: Software: Authoring Tool:	Electronic Docs: Software: Authoring Tool:
2.2.1 Timing Adjustable (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
2.2.2 Pause, Stop, Hide (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
2.3.1 Three Flashes or Below Threshold (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
2.4.1 Bypass Blocks (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) – Does not apply to non-web software • 504.2 (Authoring Tool) • 602.3 (Support Docs) – Does not apply to non-web docs	Web: Electronic Docs: Authoring Tool:	Web: Electronic Docs: Authoring Tool:
2.4.2 Page Titled (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:

Criteria	Conformance Level	Remarks and Explanations
• 504.2 (Authoring Tool) • 602.3 (Support Docs)		
[2.4.3 Focus Order] (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
[2.4.4 Link Purpose (In Context)] (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
[3.1.1 Language of Page] (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
[3.2.1 On Focus] (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
[3.2.2 On Input] (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:

Criteria	Conformance Level	Remarks and Explanations
[3.3.1 Error Identification](#) (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
[3.3.2 Labels or Instructions](#) (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
[4.1.1 Parsing](#) (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
[4.1.2 Name, Role, Value](#) (Level A) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:

Table 2: Success Criteria, Level AA

Notes:

Criteria	Conformance Level	Remarks and Explanations
[1.2.4 Captions (Live)](#) (Level AA) Also applies to:	Web: Electronic Docs:	Web: Electronic Docs:

Criteria	Conformance Level	Remarks and Explanations
Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Software: Authoring Tool:	Software: Authoring Tool:
1.2.5 Audio Description (Prerecorded) (Level AA) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
1.4.3 Contrast (Minimum) (Level AA) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
1.4.4 Resize text (Level AA) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
1.4.5 Images of Text (Level AA) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
2.4.5 Multiple Ways (Level AA) Also applies to: Revised Section 508 • 501 (Web)(Software) – Does not apply to non-web software • 504.2 (Authoring Tool)	Web: Electronic Docs: Authoring Tool:	Web: Electronic Docs: Authoring Tool:

Criteria	Conformance Level	Remarks and Explanations
• 602.3 (Support Docs) – Does not apply to non-web docs		
2.4.6 Headings and Labels (Level AA) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
2.4.7 Focus Visible (Level AA) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
3.1.2 Language of Parts (Level AA) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:
3.2.3 Consistent Navigation (Level AA) Also applies to: Revised Section 508 • 501 (Web)(Software) – Does not apply to non-web software • 504.2 (Authoring Tool) • 602.3 (Support Docs) – Does not apply to non-web docs	Web: Electronic Docs: Authoring Tool:	Web: Electronic Docs: Authoring Tool:
3.2.4 Consistent Identification (Level AA) Also applies to: Revised Section 508 • 501 (Web)(Software) – Does not apply to non-web software • 504.2 (Authoring Tool) • 602.3 (Support Docs) – Does not apply to non-web docs	Web: Electronic Docs: Authoring Tool:	Web: Electronic Docs: Authoring Tool:
3.3.3 Error Suggestion (Level AA)	Web:	Web:

Criteria	Conformance Level	Remarks and Explanations
Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Electronic Docs: Software: Authoring Tool:	Electronic Docs: Software: Authoring Tool:
3.3.4 Error Prevention (Legal, Financial, Data) (Level AA) Also applies to: Revised Section 508 • 501 (Web)(Software) • 504.2 (Authoring Tool) • 602.3 (Support Docs)	Web: Electronic Docs: Software: Authoring Tool:	Web: Electronic Docs: Software: Authoring Tool:

Table 3: Success Criteria, Level AAA

Notes:

Criteria	Conformance Level	Remarks and Explanations
1.2.6 Sign Language (Prerecorded) (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
1.2.7 Extended Audio Description (Prerecorded) (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
1.2.8 Media Alternative (Prerecorded) (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
1.2.9 Audio-only (Live) (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
1.4.6 Contrast (Enhanced) (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
1.4.7 Low or No Background Audio (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
1.4.8 Visual Presentation (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
1.4.9 Images of Text (No Exception) (Level AAA)	Web:	Web:

Criteria	Conformance Level	Remarks and Explanations
Revised Section 508 – Does not apply		
2.1.3 Keyboard (No Exception) (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
2.2.3 No Timing (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
2.2.4 Interruptions (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
2.2.5 Re-authenticating (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
2.3.2 Three Flashes (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
2.4.8 Location (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
2.4.9 Link Purpose (Link Only) (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
2.4.10 Section Headings (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
3.1.3 Unusual Words (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
3.1.4 Abbreviations (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
3.1.5 Reading Level (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
3.1.6 Pronunciation (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
3.2.5 Change on Request (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
3.3.5 Help (Level AAA) Revised Section 508 – Does not apply	Web:	Web:
3.3.6 Error Prevention (All) (Level AAA) Revised Section 508 – Does not apply	Web:	Web:

Revised Section 508 Report

Notes:

Chapter 3: Functional Performance Criteria (FPC)

Notes:

Criteria	Conformance Level	Remarks and Explanations
302.1 Without Vision		
302.2 With Limited Vision		
302.3 Without Perception of Color		
302.4 Without Hearing		
302.5 With Limited Hearing		
302.6 Without Speech		
302.7 With Limited Manipulation		
302.8 With Limited Reach and Strength		
302.9 With Limited Language, Cognitive, and Learning Abilities		

Chapter 4: Hardware

Notes:

Criteria	Conformance Level	Remarks and Explanations
402 Closed Functionality	Heading cell – no response required	Heading cell – no response required
402.1 General	Heading cell – no response required	Heading cell – no response required
402.2 Speech-Output Enabled	Heading cell – no response required	Heading cell – no response required
402.2.1 Information Displayed On-Screen		
402.2.2 Transactional Outputs		
402.2.3 Speech Delivery Type and Coordination		
402.2.4 User Control		
402.2.5 Braille Instructions		

Criteria	Conformance Level	Remarks and Explanations
402.3 Volume	Heading cell – no response required	Heading cell – no response required
402.3.1 Private Listening		
402.3.2 Non-private Listening		
402.4 Characters on Display Screens		
402.5 Characters on Variable Message Signs		
403 Biometrics	Heading cell – no response required	Heading cell – no response required
403.1 General		
404 Preservation of Information Provided for Accessibility	Heading cell – no response required	Heading cell – no response required
404.1 General		
405 Privacy	Heading cell – no response required	Heading cell – no response required
405.1 General		
406 Standard Connections	Heading cell – no response required	Heading cell – no response required
406.1 General		
407 Operable Parts	Heading cell – no response required	Heading cell – no response required
407.2 Contrast		
407.3 Input Controls	Heading cell – no response required	Heading cell – no response required
407.3.1 Tactilely Discernible		
407.3.2 Alphabetic Keys		
407.3.3 Numeric Keys		
407.4 Key Repeat		
407.5 Timed Response		
407.6 Operation		
407.7 Tickets, Fare Cards, and Keycards		
407.8 Reach Height and Depth	Heading cell – no response required	Heading cell – no response required
407.8.1 Vertical Reference Plane		
407.8.1.1 Vertical Plane for Side Reach		
407.8.1.2 Vertical Plane for Forward Reach		
407.8.2 Side Reach		
407.8.2.1 Unobstructed Side Reach		
407.8.2.2 Obstructed Side Reach		

Criteria	Conformance Level	Remarks and Explanations
407.8.3 Forward Reach		
407.8.3.1 Unobstructed Forward Reach		
407.8.3.2 Obstructed Forward Reach		
407.8.3.2.1 Operable Part Height for ICT with Obstructed Forward Reach		
407.8.3.2.2 Knee and Toe Space under ICT with Obstructed Forward Reach		
408 Display Screens	Heading cell – no response required	Heading cell – no response required
408.2 Visibility		
408.3 Flashing		
409 Status Indicators	Heading cell – no response required	Heading cell – no response required
409.1 General		
410 Color Coding	Heading cell – no response required	Heading cell – no response required
410.1 General		
411 Audible Signals	Heading cell – no response required	Heading cell – no response required
411.1 General		
412 ICT with Two-Way Voice Communication	Heading cell – no response required	Heading cell – no response required
412.2 Volume Gain	Heading cell – no response required	Heading cell – no response required
412.2.1 Volume Gain for Wireline Telephones		
412.2.2 Volume Gain for Non-Wireline ICT		
412.3 Interference Reduction and Magnetic Coupling	Heading cell – no response required	Heading cell – no response required
412.3.1 Wireless Handsets		
412.3.2 Wireline Handsets		
412.4 Digital Encoding of Speech		
412.5 Real-Time Text Functionality	Reserved for future	Reserved for future
412.6 Caller ID		
412.7 Video Communication		
412.8 Legacy TTY Support	Heading cell – no response required	Heading cell – no response required
412.8.1 TTY Connectability		
412.8.2 Voice and Hearing Carry Over		
412.8.3 Signal Compatibility		
412.8.4 Voice Mail and Other Messaging Systems		

Criteria	Conformance Level	Remarks and Explanations
413 Closed Caption Processing Technologies	Heading cell – no response required	Heading cell – no response required
413.1.1 Decoding and Display of Closed Captions		
413.1.2 Pass-Through of Closed Caption Data		
414 Audio Description Processing Technologies	Heading cell – no response required	Heading cell – no response required
414.1.1 Digital Television Tuners		
414.1.2 Other ICT		
415 User Controls for Captions and Audio Descriptions	Heading cell – no response required	Heading cell – no response required
415.1.1 Caption Controls		
415.1.2 Audio Description Controls		

Chapter 5: Software

Notes:

Criteria	Conformance Level	Remarks and Explanations
501.1 Scope – Incorporation of WCAG 2.0 AA	See WCAG 2.0 section	See information in WCAG 2.0 section
502 Interoperability with Assistive Technology	Heading cell – no response required	Heading cell – no response required
502.2.1 User Control of Accessibility Features		
502.2.2 No Disruption of Accessibility Features		
502.3 Accessibility Services	Heading cell – no response required	Heading cell – no response required
502.3.1 Object Information		
502.3.2 Modification of Object Information		
502.3.3 Row, Column, and Headers		
502.3.4 Values		
502.3.5 Modification of Values		
502.3.6 Label Relationships		
502.3.7 Hierarchical Relationships		
502.3.8 Text		
502.3.9 Modification of Text		
502.3.10 List of Actions		
502.3.11 Actions on Objects		

Criteria	Conformance Level	Remarks and Explanations
502.3.12 Focus Cursor		
502.3.13 Modification of Focus Cursor		
502.3.14 Event Notification		
502.4 Platform Accessibility Features		
503 Applications	Heading cell – no response required	Heading cell – no response required
503.2 User Preferences		
503.3 Alternative User Interfaces		
503.4 User Controls for Captions and Audio Description	Heading cell – no response required	Heading cell – no response required
503.4.1 Caption Controls		
503.4.2 Audio Description Controls		
504 Authoring Tools	Heading cell – no response required	Heading cell – no response required
504.2 Content Creation or Editing (if not authoring tool, enter “not applicable”)	See WCAG 2.0 section	See information in WCAG 2.0 section
504.2.1 Preservation of Information Provided for Accessibility in Format Conversion		
504.2.2 PDF Export		
504.3 Prompts		
504.4 Templates		

Chapter 6: Support Documentation and Services

Notes:

Criteria	Conformance Level	Remarks and Explanations
601.1 Scope	Heading cell – no response required	Heading cell – no response required
602 Support Documentation	Heading cell – no response required	Heading cell – no response required
602.2 Accessibility and Compatibility Features		
602.3 Electronic Support Documentation	See WCAG 2.0 section	See information in WCAG 2.0 section
602.4 Alternate Formats for Non-Electronic Support Documentation		
603 Support Services	Heading cell – no response required	Heading cell – no response required
603.2 Information on Accessibility and Compatibility Features		

Criteria	Conformance Level	Remarks and Explanations
603.3 Accommodation of Communication Needs		

Legal Disclaimer (Company)

Include your company legal disclaimer here, if needed.

Electronic Visit Verification (EVV) System Management Services Criteria, Subcriteria Sheet HHS0011055				
Evaluator				
Respondent				
#	**Criteria**	**Weight**	**Score**	**Comments**
1	**Project Work Plan**			
1.1	Evaluate the Respondent's ability to successfully fulfill the Solicitation requirements in **Article II** not covered by sub-criteria 1.2, 1.3, 1.4, and 1.5 in a timely, accurate, and thorough manner.	10%		
1.2	Evaluate the Respondent's ability to successfully fulfill the Solicitation requirements for **State Pool System Management and Oversight (SPSR)** in a timely, accurate, and thorough manner.	10%		
1.3	Evaluate the Respondent's ability to successfully fulfill the Solicitation requirements for **State Pool System Operations (SPOR)** in a timely, accurate, and thorough manner.	10%		
1.4	Evaluate the Respondent's ability to successfully fulfill the Solicitation requirements for **Proprietary System Management and Oversight (PSMR)** in a timely, accurate, and thorough manner.	10%		
1.5	Evaluate the Respondent's ability to successfully fulfill the Solicitation requirements for **Transition (TRAR)** in a timely, accurate, and thorough manner.	10%		
	Subtotal	**50%**		
2	**Relevant Qualifications, Past Performance and Experience**			
2.1	Evaluate the Respondent's qualifications, experience, and history of providing oversight and management Services for similar public-sector organizations, programs, and budgets demonstrating the Respondent's ability to successfully fulfill the Solicitation requirements in a timely, accurate, and thorough manner.	5%		
2.2	Evaluate the Respondent's proposed State Pool System Operator's (SPSO's) qualifications, experience, and history of providing an EVV System demonstrating the Respondent's ability to successfully fulfill the Solicitation requirements in a timely, accurate, and thorough manner.	5%		
	Subtotal	**10%**		
3	**Personnel, Organization and Qualifications**			
3.1	Evaluate the Respondent's Proposal demonstrating appropriate staffing and organizational structure to successfully fulfill the Solicitation requirements in a timely, accurate, and thorough manner.	5%		
3.2	Evaluate the Respondent's proposed Key Personnel demonstrating the necessary qualifications, experience, and history of success to successfully fulfill the Solicitation requirements in a timely, accurate, and thorough manner.	5%		
	Subtotal	**10%**		
4	**Cost and Comprehensiveness of Pricing Schedules**			
4.1	Evaluate Respondent's "Total Price Base Contract Term (Years 1-4, includes Transition)" submitted in the Total Price Summary Worksheet within Attachment A-1, Pricing Workbook.	20%		
4.2	Evaluate the Respondent's proposed pricing schedules, narrative, and cost allocations are complete, accurate, thorough, reasonable and clearly map the proposed costs to the Respondent's work plan and deliverables demonstrating the Respondent's ability to fulfill the Solicitation requirements in a timely, accurate, and thorough manner.	10%		
	Subtotal	**30%**		
	TOTAL (%)	**100%**		

Electronic Visit Verification (EVV) System Management Services HHS0011055		
Evaluation Scoring Guide		
Score	**Level**	**Description**
Unacceptable	**1**	Response does not address requirement. Response is completely unacceptable.
Unacceptable	**2**	Response mentions requirement, but is not responsive to the elements of the requirement.
Unacceptable	**3**	Response addresses requirement, but response described does not allow the agency to fulfill mission.
Marginal. Fails to meet evaluation standards but failures are correctable.	**4**	Response meets fundamental requirements, however could not be implemented as described (would require both the agency and Respondent to make significant changes not currently anticipated).
Marginal. Fails to meet evaluation standards but failures are correctable.	**5**	Response meets fundamental requirements, however could not be implemented as described (implementation would require both the agency and Respondent to make minor changes not currently anticipated).
Marginal. Fails to meet evaluation standards but failures are correctable.	**6**	Response meets fundamental requirements, however could not be implemented as described (implementation would require changes to be made by Respondent only).
Acceptable	**7**	Response clearly satisfies requirement but has some minor weaknesses.
Acceptable	**8**	Response clearly satisfies requirement.
Acceptable	**9**	Response satisfies requirements and has some benefits above requirement.
Exceptional	**10**	Response far exceeds all aspects of requirement.

For the purposes of this exhibit, "the agency" means the contracting state agency as specified in the solicitation.

Electronic Visit Verification (EVV) System Management Services HHS0011055		
No.	**Best Value Criteria**	**Weight**
1	Project Work Plan	50%
2	Relevant Qualifications, Past Performance and Experience	10%
3	Personnel, Organization and Qualifications	10%
4	Cost and Comprehensiveness of Pricing Schedules	30%
	GRAND TOTAL	**100%**

Exhibit N - HHS Information Security and Privacy Requirements

Standards and Regulations:

Contractors are required to comply with HHS Information Security and Privacy requirements in order to maintain a business relationship with Texas HHS. Accordingly, Contractors are required to adhere to all applicable standards and regulations (and their associated security controls) to include state laws, federal laws, executive orders, policies, regulations, standards, and guidance.

Standards and Regulations that Apply to this Contract:

Based on data types that are accessed, created, disclosed, received, transmitted, maintained, or stored within information system(s) of this Contract the following standards and regulations apply:

Texas HHS Requirements:

The contractor is responsible for implementing the **HHS MODERATE** (NIST SP 800-53R4 MODERATE equivalent) security baseline and the **HIPAA** overlay found in the IS-Controls and the following Texas HHS standards and regulations:

1. Information Security Controls (IS-Controls)
2. Information Security Risk Assessment Monitoring Process (IS-RAMP)
3. Security and Privacy Inquiry (SPI)
4. Information Security Web & Mobile Standard (IS-Web & Mobile)

State and Federal Requirements:

The contractor is additionally responsible for implementing following state and federal standards and regulations:

1. Texas Department of Information Resources (DIR) Security Control Standards Catalog
2. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
3. NIST SP 800-66, An Introductory Resource Guide for Implementing the HIPAA Security Rule
4. US Department of Health and Human Services HIPAA Security Rule Crosswalk to NIST Cybersecurity Framework

Contract Monitoring:

Contractors are required to fulfill HHS monitoring requirements for continuing compliance as outlined in the IS-RAMP.

Required Information Security & Privacy Controls that Apply to this Contract:

Table 1 below is a list of required security controls mandated by the applicable state and federal regulations listed above. The contractor is required to implement the following list of Information Security and Privacy controls unless there exists a documented agreement that establishes HHS as the provider for a specified control(s).

Additionally, the contractor is required to implement any additional controls added or modified in subsequent updates to applicable state or federal laws, regulations or standards.

If more than one applicable standard and/or regulation requires the same Information Security and Privacy control, then the contractor must implement the most restrictive requirements for the specified control.

Table 1: Information Security & Privacy Controls Minimum Baseline that apply to this Contract

Control ID	Control Name
AC-01	ACCESS CONTROL POLICY AND PROCEDURES
AC-02	ACCOUNT MANAGEMENT
AC-02(01)	AUTOMATED SYSTEM ACCOUNT MANAGEMENT
AC-02(02)	REMOVAL OF TEMPORARY / EMERGENCY ACCOUNTS
AC-02(03)	DISABLE INACTIVE ACCOUNTS
AC-02(04)	AUTOMATED AUDIT ACTIONS
AC-03	ACCESS ENFORCEMENT
AC-04	INFORMATION FLOW ENFORCEMENT
AC-05	SEPARATION OF DUTIES
AC-06	LEAST PRIVILEGE
AC-06(01)	AUTHORIZE ACCESS TO SECURITY FUNCTIONS
AC-06(02)	NON-PRIVILEGED ACCESS FOR NONSECURITY FUNCTIONS
AC-06(05)	PRIVILEGED ACCOUNTS
AC-06(09)	AUDITING USE OF PRIVILEGED FUNCTIONS
AC-06(10)	PROHIBIT NON-PRIVILEGED USERS FROM EXECUTING PRIVILEGED FUNCTIONS
AC-07	UNSUCCESSFUL LOGON ATTEMPTS
AC-08	SYSTEM USE NOTIFICATION
AC-11	SESSION LOCK
AC-11(01)	PATTERN-HIDING DISPLAYS
AC-12	SESSION TERMINATION
AC-14	PERMITTED ACTIONS WITHOUT IDENTIFICATION OR AUTHENTICATION
AC-16	SECURITY ATTRIBUTES

AC-17	REMOTE ACCESS
AC-17(01)	AUTOMATED MONITORING / CONTROL
AC-17(02)	PROTECTION OF CONFIDENTIALITY / INTEGRITY USING ENCRYPTION
AC-17(03)	MANAGED ACCESS CONTROL POINTS
AC-17(04)	PRIVILEGED COMMANDS / ACCESS
AC-18	WIRELESS ACCESS
AC-18(01)	AUTHENTICATION AND ENCRYPTION
AC-19	ACCESS CONTROL FOR MOBILE DEVICES
AC-19(05)	FULL DEVICE / CONTAINER-BASED ENCRYPTION
AC-20	USE OF EXTERNAL INFORMATION SYSTEMS
AC-20(01)	LIMITS ON AUTHORIZED USE
AC-20(02)	PORTABLE STORAGE DEVICES
AC-21	INFORMATION SHARING
AC-22	PUBLICLY ACCESSIBLE CONTENT
AT-01	SECURITY AWARENESS AND TRAINING POLICY AND PROCEDURES
AT-02	SECURITY AWARENESS TRAINING
AT-02(02)	INSIDER THREAT
AT-03	ROLE-BASED SECURITY TRAINING
AT-04	SECURITY TRAINING RECORDS
AU-01	AUDIT AND ACCOUNTABILITY POLICY AND PROCEDURES
AU-02	AUDIT EVENTS
AU-02(03)	REVIEWS AND UPDATES
AU-03	CONTENT OF AUDIT RECORDS
AU-03(01)	ADDITIONAL AUDIT INFORMATION
AU-04	AUDIT STORAGE CAPACITY
AU-05	RESPONSE TO AUDIT PROCESSING FAILURES
AU-06	AUDIT REVIEW, ANALYSIS, AND REPORTING
AU-06(01)	PROCESS INTEGRATION

AU-06(03)	CORRELATE AUDIT REPOSITORIES
AU-07	AUDIT REDUCTION AND REPORT GENERATION
AU-07(01)	AUTOMATIC PROCESSING
AU-08	TIME STAMPS
AU-08(01)	SYNCHRONIZATION WITH AUTHORITATIVE TIME SOURCE
AU-09	PROTECTION OF AUDIT INFORMATION
AU-09(04)	ACCESS BY SUBSET OF PRIVILEGED USERS
AU-11	AUDIT RECORD RETENTION
AU-12	AUDIT GENERATION
AU-13	MONITORING FOR INFORMATION DISCLOSURE
CA-01	SECURITY ASSESSMENT AND AUTHORIZATION POLICY AND PROCEDURES
CA-02	SECURITY ASSESSMENTS
CA-02(01)	INDEPENDENT ASSESSORS
CA-03	SYSTEM INTERCONNECTIONS
CA-03(05)	RESTRICTIONS ON EXTERNAL SYSTEM CONNECTIONS
CA-05	PLAN OF ACTION AND MILESTONES
CA-05(01)	AUTOMATION SUPPORT FOR ACCURACY / CURRENCY
CA-06	SECURITY AUTHORIZATION
CA-07	CONTINUOUS MONITORING
CA-07(01)	INDEPENDENT ASSESSMENT
CA-08	PENETRATION TESTING
CA-09	INTERNAL SYSTEM CONNECTIONS
CM-01	CONFIGURATION MANAGEMENT POLICY AND PROCEDURES
CM-02	BASELINE CONFIGURATION
CM-02(01)	REVIEWS AND UPDATES
CM-02(03)	RETENTION OF PREVIOUS CONFIGURATIONS
CM-03	CONFIGURATION CHANGE CONTROL
CM-03(02)	TEST / VALIDATE / DOCUMENT CHANGES

CM-04	SECURITY IMPACT ANALYSIS
CM-04(01)	SEPARATE TEST ENVIRONMENTS
CM-05	ACCESS RESTRICTIONS FOR CHANGE
CM-06	CONFIGURATION SETTINGS
CM-07	LEAST FUNCTIONALITY
CM-07(01)	PERIODIC REVIEW
CM-07(02)	PREVENT PROGRAM EXECUTION
CM-07(04)	UNAUTHORIZED SOFTWARE / BLACKLISTING
CM-08	INFORMATION SYSTEM COMPONENT INVENTORY
CM-08(01)	UPDATES DURING INSTALLATIONS / REMOVALS
CM-08(03)	AUTOMATED UNAUTHORIZED COMPONENT DETECTION
CM-08(05)	NO DUPLICATE ACCOUNTING OF COMPONENTS
CM-09	CONFIGURATION MANAGEMENT PLAN
CM-10	SOFTWARE USAGE RESTRICTIONS
CM-11	USER-INSTALLED SOFTWARE
CP-01	CONTINGENCY PLANNING POLICY AND PROCEDURES
CP-02	CONTINGENCY PLAN
CP-02(01)	COORDINATE WITH RELATED PLANS
CP-02(03)	RESUME ESSENTIAL MISSIONS / BUSINESS FUNCTIONS
CP-02(05)	CONTINUE ESSENTIAL MISSIONS / BUSINESS FUNCTIONS
CP-02(08)	IDENTIFY CRITICAL ASSETS
CP-03	CONTINGENCY TRAINING
CP-04	CONTINGENCY PLAN TESTING
CP-04(01)	COORDINATE WITH RELATED PLANS
CP-06	ALTERNATE STORAGE SITE
CP-06(01)	SEPARATION FROM PRIMARY SITE
CP-06(03)	ACCESSIBILITY
CP-07	ALTERNATE PROCESSING SITE

CP-07(01)	SEPARATION FROM PRIMARY SITE
CP-07(02)	ACCESSIBILITY
CP-07(03)	PRIORITY OF SERVICE
CP-08	TELECOMMUNICATIONS SERVICES
CP-08(01)	PRIORITY OF SERVICE PROVISIONS
CP-08(02)	SINGLE POINTS OF FAILURE
CP-09	INFORMATION SYSTEM BACKUP
CP-09(01)	TESTING FOR RELIABILITY / INTEGRITY
CP-10	INFORMATION SYSTEM RECOVERY AND RECONSTITUTION
CP-10(02)	TRANSACTION RECOVERY
CP-11	ALTERNATE COMMUNICATIONS PROTOCOLS
IA-01	IDENTIFICATION AND AUTHENTICATION POLICY AND PROCEDURES
IA-02	IDENTIFICATION AND AUTHENTICATION (ORGANIZATIONAL USERS)
IA-02(01)	NETWORK ACCESS TO PRIVILEGED ACCOUNTS
IA-02(08)	NETWORK ACCESS TO PRIVILEGED ACCOUNTS - REPLAY RESISTANT
IA-02(11)	REMOTE ACCESS - SEPARATE DEVICE
IA-03	DEVICE IDENTIFICATION AND AUTHENTICATION
IA-04	IDENTIFIER MANAGEMENT
IA-05	AUTHENTICATOR MANAGEMENT
IA-05(01)	PASSWORD-BASED AUTHENTICATION
IA-05(02)	PKI-BASED AUTHENTICATION
IA-05(03)	IN-PERSON OR TRUSTED THIRD-PARTY REGISTRATION
IA-05(07)	NO EMBEDDED UNENCRYPTED STATIC AUTHENTICATORS
IA-05(11)	HARDWARE TOKEN-BASED AUTHENTICATION
IA-06	AUTHENTICATOR FEEDBACK
IA-07	CRYPTOGRAPHIC MODULE AUTHENTICATION
IA-08	IDENTIFICATION AND AUTHENTICATION (NON-ORGANIZATIONAL USERS)
IR-01	INCIDENT RESPONSE POLICY AND PROCEDURES

IR-02	INCIDENT RESPONSE TRAINING
IR-03	INCIDENT RESPONSE TESTING
IR-03(02)	COORDINATION WITH RELATED PLANS
IR-04	INCIDENT HANDLING
IR-04(01)	AUTOMATED INCIDENT HANDLING PROCESSES
IR-05	INCIDENT MONITORING
IR-06	INCIDENT REPORTING
IR-06(01)	AUTOMATED REPORTING
IR-07	INCIDENT RESPONSE ASSISTANCE
IR-07(01)	AUTOMATION SUPPORT FOR AVAILABILITY OF INFORMATION / SUPPORT
IR-08	INCIDENT RESPONSE PLAN
MA-01	SYSTEM MAINTENANCE POLICY AND PROCEDURES
MA-02	CONTROLLED MAINTENANCE
MA-03	MAINTENANCE TOOLS
MA-03(01)	INSPECT TOOLS
MA-03(02)	INSPECT MEDIA
MA-04	NONLOCAL MAINTENANCE
MA-04(02)	DOCUMENT NONLOCAL MAINTENANCE
MA-05	MAINTENANCE PERSONNEL
MA-06	TIMELY MAINTENANCE
MP-01	MEDIA PROTECTION POLICY AND PROCEDURES
MP-02	MEDIA ACCESS
MP-03	MEDIA MARKING
MP-04	MEDIA STORAGE
MP-05	MEDIA TRANSPORT
MP-05(04)	CRYPTOGRAPHIC PROTECTION
MP-06	MEDIA SANITIZATION
MP-07	MEDIA USE

MP-07(01)	PROHIBIT USE WITHOUT OWNER
PE-01	PHYSICAL AND ENVIRONMENTAL PROTECTION POLICY AND PROCEDURES
PE-02	PHYSICAL ACCESS AUTHORIZATIONS
PE-03	PHYSICAL ACCESS CONTROL
PE-04	ACCESS CONTROL FOR TRANSMISSION MEDIUM
PE-05	ACCESS CONTROL FOR OUTPUT DEVICES
PE-06	MONITORING PHYSICAL ACCESS
PE-06(01)	INTRUSION ALARMS / SURVEILLANCE EQUIPMENT
PE-08	VISITOR ACCESS RECORDS
PE-09	POWER EQUIPMENT AND CABLING
PE-10	EMERGENCY SHUTOFF
PE-11	EMERGENCY POWER
PE-12	EMERGENCY LIGHTING
PE-13	FIRE PROTECTION
PE-13(03)	AUTOMATIC FIRE SUPPRESSION
PE-14	TEMPERATURE AND HUMIDITY CONTROLS
PE-15	WATER DAMAGE PROTECTION
PE-16	DELIVERY AND REMOVAL
PE-17	ALTERNATE WORK SITE
PE-18	LOCATION OF INFORMATION SYSTEM COMPONENTS
PE-19	INFORMATION LEAKAGE
PE-20	ASSET MONITORING AND TRACKING
PL-01	SECURITY PLANNING POLICY AND PROCEDURES
PL-02	SYSTEM SECURITY PLAN
PL-02(03)	PLAN / COORDINATE WITH OTHER ORGANIZATIONAL ENTITIES
PL-04	RULES OF BEHAVIOR
PL-04(01)	SOCIAL MEDIA AND NETWORKING RESTRICTIONS
PL-08	INFORMATION SECURITY ARCHITECTURE

PS-01	PERSONNEL SECURITY POLICY AND PROCEDURES
PS-02	POSITION RISK DESIGNATION
PS-03	PERSONNEL SCREENING
PS-04	PERSONNEL TERMINATION
PS-05	PERSONNEL TRANSFER
PS-06	ACCESS AGREEMENTS
PS-07	THIRD-PARTY PERSONNEL SECURITY
PS-08	PERSONNEL SANCTIONS
RA-01	RISK ASSESSMENT POLICY AND PROCEDURES
RA-02	SECURITY CATEGORIZATION
RA-03	RISK ASSESSMENT
RA-05	VULNERABILITY SCANNING
RA-05(01)	UPDATE TOOL CAPABILITY
RA-05(02)	UPDATE BY FREQUENCY / PRIOR TO NEW SCAN / WHEN IDENTIFIED
RA-05(05)	PRIVILEGED ACCESS
SA-01	SYSTEM AND SERVICES ACQUISITION POLICY AND PROCEDURES
SA-02	ALLOCATION OF RESOURCES
SA-03	SYSTEM DEVELOPMENT LIFE CYCLE
SA-04	ACQUISITION PROCESS
SA-04(01)	FUNCTIONAL PROPERTIES OF SECURITY CONTROLS
SA-04(02)	DESIGN / IMPLEMENTATION INFORMATION FOR SECURITY CONTROLS
SA-04(09)	FUNCTIONS / PORTS / PROTOCOLS / SERVICES IN USE
SA-05	INFORMATION SYSTEM DOCUMENTATION
SA-08	SECURITY ENGINEERING PRINCIPLES
SA-09	EXTERNAL INFORMATION SYSTEM SERVICES
SA-09(02)	IDENTIFICATION OF FUNCTIONS / PORTS / PROTOCOLS / SERVICES
SA-09(05)	PROCESSING, STORAGE, AND SERVICE LOCATION
SA-10	DEVELOPER CONFIGURATION MANAGEMENT

SA-11	DEVELOPER SECURITY TESTING AND EVALUATION
SA-11(01)	STATIC CODE ANALYSIS
SA-11(02)	THREAT AND VULNERABILITY ANALYSES
SA-11(05)	PENETRATION TESTING
SA-11(08)	DYNAMIC CODE ANALYSIS
SA-12	SUPPLY CHAIN PROTECTION
SA-14	CRITICALITY ANALYSIS
SA-15	DEVELOPMENT PROCESS, STANDARDS, AND TOOLS
SA-17	DEVELOPER SECURITY ARCHITECTURE AND DESIGN
SC-01	SYSTEM AND COMMUNICATIONS PROTECTION POLICY AND PROCEDURES
SC-02	APPLICATION PARTITIONING
SC-04	INFORMATION IN SHARED RESOURCES
SC-05	DENIAL OF SERVICE PROTECTION
SC-07	BOUNDARY PROTECTION
SC-07(03)	ACCESS POINTS
SC-07(04)	EXTERNAL TELECOMMUNICATIONS SERVICES
SC-07(05)	DENY BY DEFAULT / ALLOW BY EXCEPTION
SC-07(07)	PREVENT SPLIT TUNNELING FOR REMOTE DEVICES
SC-08	TRANSMISSION CONFIDENTIALITY AND INTEGRITY
SC-08(01)	CRYPTOGRAPHIC OR ALTERNATE PHYSICAL PROTECTION
SC-10	NETWORK DISCONNECT
SC-12	CRYPTOGRAPHIC KEY ESTABLISHMENT AND MANAGEMENT
SC-13	CRYPTOGRAPHIC PROTECTION
SC-15	COLLABORATIVE COMPUTING DEVICES
SC-17	PUBLIC KEY INFRASTRUCTURE CERTIFICATES
SC-18	MOBILE CODE
SC-19	VOICE OVER INTERNET PROTOCOL

SC-20	SECURE NAME / ADDRESS RESOLUTION SERVICE (AUTHORITATIVE SOURCE)
SC-21	SECURE NAME / ADDRESS RESOLUTION SERVICE (RECURSIVE OR CACHING RESOLVER)
SC-22	ARCHITECTURE AND PROVISIONING FOR NAME / ADDRESS RESOLUTION SERVICE
SC-23	SESSION AUTHENTICITY
SC-28	PROTECTION OF INFORMATION AT REST
SC-28(01)	CRYPTOGRAPHIC PROTECTION
SC-31	COVERT CHANNEL ANALYSIS
SC-39	PROCESS ISOLATION
SC-44	DETONATION CHAMBERS
SI-01	SYSTEM AND INFORMATION INTEGRITY POLICY AND PROCEDURES
SI-02	FLAW REMEDIATION
SI-02(02)	AUTOMATED FLAW REMEDIATION STATUS
SI-03	MALICIOUS CODE PROTECTION
SI-03(01)	CENTRAL MANAGEMENT
SI-03(02)	AUTOMATIC UPDATES
SI-04	INFORMATION SYSTEM MONITORING
SI-04(02)	AUTOMATED TOOLS FOR REAL-TIME ANALYSIS
SI-04(04)	INBOUND AND OUTBOUND COMMUNICATIONS TRAFFIC
SI-04(05)	SYSTEM-GENERATED ALERTS
SI-05	SECURITY ALERTS, ADVISORIES, AND DIRECTIVES
SI-07	SOFTWARE, FIRMWARE, AND INFORMATION INTEGRITY
SI-07(01)	INTEGRITY CHECKS
SI-07(07)	INTEGRATION OF DETECTION AND RESPONSE
SI-08	SPAM PROTECTION
SI-08(01)	CENTRAL MANAGEMENT
SI-08(02)	AUTOMATIC UPDATES

SI-10	INFORMATION INPUT VALIDATION
SI-11	ERROR HANDLING
SI-12	INFORMATION HANDLING AND RETENTION
SI-16	MEMORY PROTECTION
PM-01	INFORMATION SECURITY PROGRAM PLAN
PM-02	SENIOR INFORMATION SECURITY OFFICER
PM-03	INFORMATION SECURITY RESOURCES
PM-04	PLAN OF ACTION AND MILESTONES PROCESS
PM-05	INFORMATION SYSTEM INVENTORY
PM-06	INFORMATION SECURITY MEASURES OF PERFORMANCE
PM-07	ENTERPRISE ARCHITECTURE
PM-08	CRITICAL INFRASTRUCTURE PLAN
PM-09	RISK MANAGEMENT STRATEGY
PM-10	SECURITY AUTHORIZATION PROCESS
PM-11	MISSION/BUSINESS PROCESS DEFINITION
PM-12	INSIDER THREAT PROGRAM
PM-13	INFORMATION SECURITY WORKFORCE
PM-14	TESTING, TRAINING, AND MONITORING
PM-15	CONTACTS WITH SECURITY GROUPS AND ASSOCIATIONS
PM-16	THREAT AWARENESS PROGRAM
AR-01	GOVERNANCE AND PRIVACY PROGRAM
IP-01	CONSENT
SE-01	INVENTORY OF PERSONALLY IDENTIFIABLE INFORMATION
TR-01	PRIVACY NOTICE
UL-01	INTERNAL USE

Exhibit O
Information Technology Infrastructure Library (ITIL) Severity Levels

Severity Levels

HHSC has adopted the Information Technology Infrastructure Library (ITIL) framework for service management. As part of this framework, each Incident and Problem is assessed in terms of its HHSC business Impact and the Urgency with which HHSC requires the Incident or Problem to be Resolved or a workaround to be implemented. The Incident or Problem shall be assigned a Severity Level based on this assessment. This Section qualitatively defines Severity Levels associated with Services.

"*Impact"* is defined under ITIL as a "measure of the business criticality of an Incident, Problem or Request for Change, often equal to the extent of a distortion of agreed or expected Key Performance Measures." As such, Impact can be assessed based on the effect of an *Incident* or *Problem* on HHSC's business operations. An Impact may be assessed by taking into account the number and business roles of the people affected, the business functions supported by the systems affected or mandates (e.g. regulatory, legal, or business) for provision of outputs in a prescribed timeframe.

"*Urgency*" is defined under ITIL as a "measure of the business criticality of an Incident or Problem based on the Impact and on the business needs of the Customer." As such, Urgency can be assessed based on how quickly the business of HHSC will be affected by the loss of Service resulting from the Incident or Problem. A high-impact Incident does not necessarily have an immediate Impact. For example, a system supporting end-of-month processing (impact "high") can be assessed as urgency "low" if it occurs early in the monthly processing cycle but may be assessed as "high" if it nears the end of the cycle. A system that supports HHSC in achieving online, real-time transactions may always be assessed as a "high" urgency, even if it is only of moderate impact.

There may be different Key Performance Measures associated with the Resolution of an Incident or Problem based on the assigned Severity Level.

1.1 Severity Level 1

1. A Severity Level 1 event is one that has a high impact on the operation of the affected Application or other Service and cannot be circumvented (i.e. there is no Workaround available), including an error or outage (period of unavailability or disruption of service) which negatively impacts compliance with regulatory mandated timeframes, or jeopardizes privacy of information or could lead to the imposition of penalties, fines, or other financial impacts on HHSC.
2. A Severity Level 1 event is further defined as:
    a. a life-safety event/issue;
    b. a critical impact to the security of data and information systems;
    c. a business/mission critical System, Service, Application System, Equipment or network component that is substantially unavailable or seriously impacts normal business operations;
    d. an error or outage (period of unavailability or disruption of service) that affects groups of people, or a single individual performing a business/mission critical function;
    e. an error or outage which:
        i. negatively impacts compliance with regulatory mandated mailing timeframes, or
        ii. jeopardizes privacy of information, or
        iii. could lead to the imposition of penalties, fines, or other financial impacts on HHSC.

3. An event, due to the immediacy of its effect on critical business functions, requires a Change be made on an immediate-response basis.

1.2 Severity Level 2

1. A Security Level 2 event can materially affect HHSC, causing a substantial impact; including missed output commitments not governed by regulatory mandates.
2. A Severity Level 2 event is defined as:
    a. a department or group can use a business-critical System, Service, Application System, Equipment or network component, but some functions are not available or functioning as they should, or
    b. an error or outage (period of unavailability or disruption of service) affects a group or groups of people, or a single individual performing a critical business function.
3. The effect of a Security Level 2 event is such that it does not require an immediate response, but it does require that a Change be made through the Change Management Process.

1.3 Severity Level 3

1. A Severity Level 3 event does not materially affect HHSC and does not cause a substantial impact but has the potential to do so if not resolved expeditiously.
2. A Severity Level 3 event is defined as:
    a. a group or individual experiences a situation accessing or using a System, Service, Application System or network component, or a key feature thereof, but the situation is not prohibiting the execution of productive work.
3. The effect of the event is such that it does not require an immediate response. If a Change is required, the Change Management Process will be followed.

1.4 Severity Level 4

1. A Severity Level 4 event is defined as an event that may require an extended Resolution time, but the individual or group has a reasonable workaround to use while waiting for the Resolution.
2. The event does not have an adverse impact on the business operations of HHSC because
    a. of either the nature of the fault or the extent of the fault and
    b. an acceptable workaround is already in place.
3. The effect of the event is such that it does not require immediate Resolution. If a Change is required, the Change Management Process will be observed.

EXHIBIT P – CONSENSUS SCORING RUBRIC
DEMONSTRATIONS

SOLICITATION #: HHS0011055
SOLICITATION TITLE: RFO for Electronic Visit Verification (EVV) System Management Services
RESPONDENT: (Insert name of Respondent whose proposal is being evaluated/scored)
DATE: (Insert date proposal was evaluated/scored)

****

DEMONSTRATIONS

****

SCORING SUMMARY

Demonstrations will add up to **10 additional points** to the Respondent's Final Written Response Score, the calculation of which will be the Total Score as defined by the Solicitation.

Each category will receive a raw score of 0-10. The points awarded will be calculated based on the raw score and the number of points available for each category. For example, if a category has 2 points available and the Respondent receives a raw score of 8/10 (80%), the Respondent would get 1.6 points for that category (0.8 x 2 = 1.6). There may be multiple [use cases or site visit items] per category. The evaluators will use the scoring guidelines to score the entire category of [use cases or site visit items] as one unit.

Raw Score: Excellent= 10 Acceptable= 7-9 Marginal= 4-6 Unacceptable= 1-3 Nonresponsive= 0

ID	Category	Raw Score (out of 10)	Number of Available Points	Points Awarded	Justification
1.	Clock-in and Clock-out Methods		3		
2.	Visit Maintenance		4		
3.	Profile Setup		1		
4.	Reporting		2		
Demonstration Score					
Final Written Response Score:					
Total Score = *Final Written Response Score + Demonstration Score.*					

EXHIBIT P – CONSENSUS SCORING RUBRIC
DEMONSTRATIONS

SOLICITATION #: HHS0011055
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RESPONDENT: (Insert name of Respondent whose proposal is being evaluated/scored)
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Specific Use Cases

No.	Category	Use Case	Discussion
1.	Clock-in and Clock-out Methods		
2.	Visit Maintenance		
3.	Profile Setup		
4.	Reporting		

EXHIBIT P – CONSENSUS SCORING RUBRIC
DEMONSTRATIONS

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SUPPLEMENTAL SCORING GUIDELINES FOR USE CASES ONLY (IT)

When considering the success of each scenario, evaluators must refer to **Section 4.2.8 (Demonstration Criteria), Table 35 – Guidelines for Use Case Evaluation,** of the solicitation.

Guidelines for Use Case Evaluation		
No.	**Guideline**	**Explanation**
1	Visibility of system status	The system should always keep users informed about what is going on, through appropriate feedback within reasonable time.
2	Match between system and the real world	The system should speak the user's language with words, phrases and concepts familiar to the user, rather than system-oriented terms. Follow real-world conventions and make information appear in natural order.
3	User control and freedom	Users often choose system functions by mistake and will need a clearly marked "emergency exit" to leave the unwanted state without having to go through an extended dialogue. Support undo and redo.
4	Consistency and standards	Users should not have to wonder whether different words, situations, or actions mean the same thing. Follow platform conventions.
5	Error prevention	Even better than good error messages, is a careful design which prevents a problem from occurring in the first place. Eliminate error-prone conditions or handle them gracefully.
6	Recognition rather than recall	Minimize the user's memory load by making objects, actions, and options visible. The user should not have to remember information form one part of the dialogue to another.
7	Flexibility and efficiency of use	Accelerators – unseen by the novice user – may often speed up interaction for the expert user such that the system can cater to both inexperienced and experienced users.
8	Help uses recognize, diagnose, and recover from errors	Error messages should be expressed in plain language (no codes), precisely indicate the problem, and constructively suggest a solution.
9	Avoid hard mental operations and lower workload	Do not force the user into hard mental operation and keep the user's workload at a minimum.
10	Avoid forcing the user to premature commitment	Do not force the user to perform a particular task or decision until it is needed. Will the user know why something must be done?
11	Provide functions that are of utility to the user	Consider whether the functionality described is likely to be useful to users and whether functions/data are missing.
Source: Kasper Hornbæk, University of Copenhagen, Dept. of Computer Science; Rune Thaarup Høegh, Aalborg University, Dept. of Computer Science; Michael Bach Pedersen, ETI A/S, Bouet Moellevej; and Jan Stage, University of Copenhagen, Dept. of Computer Science (2007), Use Case Evaluation (UCE): A Method for Early Usability Evaluation in Software Development.		

EXHIBIT P – CONSENSUS SCORING RUBRIC
DEMONSTRATIONS

SOLICITATION #: HHS0011055
SOLICITATION TITLE: RFO for Electronic Visit Verification (EVV) System Management Services
RESPONDENT: (Insert name of Respondent whose proposal is being evaluated/scored)
DATE: (Insert date proposal was evaluated/scored)

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Demonstrations

****

SCORING GUIDE

Excellent (Raw Score 10)	Respondent's Demonstration displays a high level of proficiency in applicable guidelines from the Guidelines for Use Case Evaluation table with innovative approaches that exceed the use case request. The Respondent's Demonstration relates directly to the use cases tested and use case Demonstration was successful in all instances for the category. The evaluation team has a high degree of confidence in the Respondent's ability to execute the requirements of the use cases for the category in production.
Acceptable (Raw Score 7-9)	Respondent's Demonstration displays a moderately high level of proficiency in applicable guidelines from the Guidelines for Use Case Evaluation table. The Respondent's Demonstration relates generally to the use cases tested and use case Demonstration was successful in all instances for the category with only minor issues. The evaluation team has confidence in Respondent's ability to execute the requirements of the use cases for the category in production.
Marginal (Raw Score 4-6)	Respondent's Demonstration displays an adequate level of proficiency in applicable guidelines from the Guidelines for Use Case Evaluation table. The Respondent's Demonstration may not relate to all use cases requested, and use case Demonstration was unsuccessful in several, but not an unacceptable number, of use cases for the category tested. The evaluation team has a somewhat low degree of confidence in the Respondent's ability to execute the requirements of the use cases for this category in production.
Unacceptable (Raw Score 1-3)	Respondent's Demonstration displayed a lack proficiency in applicable guidelines from the Guidelines for Use Case Evaluation table. The Respondent's Demonstration does not relate to the use cases requested and was unsuccessful in an unacceptable number for the use cases demonstrated for this category. The evaluation team has a very low degree of confidence Respondent's ability to execute the requirements of the use cases for this category in production.
Nonresponsive (Raw Score 0)	Respondent's Demonstration was unsuccessful in most or all use cases demonstrated for the category or presented use cases unrelated to what was requested, such that the Demonstration was nonresponsive to the requested Demonstration for that category. The Demonstration displayed a lack of proficiency in applicable guidelines from the Guidelines for Use Case Evaluation table. The evaluation team has no degree of confidence in Respondent's ability to execute the requirements of the use cases for this category in production.

*The relative success of the Demonstration of a use case scenario is determined by the consensus scoring team using subject matter experts based on the execution of the defined scenario being tested and is only a partial consideration in the final Demonstration score. Under no circumstances does the simple completion of all use cases mean that the Demonstration should fall into a specific scoring category, as several other considerations are made. The justifications for the score will be provided on the final consensus scoring rubric below. **A complete list of scenarios will be provided to the Respondents selected for Demonstrations prior to their Demonstration date.**

Exhibit Q: HHSC EVV Policies

HHSC periodically updates EVV policies. The following includes the HHSC EVV policies as of Nov. 1, 2021. Respondents may visit the HHSC EVV webpage for current policies.

Electronic Verification Visit (EVV) System Management Services
RFO No. HHS0011055

1000, Electronic Visit Verification Policy Handbook Introduction

- 1100 EVV Overview
- 1200 State Laws and Rule
- 1300 Federal Law
- 1400 Failure to use an EVV System
- 1500 Resources and Communications
- 1600 Key Terms

2000, EVV Stakeholders

- 2100 Payer
- 2200 Texas Medicaid and Health Care Partnership
- 2300 EVV Vendors
- 2400 EVV Proprietary System Operator
- 2500 Program Provider
- 2600 Financial Management Services Agency
- 2700 Member
- 2800 CDS Employer

3000, Programs and Services Required to Use EVV

- 3100, EVV Service Bill Codes

4000, EVV System and Setup

- 4100 EVV System Selection
- 4110 EVV Vendor System
- 4120 EVV Proprietary Systems
- 4130 Select an EVV System
- 4200 EVV Training
- 4210 EVV Training Requirements for Program Providers
- 4220 EVV Training Requirements for FMSAs
- 4230 Training Requirements for CDS Employers
- 4240 Training Requirements for Service providers and CDS Employees
- 4250 EVV Training Registration
- 4300 Credentialing
- 4400 Data Collection
- 4410 Data Collection Overview Diagram
- 4500 Service Authorizations
- 4600 Schedules
- 4700 EVV System Transfer
- 4710 Transferring EVV Systems
- 4720 How to Transfer to an EVV Vendor within the State Vendor Pool
- 4730 How to Transfer to an EVV Proprietary System

5000, EVV Proprietary System

- 5010 Eligibility to Use an EVV Proprietary System
- 5020 Reimbursement for Use of an EVV Proprietary System
- 5030 EVV Proprietary System Operator Responsibilities
- 5040 EVV Proprietary System Onboarding Process
- 5050 EVV Proprietary System Readiness Review
- 5060 Success or Failure of the Readiness Review
- 5070 EVV Proprietary System General Operations
- 5080 Access to the EVV Proprietary System
- 5090 Required EVV Proprietary System Standard Reports
- 5100 Compliance Reviews
- 5200 HHSC Cancellation of EVV Proprietary System Approval
- 5300 Transferring EVV Systems
- 5400 Fraud, Waste and Abuse

6000, EVV Visit Transaction

- 6100 EVV System
- 6200 EVV Aggregator
- 6300 EVV Portal

7000, Clock In and Clock Out Methods

- 7010 Manually Entered EVV Visits
- 7020 Mobile Method
- 7030 Home Phone Landline
- 7040 Alternative Device
- 7050 Using Multiple Clock in and Clock Out Methods
- 7060 EVV Services Delivered Outside the Member's Home

8000, Visit Maintenance

- 8010 Required Visit Maintenance
- 8020 Auto Verification, Exceptions and Schedules
- 8030 EVV System Validation
- 8040 EVV Aggregator Validation
- 8050 EVV Visit Maintenance Timeframes
- 8060 Visit Maintenance Unlock Request
- 8070 Visit Maintenance and Billing EVV Claims
- 8080 Last Visit Maintenance Date
- 8090 Rounding Rules
- 8100 Visit Maintenance Reduction Features

9000, EVV Reason Codes

- 9010 EVV Reason Code Free Text Requirements

10000, EVV Compliance Reviews

- 10010 EVV Usage Reviews
- 10020 EVV Landline Phone Verification Reviews
- 10030 EVV-Required Free Text Reviews
- 10040 HHSC EVV Informal Reviews and MCO Disputes
- 10050 EVV Formal Appeal of the Review

11000, Usage

- 11010 EVV Usage Score
- 11020 Manually Entered EVV Visit Transactions
- 11030 Rejected EVV Visit Transactions
- 11040 EVV Usage Reviews
- 11050 Compliance

12000, EVV Claims

- 12100 Claims Submission
- 12200 Claims Matching
- 12210 Claims Matching Process
- 12220 Exceptions to the Claims Matching Process
- 12230 Claims Match Result Codes

13000, Reports

- 13010 EVV Portal Standard Reports
- 13020 EVV System Standard Reports
- 13030 EVV Vendor Ad Hoc Reporting
- 13040 EVV Portal Search Tools

14000, Non-EVV Services

- 14000 Non-EVV Services

15000, Fraud, Waste and Abuse

- 15000 Fraud, Waste and Abuse

Section 1000, Electronic Visit Verification Policy Handbook Introduction

Revision 21-1; Effective November 1, 2021

The Electronic Visit Verification (EVV) Policy Handbook provides EVV standards and policy requirements that program providers and Financial Management Services Agencies (FMSAs) contracted with Texas Health and Human Services Commission (HHSC) and managed care organizations (MCOs) must follow. The EVV Policy Handbook also includes requirements for Consumer Directed Services (CDS) employers.

EVV standards and policy requirements do not replace or supersede program or licensure requirements. Program providers and FMSAs must follow all program and licensure rules and policies in addition to EVV policies.

The EVV Policy Handbook has EVV requirements for both HHSC and MCOs (the payers). Program providers and FMSAs must adhere to their individual contracts with HHSC or an MCO and contact the payer for questions on EVV and non-EVV requirements.

The requirements in this handbook apply to the programs and services identified in the HHSC Texas Administrative Code (TAC) Title 1, Part 15, Chapter 354, Subchapter O, RULE Section 354.4005, Applicability Code, Section Applicability.

1100 EVV Overview

Revision 21-1; Effective November 1, 2021

A program provider, FMSA or CDS employer must use an EVV vendor system or an HHSC-approved EVV proprietary system to electronically document the delivery of an EVV service.

EVV is a computer-based system that electronically documents and verifies service delivery information, such as date, time, service type and location for certain Medicaid service visits.

An EVV system must capture the following data elements:

- The type of service provided
- The name of the recipient to whom the service is provided
- The date and times the provider began and ended the service delivery visit
- The location, including the address and geolocation, at which the service was provided
- The name of the service provider who provided the service
- Other information the commission determines is necessary to ensure the accurate adjudication of Medicaid claims

To ensure that EVV is used for all required services, HHSC or an MCO will not pay an EVV claim without a matching EVV visit transaction.

Texas HHSC determines when a program provider, FMSA or CDS employer must use EVV based on the services delivered. EVV is required for all programs and services listed in the Programs and Services Required to Use EVV document.

1200 State Laws and Rule

Revision 21-1; Effective November 1, 2021

The following Texas governing rules require HHSC to implement an EVV program. Program providers or FMSAs contracted with HHSC and/or MCOs must follow the rules and associated policies established by HHSC when delivering certain Medicaid services.

EVV state statutes and rules include:

- Texas Government Code Section 531.024172
- Human Resource Code, Title 11, Chapter 161, Subchapter A, Section 161.086
- Texas Administrative Code, Title, 1 Part 15, Chapter 354, Subchapter O, Rule Section 354.4007

Texas EVV requirements do not exempt live-in caregivers.

1300 Federal Law

Revision 21-1; Effective November 1, 2021

The 21st Century Cures Act (the Cures Act), enacted by the U.S. Congress in Dec. 2016, added Section 1903(l) to the Social Security Act to require all states to use EVV.

The Cures Act requires the use of EVV for personal care services (PCS) provided under a State plan of the Social Security Act or under a waiver of the plan including sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k) and Section 1115; and home health care services (HHCS) provided under 1905(a)(7) provided under a State plan of the Social Security Act or a waiver of the plan. This includes services delivered under the CDS option.

States must implement EVV by the following deadlines or risk a loss of federal Medicaid matching dollars:

- PCS by Jan. 1, 2020.
    - Texas received approval for a one-year delay of the deadline to Jan. 1, 2021.
- HHCS by Jan. 1, 2023.
    - Texas may apply for a one-year delay of the deadline to Jan. 1, 2024

Failure to implement EVV in accordance with the Cures Act will result in a reduction of federal Medicaid funding for Texas.

1400 Failure to use an EVV System

Revision 21-1; Effective November 1, 2021

Program providers, FMSAs and CDS employers must ensure an approved EVV system is used to document the delivery of EVV-required services.

Failure to use an approved EVV system to document service delivery for required programs and services will result in denied or recouped EVV claims. Per the TAC Title, 1 Part 15, Chapter 354, Subchapter O, Rule Section 354.4009 HHSC and MCOs will not pay a claim for reimbursement unless the data from the EVV system corresponds with the claim line item and is consistent with an approved prior authorization.

Program providers and FMSAs who fail to use an EVV system may also be subject to contract actions, such as, but not limited to, corrective action(s) or contract termination. CDS employers who fail to use an EVV system may be subject to removal from the CDS option.

If the service provider or CDS employee fails to clock in and clock out of the EVV system, the program provider, FMSA or CDS employer must manually enter the visit into the EVV system. Manually entered visits will negatively impact EVV compliance.

In the event the EVV system is unavailable, the service provider or CDS employee must document service delivery information and submit the documentation to the program provider, FMSA or CDS employer for manual entry of an EVV visit.

Service delivery documentation should include:

- Program Provider, FMSA and CDS employer Name;
- Member First and Last Name
- Member Medicaid ID
- Services Delivered
- Date of the Visit
- Actual Time In and Actual Time Out
- Service provider First and Last Name
- Location of the Visit - in the home or in the community

Program providers, FMSAs and CDS employers must keep all service delivery documentation and manually enter EVV visits into the EVV system according to the service delivery documentation once the EVV system is operational or as otherwise instructed by HHSC.

1500 Resources and Communications

Revision 21-1; Effective November 1, 2021

All program providers, FMSAs and CDS employers must sign up for GovDelivery to receive the most current news and alerts related to EVV.

Program providers, FMSAs and CDS employers can visit the HHSC EVV webpage to access the most up to date information such as:

- EVV News and Alerts
- Programs and services which require the use of EVV
- Statutes and rules governing EVV
- Service bill codes for EVV
- EVV contact information guide
- EVV training requirements and resources

1600 Key Terms

Revision 21-1; Effective November 1, 2021

Consumer Directed Service (CDS) employer means a member or Legally Authorized Representative (LAR) who chooses to participate in the CDS option. A CDS employer is responsible for hiring and retaining a service provider who delivers a service.

Consumer Directed Services option means a service delivery option in which a member or LAR employs and retains a service provider and directs the delivery of a service.

Electronic Visit Verification (EVV) means the documentation and verification of service delivery through an EVV system.

EVV Aggregator means a centralized database that collects, validates, and stores statewide EVV visit data transmitted by an EVV System.

EVV Compliance Reviews means a set of standards established by Texas HHSC and MCOs to review on a regular basis to ensure program providers, FMSAs and CDS employers adhere to EVV requirements.

EVV Portal means an online system that allows users to perform searches and view reports associated with EVV visit data in the EVV Aggregator.

EVV proprietary system means an HHSC-approved EVV system that a program provider or FMSA may choose to use instead of an EVV vendor system that:

- is purchased or developed by a program provider or an FMSA
- is used to exchange EVV information with HHSC or an MCO
- complies with the requirements of Texas Government Code Section 531.024172 or its successors.

EVV Reason Code means a standardized HHSC-approved code entered in an EVV system to explain the specific reason a change was made to an EVV visit transaction.

EVV system means an EVV vendor system or an EVV proprietary system used to electronically document and verify the data elements for a visit conducted to provide an EVV service.

EVV System Administrator means a person appointed by a program provider or an FMSA to serve as the EVV System Administrator for the agency.

EVV vendor system means an EVV system provided by an EVV vendor selected by the claims administrator, on behalf of HHSC that a program provider or FMSA may opt to use instead of an EVV proprietary system.

EVV visit maintenance means a process used by the program provider, FMSA, or CDS employer to correct the identification and visit data in the EVV system to accurately reflect the delivery of service.

EVV visit transaction means a data record generated by an EVV system that contains data elements for a visit conducted to provide an EVV service.

Financial Management Service Agency (FMSA) means 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).

Member means a person eligible to receive Medicaid services requiring the use of Electronic Visit Verification under TAC, Chapter 354.

Payer means HHSC or an MCO whose contracted program providers and FMSAs are required to use EVV.

Program Provider (Provider) means an entity that contracts with HHSC or an MCO to provide an EVV service.

Service provider (or CDS employee) means a person who provides an EVV service and who is employed or contracted by:

A. a program provider; or
B. a CDS employer

Service Responsibility Option (SRO) means a service delivery option in which a member or LAR 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.

For more key terms and definitions, refer to the Resources section on the HHSC EVV webpage for the EVV Glossary of Terms (PDF).

Section 2000, EVV Stakeholders

Revision 21-1; Effective November 1, 2021

The following EVV stakeholders must meet all state and federal EVV requirements:

- Payers (HHSC and MCOs)
- Texas Medicaid and Healthcare Partnership (TMHP)
- EVV vendors
- Program providers delivering services under the agency option
- FMSAs
- Medicaid members and SRO participants
- CDS employers

2100 Payers

Revision 21-1; Effective November 1, 2021

The payers are responsible for administering the EVV program and enforcing EVV requirements.

The payer's responsibilities include, but are not limited to:

- Following state and federal requirements for processing claims for services required to use EVV
- Developing EVV policies, processes, and procedures
- Performing EVV compliance of program providers and FMSAs

In Texas, HHSC requires EVV for Medicaid personal care services authorized by the following HHSC programs:

- Long-term Care Fee-for-Service
- Acute Care FFS
- Managed Care

HHSC is the payer for Long-term Care and acute care services administered by the state, known as Fee-for-Service.

Long-Term Care (LTC) Fee-for-Service (FFS)

Programs
Community Attendant Services (CAS)
Family Care (FC)
Community Living Assistance and Support Services (CLASS) Waiver
Primary Home Care (PHC)
Deaf Blind Multiple Disability (DBMD) Waiver
Home and Community-based Services (HCS) Waiver
Texas Home Living (TxHmL) Waiver

Acute Care FFS

Programs
Personal Care Services (PCS)
Community First Choice (CFC)
Youth Empowerment Services (YES) Waiver
Home and Community-based Services-Adult Mental Health (HCBS-AMH) Waiver

MCOs are the payers for managed care services under contract with the state.

Managed Care

Programs
STAR Health
STAR Health - Medically Dependent Children's Program (MDCP) Covered Services
STAR+PLUS
STAR+PLUS Home and Community Based Services (HCBS)
STAR Kids
STAR Kids MDCP Covered Services
STAR+PLUS Medicare-Medicaid Plan (MMP)

2200 Texas Medicaid and Health Care Partnership

Revision 21-1; Effective November 1, 2021

Texas Medicaid and Healthcare Partnership (TMHP) is the state's claims administrator and is responsible for the Medicaid Management Information System (MMIS) where the EVV Aggregator resides. TMHP is also responsible for the EVV Portal, the EVV vendor pool and coordinates all data exchange for EVV systems.

TMHP responsibilities include, but are not limited to, the following:

- Processing claims for EVV services, including forwarding claims to MCOs
- Paying claims for Acute Care FFS on behalf of HHSC
- Managing the EVV Aggregator and EVV Portal
- Selecting and managing the approved EVV vendors on behalf of HHSC
- Training on the EVV Portal

The TMHP EVV webpage has more information.

2300 EVV Vendors

Revision 21-1; Effective November 1, 2021

EVV vendor responsibilities include, but are not limited to, the following:

- Adhering to all HHSC EVV vendor business rules for system operation
- Following all EVV requirements such as:
  - The HHSC EVV Policy Handbook and policies on the HHSC EVV webpage
  - TAC Chapter 354 Subchapter O
- Supporting multiple clock in and clock out methods required to use the EVV vendor system
- Providing EVV system training and technical support

Please refer to 4100 EVV System Selection for more information.

2400 EVV Proprietary System Operator

Revision 21-1; Effective November 1, 2021

EVV Proprietary System Operator (PSO) is a program provider or FMSA that selects to use an EVV system to meet HHSC EVV requirements, instead of an EVV vendor system from the state vendor pool.

EVV PSO responsibilities include but are not limited to:

- Adhering to all HHSC EVV proprietary system business rules for system operation
- Following all EVV requirements such as:
  - The HHSC EVV Policy Handbook and policies on the HHSC EVV webpage
  - TAC Chapter 354 Subchapter O
- Supporting one or more clock in and clock out methods required to use the EVV proprietary system
- Providing EVV system training and technical support

Please refer to 5000, EVV Proprietary System for more information.

2500 Program Provider

Revision 21-1; Effective November 1, 2021

Program provider responsibilities for EVV include but are not limited to:

- Following all EVV requirements such as:
  - The HHSC EVV Policy Handbook and policies on the HHSC EVV webpage
  - TAC Chapter 354 Subchapter O
- Following policies and requirements of their Medicaid program
- Following other applicable HHSC and MCO requirements
- Completing all required EVV training
- Using the EVV system
- Ensuring service providers use the EVV system to clock in and clock out during visits
- Managing program provider, member and service provider data within the EVV system

2600 Financial Management Services Agency

Revision 21-1; Effective November 1, 2021

Financial Management Services Agency (FMSA) responsibilities for EVV include but are not limited to:

- Following all EVV requirements such as:
  - The HHSC EVV Policy Handbook and policies on the HHSC EVV webpage
  - TAC Chapter 354 Subchapter O
- Following policies and requirements of their Medicaid program
- Following other applicable HHSC and MCO requirements
- Review Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities, with the CDS employer
  - Submit Form 1722 within 10 business days of a written request from an MCO
- Completing all required EVV training
- Using the EVV system
- Managing FMSA, CDS employers, member and service provider data within the EVV system

2700 Member

Revision 21-1; Effective November 1, 2021

Member responsibilities for EVV include but are not limited to:

- Reviewing and signing the Form 1718, Responsibilities and Additional Information
- Notifying the program provider if a service provider asks the member to clock in or clock out of the EVV system for them

2800 CDS Employer

Revision 21-1; Effective November 1, 2021

CDS Employer responsibilities for EVV include but are not limited to:

- Complete all required EVV training
- Train their service providers on the use of the EVV system
- Ensure the service provider uses the EVV system to clock in when services begin and clock out when services end
- Approve time worked by the service provider

Section 3000, Programs and Services Required to Use EVV

Revision 21-1; Effective November 1, 2021

The programs and services required to use EVV are also defined in the HHSC Texas Administrative Code Rule Section 354.4005, Applicability.

A summary of the Personal Care Services Required to use EVV (PDF) is also available on the HHSC EVV webpage.

3100 EVV Service Bill Codes

Revision 21-1; Effective November 1, 2021

The EVV Service Bill Codes Table provides current billing codes for EVV-relevant services in long-term care, acute care and managed care programs. Program providers and FMSAs must use the appropriate Healthcare Common Procedure Coding System (HCPCS) and modifier combinations in the EVV Services Bill Codes table to prevent EVV visit transaction rejections and EVV claim match denials.

Section 4000, EVV System and Setup

Revision 21-1; Effective November 1, 2021

All program providers and FMSAs must implement and begin using EVV prior to submitting a claim for reimbursement for a service required to use EVV.

The program provider or FMSA must complete the following steps prior to using an EVV system.

Step 1: Select an EVV system (refer to 4100 EVV System Selection)

- EVV vendor system
- EVV proprietary system

Step 2: Complete all EVV trainings (refer to 4200 EVV Training):

- EVV System
- EVV Policy
- EVV Portal

Step 3: Complete EVV system Onboarding

- Manually enter or electronically import identification data (refer to 4400 Data Collection)
- Enter or verify member service authorizations (refer to 4500 Service Authorizations)
- Setup member schedules (if required) (refer to 4600 Schedules)
- Create the CDS employer profile for CDS employer credentials to the EVV system

4100 EVV System Selection

Revision 21-1; Effective November 1, 2021

State and federal law require program providers and FMSAs to use an EVV system for Medicaid services required to use EVV.

Program Providers and FMSAs must complete the following:

- Select a single EVV system
- Complete the EVV system training, EVV policy training and EVV Portal Trainings

- Complete the EVV system onboarding process
- Begin using the EVV system

Failure to use an EVV system to verify and document the occurrence of a service visit will result in the denial or recoupment of EVV claims by HHSC and MCOs.

Subcontracted providers must use the EVV system selected by the program provider directly contracted with HHSC or an MCO. CDS employers must use the EVV system selected by their FMSA.

There are two types of EVV systems:

- EVV vendor systems from the state vendor pool
- EVV proprietary systems purchased or developed by a program provider or FMSA

4110 EVV Vendor Systems

Revision 21-1; Effective November 1, 2021

An EVV vendor is an entity contracted with TMHP, the state's claims administrator. This vendor provides an HHSC-approved EVV system at no cost to the program provider, FMSA or CDS employer. An EVV vendor also provides EVV system training and support to its users. The program provider or FMSA may select one of the following EVV vendors available from the state vendor pool.

State Vendor Pool		
EVV Vendor	**EVV Vendor System Name**	**EVV Vendor Contact Information**
DataLogic Software, Inc.	**Vesta EVV**	**Website:** vestaevv.com/ Phone: 844-880-2400
First Data Government Solutions	**AuthentiCare EVV**	**Website:** solutions.fiserv.com/authenticare-tx Phone: 877-829-2002

EVV vendor responsibilities include, but are not limited to the following:

- Adhering to all HHSC EVV vendor business rules for system operation
- Following HHSC EVV Policy
- Supporting multiple clock in and clock out methods required to use the EVV system
- Providing EVV system training and technical support

4120 EVV Proprietary Systems

Revision 21-1; Effective November 1, 2021

An EVV proprietary system is an HHSC-approved EVV system that a program provider or FMSA may choose to use instead of an EVV vendor system that:

A. is purchased or developed by a program provider or an FMSA;
B. is used to exchange EVV information with HHSC or an MCO; and
C. complies with the requirements of Texas Government Code Section 531.024172 or its successors.

An EVV PSO is a program provider or FMSA that chooses to use an EVV proprietary system by completing the EVV Proprietary System Request Form to initiate the proprietary system onboarding and approval process.

A program provider or FMSA who chooses to operate their own EVV proprietary system agrees to:

- Forego use of one of the cost-free EVV systems provided by the state as part of the EVV vendor pool.
- Assume full responsibility for the design, development, operation and performance of the EVV proprietary system.
- Assume responsibility for all costs to develop, implement, operate and maintain the EVV proprietary system.
- Ensure the accuracy of EVV data collected, stored and reported by the proprietary system. Take responsibility for the submission of EVV visit transactions to the EVV Aggregator.
- Assume all liability and risk for the use of the EVV proprietary system.
- Maintain all system data, backup data, and historical data to comply with and support all legal, regulatory and business needs.
- Train all EVV proprietary system users, including state and MCO staff.
- Provide system access to state staff, TMHP staff, MCO staff (if applicable) and other state and federal entities as required.

- Take responsibility for the provision and management of HHSC-approved electronic verification methods and devices associated with the EVV proprietary system.

Please refer to Section 5000, EVV Proprietary System for more information.

4130 Select an EVV System

Revision 21-1; Effective November 1, 2021

EVV Vendor Selection

To select an EVV vendor from the state vendor pool, the program provider or FMSA and, the agency's appointed EVV system administrator, must complete, sign and date the EVV Provider Onboarding Form located on the EVV vendor's website.

The program provider or FMSA must submit an accurate and completed form directly to the selected EVV vendor. There is no charge to the program provider or FMSA to use an EVV vendor system from the state vendor pool.

EVV vendors may offer additional software such as billing solutions for a fee. HHSC does not require program providers or FMSAs to purchase any software when selecting an EVV vendor system.

HHSC encourages program providers and FMSAs to research all EVV vendors before they select one. For example, program providers and FMSAs should learn about the vendor clock in and clock out methods, visit maintenance process and training options.

To aid in the selection of an EVV vendor, the program provider or FMSA may visit the TMHP EVV Vendors webpage to learn more about the EVV vendor systems in the state vendor pool.

EVV Proprietary System Selection

To elect the use of an EVV proprietary system, the program provider or FMSA and the agency's appointed EVV System Administrator, must visit the TMHP Proprietary System webpage to review the proprietary system request and HHSC approval process.

Interested program providers or FMSAs must submit the EVV Proprietary System Onboarding Request Form to apply for EVV proprietary system implementation.

A program provider or FMSA must complete the EVV proprietary system onboarding process and receive written approval from HHSC in order to use their system to comply with HHSC EVV requirements.

EVV System Administrator

The program provider or FMSA must appoint a person to serve as the EVV System Administrator for the agency. This person will administer access to the EVV system for agency personnel and ensure that the program provider or FMSA enters all necessary data into the system for EVV visit collection to begin.

The EVV System Administrator will assign user account access for agency staff. The user accounts may include subcontracted, or third party, personnel as necessary to complete visit maintenance tasks. Only designated staff with appropriate security credentials may add or update the program provider or FMSA EVV user accounts. The EVV System Administrator must ensure that users of the agency's EVV system follow HIPAA laws and appropriate security protocols.
Contact TMHP at EVV@tmhp.com for questions regarding EVV system selection.

4200 EVV Training

Revision 21-1; Effective November 1, 2021

The HHSC EVV Training Policy requires program providers, FMSAs and CDS employers or any staff who performs EVV system operations to complete all required EVV training:

- Prior to using either an EVV vendor system or an EVV proprietary system
- Yearly thereafter

If the program provider or FMSA does not take the following EVV training, it may result in the payer taking contract and enforcement action:

- EVV System
- EVV Policy
- EVV Portal

If the CDS employer does not take EVV system and EVV policy trainings, the following may result:

- CDS employee(s) may experience a delay in payment.
- CDS employer must either:
  - Complete a corrective action plan
  - Leave the CDS option and begin using a provider agency for services required to use EVV

The EVV vendor or EVV PSO will not grant access to the EVV system until the program provider, FMSA or CDS employer has completed EVV system training. An EVV PSO is a program provider or an FMSA who has selected to use their own EVV proprietary system.

The payers may request proof of completed trainings. Do not submit proof of training completion to HHSC, an MCO or TMHP unless requested.

Proof of completed trainings must include the:

- Name of the training
- Name of the person completing the training
- Date of the training

Program providers, FMSAs and CDS employers can review the HHSC EVV Required Training Requirements Checklists (PDF) for more information.

The EVV vendor, HHSC, MCOs and TMHP may offer EVV trainings in different delivery methods, such as but not limited to:

- Computer-based training (CBT)
- Instructor-led training (ILT)
- Webinars

Contact your EVV vendor, HHSC, MCO or TMHP for details on specific training delivery methods.

4210 EVV Training Requirements for Program Providers

Revision 21-1; Effective November 1, 2021

Program providers must complete the required EVV training shown in the table below.

EVV system users are staff who have access to the EVV system, perform EVV system operations and visit maintenance in the EVV vendor system or EVV proprietary system. EVV portal users are staff who have access to the EVV portal, conduct visit or claim searches and generate reports. Billing staff are staff who submit Medicaid claims for an EVV-required service.

Program Providers:

EVV Training Requirement	Taken By	Provided By
EVV System Training	EVV system users	EVV vendor or EVV PSO
EVV Portal Training	• EVV portal users • Billing staff	TMHP
EVV Policy Training	• EVV system users • EVV portal users • Billing staff	Payer (HHSC or MCO)

Program providers must keep up-to-date training records for their staff.

Program providers who have received written approval from HHSC to use an EVV proprietary system must train all users on the proper use of the EVV proprietary system, to include clock in and clock out methods.

4220 EVV Training Requirements for FMSAs

Revision 21-1; Effective November 1, 2021

FMSA staff must complete the required EVV training shown in the table below.

EVV system users are staff who have access to the EVV system, perform EVV system operations and complete visit maintenance in the EVV vendor system or EVV proprietary system. EVV portal users are staff who have access to the EVV portal, conduct visit or claim searches and generate reports. Billing staff are staff who submit Medicaid claims for an EVV-required service.

FMSAs:

EVV Training Requirement	Taken By	Provided By
EVV System Training	• FMSA EVV system users	EVV vendor or EVV PSO
EVV Portal Training	• FMSA EVV portal users • FMSA billing staff	TMHP
EVV Policy Training	• FMSA EVV system users • FMSA EVV portal users • FMSA billing staff	Payer (HHSC or MCO)

FMSAs must keep up-to-date training records for their staff. FMSAs must also keep up-to-date training records for their CDS employers.

4230 EVV Training Requirements for CDS Employers

Revision 21-1; Effective November 1, 2021

CDS employers must complete the required EVV training shown in the table below, if applicable. If the CDS employer has a designated representatives (DRs), the DR must complete the required EVV training shown in the table below based on the option selected by the CDS employer.

CDS employers must train their CDS employees on the clock in and clock out methods with assistance from the EVV vendor or the EVV PSO.

See table below for CDS employer training based on delegation of visit maintenance on Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities.

If a CDS employer switches their option by completing a new Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities, they must take the proper training for that option, as detailed in the table

below, before being granted greater access to the EVV system by an EVV vendor, their FMSA or an EVV PSO.

Note: HHSC policy training is available in Spanish or English.

If the CDS employer selected:
Note: EVV policy trainings may vary if your payer is an MCO. Please check with your MCO if you have questions on EVV policy trainings and requirements.

Form 1722 Options	EVV Training Requirement	Provided By
Option 1: The CDS employer agrees to complete all visit maintenance and approve their employee's time worked in the EVV system.	• Full EVV system training • Includes clock in and clock out methods	EVV vendor or EVV PSO (FMSA)
	• EVV policy training	Payer (HHSC or MCO) or FMSA
Option 2: The CDS employer elects to have their FMSA complete all visit maintenance on their behalf. However, the CDS employer will approve their employee's time worked in the EVV system.	• Full EVV system training • Includes clock in and clock out methods	EVV vendor or EVV PSO (FMSA)
	• EVV policy training	Payer (HHSC or MCO) or FMSA

Option 3: The CDS employer elects to have their FMSA complete all visit maintenance on their behalf and confirm the employee's time worked in the EVV system based on approval documentation from the CDS employer.	• Overview of EVV system • Includes clock in and clock out methods	EVV vendor or EVV PSO (FMSA)
	• EVV policy training	Payer (HHSC or MCO) or FMSA

The CDS employer must keep up-to-date training records of their training completions and provide training records to their FMSA, HHSC or their MCO, if requested.

4240 Training Requirements for Service providers and CDS Employees

Revision 21-1; Effective November 1, 2021

Service providers and CDS employees must complete the required EVV training shown in the table below.

The EVV vendor or EVV PSO will provide materials and resources.

Service providers and CDS Employees:

EVV Training Requirement	Provided By
Clock In and Clock Out Methods	Program Provider or CDS Employer

The CDS employer must keep up-to-date training records of service provider and CDS employee training completions by using Form 1732. Form 1732 should be provided to the FMSA.

4250 EVV Training Registration

Revision 21-1; Effective November 1, 2021

To register for EVV training:

- EVV System: Visit your EVV vendor website or contact your EVV PSO (FMSA).
- EVV Policy: Visit the HHSC or MCO EVV webpage.
    - Access the HHSC Learning Portal then create an account.
- EVV Portal Training: Visit the TMHP website
    - Access the TMHP Learning Management System (LMS) and create an account.

For questions related to training, contact:

Topic	Contact
EVV Policy	• HHSC EVV Operations at EVV@hhs.texas.gov • Your MCO (refer to EVV Contact Guides found in Resources section on HHSC EVV webpage)
EVV Portal	• TMHP at EVV@tmhp.com
EVV vendor or EVV PSO System	• Your EVV vendor or EVV PSO (FMSA)

4300 Credentialing

Revision 21-1; Effective November 1, 2021

The FMSA is responsible for creating credentials (username and temporary password) for the CDS employer and the CDS employee.

For the CDS Employer
The credentials will be sent by the EVV system or the FMSA to the CDS employer based on the email account the FMSA entered in the EVV system.

If a member is not the CDS employer, the FMSA will include the CDS employer's name in the member profile and provide credentials to the CDS employer. If the member also has a DR, both the CDS employer and the DR will have their own unique credentials.

The CDS employer uses the credentials to log in to the EVV system. After the CDS employer logs in to the EVV system, the temporary password can be changed, and a new unique password can be created.

The FMSA can only see the CDS employer's username and email address in the EVV system. However, both the FMSA and the CDS employer can change the password.

There are two common reasons why a CDS employer has not received their credentials, and therefore must contact their FMSA.

- The FMSA has not created credentials for the CDS employer
- The information entered by the FMSA was incorrect
  - The FMSA can correct the email address and resend credentials to the CDS employer

For the CDS Employee
The FMSA or the CDS employer provides the credentials to the CDS employee.

Contact your EVV vendor to determine if the FMSA or the CDS employer will provide the CDS employee credentials.

Program Providers
The program provider is responsible for creating credentials such as username and temporary password, for all program provider staff including service providers.

4400 Data Collection

Revision 21-1; Effective November 1, 2021

In alignment with Texas Government Code Section 531.024172 and federal requirements, the EVV system must allow for verification of the following critical data elements relating to the delivery of Medicaid services:

- The type of service provided
- The name of the recipient to whom the service is provided
- The date and times the provider began and ended the service delivery visit
- The location, including the address, at which the service was provided
- The name of the person who provided the service
- Other information the commission determines is necessary to ensure the accurate adjudication of Medicaid claims

HHSC categorizes critical data elements as:

- Identification data
- Visit data

Identification Data
Before using the EVV system, the program provider or FMSA must enter or import the following identification data into the EVV system:

- The type of service provided (Service Authorization Data)
- The name of the recipient to whom the service is provided (Member Data)
- The name of the person who provided the service (Service provider Data)
- Other information HHSC determines is necessary to ensure the accurate adjudication of Medicaid claims (Program provider or FMSA information)

Program providers and FMSAs must manually enter or electronically import identification data during the EVV system onboarding process, or after the onboarding process for new members.

Once the program provider or FMSA has completed the entry of all identification data, the service provider or CDS employee may begin to use the EVV system. Program Providers and FMSAs must maintain the identification data as needed.

The program provider or FMSA is solely responsible for maintaining accurate data within the EVV system, including information managed or maintained by a third party or subcontractor. If the program provider or FMSA identifies data errors, they must take action to resolve the inaccuracy.

Visit Data
When the service provider clocks in and clocks out of the EVV system, the system captures the following visit data:

- The type of service provided (Service Authorization Data)
- The name of the recipient to whom the service is provided (Member Data)
- The date and times the provider began and ended the service delivery visit
- The location, including the address, at which the service was provided
- The name of the person who provided the service (Service provider Data)

Missing or incorrect identification data and visit data in the EVV system will result in rejected EVV visit transactions, denied or recouped EVV claims and inaccurate EVV standard reports.

4410 Data Collection Overview Diagram

Revision 21-1; Effective November 1, 2021

The EVV system:

- Electronically captures and verifies critical data elements to confirm service delivery.
- Validates identification data against data received from the Texas Medicaid system.
- Sends a complete, accurate and validated EVV visit transaction to the EVV Aggregator for use in the EVV claims matching process.

Contact your payer for questions about the data elements.

Contact your EVV vendor or EVV PSO for questions about entering data into the EVV system.

4500 Service Authorizations

Revision 21-1; Effective November 1, 2021

The HHSC EVV Service Authorization Policy requires program providers and FMSAs to enter and maintain the most current service authorization in the EVV system for each member receiving services required to use EVV.

The payers must authorize the program provider or FMSA to deliver services to a member. An authorization is documentation for the services a member is eligible to receive.

A program provider or FMSA may receive authorization documentation for member services through the:

- Service authorization
- Prior authorization
- Individual plan of care (IPC)
- Individual service plan (ISP)
- Community care service notification

The EVV system refers to authorization documentation as a service authorization.

Information from the service authorization must include, at a minimum:

- Payer
- Provider (National Provider Identifier (NPI)/Atypical Provider Identifier (API), Texas Identification Number (TIN), Texas Provider Identifier (TPI), if applicable)
- Member Medicaid ID
- Service group, service code or Healthcare Common Procedure Coding System (HCPCS) and Modifier, (if applicable)
- Authorization start date
- Authorization end date

The EVV system will electronically retrieve the most recent service authorization from TMHP for the following HHSC programs:

- Community Living Assistance and Support Services (CLASS) Waiver
- Deaf Blind Multiple Disabilities (DBMD) Waiver
- Personal Care Services (PCS)
- Primary Home Care (PHC)
- Family Care (FC)
- Community Attendant Services (CAS)
- Youth Empowerment Service (YES) Waiver

The EVV vendor or an EVV PSO will instruct program providers and FMSAs on the entry of service authorizations into the EVV system.

Program providers and FMSAs must enter service authorizations manually into the EVV system for the following HHSC and managed care programs:

- Home and Community-based Services (HCS) Waiver
- Texas Home Living (TxHmL) Waiver
- Home and Community-based Services - Adult Mental Health (HCBS-AMH)
- STAR Kids
- STAR Kids Medically Dependent Children's Program (MDCP)
- STAR+PLUS
- STAR+PLUS Home and Community Based Services (HCBS)
- STAR+PLUS Medicare-Medicaid Plan (MMP)
- STAR Health
- STAR Health MDCP

The program provider or FMSA may manually enter service authorization changes and updates into the EVV system at any time.

Failure to enter the most current service authorization issued by the payer into the EVV system may result in the need for visit maintenance or the payer may deny or recoup related claims.

Program providers and FMSAs must confirm all electronically received service authorization information in the EVV system to ensure the accuracy for each member.

Contact your payer with questions about service authorization requirements.

4600 Schedules

Revision 21-1; Effective November 1, 2021

EVV systems do not require schedules.

Program and payer requirements for following a service delivery schedule, service delivery requirements and using schedules in the EVV system vary. Program providers, FMSAs and CDS employers must follow their program and payer schedule and service delivery requirements or EVV claims may be recouped.

The EVV vendor or EVV PSO will provide instructions on how the EVV system will verify EVV visits with or without schedules.

Contact your payer with questions about schedule requirements.

4700 EVV System Transfer

Revision 21-1; Effective November 1, 2021

This policy provides guidance on transferring from one EVV system to another EVV system and includes the transfer to or from an EVV proprietary system.

A program provider or FMSA may:

- Transfer from one EVV vendor system to another EVV vendor system within the state vendor pool.
- Transfer from an EVV vendor system to an EVV proprietary system.
- Transfer from an EVV proprietary system to an EVV vendor system.
- Transfer from one EVV proprietary system to another EVV proprietary system.

Program providers and FMSAs that have not selected an EVV system must follow 4100 EVV System Selection.

4710 Transferring EVV Systems

Revision 21-1; Effective November 1, 2021

Program providers and FMSAs must request a transfer to another EVV system at least 120 days prior to the desired transfer date.

- If transferring to a vendor within the state vendor pool:
    - The new vendor will communicate with the current vendor to determine the timing of the transfer.
    - The transfer may occur sooner than 120 days if the program provider or FMSA and the EVV vendors agree on an earlier date.
- If transferring to an EVV proprietary system:
    - TMHP will communicate the details of the transfer to the current vendor.
    - The transfer may only occur after HHSC agrees on an implementation date with the program provider or FMSA, and HHSC provides written approval of the EVV proprietary system.

The 120-day transfer time frame allows for:

- Training on the new EVV system
- Transfer and verification of identification and visit data elements
- Completion of all import tasks necessary to begin using the new EVV system

The effective transfer date will be the date the program provider or FMSA begins using the selected EVV system. Program providers and FMSAs must continue to use their current EVV system until they have successfully transferred to the new EVV system.

After transferring from an EVV vendor system, the program provider or FMSA must collect and return all alternative devices supplied by the prior EVV vendor.

FMSAs must notify CDS employers 60 days in advance of the planned transfer date to allow time for retraining employers and their employees on the new EVV system.

4720 How to Transfer to an EVV Vendor within the State Vendor Pool

Revision 21-1; Effective November 1, 2021

To initiate a transfer to an EVV vendor system, the program provider or FMSA:

- Must submit a complete and accurate EVV Provider Onboarding Form directly to the selected EVV vendor.
    - The EVV vendor will provide further onboarding and EVV system training instructions once the form is received.
    - All required EVV system trainings must be completed prior to any user receiving access to the EVV system.

Program providers or FMSAs who transfer to a new EVV vendor system:

- Must follow 4100 EVV System Selection.
- Will not receive a grace period and will be subject to all EVV policies, including those related to compliance and enforcement.

- May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.

4730 How to Transfer to an EVV Proprietary System

Revision 21-1; Effective November 1, 2021

To initiate a transfer to an EVV proprietary system, the program provider or FMSA:

- Must submit an EVV Proprietary System Request Form directly to TMHP.
    - TMHP will contact the program provider or FMSA and provide additional instructions and set up an initial planning meeting.
    - The program provider or FMSA, TMHP and HHSC will establish an implementation date for the EVV proprietary system.

Program providers or FMSAs who transfer to an EVV proprietary system:

- Must provide training on the EVV proprietary system and must ensure EVV system training is complete prior to any user receiving access to the EVV proprietary system. See Section 5000, EVV Proprietary System for more information.
- Will not receive a grace period and will be subject to all EVV policies, including those related to compliance and enforcement.
- May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.

Contact the selected EVV vendor or email TMHP at evv@tmhp.com for questions about the EVV system transfer.

Section 5000, EVV Proprietary System

Revision 21-1; Effective November 1, 2021

HHSC EVV Proprietary Systems Policy explains the selection and use of an EVV proprietary system by a program provider or FMSA.

Section 531.024172 of the Texas Government Code provides the authority for HHSC to recognize an EVV proprietary system to comply with EVV

requirements. Program providers or FMSAs authorized by HHSC to operate an EVV proprietary system must comply fully with the EVV Policy Handbook including all specific EVV proprietary system policies, except where noted.

An EVV proprietary system is an HHSC-approved EVV system that a program provider or FMSA may opt to use, instead of an EVV vendor system from the state vendor pool, that:

- Is purchased or developed by a program provider or an FMSA.
- Is used to exchange EVV information with the EVV Aggregator.
- Complies with the requirements of Texas Government Code Section 531.024172 or its successors.

A PSO is a program provider or FMSA that chooses to use an EVV proprietary system by completing the EVV Proprietary System Request Form to initiate the proprietary system onboarding and approval process.

The program provider or FMSA seeking HHSC approval to become a PSO must meet applicable EVV Proprietary System Business Rules and follow all HHSC EVV standards and requirements. These include, but not limited to:

- State and federal laws governing EVV
- Health Insurance Portability and Accountability Act (HIPAA) and the American Disabilities Act (ADA)
- HHSC EVV Policy Handbook
- HHSC EVV Policies posted on the HHSC EVV webpage
- EVV Proprietary System Business Rules
- EVV PSO Onboarding Process

The PSO must continue to follow all requirements specified through HHSC or MCO program provider or FMSA contracts and will be subject to HHSC and MCO EVV Compliance Reviews and other compliance monitoring under the program provider or FMSA contract(s).

The PSO must inform the state if the EVV proprietary system is not compliant with EVV standards and requirements and may be subject to periodic verification, system testing, and auditing as specified by HHSC.

5010 Eligibility to Use an EVV Proprietary System

Revision 21-1; Effective November 1, 2021

Program providers and FMSAs under contract with HHSC or an MCO and required to use EVV may be eligible to operate and use an EVV proprietary system.

Program providers or FMSAs using an EVV vendor system from the state vendor pool must continue to use their current EVV vendor until the program provider or FMSA has:

- Successfully completed the EVV Proprietary System onboarding process.
- Received HHSC written approval within the appropriate timeline to meet EVV requirements and to operate an EVV proprietary system.

5020 Reimbursement for Use of an EVV Proprietary System

Revision 21-1; Effective November 1, 2021

HHSC does not directly reimburse program providers and FMSAs for the use of an EVV proprietary system. However, program providers and FMSAs can report costs related to their EVV proprietary system through established Medicaid cost reporting processes.

HHSC evaluates this data when setting future Medicaid rates. Not all Medicaid programs utilize cost reports.

Contact the HHSC Provider Finance Department at ProviderFinanceDept@hhs.texas.gov or contact your MCO for more information about Medicaid cost reporting.

5030 EVV Proprietary System Operator Responsibilities

Revision 21-1; Effective November 1, 2021

The PSO will build or modify their EVV proprietary system to meet Texas Government Code and EVV Proprietary System Business Rules governing the use of EVV proprietary systems.

The PSO:

- Agrees to forego use of one of the cost free EVV systems provided by the state as part of the EVV vendor pool.
- Assumes full responsibility for the design, development, operation and performance of the EVV proprietary system.
- Is responsible for all costs to develop, implement, operate and maintain the EVV proprietary system.
- Is responsible for the accuracy of EVV data collected, stored and reported by the proprietary system.
- Is responsible for the submission of EVV visit transactions to the EVV Aggregator.
- Assumes all liability and risk for the use of the EVV proprietary system.
- Maintains all system data, backup data and historical data to comply with and support all legal, regulatory and business needs.
- Will train all EVV proprietary system users, including state and MCO staff.
- Will provide system access to state staff, TMHP staff, MCO staff (if applicable) and other state and federal entities as required
- Is responsible for the provision and management of HHSC-approved electronic verification methods and devices associated with the EVV proprietary system.

The PSO must provide clock in and clock out method(s) at no cost to the member, HHSC, MCO or TMHP.

The PSO is solely responsible for the functionality and accuracy of all clock in and clock out methods distributed to the service provider and CDS employee.

The PSO must ensure use of the EVV proprietary system will not conflict with EVV Member Responsibilities and Additional Information or any other EVV policy, requirement, EVV Proprietary System Business Rule or Texas Government Code.

5040 EVV Proprietary System Onboarding Process

Revision 21-1; Effective November 1, 2021

A PSO must identify and assign key personnel to administer the EVV proprietary system. This must include an EVV system administrator that will serve as the primary contact for HHSC and TMHP. The EVV system administrator will perform, or assign a staff member to perform, all activities related to the onboarding and readiness of the EVV proprietary system.

The PSO must follow the EVV Proprietary System Onboarding Process posted on the TMHP Proprietary Systems webpage. The PSO may also refer to the HHSC EVV Proprietary Systems webpage for more information.

Prior to HHSC approval, the PSO must submit procedures and contact information to HHSC indicating how users will gain EVV proprietary system credentials, receive system training and access technical support.

The PSO must submit an EVV Proprietary System Request Form posted on the TMHP EVV Proprietary System webpage. The PSO must have a fully developed and compliant EVV PSO system which meets all HHSC requirements by the Readiness Review begin date for the selected Onboarding Session.

After submission of the EVV Proprietary System Request Form, HHSC, TMHP and the PSO will meet to review the detailed requirements for onboarding and the major milestones associated with the Readiness Review process.

The PSO must notify HHSC of any conflicts from the agreed project implementation timeline associated with the PSO Onboarding Sessions. If HHSC, TMHP and the PSO determine the completion of the timeline is at risk, HHSC may require the PSO to onboard with an EVV vendor system from the state vendor pool to meet EVV requirements.

The PSO may choose to implement the EVV proprietary system for one or more NPIs or API/TIN combinations when onboarding if the PSO intends to use the same EVV proprietary system for each NPI or API/TIN combination.

5050 EVV Proprietary System Readiness Review

Revision 21-1; Effective November 1, 2021

To determine approval for a PSO to operate an EVV proprietary system, HHSC and TMHP will conduct a validation process referred to as the Readiness Review as part of the onboarding process.

As part of the Readiness Review, the PSO must accomplish a series of tests designed to ensure the EVV proprietary system meets all HHSC requirements. The PSO must complete all required steps within the established timeline of the Readiness Review.

As part of the Readiness Review, HHSC will require the PSO to:

- Certify compliance with Texas Government Code Section 531.024172 and HHSC EVV Policy Handbook
- Ensure compliance to EVV Proprietary System Business Rules through a combination of certification, documentation and demonstration using specific HHSC-approved scenarios.
- Successfully complete Trading Partner Testing with TMHP to include system set up and submission of EVV visit transaction data according to specific HHSC-approved scenarios.

HHSC requires the PSO to complete EVV system access documentation for TMHP data exchange before beginning the Readiness Review process.

5060 Success or Failure of the Readiness Review

Revision 21-1; Effective November 1, 2021

The PSO must successfully complete the Readiness Review prior to HHSC approving the EVV proprietary system.

HHSC will determine the success or failure of the EVV proprietary system based on the outcome of the Readiness Review.

HHSC will notify the PSO in writing of the Readiness Review outcome.

If the PSO succeeds in passing the Readiness Review process, the PSO will complete the remaining onboarding tasks.

If the PSO fails the Readiness Review process, the PSO must select and onboard with an EVV vendor from the state pool to comply with HHSC EVV requirements.

Refer to 4100 EVV System Selection for more information.

5070 EVV Proprietary System General Operations

Revision 21-1; Effective November 1, 2021

EVV Proprietary System Training

The PSO assumes full responsibility for training all users on the proper use of the EVV proprietary system including clock in and clock out methods. Please see the EVV PSO Responsibilities section in this policy for more information.

Clock In and Clock Out Methods

The PSO must obtain written approval from HHSC for all clock in and clock out methods during the Readiness Review. The PSO must select one or more clock in or clock out method from the three HHSC-approved methods described in Section 7000, Clock In and Clock Out Methods.

The PSO must follow HHSC EVV policies and comply with specific EVV Proprietary System Business Rules related to the selected clock in and clock out method(s). HHSC may waive any rules and reports specific to a clock in and clock out method not selected.

Any alternative device approved by HHSC must derive the exact clock in and clock out date and time. If there is no geo-location capability within the device, the device must stay in the home even during an evacuation.

If the CDS employer, member, service provider or CDS employee provides the clock in and clock out method such as a:

- home phone landline; or
    - personal mobile device; and
    - the method malfunctions

The PSO or CDS employer must allow:

- manual entry of EVV visits; or
- offer a secondary clock in or clock out method.

Refer to Section 7000, Clock In and Clock Out Methods for more information.

EVV Proprietary System Maintenance

The PSO is fully responsible for ongoing maintenance of the EVV proprietary system.

The PSO may not make changes to its approved EVV proprietary system that conflict with any EVV Proprietary System Business Rules. In addition, the PSO must inform HHSC within two business days of discovery if the PSO is not compliant with any EVV Proprietary System Business Rules.

HHSC may change or update EVV standards, policies and requirements, including the EVV Proprietary System Business Rules. HHSC will notify the PSO of updates to policies and business rules. The PSO assumes full responsibility to make updates to the EVV proprietary system and gain HHSC approval when HHSC publishes new EVV Proprietary System Business Rules.

HHSC will allow the PSO 90 days to make necessary modifications to comply with updated policies and EVV Proprietary System Business Rules unless otherwise instructed by HHSC. In the event HHSC requires an emergency system or policy change, HHSC and the PSO will mutually agree on an earlier effective date.

The PSO must notify HHSC of any planned system changes that change a component of the EVV proprietary system which the PSO tested, demonstrated or documented during the Readiness Review. Based on the nature of the change, HHSC may require approval prior to making the change.

For any system changes HHSC requires, or changes HHSC approves, HHSC will specify Readiness Review steps that the PSO must complete prior to implementation.

TMHP will assist the PSO with resolving production problems in the EVV proprietary system related to data exchange with the EVV Aggregator as needed.

5080 Access to the EVV Proprietary System

Revision 21-1; Effective November 1, 2021

The PSO must provide EVV proprietary system read-only access. They must also provide immediate, direct, on-site access to state staff and MCOs with which it has a contractual relationship at no cost to the state or MCO.

The PSO must limit MCO access to the MCO's respective member visit data only, and only for dates of service within the time frame covered by the PSO contract with the MCO. The PSO must allow this access indefinitely after the PSO's contract with the MCO ends, in accordance with applicable law.

The PSO must provide HHSC and the MCOs access to reports and data necessary to verify EVV usage. This includes those standard reports identified in the EVV Business Rules for Proprietary Systems.

Access for CDS Employers
The PSO must provide access for CDS employers to the EVV proprietary system. The PSO must train the CDS employers on the use of the system including clock in and clock out methods.

5090 Required EVV Proprietary System Standard Reports

Revision 21-1; Effective November 1, 2021

The PSO must make standard reports available to EVV proprietary system users per the EVV Business Rules for Proprietary Systems. HHSC and the PSO will identify and document any applicable exceptions in the individual PSO Certification Letter during the EVV Proprietary System Onboarding process.

EVV proprietary system standard and ad hoc reports must be available on demand to HHSC and, if applicable, to MCOs and CDS employers.

5100 Compliance Reviews

Revision 21-1; Effective November 1, 2021

Program providers and FMSAs who are also an approved PSO are subject to EVV Compliance Reviews.

The state will use EVV visits in the EVV Aggregator as the system of record for compliance reviews, specifically the EVV Usage Report and the EVV Reason Code Usage and Free Text Report available in the EVV Portal. The state may perform other compliance reporting and oversight based on data in the EVV proprietary system.

The PSO is responsible for transmitting all confirmed EVV visits to the EVV Aggregator and ensuring that the EVV Aggregator accepts the EVV visit transactions.

Refer to the HHSC EVV Compliance Reviews for more information.

5200 HHSC Cancellation of EVV Proprietary System Approval

Revision 21-1; Effective November 1, 2021

The state may cancel the use of an EVV proprietary system at any time if the state deems the EVV proprietary system is unable to ensure data accuracy or integrity, or if the PSO fails to meet HHSC EVV standards and requirements.

HHSC, at its discretion, may allow the PSO to submit a Root Cause Analysis and Corrective Action (RCCA) plan to the state, within a time frame specified by HHSC, and attempt to correct the deficiencies within the EVV proprietary system.

HHSC has the sole authority to cancel the use of an EVV proprietary system and require the PSO transition to an EVV vendor system from the state vendor pool within a timeframe determined by HHSC.

5300 Transferring EVV Systems

Revision 21-1; Effective November 1, 2021

The PSO must follow 4700 EVV System Transfer and the EVV Data Transfer Guide located on the TMHP EVV Proprietary Systems webpage to either:

- Transfer from an EVV vendor system in the state vendor pool to an EVV proprietary system.
- Transfer from an EVV proprietary system to an EVV vendor system in the state vendor pool.

The PSO must **not** collect productional EVV visit data in more than one EVV system at a time. They must transition all EVV visit collection to the new EVV vendor or EVV proprietary system as of the onboarding effective date with the new EVV system.

The PSO must complete visit maintenance in the originating system and may transmit updates to the EVV Aggregator from the originating system for EVV visits occurring before the onboarding effective date with the new EVV system.

In the event the PSO decides to transfer from one EVV proprietary system to another, and HHSC approves the new proprietary system, the PSO is responsible for:

- Migrating all necessary data prior to beginning EVV visit collection in the new EVV proprietary system.
- Importing existing EVV visit data into the new EVV proprietary system if needed, before decommissioning the originating EVV proprietary system.
- Completion of visit maintenance for EVV visits captured in the originating system in accordance with the visit maintenance time frame.
- Ensuring the transmission and acceptance of all EVV visit data to the EVV Aggregator.

In addition, during any EVV system transfer, either between EVV proprietary systems or to or from an EVV vendor, the PSO is responsible for:

- Completion of visit maintenance for visits captured in the originating system in accordance with the visit maintenance time frame.
- Migration of data from the originating system if needed before decommissioning the originating system.

- Ensuring access by the PSO, HHSC and MCOs, if applicable, to historical data which may reside in the originating system.

5400 Fraud, Waste and Abuse

Revision 21-1; Effective November 1, 2021

Non-compliance with EVV standards and requirements may result in fraud, waste and abuse investigations in accordance with Texas Government Code.

Non-compliance with EVV standards and requirements may result in the recoupment of funds for any EVV claim paid or any overpayment made based on inaccurate data.

The state may require the EVV Aggregator to reject all EVV visit transactions from an EVV proprietary system effective immediately if the state confirms an allegation of fraud, waste or abuse related to the functionality of the EVV proprietary system.

In addition, the state may cancel the approval of an EVV proprietary system and require the PSO to immediately transfer to a selected EVV vendor system from the state vendor pool.

Section 6000, EVV Visit Transaction

Revision 21-1; Effective November 1, 2021

An EVV visit transaction is a complete, verified and confirmed visit generated by an EVV system which contains the program provider or FMSA identification data and the member's visit data. The EVV visit transaction includes the following data:

- Service Authorization Data
- Member Data
- Service provider Data
- Program Provider or FMSA Information
- Data and Time of the Services
- Location of the Service

Once steps 1-3 as described in Section 4000 are complete, the program provider or FMSA is ready to begin using the EVV system.

The following steps explain how to use the EVV system and how the EVV system processes EVV visit transactions.

Step 4: The service provider must:

- Clock in at the beginning of service delivery using an approved clock in and clock out method.
- Clock out at the end of service delivery using an approved clock in and clock out method.

Step 5: The EVV system:

- Captures and verifies visit data elements. (See 4400 Data Collection)
- Validates the identification and visit data against Texas Medicaid data.
- Notifies the program provider, FMSA or CDS employer of errors in the EVV Visit Transaction.
- Submits EVV visit transaction to the EVV Aggregator.

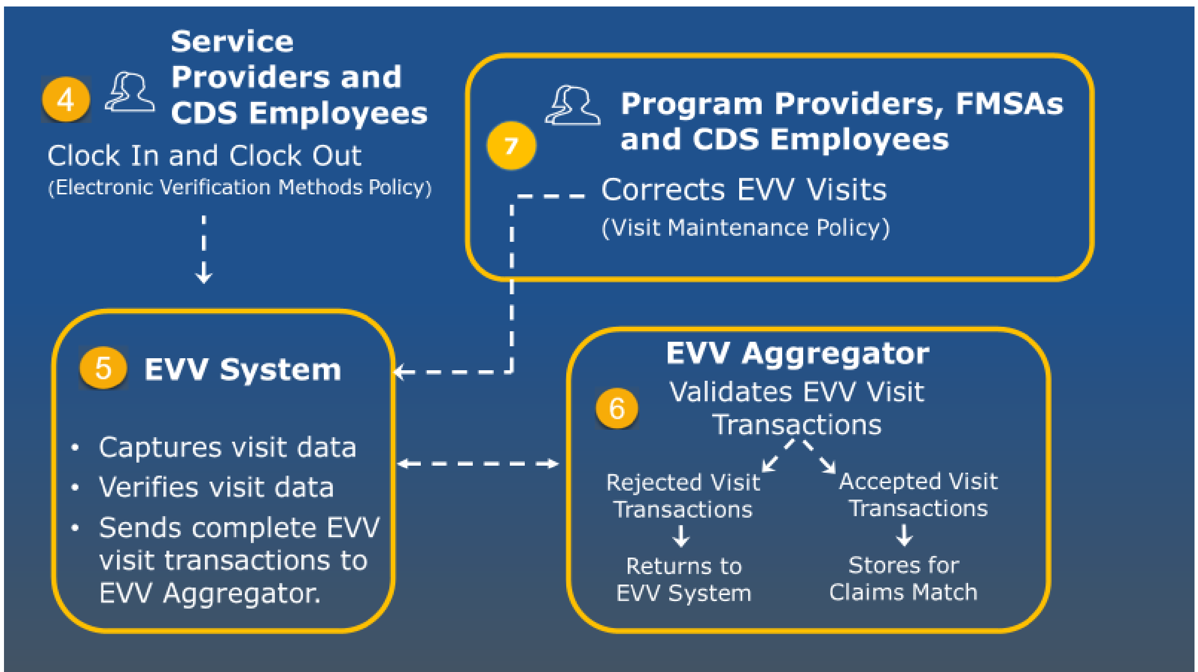
Step 6: The EVV Aggregator:

- Conducts data validation.
- Determines if the EVV visit transaction is an accepted or rejected EVV visit transaction.
  - Stores accepted visit transactions for the claims matching process.
  - Stores rejected visit transactions and returns results to the EVV system.

Step 7: Program Providers and FMSAs conduct visit maintenance, if necessary, to:

- Correct visit errors from EVV system validations.
- Adjust Bill Hours.
- Add Reason Codes as required.
- Correct rejected visit transactions sent back by the EVV Aggregator.

EVV Steps 4 through 7:



Step 8: Program Providers and FMSAs use the EVV Portal to:

- Search and review EVV visit data.
- Verify accepted visits for billing.
- Access the claims matching results.

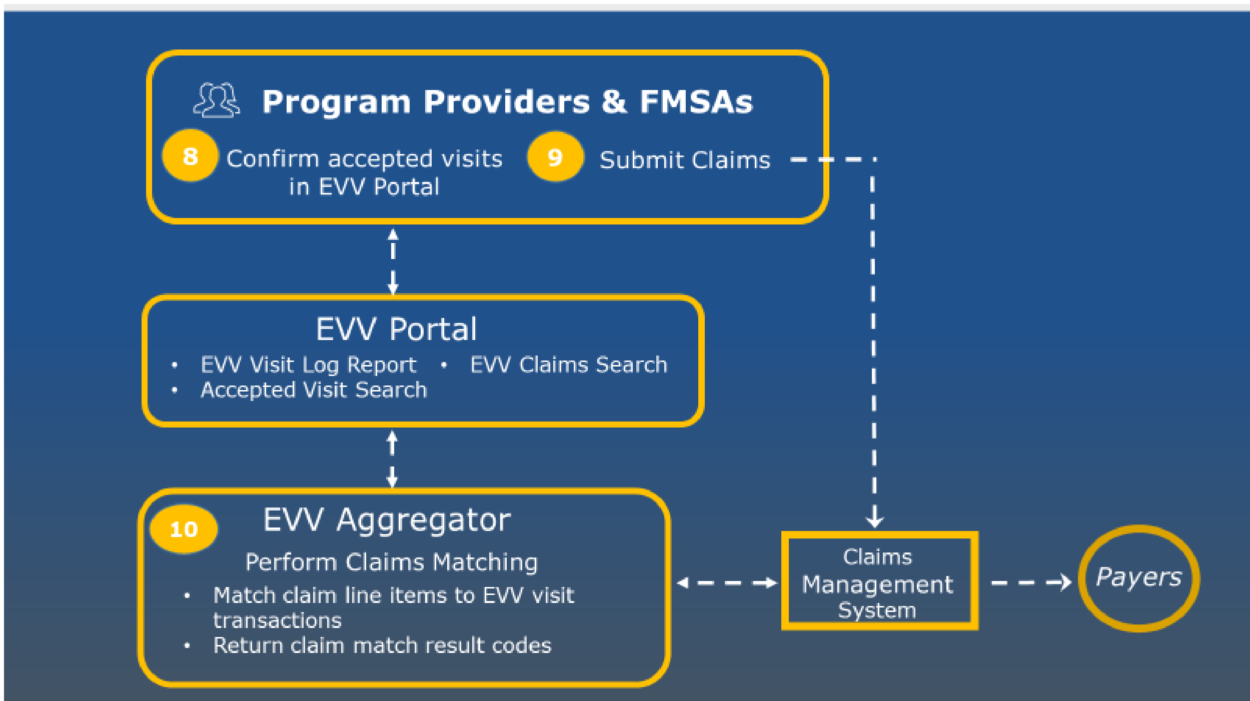
Step 9: Program Provider and FMSAs:

- Submit EVV claims to the appropriate claims management system.

Step 10: EVV Aggregator:

- Matches EVV claim line items to accepted EVV visit transactions.
- Returns EVV claims match result codes to the claims management system.

EVV Steps 8 through 10:



6100 EVV System

Revision 21-1; Effective November 1, 2021

The EVV system identifies errors in a visit and notifies the program provider, CDS employer or FMSA of any exceptions in the EVV visit data that they must correct.

Each night the EVV system will transmit an EVV visit transaction to the EVV Aggregator. Once the EVV Aggregator receives an EVV visit transaction, it will validate the data.

If the EVV Aggregator rejects an EVV visit transaction, the EVV system will receive a rejection code. The rejection code will be available in the EVV system and accessible by the program provider and FMSA. Contact your EVV vendor or EVV PSO for details on how to view the rejection codes.

Program providers and FMSAs can use EVV Portal reports and search tools to identify visits that they need to correct. Once corrected, the EVV system will re-send the EVV visit transaction to the EVV Aggregator.

HHSC and MCOs will not pay an EVV claim for reimbursement unless there is an accepted EVV visit transaction in the EVV Aggregator that matches the claim line item detail. Please refer to 12200 Claims Matching.

6200 EVV Aggregator

Revision 21-1; Effective November 1, 2021

The EVV Aggregator is a centralized database that collects, validates and stores statewide EVV visit transaction data transmitted by an EVV system.

Once the EVV Aggregator receives an EVV visit transaction from an EVV system, the EVV Aggregator:

- Conducts validation on data from the EVV visit transaction received from the EVV system.
- Stores all accepted and rejected EVV visit transactions.
- Accepts or rejects EVV visit transaction and returns results to the EVV system.
- Matches EVV claim line items to accepted EVV visit transactions in the EVV Aggregator and
- Sends claims match results to the claims management system for final processing by the appropriate payer.

6300 EVV Portal

Revision 21-1; Effective November 1, 2021

The EVV Portal is an online system that allows users to perform searches and view reports associated with the EVV visit transaction data in the EVV Aggregator.

Program providers, FMSAs, MCOs and HHSC can search, view, print and export:

- EVV Portal Reports
- Accepted Visits
- Visit History
- EVV Claim Search

Note: CDS employers will not use the EVV Portal but will have access to EVV visit logs and related reports in the EVV system.

Program providers and FMSAs can:

- View accepted EVV visit transactions ready for billing.
- Access standard EVV reports and run queries on EVV visit data.
- Check the status and identify reasons for rejection of submitted EVV visit transactions.

Section 7000, Clock In and Clock Out Methods

Revision 21-1; Effective November 1, 2021

The Clock In and Clock Out Methods Policy was previously known as the Electronic Verification Methods Policy. It requires the service provider or CDS employee use an HHSC approved clock in and clock out method to begin service delivery and to end service delivery when providing services to a member in the home or the community.

EVV vendors offer the following three approved clock in and clock out methods:

- Mobile method (a downloadable application for use on a smart phone or tablet)
- Home phone landline
- Alternative device

A program provider or FMSA operating their own EVV proprietary system, known as the EVV PSO, must offer one or more of the three approved clock in and clock out methods listed above. The EVV PSO or the EVV vendor will not charge the member for a clock in or clock out method.

If the clock in and clock out method malfunctions the EVV system must allow manual entry by the program provider, FMSA or CDS employer.

When the service provider or CDS employee clocks in and clocks out using an approved method, the EVV system captures the following visit data:

- The type of service provided (Service Authorization Data)
- The name of the recipient to whom the service is provided (Member Data)

- The date and times the provider began and ended the service delivery visit
- The location, including the address, where the service is provided
- The name of the person who provided the service (Service provider Data)

Failure to Clock in or Clock out of the EVV system
If the service provider or CDS employee fails to, or is unable to, clock in or clock out using one of the approved methods, the program provider, CDS employer or FMSA (if the CDS employer has designated the FMSA) must manually enter visit data in the EVV system.

Failure to complete all required visit maintenance prior to the program provider or FMSA submitting an EVV claim will result in the denial or recoupment of the EVV claim.

Refer to 1400 Failure to Use an EVV System.

7010 Manually Entered EVV Visits

Revision 21-1; Effective November 1, 2021

When the service provider or CDS employee fails to clock in or clock out of the EVV system or an approved clock in or clock out method is not available, the program provider, FMSA or CDS employer must manually enter the EVV visit into the EVV system.

Manually entered visits will negatively impact the EVV Usage Score. Refer to the Section 11000, Usage for more information.

If the service provider or CDS employee fails to clock in or clock out of the EVV system for any reason, program providers, FMSAs or CDS employers must complete the following steps:

- Verify the service provider or CDS employee delivered services according to program policy and requirements
- Receive and retain service delivery documentation from the service provider or CDS employee. Service delivery documentation should include:
    - Program provider, FMSA and CDS employer name
    - Members first and last name
    - Member Medicaid ID
    - Services delivered

    - Date of the visit
    - Actual Time In and Time Out
    - Service provider first and last Name
    - Location of the visit in the home or in the community
- Enter visit data manually into the EVV system
- Complete visit maintenance using the most appropriate EVV Reason Code(s), EVV Reason Code Description(s) and free text, if applicable
- Ensure the visit is accepted at the EVV Portal (applicable to program providers and FMSAs)

7020 Mobile Method

Revision 21-1; Effective November 1, 2021

The service provider or CDS employee may use a mobile method for clocking in and clocking out of the EVV system. Each EVV vendor and EVV PSO, if applicable, will supply a downloadable application for use on a smart phone or device with Internet connectivity. The service provider or CDS employee may use the mobile method to clock in and clock out in the home or in the community.

If a service provider or CDS employee clocks in or clocks out within 250 feet (EVV allowed geo-perimeter) of the member's home, the default service delivery location is the member home. If a service provider or CDS employee clocks in or clocks out beyond the 250-foot radius, the service provider or CDS employee must select a service delivery location.

Service Delivery Locations:

- Member Home
- Family Home
- Neighbors Home
- Community
- Other

When an internet connection or a cellular network is not available, the service provider or CDS employee can still use the mobile method to log in to the mobile application and clock in or clock out of the EVV system.

The service provider must do one of the following:

- May use their own personal smart phone or tablet.
- May use a smart phone or tablet issued by the program provider

The service provider must not use a member’s personal smart phone or tablet to clock in and clock out.

The CDS employee:

- May use their own personal smart phone or tablet
- May use a smart phone or tablet issued by the FMSA
- May use a smart phone or tablet owned by the CDS employer, if the CDS employer has authorized the CDS employee to use their smart phone or tablet.

A mobile method is the only clock in and clock out method the service provider or CDS employee may use when delivering services in the community or when traveling out of state. Please contact your program representative to determine if your service provider or CDS employee may deliver EVV services while the member is out of state.

The mobile method:

- Utilizes a secure login function for each user.
- Records the specific location at the exact time of clocking in and clocking out.
- Does not track location before clocking in, during the visit or after clocking out.
- Does not use mobile device plan minutes and only uses minimal data.
- Does not store Protected Health Information (PHI) on the mobile device.

Note: Location data cannot be sold, shared or used by a third party for any reason.

Clock in and Clock Out Requirements:

- The program provider, FMSA or CDS employer must setup the mobile method in the member’s profile and notify the EVV vendor or EVV PSO, if applicable, to allow service providers or CDS employees to use a mobile device.
- The mobile device must be operational to use the mobile method. For example the phone must be working and the battery charged.

Service providers and CDS Employees:

- Must follow instructions from their program provider, CDS employer or FMSA to download and activate the mobile application and obtain their own unique login credentials from the EVV vendor or EVV PSO.
- Must only access the EVV mobile application method using their own login credentials
- Must **not** share login credentials to access the EVV mobile application method

A program provider or CDS employer may contact their EVV vendor or EVV PSO, if applicable, for a full list of mobile application method specifications, including supported mobile devices.

User Liability if Using the Mobile Method:

- HHSC, TMHP, EVV vendors and MCOs are not liable for:
  - Any cost incurred while using the mobile method.
  - Any viruses on the mobile device.
  - A hacked, broken, damaged, lost or stolen mobile device.
  - A non-working mobile device.

7030 Home Phone Landline

Revision 21-1; Effective November 1, 2021

The service provider or CDS employee may use the member’s home phone landline, if the member agrees, for clocking in and clocking out of the EVV system by calling the EVV vendor’s or EVV PSO toll-free number.

If a member does not agree to allow the service provider or CDS employee to use their home phone landline or if the member’s home phone landline is frequently not available for the service provider or CDS employee to use, the service provider or CDS employee will need to use another approved clock in and clock out method.

Landline Requirements

- Program providers and FMSAs must follow the instructions from the vendor or EVV PSO to set up the landline.
- The landline must be the member’s current primary home phone landline

    - The systems must allow the use of alternate home phone landline numbers if the member frequently receives services in a secondary location.
- The phone must be a landline phone and must not be an unallowable type.

The program provider or FMSA must enter the member's primary home phone landline number in the EVV system. Enter it under the member's profile before the service provider or CDS employee can use the home phone landline to clock in and clock out.

The program provider or FMSA may also enter one or more alternate landline phone numbers if the member frequently receives services in a secondary location.

The program provider or FMSA must **not** enter an unallowable landline phone type into the EVV system as the member's home phone landline. An unallowable landline phone type is a mobile phone number or cellular enabled phone number. See below for information on EVV Unallowable Landline Phone Types.

The program provider or FMSA must ensure the landline phone number listed in the member's profile is current. The program provider, CDS employer or FMSA must complete visit maintenance in the EVV system if the landline phone number used for clocking in and clocking out does not match the member's profile.

Unallowable Landline Phone Type

Home phones used to clock in or out through the landline method must be a landline phone, and **not** a cellular phone or device.

Visits are subject to recoupment by the payer if the service provider or CDS employee uses an unallowable landline phone type to clock in or clock out.

Unallowable landline phone types include:

- Cellular phones
- Cellular enabled devices such as tablets and smart watches

Note: If the service provider or CDS employee wants to use a cell phone or tablet, they must use the mobile method.

Program providers, FMSAs and CDS employers must use The EVV Landline Phone Verification Report in the EVV system to identify an unallowable landline phone type as "mobile".

7040 Alternative Device

Revision 21-1; Effective November 1, 2021

An alternative device is an HHSC-approved electronic device provided at no cost by an EVV vendor or EVV PSO, if applicable. It allows the service provider or CDS employee to clock in and clock out of the EVV system from the member's home.

A program provider, a program provider representative, CDS employer or CDS employee must place the alternative device in the member's home, if the member agrees. An example of the program provider representative may be the service provider or supervisor.

If the device is damaged or lost the program provider, FMSA or CDS employer must always:

- Document in the member's case file each time the device is damaged or lost.
- Order a new device.

If the device was damaged or lost by a member then the program provider, FMSA or CDS employer is also responsible for:

- Requesting an interdisciplinary team (IDT) meeting.
- A service planning team (SPT) meeting.
- A child and family team (CFT) meeting or a meeting with the member, their LAR and any natural or formal support to discuss the use of the alternative device with the member.

Failure to document a lost or damaged alternative device in the member's case file or schedule an IDT, SPT or CFT meeting with the member may result in the payer or the EVV vendor holding the program provider or FMSA responsible for the lost or damaged device.

The program provider representative or CDS employer must explain to the member the purpose of the alternative device and how the alternative device works.

The alternative device must always remain in the member's home even during an evacuation. If the alternative device does not remain in the home, the payer may make a Medicaid fraud referral to the HHS Office of the Inspector General.

The alternative device produces codes or information that identify the precise date and time service delivery begins and ends. Codes from alternative devices expire seven days from the date of the visit. To record the visit in the EVV system within the seven-day time frame, please contact your EVV vendor or EVV PSO for instructions.

The service provider or CDS employee must follow the instructions provided by the program provider or CDS employer to use the alternative device to record a visit.

The service provider or CDS employee may use any phone to call the toll-free number and enter the alternative device codes. However, the service provider or CDS employee should never use or request to use the member's mobile phone unless the member is a CDS employer and the CDS employer has given the service provider or CDS employee authorization to use the CDS employer's mobile phone.

The program provider or CDS employer must train the service provider or CDS employee in the use of the alternative device to clock in and clock out of the EVV system.

If a member does not want an alternative device in their home, the program provider or CDS employer must document the reason in the member's case file. If another HHSC approved clock in or clock out method is not available an SPT, IDT or a CFT meeting must be conducted.

Note: EVV PSOs may offer different types of alternative devices. All alternative devices must support the collection of the critical data elements. HHSC must approve any alternative device used by the EVV PSO before use. Refer to Section 5000, EVV Proprietary System and 4400 Data Collection.

Ordering an Alternative Device from an EVV vendor

Once the program provider, FMSA or CDS employer has determined a member needs an alternative device, they have 10 business days to order an alternative device from the EVV vendor.

Program providers, CDS employers or FMSAs on behalf of a CDS employer, can order an alternative device through an EVV vendor. The EVV vendor will provide instructions on how to order a device.

The EVV vendor has 10 business days to process and ship the alternative device to the requestor upon receipt of a complete order. Depending on the shipping method, it may take additional days to deliver the order.

If a clock in or clock out method is not available for the service provider or CDS employee to use prior to the delivery of an alternative device, the service provider or CDS employee must manually document the visit.

Using the EVV vendor electronic ordering method, program providers, CDS employers or FMSAs on behalf of CDS employers can:

- Order a new or replacement alternative device
- Track orders for the alternative device
- Manage, assign and un-assign alternative devices
- Manage shipping addresses

Installing an Alternative Device

The program provider, the program provider’s representative, a CDS employer or CDS employee must install the alternative device by placing the device in the member’s home for use by the service provider or CDS employee.

Program providers and CDS employers must ask the member where to place the device in the member’s home. The device should be in a location where it is always accessible to the service provider or CDS employee.

The program provider representative or the CDS employer may attach the device using a zip tie. However, the device must not be mounted in a location that may be dangerous to a member or cause damage to the member’s home.

Examples of places where the program provider or CDS employer may locate the device in the home include:

- Kitchen counter
- Coffee table
- Lockbox located in the garage or on the patio

Malfunctioning Alternative Device

The service provider or CDS employee must notify the program provider or CDS employer immediately if the alternative device malfunctions or fails to generate codes.

When the service provider or CDS employee reports that the device has malfunctioned:

- The service provider or CDS employee must manually document the visit .
- The program provider, CDS employer or FMSA must contact the EVV vendor or EVV PSO to report the malfunctioning device and order a replacement alternative device.

Equipment provided by an HHSC-approved EVV vendor, must be returned when the equipment is no longer needed.

7050 Using Multiple Clock in and Clock Out Methods

Revision 21-1; Effective November 1, 2021

A service provider or CDS employee may use one method to clock in and clock out one day and a different method to clock in and clock out the next day. A service provider or CDS employee may also use one method to clock in and clock out for a single visit or use multiple clock in and clock out methods for a single visit.

Examples of using **one** method to clock in and clock out happens when the service provider or CDS employee:

- Clocks in and clocks out using the mobile method.
- Clocks in and clocks out using a home phone landline.
- Clocks in and clocks out using an alternative device.

Examples of using **multiple** methods to clock in and clock out happens when the service provider or CDS employee:

- Clocks in using a home phone landline and clocks out using a different clock out method such as alternative device or mobile
- Clocks in using an alternative device and clocks out using a different clock out method such as home phone landline or mobile
- Clocks in using the mobile method and clocks out using a different clock out method such as home phone landline or alternative device

Program providers and CDS employers may contact their EVV vendor or EVV PSO for additional questions or need training on clock in and clock out methods.

7060 EVV Services Delivered Outside the Member’s Home

Revision 21-1; Effective November 1, 2021

A service provider or CDS employee must record the visit when they begin or end an EVV service outside the member’s home by either:

- Using the mobile method
- Manually documenting the visit

The mobile method is the recommended clock in and clock out method when an EVV service begins or ends in the community. Using the mobile method for clocking in and clocking out in the community will avoid negative impacts to the EVV Usage Score.

Program providers and CDS employers may contact their EVV vendor or EVV PSO for more information and training on available clock in or clock out methods to document visits in the community.

Section 8000, Visit Maintenance

Revision 21-1; Effective November 1, 2021

Visit maintenance is the process used by the program provider, FMSA or CDS employer to correct the identification and visit data in the EVV system to accurately reflect the delivery of service.

EVV visit maintenance is like correcting a paper timesheet. Instead of making the correction on the paper timesheet, the program provider, FMSA or CDS employer will make the correction in the EVV system. See 4400 Data Collection for more information about identification and visit data.

The program provider, FMSA or CDS employer must complete all required visit maintenance and ensure the visit transaction is accepted by the EVV Aggregator before a program provider or FMSA submits an EVV claim. If additional visit maintenance is completed after a claim is submitted, the program provider or FMSA must submit an adjusted claim to match the updated visit transaction.

If a program provider or FMSA submits an EVV claim before required visit maintenance is complete, the payer may deny or recoup the EVV claim as part of contract oversight.

If a program provider or FMSA delegates visit maintenance responsibilities to a third party (such as a subcontractor), the program provider or FMSA is always responsible for actions taken by the third party.

If the program provider or FMSA delegates visit maintenance responsibilities to a third party, the program provider or FMSA ensures that the third party follows all privacy and security protocols, including when the subcontractor or third-party accesses EVV data.

If the CDS employer delegates visit maintenance responsibilities to their Designated Representative (DR), the CDS employer is responsible for any actions taken by their DR. They must ensure that the DR follows all privacy and security protocols, including when the DR accesses EVV data.

8010 Required Visit Maintenance

Revision 21-1; Effective November 1, 2021

The program provider, FMSA or CDS employer must complete visit maintenance when the:

- EVV system cannot "auto-verify". Automatically confirm an EVV visit based on existing identification and visit data in the EVV system.
- EVV system identifies exceptions which are errors.
- EVV Aggregator (centralized database that collects, validates and stores statewide EVV visit data transmitted by an EVV system) rejects the EVV visit transaction due to incorrect or missing data.
- Program provider, FMSA or CDS employer reduces bill hours after the EVV system auto-verifies the EVV visit transaction.
- EVV system is unavailable.
- Service provider or CDS employee fails to use the EVV system.

Refer to 1400 Failure to Use an EVV System in the EVV Policy Handbook for more information on what the program provider, FMSA, CDS employer, service provider or CDS employee must do when an EVV system is unavailable or a service provider or a CDS employee fails to use the EVV system.

8020 Auto Verification, Exceptions and Schedules

Revision 21-1; Effective November 1, 2021

Auto Verification

Each time a service provider or CDS employee clocks in or clocks out during service delivery, the EVV system will:

- Record the visit data.
- Verify the clock in and clock out method.
- Compare the visit data to the member's data in the EVV system.

If all the visit data and the identification data in the EVV system match, the EVV system will automatically verify the visit, also known as "auto-verify". An auto-verified EVV visit means the EVV system found no exceptions or errors.

If the EVV visit transaction is missing a clock in or a clock out or if the data collected at the time of clock in or clock out does not match the data elements in the EVV system, the EVV system notifies the program provider or FMSA of an exception. The program provider, FMSA or CDS employer must clear all exceptions through visit maintenance.

Clearing Exceptions

The EVV system may generate one or more exceptions when the EVV system cannot auto-verify the data collected at the time of clock in or clock out.

To clear an exception, the program provider, FMSA or CDS employer must complete visit maintenance in the EVV system by:

- Updating the identification or visit data for a member, if required. Refer to 4400 Data Collection for more information .
- Selecting the most appropriate EVV Reason Code(s), if required.
- Confirming the visit.

Selecting the most appropriate EVV Reason Code(s) explains the reason for completing visit maintenance. The process involves:

- Selecting an EVV Reason Code Number.
- Selecting an EVV Reason Code Description.
- Entering required free text, if applicable.

Refer to Section 9000, EVV Reason Codes and Current HHSC EVV Reason Codes for more information.

The following are some examples that describe when the EVV system will not auto-verify a service visit:

- Clock in or clock out time is less than or greater than an existing scheduled visit in the EVV system
- Clock in time or clock out time is missing
- Service delivery is outside the home and the service provider or CDS employee is not using the mobile method to clock in or clock out
- Service provider or CDS employee calls from a number not registered in the member's profile

Program policy requirement for schedules
Program providers must enter schedules in the EVV system if program policy or rule requires schedules in the EVV system.

FMSAs and CDS employers may choose to use a schedule regardless of the program requirement. CDS employers should communicate with their FMSA to determine the use of schedules.

The EVV system and schedules
The EVV system does not require schedules. If program policy does not require entering schedules into the EVV system, schedules are optional.

A schedule in the EVV system documents the planned begin and end time when the service provider or CDS employee will provide authorized services to a member.

If a schedule is entered into the EVV system, the EVV system compares the following data elements collected at the time of clock in and clock out with the schedule entered in the EVV system for the member:

- Visit date
- Visit begin and end time
- Service provider or CDS employee name
- Visit duration
- Service type for the visit

If the data elements collected at time of clock in and clock out match the schedule entered in the EVV system, the EVV system will auto-verify without exceptions.

If the data elements collected at time of clock in and clock out do not match the schedule entered in the EVV system, the EVV system will flag the exception for visit maintenance.

No Schedules
If there is no schedule in the EVV system for an EVV visit, the EVV system will validate the following data elements:

- The identity of the service provider or CDS employee
- The identity of the member
- The actual hours worked
- The clock in and clock out method(s)
- The service type for the visit

If the above data elements match the data in the member's profile, the visit will auto-verify without exceptions.

If any of the above data elements do not match, the EVV system will not auto-verify the EVV visit and visit maintenance must be completed.

8030 EVV System Validation

Revision 21-1; Effective November 1, 2021

Once the EVV system has verified a visit, the EVV system conducts additional system validation checks on the EVV visit transaction before sending the EVV visit transaction to the EVV Aggregator.

The EVV system validation ensures the identification data and visit data is in the correct format. It compares the critical data elements to Texas Medicaid data stored at TMHP.

An EVV system must perform the following validation before sending an EVV visit transaction to the EVV Aggregator:

- Verifies that no required visit data elements are missing
- Verifies that all required visit data elements are in the correct format (length, alphanumeric, only valid values)
- Verifies that all required identification data elements are in the correct format (NPI, API, Provider Number)
- Verifies the service group and service code or HCPCS and modifier combination is valid for the member or EVV visit transaction.

If an EVV visit transaction fails the system validation, the EVV system will:

- Not send the EVV visit transaction to the EVV Aggregator.
- Notify the program provider, FMSA or CDS employer of the exceptions that must be corrected.

To clear EVV system validation exceptions, the program provider, FMSA or CDS employer must complete visit maintenance. Once the program provider, FMSA or CDS employer clears the exceptions, the EVV system will send the EVV visit transaction to the EVV Aggregator for final processing.

8040 EVV Aggregator Validation

Revision 21-1; Effective November 1, 2021

The EVV Aggregator performs numerous validations of all data elements on the EVV visit transaction. The EVV Aggregator validations include verifying the:

- NPI or API for the program provider or FMSA to ensure it is active for the visit date.
- Provider number is valid for the NPI or API on the visit date.
- Member's payer matches the Medicaid data.
- Member has Medicaid eligibility for the visit date.
- Service group, service code or HCPCS and Modifier on the visit date.

Based on the above validations, the EVV Aggregator will either accept or reject the EVV visit transaction received from an EVV system then display the status in the EVV Portal.

After the EVV Aggregator accepts an EVV visit transaction, the program provider or FMSA can submit an EVV claim associated with the EVV visit transaction.

When the EVV Aggregator rejects an EVV visit transaction, the EVV Aggregator returns the EVV visit transaction to the EVV system with the reason for the rejection or rejection code. The program provider, FMSA or CDS employer must complete visit maintenance. After visit maintenance is complete the program provider or FMSA must resubmit the EVV visit transaction to the EVV Aggregator.

8050 Visit Maintenance Timeframes

Revision 21-1; Effective November 1, 2021

Program providers, FMSAs and CDS employers have 95 days from the date of service delivery to complete visit maintenance. This is known as the visit maintenance time frame. HHSC may extend the visit maintenance time frame as needed.

After the visit maintenance time frame has expired, the EVV system locks the EVV visit transaction and the program provider, FMSA or CDS employer may only complete visit maintenance if the payer approves a Visit Maintenance Unlock Request.

8060 Visit Maintenance Unlock Request

Revision 21-1; Effective November 1, 2021

A Visit Maintenance Unlock Request, when approved, allows a program provider, FMSA or CDS employer the opportunity to correct data element(s) on an EVV visit transaction(s) after the visit maintenance time frame has expired.

A program provider, FMSA or CDS employer may request the payer unlock EVV visit transaction(s) for visit maintenance. If the request is submitted by the CDS employer, the CDS employer must notify their FMSA in writing. An example is email.
Approvals and denials of Visit Maintenance Unlock Requests are at the payer's discretion and are determined on a case-by-case basis. If the request is submitted by the CDS employer and the payer has approved or denied the request, the payer must also notify the FMSA.
The payer will deny requests to create manual visits after the visit maintenance timeframe unless the reason for creating a manual visit is due to payer or EVV system error.

Making corrections to EVV visit transactions during a Long-Term Care Fee-for-Service (LTC FFS) contract monitoring review or after it has occurred will not change any type of contract action such as recoupment or settlement reviews, taken as result of the LTC FFS contract monitoring review.

Unlock Request Process
To request an unlock of EVV visit transaction(s) for visit maintenance after the visit maintenance time frame has expired, program providers, FMSAs and CDS employers must complete a Visit Maintenance Unlock Request found on the payer's website.

Initial Request to Payer
Payers must process Visit Maintenance Unlock Requests from the program provider, FMSA or CDS employer within the following time frames:

- Ten business days after receiving a secure and complete request
    - Email requests not sent securely will result in the payer denying the request due to a violation of the Health Insurance Portability and Accountability Act.
    - Contact the payer for assistance with sending a secure email request.
- Thirty business days after receiving a secure and complete request
    - If the request was submitted as supporting documentation of a claims appeal.

Payer Request for More Information
The payer may request more information from the program provider, FMSA or CDS employer. The program provider, FMSA or CDS employer must submit the additional information back to the payer within the following time frames:

- Ten business days of the request for more information
    - If the payer does not receive the additional information within 10 business days, the payer may deny the request and the program provider, FMSA or CDS employer must submit a new Visit Maintenance Unlock Request.
- Fifteen business days of the request for more information
    - If the request for more information is part of a claims appeal.

Payer Denial of Request
If the payer denies the request, the payer:

- Must notify the program provider, FMSA or CDS employer through email within 10 business days of the request with the reason for the denial.
    - The email notification must include at a minimum the following information on how to:
        - Submit a new Visit Maintenance Unlock Request
        - Request a claims appeal, if applicable

        - Submit a formal complaint against the payer

The payer may automatically deny a Visit Maintenance Unlock Request for the following reasons:

- The request was not sent through a secure method
- The request is incomplete or missing required information

Payer Approval of Request
If the payer approves the Visit Maintenance Unlock Request, the payer will:

- Send the approved Visit Maintenance Unlock Request to the EVV vendor or EVV PSO within three business days of the approved request.
    - Only approved data elements listed on the Visit Maintenance Unlock Request will be unlocked for editing.
    - The EVV vendor or EVV PSO must only allow changes to the fields approved by the payer.

Payer Incorrect, Incomplete or Retroactive Authorization Approvals
The payer must approve the Visit Maintenance Unlock Request under the following circumstances:

- When the payer previously provided incorrect or incomplete information on the prior authorization for a member and the updated authorization will require updates to EVV visit transactions outside of the EVV visit maintenance time frame.
- When the payer submits a retroactive authorization for a member that will require the program provider, FMSA or CDS employer to resubmit an EVV visit transaction or EVV claim outside of the EVV visit maintenance time frame.
- Upon request by HHSC and within the initial request time frame specified in this policy.

EVV Vendor and EVV PSO Approval and Denial
Once the EVV vendor or EVV PSO receives the approved Visit Maintenance Unlock Request from the payer, the EVV vendor or EVV PSO must validate the information submitted.

The EVV vendor has 10 business days from receipt of the approved Visit Maintenance Unlock Request to complete visit maintenance or schedule a meeting with the program provider, FMSA or CDS employer to complete visit maintenance.

If the information submitted by the program provider, FMSA or CDS employer is incorrect, invalid or missing data elements, the EVV vendor will:

- Not unlock EVV visit transaction(s) for visit maintenance.
- Return the Visit Maintenance Unlock Request to the program provider, FMSA or CDS employer.
- Notify the payer, program provider, FMSA or CDS employer why the EVV visit transaction(s) cannot be unlocked for visit maintenance.

If the information submitted by the program provider, FMSA or CDS employer is incorrect, invalid or missing data elements, the EVV PSO will:

- Not unlock EVV visit transaction(s) for visit maintenance.
- Notify the payer, program provider, FMSA and CDS employer (if applicable) why the EVV visit transaction(s) cannot be unlocked for visit maintenance.

Once the information is corrected, the program provider, FMSA or CDS employer must submit a new Visit Maintenance Unlock Request to the payer.

8070 Visit Maintenance and Billing EVV Claims

Revision 21-1; Effective November 1, 2021

It is the responsibility of the program provider, FMSA and CDS employer to ensure all required data elements are correct and visit maintenance is complete before the program provider or FMSA submit an EVV claim to the appropriate claims management system.
If the program provider, FMSA or CDS employer needs to complete visit maintenance on an accepted EVV visit transaction that has already been billed, the program provider or FMSA must:

- Complete visit maintenance on the EVV visit transaction(s).
- Ensure the EVV Aggregator accepts the corrected EVV visit transaction.
- Resubmit the EVV claim in accordance with the payer's corrected claim process (e.g. negative bill the original claim and resubmit a corrected claim).

Note: The EVV Visit Maintenance Unlock Request does not override the timely filing deadline for submission of a new or corrected claim.

8080 Last Visit Maintenance Date

Revision 21-1; Effective September 21, 2021

The Last Visit Maintenance Date field on the EVV visit transaction identifies the last date visit maintenance was completed. Payers may review the Last Visit Maintenance Date on the EVV visit transaction and the date and time TMHP received the associated EVV claim.

If the Last Visit Maintenance Date is after the EVV claim receipt date, the EVV claim is subject to recoupment. To avoid recoupment, program providers and FMSAs must submit an adjusted claim if visit maintenance is completed after initial claim submission.

The EVV system will update the Last Visit Maintenance Date when any of the following fields are updated:

- API
- NPI
- Contract number
- Member Medicaid number
- Service group
- Service code
- HCPCS code
- Modifier
- Bill hours
- Units
- Adding a Reason Code number
- Adding a Reason Code description
- Entering Reason Code free text

The program provider or FMSA may review the Last Visit Maintenance Date on the EVV Visit Log Report and the EVV visit detail screen located in the EVV Portal.

8090 Rounding Rules

Revision 21-1; Effective November 1, 2021

The EVV system calculates bill hours on an EVV visit transaction by rounding the actual hours worked to the nearest quarter hour increment.

The EVV system rounds up to the next quarter hour increment when the actual hours worked are eight minutes or more than the previous quarter

hour increment. The EVV system rounds down to the previous quarter hour increment when the actual hours worked are seven minutes or less from the previous quarter hour.

Actual Hours Worked	Quarter Hour Increment	Bill Hours
0 - 7 minutes	0 minutes	0.00
8 - 22 minutes	15 minutes	0.25
23 - 37 minutes	30 minutes	0.50
38 - 52 minutes	45 minutes	0.75
53 - 67 minutes	60 minutes or 1 hour	1.00

Rounding rules examples:

- If a service provider works two hours and 53 minutes of actual hours for a shift, the bill hours will round up to three hours.
- If a service provider works two hours and 52 minutes of actual hours for a shift, the bill hours will round down to 2.75 hours.
- If a service provider works four hours and 10 minutes of actual hours for a shift, the bill hours will round up to 4.25 hours.
- If a service provider works four hours and six minutes of actual hours for a shift, the bill hours will round down to four hours.

The EVV system **does not** round each clock in or clock out time. The EVV system only rounds the total duration of the actual hours worked for each visit.
The program provider, FMSA or CDS employer may downward adjust bill hours if the actual hours worked, captured in the EVV system, are incorrect or if the program provider or FMSA intends to bill Medicaid for less time than actual hours worked in the EVV system.

The program provider, FMSA or CDS employer may never increase bill hours beyond the actual hours worked.

Program providers and FMSA must bill according to the EVV Service Bill Codes Table and follow program rules and policies, including any additional program or MCO requirements regarding rounding.

8100 Visit Maintenance Reduction Features

Revision 21-1; Effective November 1, 2021

EVV visit maintenance reduction features are available in the EVV vendor systems for all program providers and FMSAs who enter schedules in the EVV system. EVV PSOs may also choose to offer EVV visit maintenance reduction options.

These features do not apply when the program provider or FMSA has not entered a schedule in the EVV system.

EVV visit maintenance reduction features help to:

- Reduce visit maintenance.
- Increase auto-verified visits.
- Provide more flexibility for clocking in or out of the EVV system.

Note: When EVV visit maintenance reduction features are enabled, the program provider or FMSA must check with their EVV vendor to verify how the features are applied.

Call Matching Window

The 24-hour call matching window is an EVV system default setting that is in effect when using schedules and allows a visit to auto-verify if the EVV visit is delivered for the duration of the scheduled visit on the scheduled day.

The visit must occur between midnight and 11:59 p.m. on the scheduled day. The duration of the EVV visit (represented in bill hours) must equal the duration of the scheduled visit. The visit will auto-verify if there are no additional flagged exceptions for the EVV visit.

For example:

- The schedule in the EVV system is 10 a.m. – noon, the duration of the scheduled visit is two hours.
    - The service provider or CDS employee clocked in at 8 a.m. and clocked out at 10:07 a.m., actual hours worked are two hours and seven minutes.
    - The EVV system will automatically round down the bill hours to two hours.
    - The EVV system will auto-verify the EVV visit to the schedule in the EVV system if no other exceptions are flagged.

    - If the service provider or CDS employee clocked out at 10:08 a.m., the EVV system will round up to the next quarter hour increment (2.25 bill hours), and the EVV visit will **not** auto-verify to the schedule in the EVV system because the bill hours are .25 over the scheduled visit of two hours.

Optional Expanded Time for Auto-Verification
The Optional Expanded Time for Auto-Verification is a feature that the program provider or FMSA must enable to allow a visit to auto-verify if the duration of the EVV visit is no more than .25 bill hours greater or less than the duration of the scheduled visit with no additional flagged exceptions.

An example of a scheduled EVV visit auto-verifying:

- The schedule in the EVV system is 1 to 3 p.m., the duration of the scheduled visit is two hours.
    - The program provider or FMSA has enabled the Optional Expanded Time for Auto-Verification.
    - The service provider or CDS employee clocked in at 12:45 p.m. and clocked out at 3 p.m.
    - The actual hours worked are two hours and 15 minutes which rounds to 2.25 bill hours.
    - The EVV visit will auto-verify because 2.25 bill hours is .25 bill hours greater than the scheduled duration of the EVV visit.

An example of a scheduled EVV visit **not** auto-verifying:

- The schedule in the EVV system is 1 to 3 p.m., the duration of the scheduled visit is two hours.
    - The program provider or FMSA has enabled the Optional Expanded Time for Auto-Verification.
    - The service provider or CDS employee clocked in at 12:45 p.m. and clocked out at 3:09 p.m.
    - The actual hours worked are two hours and 24 minutes which rounds to 2.50 bill hours.
    - The EVV visit will **not** auto-verify because 2.50 bill hours is not within .25 bill hours of the scheduled duration of the EVV visit.

Optional Automatic Downward Adjustment
The Optional Automatic Downward Adjustment is a feature that the program provider or FMSA must enable to automatically downward adjust bill hours by .25 to match the duration of the scheduled visit. This optional adjustment is only available if the program provider or FMSA also enables the Optional Expanded Time for Auto-Verification in the EVV system.

The Optional Automatic Downward Adjustment only applies to bill hours and does not change actual hours worked.

For example:

- The schedule in the EVV system is 1 – 3 p.m., the duration of the scheduled visit is two hours.
  - The program provider or FMSA has enabled the Optional Automatic Downward Adjustment and Optional Expanded Time for Auto-Verification.
  - The service provider or CDS employee clocked in at 12:45 p.m. and clocked out at 3 p.m.
  - The actual hours worked are two hours and 15 minutes which rounds to 2.25 bill hours.
  - 2.25 bill hours is within .25 bill hours of the scheduled duration of the EVV visit.
  - The EVV visit will auto-verify and automatically downward adjust the bill hours to 2.00.

Important Note: EVV PSOs may also choose to offer EVV visit maintenance reduction features.

Program providers, FMSAs or CDS employers must follow the members' authorized service plan. Although EVV Visit Maintenance Reduction features are available and add some flexibility, the needs of the member must always come first.

For example, if a member needs their service provider or CDS employee to be at the home at the scheduled time of 8 a.m. to receive help getting out of bed, the service provider or CDS employee must be there on time. The program provider, FMSA and CDS employer must document all situations as needed and in accordance with program policy and licensure requirements.

Section 9000, EVV Reason Code

Revision 21-1; Effective November 1, 2021

The EVV Reason Code Policy describes the requirements for using reason codes when completing visit maintenance in the EVV system. Refer to 8000 Visit Maintenance for more information about visit maintenance.

Reason Code Number(s) describe the purpose for completing visit maintenance on an EVV visit transaction. Reason Code Description(s) describe the specific reason visit maintenance is necessary.

Program providers, FMSAs or CDS employers must select the most appropriate Reason Code Number(s), Reason Code Description(s) and must enter any required free text when completing visit maintenance in the EVV system.

If the EVV visit is missing a clock in or clock out, the program provider, FMSA or CDS employer must use Reason Code Number 900 Non-Preferred, the appropriate Reason Code Description(s), and any other applicable EVV reason code.

Program providers, FMSAs and CDS employers can use multiple Reason Code Numbers and Reason Code Descriptions to clarify more than one exception when completing visit maintenance on a single visit.

Exceptions that could cause visit maintenance include but are not limited to:

- Service provider or CDS employee forgot to clock in or clock out
- Visit did not begin or end as scheduled due to an emergency
- The clock in and clock out method was not accessible when services began
- EVV system unavailable

If the system is unavailable the service provider or CDS employee must document service delivery information and submit to the program provider, FMSA or CDS employer.

Program providers, FMSAs and CDS employers must keep all service delivery documentation and enter EVV visits into the EVV system once operational.

Refer to 1400 Failure to Use an EVV System for more information regarding service delivery documentation.

See the current HHSC EVV Reason Codes table for the Reason Code Number(s), Reason Code Description(s) and required free text that must be documented for each reason code.

9010 EVV Reason Code Free Text Requirements

Revision 21-1; Effective November 1, 2021

Free text is additional information the program provider, FMSA or CDS employer enters to further describe the need for visit maintenance.

Program providers, FMSAs or CDS employers completing visit maintenance in the EVV system must enter additional information in the free text field when:

- The visit is missing a clock in time, a clock out time or both.
  - Enter the actual missing clock in or clock out time
- Using the following Reason Code Numbers:
  - 131-Emergency
  - 600-Other
  - 900-Non-preferred

See the current HHSC EVV Reason Codes table for the free text requirement that must be documented for each reason code.

Compliance

Failure to document required free text may result in enforcement actions including recoupment of associated claim(s).
The Required Free Text Review may begin on or after the visit maintenance time frame has expired. This is to review the entry of required free text when a clock in or clock out is missing and when the following Reason Code Numbers are used:

- 131-Emergency
- 600-Other
- 900-Non-preferred

Refer to 10000 EVV Compliance Reviews for more information.

The table below lists examples of required free text.

Reason for Visit Maintenance	Reason Code Number	Free Text Required (Examples)
Missing Clock In Time	900 A: Failure to call in 200 A: Alternative device ordered	• "Actual clock in was 8:05 a.m. and actual clock out was 10 a.m." or • "Actual start time was 8:05 a.m. and actual end time was 10 a.m." • "8:05 a.m. and 10 a.m."

Missing Clock Out Time	900 B: Failure to call out 300 A: Phone lines not working	• "Actual clock in was 11 a.m. and actual clock out was 1 p.m." or • "Actual start time was 11 a.m. and actual end time was 1 p.m." • "11 a.m. & 1 p.m."
Missing Clock In and Clock Out Time	900 C: Failure to call in and out 130 C: Ice or Snow storm	• "Actual clock in was 10 a.m. and actual clock out was at 4 p.m. Due to Winter Storm Uri, service provider was unable to use the EVV system." or • "10 a.m. 4 p.m. Due to Winter Storm Uri, service provider was unable to use the EVV system."
Emergency	131	• "When service provider arrived, member unresponsive." • "Actual clock in was 10 a.m."
Other	600	• "EVV system not available. Actual clock in was 9 a.m. and actual clock out was 11 a.m." • "Missing clock in or clock out time. Actual clock in was 9 a.m. and actual clock out was 11 a.m."

Section 10000, EVV Compliance Reviews

Revision 21-1; Effective November 1, 2021

The Health and Human Services Commission (HHSC) is revising the Electronic Visit Verification (EVV) Compliance Oversight Reviews policy to:

- Include new program providers, financial management service agencies (FMSAs) and Consumer Directed Services (CDS) employers required to use EVV beginning Jan. 1, 2021
- Rename the EVV Compliance Oversight Reviews policy to EVV Compliance Reviews policy
- Rename the EVV Allowable Phone Identification Review to the EVV Landline Phone Verification Reviews.
- Rename the EVV Reason Code and Required Free Text Review to EVV Required Free Text Review
- Remove the compliance standard, Misuse of Reason Codes

HHSC and managed care organizations (MCO), the payers, conduct EVV compliance reviews to ensure program providers, FMSAs and CDS employers are in compliance with EVV requirements and policies.

Payers will not start reviews until the EVV visit maintenance timeframe has expired.

Payers will conduct reviews and initiate contract or enforcement action if the program providers, FMSAs or CDS employers do not meet any of the following EVV compliance requirements:

- EVV Usage
  - Meet the minimum EVV Usage Score
- EVV Landline Phone Verification
  - Ensure valid phone type is used
- EVV Required Free Text
  - Document required free text

See the Clock In or Clock Out Methods policy, EVV Reason Code policy, and the Usage policy for more information.

HHSC may change compliance requirements due to a natural disaster or at the discretion of HHSC.

Compliance Grace Periods

If program providers, FMSAs and CDS employers do not meet any of the

EVV compliance requirements during the compliance grace period, payers will not initiate enforcement action unless noted by HHSC.

Payers will post a notice on their websites 90 days prior to the start of reviews.

During the Compliance Grace Periods

Program providers and FMSAs must monitor compliance reports monthly, at a minimum, in the EVV portal and perform the following:

- Use the EVV system as required
- Establish a process to monitor compliance reports with their CDS employer (if Option 3 on Form 1722, Employers Selection for Electronic Visit Verification Responsibilities) unless the CDS employer has read only access in the EVV system
- Complete all required visit maintenance before billing
- Train or re-train service providers on clock in and clock out methods
- Ask questions

The CDS employer must monitor compliance reports monthly, at a minimum, in the EVV system and perform the following:

- Use the EVV system as required
- Complete all required visit maintenance (if Option 1 on Form 1722, Employers Selection for Electronic Visit Verification Responsibilities)
- Establish a process to monitor compliance reports with their FMSA (if Option 3 on Form 1722, Employers Selection for Electronic Visit Verification Responsibilities) unless they have read only access in the EVV system
- Train or re-train CDS employees on clock in and clock out methods
- Ask questions

State-Required Personal Care Services Grace Period

State-Required Personal Care Services are personal care services provided by program providers required to use EVV in 2016 or earlier per Texas Government Code, Section 531.024172.

The grace period dates of service for program providers started Sept. 1, 2019 and ended Aug. 31, 2020 and included:

- EVV Usage Reviews

Cures Act Personal Care Services Grace Period

Cures Act Personal Care Services are personal care services provided by

program providers, FMSAs and CDS employers required to use EVV by Jan.1, 2021 per the 21st Century Cures Act.

The grace period dates of service program providers, FMSAs and CDS employers started Jan. 1, 2021 and will end Dec. 31, 2021 and includes:

- EVV Usage Reviews (Program provider and FMSA only)
- EVV Landline Phone Verification Reviews
- EVV Required Free Text Reviews

Due to availability of the EVV CDS Employer Usage report, the grace period dates of service for CDS employers EVV Usage Reviews started Jan. 1, 2021 and will end Aug. 31, 2022 unless noted by HHSC.

See Personal Care Services required to use EVV (PDF) for the complete list of services included in each grace period.

10010 EVV Usage Reviews

Revision 21-1; Effective November 1, 2021

The payers will review the EVV Usage Score quarterly.

EVV Usage Reviews are conducted after the visit maintenance timeframe has expired based on the last date of the quarter to determine compliance.

The EVV Usage Score measures manually entered EVV visit transactions and rejected EVV visit transactions.

Manually entered EVV visit transactions are EVV visits that were manually entered into the EVV system when the service provider or CDS employee did not use the EVV system to clock in and clock out when service delivery started and ended.

Rejected EVV visit transactions are EVV visit transactions that were not accepted by the EVV Aggregator and may require visit maintenance.

See the Visit Maintenance policy and Usage policy for more information.

Program Providers
The payers will use the EVV Usage Report (located in the EVV Portal) to determine the EVV Usage Score for each program provider’s contract with HHSC and the MCOs.

FMSAs
The payers will use the EVV FMSA Usage Report (available in the EVV Portal in 2021) to determine the EVV Usage Score for each FMSAs contract with HHSC and the MCOs.

CDS Employers
The payers will use the EVV CDS Employer Usage Report (available in the EVV Portal or EVV System in 2022) to determine the EVV Usage Score for each Medicaid member that selects the CDS option with HHSC or an MCO.

See EVV Usage Policy for more information.

Failure to Meet the Compliance Standard
Failure to meet the compliance standard may result in the following actions.

Program Providers and FMSAs Enforcement Actions
When a program provider or FMSA fails to meet and maintain the minimum EVV Usage Score (80%) in a state fiscal year quarter the payer may send a non-compliance notice to enforce one or more of the following progressive enforcement actions based on the number of occurrences within a 24-month period:

- First occurrence within a 24-month period - Require additional EVV policy, system and portal trainings within a specific timeframe
    - The payer must review the EVV Usage Score for the following quarter from the date of the non-compliance notice requiring additional EVV training.
        - If the minimum EVV Usage Score is met, no further action will be taken by the payer for the compliant quarter
        - If the minimum EVV Usage Score is not met, the payer may document and apply a corrective action plan (CAP)
- Two or more occurrences within a 24-month period - Require completion of a CAP within ten business days of the notice of non-compliance
    - The payer must review the EVV Usage Score for the following quarter from the date of implementation of an accepted CAP.
        - If the minimum EVV Usage Score is met, no further action will be taken by the payer for the compliant quarter
        - If the minimum EVV Usage Score is not met, the payer may initiate contract termination.
- Three or more occurrences within a 24-month period - Initiate contract termination
    - Payers cannot terminate a contract unless:

        - The payers have followed the above progressive enforcement actions.
        - The program provider or FMSA has not met the minimum EVV Usage Score for a total of 3 quarters (9 months) within in a 24-month period

Prior to a payer enforcing action, payers must ensure failure to meet and maintain the compliance score was not due to:

- Payer errors such as:
    - Late authorizations
    - Missing or incorrect Healthcare Common Procedure Coding System (HCPCS), Modifiers, Service Group and Service Codes provided by the payer
- A system outage, defect or issue related to the EVV Aggregator, EVV Portal or EVV Vendor System
- Natural disasters

CDS Employers Enforcement Actions

When a CDS employer fails to meet and maintain the minimum EVV Usage score in a state fiscal year quarter the payer may send a non-compliance notice to enforce one or more of the following progressive enforcement actions based on the number of occurrences within a 24-month period:

- First occurrence within a 24-month period - Require additional EVV policy, system and portal trainings within a specific timeframe
    - The payer must review the EVV Usage Score for the following quarter from the date of the non-compliance notice requiring additional EVV training.
        - If the minimum EVV Usage Score is met, no further action will be taken by the payer for the compliant quarter
        - If the minimum EVV Usage Score is not met, the payer may document and apply a corrective action plan (CAP)
- Two or more occurrences within a 24-month period - Require completion of a CAP within ten business days of the notice of non-compliance
    - The payer must review the EVV Usage Score for the following quarter from the date of implementation of an accepted CAP.
        - If the minimum EVV Usage Score is met, no further action will be taken by the payer for the compliant quarter
        - If the minimum EVV Usage Score is not met, the payer may recommend removal from the CDS option.
- Three or more occurrences within a 24-month period - Recommend removal from the CDS option

Prior to a payer enforcing action, payers must ensure failure to meet and maintain the compliance score was not due to:

- FMSA errors such as not responding to the CDS employer
- A system outage, defect or issue related to the EVV Aggregator, EVV Portal, EVV Vendor System or EVV Proprietary System
- Natural disasters

Review Period Schedule
The EVV usage review period schedule follows the state fiscal year quarters. Payers may begin reviews any time after the visit maintenance timeframe has expired for the specified state fiscal year quarter.

EVV Usage Review Period Schedule

Quarter Number	Review Period/State Fiscal Year Quarters (based on date of service)	EVV Usage Review Dates
1	September, October, November	After the visit maintenance timeframe has expired from the last date of the specified quarter, November 30.
2	December, January, February	After the visit maintenance timeframe has expired from the last date of the specified quarter, February 28.
3	March, April, May	After the visit maintenance timeframe has expired from the last day of the specified quarter, May 31.
4	June, July, August	After the visit maintenance timeframe has expired from the last day of the specified quarter, August 31.

EVV Usage Report
Payers will use the EVV Usage Report (located in the EVV Portal) to conduct EVV Usage Reviews for visits with a date of service within the Review Period.

Program providers and FMSAs currently have access to the EVV Usage Report in the EVV Portal.

The EVV FMSA Usage Report will be available in the EVV Portal in 2021 and the EVV CDS Employer Usage Report will be available in 2022 in the EVV Portal and EVV systems.
See the Reports Policy for more information.

State-Required Personal Care Services Grace Period
EVV Usage Reviews will begin any time after the visit maintenance timeframe has expired from the last day of the specified state fiscal year quarter. The grace period dates of service started Sept. 1, 2019 and ended Aug. 31, 2020 for these services.

Cures Act Personal Care Services Grace Period
EVV Usage Reviews will begin after:

- The visit maintenance timeframe has expired
- The grace period has ended
  - The grace period dates of service started Jan. 1, 2021 and will end on Dec. 31, 2021 for program providers and FMSAs.
  - Due to availability of the EVV CDS Employer Usage report, the grace period dates of service for CDS employers started Jan. 1, 2021 and will end Aug. 31, 2022 unless noted by HHSC.

10020 EVV Landline Phone Verification Reviews

Revision 21-1; Effective November 1, 2021

The payers will review the phone number used for clocking in and clocking out of the EVV system to ensure the phone number is from an allowable phone type.

See the Clock In and Clock Out Methods Policy for more information.

Failure to Meet the Compliance Standard
Failure to meet one of the required actions outlined in the notification sent by the payer may result in the payer placing the program provider or FMSA

on a referral hold until the program provider or FMSA submits required documentation.

Program Providers and FMSAs Enforcement Actions
When a program provider or FMSA fails to submit required documentation showing compliance with EVV home phone landline requirements, the payer may enforce a progressive referral hold of three months, six months or nine months (not to exceed a total of eighteen months) after the end of the EVV Landline Phone Verification Review.

Failure to submit the required documentation within the referral hold timeframe may result in the payer applying a six month or a nine-month referral hold depending on the occurrence after the end of the EVV Landline Phone Verification Review.

If the program provider or FMSA has been placed on a referral hold for a total of 18 months within a 24-month period, the payer may initiate contract termination.

If supporting documentation is received by the payer within the referral hold timeframe, the referral hold will be removed.

Review Period Schedule
EVV Landline Phone Verification Reviews will be at the payer's discretion and may occur any time after the date of the visit if the phone number used to clock in and clock out has already been captured in the EVV system.

See the Clock In and Clock Out Methods policy for more information.

EVV Landline Phone Verification Report
The payers will use the EVV Landline Phone Verification Report (located in the EVV system) to conduct EVV Landline Phone Verification Reviews.

Program providers, FMSAs and CDS employers who have selected Option 1 or 2 on Form 1722, Employers Selection for Electronic Visit Verification Responsibilities, have access to the EVV Landline Phone Verification Report in the EVV system.

CDS employers who selected Option 3 on Form 1722, Employers Selection for Electronic Visit Verification Responsibilities, must establish a process to obtain the EVV Landline Phone Verification Report with their FMSA unless the CDS Employer has read only access to the EVV system. Contact your FMSA for more information.

See the Reports Policy for more information.

State-Required Personal Care Services Grace Period
There is no grace period for EVV Landline Phone Verification Reviews. Reviews may occur any time after the date of the visit if the phone number used to clock in and clock out has already been captured in the EVV system.

Cures Act Personal Care Services Grace Period
EVV Landline Phone Verification Reviews will begin after the grace period has ended. The grace period dates of service started Jan. 1, 2021 and will end on Dec. 31, 2021.

10030 EVV Required Free Text Reviews

Revision 21-1; Effective November 1, 2021

The payers will review EVV visit transactions to determine if required free text is entered on the visit when using a reason code.

Failure to document any required free text may result in recoupment of associated claim(s).

See *EVV Reason Code* Policy for more information.

Failure to Meet Compliance Standard

Program providers who fail to ensure required free text is entered into the EVV system prior to submitting an EVV claim may have associated claims recouped.

FMSAs who fail to ensure required free text is entered into the EVV system prior to confirming an EVV visit transaction and submitting an EVV claim may have associated claims recouped.

Review Period Schedule

The review period occurs any time after the visit maintenance timeframe has expired and at the payer’s discretion.

EVV Reason Code Usage and Free Text Report or EVV Visit Log Report

Payers will use the EVV Reason Code Usage and Free Text Report or the EVV Visit Log Report (located in the EVV Portal) to conduct EVV Required Free Text Reviews.

Program providers and FMSAs must use the EVV Reason Code Usage and Free Text Report or the EVV Visit Log Report (located in the EVV Portal) to monitor compliance of required free text.

See the *Reports Policy* for more information.

State-Required Personal Care Services Grace Period

There is no grace period for EVV Required Free Text Reviews. Reviews may begin any time after the visit maintenance timeframe has expired.

Cures Act Personal Care Services Grace Period

EVV Required Free Text Reviews will begin after:

- The visit maintenance timeframe has expired
- The grace period has ended
    - The grace period started Jan. 1, 2021 and will end on Dec. 31, 2021

10040 HHSC EVV Informal Reviews and MCO Disputes

Revision 21-1; Effective November 1, 2021

HHSC EVV Informal Reviews

Program providers, FMSAs and CDS employers

If program providers, FMSAs and CDS employers disagree with the EVV compliance review findings provided by HHSC and believe the review did not adhere to current HHSC EVV rules, policies and procedures they may request an informal review of EVV Compliance Review results for re-examination.

EVV Informal Reviews are:

- Conducted to re-examine the disputed results

- Conducted by HHSC EVV Operations staff who were not involved in the review under question
- Completed within 20 business days of the request receipt date

The EVV Informal Reviews process includes the following activities:

- Acknowledgment of receipt through email of the EVV Informal Reviews request
- Establishing the informal review team
- Conducting the EVV Informal Reviews
- Notifying the program provider, FMSA, or CDS employer in writing of the EVV Informal Reviews results

The results of the EVV Informal Review are final.

Requesting an EVV Informal Review

Program providers, FMSAs, or CDS employers may request EVV Informal Reviews within 10 business days after receipt of the EVV Notice of Non-Compliance by submitting a secure email request to the EVVcompliance@hhs.texas.gov

The request must include:

- Disputed EVV Compliance Review results
- Explanation of the basis for believing the EVV Compliance Review was not conducted according to rules, policies, and procedures
- Supporting documentation
  - Any relevant communication with TMHP-, EVV vendors or payers
  - Notification of relevant systems issues
  - Any other documentation that supports the program provider's, FMSA's, or CDS employer's disagreement with the EVV Compliance Review results

Failure to follow the steps above will result in the payer denying the EVV Informal Review request.

Please contact your MCO for instructions on how to dispute the EVV Compliance Review results.

MCO Disputes

Program providers, FMSAs and CDS employers

If program providers, FMSAs and CDS employers disagree with the EVV compliance review findings provided by an MCO and believe the review did not adhere to current HHSC EVV rules, policies and procedures they may request a dispute of the EVV Compliance Review results for re-examination with their MCO.

10050 EVV Formal Appeal of the Review

Revision 21-1; Effective November 1, 2021

As per Texas Administrative Code Title 1, Part 15, Chapter 357, Subchapter I, Rule §357.484 program providers, FMSAs or CDS employers may request in writing an administrative hearing within 15 days after receipt of the EVV Notice of Non-Compliance if appealing the following actions:

- Referral Hold
- Recoupment
- Contract termination

The written request must be sent to:

Texas Health and Human Services Commission
Legal Services
Office of General Counsel
P.O. Box 149030
Mail Code W-615
Austin, Texas 78714
Fax: 512-438-5759

Section 11000, Usage

Revision 21-1; Effective November 1, 2021

The Health and Human Services Commission (HHSC) Electronic Visit Verification (EVV) Usage Policy requires HHSC and Managed Care Organizations (MCOs), the payers, to monitor the number of manually entered EVV visit transactions and the number of rejected EVV visit

transactions to meet the minimum state fiscal year quarter EVV Usage Score.

See the EVV Compliance Reviews policy for more information.

Manually entered EVV visit transactions are EVV visits that were manually entered into the EVV system when the service provider or CDS employee did not use the EVV system to clock in and clock out when service delivery started and ended.

See the Clock In and Clock Out Methods policy for more information.

Rejected EVV visit transactions are EVV visit transactions that were not accepted by the EVV Aggregator and may require visit maintenance.

See the TMHP EVV website for additional information on the EVV Visit Transaction Rejection Guide.

11010 EVV Usage Score

Revision 21-1; Effective November 1, 2021

The EVV Usage Score measures:

- Manually entered EVV visit transactions
    - Excludes a manual EVV visit transaction with zero bill hours
    - Includes a manual EVV visit transaction accepted into the EVV Aggregator
    - Negatively impact the EVV Usage Score one time
        - A manually entered EVV visit transaction will negatively impact and count against the EVV Usage Score one time. Example: If the service provider or CDS employee does not use the EVV system to clock in and clock out, a manually entered EVV visit transaction must be entered into the EVV system. The manually entered EVV visit transaction will count against the EVV Usage Score once.
- Rejected EVV visit transactions
    - Negatively impact the EVV Usage Score each time the EVV Aggregator rejects an EVV visit transaction
        - A rejected EVV visit transaction will negatively impact and count against the EVV Usage Score as many times as the EVV visit transaction is rejected. Example: If the EVV visit transaction was rejected and the program provider, FMSA

or CDS employer corrected the rejected visit transaction then resubmitted the EVV visit transaction and the EVV visit transaction was rejected again, the EVV visit transaction would count against the EVV Usage Score twice.

Program Providers

Program providers must achieve and maintain a minimum EVV Usage Score of 80% rounded to the nearest whole percentage, each state fiscal year quarter, unless noted by HHSC.

Program providers below the EVV Usage Score will be reviewed. Payers may choose to review all program providers or a sample of program providers that did not meet the minimum EVV Usage Score.

Score Calculations

The EVV Usage Score for a program provider equals the manual EVV visit transaction score plus the rejected EVV visit transaction score.

The manual EVV visit transaction score equals the number of total electronic (non-manual) visit transactions divided by the total number of accepted visit transactions by the EVV Aggregator and then multiplied by 60 percent.

The rejected EVV visit transaction score equals the number of non-rejected visit transactions divided by the total number of exported visit transactions sent to the EVV Aggregator and then multiplied by 40 percent.

FMSAs

FMSAs must achieve and maintain a minimum EVV Usage score of 80% rounded to the nearest whole percentage, each state fiscal year quarter, unless noted by HHSC.

FMSAs below the EVV Usage Score will be reviewed. Payers may choose to review all FMSAs or a sample of FMSAs that did not meet the minimum EVV Usage Score.

Score Calculations

The EVV Usage Score, for an FMSA, equals the rejected EVV visit transaction score.

The rejected EVV visit transaction score equals the number of non-rejected visit transactions divided by the total number of exported visit transactions sent to the EVV Aggregator.

CDS Employers
CDS Employers must achieve and maintain a minimum EVV Usage Score of 80% rounded to the nearest whole percentage, each state fiscal year quarter, unless noted by HHSC. See table below for CDS employer EVV Usage Score requirements based on service delivery dates.

CDS employers below the EVV Usage Score will be reviewed. Payers may choose to review all CDS employers or a sample of CDS employers that did not meet the minimum EVV Usage Score.

Fiscal Year (FY)	Quarter (Q)	Service Delivery Dates	EVV Usage Score
FY 22	Q1	9/1/2021 – 11/30/2021	Grace Period
FY 22	Q2	12/01/2021 – 2/28/2022	Grace Period
FY 22	Q3	3/1/2022 – 5/31/2022	Grace Period
FY 22	Q4	6/1/2022 – 8/31/2022	Grace Period
FY 23	Q1	9/1/2022 – 11/30/2022	40%
FY 23	Q2	12/1/2022 - 2/28/2023	60%
FY 23	Q3	3/1/2023 - ongoing	80%

Score Calculations
The EVV Usage Score, for a CDS employer, equals the manual EVV visit transaction score.

The manual EVV visit transaction score equals the number of total electronic (non-manual) visit transactions divided by the total number of accepted visit transactions by the EVV Aggregator.

11020 Manually Entered EVV Visit Transactions

Revision 21-1; Effective November 1, 2021

Program providers and CDS employers must ensure an HHSC-approved method is used to clock in and clock out of the EVV system.

When a service provider or CDS employee does not use an HHSC-approved method to clock in or clock out of the EVV system, the program provider, FMSA or CDS employer (if Option 1 is selected on Form 1722, Employer's Selection for Electronic Visit Verification Responsibilities) must manually enter the missing visit data into the EVV system.

Refer to the Clock In and Clock Out Methods policy for more information.

11030 Rejected EVV Visit Transactions

Revision 21-1; Effective November 1, 2021

When an EVV visit transaction is sent to the EVV Aggregator and does not pass all EVV visit transaction validations, the EVV visit transaction is rejected and sent back to the EVV system to notify the program provider, FMSA or CDS employer visit maintenance is required.

Rejected EVV visit transactions identified as program provider or FMSA errors count against the EVV Usage Score for the state fiscal year quarter even after being accepted by the EVV Aggregator.

The following table shows data elements, as applicable, and EVV visit rejection reasons identified as program provider or FMSA errors that count as a rejected EVV visit transaction.

Edit Number	Data Elements (as applicable)	EVV Visit Rejection Reason
Ex0002C	NPI	Provider NPI cannot be validated as active for the visit date.
Ex0003C1	API	Provider API cannot be validated as active for the visit date.

Ex00031C	Payer	The Member's Payer on the EVV visit does not match our records for this Member.
Ex00034C1	Member Medicaid ID	The member Medicaid ID on the EVV visit is not found in our records.
Ex00034C2	Member Medicaid ID (no active eligibility)	The member Medicaid ID on the EVV visit does not have active Medicaid eligibility for the visit date.
Ex00043C	MCO Member Service Delivery Area (SDA)	The MCO member SDA on the EVV visit does not match the Plan Code associated with the member's payer.
Ex00057C1	Service Group and Service Code combination	The service group and service code combination on the EVV visit are not eligible for EVV.
Ex00057C2	Service Group not valid for Provider Number	The service group and Service Code combination on the EVV visit are not valid for the Provider number on the visit.
Ex00057C3	Member not authorized for Service Group/Service Code combination	The member on the EVV visit is not authorized for this service group/service code on this visit date in our records.
Ex00059C	HCPCS and Modifier combination not eligible for EVV	The HCPCS Code and EVV Modifier combination on the EVV visit is not eligible for EVV.

11040 EVV Usage Reviews

Revision 21-1; Effective November 1, 2021

Payers conduct EVV Usage Reviews by the following contract and agreement types:

- Program providers and FMSAs with Long-Term Care (LTC) Fee-for-Service (FFS) contracts are monitored at the provider number level.
  - **Example:** If a program provider or FMSA have five different LTC FFS contracts, each unique provider number will receive an EVV Usage Score.
- Program providers and FMSAs enrolled with TMHP for Acute Care FFS are monitored at the NPI or API/TIN combination level.
  - **Example:** If a program provider or FMSA have three different NPIs or APIs with the same TIN or three different TINs, each NPI or API/TIN combination will receive an EVV Usage Score regardless if the TIN is the same or different.
- Program providers and FMSAs with MCO contracts are monitored at the NPI or API/TIN combination level.
  - **Example:** If a program provider or FMSA have three different NPIs or APIs with the same TIN or three different TINs, each NPI or API/TIN combination will receive an EVV Usage Score regardless if the TIN is the same or different.
- CDS employers are monitored at the Member level.
  - **Example:** Each Member who has selected the CDS option will be reviewed.

Review Period Schedule
Reviews may begin any time after the EVV visit maintenance timeframe has expired for the specified state fiscal year quarter.

The EVV usage review period schedule follows the state fiscal year quarters and is based on dates of service.

State Fiscal Year Quarters

Quarter	Months
1	September, October, November
2	December, January, February
3	March, April, May
4	June, July, August

See the EVV Compliance Reviews policy for additional information.

EVV Usage Report
To determine the EVV Usage Score, payers will use the:

- EVV Usage Report, available in the EVV Portal, for program providers
- EVV FMSA Usage Report, available in the EVV Portal, for FMSAs
- EVV CDS Employer Usage Report, available in the EVV System, for CDS Employers.

A notification will be sent out when the EVV FMSA Usage Report and *EVV CDS Employer Usage Report* is available in fiscal year 2022.

See the *Report policy* for additional information.

11050 Compliance

Revision 21-1; Effective November 1, 2021

Program Providers
Failure to meet the EVV Usage Score may result in contract or agreement action leading up to contract or agreement termination.

FMSAs
Failure to meet the EVV Usage Score may result in contract or agreement action leading up to contract or agreement termination.

CDS Employers
Failure to meet the EVV Usage Score may result in a corrective action plan (CAP) leading up to removal from the CDS option.

Refer to the EVV Compliance Reviews policy for more information.

Section 12000, EVV Claims

Revision 21-1; Effective November 1, 2021

The program provider or FMSA must only submit claims for reimbursement once all the visits for the claim line items have been completed and accepted in the EVV Aggregator. The EVV Aggregator will perform a claims match against the accepted EVV visit transactions stored in the EVV Portal.

The payer must not pay a claim without a matching accepted EVV visit transaction stored in the EVV Portal.

12100 Claims Submission

Revision 21-1; Effective November 1, 2021

All EVV services listed in the EVV Service Bill Codes Table on the HHSC EVV webpage are subject to this policy.

Program providers and FMSAs must follow the billing guidelines of their payer, either HHSC or their MCO, when submitting an EVV claim.

Each claims management system will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the claims management system for further claims processing.

Program providers and FMSAs must submit EVV claims per claim line item with either a single date of service or a span of dates as required by their payer billing guidelines. See 12200 Claims Matching for more information about how the EVV Aggregator performs the EVV claims match for each type of billing.

Program providers and FMSAs using a third-party claims submitter or billing agent, must notify the third-party submitter of 12100 Claims Submission.

Program providers and FMSAs must submit EVV claims for the program and services as detailed in the tables below.

Program providers and FMSAs must meet all timely filing requirements.

Long-Term Care (LTC) Fee-for-Service (FFS)
Program providers and FMSAs must submit EVV claims for LTC FFS to the TMHP Claims Management System for the following program and services:

Program	Services	Service Delivery Options
Community Attendant Services (CAS)	• Personal Attendant Services	• Agency • Consumer Directed Services (CDS) • Service Responsibility Option (SRO)
Community Living Assistance and Support Services (CLASS) Waiver	• Community First Choice (CFC) Personal Assistance Services (PAS)/Habilitation (HAB) • In-Home Respite	• Agency • CDS
Deaf Blind with Multiple Disabilities (DBMD) Waiver	• CFC PAS / HAB • In-Home Respite	• Agency • CDS
Family Care (FC)	• Personal Attendant Services	• Agency • CDS
Primary Home Care (PHC)	• Personal Attendant Services	• Agency • CDS • SRO

Home and Community-based Services (HCS) Waiver and Texas Home Living (TxHmL) Waiver

Program providers and FMSAs must submit EVV claims to the HHSC Client Assignment and Registration (CARE) system for the following programs and services:

Program	Services	Service Delivery Options
HCS Waiver	• CFC PAS / HAB • In-Home Respite provided in own home or family home settings • In-Home Day Habilitation provided in own home or family home settings (Agency only)	• Agency • CDS
TxHmL Waiver	• CFC PAS / HAB • In-Home Respite • Day Habilitation provided in the home	• Agency • CDS

Acute Care FFS

Program providers and FMSAs must submit EVV claims for Acute Care FFS to the TMHP Compass 21 (C21) system for the following programs and services:

Program	Services	Service Delivery Options
Personal Care Services (PCS)	• PCS	• Agency • CDS
Community First Choice (CFC)	• CFC PCS • CFC HAB	• Agency • CDS

Youth Empowerment Services (YES)

Program providers must submit EVV Claims for YES to the HHSC Clinical Management for Behavioral Health Services (CMBHS) system for the following program service:

Program	Services	Service Delivery Options
YES Waiver	In-Home Respite	• Agency

Home and Community Based Services Adult Mental Health (HCBS-AMH) Waiver

Program providers must submit EVV Claims for HCBS-AMH to HHSC using an Encounter Invoice Template for the following program services:

Program	Services	Service Delivery Options
HCBS-AMH Waiver	• In-Home Respite • Supported Home Living – Habilitative Support (SHL)	• Agency

Managed Care Long-Term Services and Supports (LTSS)

Program providers and FMSAs must submit EVV claims to TMHP C21 for the following managed care programs and services:

Program	Services	Service Delivery Options
STAR Health	• CFC HAB • CFC PAS • PCS	• Agency • CDS • SRO
STAR Health – Medically Dependent Children's Program (MDCP) Covered Services	• In-Home Respite • Flexible Family Supports	• Agency • CDS • SRO
STAR Kids	• CFC HAB • CFC PAS • PCS	• Agency • CDS • SRO
STAR Kids – MDCP Covered Services	• In-Home Respite • Flexible Family Supports	• Agency • CDS • SRO

STAR+PLUS	• CFC PAS • CFC HAB • PAS	• Agency • CDS • SRO
STAR+PLUS – Home and Community Based Services (HCBS)	• CFC PAS • CFC HAB • PAS • In-Home Respite • Protective Supervision	• Agency • CDS • SRO
STAR+PLUS - Medicare-Medicaid Plan (MMP)	• CFC PAS • CFC HAB • PAS • In-Home Respite • Protective Supervision	• Agency • CDS • SRO

See the EVV Contact Information Guide on the HHSC EVV webpage to determine who to contact for other questions about the EVV claims submission process.

Program providers and FMSAs can access TMHP's EDI homepage for basic information needed to submit claims electronically including:

- User guides
- Forms
- Technical information intended for billing agents that file claims on behalf of program providers and FMSAs

12200 Claims Matching

Revision 21-1; Effective November 1, 2021

All EVV claims for services required to use EVV must match to an accepted EVV visit transaction in the EVV Aggregator (the state's centralized EVV database) before reimbursement of an EVV claim by the payer. TMHP, the claims administrator for the state of Texas, oversees this process.

Payers will deny or recoup an EVV claim that does not match an accepted EVV visit transaction. This includes fee-for-service claims paid by HHSC, acute care claims paid by TMHP on behalf of HHSC and managed care claims paid by the MCO.

Program providers and FMSAs using a third party to bill claims must notify the third party of 12200 Claims Matching.

12210 Claims Matching Process

Revision 21-1; Effective November 1, 2021

HHSC uses the EVV claims matching process to identify one or more EVV visits that support a Medicaid claim. Once a program provider or FMSA submits an EVV claim to a claims management system operated by HHSC or TMHP, the claims management system forwards any claims for EVV services to the EVV Aggregator for the claims matching process.

The automated claims matching process includes:

- Receiving an EVV claim line item.
- Matching data elements from each EVV claim line item to data elements from one or more accepted EVV visit transactions in the EVV Aggregator.
- Forwarding an EVV claim match result code to the payer once the claims match process is complete.

Program providers and FMSAs must use the EVV Portal to review and confirm the EVV Aggregator has accepted the EVV visit transactions before submitting the EVV claim(s) for those services.

The following data elements from the claim line item and the EVV visit transaction must match:

EVV Claim Line Item	Accepted EVV Visit Transaction
Medicaid ID	Medicaid ID
Date of Service	EVV Visit Date
National Provider Identifier (NPI) or Atypical Provider Identifier (API)	NPI or API
Healthcare Common Procedure Coding System (HCPCS) Code	HCPCS Code
HCPCS Modifiers	HCPCS Modifiers
Billed Units	Billable Units (if applicable)

If any of the above data elements do not match, the claim matching process will return an unsuccessful match result code and the payer will deny the claim.

The EVV claims matching process supports EVV claims submitted with a single date of service and EVV claims submitted with a span of service dates.

Unit Matching for Multiple Visits on the Same Date of Service
If there are multiple visits for the same member for the same service (HCPCS and Modifier combination) from the same provider on the same date of service, the claims matching process combines the total number of units on all accepted EVV visits for that date and compares the unit total to the billed units on the claim line item.

Unit Matching Requirement for EVV Claims with Single Line Item
Program providers and FMSAs submitting EVV claims with a single EVV claim line item for each date of service must have one or more matching accepted EVV visit transactions for the same date in the EVV Aggregator or the payer may deny or recoup the EVV claim line item.

Unit Matching Requirement for EVV Claims with Span Dates (more than one consecutive date)

Program providers and FMSAs submitting an EVV claim with a span of dates for a line item must ensure that:

- Each date of service within the span of dates has one or more matching EVV visit transactions accepted in the EVV Aggregator.
- The total units on the EVV claim line item must match the combined total units on the accepted EVV visit transactions for the span of dates, if applicable.

The payer will deny or recoup an EVV claim line item with span dates that does not meet the above criteria.

12220 Exceptions to the Claims Matching Process

Revision 21-1; Effective November 1, 2021

HHSC will establish any exceptions to the claims matching process in the EVV Service Bill Codes Table.

Service-Specific Bypass
HHSC will bypass the claims matching process for specific services. Refer to the EVV Service Bill Codes Table for the specific services that bypass the claims matching process.

Units Matching Bypass
The EVV claims matching process does not match units on the EVV visit transaction against the billed units on the EVV claim line item for any of the services associated with the CDS option.

In addition, the claims matching process does not match units on the EVV visit transactions against the billed units on the claim line item for other specific services. Refer to the EVV Service Bill Codes Table for the specific services that bypass the units matching process.

Bypass for Disasters and Temporary Circumstances
HHSC may temporarily set the EVV claims matching process to bypass EVV claims in response to a disaster or temporary circumstances that may disrupt delivery of services. In such cases, HHSC will provide written direction to program providers and FMSAs, including the effective dates of the bypass.

12230 Claims Match Result Codes

Revision 21-1; Effective November 1, 2021

Based on the result of the EVV claims matching process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.

EVV claim match result codes viewable in the EVV Portal are:

- EVV01 – EVV Successful Match
- EVV02 – Medicaid ID Mismatch
- EVV03 – Visit Date Mismatch
- EVV04 – Provider Mismatch (NPI/API)
- EVV05 – Service Mismatch (HCPCS and Modifiers if applicable)
- EVV06 – Units Mismatch
- EVV07 – Match Not Required
- EVV08 – Natural Disaster

The payer will communicate the outcome of the final claims processing to program providers and FMSAs.

EVV Claim Match Result Code EVV01
If the EVV Aggregator identifies one or more accepted EVV visit transactions matching the EVV claim line item, the EVV claims matching process will return an EVV01 – EVV Successful Match result code. A payer may still deny or recoup an EVV claim with a match code result of EVV01 if other claim requirements fail the claims adjudication process.

For example:

- The payer may deny the claim if the claim amount billed exceeds the authorized amount for the member.
- The payer may recoup an EVV claim if the program provider or FMSA changes an EVV visit after the match and does not submit an updated claim.

EVV Claim Match Result Codes EVV02 – EVV06
If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05 or EVV06. The payer will deny the EVV claim if the EVV claim line

item receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05 or EVV06.

EVV Claim Match Result Codes EVV07 and EVV08

When HHSC implements a bypass of the claims matching process for a disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- Payers will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- A payer may still deny an EVV claim if other claim requirements fail the claims adjudication process.

When HHSC sets the EVV claims match bypass, the EVV Aggregator will still perform a match between the EVV claim line item and the EVV visit transactions and record the actual match outcome. Program providers and FMSAs can view the actual match results using the Informational Match Result column in the EVV Claim Search results in the EVV Portal to determine whether the claim would have matched without the bypass.

Even though the payer will not deny the claim for an EVV07 or EVV08 upfront, payers may recoup the EVV claim if the program provider or FMSA does not follow instructions from HHSC or their MCO for an EVV claim match result code of EVV07 or EVV08.

Claims Status Report

The payer will return a claims status report for each EVV claim. The claims status report includes the EVV claim match result code and the EVV claims processing result. This may include an Explanation of Benefit (EOB), Explanation of Payment (EOP) or a Denial Claims Report. Claims status reports differ by the payer and program.

See the table below for the claims management system responsible for sending an EVV claim to the EVV Aggregator and the system that will report the EVV claims status.

Payer	Claims Management System	Claims Status Reports
TMHP on behalf of HHSC (Acute Care Fee-for-Service)	TMHP Compass 21	Remittance and Status (R&S) Report

HHSC (Long Term Care Fee-for-Service)	TMHP Claims Management System	R&S Report
HHSC (HCS1 / TxHmL2)	CARE Claims System	R&S Report
Managed Care	MCO Claims Systems	Varies
HHSC (YES3)	CMBHS Claims System	R&S Report
HHSC (HCBS-AMH4)	Encounter Invoice Template	HHSC-AMH

1. HCS – Home and Community Based Services Waiver
2. TxHmL – Texas Home Living Waiver
3. YES – Youth Empowerment Services Waiver
4. HCBS-AMH – Home and Community Based Services (HCBS) Adult Mental Health
5. CARE – Client Assignment and Registration System
6. 6 CMBHS – Clinical Management for Behavioral Health Services
7. Encounter Invoice Template – a manual process and EVV claims will not be sent to the EVV Aggregator.

See the EVV Contact Information Guide on the HHSC EVV webpage to determine who to contact for more questions about the EVV claims matching process or EVV claim denial.

Section 13000, Reports

Revision 21-1; Effective November 1, 2021

The EVV Reports Policy covers EVV standard reports that HHSC and MCOs use for oversight and data analysis; such as but not limited to:

- Contract monitoring
- Recoupment
- EVV compliance reviews
- Fraud, waste, and abuse reviews

Program providers and FMSAs must access the HHSC EVV standard reports located in the EVV Portal and EVV systems.

CDS employers must access HHSC EVV standard reports in the EVV system.

13010 EVV Portal Standard Reports

Revision 21-1; Effective November 1, 2021

Below are the EVV standard reports available to program providers, FMSAs, MCOs and state staff in the EVV Portal.

EVV Attendant History Report

- Verifies which service providers and CDS employees provided services to a member for a requested date range

EVV Claim Match Reconciliation Report

- EVV01 Report
    - Identifies claims that received a match code of EVV01 at the time of the claims matching process and receive a different match code on the report run date.
    - Displays the match code the claim would receive on the report run date. These include match codes EVV02, EVV03, EVV04, EVV05, EVV06, EVV07 or EVV08.
    - Serves as a tool for program providers, FMSAs and payers to research claim matching codes.
- EVV07 or EVV08 Report
    - Identifies claims that received a match code of EVV07 or EVV08 and an informational match code of EVV02, EVV03, EVV04, EVV05 or EVV06 at the time of the claims matching process.
    - Displays the match code the claim would receive on the report run date. These include match codes EVV01, EVV02, EVV03, EVV04, EVV05 or EVV06
    - Serves as a tool for program providers, FMSAs and payers to research informational claim matching codes.

EVV Clock In/Clock Out Usage Report

- Displays the service provider’s and CDS employee’s:

- Use of EVV clock in and clock out methods
- Total visits worked within a specific date range
- Percentage of total visits worked for each clock in and clock out method within a specific date range

EVV Provider Report

- Displays contract or enrollment data used by the program provider or FMSA during setup in the EVV system.
- Displays the program provider or FMSA EVV system onboarding date, start date and end date.

EVV Reason Code Usage and Free Text Report

- Used to conduct EVV compliance reviews for reason code and required free text. See Section 10000, EVV Compliance Reviews for more information.
- Displays the EVV reason code number, reason code description and any free text entered on accepted EVV visits transactions during a specified month, sorted by each program provider's or FMSAs unique identifier.
- Allows program providers and FMSAs, on behalf of the CDS employers, to search reason code usage and entered free text by Medicaid ID.

EVV Units of Service Summary

- Displays daily, weekly and monthly totals of services delivered for a Medicaid ID
- Allows for identifying breaks in service for a Medicaid ID

EVV Usage Report

- Used to conduct EVV usage reviews. See Section 10000, EVV Compliance Reviews and Section 11000, EVV Usage for more information.
- Displays the EVV Usage Score for each program provider and FMSA for the preceding quarter(s)

EVV Visit Log

- Displays the hours of service delivered by the service provider or CDS employee to the member.

- Includes all EVV accepted visit data sent to the EVV Aggregator for service delivery visits on or after Sept. 1, 2019.
- Displays the:
    - Schedule, if applicable
    - Actual hours
    - Location
    - EVV clock in and clock out method for each visit

13020 EVV System Standard Reports

Revision 21-1; Effective November 1, 2021

Below are the EVV system standard reports available to program providers, FMSAs, CDS employers, MCOs and state staff in the EVV system.

EVV Alternative Device Order Status Report

- Used to verify and track the status of alternate devices orders

EVV Attendant History Report*

- Verifies which service providers and CDS employees provided services to a member for a requested date range

EVV CDS Service Delivery Log

- Displays EVV visit data for CDS employers for a requested date range
- Data is based only on completed and verified visits from the EVV system

EVV Clock In/Clock Out Usage Report*

- Displays the service provider's and CDS employee's:
    - Use of EVV clock in and clock out methods
    - Total visits worked within a specific date range
    - Percentage of total visits worked for each clock in and clock out method within a specific date range

EVV Landline Phone Verification Report

- Used to conduct EVV compliance landline phone reviews. See Section 10000, EVV Compliance Reviews for more information.

- Displays the phone number used for clocking in and clocking out of the EVV system to ensure the home phone landline number is an allowable phone type.

EVV Reason Code Usage and Free Text Report*

- Used to conduct EVV compliance reviews for reason code and required free text. See Section 10000, EVV Compliance Reviews for more information.
- Displays the EVV reason code number, EVV reason code description and any free text entered on accepted EVV visits transactions during a specified month, sorted by each program provider's or FMSAs unique identifier.
- Allows program providers and FMSAs, on behalf of the CDS employers, to search reason code usage and entered free text by Medicaid ID.

EVV Service Delivery Exception Report

- This report shows the number of visits that varied from the schedule or authorization, as well as the number of visits that were not approved, for a requested date range.
- This data must include services regardless of service delivery locations including home or community location, and 'GPS' coordinates when the mobile method is used to clock in and clock out.

EVV Units of Service Summary*

- Displays daily, weekly and monthly totals of services delivered for a Medicaid ID
- Identifies breaks in service for a Medicaid ID

Non-EVV Relevant Time Logged Report

- Displays service provider and CDS employee time spent on non-EVV services during each visit for a requested date range.

*The report is exported from the EVV Portal.

13030 EVV Vendor Ad Hoc Reporting

Revision 21-1; Effective November 1, 2021

Ad hoc reports are EVV non-standard reports. HHSC and MCOs will not use ad hoc reports for contract oversight monitoring or compliance reviews.

The EVV vendor, or EVV PSO where applicable, must provide ad hoc reporting of any EVV data available in the EVV system at no additional cost to HHSC, MCOs, program providers, FMSAs or CDS employers.

Contact your EVV vendor or EVV PSO with questions about ad hoc reporting.

13040 EVV Portal Search Tools

Revision 21-1; Effective November 1, 2021

HHSC, MCOs, program providers and FMSAs can perform the following searches for EVV visit transactions in the EVV Portal.

Accepted Visit Search

- Displays the current accepted EVV visit transactions within a specific date range.

Visit History Search

- Allows users to search for EVV visit transactions that have been accepted or rejected by the EVV aggregator.
- Search results display all changes made to an EVV visit transaction through visit maintenance in the EVV system; including EVV visit transactions rejections and the EVV rejection code(s).

EVV Claim Search

- Allows users to search for EVV claims.
- Search results display EVV claims, claims match result codes and other claim information.
- Claims with a claim mismatch result codes will not have an EVV Visit ID because the EVV Aggregator was unable to match those claims to a visit.

For questions about:

- EVV standard reports in the EVV Portal, contact TMHP@EVV.com.
- EVV standard reports in the EVV system, contact your EVV vendor or EVV PSO.
- EVV policy, contact your payer.

Section 14000, Non-EVV Services

Revision 21-1; Effective November 1, 2021

A non-EVV service is an authorized service that is not required to use EVV.

Program providers and CDS employers must continue to follow program documentation requirements for non-EVV services. Using the EVV system does not replace paper documentation for non-EVV services.

The program provider, FMSA or CDS employer will determine how the service provider or the CDS employee will clock in and clock out of the EVV system when delivering non-EVV services and EVV services throughout the day.

The program provider or the CDS employer may select one of the following options for their service provider or CDS employee to document a non-EVV service that occurs during an EVV visit:

- **Option 1:** Clock in to the EVV system and clock out of the EVV system before the non-EVV service begins and clock back in to the EVV system after the non-EVV service has ended.
- **Option 2:** Remain clocked in to the EVV system while delivering the non-EVV service and document the amount of time spent on the non-EVV service. **Note:** Follow the EVV vendor or EVV PSO instructions on how to subtract the non-EVV service time at the end of the visit and use an appropriate EVV Reason Code Number and EVV Reason Code Description as necessary.

Examples for recording non-EVV time:
The service provider or CDS employee is working from 8 a.m. to 2 p.m. The service provider or CDS employee spends five hours on EVV required services from 8 a.m. – noon and 1 – 2 p.m. and one hour on non-EVV services from noon – 1 p.m.

- **Option 1:** Clock out of the EVV system before the non-EVV service begins and clock back in to the EVV system after the non-EVV service has ended.

    - The service provider or CDS employee will:
        - Clock in to the EVV system at 8 a.m. and clock out at noon
        - Begin the non-EVV service
        - Clock back in to the EVV system at 1 p.m. and clock out at 2 p.m.
        - Documents the non-EVV services in accordance with program policy
- **Option 2:** Remain clocked in to the EVV system while delivering the non-EVV service and document the amount of time spent on the non-EVV service.
    - The service provider or CDS employee will:
        - Clock in to the EVV system at 8 a.m. and clock out at 2 p.m.
        - Record the non-EVV service time in accordance with program policy and report the time to the program provider.
            - The program provider, CDS employer, or FMSA will use the EVV system to indicate one hour of time spent.
            - Contact your EVV vendor or EVV PSO for instruction to adjust the bill hours for a claim that is delivering a non-EVV service.

The program provider, CDS employer and FMSA can review the reported non-EVV service time by accessing the Non-EVV Relevant Time Report in the EVV system. The report will show the total hours worked for non-EVV services.

Note: The program provider or CDS employer must contact their EVV vendor or EVV PSO to determine how to document non-EVV services for members with pre-scheduled visits.

Section 15000, Fraud, Waste and Abuse

Revision 21-1; Effective November 1, 2021

If HHSC or an MCO determines that a program provider is not compliant with EVV policy and procedures, it could result in a referral for a fraud, waste, and abuse investigation.
If you are made aware of, or suspect situations that may be considered Medicaid fraud, waste, or abuse, report it to the HHSC Inspector General online or by calling their toll-free fraud hotline at 800-436-6184.

Exhibit R: HHSC EVV Business Rules

This document provides the HHSC Electronic Visit Verification (EVV) Business Rules version 9.0, which is the current version as of February 2022.

The functionality of the State Pool System/State Pool System Operator (referred to as "EVV system" and "EVV vendor" within this document) must comply with the HHSC EVV Business Rules. HHSC regularly updates the business rules and will provide the most current version to the awarded Contractor upon the Contract Effective Date or as otherwise agreed between the Parties.

Version 9.0

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EVV Vendor Compliance and Processing Guidelines

This document outlines the set of standards that any EVV Vendor must adhere to as a condition of participation in the Texas Medicaid EVV Program. The standards cover the guidelines for business processes related to EVV, and compliance with them is critical to producing successful outcomes for the program.

The guidelines govern the system set up (onboarding) for new users, the documentation and verification of services requiring EVV, the maintenance of the visit data, and transmission of the data to the EVV Aggregator.

User Onboarding

Vendor Selection

Vendor Selection	
PAO-1	EVV Vendors must receive complete Program Provider or FMSA profile information from the MES service providers for each Business Unit before beginning the onboarding process.
PAO-2	EVV Vendors must contact the Program Provider or FMSA within required time frames to review the onboarding process, expectations, and when required, schedule a time and date to install the EVV System.

Program Provider or FMSA Profile Set-Up and Data Elements Validation

Program provider or FMSA/System User Profile Set-up and Data Elements Validation	
PAO-3	EVV System must create a unique profile for each Program Provider or FMSA Business Unit containing the identification information from the EVV Master Provider web service. This includes distinct profiles for each type of System User and security access. See Appendix I for details on Security Roles.
PAO-4	EVV System must electronically document identification data for each Program Provider or FMSA Business Unit through the EVV Master Provider web service described in Appendix D.
PAO-5	EVV System must validate identification data entered by the System User against the Texas Medicaid data using the EVV Master Provider web service. The EVV System must communicate an error to the System User for any required data elements that do not match and creation of the Program Provider or FMSA Business Unit profile must not occur until the System User corrects the errors. See Appendix D for details on EVV Master Provider web service.

Program provider or FMSA/System User Profile Set-up and Data Elements Validation	
PAO-6	EVV System must allow System Users with appropriate security access to initiate Program Provider or FMSA Business Unit profile updates. The EVV System must validate all updates initiated by the System User against the Texas Medicaid data as described in PAO-5.
PAO-7	EVV System must support auto-population of Texas Medicaid data presented from the EVV Master Provider web service, limiting the entry of data by the System User. The EVV System must not allow a System User to update required auto-populated fields. See Appendix D for details on EVV Master Provider web service.
PAO-30	EVV System must allow the following relationships, at a minimum: A Program Provider or FMSA Business Unit can be associated with multiple Members. A Program Provider or FMSA Business Unit can be associated with multiple Service Providers. A Program Provider or FMSA Business Unit can be associated with multiple Subcontracted Providers. A Subcontracted Provider can be associated with multiple Program Provider or FMSA Business Units. A Program Provider or FMSA Business Unit can be associated with multiple CDS employers. A CDS Employer can be associated with multiple Members. A CDS Employer can be a Member. A CDS Employer can be associated with multiple Service Providers.
PAO-31	EVV System must allow an FMSA to capture the designation provided by the CDS Employer, to identify the Designated Representative (DR) to perform all system actions on behalf of a CDS Employer. EVV System must adhere to HHSC EVV Policy regarding the CDS Employer's appointment of a DR.

Service Provider Profile Set-up and Data Elements Validation

Service Provider Profile Set-up and Data Elements Validation	
PAO-8	EVV System must create a unique profile for each Service Provider containing the Service Provider identification information listed in PAO-9 (at a minimum). This includes CDS Employees.
PAO-9	EVV System must electronically document the following data elements for the Service Provider's identification information: Texas EVV Service Provider Identification Number Legal Name (Last, First, MI) Permanent address (Street, City, State, Zip+4)
PAO-10	EVV System must allow System Users with the appropriate security access to update Service Provider profiles.
PAO-11	** Business Rule removed ** ~~EVV system must allow unlimited number of service attendants to be associated with each provider user.~~
PAO-12	** Business Rule removed ** ~~EVV system must allow one service attendant to be associated with multiple provider user profiles.~~
PAO-13	** Business Rule moved to Service Delivery – SDV-42 **
PAO-32	EVV System must allow the following relationships, at a minimum:

Service Provider Profile Set-up and Data Elements Validation	
	A Service Provider can be associated with multiple Program Provider or FMSA Business Units. A Service Provider can be associated with multiple CDS Employers. A Service Provider can be associated with both Program Provider or FMSA Business Units and CDS Employers. A Service Provider can be associated with multiple Members.

Member Profile and Data Elements Validation

Member Profile and Data Elements Validation	
PAO-14	EVV System must create a unique profile for each Member receiving Services containing the identification information listed in PAO-15 (at a minimum).
PAO-15	EVV System must electronically document the following critical data elements for the Member's identification information: Texas Medicaid Identification Number Legal Name (Last, First, MI) Date of Birth Medicaid Eligibility start date Medicaid Eligibility end date Managed Care Eligibility start date Managed Care Eligibility end date Member Home Address (Street, City, State, Zip+4) Member phone number Conditional data elements depending on selected electronic verification method(s): When the Member selects Landline Method: Member Home Phone Landline Number Member Alternate Phone Landline Number(s) When the Member selects mobile method: Member Home Geo-Location (system assigned) When the Member selects Alternative Device: Member Alternative Device identifier
PAO-16	EVV System must validate any Member data entered by the System User against Texas Medicaid data using the x12 270/271 exchange. The EVV System must communicate an error to the System User for any required data elements that do not match but must not prevent the creation of the Member profile. See Appendix E – Member Eligibility Companion Guides for details on the X12 270/271.
PAO-17	EVV System must allow System Users with appropriate security access to initiate Member profile updates. The EVV System must validate all System User-initiated updates against Texas Medicaid data as described in PAO-16.
PAO-18	EVV System must support auto-population of Member data presented from the x12 270/271, limiting the entry of data by the System User. The EVV System must not allow the System User to update required auto-populated fields. See Appendix E – Member Eligibility Companion Guides for details on the X12 270/271.
PAO-19	EVV System must support multiple electronic verification methods for one Member.
PAO-33	EVV System must allow the following relationships, at a minimum: A Member can be associated with multiple Program Provider or FMSA Business Units. A Member can be associated with only one CDS Employer.

Member Profile and Data Elements Validation	
	A Member can be associated with both Program Provider and FMSA Business Units, and a CDS Employer. A Member can be associated with multiple Service Providers.
PAO-34	EVV System must allow a System User with the appropriate security access to adjust the Member Home Geo-location in the Member profile.

EVV System Training

EVV System Training	
PAO-21	EVV Vendor must provide ongoing system training on an annual basis to Program Provider and FMSA agencies and their staff, CDS Employers, MES service provider staff, HHSC employees and MCO staff. The training must include access to, and use of, a test environment where the EVV Vendor demonstrates full EVV System functionality.
PAO-22	EVV Vendor must provide complete and accurate system training to System Users, including CDS Employers and Service Providers, prior to allowing access to the EVV System for the first time.
PAO-24	EVV Vendor must provide system training to System Users including the following topics (at a minimum): System access and log-on Data entry and updates Visit capture and validation Device ordering and usage Visit maintenance/updates to EVV Visit Transactions Clock in and Clock out methods Access and creation of reporting, as well as an overview of report usage Customer Service (system troubleshooting, issue reporting, complaints, etc.) Refer to EVV Training Requirements Checklists on the HHSC EVV website.
PAO-25	EVV Vendor must provide training adhering to the accessibility standards contained in federal laws and regulations, including Americans With Disabilities Act and Section 508 of the Federal Rehabilitation Act. This includes making videos and other learning methodologies available as a presentation method for training materials/sessions.
PAO-26	EVV Vendor must provide training materials in English, Spanish, and other languages.
PAO-27	EVV Vendor must provide notice and training to System Users prior to the release of major system changes.

Third Party System Integration

Third Party System Integration	
PAO-28	EVV System must support integration with 3rd Party Systems used to support other aspects of a Program Provider's or FMSA's business, including time tracking/payroll, and scheduling, allowing Program Providers and FMSAs to set up data exchange through an automated process. The EVV Vendor must provide this at no additional cost.
PAO-29	EVV Systems integrating with a 3rd Party system must adhere to data validation standards described in this document before accepting data from the 3rd Party System.

Establishing Service

Service Authorization

Service Authorization	
ESA-1	**Business Rule removed** ~~*EVV system must allow provider users to opt out of the Prior Authorization Pilot until the pilot completion. When the pilot ends, the functionality will be required for all provider users and provider users will no longer be allowed to opt out.*~~
ESA-2	EVV System must request, receive, and store available electronic Fee for Service authorization data from MES service providers using the standardized file format found in Appendix F. This activity must occur at least once daily.
ESA-3	EVV System must allow the System User to confirm Member Service Authorizations using the authorization data received from the payer. The EVV System must reject Service Authorizations not confirmed by the System User, unless it matches what the System User created manually.
ESA-4	EVV System must alert System Users to changes in Service Authorization data received from the payer.
ESA-5	** Business rule moved to section Schedules – General **
ESA-6	** Business rule removed; covered by ESA-13 and SDV-51 ** ~~*EVV System must alert the System User when the Member authorized units are reaching the maximum allowed from the Service Authorization.*~~
ESA-7	EVV System must verify the accuracy of the EVV Visit Transaction, prior to confirmation and transmission to the EVV Aggregator, to ensure it matches the Service Authorization data. The verification must ensure that the relationship between the Program Provider or FMSA ID (NPI, API, TIN, Provider Number), the Medicaid ID for the Member and the Service Codes match the authorization data. If they do not match, then the EVV System must notify the System User and, if within the Visit Maintenance Time Frame, allow the System User to make corrections prior to transmission of the EVV Visit Transaction to the EVV Aggregator.
ESA-15	EVV System must allow the System User to manually create a Service Authorization for a Member if one from the payer does not exist. Service Authorization data subsequently received from the payer will take precedence and the System User must confirm the data unless the data match what the System User created manually.
ESA-16	EVV System must validate manually entered Service Authorization data against existing profile data in the system.
ESA-17	EVV System must validate electronic Service Authorization data received from the payer to ensure that the data format is correct, and that the payer populated all required fields. See Appendix F for technical specifications.

Schedules – No Schedule

ESA-9	EVV system must allow Service Providers to clock in and clock out for a Visit that the Service Provider delivers without a Schedule.

ESA-52	EVV System must allow a System User to manually document a Visit that the Service Provider delivered without a Schedule and did not use an electronic verification method to clock in or clock out.
ESA-53	If the System User does not choose a Schedule Type for a Member, then the EVV System must default to no Schedule.
ESA-54	The EVV System must Auto-verify a Visit with no Schedule if no critical exceptions are present on the Visit. Refer to Appendix P for Auto-verification specifications.

Schedules - General

Schedules - General	
ESA-5	EVV System must alert the System User when the System User enters a Service Schedule without a supporting Service Authorization. The System User must acknowledge the alert to proceed with the Schedule creation or may cancel the action.
ESA-8	EVV System must provide a scheduling function, giving the System Users the option to enter and maintain any of the Schedule Types for planned Service delivery.
ESA-10	** Business Rule removed; see SDV-14 ** ~~*EVV system must identify when member on a schedule is not valid or eligible using data from the x12 270/271 and not allow transmission of associated visit transactions to the EVV Aggregator, unless there is an approved exception from [CONTRACTOR]. EVV system must alert system users when these transactions are identified and allow for correction of the schedule and associated visit transactions.*~~
ESA-11	** Business Rule removed; see SDV-15 ** ~~*EVV system must identify when the provider on the schedule is not valid or eligible according to the EVV Master Provider web service and not allow transmission of associated visit transactions to the EVV Aggregator. EVV system must alert provider users when these transactions are identified and allow for correction of the schedule and associated visit transactions.*~~
ESA-12	EVV System must alert the System User when the Service Provider on the Schedule does not have a complete Service Provider profile in the EVV System. The EVV System must not consider the Schedule complete until the System User has a complete Service Provider profile in the EVV system. .
ESA-13	EVV System must alert the System User when the Schedule does not match an existing or updated Service Authorization available in the EVV System. The System User must acknowledge the alert and may cancel or modify the schedule.
ESA-14	EVV System must have the ability to track and report EVV Visits that the System User scheduled but that the Service Provider did not deliver.
ESA-18P	EVV System must allow the System User to choose any of the Schedule Types for each of the Member's services.

Schedules - General	
ESA-19P	EVV System must allow the System User to choose only one Schedule Type per service per Member at a time.
ESA-20P	The EVV System must allow the System User to create a Recurring Weekly Variable Schedule, Daily Variable Schedule, or Daily Fixed Schedule.
ESA-21P	EVV System must alert the System User when a change in the Member's Schedule Type will cause the EVV System to delete all Member Schedules associated with the previous Schedule Type. The System User must acknowledge the alert to proceed with the change or may cancel the change.

Schedule Type – Daily Variable

Daily Variable Schedules	
ESA-22	EVV System must allow the System User to set up a Daily Variable Schedule for a specific Member, Service (HCPCS/Modifier), Service Provider, Service Delivery Location, Visit Duration and Visit Date.
ESA-23	EVV System must match the Member, Service (HCPCS/Modifier) and Service Provider from a Visit to the specified data elements on the Daily Variable Schedule to Auto-verify the Visit. Refer to Appendix P for Auto-verification specifications.
ESA-24	EVV System must match the Visit date to the Scheduled Visit Date to Auto-verify the Visit for a Member on a Daily Variable Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-25	EVV System must match the Visit Duration within 7 minutes of the Scheduled Visit Duration to Auto-verify the Visit. Refer to Appendix P for Auto-verification specifications.
ESA-26	EVV System must match the Visit Duration to the Scheduled Visit Duration using the Call Matching Window to Auto-verify the Visit for a Member on a Daily Variable Schedule. Refer to Appendix P for Auto-verification specifications.
ESA- 27	EVV System must allow the System User to apply the Optional Expanded Time for Auto-verification feature by Member when using a Daily Variable Schedule. Refer to Appendix P for Auto-verification specifications.
ESA- 28	EVV System must allow the System User to apply the Optional Automatic Downward Adjustment feature by Member when using a Daily Variable Schedule. Refer to Appendix P for Auto-verification specifications.

Schedule Type – Weekly Variable

Weekly Variable Schedules	
ESA-29	EVV System must allow the System User to set up a Weekly Variable Schedule for a seven-calendar day period (Sunday through Saturday) for a specific Member, Service (HCPCS/Modifier), Service Provider and Service Delivery Location.
ESA-30	EVV System must allow the System User to select any Sunday as the Weekly Variable Schedule Begin Date for a Weekly Variable Schedule.

Weekly Variable Schedules	
ESA-31	EVV System must allow the System User to set the Total Weekly Scheduled Hours equal to or less than 168 hours for the Weekly Variable Schedule.
ESA-32	EVV System must set the Weekly Variable Schedule End Date to be a Saturday that is six calendar days after the Weekly Variable Schedule Begin Date.
ESA-33	EVV System must allow the System User to delete a Weekly Variable Schedule at any point prior to the Auto-verification of a Visit against that Schedule.
ESA-34	EVV System must match the Member, Service (HCPCS/Modifier) and Service Provider data from a Visit to the specified data elements on the Weekly Variable Schedule to Auto-verify the Visit. Refer to Appendix P for Auto-verification specifications.
ESA-35	EVV System must Auto-verify a Visit for a Weekly Variable Schedule when the Visit Date is between the Weekly Variable Schedule Begin Date and the Weekly Variable Schedule End Date, and the Visit Duration does not exceed the Remaining Weekly Scheduled Hours.
ESA-36	EVV System must track and report the Remaining Weekly Scheduled Hours based on the decrementing of Bill Hours of Visits that Auto-verify against a Weekly Variable Schedule.
ESA-37	EVV System must update the Remaining Weekly Scheduled Hours of a Weekly Variable Schedule when the System User adjusts the Bill Hours during Visit Maintenance for a Visit previously Auto-verified against the Weekly Variable Schedule.
ESA-38	During a Member's Weekly Variable Schedule, the EVV System must allow the System User to increase or decrease the Total Weekly Scheduled Hours of the Weekly Variable Schedule prior to the Weekly Variable Schedule End Date. The Total Weekly Scheduled Hours adjusted amount must be equal to or greater than the Remaining Weekly Scheduled Hours.
ESA-39	During a Member's Weekly Variable Schedule, the EVV System must allow the System User to make changes to the Service Provider data associated with the Weekly Variable Schedule for future Visit Schedule dates.
ESA-40	EVV System must not enable the Call Matching Window when the System User chooses a Weekly Variable Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-41	EVV System must not enable the Optional Expanded Time for Auto-verification feature when using a Weekly Variable Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-42	EVV System must not enable the Optional Automatic Downward Adjustment feature when using a Weekly Variable Schedule. Refer to Appendix P for Auto-verification specifications.

Schedule Type – Daily Fixed

Daily Fixed Schedules	
ESA-43	EVV System must allow the System User to set up a Daily Fixed Schedule for a specific Member, Service (HCPCS/Modifier), Service Provider, Service Delivery Location, Visit clock in and Visit clock out time, and Visit Date.
ESA-44	EVV System must match the Member, Service (HCPCS/Modifier) and Service Provider from a Visit to the specified data elements on the Daily Fixed Schedule to Auto-verify the Visit. Refer to Appendix P for Auto-verification specifications.
ESA-45	EVV System must match the Visit Date to the Scheduled Visit Date to Auto-verify the Visit for a Member on a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-46	EVV System must match the Visit clock in time within 7 minutes of the scheduled clock in time to Auto-verify the Visit for a Member on a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-47	EVV System must match the Visit clock out time within 7 minutes of the scheduled clock out time to Auto-verify the Visit for a Member on a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-48	EVV System must match the Visit Duration within 7 minutes of the Scheduled Visit Duration to Auto-verify the EVV Visit Transaction for a Member on a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-49	EVV System must not enable the Call Matching Window when the System User chooses a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-50	EVV System must allow the System User to apply the Optional Expanded Time for Auto-verification feature by Member when using a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-51	EVV System must allow the System User to apply the Optional Automatic Downward Adjustment feature by Member when using a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.

Electronic Verification Methods

General

Electronic Verification Methods - General	
EVM-1	EVV Vendor must provide toll-free numbers for use by Service Providers during the clock in and clock out procedure from an approved phone.
EVM-2	EVV Vendor must provide at least one clock in and clock out electronic verification method that includes Geo-location services. The EVV Vendor must provide this method at no cost to the Program Provider or FMSA.
EVM-16	EVV System must only collect data specifically required to verify the EVV Visit Transaction. The EVV System must not capture personal data on the Service Provider’s mobile device.

Home Phone Landline

Electronic Verification Methods – Home Phone Landline	
EVM-3	EVV System must accept clock in and clock out data via the Member home phone landline or a Member alternate phone landline number identified in the Member profile.
EVM-4	EVV System must verify that the Member home phone landline number, or Member alternate phone landline number, on the EVV Visit Transaction is associated with the Member profile. If the EVV System finds a mismatch, the EVV System must flag the EVV Visit Transaction and alert the System User.
EVM-22	EVV System must assign value 'Member Home' to the Service Delivery Location when the EVV System verifies the clock in or clock out method used for the Visit matches the Member home phone landline number in the Member profile.

Alternative Methods/Devices

Electronic Verification Methods – Alternative Methods/Devices	
EVM-5	EVV Vendor must provide HHSC-approved alternatives for clock in and clock out in the event a Member does not have a home phone landline, or a recipient is unwilling to allow the Service Provider use of the home phone landline.
EVM-6	EVV System must identify a Service Provider's use of alternative methods/devices used for clock in and clock out and confirm association to a Member. If the EVV System finds a mismatch, the EVV System must flag the EVV Visit Transaction, and alert the System User.
EVM-23	EVV System must assign the value 'Member Home' to Service Delivery Location when the EVV System verifies the clock in or clock out method used for the Visit matches the Alternative Device in the Member profile.

Mobile method

Electronic Verification Methods – Mobile method	
EVM-7	EVV Vendor must allow clock in and clock out via mobile methods. The EVV Vendor must provide the mobile methods at no charge to the Program Provider or FMSA or Member.
EVM-8	EVV Vendor must receive consent from a Program Provider or FMSA and Service Provider when the Service Provider uses a personal cell phone for clock in and clock out through EVV.
EVM-9	EVV System must verify that the mobile method used for clock in, and clock out is associated with the Service Provider delivering services to the Member. If the EVV System finds a mismatch, the EVV System must flag the EVV Visit Transaction and alert the System User.
EVM-10	EVV System must capture Geo-location only at clock in and clock out via mobile methods. Mobile method must not allow for persistent tracking. The EVV System must not allow the Service Provider or System User to alter Geo-location data captured through the mobile method.

Electronic Verification Methods – Mobile method	
EVM-11	EVV System must allow Service Providers to access mobile methods.
EVM-12	EVV System must not utilize minutes from the Service Provider's cellular plan or require significant data usage through the cellular network for the mobile methods when the cost associated with that data use is the responsibility of the Program Provider or FMSA or Service Provider.
EVM-17	EVV mobile method provided by the EVV Vendor must allow multiple users to use the same device but must require logon credentials unique to each Service Provider/System User.
EVM-18	EVV mobile method provided by the EVV Vendor must allow the Service Provider to download, set up and begin using the mobile method without hands on interaction by the EVV Vendor or Program Provider or FMSA or System User.
EVM-19	The EVV Vendor must only use the Geo-location data to document the location of the Service delivery visit. The EVV Vendor must not sell, share, or allow use of the Geo-location data by a 3rd party for any reason.
EVM-20	The EVV mobile method provided by the EVV Vendor must not restrict usage of the mobile method based on the proximity of the home address of the Service Provider and the Member receiving Services.
EVM-21	EVV System must assign the value 'Member Home' to the Service Delivery Location when the EVV System verifies the Geo-Location captured using the mobile method is within the EVV Allowed Geo-perimeter of the Member Home Geo-location.
EVM-24	EVV mobile method must auto-populate the Service Delivery Location as 'Member Home' if the device determines that the Service Provider is within the EVV Allowed Geo-perimeter of the Member Home Geo-location when clocking in or clocking out. The Service Provider can modify the Service Delivery Location as needed on the mobile device.
EVM-25	The EVV mobile method must restrict the selection of Service Delivery Location during clock in and clock out to the allowable values identified in Appendix J – Service Delivery Locations.

EVV device distribution and management

Electronic Verification Methods – EVV device distribution and management	
EVM-13	EVV Vendor must adhere to HHSC EVV Policy regarding all aspects of device management when the EVV Vendor must distribute equipment to provider agencies, FMSAs, or CDS Employers. This includes the following at a minimum: Electronic order capture and fulfillment process within required time frames Delivery of devices to provider agencies, FMSAs or CDS employers. Replacement of broken, malfunctioning, or lost devices within required time frames
EVM-14	EVV Vendor must maintain enough device inventory to support current and future Member population.
EVM-15	EVV Vendor must provide electronic verification methods at no cost to the Member, Program Provider or FMSA, service provider, HHSC, MCO or CDS employer.

Service Delivery Verification

Service Delivery (EVV Visit) Transaction Documentation

Service Delivery (EVV Visit) Transaction Documentation	
SDV-1	EVV System must capture and verify the following Visit data for each EVV Visit Transaction: Member receiving the Service Service Provider providing the Service Program Provider or FMSA Business Unit the Service Provider is performing the Service on behalf of Service Delivery Location Date the Service Provider performed the Service Time the Service Provider performed the Service (start and end) Type of Service the Service Provider performed The EVV System must capture this data even in the absence of verification. See specific data elements required to support this data capture and validation in Appendices C and J.
SDV-2	EVV System must capture the clock in and clock out method used for each transaction and allow for a different method on the clock in than the clock out. EVV System must accommodate multiple methods for a single Member.
SDV-3	EVV System must allow login as well as the capture of clock in and clock out data when using a mobile method in instances when internet connection or cellular data is unavailable. This must not require manual entry of data by System Users.
SDV-4	EVV System must allow for manual data entry of EVV Visit Transactions during the Visit Maintenance Time Frame. All EVV Visit Transactions created using this manual method must identify the input method and output method as “GUI” (manual entry). EVV System must require extra certification that supporting documentation is available when the System User creates a manual Visit.
SDV-64	EVV System must only allow for manual data entry of EVV Visit Transactions outside of the Visit Maintenance Time Frame when the payer has approved the creation of visits via the HHSC-approved process.
SDV-5	EVV System must calculate Service delivery time using clock in and clock out time in standard format (MMDDYYYY HH:MM AM/PM).
SDV-6	EVV System must round actual Service delivery time to the nearest quarter hour increment and submit this separately as Bill Hours.
SDV-7	EVV System must allow System Users to adjust Bill Hours in cases where the Service Provider clock in and clock out were not appropriate. The System User may not adjust Bill Hours to an amount greater than the actual hours recorded by the EVV System.
SDV-8	EVV System must allow for multiple Service Providers to deliver the same Service at the same location, at the same date and time with the same Member.
SDV-9	EVV System must support overnight shifts in a way that does not require Service Providers to clock in and clock out multiple times per shift. The EVV System must split

Service Delivery (EVV Visit) Transaction Documentation	
	the overnight shift into two separate EVV Visit Transactions for the two affected days. The EVV System must not require the use of a schedule to implement this business rule.
SDV-10	EVV System must allow Service Providers as optional or the System User to document the amount of time associated with non-EVV relevant Services that the Service Provider delivered during an EVV Service delivery period. The EVV System must store that data, and not require multiple clock in and clock out activity to account for non-EVV relevant Service delivery. The EVV System must not use the non-EVV relevant Service time in the calculation of the units.
SDV-11	EVV System must identify duplicate EVV Visit Transactions and not allow transmission of the duplicate EVV Visit Transaction to the EVV Aggregator. EVV System must alert the System User when the EVV System identifies a duplicate and allow the System User to correct the EVV Visit Transaction.
SDV-58	EVV System must not allow the System User to create a new EVV Visit Transaction to replace an existing EVV Visit Transaction. Instead, the System User must perform Visit Maintenance to make changes to the existing EVV Visit Transaction as needed. If after the Visit Maintenance Time Frame, the System User must receive payer approval to proceed with the change.
SDV-42	EVV System must identify Service delivery to multiple Members at the same time at separate Service Delivery Locations by the same Service Provider, and not allow transmission of those transactions to the EVV Aggregator. EVV System must alert System Users when the EVV System identifies these transactions and allow for correction or attestation that the Service delivery was accurate using the most appropriate EVV Reason Code, if allowed by program rules. EVV System must allow transmission of the EVV Visit Transaction to the EVV Aggregator when the same Service Provider delivers Services to multiple Members at the same time at the same location. The EVV System must allow the capture the Service delivery in a user-friendly and efficient manner to reduce input by the Service Provider.

Service Delivery (EVV Visit) Transaction Validation

Service Delivery (EVV Visit) Transaction Validation	
SDV-12	**Business Rule Removed – replaced by SDV-60** ~~*EVV system must auto-verify a service delivery transaction received via approved method (except GUI) that matches to a previously entered schedule when applicable.*~~
SDV-13	** Business Rule removed– replaced by SDV-60 ** ~~*EVV system must auto-verify a service delivery transaction received that matches Texas Medicaid EVV program criteria, in lieu of a schedule, without provider user performing visit maintenance.*~~
SDV-60	EVV System must adhere to HHSC EVV Policy regarding Auto-Verification of EVV Visit Transactions and must comply with Appendix P for Auto-verification specifications.

Service Delivery (EVV Visit) Transaction Validation	
SDV-14	EVV System must verify Member profile data using the client Medicaid eligibility data available from MES service providers for the Texas Medicaid program prior to verifying Service delivery transaction. The EVV System will complete this validation using the x12 270/271. The EVV System must notify the System User and allow the System User to correct errors prior to the transmission of the EVV Visit Transaction to the EVV Aggregator. See Appendix E for details on the Member Eligibility Companion Guides.
SDV-55	EVV System must verify payer and plan code using the Payer Plan Code web service prior to verifying EVV Visit Transactions. The EVV System must notify the System User and allow the System User to correct errors. See Appendix L for details on the Payer Plan Code web service.
SDV-15	EVV System must verify Program Provider or FMSA profile using the EVV Master Provider web service prior to verifying EVV Visit Transactions. The EVV System must notify the System User and allow the System User to correct errors.
SDV-16	EVV System must accept only valid Texas Medicaid EVV program HCPCS (procedure codes) and modifier(s). The EVV System must notify the System User and allow the System User to correct errors. EVV System must use the EVV Service Bill Codes Table to identify these valid codes, see Appendix B.
SDV-17	EVV System must verify that the payer has authorized the HCPCS/modifiers captured for the Member. Should the EVV System find any errors, the EVV System must notify the System User and allow the System User to correct the errors before the EVV System will transmit changes to the EVV Aggregator.
SDV-18	EVV System must use the EVV Service Bill Codes Table in Appendix B for EVV Services to verify the HCPCS/modifiers captured are for the Service Group/Service Code combination that the payer has authorized for the Member.
SDV-19	EVV System must adhere to the HHSC EVV Policy when applying the Call Matching Window for the Daily Variable Schedule.
SDV-49	EVV System must adhere to HHSC EVV Policy when applying the Optional Expanded Time for Auto-Verification for the Daily Variable Schedule or Daily Fixed Schedule. See Appendix P for Auto Verification specifications.
SDV-50	EVV System must adhere to HHSC EVV Policy when applying the Optional Automatic Downward Adjustment for the Daily Variable Schedule or Daily Fixed Schedule. See Appendix P for Auto Verification specifications.
SDV-51	EVV System must alert the System User when the Member units used are reaching the authorized units on the Service Authorization.

Visit Maintenance

Visit Maintenance	
SDV-20	EVV System must allow System Users to complete Visit Maintenance within the Visit Maintenance Time Frame.
SDV-65	EVV System must only allow the System Users to complete Visit Maintenance outside of the Visit Maintenance Time Frame when the payer has approved Visit Maintenance via the HHSC-approved process.

Visit Maintenance	
SDV-21	** Business Rule added back for clarity ** EVV System must restrict System users from performing visit maintenance on the following fields: • Actual service delivery date • Actual service delivery clock-in time • Actual service delivery clock-out time • Actual hours worked • Auto-populated data fields • GPS coordinates See Appendix O for Visit Maintenance rules.
SDV-46	EVV System must identify the input method on the EVV Visit Transaction as "GUI" when the clock in time for a Visit is missing (missed clock in) and the System User manually completes the Visit.
SDV-47	EVV System must identify the input method on the EVV Visit Transaction as "GUI" when the clock out time for a Visit is missing (missed clock out) and the System User manually completes the Visit.
SDV-61	EVV System must adhere to HHSC EVV Policy regarding Visit Maintenance of EVV Visit Transactions and must comply with technical specifications for Visit Maintenance. Refer to Appendix O for the Visit Maintenance specifications.
SDV-48	EVV System must require entry of an EVV Reason Code and required free text when the System User makes changes to the EVV Visit Transaction after the System User/Service Provider has documented the Visit. EVV system must adhere to the HHSC EVV Policy regarding EVV Reason Codes.
SDV-22	EVV System must record changes made by the System User to the EVV Visit Transaction after the System User/Service Provider has documented the Visit. The EVV System must collect the following audit trail data at a minimum: Data elements changed (including the before and after values) Name of the System User making the changes Date and time the System User made the changes EVV Reason Code(s) with associated free text
SDV-56	EVV System must update the last visit maintenance date in the EVV Visit Transaction to the current date whenever the EVV System identifies a change to one or more fields listed in HHSC EVV Policy as impacting the last visit maintenance date and the EVV System saves the change to the EVV Visit Transaction after the System User/Service Provider has documented the Visit.
SDV-23	EVV System must compare data elements from the original EVV Visit Transaction to the updated EVV Visit Transaction according to HHSC EVV Policy to confirm the EVV System made updates, prior to establishing the last visit maintenance date value for the field EVV_LASTVISITMAINT in the EVV Visit Transaction.
SDV-24	EVV System must re-validate Service delivery details, when a System User has updated the EVV Visit Transaction, using the same validations as an initial EVV Visit Transaction. Should the EVV System find any errors, the EVV System must alert the System User that the System User must correct errors before the EVV System will transmit changes to the EVV Aggregator. When re-validating Visit details for multiple Visit records at a time, the EVV System must alert the System User of only those visit records with errors.
SDV-25	EVV System must allow System Users to confirm an EVV Visit Transaction after completing Visit Maintenance prior to transmitting to the EVV Aggregator.
SDV-26	EVV System must not allow the System User to delete delivered/documented Visits from the system. This includes instances of Visit Maintenance where the System User has

Visit Maintenance	
	added an EVV Reason Code to an EVV Visit Transaction. The EVV System must not allow the System User to delete that EVV Reason Code and associated free text.
SDV-43	The EVV System must allow for efficient, mass creation and editing of EVV Visit Transactions through Visit Maintenance. EVV Visit Transactions created or edited in mass are subject to the same requirements in this "HHSC EVV Business Rules" document as individually created or edited EVV Visit Transactions.
SDV-44	EVV System must allow an FMSA to capture the designation provided by the CDS Employer, to perform Visit Maintenance. EVV System must adhere to HHSC EVV Policy regarding the CDS Employer's Selection for Electronic Visit Verification Responsibilities.
SDV-45	EVV System must allow an FMSA to capture the designation provided by the CDS Employer, to perform visit approval and Visit Maintenance. Note that if the CDS Employer designates the FMSA to perform visit approval, the CDS Employer must also designate the FMSA to perform Visit Maintenance. EVV System must adhere to HHSC EVV Policy regarding the CDS Employer's Selection for Electronic Visit Verification Responsibilities.
SDV-52	EVV System must allow System Users to modify Bill Hours by either entering bill time in and bill time out, or by directly modifying the Bill Hours, to reflect that the Program Provider or FMSA will not bill the actual visit hours in full.
SDV-53	EVV System must use bill time in and bill time out, when entered, to calculate Bill Hours in the same manner as the EVV System calculates actual service delivery time.

EVV Reason codes

EVV Reason Codes	
SDV-27	EVV System must only accept valid EVV Reason Codes as defined in the HHSC EVV Policy, see Appendix A.
SDV-28	EVV System must allow the System User to select multiple EVV Reason Codes for a single visit.
SDV-29	EVV System must allow for modification of the EVV Reason Codes as directed by HHSC. Modifications may include adding new EVV Reason Codes, discontinuing EVV Reason Codes, changing EVV Reason Code usage guidelines and changing EVV Reason Code text.
SDV-30	EVV System must capture free text/comments to allow the System User to further explain the reason for visit maintenance. HHSC EVV Policy may require free text/comments when using certain EVV Reason Codes.
SDV-57	** Business Rule Removed ** ~~*EVV System must alert the System User when the System User uses the same Reason Code number and description combination on a Member's visits for occurrences 10 through 14 during a calendar month, to notify the System User that Reason Code usage is approaching the limit specified in the HHSC EVV Policy.*~~

Transmission of Service Delivery (EVV Visit) transactions

Transmission of Service Delivery (EVV Visit) transactions	
SDV-31	EVV System must transmit confirmed EVV Visit Transactions to the EVV Aggregator in the standard format found in Appendix C.

Transmission of Service Delivery (EVV Visit) transactions	
SDV-32	EVV System must transmit confirmed EVV Visit Transactions to the EVV Aggregator within 24 hours of completion, or after the System User has corrected errors. The EVV Vendor must ensure that 98% of initial EVV Visit Transactions submitted to the EVV Aggregator contain complete and accurate data elements and that 100% of subsequent EVV Visit Transactions submitted to the EVV Aggregator contain complete and accurate data elements. For this rule, "complete and accurate" is defined as no file-level errors, no field formatting errors, and all required fields populated, per the EVV Visit Data Layout Edits Crosswalk, found in Appendix M.
SDV-33	EVV System must process responses from EVV Aggregator and alert System Users to the status (acceptance or rejection) of each individual EVV Visit Transaction within 24 hours of response receipt. The EVV System must notify the System User of rejection alerts, including the reason for the rejection.
SDV-34	EVV System must allow System Users to correct errors in allowable data elements on the EVV Visit Transactions previously submitted to the EVV Aggregator. Once complete the EVV System must allow System User to indicate that the EVV Visit Transaction is ready for the EVV System to re-transmit it to the EVV Aggregator.
SDV-35	EVV Vendor must collaborate with Contractor and MES service providers to correct any format/file errors as well as any business errors received from the EVV Aggregator.
SDV-36	EVV Vendor must complete a monthly reconciliation process with the EVV Aggregator to ensure the EVV System transmitted all EVV Visit Transactions to the EVV Aggregator and that the EVV Aggregator accepted all transmitted EVV Visit Transactions. The EVV Vendor must collaborate with Contractor and MES service providers to correct any discrepancies found and identify records that the EVV System did not successfully transmit to the EVV Aggregator.
SDV-37	EVV System must require CDS Employers to approve the EVV Visit Transactions (offline or through the EVV System) and require the FMSA to review the EVV Visit Transactions prior to export to the EVV Aggregator, even if the EVV System Auto-verified the EVV Visit Transaction. For the sequence of events of the CDS service delivery model refer to the CDS Process Flow diagram, found in Appendix Q.
SDV-59	EVV System must allow an FMSA to review approved EVV Visit Transactions prior to export to the EVV Aggregator. For the sequence of events of the CDS service delivery model refer to the CDS Process Flow diagram, found in Appendix Q.
SDV-62	EVV System must allow an FMSA to send EVV Visit Transactions to the EVV Aggregator at any point in time. The FMSA may send the EVV Visit Transactions when they have completed review against their Weekly Authorization/Budget.
SDV-63	EVV System Reason Code table must list all EVV Reason Codes as defined in the HHSC EVV Policy. See Appendix A.

Vendor Reporting Requirements

Standard System Reports

Standard System Reports	
EVR-1	EVV System must provide reporting to Program Providers, FMSAs and CDS Employers (as applicable) to support program requirements and monitoring. The EVV System must make the following standard reports available on demand based on data native to the EVV System. See Appendix G:

Standard System Reports	
	• EVV Alternative Device Order Status Report • EVV CDS Service Delivery Log • EVV Landline Phone Verification Report • EVV Service Delivery Exception Report • Non-EVV Relevant Time Logged
EVR-8	EVV System must provide reporting to CDS Employers to support program requirements and monitoring. The EVV System must make the following standard reports available on demand to CDS Employers (as applicable) based on data retrieved from the EVV Standard System Reports web service provided by the MES service providers. Program Providers, FMSAs, HHSC and MCOs will access these reports from the EVV Portal. See Appendix G: EVV Attendant History Report EVV CDS Employer Usage Report EVV Clock In/Clock Out Usage Report EVV Reason Code Usage and Free Text Report EVV Units of Service Summary Report
EVR-2	EVV Vendor must provide ad-hoc reporting of any data available in the EVV System with request and delivery requirements based on specifications in the Data Request process. The EVV Vendor will provide these reports at no additional cost.
EVR-4	**Business Rule removed** ~~*EVV system must provide Service Delivery Exception Report to [CONTRACTOR] monthly. The Service Delivery Exception Report must include the following data points at a minimum:*~~ ~~*• Service scheduled but not performed*~~ ~~*• Service performed but not scheduled*~~ ~~*• Service performed but not authorized*~~ ~~*• Service authorized but not performed*~~ ~~*• Service performed but not approved/confirmed*~~ ~~*This data must include services regardless of service delivery locations (home or community location, and GPS coordinates when the mobile method is used to clock in/out).*~~
EVR-5	**Business Rule removed** ~~*EVV system must provide Service Authorization Report to [CONTRACTOR] monthly. The Service Authorization Report must include the following data points at a minimum:*~~ ~~*• Frequency of Changes (sorted by Payer)*~~ ~~*• Retroactive Service Authorizations Received (sorted by Payer)*~~
EVR-6	EVV Vendor must limit Texas EVV reporting to those reports defined with, and by, HHSC. The EVV Vendor shall only create custom reports for other entities in the Texas EVV program with HHSC approval. This rule does not apply to reports the EVV Vendor includes in the EVV System base product and only prohibits the creation of custom reports for Texas Medicaid users beyond the standard reports listed.
EVR-7	All standard system reports must comply with the specifications provided in Appendix G – EVV Standard System Reports.

EVV Vendor System Specifications

EVV System Specifications

EVV System Specifications	
VSS-1	EVV System must support commonly available operating systems, browsers, and software/hardware platforms. This includes the following at a minimum: Windows Operating Systems Macintosh Operating Systems Internet Explorer Firefox Chrome Safari Edge
VSS-2	EVV System must adhere to the accessibility standards contained in state and federal laws and regulations, including Americans With Disabilities Act and Section 508 of the Federal Rehabilitation Act. This includes providing accessibility for Program Provider's or FMSA's with disabilities, such as hearing or visual disabilities (e.g., ability to use a text telephone (TTY) or telecommunication device for the deaf (TDD), or use of interactive voice response (IVR), screen readers, text to speech, etc.). EVV System must adhere to Health and Human Services (HHS) Electronic and Information Resources (EIR) Accessibility Policy.
VSS-4	EVV System must create a unique profile for individual Contractor, MES service provider, HHSC and MCO users as directed by HHSC.
VSS-5	EVV System must provide read-only access to Contractor, HHSC and MCO staff to view the same information that System Users can access and view. The EVV System must limit individual MCO access to view only the data of the Members contracted with the MCO.
VSS-12	EVV System must support the requirements in this "HHSC EVV Business Rules" document in their entirety at no cost to Program Providers or FMSAs, service providers, CDS employers, or MCOs. EVV Vendor must not opt Program Providers or FMSAs into any paid services without first notifying the Program Provider or FMSA of the cost and receiving consent from the Program Provider or FMSA.

Audit Trail & Quality

Audit Trail & Quality	
VSS-13	EVV System must maintain an audit trail for all data entered and updated in the EVV System, including the following data at a minimum: EVV Visit Transaction data elements Program Provider or FMSA profile Service Provider profile Member profile Service Authorization data Service Schedule, if applicable System User credentials

Audit Trail & Quality	
VSS-24	EVV System must account for Daylight Savings Time (DST) when calculating actual hours and Bill Hours. For Spring DST, the EVV System must subtract one (1) hour when a Service Provider works a shift during the date and time when DST occurs. For Fall DST, the EVV System must add one (1) hour when a Service Provider works a shift during the date and time when DST occurs.

System Security

System Security	
VSS-15	EVV System must provide System User access determined by security roles that limit access based on business need consistent with Appendix I.
VSS-16	EVV Vendor must give System Users secure access to the EVV System in a way that creates unique login credentials which allows for the identification of System Users accessing the EVV System.
VSS-17	EVV System must disable System User accounts within 24 hours of notification or action taken by the Program Provider or FMSA.
VSS-19	EVV System must meet secure data standards, especially those related to Confidential and Personal Information to protect it from unauthorized access, use, or disclosure.
VSS-20	EVV Vendor must allow for System User initiated systematic and/or Customer Support password reset requests.
VSS-21	EVV System must follow state approved password standards, including resetting every 90 days with character limit.

EVV System Transition

Transition Coordination with other EVV System(s)

Transition Coordination with other EVV System(s)	
VTA-1	EVV Vendor must follow and execute Program Provider and FMSA Transfer Process when notified that a Program Provider or FMSA is changing EVV Systems. This process will include: Transfer (or acceptance) of Authorization Information Transfer (or acceptance) of Member Information Transfer (or acceptance) of Service Provider Information See Appendix N for details on EVV System to System Data Transfer Process.
VTA-2	EVV Vendor must transition Texas Medicaid EVV data to HHSC or its designee prior to terminating from the program.

Operational Readiness

EVV Vendor Testing/Preparedness

EVV Vendor Testing/Preparedness	
OPR-1	EVV System must successfully execute User Acceptance Testing process conducted by MES service providers, HHSC and its designees to confirm adherence to guidelines included in this document prior to participation in the Texas Medicaid EVV program.
OPR-2	EVV System must conduct and successfully execute Trading Partner Testing process with MES service providers, EVV Aggregator, 3rd Party integration systems, and MCOs prior to implementing any system modification impacting these entities.

Glossary

The terms defined in this glossary, when used in this document, have the following meanings.

Acronym/Term	Definition
3rd Party System	A separate system used by Program Providers or FMSAs to support aspects of their business outside of EVV. This system may contain data relevant to Program Provider or FMSA profile, Service Provider profile, Member profile, schedules, or claims.
Alternative Device	HHSC-approved electronic device provided at no cost by a EVV vendor that allows the Service Provider or CDS Employee to clock in and clock out of the EVV System from the Member's home. The alternative device produces codes or information that represent the precise date and time Service delivery begins and ends.
Auto-verified	EVV Visit Transactions that match a planned Schedule, include all required data elements, and have no exceptions; or EVV Visit Transactions with no planned Schedule that include all required data elements and have no exceptions. Refer to Appendix P for Auto-Verification specifications.
Bill Hours	This refers to EVV_PAYHOURS in the EVV Visit Transaction file, calculated as the difference between the electronically captured EVV_CALLOUTTIME and the electronically captured EVV_CALLINTIME rounded to the nearest quarter hour increment. May be downward adjusted.
Business Unit	A distinct entity within a Program Provider or FMSA, as identified by a unique National Provider Identifier (NPI) or Atypical Provider Identifier (API), that will submit EVV Visit Transactions to the EVV Aggregator.
Call Matching Window	The 24-hour period (12:00:00am to 11:59:59pm) used during auto-verification with a Daily Variable Schedule to determine whether the EVV visit occurred on the scheduled day and for the scheduled duration.
CDS	Consumer Directed Services. A service delivery option in which a Member or Legally Authorized Representative employs and retains Service Providers and directs the delivery of program Services. This is an option given to Members to coordinate their Texas Medicaid program services.
CDS Employee	A Service Provider aged 18 years or older who meets eligibility requirements of the Member's program, who is not prohibited by

Acronym/Term	Definition
	relationship from being a CDS Employee and who delivers Services to the Member as directed by the CDS Employer.
CDS Employer	A member or Legally Authorized Representative (LAR) who chooses to participate in the CDS option, and, therefore, is responsible for hiring and retaining service providers to delivery program services.
Communication Materials	EVV relevant materials created and approved by HHSC to include provider notifications, policy updates, etc.
Confirmed EVV Visit Transaction	EVV Visit Transaction to which the System User has completed visit maintenance or otherwise verified.
Contracted Provider	A Program Provider or FMSA the State of Texas has contracted to provide Fee For Service (FFS) EVV Services in Texas.
Daily Fixed Schedule	A Schedule Type in the EVV System that a System User may choose to plan Member Service visits. This Schedule Type allows Auto-verification of an EVV Visit Transaction on the Scheduled Visit Date when the clock in time matches the scheduled begin time within 7 minutes or less and the clock out time matches the scheduled end time within 7 minutes or less. The Daily Fixed Schedule does not use the Call Matching Window. The System User can use this Schedule Type in conjunction with other Visit Maintenance Reduction Options.
Daily Variable Schedule	A Schedule Type in the EVV System that a System User may choose to plan Member Service Visits. This Schedule Type allows Auto-verification of an EVV Visit Transaction when the Visit occurs within the Call Matching Window on the Scheduled Visit Date and the Visit Duration (rounded actual hours) matches the Scheduled Visit Duration on the Schedule. The System User can use this Schedule Type in conjunction with other Visit Maintenance Reduction Options.
Daylight Savings Time (DST)	Daylight Savings Time (DST) is the practice of advancing standard time by one hour in the spring ("spring forward") of each year and of setting it back by one hour in the fall ("fall back") to gain an extra period of daylight during the early evening.
Designated Representative (DR)	A willing adult appointed by the CDS Employer to assist with or perform or the CDS Employer’s required responsibilities to the extent approved by the CDS employer.
Electronic Visit Verification (EVV)	Electronic documentation and verification of Service delivery to a Member through an EVV System.
EVV Aggregator	A centralized database that collects, validates, and stores statewide EVV visit data transmitted by the EVV System(s).
EVV Allowed Geo-perimeter	A 250-foot perimeter (or radius) around the Member Home Geo-location.
EVV Reason Code	A standardized, HHSC-approved three-digit number and associated description used during Visit Maintenance to explain the specific reason the System User made a change to an EVV Visit Transaction.
EVV System	Electronic visit verification system that: (A) allows a Service Provider to electronically report: (i) the service recipient's identity; (ii) the service provider's identity; (iii) the date and time the service provider begins and ends the delivery of Services; (iv) the location of service delivery; and (v) tasks performed by the Service Provider

Acronym/Term	Definition
	The system includes applications and tools used to clock in and clock out such as toll-free numbers, interactive voice response applications, mobile methods, and web applications. The system also includes mechanisms to complete visit maintenance and interact with the EVV Aggregator.
EVV Vendor	An EVV vendor is an entity contracted with Contractor to provide a cost free EVV system option for program providers and Financial Management Services Agencies (FMSAs) contracted with HHSC or a managed care organization (MCO).
EVV Visit Transaction	A complete, verified visit consisting of all required data elements (visit data and identification data) needed to verify a Service delivery visit. EVV Visit Transactions can receive any of the following statuses: Unsubmitted – a visit the EVV System has received but has not yet transmitted to the EVV Aggregator. Submitted – a visit the EVV System received and transmitted to the EVV Aggregator but the EVV System has not yet received a response from the EVV Aggregator. Accepted – a visit the EVV System submitted to the EVV Aggregator which has successfully passed the EVV Aggregator validation edits. Rejected – a visit the EVV System submitted to the EVV Aggregator that did not pass the EVV Aggregator validation edits.
FMSA	Financial Management Services Agency is an entity that contracts with HHSC or an MCO to provide financial management services to a Member, CDS Employer or Designated Representative under the CDS option.
Geo-location	Geographic location as determined by the GPS (latitude/longitude) coordinates.
GPS	Global Positioning System (GPS) is a satellite-based navigation system used to determine an exact location in latitude/longitude coordinates.
GUI	Graphical User Interface. A term used in the Texas Medicaid EVV program to identify manually entered EVV Visit Transactions using an EVV System.
HCPCS	Healthcare Common Procedure Coding System is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).
HHSC EVV Policy	A set of HHSC standards organizations must adhere to regarding the EVV program which includes the HHSC EVV policy handbook and HHSC EVV policy documents posted on the HHSC EVV website.
IVR	Interactive Voice Response
Legally Authorized Representative (LAR)	A natural parent, legal/adopted parent, stepparent and/or a court-appointed guardian of a Member or the legally appointed guardian of a Member of any age.
MCO	Managed Care Organization. An entity that contracts with the State of Texas to provide health benefits and additional services and accepts a set capitation payment per Member, per month, for such services.
Member	A person enrolled in Medicaid FFS (Individual) or MCO (Member) and receiving Services through Texas Medicaid.
Member Home	The physical address where a Member who receives EVV Services resides.
MES service providers	The MES service providers are a group of contractors charged with administering Texas Medicaid and other state health care programs on behalf of the Texas Health and Human Services Commission.

Acronym/Term	Definition
Optional Automatic Downward Adjustment	A visit maintenance reduction solution offered to System Users for use with Schedules whereby the EVV System will downward adjust Bill Hours by .25 to match the planned scheduled hours, so the EVV System can still consider the visit a match to the Schedule, therefore not creating an alert to the System User. The EVV System must only allow System Users to apply this feature to the Daily Variable Schedule and the Daily Fixed Schedule Types.
Optional Expanded Time for Auto-Verification	A visit maintenance reduction solution offered to System Users for use with Schedules whereby the EVV System expands the auto-verified time frame by .25 rounded Bill Hours (22 minutes) so the EVV System can still consider the Visit a match to the Schedule, therefore not creating an alert to the System User. The EVV System must only allow System Users to apply this feature to the Daily Variable Schedule and the Daily Fixed Schedule Types.
Pending Visit	EVV Visits that the EVV System has not confirmed or submitted to the EVV Aggregator.
Program Provider	An entity that contracts with HHSC or an MCO to provide an EVV Service.
RCCA	Root Cause Analysis and Corrective Action (RCCA) is a process where the system owner reviews and analyzes an incident or deficiency to determine root cause. Corrective action defines the actions put in place to prevent re-occurrence.
Recurring	Indicates the planned service delivery event (Scheduled Visit) is to occur on a regular basis for a prescribed number of days or weeks.
Remaining Weekly Scheduled Hours	The number of hours that are available for Visit Auto-verification within a Weekly Variable Schedule after decrementing the Bill Hours of Visits that Auto-verify against the Weekly Variable Schedule and applying adjustments made by the System User to the Bill Hours of Auto-verified Visits.
Schedule	Electronic documentation of a planned service delivery event that the System User creates in the EVV System prior to a Member Visit.
Schedule Type	A distinct method the System User can choose for planning future Member Visits in the EVV System. Schedule Types include Daily Variable Schedule, Daily Fixed Schedule, and Weekly Variable Schedule.
Scheduled Visit Date	The date the System User scheduled the Service Provider to perform Services for the Member. The System User enters the Scheduled Visit Date into the EVV System prior to a Visit as part of a Daily Fixed Schedule or Daily Variable Schedule. Recorded as VISIT_VISITDATE in the EVV Visit Transaction.
Scheduled Visit Duration	The amount of time the System User scheduled the Service Provider to spend performing Services for the Member. The System User enters the Scheduled Visit Duration into the EVV System prior to a Visit as part of a Daily Fixed Schedule or Daily Variable Schedule. Recorded as VISIT_VISITHOURS in the EVV Visit Transaction.
Schedule Maintenance	Actions performed by a System User to adjust a Scheduled Visit or Visits in the EVV System.
Service	An in-home personal care service or home health care service required to use EVV as identified in Appendix B EVV Bill Code Services Table.
Service Authorization	Documentation of the Services a payer authorized for a Member, including the authorized units for the Services, the Program Provider or FMSA authorized to provide the Services, the bill codes for the Service and the

Acronym/Term	Definition
	effective dates during which the payer has authorized the Service. May be known by other names such as “prior authorization” in some Medicaid programs.
Service Provider	The person employed by the Program Provider or CDS Employer to deliver EVV Services directly to the Member.
Service Delivery Location	The physical location where the Member received EVV Services during a scheduled or unscheduled Visit. See Appendix J for allowable values.
Subcontracted Provider	An agency or individual contracted by a Program Provider or FMSA to provide EVV Services in Texas.
System User	An individual who the Program Provider or FMSA authorizes to have access to the EVV System. Authorized users may include a Program Provider or FMSA staff member, a Subcontracted Provider, or a CDS Employer.
Texas EVV Service Attendant Identification Number	A unique identifier generated by the EVV System for Service Providers. The number should be the last 4 digits of the Service Provider’s SSN or passport number plus Service Provider’s last name.
Total Weekly Scheduled Hours	The total hours scheduled by the System User for a Member Service on a Weekly Variable Schedule.
Visit	Electronic documentation of a completed EVV service delivery event.
Visit Approval	The process the System User (CDS Employer or FMSA) uses to confirm that the CDS Employee time worked in the EVV system accurately reflects the delivery of Services.
Visit Date	The calendar date when (MMDDYYYY) the Service Provider delivers Services to the Member.
Visit Duration	The total time a Service Provider spends with a Member during a service delivery Visit.
Visit Maintenance	The action the System User takes to create a Visit or correct data elements in an EVV Visit Transaction to accurately reflect the Service delivery.
Visit Maintenance Time Frame	The number of days from the Visit Date, as specified in HHSC EVV Policy when the System User can complete Visit Maintenance.
Weekly Variable Schedule	A Schedule Type in the EVV System that the System User may choose to plan Member Services for a set number of Service hours over the course of a 7-calendar day period (Sunday through Saturday). This Schedule Type will Auto-verify a Visit when the Visit is delivered on a date of service between the Weekly Variable Schedule Begin Date and the Weekly Variable Schedule End Date for a Visit Duration not to exceed the Remaining Weekly Scheduled Hours.
Weekly Variable Schedule Begin Date	The start date of a Weekly Variable Schedule set up by a System User for a Member. This is the first date (Sunday) of service during the Weekly Variable Schedule time frame when the EVV System will Auto-verify an EVV Visit Transaction if the Bill Hours of the EVV Visit do not exceed the Remaining Weekly Scheduled Hours.
Weekly Variable Schedule End Date	The last date of a Weekly Variable Schedule for a Member is set by the EVV System to be seven (7) calendar days from the Weekly Variable Schedule Begin Date. This is the last date of service during the Weekly Variable Schedule time frame when the EVV System will Auto-verify an EVV Visit Transactions if the Bill Hours of the EVV Visit do not exceed the Remaining Weekly Scheduled Hours.

Appendices

Appendix A – HHSC EVV Reason Codes

Electronic Visit Verification

Reason Codes - Effective Jan. 1, 2021

Program providers, Financial Management Services Agencies (FMSAs) and consumer directed services (CDS) employers must select the most appropriate EVV Reason Code Number(s), EVV Reason Code Description option (e.g., A, B, C, etc.), and enter any required free text when completing visit maintenance in the EVV system. All EVV Reason Code Numbers, except EVV Reason Code Number 900, are preferred EVV Reason Code Numbers.

Reason Code	Number	Reason Code Description
Overnight Visit (If applicable)	000	This EVV Reason Code Number is a system-generated reason code used by the EVV system when the EVV system auto-generates a clock out at 11:59 p.m. and a clock in at 12:00 a.m. for overnight visits. This EVV Reason Code Number is not available for program provider, FMSA or CDS employer use.
Service Variation	100	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when service variations occur.
		A - Staff hours worked differ from schedule
		B - Downward adjustment of pay hours
		C - Authorized services provided outside of home
		D - Fill-in for regular attendant
		E - Member agreed or requested staff not work
		F - Attendant failed to show up for work
		G - Confirm visits with no schedule
		H - Overlap visits
		I - Split schedules
		J - In-home respite: used when an in-home respite visit occurs and there is no schedule in the EVV system
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.

Reason Code	Number	Reason Code Description
Disaster	130	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when all or part of the scheduled visit could not be delivered due to a natural disaster.
		A - Flood
		B - Hurricane
		C - Ice/snowstorm
		D - Tornado
		E - Wildfire
		F - Public Health Disaster
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Emergency	131	The program provider, FMSA or CDS employer will select this reason code when all or part of the scheduled visit could not be delivered due to an emergency with the member. Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system and describe the nature of the emergency.
Alternative Device	200	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when an assigned alternative device could not be used to clock in and/or clock out.
		A - Alt device ordered
		B - Alt device pending placement
		C - Alt device missing
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Mobile Device	201	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when an assigned mobile device could not be used to clock in and/or clock out.
		A - Mobile device ordered
		B - Mobile device pending placement
		C - Mobile device missing

Reason Code	Number	Reason Code Description
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Technical Issues	300	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when technical issues prevented staff from clocking in and/or clocking out of the EVV system.
		A – Phone lines not working
		B – Malfunctioning alternative device
		C – Incorrect alternative device value
		D – Incorrect employee ID entered
		E – Incorrect member EVV ID entered
		F – Malfunctioning mobile device/application
		G – Multiple calls for one visit
		H – Reversal of call in/out time
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Landline Not Accessible	400	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when the member's home phone landline was not accessible and prevented staff from clocking in and/or clocking out of the EVV system.
		A - Member does not have home phone
		B - Member phone unavailable
		C - Member refused staff use of phone
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Service Suspension	500	The program provider, FMSA or CDS employer will select this EVV Reason Code Number when the member's services are suspended due to a lapse in eligibility.

Reason Code	Number	Reason Code Description
Other	600	The program provider, FMSA or CDS employer will select this EVV Reason Code Number when an exception cannot be addressed using any other EVV Reason Code Number and EVV Reason Code Description. Free text is required: The program provider, FMSA or CDS employer must explain the reason for using this code and provide any missing clock in or clock out time not electronically captured by the EVV system.
Non-Preferred	900	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when staff have failed to clock in and/or clock out of the EVV system.
		A – Failure to call in
		B – Failure to call out
		C – Failure to call in and out
		D – Wrong phone number
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.

Appendix B – EVV Service Bill Codes Table

March 1, 2022 v10.0 Legend

Column Title	Column Description
Claims Code Qualifier	Procedure code for the service used by HCS & TxHmL program providers and FMSAs in the CARE system.
Claims Modifier	A modifier provides how the reporting physician or provider can indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. Used by HCS & TxHmL program providers and FMSAs in the CARE system.
Claims Place of Service	A set of codes used to identify the physical location where services were provided. Used by HCS & TxHmL program providers and FMSAs in the CARE system. **Note: HHSC is only including the claims place of service code 12 (Home Location) because EVV is only required to capture services that require an in-home visit**.
Claims Procedure Code	A collection of codes that represent procedures and services provided to individuals. Used by HCS & TxHmL program providers and FMSAs in the CARE system.
Claims Revenue Code	A revenue code is a code set that groups services into distinct cost centers. Used by HCS & TxHmL program providers and FMSAs in the CARE system.
Effective Date for EVV Claim Denial for No Matching Visit	The begin date (based on date of service) that a claim for an EVV-relevant service will be denied when there isn't an accepted EVV visit transaction that matches the claim. The EVV visit transaction must be accepted in the EVV Portal prior to billing the claim.
End Date for EVV Claim Denial for No Matching Visit	The end date (based on date of service) that a claim for an EVV-relevant service will be denied when there isn't an accepted EVV visit transaction that matches the claim. The EVV visit transaction must be accepted in the EVV Portal prior to billing the claim.
Healthcare Common Procedure Coding System (HCPCS)	A collection of codes that represent procedures and services provided to individuals.
Mod 1-4	A modifier provides how the reporting physician or provider can indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. There can be up to 4 modifiers associated with a HCPCS code.
Payer	The organization that processes the claim for payment or denial. Payers include: The Texas Health and Human Services Commission (HHSC) - Claims are for EVV Acute Care services in Fee-for-Service (FFS) and processed by the Compass21 system on behalf of HHSC. Long-Term Care (LTC) - Organization that processes claims for LTC services in FFS. Managed Care Organization (MCO) - Organization that processes claims for services in Managed Care. By Oct. 1, 2020 all EVV claims for Managed Care services must be submitted to the HHSC-designated system for claims matching. Once the claims matching result is obtained, the claim will be forwarded to the MCO with whom the individual member is enrolled at the time of service delivery for final processing.
Proc Code Qualifier	Procedure code for the service.
Procedure Effective Begin Date	The date when the service billing code became available for use in the Texas Medicaid Program. The date corresponds to the service delivery date, not the claim submission date.
Procedure Effective End Date	The date when the service billing code is no longer to be used. The date corresponds to the service delivery date, not the claim submission date. If the date is 12/31/9999 this means that there is no effective end date.
Program	The name of the program which services are available.
Service	The name of the service.

Service Code	A code that identifies the LTC service within the program and is only used in the FFS programs for LTC.
Service Group	A code that identifies the LTC program for the service and is only used in the FFS programs for LTC.
Unit Type	The amount of time assigned to a single unit when delivering the service to a member e.g. 15 minute increments, one hour increments.
Units Matched During EVV Claims Matching?	A 'Yes' or 'No' in this column indicates if the number of Units on the EVV-relevant claim is matched to the number of Units on the EVV visit transaction. Some services are not designed for this type of match.

EVV Service Bill Codes - March 1, 2022 v10.0 Acronyms

Acronym	Description
AC	Acute Care
BH	Behavioral Health
C21	Compass 21
CAS	Community Attendant Services
CARE	Client Assignment and Registration
CDS	Consumer Directed Services
CFC	Community First Choice
CLASS	Community Living Assistance and Support Services
CMBHS	Clinical Management for Behavioral Health Services
CMS	Claims Management System
DBMD	Deaf-Blind with Multiple Disabilities
DSA	Direct Services Agency
EVV	Electronic Visit Verification
FC	Family Care
FFS	Fee-for-Service
FFSS	Flexible Family Support Services
FMSA	Financial Management Services Agency
HAB	Habilitation
HCBS-AMH	Home and Community-Based Services–Adult Mental Health
HCPCS	Healthcare Common Procedure Coding System
HCS	Home and Community-based Services
HHSC	Health and Human Services Commission
LOC	Level of Care
LON	Level of Need
LTC	Long-term Care
MCO	Managed Care Organization
MDCP	Medically Dependent Children Program
MMP	Medicare-Medicaid Plan
N/A	Not Applicable
PAS	Personal Assistance Services
PCS	Personal Care Services
PHC	Primary Home Care
RN	Registered Nurse
SRO	Service Responsibility Option
STAR	State of Texas Access Reform
TxHmL	Texas Home Living
YES	Youth Empowerment Services

EVV Service Bill Codes - March 1, 2022 v10.0 Revision History

Effective Dates	Revision Description
6/1/2019 - 7/2/2019	Created for the 6/1/2019 release of the EVV Aggregator.
7/3/2019 - 7/15/2019	Updated based on TMHP SR 6861292.
7/16/2019 - 8/18/2019	Updated for publication on the HHSC EVV Website: - Added columns in orange. - Updated the Unit Match on all CDS and SRO services to reflect a bypass on the claims matching process for units of service due to inconsistencies with other programs. All other critical data elements will be matched.
8/19/2019 - 10/7/2019	**Formatting Changes:** - Added a column 'Bypass Claim Units Match?' to indicate when units are bypassed in the EVV Aggregator claims match. - Removed the column called 'Short Description' since it duplicates the 'Service' column. - Added a tab 'Acronyms' to list acronyms and their descriptions used in the EVV Service Bill Code tables. **Service Changes:** - Updated all LTC CLASS services (Service Group 2) to indicate that units on the claim will not be matched to units on the visit transaction. - Updated HCS/TxHmL service for Respite and Day Habilitation to indicate that claims will not be matched for EVV until new bill codes can be established to distinguish in-home service delivery from out-of-home service delivery. Note: EVV Clock-in and Clock-out is required when these services begin or end in the home. - Corrected an error in the HCPCS/Modifiers for Texas Home Living CFC PAS/HAB CDS service (Service Group 15, Service Code 10CFV).
10/8/2019 - 6/14/2020	**Formatting Changes:** - Added a column 'Bypass EVV Claim Match and Apply EVV07?' to indicate when the EVV claims matching process is bypassed in the EVV Aggregator (EVV Claims Match Result Code EVV07). **Service Changes:** - Updated the EVV Aggregator Claims Match Begin Effective Date for all programs, services, and service delivery options affected by the 21st Century Cures Act due to the delayed EVV start date from 1/1/2020 to 1/1/2021. - Updated all LTC CLASS (Service Group 2) and LTC DBMD (Service Group 16) services to indicate these services are bypassing EVV units matching in the EVV Aggregator claims match. - Updated LTC CLASS CFC PAS/HAB service (Service Group 2, Service Code 10CFC T2026) column 'Bypass EVV Claim Match and Apply EVV07' to a yes to indicate that this service is bypassing EVV claims matching in the EVV Aggregator until new bill codes can be established to distinguish between EVV services and non-EVV services. Note: When billing for EVV services, an EVV Clock-in and Clock-out is required when services begin and/or end in the home. This bypass will avoid unnecessary EVV claim denials due to an EVV visit transaction never having been created for a non-EVV service. This is a temporary solution until new billing codes can be created to distinguish between EVV-required and non-EVV required services. - Updated LTC DBMD CFC PAS/HAB service (Service Group 16, Service Code 10CFC T2026) column 'Bypass EVV Claim Match and Apply EVV07' to a yes to indicate that this service is bypassing EVV claims matching in the EVV Aggregator until new bill codes can be established to distinguish between EVV services and non-EVV services. Note: EVV is not currently required for DBMD. This bypass will avoid unnecessary EVV claim denials due to an EVV visit transaction never having been created for a non-EVV service. This is a temporary solution until new billing codes can be created to distinguish between EVV-required and non-EVV required services. - Updated all LTC HCS (Service Group 12) and TxHmL (Service Group 15) procedure effective end dates from 2/29/2020 to 12/31/9999.

Effective Dates	Revision Description
6/15/2020 - 9/30/2020	**Formatting Changes:** Added new column 'EVV Claim Denial for No Matching Visit Effective Date' to the MCO, C21 AC FFS, CMS LTC FFS, and CARE LTC FFS tabs to indicate the begin date a claim for an EVV-required service will be denied if there isn't an accepted EVV visit transaction in the EVV Portal that matches the claim. Services with an effective date of 12/1/2020 are part of the Cures Act EVV Expansion and included in the EVV Practice Period beginning 7/1/2020 and ending 11/30/2020. See the TMHP article for more information about the practice period: http://www.tmhp.com/News_Items/2020/05-May/05-26-20%20Cures%20Act%20EVV%20The%20EVV%20Practice%20Period%20Begins%20July%201.pdf. Added new tab 'CARE LTC FFS EVV Services' to include HCS & TxHmL program services requiring EVV beginning 12/1/2020. Added new column 'Effective Date for EVV Claim Denial for No Matching Visit' to the MCO, C21 AC FFS, CMS LTC FFS, and CARE LTC FFS tabs to indicate the begin date a claim for an EVV-required service will be denied if there isn't an accepted EVV visit transaction in the EVV Portal that matches the claim. Renamed column 'Bypass Claim Units Match' to 'Units Matched During EVV Claims Matching?' to clarify when units on the claim are matched to units on the EVV visit transaction during the EVV claims matching process. The following columns have been removed from the MCO, C21 AC FFS, and CMS LTC FFS tabs: Unit Conversion Factor EVV Aggregator Claims Match Begin Effective Date EVV Aggregator Claims Match Begin Effective End Date Bypass EVV Claim Match and Apply EVV07? Bill Code Changed for 9/1/2019? EVV Service (Required or Optional) for 9/1/2019? EVV Services Required Starting 1/1/2021? Note: New column 'Effective Date EVV Claim Denial for No Matching Visit' has replaced this column and the date has been updated to align with the HHSC Cures Act EVV Expansion timeline. See the HHSC Cures Act EVV webpage for more information https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/21st-century-cures-act. In the 'Revision History' tab, replaced the 'Version' column with 'Effective Dates'. Minor changes to font size and color. **Service Changes:** Updated the following services to indicate units on the claim will be matched to units on the EVV visit transaction during the EVV claims matching process: Long-Term Care Services: CLASS CFC PAS/HAB (Service Group 2, Service Code 10CFC) DBMD CFC PAS/HAB (Service Group 16, Service Code 10CFC) Updated the following services to indicate units on the claim will not be matched to units on the EVV visit transaction during the EVV claims matching process: Acute Care Services: HCBS-AMH Supported Home Living (HCPCS S5130) YES Waiver Respite (In-Home) (HCPCS T2027) Long-Term Care Services: HCS CFC PAS/HAB (Service Group 12, Service Code 10CFC) TxHmL CFC PAS/HAB (Service Group 15, Service Code 10CFC) Added LTC CAS SRO service (Service Group 7, Service Code 17DS) because this service will require EVV by Dec. 1, 2020, but was not included in the previous version of the bill code table.

Effective Dates	Revision Description
10/1/2020	**Formatting Changes:** Certain program and service names were updated in all applicable tabs to be more consistent with the "EVV-Required Programs, Services, and Service Delivery Options" document on the HHS EVV webpage at: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification#programs-and-services-required-to-use-evv CMBHS was added to the 'C21 AC FFS EVV Services' tab. The STAR+PLUS/MMP bill codes with an 'Effective End Date' of 8/31/2019 were removed from the 'MCO EVV Services' tab. The 'Effective Date for EVV Claim Denial for No Matching Visit' was corrected for LTC CLASS CFC PAS/HAB (Service Group 2, Service Code 10CFC T2026) and In-Home Respite (Service Group 2, Service Code 11 G0100) from 11/1/2019 to 12/1/2020. The 'Claims Place of Service' column in the 'CARE LTC FFS EVV Services' tab was updated to only display the code relevant to EVV services: 12 (Home Location). This change was made because EVV is only required to capture services that require an in home visit. **Service Changes:** Effective Oct. 1, billed units on claims for the following EVV-required services will be matched to the billable units on the EVV visit transaction during the EVV claims matching process: All services delivered through the service responsibility option listed in the 'MCO EVV Services' tab; LTC CAS Personal Attendant Services - Level 1 and Level 2 (Service Group 7, Service Code 17DS G0755 and G0756); and LTC CLASS CFC PAS/HAB (Service Group 2, Service Code 10CFC T2026). The 'Units Matched During EVV Claims Matching?' columns in the 'MCO EVV Services' and 'CMS LTC FFS EVV Services' tabs were updated to 'Yes' to indicate this change. Program providers and FMSAs can practice units matching on EVV claims during the Cures Act EVV practice period and these claims will not be denied for an EVV mismatch. The practice period ends on Nov. 30. Read more about the practice period at
11/9/2020	**Formatting Changes:** The service names in the 'CARE LTC FFS EVV Services' tab for Day Habilitation and In-Home Respite in the HCS program were updated to match the HCS and TxHmL Bill Code Crosswalk. Additional information has been added to the bottom of the table noting that for HCS these services only require EVV when provided in own home or family home settings. The Claims Place of Service column in the 'CARE LTC FFS EVV Services' tab for CFC PAS/HAB added the community setting locations which require EVV. **Service Changes:** The Effective Date for EVV Claim Denial for No Matching Visit has been updated for services impacted by the Cures Act expansion to reflect the extension of the new EVV implementation date to Jan. 1, 2021. More information is available in the Cures Act EVV Practice Period Extended Through Dec 31 article on the HHS EVV webpage at https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification.

Effective Dates	Revision Description
5/1/2021	**Service Changes:** HCBS-AMH In Home Respite Unit type changed from Per Day to Per 15 Min Change HCPCS from S9125 (Respite care, in the home, per diem) to T1005 (Respite care services, up to 15 minutes) No change to HK and HE modifiers HCBS-AMH Supported Home Living - Habilitative Support Unit type changed from Per Hour to Per 15 Min No change to HCPCS S5130 (Homemaker service, nos; per 15 minutes) No change to HK and HE modifiers
11/1/2021	**Service Changes:** **Add to STAR Health PCS** New service combination T1019 UA (PCS BH Condition - Agency Model) New service combination T1019 U7 (PCS - CDS Model) New service combination T1019 UB (PCS BH Condition - CDS Model) **Remove from STAR Health PCS** T1019 UA, U6 (PCS BH Condition - Agency Model) T1019 UC (PCS - CDS Model) T1019 UA, UC (PCS BH Condition - CDS Model)

Effective Dates	Revision Description
3/1/2022	**Version 10.0 Service Changes:** **Updates to CARE LTC FFS Services table:** Ended HCS (Service Group 12) and TxHmL (Service Group 15) services effective 4/30/2022. Added a new column for End Date for EVV Claim Denial for No Matching Visit to reflect that Service Group 12 and Service Group 15 claims will not be denied for an EVV mismatch for dates of services after 2/28/2022.* *Program providers and FMSAs may view informational claims matching results in the EVV Portal for dates of service 3/1/2022 - 4/30/2022. **Updates to CMS LTC FFS Services table:** Added HCS (Service Group 21) and TxHmL (Service Group 22) services effective 3/1/2022. The following services include new Code Qualifier, HCPCS, Modifiers: HCS CDS Hourly Respite - LC 1, 8 - In-Home TxHmL CDS Day Habilitation - LC 1 - In-Home TxHmL CDS Hourly Respite - LC 1 - In Home The following services include an updated Unit Type (per 15 min): HCS CFC PAS/HAB - LOC 1, 8 HCS Hourly Respite - LC 1, 8 - In-Home TxHmL CFC PAS/HAB TxHmL Hourly Respite - LC 1 - In-Home The following services include an Effective Date for EVV Claim Denial for No Matching Visit of 6/1/2022*: HCS Day Habilitation - LN 1, 5, 6, 8 ,9 - In-Home HCS CFC PAS/HAB - LOC 1, 8 HCS CDS CFC PAS/HAB - LOC 1, 8 HCS Hourly Respite - LC 1, 8 - In-Home HCS CDS Hourly Respite - LC 1, 8 - In-Home TxHmL Day Habilitation - LC 1 - In-Home TxHmL CDS Day Habilitation - LC 1 - In-Home TxHmL CFC PAS/HAB TxHmL Hourly Respite - LC 1 - In-Home TxHmL CDS Hourly Respite - LC 1 - In Home *Program providers and FMSAs may view informational claims matching results in the EVV Portal for dates of service 5/1/2022 - 5/31/2022 Updates to the Legend Tab: Updated column description for: Effective Date for EVV Claim Denial for No Matching Visit Added new column title and column description for End Date for EVV Claim Denial for No Matching Visit

EVV Service Bill Codes - March 1, 2022 v10.0 Managed Care

Payer	Program	Service	Proc Code Qualifier	HCPCS	mod 1	mod 2	mod 3	mod 4	Unit Type	Units Matched During EVV Claims Matching?	Procedure Effective Begin Date	Procedure Effective End Date	Effective Date for EVV Claim Denial for No Matching Visit
MCO	STAR Health, STAR Kids	CFC HAB - Agency Model	HC	T1019	U9				per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	CFC HAB - CDS Model	HC	T1019	U4				per 15 min	No	3/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	CFC HAB - SRO Model	HC	T1019	U2				per 15 min	Yes	3/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	CFC PCS Only - Agency Model	HC	T1019	UD				per 15 min	Yes	3/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	CFC PCS Only - CDS Model	HC	T1019	U3				per 15 min	No	3/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	CFC PCS Only - SRO Model	HC	T1019	U1				per 15 min	Yes	3/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant - Agency Model	HC	H2015	99	U1			per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant - CDS Model	HC	H2015	99	U1	UC		per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant - SRO Model	HC	H2015	99	U1	US		per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant with RN Delegation - Agency Model	HC	H2015	99	U1	UA		per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant with RN Delegation - CDS Model	HC	H2015	99	U1	UA	UC	per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant with RN Delegation - SRO Model	HC	H2015	99	U1	UA	US	per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant - Agency Model	HC	H2015	U1				per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant - CDS Model	HC	H2015	U1	UC			per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant - SRO Model	HC	H2015	U1	US			per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant with RN Delegation - Agency Model	HC	H2015	U1	UA			per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant with RN Delegation - CDS Model	HC	H2015	U1	UA	UC		per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant with RN Delegation - SRO Model	HC	H2015	U1	UA	US		per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	PCS - Agency Model	HC	T1019	U6				per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Kids	PCS - CDS Model	HC	T1019	UC				per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health	PCS - CDS Model	HC	T1019	U7				per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	PCS - SRO Model	HC	T1019	US				per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Kids	PCS, BH Condition - Agency Model	HC	T1019	UA	U6			per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health	PCS, BH Condition - Agency Model	HC	T1019	UA				per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Kids	PCS, BH Condition - CDS Model	HC	T1019	UA	UC			per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health	PCS, BH Condition - CDS Model	HC	T1019	UB				per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	PCS, BH Condition - SRO Model	HC	T1019	UA	US			per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC HAB - Agency Model (HCBS)	HC	T2017	U3	U7			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	CFC HAB - Agency Model (Non-HCBS)	HC	T2017	U5	U7			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	CFC HAB - CDS Model (HCBS)	HC	T2017	U3	UC	U7		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC HAB - CDS Model (Non-HCBS)	HC	T2017	U5	UC	U7		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC HAB - SRO Model (HCBS)	HC	T2017	U3	UD	U7		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC HAB - SRO Model (Non-HCBS)	HC	T2017	U5	UD	U7		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC PAS - Agency Model (HCBS)	HC	S5125	U3	U7			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	CFC PAS - Agency Model (Non-HCBS)	HC	S5125	U5	U7			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	CFC PAS - CDS Model (HCBS)	HC	S5125	U3	UC	U7		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC PAS - CDS Model (Non-HCBS)	HC	S5125	U5	UC	U7		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC PAS - SRO Model (HCBS)	HC	S5125	U3	UD	U7		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC PAS - SRO Model (Non-HCBS)	HC	S5125	U5	UD	U7		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	In-Home Respite - Agency Model (HCBS)	HC	T1005	U3				per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	In-Home Respite - CDS Model (HCBS)	HC	T1005	U3	UC			per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	In-Home Respite - SRO Model (HCBS)	HC	T1005	U3	UD			per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	PAS - Agency Model (HCBS)	HC	S5125	U3				per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	PAS - Agency Model (Non-HCBS)	HC	S5125	U5				per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	PAS - CDS Model (HCBS)	HC	S5125	U3	UC			per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	PAS - CDS Model (Non-HCBS)	HC	S5125	U5	UC			per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	PAS - SRO Model (HCBS)	HC	S5125	U3	UD			per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	PAS - SRO Model (Non-HCBS)	HC	S5125	U5	UD			per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	Protective Supervision - Agency Model (HCBS)	HC	S5125	U3	U1			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	Protective Supervision - CDS Model (HCBS)	HC	S5125	U3	UC	U1		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	Protective Supervision - SRO Model (HCBS)	HC	S5125	U3	UD	U1		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021

EVV Service Bill Codes - March 1, 2022 v10.0 Acute Care Fee-for-Service

Payer	Program	Service	Proc Code Qualifier	HCPCS	mod 1	mod 2	mod 3	mod 4	Unit Type	Units Matched During EVV Claims Matching?	Procedure Effective Begin Date	Procedure Effective End Date	Effective Date for EVV Claim Denial for No Matching Visit
HHSC	CFC	CFC - HAB (Non-FMSA)	HC	T1019	U9				per 15 min	Yes	6/1/2015	12/31/9999	11/1/2019
HHSC	CFC	CFC - HAB CDS (FMSA)	HC	T1019	U4				per 15 min	No	6/1/2015	12/31/9999	1/1/2021
HHSC	CFC	CFC - PCS Only (Non-FMSA)	HC	T1019	UD				per 15 min	Yes	6/1/2015	12/31/9999	11/1/2019
HHSC	CFC	CFC - PCS Only CDS (FMSA)	HC	T1019	U3				per 15 min	No	6/1/2015	12/31/9999	1/1/2021
HHSC	HCBS-AMH	In-Home Respite	HC	S9125	HK	HE			per day	No	8/1/2016	4/30/2021	1/1/2021
HHSC	HCBS-AMH	In-Home Respite	HC	T1005	HK	HE			per 15 min	No	5/1/2021	12/31/9999	5/1/2021
HHSC	HCBS-AMH	Supported Home Living - Habilitative Support	HC	S5130	HK	HE			per hour	No	8/1/2016	4/30/2021	1/1/2021
HHSC	HCBS-AMH	Supported Home Living - Habilitative Support	HC	S5130	HK	HE			per 15 min	No	5/1/2021	12/31/9999	5/1/2021
HHSC	PCS	PCS (non-FMSA)	HC	T1019	U6				per 15 min	Yes	9/1/2015	12/31/9999	11/1/2019
HHSC	PCS	PCS - CDS (FMSA)	HC	T1019	U7				per 15 min	No	9/1/2015	12/31/9999	1/1/2021
HHSC	PCS	PCS BH Condition (non-FMSA)	HC	T1019	UA				per 15 min	Yes	9/1/2011	12/31/9999	11/1/2019
HHSC	PCS	PCS BH Condition - CDS (FMSA)	HC	T1019	UB				per 15 min	No	9/1/2011	12/31/9999	1/1/2021
HHSC	YES	In-Home Respite	HC	T2027	U9				per 15 min	No	6/30/2010	12/31/9999	1/1/2021

EVV Service Bill Codes - March 1, 2022 v10.0 Long-term Care Fee-for-Service

Payer	Program	Service	Proc Code Qualifier	HCPCS	mod 1	mod 2	mod 3	mod 4	Unit Type	Units Matched During EVV Claims Matching?	Procedure Effective Begin Date	Procedure Effective End Date	Service Group	Service Code	Effective Date for EVV Claim Denial for No Matching Visit
LTC	CAS	Personal Attendant Services (1929B) - Level 1, 2	HC	S5125					per hour	Yes	10/16/2003	12/31/2199	7	17D	11/1/2019
LTC	CAS	Personal Attendant Services (1929B) - Level 1 (Non-Priority) - CDS	ER	G0749					per $1	No	1/1/1900	12/31/2199	7	17DV	1/1/2021
LTC	CAS	Personal Attendant Services Level 1 (Non-Priority) - SRO	ER	G0756					per hour	Yes	1/2/2006	12/31/2199	7	17DS	1/1/2021
LTC	CAS	Personal Attendant Services (1929B) - Level 2 (Priority) - CDS	ER	G0748					per $1	No	1/1/1900	12/31/2199	7	17DV	1/1/2021
LTC	CAS	Personal Attendant Services Level 2 (Priority) - SRO	ER	G0755					per hour	Yes	1/2/2006	12/31/2199	7	17DS	1/1/2021
LTC	CLASS	CFC PAS/HAB	HC	T2026					per hour	Yes	6/1/2015	12/31/2199	2	10CFC	1/1/2021
LTC	CLASS	CFC PAS/HAB - CDS	HC	T2016					per $1	No	6/1/2015	12/31/2199	2	10CFV	1/1/2021
LTC	CLASS	In-Home Respite - DSA	ER	G0100					per day	No	1/1/1900	12/31/2199	2	11	1/1/2021
LTC	CLASS	In-Home Respite - CDS	HC	S9125					per $1	No	3/1/2008	12/31/2199	2	11PV	1/1/2021
LTC	DBMD	CFC PAS/HAB	HC	T2026					per hour	Yes	6/1/2015	12/31/2199	16	10CFC	1/1/2021
LTC	DBMD	CFC PAS/HAB - CDS	HC	T2016	UC				per $1	No	6/1/2015	12/31/2199	16	10CFV	1/1/2021
LTC	DBMD	In-Home Respite	ER	G0100					per day	No	1/1/1900	12/31/2199	16	11	1/1/2021
LTC	DBMD	In-Home Respite - CDS	HC	S9125					per $1	No	12/01/2008	12/31/2199	16	11PV	1/1/2021
LTC	FC	Personal Attendant Services	HC	S5125					per hour	Yes	10/16/2003	12/31/2199	7	17C	11/1/2019
LTC	FC	Personal Attendant Services - Level 1 (Non-Priority) - CDS	ER	G0746					per $1	No	1/1/1900	12/31/2199	7	17CV	1/1/2021
LTC	FC	Personal Attendant Services - Level 2 (Priority) - CDS	ER	G0745					per $1	No	1/1/1900	12/31/2199	7	17CV	1/1/2021
LTC	PHC	Personal Attendant Services - Level 1, 2	HC	S5125					per hour	Yes	10/16/2003	12/31/2199	7	17	11/1/2019
LTC	PHC	Personal Attendant Services - CDS	HC	S5125	UB				per $1	No	6/1/2015	12/31/2199	7	17V	1/1/2021
LTC	HCS	Day Habilitation - LN 1, 5, 6, 8 ,9 - In-Home	HC	T2020					per day	No	3/1/2022	12/31/2199	21	10C	6/1/2022
LTC	HCS	CFC PAS/HAB - LOC 1, 8	HC	T2016					per hour	No	3/1/2022	12/31/2199	21	10CFC	6/1/2022
LTC	HCS	CDS CFC PAS/HAB - LOC 1, 8	HC	T2016	UC				per $1	No	3/1/2022	12/31/2199	21	10CFV	6/1/2022
LTC	HCS	Hourly Respite - LC 1, 8 - In-Home	HC	S5150					per hour	No	3/1/2022	12/31/2199	21	11X	6/1/2022
LTC	HCS	CDS Hourly Respite - LC 1, 8 - In-Home	HC	S9125					per $1	No	3/1/2022	12/31/2199	21	11XV	6/1/2022
LTC	TxHmL	Day Habilitation - LC 1 - In-Home	HC	T2020					per day	No	3/1/2022	12/31/2199	22	10C	6/1/2022
LTC	TxHmL	CDS Day Habilitation - LC 1 - In-Home	HC	T2020	UC				per $1	No	3/1/2022	12/31/2199	22	10CV	6/1/2022
LTC	TxHmL	CFC PAS/HAB	HC	T2016					per hour	No	3/1/2022	12/31/2199	22	10CFC	6/1/2022
LTC	TxHmL	CDS CFC PAS/HAB	HC	T2016	UC				per $1	No	3/1/2022	12/31/2199	22	10CFV	6/1/2022
LTC	TxHmL	Hourly Respite - LC 1 - In-Home	HC	S5150					per hour	No	3/1/2022	12/31/2199	22	11X	6/1/2022
LTC	TxHmL	CDS Hourly Respite - LC 1 - In Home	HC	S9125					per $1	No	3/1/2022	12/31/2199	22	11XV	6/1/2022

More Information for HCS Day Habilitation and Respite
EVV is only required for HCS Day Habilitation and HCS Respite when services are provided in own home or family home settings.

EVV Service Bill Codes - March 1, 2022 v10.0 HCS and TxHmL Long-term Care Fee-for-Service

Payer	Program	Service	Claims Code Qualifier	Claims Procedure Code	Claims Modifier	Claims Revenue Code	Claims Place of Service	Unit Type	Units Matched During EVV Claims Matching?	Procedure Effective Begin Date	Procedure Effective End Date	Service Group	Service Code	Effective Date for EVV Claim Denial for No Matching Visit	End Date for EVV Claim Denial for No Matching Visit
LTC	HCS	CFC PAS/HAB - LOC 1, 8	HC	T2016			3, 11, 12, 22, 49, 99	per 15 min	No	6/1/2015	4/30/2022	12	10CFC	1/1/2021	2/28/2022
LTC	HCS	CFC PAS/HAB - LOC 1, 8 - CDS	HC	T2016	UC		3, 11, 12, 22, 49, 99	per $1	No	6/1/2015	4/30/2022	12	10CFV	1/1/2021	2/28/2022
LTC	HCS	Day Habilitation - LON 1, 5, 6, 8, 9	HC	T2020		0942	12	per day	No	9/1/2011	4/30/2022	12	10C	N/A	N/A
LTC	HCS	Hourly Respite LOC 1, 8	HC	S5150		0660	12	per 15 min	No	2/1/2008	4/30/2022	12	11X	N/A	N/A
LTC	HCS	CDS Hourly Respite LOC 1	ZZ	M0145			12	per $1	No	2/1/2008	4/30/2022	12	11XV	N/A	N/A
LTC	HCS	CDS Hourly Respite LOC 8	ZZ	M0146			12	per $1	No	2/1/2008	4/30/2022	12	11XV	N/A	N/A
LTC	TxHmL	CFC PAS/HAB	HC	T2016			3, 11, 12, 22, 49, 99	per 15 min	No	6/1/2015	4/30/2022	15	10CFC	1/1/2021	2/28/2022
LTC	TxHmL	CFC PAS/HAB - CDS	HC	T2016	UC		3, 11, 12, 22, 49, 99	per $1	No	6/1/2015	4/30/2022	15	10CFV	1/1/2021	2/28/2022
LTC	TxHmL	In-Home Day Habilitation - LOC 1	HC	T2020		0942	12	per day	No	2/1/2011	4/30/2022	15	10C	N/A	N/A
LTC	TxHmL	In-Home Day Habilitation - LOC 1 - CDS	ZZ	M0202			12	per $1	No	2/1/2011	4/30/2022	15	10CV	N/A	N/A
LTC	TxHmL	In-Home Respite (Hourly) - LOC 1	HC	S5150		0660	12	per 15	No	2/1/2008	4/30/2022	15	11X	N/A	N/A

Payer	Program	Service	Claims Code Qualifier	Claims Procedure Code	Claims Modifier	Claims Revenue Code	Claims Place of Service	Unit Type	Units Matched During EVV Claims Matching?	Procedure Effective Begin Date	Procedure Effective End Date	Service Group	Service Code	Effective Date for EVV Claim Denial for No Matching Visit	End Date for EVV Claim Denial for No Matching Visit
								min							
LTC	TxHmL	In-Home Respite (Hourly) - LOC 1 - CDS	ZZ	M0241			12	per $1	No	2/1/2008	4/30/2022	15	11XV	N/A	N/A

More Information for HCS Day Habilitation and Respite

EVV is only required for HCS Day Habilitation and HCS Respite when services are provided in own home or family home settings.

Appendix C – EVV Visit Transaction File

HHSC Electronic Visit Verification (EVV) Technical Documentation Appendix C - EVV Visit Transaction Layout
Published Date: 02/25/2022 Effective Date: 05/31/2022

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
Header record	1	This header record contains HHSC approved EVV vendor data transfer headers for all extract data elements contained in this file.	0	0	0				
File record	1	PROVIDER_TIN	30	1	30	Varchar			Provider Taxpayer Identification Number: A unique Identifier assigned by the Social Security Administration or Internal Revenue Service (IRS) to a Program Provider or Financial Management Services Agency (FMSA) for tax purposes.
File record	2	PROVIDER_NPI	10	31	40	Varchar			Provider National Provider Identifier (NPI): A Health Insurance Portability and Accountability Act (HIPAA) mandated unique identifier assigned by the Centers for Medicare and Medicaid Services (CMS) to a healthcare Program Provider or Financial Management Services Agency (FMSA).
File record	3	PROVIDER_API	10	41	50	Varchar			Provider Atypical Provider Identifier (API): A unique identifier assigned to a Program Provider or Financial Management Services Agency (FMSA) who does not provide healthcare services (i.e., Respite, transportation). Medicaid or State Issued API number.
File record	4	PROVIDER_TPI	9	51	59	Varchar			Texas Provider Identifier (TPI): A unique identifier assigned by the Claims Administrator to a Program Provider or Financial Management Services Agency (FMSA) delivering Acute Care fee-for-service services in Texas.
File record	5	PROVIDER_LEGALNAME	50	1	50	Varchar			Provider Legal Name: Provider Agency or Financial Management Services Agency (FMSA) legal name.
File record	6	PROVIDER_DBA	50	51	100	Varchar			Provider Doing Business As Name: Program Provider or Financial Management Services Agency (FMSA) Doing Business As name. This is a name that a person or business uses, other than their official name, in order to transact business.
File record	7	PROVIDER_CONTRACTNUMBER	9	101	109	Number			Provider Contract Number: A unique number assigned by HHSC when a Program Provider/FMSA contracts directly with HHSC to provide Long Term Services and Supports (aka Long-term Care) program services.
File record	8	PROVIDER_ADDRESS1	50	110	159	Varchar			Provider Address Line 1: Mailing address for the Program Provider or Financial Management Services Agency (FMSA). This address may be the same for many different office locations.
File record	9	PROVIDER_ADDRESS2	50	160	209	Varchar			Provider Address Line 2: Additional mailing address information for the Program Provider or Financial Management Services Agency (FMSA). This address may be the same for many different office locations.

File record	10	PROVIDER_CITY	50	1	50	Varchar			Provider City: The city where the Program Provider or Financial Management Services Agency (FMSA) address is located.
File record	11	PROVIDER_STATE	2	51	52	Varchar			Provider State: The state where the Program Provider or Financial Management Services Agency (FMSA) address is located.
File record	12	PROVIDER_ZIP	5	53	57	Number			Provider Zip: The zip code for which the Program Provider or Financial Management Services Agency (FMSA) address is located.

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	13	PROVIDER_LOCATIONID	30	58	87	Varchar			Provider Location Identification: A number assigned by the Program Provider or Financial Management Services Agency (FMSA) for a particular physical address from which services are provided.
File record	14	PROVIDER_REGION	2	88	89	Number			HHSC Provider Region: The location of where the Program Provider or Financial Management Services Agency (FMSA) is located. HHSC Medicaid LTC has 11 regions.
File record	15	PROVIDER_EVVEFFDATE	8	90	97	Date	MMDDYYYY		Provider Electronic Visit Verification Effective Date: The date the Program Provider or Financial Management Services Agency (FMSA) became effective in the EVV System. This is the first verified visit date by the Program Provider or FMSA.
File record	16	PROVIDER_EVVENDDATE	8	1	8	Date	MMDDYYYY		Provider Electronic Visit Verification End Date: The date the Program Provider or Financial Management Services Agency (FMSA) terminates from the EVV System.
File record	17	EMPLOYEE_EMPLOYEEID	30	9	38	Varchar			Employee Identification: An identifier assigned to the Service Provider by his or her employer for HR and payroll purposes.
File record	18	EMPLOYEE_SOCSEC_VISA_PASSPORT	54	39	92	Varchar			Employee Social Security Visa Passport: It consists of the last four digits of a Service Provider’s SSN or passport number concatenated with the Service Provider's last name.
File record	19	EMPLOYEE_EMPLOYEEDISCIPLINE	30	93	122	Varchar		Attendant, Nurse, CNA, PT, OT, SLP, Other	Employee Discipline: Credentials of the Service Provider.
File record	20	EMPLOYEE_FIRSTNAME	50	123	172	Varchar			Employee First Name: The Service Provider's first name.
File record	21	EMPLOYEE_LASTNAME	50	173	222	Varchar			Employee Last Name: The Service Provider's last name.
File record	22	EMPLOYEE_EVVID	30	223	252	Varchar			Electronic Visit Verification Identification: The Service Provider EVV System identifier number. This Identifier is assigned by the EVV System.
File record	23	EMPLOYEE_STARTDATE	8	253	260	Date	MMDDYYYY		Employee Start Date: The Service Provider start date. This is the date when the Service Provider became active on the EVV System.
File record	24	EMPLOYEE_ENDDATE	8	261	268	Date	MMDDYYYY		Employee End Date: The Service Provider end date. This is the date when the Service Provider was terminated on the EVV System.
File record	25	EMPLOYEE_EVVUSERID	30	269	298	Varchar			Electronic Visit Verification Identification: This is an account name or login identifier, used by the Service Provider to log onto the EVV System. This is assigned by the EVV System. The EVV User identifier and Password are required credentials for logging onto the EVV System.
File record	26	EMPLOYEE_EVVUSERFIRSTNAME	50	299	348	Varchar			Electronic Visit Verification User First Name: The first name of the person associated with the EVV User ID.
File record	27	EMPLOYEE_EVVUSERLASTNAME	50	349	398	Varchar			Electronic Visit Verification User Last Name: The last name of the person associated with the EVV User ID.
File record	28	EMPLOYEE_CDSEMPLOYEREVVID	30	399	428	Varchar			Consumer Directed Services Employer Electronic Visit Verification Identification: CDS employer identifier (if different from the individual receiving services e.g., a parent or guardian) assigned by the EVV System.
File record	29	EMPLOYEE_CDSEMPLOYERFIRSTNAME	50	429	478	Varchar			Consumer Directed Services Employer First Name: CDS employer first name (if different from the individual receiving services- e.g. a parent or guardian).
File record	30	EMPLOYEE_CDSEMPLOYERLASTNAME	50	479	528	Varchar			Consumer Directed Services Employer Last Name: CDS employer last name (if different from the individual receiving services- e.g. a parent or guardian).

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	31	INDVMBR_PAYOR	4	529	532	Varchar		AGP, BCB, CHS, CKC, CMC, LTC, HHSC, MOL, SHP, UHC	Individual/Member Payor: A unique identifier assigned to the payor, which is obtained through the Payer Plan Code Web Service.
File record	32	INDVMBR_FIRSTNAME	50	533	582	Varchar			Individual/Member First Name: The first name of the individual/member receiving services.
File record	33	INDVMBR_LASTNAME	50	583	632	Varchar			Individual/Member Last Name: The last name of the individual/member receiving services.
File record	34	INDVMBR_MEDICAIDID	9	633	641	Varchar			Invoice Individual/Member Medicaid Identification: The individual's/member's Medicaid ID number.
File record	35	INDVMBR_MEMBERDOB	8	642	649	Date	MMDDYYYY		Individual/Member Date of Birth: The individual's/member's date of birth.
File record	36	INDVMBR_MEMBEREVVID	30	650	679	Varchar			Individual/Member Electronic Visit Verification Identification: The individual /member's EVV System identifier number. This identifier is assigned by the EVV System.
File record	37	INDVMBR_STARTDATE	8	680	687	Date	MMDDYYYY		Individual/Member Start Date: The start date of when the individual/member became Medicaid eligible.
File record	38	INDVMBR_ENDDATE	8	688	695	Date	MMDDYYYY		Individual/Member End Date: The end date of when the individual/member became Medicaid eligible.
File record	39	INDVMBR_PRIORITY	1	696	696	Varchar			Individual/Member Priority: A numerical value assigned to the individual/member by the Program Provider or Financial Management Services Agency (FMSA) based on their level of need. https://hhs.texas.gov/laws-regulations/handbooks/hcs/section-5000-level-care-level-need
File record	40	INDVMBR_PHONE	10	697	706	Varchar			Individual/Member Phone: The primary phone number registered for EVV phone calls for the individual/member receiving services.
File record	41	INDVMBR_ALTPHONE	10	707	716	Varchar			Individual/Member Alternative Phone: A secondary (additional) phone number registered for EVV telephone calls to the individual/member receiving services.
File record	42	INDVMBR_ALTPHONE2	10	717	726	Varchar			Individual/Member Alternative Phone 2: Another secondary (additional) phone number registered for EVV telephone calls to the individual/member receiving services.
File record	43	MCO_MBR_SDA	2	727	728	Varchar			Managed Care Organization (MCO) Plan code for which the member is enrolled. Member MCO Plan Code is available in the Payer Plan Code Web Service.
File record	44	INDVMBR_ADDRESS_LATITUDE	50	729	778	Varchar			Individual/Member Address Latitude: The latitude of the individual's/member's address. This is pre saved information in the EVV System (Based on the individual/member's address)
File record	45	INDVMBR_ADDRESS_LONGITUDE	50	779	828	Varchar			Individual/Member Address Longitude: The longitude of the individual's/member's address. This is pre saved information in the EVV System (Based on the individual/member's address)
File record	46	INDVMBR_TOTAL_AUTHUNITS	11	829	839	Number	NNNNNNNN.NN		Individual/Member Total Authorized Units: The total number of units authorized for an individual/member for a service to be delivered for a given time period.
File record	47	AUTH_UNITS_TYPE	10	840	849	Varchar			Individual/Member Authorized Units Type: The type of units authorized. Can be daily, weekly, monthly or per auth.

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	48	INDVMBR_TOTAL_AUTHUNITSREMAINING	11	850	860	Number	NNNNNNNN.NN		Individual/Member Total Authorized Units Remaining: The total number of units remaining for an individual/member for a service to be delivered for a given time period. This is the value after the delivery of the units of service.
File record	49	VISIT_VISITID	30	861	890	Varchar			Electronic Visit Verification Visit Identification: A unique ID number assigned to the EVV visit by the EVV System.
File record	50	VISIT_SCHEDULEID	30	891	920	Varchar			Schedule Identification: A unique identifier number assigned to the scheduled visit by the EVV System.
File record	51	VISIT_VISITDATE	8	921	928	Date	MMDDYYYY		Scheduled Visit Date: The date that the System User scheduled the Service Provider to perform services for the individual/member. Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Weekly Variable Schedule Begin Date is populated for Weekly Variable Schedule. Null for No Schedule.
File record	52	VISIT_VISITTIMEIN	17	929	945	Date	MMDDYYYY HH:MM AM		Scheduled Visit Time In: Scheduled service delivery start time in date/time format.
File record	53	VISIT_VISITTIMEOUT	17	946	962	Date	MMDDYYYY HH:MM AM		Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Null for Weekly Variable Schedule or No Schedule.
File record	54	VISIT_VISITHOURS	5	963	967	Number	NN.NN		Scheduled Visit Time Out: Service delivery stop time in date/time format. Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Total Weekly Scheduled Hours is populated for Weekly Variable Schedule. Null for No Schedule.
File record	55	VISIT_VISITLOCATION	50	968	1017	Varchar			Scheduled Visit Location: The scheduled location where services are to be provided.
File record	56	VISIT_SVCGRP	3	1018	1020	Number		Full list can be found on HHSC Service Group/Service Code List	Visit Service Group: A code assigned by HHSC for the Long Term Services and Supports (aka Long Term Care) fee-for-service program through which the Individual is receiving services.
File record	57	EVV_SVCCODE	50	1021	1070	Varchar			Visit Service Code: A code to denote a specific service or category of service within the Long Term Services and Supports (aka Long Term Care) fee-for-service program at HHSC. Example: HHSC Service Code- Specific services provided within a program (Svc Grp 7+Svc Code 17C = Family Care, but Svc Grp 7+ Svc Code 17CV = Family Care in the Consumer Directed Services (CDS) option)
File record	58	EVV_HCPCS_CODE	30	1071	1100	Varchar			The Healthcare Common Procedure Coding System (HCPCS) Code: A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes.
File record	59	EVV_MODIFIER	30	1101	1130	Varchar			The Healthcare Common Procedure Coding System (HCPCS) Modifier: Two alphanumeric characters that are appended to the HCPCS codes to differentiate between services. There may be none or up to four modifiers for the HCPCS codes.
File record	60	EVV_VISITDATE	8	1131	1138	Date	MMDDYYYY		Actual Visit Date; EVV_VisitDate (actual visit) must be on or after Visit_VisitDate (scheduled visit)
File record	61	EVV_CREATEDDATETIME	17	1139	1155	Date	MMDDYYYY HH:MM AM		Created Date/Time: The date/time stamp assigned by the EVV System on the date a valid clock in and clock out or the date a manual visit is created in the EVV System.

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	62	EVV_PHONE	10	1156	1165	Varchar			Electronic Visit Verification Phone: The phone number used in the EVV Electronically Generated Call transaction.
File record	63	EVV_CALLINTIME	17	1166	1182	Date	MMDDYYYY HH:MM AM		Actual Call In Time: The date/time the Service Provider actually called in indicating service delivery started. Must be captured from an HHSC approved electronic verification method (Landline, Mobile or Alternative device). Must be Null for manually entered (GUI) visits.
File record	64	EVV_CALLOUTTIME	17	1183	1199	Date	MMDDYYYY HH:MM AM		Actual Call Out Time: The date/time the Service Provider actually called in indicating service delivery ended. Must be captured from an HHSC approved electronic verification method (Landline, Mobile or Alternative device). Must be Null for manually entered (GUI) visits.
File record	65	EVV_ACTUALHOURS	5	1200	1204	Number	NN.NN		Actual Hours: EVV System calculated duration in Hours and Minutes (NN.NN) Difference between electronically captured EVV_CALLINTIME and EVV_CALLOUTTIME. Must be Null for manually entered (GUI) visits.
File record	66	EVV_PAYHOURS	5	1205	1209	Number	NN.NN		Pay Hours: (also referred to as Bill Hours). Calculated by EVV System by rounding EVV_ActualHours, when present. Entered by Provider/FMSA for manual visit.
File record	67	EVV_UNITS	11	1210	1220	Number	NNNNNNNN.NN		Electronic Visit Verification Units: The number of units calculated by the EVV System using the EVV_PAYHOURS and the Unit Type in the Bill Code Table for the service on the visit.
File record	68	EVV_VISITLOCATION	50	1221	1270	Varchar			Actual Visit Location: The location where services are being provided.
File record	69	EVV_VISIT_LATITUDE_IN	50	1271	1320	Varchar			Electronic Visit Verification Visit Latitude In: The latitude of the visit location using the GPS location on a mobile method for the call in time. Data may be Null unless a mobile method approved by HHSC was used.
File record	70	EVV_VISIT_LONGITUDE_IN	50	1321	1370	Varchar			Electronic Visit Verification Visit Longitude In: The longitude of the visit location using the GPS location on a mobile method for the call in time. Data may be Null unless a mobile method approved by HHSC was used.
File record	71	EVV_LEARNED_LOCATION	1	1371	1371	Varchar			Electronic Visit Verification Learned Location: An indicator that specifies if an EVV location was learned via mobile method coordinates. This is usually the coordinates of the individual's/member's home. Data may be Null unless a mobile method approved by HHSC was used.
File record	72	EVV_LAT_LONG_MATCH_IN	1	1372	1372	Boolean	Y,N	Y,N	Latitude Longitude Match In: System assigned. Indicates that the Visit clock in latitude and longitude match the Member Home Geo-location.
File record	73	EVV_INPUTMETHOD_IN	50	1373	1422	Varchar			Electronic Visit Verification Input Method In: The data input method for call In.
File record	74	EVV_INPUTMETHOD_OUT	50	1423	1472	Varchar			Electronic Visit Verification Input Method Out: The data input method for call out.
File record	75	EVV_ALTERNATIVEDEVICEID	50	1473	1522	Varchar			Electronic Visit Verification Alternative Device Identification: The serial number or device identifier for an alternative device.
File record	76	EVV_REASONCODE1	3	1523	1525	Number			Electronic Visit Verification Reason Code 1: The first reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	77	EVV_REASONCODE1DESC	50	1526	1575	Varchar			Electronic Visit Verification Reason Code 1 Description: A narrative description of the EVV Reason Code 1 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	78	EVV_REASONCODE1COMMENT	500	1576	2075	Varchar			Electronic Visit Verification Reason Code 1 Comment: Additional comments regarding the EVV Reason Code 1 value.
File record	79	EVV_REASONCODE2	3	2076	2078	Number			Electronic Visit Verification Reason Code 2: The second reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	80	EVV_REASONCODE2DESC	50	2079	2128	Varchar			Electronic Visit Verification Reason Code 2 Description: A narrative description of the EVV Reason Code 2 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	81	EVV_REASONCODE2COMMENT	500	2129	2628	Varchar			Electronic Visit Verification Reason Code 2 Comment: Additional comments regarding the EVV Reason Code 2 value.
File record	82	EVV_REASONCODE3	3	2629	2631	Number			Electronic Visit Verification Reason Code 3: The third reason code that explains why maintenance occurred on an EVV transaction.
File record	83	EVV_REASONCODE3DESC	50	2632	2681	Varchar			Electronic Visit Verification Reason Code 3 Description: A narrative description of the EVV Reason Code 3 value. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	84	EVV_REASONCODE3COMMENT	500	2682	3181	Varchar			Electronic Visit Verification Reason Code 3 Comment: Additional comments regarding the EVV Reason Code 3 value.
File record	85	EVV_REASONCODE4	3	3182	3184	Number			Electronic Visit Verification Reason Code 4: The fourth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	86	EVV_REASONCODE4DESC	50	3185	3234	Varchar			Electronic Visit Verification Reason Code 4 Description: A narrative description of the EVV Reason Code 4 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	87	EVV_REASONCODE4COMMENT	500	3235	3734	Varchar			Electronic Visit Verification Reason Code 4 Comment: Additional comments regarding the EVV Reason Code 4 value.
File record	88	EVV_REASONCODE5	3	3735	3737	Number			Electronic Visit Verification Reason Code 5: The fifth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	89	EVV_REASONCODE5DESC	50	3738	3787	Varchar			Electronic Visit Verification Reason Code 5 Description: A narrative description of the EVV Reason Code 5 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	90	EVV_REASONCODE5COMMENT	500	3788	4287	Varchar			Electronic Visit Verification Reason Code 5 Comment: Additional comments regarding the EVV Reason Code 5 value.
File record	91	EVV_REASONCODE6	3	4288	4290	Number			Electronic Visit Verification Reason Code 6: The sixth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	92	EVV_REASONCODE6DESC	50	4291	4340	Varchar			Electronic Visit Verification Reason Code 6 Description: A narrative description of the EVV Reason Code 6 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	93	EVV_REASONCODE6COMMENT	500	4341	4840	Varchar			Reason Code Full Comment Text field - full text entry Electronic Visit Verification Reason Code 6 Comment: Additional comments regarding the EVV Reason Code 6 value.
File record	94	EVV_REASONCODE7	3	4841	4843	Number			Electronic Visit Verification Reason Code 7: The seventh reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	95	EVV_REASONCODE7DESC	50	4844	4893	Varchar			Electronic Visit Verification Reason Code 7 Description: A narrative description of the EVV Reason Code 7 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	96	EVV_REASONCODE7COMMENT	500	4894	5393	Varchar			Electronic Visit Verification Reason Code 7 Comment: Additional comments regarding the EVV Reason Code 7 value.
File record	97	EVV_REASONCODE8	3	5394	5396	Number			Electronic Visit Verification Reason Code 8: The eighth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	98	EVV_REASONCODE8DESC	50	5397	5446	Varchar			Electronic Visit Verification Reason Code 8 Description: A narrative description of the EVV Reason Code 8 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	99	EVV_REASONCODE8COMMENT	500	5447	5946	Varchar			Electronic Visit Verification Reason Code 8 Comment: Additional comments regarding the EVV Reason Code 8 value.
File record	100	EVV_REASONCODE9	3	5947	5949	Number			Electronic Visit Verification Reason Code 9: The ninth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	101	EVV_REASONCODE9DESC	50	5950	5999	Varchar			Electronic Visit Verification Reason Code 9 Description: A narrative description of the EVV Reason Code 9 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	102	EVV_REASONCODE9COMMENT	500	6000	6499	Varchar			Reason Code Full Comment Text field - full text entry Electronic Visit Verification Reason Code 9 Comment: Additional comments regarding the EVV Reason Code 9 value.
File record	103	EVV_REASONCODE10	3	6500	6502	Number			Electronic Visit Verification Reason Code 10: The tenth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	104	EVV_REASONCODE10DESC	50	6503	6552	Varchar			Electronic Visit Verification Reason Code 10 Description: A narrative description of the EVV Reason Code 10 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	105	EVV_REASONCODE10COMMENT	500	6553	7052	Varchar			Electronic Visit Verification Reason Code 10 Comment: Additional comments regarding the EVV Reason Code 10 value.

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	106	EVV_OVERALLREASONCODE	2	7053	7054	Varchar		Null, P, NP	HHSC no longer uses the Overall Reason Code field. This field should be populated as Null. If a value is captured, it must be a "P" or "NP".'
File record	107	EVV_VISITNOTES	500	7055	7554	Varchar			Visit Notes: Additional information (if any) related to the visit, needs to be added to the Visit Notes field.
File record	108	EVV_LASTVISITMAINT	17	7555	7571	Date	MMDDYYYY HH:MM AM		Last Visit Maintenance: The most recent date a change to one or more fields identified as impacting the last visit maintenance date in the HHSC EVV Policy Handbook are saved to the EVV visit transaction after the system User/Service Provider has documented the visit.
File record	109	EVV_UPLOADINDICATOR	2	7572	7573	Varchar			Electronic Visit Verification Upload Indicator: An indicator that specifies if a visit was finalized and uploaded (transferred) to the EVV Aggregator.
File record	110	EVV_LASTUPLOAD	17	7574	7590	Date	MMDDYYYY HH:MM AM		Electronic Visit Verification Last Upload: The last date a visit was finalized and uploaded (transferred) to the EVV Aggregator.
File record	111	EVV_VENDORID	30	7591	7620	Varchar			Electronic Visit Verification Vendor Identification: EVV System name. EVV_VendorID is assigned by MES service providers. EVV_VendorID must match the EVV System ID of the submitter of the batch file. EVV_VendorID is first part of the incoming file name.
File record	112	EVV_FILEEXPORTID	30	7621	7650	Varchar			Electronic Visit Verification File Export Identification: A specific upload identifier assigned to each data file export by the EVV System.
File record	113	EVV_DONOTEXPORTINDICATOR	1	7651	7651	Varchar			Electronic Visit Verification Do Not Export Indicator: An indicator that specifies if a visit has been manually flagged by a Program Provider or Financial Management Services Agency (FMSA) to not export to the EVV Aggregator.
File record	114	EVV_AUTOCONFIRMFLAG	2	7652	7653	Varchar			Electronic Visit Verification Auto Confirm Flag: An indicator that specifies if a visit was auto-verified by the EVV System and no visit maintenance was required.
File record	115	EVV_VISITRECORDINDICATOR	30	7654	7683	Varchar		New, Update, Cancel	Electronic Visit Verification Visit Record Indicator: An indicator that specifies the status of the EVV visit transaction.
File record	116	EVV_VISIT_LATITUDE_OUT	50	7684	7733	Varchar			Electronic Visit Verification Visit Latitude Out: The latitude of the visit location using the GPS location on a mobile method for the call out time. Data may be Null unless a mobile method was used.
File record	117	EVV_VISIT_LONGITUDE_OUT	50	7734	7783	Varchar			Electronic Visit Verification Visit Longitude Out: The longitude of the visit location using the GPS location on a mobile method for the call out time. Data may be Null unless a mobile method was used.
File record	118	EVV_MATERIAL_VM_CHANGE	1	7784	7784	Varchar	Y,N	Y,N	Visit Maintenance Material Change: Indicates if a Material visit maintenance change was made. Required if a material field was changed during visit maintenance

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	119	EVV_MATERIAL_VM_FIELD_ID	50	7785	7834	Varchar		include: First time GUI input Methods, Provider_TIN Provider_NPI Provider_API 007 Provider_ContractNumber 035 IndvMbr_MedicaidID EVV_SvcCode EVV_HCPCS Code EVV_Modifier EVV_VisitDate EVV_CreatedDateTime EVV_CallInTime EVV_CallOutTime EVV_ActualHours EVV_PayHours EVV_Units	Visit Maintenance Material Change Field Identification: Lists the Field identifier of each 'material change' field that was updated during visit maintenance, delimited by a comma. Required if Field EVV_MATERIAL_VM_CHANGE = Y.

Appendix D – EVV Master Provider Web Service

HHSC Electronic Visit Verification (EVV) Technical Documentation Appendix D - EVV Master Provider Web Service
Published Date: 02/25/2022 Effective Date: 05/31/2022

EVV Master Provider Web Service layout:

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic
Input	1	npiOrApi	10	STRING		
Input	2	asOfDate	19	STRING		
Output	3	errorMessage	N/A	STRING	Unexpected System Error	Return 'Unexpected System Error' if there is a system error when trying to match on the input parameters and build a return object.
Output	4	validationErrors	N/A	STRING		**Format validation for NPI/API** **Validation:** If the NPI/API field is a 10-digit string. Then the system passes the validation Else the system throws a Validation Error Message **Validation Error Message:** The NPI/API field is not in a valid format. **Range validation for AsOfDate** **Validation:** If the AsOfDate field is >= '04/01/2015' Then the system passes the validation Else the system throws a Validation Error Message **Validation Error Message:** The AsOfDate field needs to be greater than or equal to

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic
						04/01/2015. **<u>* Validate NPI/API and AsOfDate Combination</u>** **Validation:** If the search using the input parameters (As defined in the Values column of the input parameters) yield results in LongTermCareProviderResult OR AcuteCareProviderResult OR LTSSProviderResult Then the system passes the validation Else the system throws a Validation Error Message **Validation Error Message:** Provider cannot be validated/found for the NPI/API and AsOfDate Combination.
Output	5	providerResultType	26	STRING	AcuteCareProviderResult, LongTermCareProviderResult, LTSSProviderResult	
Output	6	tin	9	STRING		
Output	7	tpi	9	STRING		Required when ProviderResultType = AcuteCareProviderResult
Output	8	taxonomy	10	STRING		Required when ProviderResultType = AcuteCareProviderResult
Output	9	contractNumber	9	INTEGER		Required if the ProviderResultType = LongTermCareProviderResult

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic
Output	10	serviceGroup	5	STRING		Required if the ProviderResultType = LongTermCareProviderResult
Output	11	serviceCode	5	STRING		Required if the ProviderResultType = LongTermCareProviderResult
Output	12	fromDate	19	DATETIME		
Output	13	toDate	19	DATETIME		Required if the ProviderResultType = LongTermCareProviderResult (OR) LTSSProviderResult
Output	14	legalName	50	STRING		
Output	15	dbaName	50	STRING		Required if the ProviderResultType = LongTermCareProviderResult (OR) AcuteCareProviderResult
Output	16	address1	150	STRING		
Output	17	address2	150	STRING		
Output	18	city	100	STRING		
Output	19	state	2	STRING		
Output	20	zip	10	STRING		

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic
Output	21	region	2	STRING		Required if the ProviderResultType = LongTermCareProviderResult (OR) AcuteCareProviderResult
Output	22	badAddressIndicato r	5	BOOLEAN	TRUE, FALSE	**AcuteCareProviderResult:** BAD_ADDRESS_IND = 'N' , then FALSE BAD_ADDRESS_IND = 'Y', then TRUE **LongTermCareProviderResult:** 'FALSE' **LTSSProviderResult:** 'FALSE'
Output	23	pendingIndicator	5	BOOLEAN	TRUE, FALSE	**AcuteCareProviderResult:** ACUTEMBR.PRV_PRACTICE_LOC.PENDING_IND = 'A' and ACUTEMBR.PRV_PROVIDER.PENDING = 'A', then FALSE else TRUE **LongTermCareProviderResult:** 'FALSE' **LTSSProviderResult:** 'FALSE'
Output	24	sanctionIndicator	5	BOOLEAN	TRUE, FALSE	**AcuteCareProviderResult:** Have ACUTEMBR.PRV_PL_IMP_SANCT.FK_PROV_SANC_CODE <> (63, 67) and (ACUTEMBR.PRV_PL_IMP_SANCT.EFFECTIVE_DATE <= AsOfDate <= ACUTEMBR.PRV_PL_IMP_SANCT.TERMINATE_DATE), then 'TRUE' else, FALSE **LongTermCareProviderResult:** 'FALSE' **LTSSProviderResult:** 'FALSE'

Below is the list of Required, Conditionally Required and Informational provider fields and which may be edited in the EVV System UI:

Field	EVV System UI	Web Service Result
tin	Required - Not Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
tpi	Conditionally Required - Not Editable (This is Conditionally required only when the Payer is HHSC and not when the Payer is MCO or LTC)	AcuteCareProviderResult: Populated LongTermCareProviderResult: Default Blank LTSSProviderResult: Default Blank
taxonomy	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Default Blank LTSSProviderResult: Populated
contractNumber	Conditionally Required - Not Editable	AcuteCareProviderResult: Default Blank LongTermCareProviderResult: Populated LTSSProviderResult: Default Blank
serviceGroup	Conditionally Required - Not Editable	AcuteCareProviderResult: Default Blank LongTermCareProviderResult: Populated LTSSProviderResult: Default Blank
serviceCode	Conditionally Required - Not Editable	AcuteCareProviderResult; Default Blank LongTermCareProviderResult: Populated LTSSProviderResult; Default Blank
fromDate	Required - Not Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
toDate	Conditionally Required - Not Editable	AcuteCareProviderResult Default Blank LongTermCareProviderResult: Populated LTSSProviderResult: Populated
legalName	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
dbaName	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Default Blank
address1	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
address2	Informational - Editable	AcuteCareProviderResult: Optional LongTermCareProviderResult: Optional LTSSProviderResult: Optional

city	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
state	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
zip	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
region	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Default Blank
badAddressIndicator	INTERNAL USE ONLY DO NOT SHOW PROVIDER Conditionally Required - Not Editable	AcuteCareProviderResult: Populated ('TRUE' OR 'FALSE') LongTermCareProviderResult: default 'FALSE' LTSSProviderResult: default 'FALSE'
pendingIndicator	INTERNAL USE ONLY DO NOT SHOW PROVIDER Conditionally Required - Not Editable	AcuteCareProviderResult: Populated ('TRUE' OR 'FALSE') LongTermCareProviderResult: default 'FALSE' LTSSProviderResult: default 'FALSE'
sanctionIndicator	INTERNAL USE ONLY DO NOT SHOW PROVIDER Conditionally Required - Not Editable	AcuteCareProviderResult: Populated ('TRUE' OR 'FALSE') LongTermCareProviderResult: default 'FALSE' LTSSProviderResult: default 'FALSE'

Appendix E – Member Eligibility Companion Guides

HHSC Electronic Visit Verification (EVV) Technical Documentation Appendix E - Member Eligibility Companion Guides
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Below are links to the published X12 270/271 Eligibility Request and Response transaction companion guides.

Recommendation is for EVV systems to use of Eligibility as a Service (EaaS) X12 270/271 process over existing legacy Acute Care X12 270/271 process. EaaS better supports MCO only enrolled LTSS providers and the EaaS response returns the HHSC TIERS eligibility member residential address. The legacy Acute Care X12 270/271 response returns HHSC TIERS eligibility member mailing address which may include a PO Box address.

Eligibility as a Service (EaaS) X12 270/271 Companion Guide * Returns TIERS member residential address when available otherwise returns TIERS member mailing address	https://www.tmhp.com/topics/edi
X12 270/271 Long Term Care Companion Guide	https://www.tmhp.com/sites/default/files/file-library/edi/270-271%20Long%20Term%20Care%20Companion%20Guide.pdf
X12 270/271 Acute Care Companion Guide * NPI must be enrolled with TMHP and only returns TIERS member mailing address which may include PO Box Address.	https://www.tmhp.com/sites/default/files/file-library/edi/270-271%20Acute%20Care%20Companion%20Guide.pdf

Following fields are required to complete a member profile in the EVV System.

Field	EVV System UI
Medicaid ID	Required – Not Editable
Member Last Name	Required – Not Editable
Member First Name	Required – Not Editable
Gender	Required – Not Editable
Date of Birth	Required – Not Editable
Address	Required – Editable
City	Required – Editable
State	Required – Editable
Zip + 4	Required – Editable

Appendix F – EVV Prior Authorization File

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Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Table Name	Field Name
Input	1	medicaidID	9	STRING				
Input	2	asOfDate	19	DATETIME				
Output	3	errorMessage	N/A	STRING	Unexpected System Error	Return 'Unexpected System Error' if there is a system error when trying to match on the input parameters and build a return object.		
Output	4	validationErrors	N/A	STRING		**<u>* Format validation for MedicaidID</u>** <u>Validation:</u> 9 digit numerical Then the system passes validation Else the system sets Validation Error Message <u>Validation Error Message:</u> The Medicaid ID is not in a valid format. **<u>Range validation for AsOfDate</u>** <u>Validation:</u> If the AsOfDate field is >= '04/01/2015' Then the system passes the validation Else the system throws a Validation Error Message		

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Table Name	Field Name
						Validation Error Message: The AsOfDate field needs to be greater than or equal to 04/01/2015. **Validate MedicaidID and AsOfDate Combination** Validation: If the search using the input parameters (As defined in the Values column of the input parameters) yield result(s) in AuthorizationResult Then the system passes the validation Else the system throws a Validation Error Message Validation Error Message: Authorization cannot be found for MedicaidID and AsOfDate Combination.		
authorizationResultType CAN REPEAT MULTIPLE TIMES								
Output	5	authorizationResultType	25	STRING	LongTermCareAuthorization, AcuteCareAuthorization			
Output	6	indvMbrPayor	4	STRING	HHSC,LTC	**AcuteCareAuthorization:** HHSC **LongTermCareAuthorization:** LTC		
Output	7	indvMbrMedicaidID	9	STRING			**AcuteCareAuthorization:** ELG_CLIENT **LongTermCareAuthorization:** SRVC_AUTH	**AcuteCareAuthorization:** PATIENT_CONTROL_NO **LongTermCareAuthorization:** FK CL CLIENT ID
Output	8	indvMbrFirstName	15	STRING			**AcuteCareAuthorization:** ELG_CLIENT	**AcuteCareAuthorization:** FIRST_NAME

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Table Name	Field Name
							LongTermCareAuthorization: CLIENT	**LongTermCareAuthorization:**NM FIRST
Output	9	indvMbrLastName	25	STRING			**AcuteCareAuthorization:** ELG_CLIENT **LongTermCareAuthorization:** CLIENT	**AcuteCareAuthorization:** LAST_NAME **LongTermCareAuthorization:** LAST NM
Output	10	indvMbrMemberDOB		DATETIME			**AcuteCareAuthorization:** ELG_CLIENT **LongTermCareAuthorization:** CLIENT	**AcuteCareAuthorization:** BIRTH_DATE **LongTermCareAuthorization:** BIRTH DT
Output	11	indvMbrProgram	4	STRING	HHSC,LTC	**AcuteCareAuthorization:** HHSC **LongTermCareAuthorization:** LTC		
Output	12	mcoMbrPlanCode	2	STRING		Blank		
Output	13	providerTIN	9	STRING		**LongTermCareAuthorization:** When CONTRACT.PAYEE_ID_NBR digit 1 is not equal to 2, save digits 2-10 as TIN, else blank	**AcuteCareAuthorization:** PRV_PL_PGM_ASG_TAX **LongTermCareAuthorization:** CONTRACT	**AcuteCareAuthorization:** FK_PROV_IRS_NO **LongTermCareAuthorization:** PAYEE_ID_NBR
Output	14	providerNPI	10	STRING		**AcuteCareAuthorization:** If FK_PROVIDER_NPI first character is digit then save as NPI, else blank **LongTermCareAuthorization:** If NATIONAL_PROV_NBR first character is digit then save as NPI, else blank	**AcuteCareAuthorization:** AUT_AUTH_DETAIL **LongTermCareAuthorization:**CONTRACT	**AcuteCareAuthorization:** FK_PROVIDER_NPI **LongTermCareAuthorization:** NATIONAL_PROV_NBR
Output	15	providerAPI	10	STRING		**AcuteCareAuthorization:** If FK_PROVIDER_NPI first character is digit then save as NPI, else blank **LongTermCareAuthorization:** If NATIONAL_PROV_NBR first	**AcuteCareAuthorization:** AUT_AUTH_DETAIL **LongTermCareAuthorization:**CONTRACT	**AcuteCareAuthorization:** FK_PROVIDER_NPI **LongTermCareAuthorization:**NATIONAL_PR OV_NBR

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Table Name	Field Name
						character is digit then save as NPI, else blank		
Output	16	providerTPI	9	STRING		Required if AuthorizationResultType = AcuteCareAuthorization	**AcuteCareAuthorization:** AUT_AUTH_DETAIL	**AcuteCareAuthorization:** FK_PROVIDER_TPI+FK_PRAC_LOC_CODE
Output	17	evvhcpcsCode	7	STRING		Required if AuthorizationResultType = AcuteCareAuthorization	**AcuteCareAuthorization:** AUT_AUTH_DETAIL	**AcuteCareAuthorization:** FK_PROC_CODE_SUB
Output	18	evvModifier	5	STRING		Required if AuthorizationResultType = AcuteCareAuthorization	**AcuteCareAuthorization:** AUT_AUTH_DETAIL	**AcuteCareAuthorization:** FK_SUB1_MOD_CD:FK_SUB2_MOD_CD
Output	19	authNumber	10	STRING		Required if AuthorizationResultType = AcuteCareAuthorization	**AcuteCareAuthorization:** AUT_AUTH_HEADER	**AcuteCareAuthorization:** AUTHORIZATION_NUM
Output	20	indvMbrAuthStartDate	19	DATETIME			**AcuteCareAuthorization:** AUT_AUTH_DETAIL **LongTermCareAuthorization:** SRVC_AUTH	**AcuteCareAuthorization:** FROM_SERVICE_DT **LongTermCareAuthorization:** BEGIN DT

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Table Name	Field Name
Output	21	indvMbrAuthEndDate	19	DATETIME			**AcuteCareAuthorization:** AUT_AUTH_DETAIL **LongTermCareAuthorization:** SRVC_AUTH	**AcuteCareAuthorization:** THRU_SERVICE_DT **LongTermCareAuthorization:** END DT
Output	22	indvMbrTotalAuthUnits	11	STRING			**AcuteCareAuthorization:** AUT_AUTH_DETAIL **LongTermCareAuthorization:** SRVC_AUTH	**AcuteCareAuthorization:** APP_SRV_UNIT_NUM_H **LongTermCareAuthorization:** AUTH_UNITS
Output	23	remainingServiceUnits	11	STRING		Blank		
Output	24	authUnitsType	8	STRING	DAILY,WEEKLY,MONTHLY,YEARLY,PER AUTH	**AcuteCareAuthorization:** Database value "D" = Auth response value "DAILY" Dtabase value "W" = Auth response value "WEEKLY" Database value "M" = Auth response value "MONTHLY" Database value "Y" = Auth response value "YEARLY" Database value "Blank" = Auth response value "PER AUTH" **LongTermCareAuthorization:** Format: Database value - Auth response value Database value "D" = Auth response value "DAILY" Dtabase value "W" = Auth response value "WEEKLY" Database value "M" = Auth response value "MONTHLY"	**AcuteCareAuthorization:** AUT_DTL_PER_LIMIT **LongTermCareAuthorization:** SRVC_AUTH	**AcuteCareAuthorization:** FK_FREQ_PERIOD_CD **LongTermCareAuthorization:** FK_UTC_UNIT_TYPE

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Table Name	Field Name
Output	25	contractNumber	9	STRING		Required if AuthorizationResultType = LongTermCareAuthorization	**LongTermCareAuthorization:** SRVC_AUTH	**LongTermCareAuthorization:** FK_CN_CONTRACT_NBR
Output	26	serviceGroup	5	STRING		Required if AuthorizationResultType = LongTermCareAuthorization	**LongTermCareAuthorization:** SRVC_AUTH	**LongTermCareAuthorization:** FK_SG_SRVC_GRP
Output	27	serviceCode	5	STRING		Required if AuthorizationResultType = LongTermCareAuthorization	**LongTermCareAuthorization:** SRVC_AUTH	**LongTermCareAuthorization:** FK_SC_SRVC_CD

Appendix G – EVV Standard System Reports

HHSC Electronic Visit Verification (EVV) Technical Documentation Appendix G - EVV Standard System Reports
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HHSC requires each EVV Vendor and Proprietary System Operator (PSO) to provide the On-Demand EVV Standard System Reports as listed in the HHSC EVV Business Rules unless specifically indicated. This document contains specifications for each report. The EVV System will generate some reports using a web service provided by MES service providers, as indicated in the Report Description, to maintain consistency with the EVV Portal since the CDS Employers do not have access to that system. Therefore, the EVV System will display these reports specifically for the CDS Employer. The Program Providers, Financial Management Services Agency (FMSA), HHSC and MCOs will view these reports through the EVV Portal. The EVV System will create other reports using data native to the EVV System. MES service providers will provide sample reports upon request. All standard system reports must comply with these report specifications at a minimum.

Report Name	Description	Report Source
EVV Alternative Device Order Status Report	The EVV System must produce this report for the System User to use when verifying Alternative Devices orders placed by the program provider, CDS Employer, or FMSA on behalf of the CDS Employer, and to track the status of those orders. The EVV System must create this report using data native to the EVV System.	Native to the EVV System Not required for PSOs
EVV Attendant History Report	This report shows the Service Providers identified on accepted EVV Visit Transactions that delivered services to a Member for a requested date range. The System User will request this report through and view the results in, the EVV System. The EVV System will provide this report using the EVV Standard System Reports web service provided by MES service providers.	EVV Standard System Reports Web Service
EVV CDS Service Delivery Log	This report shows EVV Visit Transactions for visits for a requested date range. The EVV System must create this report using data native to the EVV system and. View the current CDS Delivery Log (HHS Form 1745) at the link below: https://hhs.texas.gov/laws-regulations/forms/1000- 1999/form-1745-service-delivery-log-written-narrativewritten- summary	Native to the EVV System
EVV CDS Employer Usage Report	This report shows the EVV usage score for CDS Employers. It equals the number of total electronic (non-manual) visit transactions divided by the total number of accepted visit transactions by the EVV Aggregator for a Member and requested date range. The System User will request this report through and view the results in, the EVV System. The EVV System will provide this report using the EVV Standard System Reports web service provided by MES service providers.	EVV Standard System Reports Web Service
EVV Clock In/Clock Out Usage Report	This report shows the number of accepted EVV Visit Transactions by a Service Provider, the number of times a Service Provider used each method (Mobile, GUI, etc.) to clock-	EVV Standard System Reports Web Service

Report Name	Description	Report Source
	in or clock-out, as well as the number of visits that the EVV System auto-verified. The System User will request this report through, and view the results in, the EVV System. The EVV System will provide this report using the EVV Standard System Reports web service provided by MES service providers.	
EVV Landline Phone Verification Report	This report shows the phone number, phone type and carrier used by a Service Provider to clock-in or clock-out using the home landline electronic verification method. The report allows the System User to monitor phone numbers and to identify the use of non-landline phone numbers. The EVV System must create this report using data native to the EVV system.	Native to the EVV System
EVV Reason Code Usage and Free Text Report	This report shows the count of Reason Code number and description combinations and associated free text/comments used on accepted EVV Visit Transactions for a Member and requested date range. The System User will request this report through, and view the results in, the EVV System. The EVV System will provide this report using the EVV Standard System Reports web service provided by MES service providers.	EVV Standard System Reports Web Service
EVV Service Delivery Exception Report	This report shows the number of visits that varied from the schedule or authorization, as well as the number of visits that the System User did not approve for a requested date range. This data must include services regardless of service delivery locations (home or community location, and GPS coordinates when the Service Provider used the mobile method to clock in/out). The EVV System must create this report using data native to the EVV system.	Native to the EVV System
EVV Units of Service Summary Report	This report displays a calendar view summary at the service level of the number of units delivered each day on accepted EVV Visit Transactions for a Member and requested date range. The System User will request the report through, and view the results in, the EVV System. The EVV System will provide the report using the EVV Standard System Reports web service provided by MES service providers.	EVV Standard System Reports Web Service
Non-EVV Relevant Time Logged Report	This report shows time the Service Provider spent on non-EVV services between clock in and clock out for a requested date range. The EVV System must create this report using data native to the EVV system.	Native to the EVV System

Standard Report Name: EVV Attendant History Report

Report Description

This report shows the Service Attendants identified on accepted EVV Visit Transactions that delivered services to a Member for a requested date range. The report will be requested through, and the results displayed in, the EVV System, using the EVV Standard System Reports web service provided by MES service providers.

Report Field Listing

EVV Attendant History Report Fields	Field Description	Associated EVV Visit Transaction Field
Texas EVV Attendant ID	The last four digits of the employee's social security number or passport number and last name of the person providing EVV services	EMPLOYEE_SOCSEC_VISA_PASSPORT
Attendant First Name	The first name of the person providing EVV services	EMPLOYEE_FIRSTNAME
Attendant Last Name	The last name of the person providing EVV services	EMPLOYEE_LASTNAME
Employee Discipline	The specialty of the person providing EVV services: attendant, nurse, certified nursing assistant (CNA), physical therapist (PT), occupational therapist (OT), speech-language pathologist (SLP), or other	EMPLOYEE_EMPLOYEEDISCIPLINE
Total Billable Units	The calculated sum of the Billable Units for the visits in the report.	N/A
Visit ID	A unique ID number assigned to the EVV visit transaction by the EVV system	VISIT_VISITID
Provider Name	The legal name of the program provider or Financial Management Services Agency (FMSA)	PROVIDER_LEGALNAME
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services	PROVIDER_NPI PROVIDER_API
TIN	The Tax Identification Number for the provider or FMSA	PROVIDER_TIN
Provider Number	The Long-Term Care (LTC) provider number if applicable	PROVIDER_CONTRACTNUMBER
TPI	The Texas Provider Identifier if applicable	PROVIDER_TPI
Payer Name	HHSC or name of MCO associated with the payer identifier submitted on visit transaction	INDVMBR_PAYOR (This field contains a 3–4-character identifier associated to a payer, the Payer Name should be displayed on the report)
Service Group	A code that identifies the LTC program when applicable	VISIT_SVCGRP

EVV Attendant History Report Fields	Field Description	Associated EVV Visit Transaction Field
Service Code	A code that identifies the service provided	EVV_SVCCODE
HCPCS	Identifies the service provided	EVV_HCPCS_CODE
Modifiers	The modifier associated with the HCPCS for the service if applicable	EVV_MODIFIER
Member Medicaid ID	Member's Medicaid Identification Number	INDVMBR_MEDICAIDID
Individual Last Name	Last Name of Member	INDVMBR_LASTNAME
Individual First Name	First Name of Member	INDVMBR_FIRSTNAME
Actual Visit Date	The date the EVV service occurred	EVV_VISITDATE
Actual Clock In	The time the attendant electronically clocked in when service delivery began: HH:MM AM/PM Null for manually entered (GUI) visits.	EVV_CALLINTIME
Actual Clock Out	The time the attendant electronically clocked out when service delivery ended: HH:MM AM/PM Null for manually entered (GUI) visits.	EVV_CALLOUTTIME
Actual Hours Worked	The total duration of service delivery based on electronic clock in and clock out times Null for manually entered (GUI) visits.	EVV_ACTUALHOURS
Billable Units	The billable units for the visit	EVV_UNITS
EVV System	Name of the EVV System	EVV_VENDORID

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer
Sort Order	N/A (Report Generated by MES service providers)
Default Filter (The system applies this filter)	Only Accepted EVV Transactions, Submitting EVV System

*Report Generation Criteria **

Field Name	Required/Optional
Texas EVV Attendant ID	Optional
Medicaid ID	Required and populated with all Medicaid Ids that are linked to the CDS Employer Profile. May only select one Medicaid Id.
Visit Begin Date	Required

Field Name	Required/Optional
Visit End Date	Required
Payer Name	Optional
Export Format	Required

Details of the Field Length, Field Validations and Validation Error Message will be provided with the JSON

Standard Report Name: EVV CDS Service Delivery Log

Report Description

This report shows EVV Visit Transactions for visits for a requested date range. This report is native to the EVV system and must be created by the EVV Vendor. The current CDS Delivery Log (HHS Form 1745) can be found at the link below:
https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1745-service-delivery-log-written-narrativewritten-summary

Report Field Listing

EVV CDS Service Delivery Log Report Fields	Field Description	Associated EVV Visit Transaction Field
Pay Period (header)	Dates of service delivery for the pay period as determined by the Financial Management Services Agency (FMSA).	N/A
CDS Employer (header)	CDS Employer Id and name, if the report is generated for one CDS Employer, else “All”.	EMPLOYEE_CDSEMPLOYEREVVID, EMPLOYEE_CDSEMPLOYERFIRSTNAME, EMPLOYEE_CDSEMPLOYERLASTNAME
FMSA Legal Name	Legal name of the FMSA.	PROVIDER_LEGALNAME
FMSA DBA Name	Doing Business As name of the FMSA.	PROVIDER_DBA
NPI/API	NPI or API of the FMSA.	PROVIDER_NPI PROVIDER_API
TIN	Tax Identification Number of the FMSA.	PROVIDER_TIN
Location	Location of the FMSA, as documented in the EVV System.	N/A
Region	HHSC Region of the FMSA.	PROVIDER_REGION
SDA	Managed Care Service Delivery Area of the FMSA, as documented in the EVV System.	MCO_MBR_SDA
Contract Number	Long-Term Care (LTC) provider number, if applicable.	PROVIDER_CONTRACTNUMBER
CDS Employer ID	IRS-assigned Employer Identification Number (EIN) or EVV system-generated Id of the CDS Employer.	EMPLOYEE_CDSEMPLOYEREVVID
CDS Employer First Name	First name of the CDS Employer.	EMPLOYEE_CDSEMPLOYERFIRSTNAME
CDS Employer Last Name	Last name of the CDS Employer.	EMPLOYEE_CDSEMPLOYERLASTNAME
Member ID	Member's Texas Medicaid Identification Number.	INDVMBR_MEDICAIDID
Member First Name	First name of the person receiving services.	INDVMBR_FIRSTNAME
Member Last Name	Last name of the person receiving services.	INDVMBR_LASTNAME

EVV CDS Service Delivery Log Report Fields	Field Description	Associated EVV Visit Transaction Field
CDS Employee ID	Last four digits of the social security number or passport number and last name of the person providing EVV services.	EMPLOYEE_SOCSEC_VISA_PASSPORT
CDS Employee First Name	First name of the person providing EVV services.	EMPLOYEE_FIRSTNAME
CDS Employee Last Name	Last name of the person providing EVV services.	EMPLOYEE_LASTNAME
Visit ID	Unique number assigned to the EVV visit transaction by the EVV system.	VISIT_VISITID
HCPCS and Modifiers	Identifies the service provided (each HCPCS will have zero to four modifiers in the EVV_MODIFIER field).	EVV_HCPCS_CODE plus space plus EVV_MODIFIER
Service	Description of the service provided (Service Short Description value from the EVV Service Bill Codes Table (HHSC version).	N/A
Visit Date	Date on which the service was provided (in MM/DD/YYYY format).	EVV_VISITDATE
Actual Clock In Time	Time the service began (the time the attendant electronically clocked in when service delivery began). Null for manually entered (GUI) visits.	EVV_CALLINTIME
Actual Clock Out Time	Time the service ended (the time the attendant electronically clocked out when service delivery ended). Null for manually entered (GUI) visits.	EVV_CALLOUTTIME
Actual Hours	Actual number of hours the service was provided (NN.NN format, not rounded). Null for manually entered (GUI) visits.	EVV_ACTUALHOURS
Non-EVV Relevant Hours	Number of hours identified as Non-EVV Relevant by the CDS Employee during the EVV service delivery, if applicable (NN.NN format, rounded to the quarter hour).	N/A
Billable Hours	Billable number of hours for the service that was provided (NN.NN format, rounded to the quarter hour).	EVV_PAYHOURS
Place of Service	Location where the service was delivered (home or community location per the list of valid values in the HHSC EVV Business Rules for Proprietary Systems).	EVV_VISITLOCATION
Reason Code Number	Texas EVV Reason Code Number.	EVV_REASONCODE1 EVV_REASONCODE2 ... EVV_REASONCODE10

EVV CDS Service Delivery Log Report Fields	Field Description	Associated EVV Visit Transaction Field
Reason Code	Texas EVV Reason Code (reason category name), as listed in the HHSC EVV Reason Codes list on the HHSC EVV website.	N/A
Reason Code Description	Texas EVV Reason Code Description.	EVV_REASONCODE1DESC EVV_REASONCODE2DESC … EVV_REASONCODE10DESC
Reason Code Free Text	Free text/comments (if any) entered during visit maintenance.	EVV_REASONCODECOMMENT1 EVV_REASONCODECOMMENT2 … EVV_REASONCODECOMMENT10
CDS Employee Daily Total Actual Hours	Calculated sum of the actual service delivery hours worked by the CDS Employee for the day.	N/A
CDS Employee Daily Total Non-EVV Relevant Hours	Calculated sum of the non-EVV relevant hours worked by the CDS Employee for the day.	N/A
CDS Employee Daily Total Billable Hours	Calculated sum of the billable hours for the CDS Employee for the day.	N/A
CDS Employee Pay Period Total Actual Hours	Calculated sum of the actual service delivery hours worked by the CDS Employee during the pay period.	N/A
CDS Employee Pay Period Total Non-EVV Relevant Hours	Calculated sum of the non-EVV relevant hours worked by the CDS Employee during the pay period.	N/A
CDS Employee Pay Period Total Billable Hours	Calculated sum of the billable hours worked by the CDS Employee during the pay period.	N/A
Member Pay Period Total Actual Hours	Calculated sum of the actual service delivery hours worked providing services to the Member by all CDS Employees during the pay period.	N/A
Member Pay Period Total Non-EVV Relevant Hours	The calculated sum of the non-EVV relevant hours worked providing services to the Member by all CDS Employees during the pay period.	N/A
Member Pay Period Total Billable Hours	Calculated sum of the billable hours worked providing services to the Member by all CDS Employees during the pay period.	N/A
CDS Employer Pay Period Total Actual Hours	Calculated sum of the actual service delivery hours worked for the CDS Employer by all CDS Employees providing services to the CDS Employer’s Members during the pay period.	N/A

EVV CDS Service Delivery Log Report Fields	Field Description	Associated EVV Visit Transaction Field
CDS Employer Pay Period Total Non-EVV Relevant Hours	Calculated sum of the non-EVV relevant hours worked for the CDS Employer by all CDS Employees providing services to the CDS Employer's Members during the pay period.	N/A
CDS Employer Pay Period Total Billable Hours	Calculated sum of the billable hours worked for the CDS Employer by all CDS Employees providing services to the CDS Employer's Members during the pay period.	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer, FMSA, MCO, HHSC
Sort Order	CDS Employer ID, Member ID, CDS Employee ID, Visit ID
Default Filter (The system applies this filter)	N/A

Report Generation Criteria

Field Name	Required/Optional
CDS Employer ID	*When logged in user is a CDS Employer:* Required and populated with the CDS Employer Id that is associated with the user. *When logged in user is from an FMSA:* Optional (but restricted to CDS Employer Ids that are associated with the FMSA). *When logged in user is from an MCO:* Optional (but restricted to CDS Employer Ids that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional Note: Each CDS Employer Id starts a new report page.
Visit Begin Date	Required
Visit End Date	Required

Standard Report Name: EVV Clock In/Clock Out Usage Report

Report Description

This report shows the number of accepted EVV Visit Transactions by a Service Attendant, the number of times each method (Mobile, GUI, etc.) was used to clock in or clock out, as well as the number of visits that were auto-verified. The report will be requested through, and the results displayed in, the EVV System, using the EVV Standard System Reports web service provided by MES service providers.

Report Field Listing

EVV Clock In/Clock Out Report Fields	Field Description	Associated EVV Visit Transaction Field
Texas EVV Attendant ID	The last four digits of the employee's social security number or passport number and last name of the person providing EVV services	EMPLOYEE_SOCSEC_VISA_PASSPORT
Attendant Last Name	The first name of the person providing EVV services	EMPLOYEE_FIRSTNAME
Attendant First Name	The last name of the person providing EVV services	EMPLOYEE_LASTNAME
Medicaid ID	Member's Medicaid Identification Number	INDVMBR_MEDICAIDID
Provider Name	The legal name of the program provider or Financial Management Services Agency (FMSA)	PROVIDER_LEGALNAME
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services	PROVIDER_NPI PROVIDER_API
TIN	The Tax Identification Number for the provider or FMSA	PROVIDER_TIN
Provider Number	The Long-Term Care (LTC) provider number if applicable	PROVIDER_CONTRACTNUMBER
TPI	The Texas Provider Identifier if applicable	PROVIDER_TPI
Total Accepted Visits	The total number of visits accepted by the EVV Aggregator that meet the search criteria	N/A
Auto Verified Count	The number of Auto Verified visits accepted into the EVV Aggregator that meet the search criteria.	EVV_AUTOCONFIRMFLAG
% Auto Verified	The percentage of Auto Verified visits out of the Total Accepted Visits	N/A
GUI Count	Number of visits from the Total Accepted Visits where GUI was used as the Clock In Method or the Clock Out Method	EVV_INPUTMETHOD_IN EVV_INPUTMETHOD_OUT

EVV Clock In/Clock Out Report Fields	Field Description	Associated EVV Visit Transaction Field
% GUI	The percentage of GUI visits out of the Total Accepted Visits. GUI was entered as either the clock in method or the clock out method	N/A
Landline Count	Number of visits from the Total Accepted Visits where Landline was used as the Clock In Method or the Clock Out Method	EVV_INPUTMETHOD_IN EVV_INPUTMETHOD_OUT
% Landline	The percentage of Landline visits out of the Total Accepted Visits. Landline was entered as either the clock in method or the clock out method	N/A
Alternative Device Count	Number of visits from the Total Accepted Visits where Alternative Device was used as the Clock In Method or the Clock Out Method	EVV_INPUTMETHOD_IN EVV_INPUTMETHOD_OUT
% Alt Device	The percentage of Alternative Device visits out of the Total Accepted Visits. Alternative Device was entered as either the clock in method or the clock out method	N/A
Mobile Method Count	Number of visits from the Total Accepted Visits where Mobile Method was used as the Clock In Method or the Clock Out Method	EVV_INPUTMETHOD_IN EVV_INPUTMETHOD_OUT
% Mobile Method	The percentage of Mobile Method visits out of the Total Accepted Visits. Mobile Method was entered as either the clock in method or the clock out method	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer
Sort Order	N/A (Report Generated by MES service providers)
Default Filter (The system applies this filter)	Only Accepted EVV Transactions, Submitting EVV System

*Report Generation Criteria **

Field Name	Required/Optional
Texas EVV Attendant ID	Optional

Field Name	Required/Optional
Medicaid ID	Required and populated with all Medicaid Ids that are linked to the CDS Employer Profile. May only select one Medicaid Id.
Visit Begin Date	Required
Visit End Date	Required
Payer Name	Optional
Export Format	Required

Details of the Field Length, Field Validations and Validation Error Message will be provided with the JSON

Standard Report Name: EVV Landline Phone Verification Report

Report Description

This report shows the phone number, phone type and carrier used by a Service Attendant to clock-in or clock-out using the home landline electronic verification method. The report allows for monitoring of phone numbers, to identify the use of non-landline numbers. This report is native to the EVV system and must be created by the EVV Vendor.

Report Field Listing

EVV Landline Phone Verification Report Fields	Field Description	Associated EVV Visit Transaction Field
Service Delivery Date Range (header)	Visit begin and end dates covered by the report.	N/A
Payer (header)	Name of the Payer, if the report is generated for one Payer, else “All”.	INDVMBR_PAYOR
Provider (header)	NPI/API and legal name of the program provider or Financial Management Services Agency (FMSA), if the report is generated for one program provider or FMSA, else “All”.	PROVIDER_NPI, PROVIDER_API, PROVIDER_LEGALNAME
CDS Employer (header)	CDS Employer Id and name, if the report is generated for one CDS Employer, else “All”.	EMPLOYEE_CDSEMPLOYEREVVID, EMPLOYEE_CDSEMPLOYERFIRSTNAME, EMPLOYEE_CDSEMPLOYERLASTNAME
Member ID	Member's Texas Medicaid Identification Number.	INDVMBR_MEDICAIDID
Member First Name	First Name of Member.	INDVMBR_FIRSTNAME
Member Last Name	Last Name of Member.	INDVMBR_LASTNAME
Phone Number	Phone number that was used to clock in or clock out via IVR for a visit (listed only once for a Member during a calendar month, regardless of the number of times the number was used for that Member during the month).	EVV_PHONE
Listed Phone Type	Phone type of the phone number (such as Landline, Mobile, Fixed VoIP, Non-Fixed VoIP, etc.) from a 3rd party validation service.	N/A
Listed Carrier	Registered carrier for the phone number such as AT&T, Verizon, etc., per 3rd party validation.	N/A
Month	The calendar month and year during which the phone number was used.	N/A
NPI/API	NPI or API of the program provider or FMSA.	PROVIDER_NPI PROVIDER_API
Provider Name	Legal name of the program provider or FMSA.	PROVIDER_LEGALNAME

EVV Landline Phone Verification Report Fields	Field Description	Associated EVV Visit Transaction Field
Payer (detail)	HHSC (Acute Care), LTC (Fee For Service Long Term Care) or name of MCO, as identified on the visit transaction.	INDVMBR_PAYOR

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer, Program Provider or FMSA, MCO, HHSC
Sort Order	Member ID, Phone Number, Month
Default Filter (The system applies this filter)	Only Accepted EVV Transactions

Report Generation Criteria

Field Name	Required/Optional
CDS Employer ID	*When logged in user is a CDS Employer:* Required and populated with the CDS Employer Id that is associated with the user. *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to CDS Employer Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Optional (but restricted to CDS Employer Ids that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
NPI/API	*When logged in user is a CDS Employer:* N/A *When logged in user is from a Program Provider or FMSA:* Required and restricted to the NPIs/APIs that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to NPIs/APIs that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional

Field Name	Required/Optional
Payer Name	*When logged in user is a CDS Employer:* Optional (but restricted to Payers that are associated with Member Ids that are associated with the CDS Employer). *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to Payers that are associated with Member Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Required and populated with the Payer Name that is associated with the MCO. *When logged in user is from HHSC (or its designee):* Optional
Visit Begin Date	Required
Visit End Date	Required

Standard Report Name: EVV Reason Code Usage and Free Text Report

Report Description

This report shows the count of Reason Code number and description combinations and associated free text/comments used on accepted EVV Visit Transactions for a Member and requested date range. The report will be requested through, and the results displayed in, the EVV System, using the EVV Standard System Reports web service provided by MES service providers.

Report Field Listing

EVV Reason Code Usage and Free Text Report Fields	Field Description	Associated EVV Visit Transaction Field
Reason Code Summary Section	This report section shows a summary of the reason code counts by Payer	
Reason Code Number	The Texas EVV Reason Code Number	EVV_REASONCODE1 EVV_REASONCODE2 … EVV_REASONCODE10
Reason Code	The Texas EVV Reason Code	Reference HHSC EVV Reason Codes on the HHSC EVV website.
Reason Code Description	The Texas EVV Reason Code Description	EVV_REASONCODE1DESC EVV_REASONCODE2DESC … EVV_REASONCODE10DESC
Count	The count of each reason code, reason code number, and reason code description for accepted EVV Visit transactions during the time period selected	N/A
Summary of Reason Codes by Provider Identifiers	This report section shows a summary of the reason code counts by Provider	
Provider Name	The legal name of the program provider or Financial Management Services Agency (FMSA)	PROVIDER_LEGALNAME
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services	PROVIDER_NPI PROVIDER_API
TIN	The Tax Identification Number for the provider or FMSA	PROVIDER_TIN
Provider Number	The Long-Term Care (LTC) provider number if applicable	PROVIDER_CONTRACTNUMBER
TPI	The Texas Provider Identifier if applicable	PROVIDER_TPI
EVV System	Name of the EVV System	EVV_VENDORID

EVV Reason Code Usage and Free Text Report Fields	Field Description	Associated EVV Visit Transaction Field
Reason Code Number	The Texas EVV Reason Code Number	EVV_REASONCODE1 EVV_REASONCODE2 … EVV_REASONCODE10
Reason Code	The Texas EVV Reason Code	Reference HHSC EVV Reason Codes on the HHSC EVV website.
Reason Code Description	The Texas EVV Reason Code Description	EVV_REASONCODE1DESC EVV_REASONCODE2DESC … EVV_REASONCODE10DESC
Count	The count of each reason code, reason code number, and reason code description for accepted EVV Visit transactions during the time period selected	N/A
Reason Codes/Free Text Details for Provider Identifiers by Medicaid ID	This report section shows a listing of the reason codes used by visit with the associated reason code free text description	
Provider Name	The legal name of the program provider or Financial Management Services Agency (FMSA)	PROVIDER_LEGALNAME
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services	PROVIDER_NPI PROVIDER_API
TIN	The Tax Identification Number for the provider or FMSA	PROVIDER_TIN
Provider Number	The Long-Term Care (LTC) provider number if applicable	PROVIDER_CONTRACTNUMBER
TPI	The Texas Provider Identifier if applicable	PROVIDER_TPI
Medicaid ID	Member's Medicaid Identification Number	INDVMBR_MEDICAIDID
Individual Last Name	Last Name of Member	INDVMBR_LASTNAME
Individual First Name	First Name of Member	INDVMBR_FIRSTNAME
EVV System	Name of the Proprietary System Operator	EVV_VENDORID
Reason Code Number	The Texas EVV Reason Code Number	EVV_REASONCODE1 EVV_REASONCODE2 … EVV_REASONCODE10
Reason Code	The Texas EVV Reason Code	Reference HHSC EVV Reason Codes on the HHSC EVV website.

EVV Reason Code Usage and Free Text Report Fields	Field Description	Associated EVV Visit Transaction Field
Reason Code Description	The Texas EVV Reason Code Description	EVV_REASONCODE1DESC EVV_REASONCODE2DESC … EVV_REASONCODE10DESC
Count	The count of each reason code, reason code number, and reason code description for accepted EVV Visit transactions during the time period selected	N/A
Visit Date	The date the EVV service occurred	EVV_VISITDATE
Visit ID	A unique ID number assigned to the EVV visit transaction by the EVV system	VISIT_VISITID
Actual Call In	The time the attendant electronically clocked in when service delivery began: HH:MM AM/PM Null for manually entered (GUI) visits.	EVV_CALLINTIME
Actual Call Out	The time the attendant electronically clocked out when service delivery ended: HH:MM AM/PM Null for manually entered (GUI) visits.	EVV_CALLOUTTIME
Reason Code Number	The Texas EVV Reason Code Number	EVV_REASONCODE1 EVV_REASONCODE2 … EVV_REASONCODE10
Reason Code	The Texas EVV Reason Code	Reference HHSC EVV Reason Codes on the HHSC EVV website.
Reason Code Description	The Texas EVV Reason Code Description	EVV_REASONCODE1DESC EVV_REASONCODE2DESC … EVV_REASONCODE10DESC
Reason Code Free Text Description	The free text manually entered for the specific visit	EVV_REASONCODE1COMMENT EVV_REASONCODE2COMMENT … EVV_REASONCODE10COMMENT

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer
Sort Order	N/A (Report Generated by MES service providers)
Default Filter (The system applies this filter)	Only Accepted EVV Transactions, Submitting EVV System

*Report Generation Criteria **

Field Name	Required/Optional
Year	Required
Monthly Range	Required
Medicaid ID	Required and populated with all Medicaid Ids that are linked to the CDS Employer Profile. May only select one Medicaid Id.
Payer Name	Optional
Export Format	Required

Details of the Field Length, Field Validations and Validation Error Message will be provided with the JSON

Standard Report Name: EVV Service Delivery Exception Report

Report Description

This report shows the number of visits that varied from the schedule or authorization, as well as the number of visits that were not approved, for a requested date range. This Report must include the following data points at a minimum:
Service scheduled but not performed
Service performed but not scheduled
Service performed but not authorized
Service authorized but not performed
Service performed but not approved/confirmed
This data must include services regardless of service delivery locations (home or community location, and GPS coordinates when the mobile method is used to clock in/out). This report is native to the EVV system and must be created by the EVV Vendor.

Report Field Listing

EVV Service Delivery Exception Report Fields	Field Description	Associated EVV Visit Transaction Field
Service Delivery Date Range (header)	Visit begin and end dates covered by the report. The report must accommodate a Service Delivery Date Range of at least four months.	N/A
Payer (header)	Name of the Payer, if the report is generated for one Payer, else “All”.	INDVMBR_PAYOR
Provider (header)	NPI/API and legal name of the program provider or Financial Management Services Agency (FMSA), if the report is generated for one program provider or FMSA, else “All”.	PROVIDER_NPI, PROVIDER_API, PROVIDER_LEGALNAME
CDS Employer (header)	CDS Employer Id and name, if the report is generated for one CDS Employer, else “All”.	EMPLOYEE_CDSEMPLOYEREVVID, EMPLOYEE_CDSEMPLOYERFIRSTNAME, EMPLOYEE_CDSEMPLOYERLASTNAME
Generated Date (header)	The date the report was generated by the EVV System.	N/A
Service scheduled but not performed	The count of service delivery exceptions where the service was scheduled but not performed during each calendar month included in the service delivery date range. Daily Fixed Schedule Criteria: No visit exists matching the Schedule for Member, Service Provider, Service, Date, and Time In and Time Out	N/A

EVV Service Delivery Exception Report Fields	Field Description	Associated EVV Visit Transaction Field
	Daily Variable Schedule Criteria: No visit exists matching the Schedule for Member, Service Provider, Service, Date, and Duration Weekly Variable Schedule Criteria: No visit exists matching the Schedule for Member, Service Provider, Service, and Date within the Weekly Schedule Begin and End Date range.	
Service performed but not scheduled	The count of service delivery exceptions where the service was performed but not scheduled during each calendar month included in the service delivery date range.	N/A
Service performed but not authorized	The count of service delivery exceptions where the service was performed but not authorized during each calendar month included in the service delivery date range.	N/A
Service authorized but not performed	The count of service delivery exceptions where the service was authorized but not performed during each calendar month included in the service delivery date range.	N/A
Service performed but not approved/confirmed	The count of service delivery exceptions where the service was performed but not approved/confirmed during each calendar month included in the service delivery date range.	N/A
Total	The count of services listed in each service row of the report.	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer, Program Provider or FMSA, MCO, HHSC
Sort Order	N/A
Default Filter (The system applies this filter)	N/A

Report Generation Criteria

Field Name	Required/Optional
CDS Employer ID	*When logged in user is a CDS Employer:*

Field Name	Required/Optional
	Required and populated with the CDS Employer Id that is associated with the user. *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to CDS Employer Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Optional (but restricted to CDS Employer Ids that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
NPI/API	*When logged in user is a CDS Employer:* N/A *When logged in user is from a Program Provider or FMSA:* Required and restricted to the NPIs/APIs that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to NPIs/APIs that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
Payer Name	*When logged in user is a CDS Employer:* Optional (but restricted to Payers that are associated with Member Ids that are associated with the CDS Employer). *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to Payers that are associated with Member Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Required and populated with the Payer Name that is associated with the MCO. *When logged in user is from HHSC (or its designee):* Optional
Visit Begin Date	Required
Visit End Date	Required

Standard Report Name: EVV Units of Service Summary

Report Description

This report displays a calendar view summary at the service level of the number of units delivered each day on accepted EVV Visit Transactions for a Member and requested date range. The report will be requested through, and the results displayed in, the EVV System, using the EVV Standard System Reports web service provided by MES service providers.

Report Field Listing

EVV Units of Service Summary Report Fields	Field Description	Associated EVV Visit Transaction Field
EVV Units of Service Summary	This report shows the summary information,	
Provider Legal Name	The legal name of the program provider or Financial Management Services Agency (FMSA)	PROVIDER_LEGALNAME
Provider DBA	Provider Doing Business As Name	PROVIDER_DBA
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services	PROVIDER_NPI PROVIDER_API
TIN	The Tax Identification Number for the program provider or FMSA	PROVIDER_TIN
Provider Number	The Long-Term Care (LTC) provider number if applicable	PROVIDER_CONTRACTNUMBER
Member Medicaid ID	Member's Medicaid Identification Number	INDVMBR_MEDICAIDID
Individual Last Name	Last Name of Member	INDVMBR_LASTNAME
Individual First Name	First Name of Member	INDVMBR_FIRSTNAME
Payer	HHSC or name of MCO associated with the payer identifier submitted on visit transaction	INDVMBR_PAYOR (This field contains a 3-4 character identifier associated to a payer, the payer name should be displayed on the report)
Total Units Verified on Report	Blank field used by HHSC Contract Monitoring	N/A
Total Units Authorized on Report	Blank field used by HHSC Contract Monitoring	N/A
Total Units Eligible for Payment on Report	Blank field used by HHSC Contract Monitoring	N/A
Total Units Paid on Report	Blank field used by HHSC Contract Monitoring	N/A
Total Units Disallowed on Report	Blank field used by HHSC Contract Monitoring	N/A

EVV Units of Service Summary Report Fields	Field Description	Associated EVV Visit Transaction Field
Service Group	A code that identifies the LTC program when applicable	VISIT_SVCGRP
Service Code	A code that identifies the service provided	EVV_SVCCODE
HCPCS	Identifies the service provided	EVV_HCPCS_CODE
Modifier(s)	The modifier associated with the HCPCS for the service if applicable	EVV_MODIFIER
EVV Units of Service by Month	This report section shows the daily, weekly, and monthly totals of service unit's delivery for a specific Medicaid ID.	
Month/Year	The name of the month and the year in long date format for the report	N/A
Priority Status	Blank field used by HHSC Contract Monitoring	N/A
Non Priority Status	Blank field used by HHSC Contract Monitoring	N/A
Fixed Schedule	Blank field used by HHSC Contract Monitoring	N/A
Variable Schedule	Blank field used by HHSC Contract Monitoring	N/A
SUN	The date for the month with the daily count of EVV service units delivered for the specific Medicaid ID for that day. The field is repeated for each week of the month.	EVV_UNITS (sum of all units for all visits on the day for the above criteria)
MON	The date for the month with the daily count of EVV service units delivered for the specific Medicaid ID for that day. The field is repeated for each week of the month.	EVV_UNITS (sum of all units for all visits on the day for the above criteria)
TUE	The date for the month with the daily count of EVV service units delivered for the specific Medicaid ID for that day. The field is repeated for each week of the month.	EVV_UNITS (sum of all units for all visits on the day for the above criteria)
WED	The date for the month with the daily count of EVV service units delivered for the specific Medicaid ID for that day. The field is repeated for each week of the month.	EVV_UNITS (sum of all units for all visits on the day for the above criteria)
THU	The date for the month with the daily count of EVV service units delivered for the specific Medicaid ID for that day. The field is repeated for each week of the month.	EVV_UNITS (sum of all units for all visits on the day for the above criteria)
FRI	The date for the month with the daily count of EVV service units delivered for the specific Medicaid ID for that day. The field is repeated for each week of the month.	EVV_UNITS (sum of all units for all visits on the day for the above criteria)
SAT	The date for the month with the daily count of EVV service units delivered for the specific	EVV_UNITS (sum of all units for all visits on the day for the above criteria)

EVV Units of Service Summary Report Fields	Field Description	Associated EVV Visit Transaction Field
	Medicaid ID for that day. The field is repeated for each week of the month.	
A. Units Verified	Sum of the EVV Service units for each week	N/A
B. Authorized Weekly Units	Blank field used by HHSC Contract Monitoring	N/A
C. Lesser Amt = Verified Units	Blank field used by HHSC Contract Monitoring	N/A
D. Units Paid	Blank field used by HHSC Contract Monitoring	N/A
E. Units Disallowed	Blank field used by HHSC Contract Monitoring	N/A
F. Service Interrupt (Y/N)	Blank field used by HHSC Contract Monitoring	N/A
Sum of Units Verified for the Month Reviewed	Sum of the EVV Service units for the month	N/A
Notes	Blank field used by HHSC Contract Monitoring	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF
Report Available To	CDS Employer
Sort Order	N/A (Report Generated by MES service providers)
Default Filter (The system applies this filter)	Only Accepted EVV Transactions, Submitting EVV System

*Report Generation Criteria **

Field Name	Required/Optional
Visit Begin Date	Required
Visit End Date	Required
Medicaid ID	Required and populated with all Medicaid Ids that are linked to the CDS Employer Profile. May only select one Medicaid Id.
Payer Name	Optional
Export Format	Required

Details of the Field Length, Field Validations and Validation Error Message will be provided with the JSON

Standard Report Name: Non-EVV Relevant Time Logged Report

Report Description

This report shows time that was spent on non-EVV services between clock in and clock out for a requested date range. This report is native to the EVV system and must be created by the EVV Vendor.

Report Field Listing

Non-EVV Relevant Time Logged Report Fields	Field Description	Associated EVV Visit Transaction Field
Service Delivery Date Range (header)	Visit begin and end dates covered by the report.	N/A
Provider (header)	NPI/API and legal name of the program provider or Financial Management Services Agency (FMSA), if the report is generated for one program provider or FMSA, else “All”.	PROVIDER_NPI, PROVIDER_API, PROVIDER_LEGALNAME
CDS Employer (header)	CDS Employer Id and name, if the report is generated for one CDS Employer, else “All”.	EMPLOYEE_CDSEMPLOYEREVVID, EMPLOYEE_CDSEMPLOYERFIRSTNAME, EMPLOYEE_CDSEMPLOYERLASTNAME
Member (header)	Member Id and name, if the report is generated for one Member, else “All”.	INDVMBR_MEDICAIDID, INDVMBR_FIRSTNAME, INDVMBR_LASTNAME
Provider Legal Name	Legal name of the program provider or Financial Management Services Agency (FMSA).	PROVIDER_LEGALNAME
Provider DBA Name	Doing Business As name of the program provider or FMSA.	PROVIDER_DBA
NPI/API	NPI or API of the program provider or FMSA.	PROVIDER_NPI PROVIDER_API
TIN	Tax Identification Number of the program provider or FMSA.	PROVIDER_TIN
Location	Location of the program provider or FMSA, as documented in the EVV System.	N/A
Region	HHSC Region of the program provider or FMSA, as documented in the EVV System.	N/A
SDA	Managed Care Service Delivery Area of the program provider or FMSA, as documented in the EVV System.	N/A
Contract Number	Long-Term Care (LTC) provider number, if applicable.	PROVIDER_CONTRACTNUMBER

Member ID	Member's Texas Medicaid Identification Number.	INDVMBR_MEDICAIDID
Member First Name	First Name of the Member.	INDVMBR_FIRSTNAME
Member Last Name	Last Name of the Member.	INDVMBR_LASTNAME
Texas EVV Attendant ID	Last four digits of the employee’s social security number or passport number and last name of the person providing EVV services.	EMPLOYEE_SOCSEC_VISA_PASSPORT
Service Attendant First Name	First name of the person providing EVV services.	EMPLOYEE_FIRSTNAME
Service Attendant Last Name	Last name of the person providing EVV services.	EMPLOYEE_LASTNAME
Visit ID	Unique ID number assigned to the EVV visit transaction by the EVV System.	VISIT_VISITID
Visit Date	The date of the EVV service delivery during which the Non-EVV relevant service occurred (in MM/DD/YYYY format).	EVV_VISITDATE
Non-EVV Relevant Hours	Number of hours identified as Non-EVV Relevant by the Service Attendant during the EVV service delivery (in n.nn format).	N/A
Service Attendant Total Non-EVV Relevant Hours	Calculated sum of the non-EVV relevant hours worked by the Service Attendant during the period.	N/A
Member Total Non-EVV Relevant Hours	Calculated sum of the non-EVV relevant hours worked by all Service Attendants providing non-EVV relevant services to the Member during the period.	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer, Program Provider or FMSA, MCO, HHSC
Sort Order	Member ID, Texas EVV Attendant ID, Visit ID
Default Filter (The system applies this filter)	N/A

Report Generation Criteria

Field Name	Required/Optional
CDS Employer ID	*When logged in user is a CDS Employer:*

Field Name	Required/Optional
	Required and populated with the CDS Employer Id that is associated with the user. *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to CDS Employer Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Optional (but restricted to CDS Employer Ids that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
Member ID	*When logged in user is a CDS Employer:* Optional (but restricted to the Member Ids that are associated with the CDS Employer). *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to Member Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Optional (but restricted to Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
NPI/API	*When logged in user is a CDS Employer:* N/A *When logged in user is from a Program Provider or FMSA:* Required and restricted to the NPIs/APIs that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to NPIs/APIs that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
Visit Begin Date	Required
Visit End Date	Required

Standard Report Name: EVV Alternative Device Order Status Report

Report Description

This report is used to verify that Alternative Devices have been ordered by the program provider, CDS Employer, or Financial Management Services Agency (FMSA) on behalf of the CDS Employer, and to track the status of those orders. This report is native to the EVV system and must be created by the EVV Vendor. This report is not required for PSOs.

Report Field Listing

Report Fields	Field Description	Associated EVV Visit Transaction Field
Date Range (header)	Begin and end dates covered by the report, taking ***all date fields*** into account (AD Ordered Date, AD First Used Date, AD Returned Date, etc.). If one or more dates for an AD are covered, that AD is included in the report.	N/A
Payer (header)	Name of the Payer, if the report is generated for one Payer, else “All”.	INDVMBR_PAYOR
TIN (header)	TIN of the program provider or FMSA, if the report is generated for one TIN, else “All”.	PROVIDER_TIN
Provider (header)	NPI/API and legal name of the program provider or FMSA, if the report is generated for one program provider or FMSA, else “All”.	PROVIDER_NPI, PROVIDER_API, PROVIDER_LEGALNAME
Contract (header)	HHSC Contract Number of the program provider or FMSA, if the report is generated for one Contract Number, else “All”.	PROVIDER_CONTRACTNUMBER
CDS Employer (header)	CDS Employer Id and name, if the report is generated for one CDS Employer, else “All”.	EMPLOYEE_CDSEMPLOYEREVVID, EMPLOYEE_CDSEMPLOYERFIRSTNAME, EMPLOYEE_CDSEMPLOYERLASTNAME
Member (header)	Member Id and name, if the report is generated for one Member, else “All”.	INDVMBR_MEDICAIDID, INDVMBR_FIRSTNAME, INDVMBR_LASTNAME
AD ID (header)	The serial number or device identifier for the Alternative Device, if the report is generated for one Alternative Device, else “All”.	EVV_ALTERNATIVEDEVICEID
Provider Legal Name	The legal name of the program provider or FMSA.	PROVIDER_LEGALNAME
Provider DBA Name	Program provider or FMSA Doing Business As name. This is a name that a person or business uses, other than their official name, in order to transact business.	PROVIDER_DBA

Report Fields	Field Description	Associated EVV Visit Transaction Field
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services. A Health Insurance Portability and Accountability Act (HIPAA) mandated unique identifier assigned by the Centers for Medicare and Medicaid Services (CMS) to a program provider or FMSA.	PROVIDER_NPI PROVIDER_API
TIN (detail)	A unique identifier assigned by the Social Security Administration or Internal Revenue Service (IRS) to a program provider or FMSA for tax purposes.	PROVIDER_TIN
Location	Location of the program provider or FMSA, as documented in the EVV System.	N/A
Region	HHSC Region of the program provider or FMSA, as documented in the EVV System.	N/A
SDA	Managed Care Service Delivery Area of the program provider or FMSA, as documented in the EVV System.	N/A
Contract Number	A unique number assigned by HHSC when a program provider or FMSA contracts directly with HHSC to provide Long Term Services and Supports (aka Long-Term Care) program services.	PROVIDER_CONTRACTNUMBER
Member ID	The Member's Texas Medicaid identification number.	INDVMBR_MEDICAIDID
Member First Name	The first name of the person receiving services.	INDVMBR_FIRSTNAME
Member Last Name	The last name of the person receiving services.	INDVMBR_LASTNAME
AD ID (detail)	The serial number or device identifier for an Alternative Device.	EVV_ALTERNATIVEDEVICEID
AD Status	The status of the Alternative Device (Active or Inactive).	N/A
AD Ordered Date	The date when the Alternative Device was ordered.	N/A
AD Assigned Date	The date when the Alternative Device was assigned by the Vendor.	N/A
AD Shipped Date	The date when the Alternative Device was shipped. Will be blank if the Alternative Device was picked up in person (not shipped).	N/A
Shipping Carrier	Shipping Carrier used to ship the Alternative Device to the program provider or FMSA. Will be "in Person" if the Alternative Device was picked up in person (not shipped).	N/A
Tracking Number	Tracking number associated to the Alternative Device shipment. Will be blank if the Alternative Device was picked up in person (not shipped).	N/A
AD Received Date	The date when the Alternative Device was received.	N/A

Report Fields	Field Description	Associated EVV Visit Transaction Field
AD First Used Date	The date when the Alternative Device was first used.	N/A
AD Last Used Date	The date when the Alternative Device was last used.	N/A
AD Unassigned Date	The date when the Alternative Device was relinquished by the assigned Member and made available for assignment to, and use by, another Member.	N/A
AD Deactivated Date	The date when the Alternative Device was deactivated.	N/A
AD Returned Date	The date when the Alternative Device was returned to the Vendor.	N/A
AD Returned Reason	The reason Alternative Device was return (Broken, Lost, Malfunctioning, etc.).	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer, Program Provider or FMSA, MCO, HHSC
Sort Order	TIN, NPI/API, Contract Number, Member ID, AD Ordered Date
Default Filter (The system applies this filter)	N/A

Report Generation Criteria

Field Name	Required/Optional
CDS Employer ID	*When logged in user is a CDS Employer:* Required and populated with the CDS Employer Id that is associated with the user. *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to CDS Employer Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Optional (but restricted to CDS Employer Ids that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
Member ID	*When logged in user is a CDS Employer:* Optional (but restricted to the Member Ids that are associated with the CDS Employer).

Field Name	Required/Optional
	When logged in user is from a Program Provider or FMSA: Optional (but restricted to Member Ids that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
AD ID	*When logged in user is a CDS Employer:* Optional (but restricted to the AD Ids that are associated with the CDS Employer). *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to AD Ids that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to AD Ids that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
NPI/API	*When logged in user is a CDS Employer:* N/A *When logged in user is from a Program Provider or FMSA:* Required and restricted to the NPIs/APIs that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to NPIs/APIs that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional Note: Each NPI/API starts a new report page.
Contract Number	*When logged in user is a CDS Employer:* N/A *When logged in user is from a Program Provider or FMSA:* Required and restricted to Contract Numbers that are associated with the Program Provider or FMSA.

Field Name	Required/Optional
	When logged in user is from an MCO: Optional (but restricted to Contract Numbers that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
TIN	*When logged in user is a CDS Employer:* N/A *When logged in user is from a Program Provider or FMSA:* Required and restricted to the TINs that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to TINs that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
Payer Name	*When Logged in user is a CDS Employer:* Optional (but restricted to Payers that are associated with Member Ids that are associated with the CDS Employer). *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to Payers that are associated with Member Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Required and populated with the Payer Name that is associated with the MCO. *When logged in user is from HHSC (or its designee):* Optional
Begin Date	Required
End Date	Required

Standard Report Name: EVV CDS Employer Usage Report

Report Description

This report shows the EVV usage score calculations for CDS Employers based on the percentage of total electronic EVV Visit Transactions and the total accepted EVV Visit Transactions for a Member and requested date range.

The report will be requested through, and the results displayed in, the EVV System using the EVV Standard System Reports web service provided by MES service providers.

Report Field Listing

Report Fields	Field Description	Associated EVV Visit Transaction Field
Payer	HHSC or name of MCO associated with the payer identifier submitted on visit transaction	INDVMBR_PAYOR (This field contains a 3–4-character identifier associated to a payer; the payer name should be displayed on the report)
EVV System	Name of the EVV System	EVV_VENDOR_ID
CDS Employer Name	CDS Employer Name	CDS_EMPLOYER_LAST_NAME CDS_EMPLOYER_FIRST_NAME
FMSA Name	The legal name of the program provider or Financial Management Services Agency (FMSA)	PROVIDER_LEGAL_NAME
Service Delivery Option	Agency: services are managed by a program provider CDS: services are self-directed	N/A
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services	PROVIDER_NPI PROVIDER_API
Medicaid ID	Member's Medicaid Identification Number	INDV_MBR_MEDICAID_ID
EVV Usage Score	EVV usage score calculations for CDS Employers based on the percentage of total electronic EVV Visit Transactions and the total accepted EVV Visit Transactions for a Member For CDS Employers: Total Electronic EVV Visit Transactions / Total Accepted EVV Visit Transactions	N/A
Total Accepted Visit Transactions	Total Accepted EVV Visit Transactions	N/A

Report Fields	Field Description	Associated EVV Visit Transaction Field
Total Manual Visit Transactions	Total Manual EVV Visit Transactions	N/A
Total Electronic Visit Transactions	Total Electronic EVV Visit Transactions	N/A
EVV Implementation Group	Category identifying when an EVV service implemented in production to allow report to be filtered by: State-Required Personal Care Services CURES Act Personal Care Services (2021)	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF, Excel and CSV
Report Available To	CDS Employer
Sort Order	N/A
Default Filter (The system applies this filter)	N/A

*Report Generation Criteria **

Field Name	Required/Optional
Fiscal Year	Required
Quarter	Required when Month is blank
Month	Required when Quarter is blank

Medicaid ID	Required
Payer Name	Optional
EVV Implementation Group	Optional
Export Format	Required

Details of the Field Length, Field Validations and Validation Error Message will be provided with the JSON

Appendix H – N/A

Appendix I – Security Roles

HHSC Electronic Visit Verification (EVV) System Technical Documentation Appendix I - Security Roles
Published Date: 02/25/2022 Effective Date: 05/31/2022

The EVV System must provide security roles based on business need as described below. Access to data whether Create, Read Only, Update or Delete must be restricted such that it is available based on business need. For example: Provider A cannot view or update Provider B member data.

C = Create
R = Read only U =
Update
D = Delete

Description	System Admin User (Account Setup)	Program Provider/FMSA System User	Service Provider/ CDS Employee	Designated Representative	CDS Employer	Contractor	HHSC	MCO
User Onboarding	CU	U						
Establishing Service		CRUD				R	R	R
Electronic Verification Methods		U	CU			R	R	
Service Delivery Verification		CU		CU	CU	R	R	R
Vendor Reporting	R	R		R	R	R	R	
Vendor Communications	R	R		R	R	R	R	R

Description	System Admin User (Account Setup)	Program Provider/FMSA System User	Service Provider/ CDS Employee	Designated Representative	CDS Employer	Contractor	HHSC	MCO
Vendor System Specifications						R	R	R

Appendix J – Service Delivery Locations

HHSC Electronic Visit Verification (EVV) Business Rules Appendix J – Service Delivery Locations
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Effective Date: 05/31/2022

The EVV System must utilize the following list of allowable service delivery location values:

Member Home
Community
Family Home
Neighbor Home
Other

Appendix K – Texas-EVV Specific Terms

Electronic Visit Verification (EVV) Business Rules Appendix K - Texas-EVV Specific Terms
Published Date: 2/25/2022
Effective Date: 5/31/2022

Actual Hours
Acute Care
Alternative Device
Alternative Method
Bill(able) Hours
Clock In
Clock Out
Confirmed Visit
Consumer Directed Services (CDS) Employee
Consumer Directed Services (CDS) Employer
Designated Representative (DR)
Financial Management Services Agency (FMSA)
GUI/Manual Visit Transaction
Healthcare Common Procedure Coding System (HCPCS)
Last Visit Maintenance Date
Legally Authorized Representative (LAR)
Long-term Care (LTC)
Long-term Services and Supports (LTSS)
Managed Care Plan Code
Member
Mobile Method
National Provider Identifier (NPI)
Payer

Pending Visit
Prior/Service Authorization
Program Provider
Reason Code
Service Group
Service Attendant
Service Code
Sub-contracted Provider
Tax Identification Number (TIN)
Texas Provider Identifier (TPI)
Visit
Visit Maintenance
Visit Transaction
Visit/Service Location

Appendix L – Payer Plan Code Web Service

HHSC Electronic Visit Verification (EVV) Technical Documentation
Appendix L - Payer Plan Code Web Service
Published Date: 02/25/2022
Effective Date: 05/31/2022

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Comments	Table Name	Field Name	GUI Interface	WebService Name
Input		hcpcsCode	30	String				Required				hcpcsCode
Input		modifier	11	String				Conditionally Required modifier can be blank if the services are LTC				modifier
Input		serviceGroup	3	String				Conditionally Required serviceGroup and serviceCode is required when the payer is LTC.				serviceGroup
Input		serviceCode	50	String				Conditionally Required serviceGroup and serviceCode is required when the payer is LTC.				serviceCode
Input		medicaidID	9	Numeric				Required				medicaidID
Input		asOfDate	19	DateTime				Required This is the Date that the provider has selected the services for the individual. This could also be the date visits are scheduled in [State Pool System].				asOfDate
Output		errorMessage	N/A	String		Return 'Unexpected System Error' if there is a system error when trying to match on the input parameters and build a return object.						errorMessage
Output		validationErrors	N/A	String		**Format validation for all fields**- If doesn't match below Validation Error Message: The input was not valid. **Format validation for hcpcsCode** Validation: 30 digit Alphanumeric Then the system passes validation Else the system sets Validation Error Message Validation Error Message: The hcpcsCode is not in a valid format. *** Format validation for modifier** Validation: 11 digit Alphanumeric Then the system passes validation Else the system sets Validation Error Message Validation Error Message: The modifier is not in a valid format. *** Format validation for serviceGroup** Validation: 3 digit Numeric Then the system passes validation Else the system sets Validation Error Message Validation Error Message:						validationErrors
Output		payer	4	String					EVV.REF_EVV_PLAN_CODE_NEW	PLAN_CODE		payer
Output		planCode	2	String					EVV.REF_EVV_PLAN_CODE_NEW	PAYER ID		planCode

Appendix M – EVV Visit Data Layout Edits Crosswalk

HHSC Electronic Visit Verification (EVV) Business Rules Appendix M – EVV Visit Data Layout Edits Crosswalk

Published Date: 02/25/2022
Effective Date: 05/31/2022

Please Note: This file must be in pipe delimited format. Edits included in this document are executed when the EVV System transmits the EVV Visit Transaction to the EVV Aggregator.

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
Header record	1		This header record contains HHSC approved EVV System data transfer headers for all extract data elements contained in this file.	Ex00001	Business Edit	File error: file size is 0 KB, or file contains no transaction records or contains no Header record	0			
				Ex00002	Business Edit	File error: file format is incorrect			Pipe delimited	
				Ex00003	Business Edit	File error: file size is greater than the maximum allowable size.				
File record	1	PROVIDER_TIN	Provider Taxpayer Identification Number: A unique Identifier assigned by the Social Security Administration or Internal Revenue Service (IRS) to a Program Provider or Financial Management Services Agency (FMSA) for tax purposes.	Ex0001A	Format Edit	The Provider TIN on the EVV visit is not in a valid 9 digit TIN format.	30	Varchar	9 digit numeric NNNNNNNNN	Provider Web Service
				Ex0001B	Required Field Edit	The Provider TIN on the EVV visit is missing.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	2	PROVIDER_NPI	Provider National Provider Identifier (NPI): A Health Insurance Portability and Accountability Act (HIPAA) mandated unique identifier assigned by the Centers for Medicare and Medicaid Services (CMS) to a healthcare Program Provider or Financial Management Services Agency (FMSA).	Ex0002A	Format Edit	The Provider NPI on the EVV visit is not in a valid 10 character NPI format.	10	Varchar	10 digit numeric NNNNNNNNNN	
				Ex0002B	Required Field Edit	Provider NPI is required if Provider API is missing.				
				Ex0002C	Business Edit	Provider NPI cannot be validated as active for the visit date.				Provider Web Service
File record	3	PROVIDER_API	Provider Atypical Provider Identifier (API): A unique identifier assigned to a Program Provider or Financial Management Services Agency (FMSA) who does not provide healthcare services (i.e. Respite, transportation). Medicaid or State Issued API number.	Ex0003A	Format Edit	The Provider API on the EVV visit is not in a valid 10 character API format.	10	Varchar	10 character alphanumeric	
				Ex0003B	Required Field Edit	Provider API is required if Provider NPI is missing.				
				Ex0003C1	Business Edit	Provider API cannot be validated as active for the visit date.				
				Ex0003C2	Business Edit	Provider API cannot be sent in if Provider NPI is present on the visit file.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	4	PROVIDER_TPI	Texas Provider Identifier (TPI): A unique identifier assigned by the Claims Administrator to a Program Provider or Financial Management Services Agency (FMSA) delivering Acute Care fee-for-service services in Texas.	Ex0004A	Format Edit	Provider TPI on the EVV Visit is not in a valid 9 digit format.	9	Varchar	9 digit numeric NNNNNNNNN	Provider Web Service
				Ex0004C	Business Edit	The Provider TPI on the EVV visit is not associated with this provider NPI/API for the visit date.				
File record	5	PROVIDER_LEGALNAME	Provider Legal Name: Program Provider or Financial Management Services Agency (FMSA) legal name.	Ex0005A	Format Edit	Provider Legal Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Provider Web Service
				Ex0005B	Required Field Edit	The Provider Legal Name on the EVV visit is missing.				
File record	6	PROVIDER_DBA	Provider Doing Business As Name: Program Provider or Financial Management Services Agency (FMSA) Doing Business As name. This is a name that a person or business uses, other than their official name, in order to transact business.	Ex0006A	Format Edit	Provider DBA on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Provider Web Service
File record	7	PROVIDER_CONTRACT NUMBER	Provider Contract Number: A unique number assigned by HHSC when a Program Provider/FMSA contracts directly with HHSC to provide Long Term Services and Supports (aka Long Term Care) program services.	Ex0007A	Format Edit	The Provider Number on the EVV visit is not in a valid 9 digit format.	9	Number	9 digit numeric NNNNNNNNN	Provider Web Service

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex0007B	Required Field Edit	The Provider Number is a required field on the EVV visit if Service Group or Service Code is present on the EVV Visit File.				
				Ex0007C1	Business Edit	The Provider Number on the EVV visit is not associated with this provider NPI/API for the Visit Date.				
				Ex0007C2	Business Edit	Member on the EVV visit is not authorized for this Provider Number on this visit date in our records.				
File record	8	PROVIDER_ADDRESS1	Provider Address Line 1: Physical address for the Program Provider or Financial Management Services Agency (FMSA). This address may be the same for many different office locations.	Ex0008A	Format Edit	Provider Address 1 on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Provider Web Service
				Ex0008B	Required Field Edit	The Provider Address 1 on the EVV visit is missing.				
File record	9	PROVIDER_ADDRESS2	Provider Address Line 2: Additional mailing address information for the Program Provider or Financial Management Services Agency (FMSA). This address may be the same for many different office locations.	Ex0009A	Format Edit	Provider Address 2 on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Provider Web Service
File record	10	PROVIDER_CITY	Provider City: The city where the Program Provider or Financial Management Services Agency (FMSA) address is located.	Ex00010A	Format Edit	Provider City on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Provider Web Service

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00010B	Required Field Edit	The Provider City on the EVV visit is missing.				
File record	11	PROVIDER_STATE	Provider State: The state where the Program Provider or Financial Management Services Agency (FMSA) address is located.	Ex00011A	Format Edit	Provider State on the EVV Visit has exceeded the maximum allowed length for that field.	2	Varchar		Provider Web Service
				Ex00011B	Required Field Edit	The Provider State on the EVV visit is missing.				
File record	12	PROVIDER_ZIP	Provider Zip: The zip code for which the Program Provider or Financial Management Services Agency (FMSA) address is located.	Ex00012A	Format Edit	The Provider Zip on the EVV visit is not in a valid 5 digit format.	5	Number	5 digit numeric NNNNN	Provider Web Service
				Ex00012B	Required Field Edit	The Provider Zip on the EVV visit is missing.				
File record	13	PROVIDER_LOCATIONID	Provider Location Identification: A number assigned by the Program Provider or Financial Management Services Agency (FMSA) for a particular physical address from which services are provided.	Ex00013A	Format Edit	Provider Location ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
File record	14	PROVIDER_REGION	HHSC Provider Region: The location of where the Program Provider or Financial Management Services Agency (FMSA) is located. HHSC Medicaid LTC has 11 regions.	Ex00014A	Format Edit	The Provider Region on the EVV visit is not in a valid format.	2	Number	1 (or) 2 digit Numeric format	Provider Web Service
File record	15	PROVIDER_EVVEFFDATE	Provider Electronic Visit Verification Effective Date: The date the Program Provider or Financial Management Services Agency (FMSA) became effective in the EVV System. This is the first verified visit date by the Program Provider or FMSA.	Ex00015A	Format Edit	The Provider EVV Effective Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00015B	Required Field Edit	The Provider EVV Effective Date on the EVV visit is missing.				
File record	16	PROVIDER_EVVENDDATE	Provider Electronic Visit Verification End Date: The date the Program Provider or Financial Management Services Agency (FMSA) terminates from the EVV System.	Ex00016A	Format Edit	The Provider EVV End Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	
				Ex00016C	Business Edit	The Provider EVV End Date on the EVV visit file should be greater than or equal to the EVV Visit Date.				
File record	17	EMPLOYEE_EMPLOYEEID	Employee Identification: An identifier assigned to the Service Provider by his or her employer for HR and payroll purposes.	Ex00017A	Format Edit	Employee ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex00017B	Required Field Edit	The Employee ID on the EVV visit is missing.				
File record	18	EMPLOYEE_SOCSEC_VISA_PASSPORT	Employee Social Security Visa Passport: It consists of the last four digits of a Service Provider’s SSN or passport number concatenated with the Service Provider's last name.	Ex00018A1	Format Edit	Texas EVV Attendant ID on the EVV Visit has exceeded the maximum allowed length for that field.	54	Varchar		
				Ex00018A2	Format Edit	Texas EVV Attendant ID on the EVV Visit is not in a valid format.			4 Numeric followed by up to 50 characters.	
				Ex00018B	Required Field Edit	Texas EVV Attendant ID on the EVV visit is missing.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	19	EMPLOYEE_EMPLOYEE DISCIPLINE	Employee Discipline: Credentials of the Service Provider.	Ex00019A	Format Edit	The Employee Discipline on the EVV visit must be one of the valid values.	30	Varchar	Preselected list of valid values.	Attendant, Nurse, CNA, PT, OT, SLP, Other
				Ex00019B	Required Field Edit	The Employee Discipline on the EVV visit is missing.				
File record	20	EMPLOYEE_FIRSTNAME	Employee First Name: The Service Provider's first name.	Ex00020A	Format Edit	Employee First Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		
				Ex00020B	Required Field Edit	The Employee First Name on the EVV visit is missing.				
File record	21	EMPLOYEE_LASTNAME	Employee Last Name: The Service Provider's last name.	Ex00021A	Format Edit	Employee Last Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		
				Ex00021B	Required Field Edit	The Employee Last Name on the EVV visit is missing.				
File record	22	EMPLOYEE_EVVID	Electronic Visit Verification Identification: The Service Provider EVV System identifier number. This Identifier is assigned by the EVV System.	Ex00022A	Format Edit	Employee EVV ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex00022B	Required Field Edit	The Employee EVV ID on the EVV visit is missing.				
File record	23	EMPLOYEE_STARTDATE	Employee Start Date: The Service Provider start date. This is the date when the Service Provider became active on the EVV System.	Ex00023A	Format Edit	The Employee Start Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00023B	Required Field Edit	The Employee Start Date on the EVV visit is missing.				
File record	24	EMPLOYEE_ENDDATE	Employee End Date: The Service Provider end date. This is the date when the Service Provider was terminated on the EVV System.	Ex00024A	Format Edit	The Employee End Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	
File record	25	EMPLOYEE_EVVUSERID	Electronic Visit Verification Identification: This is an account name or login identifier, used by the Service Provider to log onto the EVV System. This is assigned by the EVV System. The EVV User identifier and Password are required credentials for logging onto the EVV System.	Ex00025A	Format Edit	Employee EVV User ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex00025B	Required Field Edit	The Employee EVV User ID on the EVV visit is required if it is a visit maintenance.				
File record	26	EMPLOYEE_EVVUSERFIRSTNAME	Electronic Visit Verification User First Name: The first name of the person associated with the EVV User ID.	Ex00026A	Format Edit	The Employee EVV User First Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		
				Ex00026B	Required Field Edit	The Employee EVV User First Name on the EVV visit is required if Employee EVV User ID is populated.				
File record	27	EMPLOYEE_EVVUSERLASTNAME	Electronic Visit Verification User Last Name: The last name of the person associated with the EVV User ID.	Ex00027A	Format Edit	Employee EVV User Last Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00027B	Required Field Edit	The Employee EVV User Last Name on the EVV visit is required if Employee EVV User ID is populated.				
File record	28	EMPLOYEE_CDSEMPLOYEREVVID	Consumer Directed Services Employer Electronic Visit Verification Identification: CDS employer identifier (if different from the individual receiving services e.g., a parent or guardian) assigned by the EVV System.	Ex00028A	Format Edit	CDS Employer EVV ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
File record	29	EMPLOYEE_CDSEMPLOYERFIRSTNAME	Consumer Directed Services Employer First Name: CDS employer first name (if different from the individual receiving services- e.g. a parent or guardian).	Ex00029A	Format Edit	CDS Employer First Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		
				Ex00029B	Required Field Edit	The CDS Employer First Name on the EVV visit is required if CDS Employer EVV ID is populated.				
File record	30	EMPLOYEE_CDSEMPLOYERLASTNAME	Consumer Directed Services Employer Last Name: CDS employer last name (if different from the individual receiving services- e.g., a parent or guardian).	Ex00030A	Format Edit	CDS Employer Last Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		
				Ex00030B	Required Field Edit	The CDS Employer Last Name on the EVV visit is required if CDS Employer EVV ID is populated.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	31	INDVMBR_PAYOR	Individual/Member Payor: A unique identifier assigned to the payor, which is obtained through the Payer Plan Code Web Service.	Ex00031A	Format Edit	The Member's Payer on the EVV visit must be one of the valid values.	4	Varchar	Preselected list of valid values.	AET, AGP, BCB, CFC, CHS, CKC, CMC, DRC, HHSC, LTC, MOL, SHP, TXC, UHC From Payer Plan Code Web service.
				Ex00031B	Required Field Edit	The Member's Payer on the EVV visit is missing.				
				Ex00031C	Business Edit	The Member's Payer on the EVV visit does not match our records for this Member.				
File record	32	INDVMBR_FIRSTNAME	Individual/Member First Name: The first name of the individual/member receiving services.	Ex00032A	Format Edit	Member First Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		271 Response File
				Ex00032B	Required Field Edit	The Member First Name on the EVV visit is missing.				
File record	33	INDVMBR_LASTNAME	Individual/Member Last Name: The last name of the individual/member receiving services.	Ex00033A	Format Edit	Member Last Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		271 Response File
				Ex00033B	Required Field Edit	The Member Last Name on the EVV visit is missing.				
File record	34	INDVMBR_MEDICAIDID	Individual/Member Medicaid Identification: The individual's/member's Medicaid identifier number.	Ex00034A	Format Edit	Member Medicaid ID on the EVV Visit is not in a valid 9-digit Medicaid ID format.	9	Varchar		

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00034B	Required Field Edit	The Member Medicaid ID on the EVV visit is missing.				
				Ex00034C1	Business Edit	The Member Medicaid ID on the EVV visit is not found in our records.				
				Ex00034C2	Business Edit	The Member Medicaid ID on the EVV visit does not have active Medicaid eligibility for the visit date.				
File record	35	INDVMBR_MEMBERDOB	Individual/Member Date of Birth: The individual's/member's date of birth.	Ex00035A	Format Edit	The Member DOB on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	271 Response File
				Ex00035B	Required Field Edit	The Member DOB on the EVV visit is missing.				
File record	36	INDVMBR_MEMBEREVVID	Individual/Member Electronic Visit Verification Identification: The individual /member’s EVV System identifier number. This identifier is assigned by the EVV System.	Ex00036A	Format Edit	Member EVV ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex00036B	Required Field Edit	The Member EVV ID on the EVV visit is missing.				
File record	37	INDVMBR_STARTDATE	Individual/Member Start Date: The start date of when the individual/member became Medicaid eligible.	Ex00037A	Format Edit	The Member Start Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	271 Response File
				Ex00037B	Required Field Edit	The Member Start Date on the EVV visit is missing.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	38	INDVMBR_ENDDATE	Individual/Member End Date: The end date of when the individual/member became Medicaid eligible.	Ex00038A	Format Edit	The Member End Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	271 Response File
File record	39	INDVMBR_PRIORITY	Individual/Member Priority: A numerical value assigned to the individual/member by the Program Provider or Financial Management Services Agency (FMSA) based on their level of need. https://hhs.texas.gov/laws-regulations/handbooks/hcs/section-5000-level-care-level-need	Ex00039A	Format Edit	Member Priority on the EVV Visit has exceeded the maximum allowed length for that field.	1	Varchar		
File record	40	INDVMBR_PHONE	Individual/Member Phone: The primary phone number registered for EVV phone calls for the individual/member receiving services.	Ex00040A	Format Edit	The Member Phone on the EVV visit is not in a valid 10-digit numeric format.	10	Varchar	10-digit numeric format	
File record	41	INDVMBR_ALTPHONE	Individual/Member Alternative Phone: A secondary (additional) phone number registered for EVV telephone calls to the individual/member receiving services.	Ex00041A	Format Edit	The Member Alternate Phone on the EVV visit is not in a valid 10-digit numeric format.	10	Varchar	10-digit numeric format	
File record	42	INDVMBR_ALTPHONE2	Individual/Member Alternative Phone 2: Another secondary (additional) phone number registered for EVV telephone calls to the individual/member receiving services.	Ex00042A	Format Edit	The Member Alternate Phone 2 on the EVV visit is not in a valid 10-digit numeric format.	10	Varchar	10-digit numeric format	
File record	43	MCO_MBR_SDA	Managed Care Organization (MCO) Plan code for which the member is enrolled. Member MCO Plan Code is available in the Payer Plan Code Web Service.	Ex00043A	Format Edit	MCO Member SDA on the EVV Visit has exceeded the maximum allowed length for that field.	2	Varchar		Plan Code from Payer Plan Code Web service.

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00043B	Required Field Edit	The MCO Member SDA on the EVV visit is required if the Member's Payer is Managed Care.				Null for HHSC or LTC payer
				Ex00043C	Business Edit	The plan code on the visit is not associated with the Member's Payer.				Plan Code is not required for HHSC or LTC payer but if submitted must be the MCO plan code for which the member is enrolled.
File record	44	INDVMBR_ADDRESS_LATITUDE	Individual/Member Address Latitude: The latitude of the individual's/member's address. This is pre saved information in the EVV System (Based on the individual/member's address)	Ex00044A	Format Edit	Invalid GPS data format. Numeric fields must contain only numeric digits and not exceed length allowed. GPS must be in decimal degree format only.	50	Varchar	decimal degree format Java BigDecimal Precision and Scale PRECISION=50; SCALE up to 47;	Derived through geo-coding of member physical address
File record	45	INDVMBR_ADDRESS_LONGITUDE	Individual/Member Address Longitude: The longitude of the individual's/member's address. This is pre saved information in the EVV System (Based on the individual/member's address)	Ex00045A	Format Edit	Invalid GPS data format. Numeric fields must contain only numeric digits and not exceed length allowed. GPS must be in decimal degree format only.	50	Varchar	decimal degree format Java BigDecimal Precision and Scale PRECISION=50; SCALE up to 47;	Derived through geo-coding of member physical address
File record	46	INDVMBR_TOTAL_AUTHUNITS	Individual/Member Total Authorized Units: The total number of units authorized for an individual/member for a service to be delivered for a given time period.	Ex00046A	Format Edit	The Member Total Authorization units on the EVV visit is not in a valid numeric format.	11	Number	NNNNNNNN.NN	

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	47	AUTH_UNITS_TYPE	Individual/Member Authorized Units Type: The type of units authorized. Can be daily, weekly, monthly or per auth.	Ex00047A	Format Edit	Authorization Units Type on the EVV Visit has exceeded the maximum allowed length for that field.	10	Varchar		
File record	48	INDVMBR_TOTAL_AUTHUNITSREMAINING	Individual/Member Total Authorized Units Remaining: The total number of units remaining for an individual/member for a service to be delivered for a given time period. This is the value after the delivery of the units of service.	Ex00048A	Format Edit	The Member Total Authorization units remaining on the EVV visit is not in a valid numeric format.	11	Number	NNNNNNNN.NN	
File record	49	VISIT_VISITID	Electronic Visit Verification Visit Identification: A unique identifier number assigned to the EVV visit by the EVV System.	Ex00049A	Format Edit	Visit ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex00049B	Required Field Edit	The Visit ID on the EVV visit is missing.				
				Ex00049C1	Business Edit	Duplicate visit transaction found with this Visit ID.				
				Ex00049C2	Business Edit	No previous record found with this Visit ID for update.				
				Ex00049C3	Business Edit	This Visit ID was previously voided.				
File record	50	VISIT_SCHEDULEID	Schedule Identification: A unique identifier number assigned to the scheduled visit by the EVV System.	Ex00050A	Format Edit	Visit Schedule ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	51	VISIT_VISITDATE	Scheduled Visit Date: The date that the System User scheduled the Service Provider to perform services for the individual/member. Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Weekly Variable Schedule Begin Date is populated for Weekly Variable Schedule. Null for No Schedule.	Ex00051A	Format Edit	The Visit Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	The EVV System will populate this field with the Scheduled Visit Date from a Daily Fixed or Daily Variable Schedule Types and with the Weekly Variable Schedule Begin Date for a Weekly Variable Schedule Type.
File record	52	VISIT_VISITTIMEIN	Scheduled Visit Time In: Scheduled service delivery start time in date/time format. Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Null for Weekly Variable Schedule or No Schedule.	Ex00052A	Format Edit	The Visit Time in on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM/PM.	The EVV System will populate this field with the Scheduled Visit Time In from a Daily Fixed or Daily Variable Schedule, but Null for a Weekly Variable Schedule Type.
File record	53	VISIT_VISITTIMEOUT	Scheduled Visit Time Out: Service delivery stop time in date/time format. Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Null for Weekly Variable Schedule or No Schedule.	Ex00053A	Format Edit	The Visit Time Out on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM/PM.	The EVV System will populate this field with the Scheduled Visit Time Out from a Daily Fixed or Daily Variable Schedule but Null for a Weekly Variable Schedule Type.
File record	54	VISIT_VISITHOURS	Scheduled Visit Hours: Duration of services provided to the individual/member, shown as a decimal (Example: 1.25). Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Total Weekly Scheduled Hours is populated for Weekly Variable Schedule. Null for No Schedule.	Ex00054A	Format Edit	The Visit Hours on the EVV visit is not in a valid numeric format.	5	Number	NN.NN	The EVV System will populate this field with the Scheduled Visit Hours for a Daily Fixed or Daily Variable Schedule and with the Total Weekly Scheduled Hours for a Weekly Variable Schedule Type.

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	55	VISIT_VISITLOCATION	Scheduled Visit Location: The scheduled location where services are to be provided.	Ex00055A	Format Edit	Visit Location on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Appendix J
File record	56	VISIT_SVCGRP	Visit Service Group: A code assigned by HHSC for the Long Term Services and Supports (aka Long Term Care) fee-for-service program through which the Individual is receiving services.	Ex00056A	Format Edit	Service Group on the EVV Visit has exceeded the maximum allowed length for that field.	3	Number		HHSC EVV Service Bill Codes Table contains the full list of valid values
				Ex00056B1	Required Field Edit	The Service Group on the EVV visit is required when EVV Service Code is present in the EVV visit.				
				Ex00056B2	Required Field Edit	The Service Group on the EVV visit is required when Provider Number is present in the EVV visit.				
File record	57	EVV_SVCCODE	Visit Service Code: A code to denote a specific service or category of service within the Long Term Services and Supports (aka Long Term Care) fee-for-service program at HHSC. Example: HHSC Service Code- Specific services provided within a program (Svc Grp 7+Svc Code 17C = Family Care, but Svc Grp 7+ Svc Code 17CV = Family Care in the Consumer Directed Services (CDS) option)	Ex00057A	Format Edit	Service Code on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Service Bill Codes Table contains the full list of valid values

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00057B1	Required Field Edit	The Service Code on the EVV visit is required when Service Group is present in the EVV visit.				
				Ex00057B2	Required Field Edit	The Service Code on the EVV visit is required when Provider Number is present in the EVV visit.				
				Ex00057C1	Business Edit	The Service Group and Service Code combination on the EVV visit are not eligible for EVV.				
				Ex00057C2	Business Edit	The Service Group and Service Code combination on the EVV visit are not valid for the Provider number on the visit.				
				Ex00057C3	Business Edit	The Member on the EVV visit is not authorized for this service group/service code on this visit date in our records.				
File record	58	EVV_HCPCS_CODE	The Healthcare Common Procedure Coding System (HCPCS) Code: A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes.	Ex00058A	Format Edit	EVV HCPCS Code on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		HHSC EVV Service Bill Codes Table contains the full list of valid values
				Ex00058B	Required Field Edit	The EVV HCPCS Code on the EVV visit is missing.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	59	EVV_MODIFIER	The Healthcare Common Procedure Coding System (HCPCS) Modifier: Two alphanumeric characters that are appended to the HCPCS codes to differentiate between services. There may be none or up to four modifiers for the HCPCS codes.	Ex00059A1	Format Edit	EVV Modifier on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar	Alphanumeric characters are allowed and Colon (:) is the only special character allowed for this field. The EVV System must separate each 2-character modifier with a colon with no beginning or ending colon.	HHSC EVV Service Bill Codes Table contains the full list of valid values
				Ex00059A2	Format Edit	The EVV Modifier on the EVV visit is not in a valid format.				
				Ex00059C	Business Edit	The EVV HCPCS Code and EVV Modifier combination on the EVV visit is not eligible for EVV.				
File record	60	EVV_VISITDATE	Actual Visit Date: The date the visit occurred. Note: EVV_VisitDate (actual visit) must be on or after Visit_VisitDate (scheduled visit).	Ex00060A	Format Edit	The EVV Visit Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	
				Ex00060B	Required Field Edit	The EVV Visit Date on the EVV visit is missing.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00060C	Business Edit	The actual visit date must be between 4/1/2015 and the date the EVV Visit batch is submitted.				
File record	61	EVV_CREATEDDATETIME	Created Date/Time: The date/time stamp assigned by the EVV System on the date a valid clock in and clock out or the date a manual visit is created in the EVV System.	Ex00061A	Format Edit	The EVV Created Date Time on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM.	
				Ex00061B	Required Field Edit	The EVV Created Date Time on the EVV visit is missing.				
File record	62	EVV_PHONE	Electronic Visit Verification Phone: The phone number used in the EVV Electronically Generated Call transaction.	Ex00062A	Format Edit	The EVV Phone on the EVV visit is not in a valid 10-digit numeric format.	10	Varchar	10-digit numeric format	
File record	63	EVV_CALLINTIME	Actual Call In Time: The date/time the Service Provider actually called in indicating service delivery started. Must be captured from an HHSC approved electronic verification method (Landline, Mobile or Alternative device). Must be Null for manually entered (GUI) visits.	Ex00063A	Format Edit	The EVV Call In Time on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM/PM.	System derived when a Service Provider clocks in using an electronic method. Null for manual entry.
File record	64	EVV_CALLOUTTIME	Actual Call Out Time: The date/time the Service Provider actually called in indicating service delivery ended. Must be captured from an HHSC approved electronic verification method (Landline, Mobile or Alternative device). Must be Null for manually entered (GUI) visits.	Ex00064A	Format Edit	The EVV Call Out Time on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM/PM.	System derived when a Service Provider clocks out using an electronic method. Null for manual entry.

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	65	EVV_ACTUALHOURS	Actual Hours: EVV System calculated duration in Hours and Minutes (NN.NN) Difference between electronically captured EVV_CALLINTIME and EVV_CALLOUTTIME. Must be Null for manually entered (GUI) visits.	Ex00065A	Format Edit	The EVV Actual Hours on the EVV visit is not in a valid hours and minutes format.	5	Number	Numeric and has to be in NN.NN format.	System derived
				Ex00065B	Required Field Edit	The EVV Actual Hours on the EVV visit is required if EVV Call In Time and EVV Call Out Time is present in the EVV visit.			Numeric and has to be in NN.NN format.	
				Ex00065C	Business Edit	The EVV Actual Hours calculation on the EVV visit is not correct for the Call In and Call Out time on the visit.			Numeric and has to be in NN.NN format.	
File record	66	EVV_PAYHOURS	Pay Hours: (also referred to as Bill Hours). Calculated by EVV System by rounding EVV_ActualHours, when present. Entered by Provider/FMSA for manual visit.	Ex00066A	Format Edit	The EVV Billed Hours on the EVV visit is not in a valid hours and minutes format.	5	Number	Numeric and has to be in NN.NN format.	
				Ex00066B	Required Field Edit	The EVV Billed Hours on the EVV visit is missing.				
File record	67	EVV_UNITS	Electronic Visit Verification Units: The number of units calculated by the EVV System using the EVV_PAYHOURS and the Unit Type in the Bill Code Table for the service on the visit.	Ex00067A	Format Edit	The EVV Units on the EVV visit is not in a valid numeric format.	11	Number	NNNNNNNN.NN	EVV Service Bill Codes Table

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00067B	Required Field Edit	The EVV Units on the EVV visit is missing.				
				Ex00067C	Business Edit	The EVV Units on the EVV visit do not match the EVV Billed Hours based on the Unit of Measurement.				
File record	68	EVV_VISITLOCATION	Actual Visit Location: The location where services are being provided.	Ex00068A	Format Edit	EVV Visit Location on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Appendix J
				Ex00068B	Required Field Edit	The EVV Visit Location on the EVV visit is missing.				
File record	69	EVV_VISIT_LATITUDE_IN	Electronic Visit Verification Visit Latitude In: The latitude of the visit location using the GPS location on a mobile method for the call in time. Data may be Null unless a mobile method approved by HHSC was used.	Ex00069A	Format Edit	Invalid GPS data format. Numeric fields must contain only numeric digits and not exceed length allowed. GPS must be in decimal degree format only.	50	Varchar	decimal degree format Java BigDecimal Precision and Scale PRECISION=50; SCALE up to 47;	
File record	70	EVV_VISIT_LONGITUDE_IN	Electronic Visit Verification Visit Longitude In: The longitude of the visit location using the GPS location on a mobile method for the call in time. Data may be Null unless a mobile method approved by HHSC was used.	Ex00070A	Format Edit	Invalid GPS data format. Numeric fields must contain only numeric digits and not exceed length allowed. GPS must be in decimal degree format only.	50	Varchar	decimal degree format Java BigDecimal Precision and Scale PRECISION=50; SCALE up to 47;	

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	71	EVV_LEARNED_LOCATION	Electronic Visit Verification Learned Location: An indicator that specifies if an EVV location was learned via mobile method coordinates. This is usually the coordinates of the individual's/member's home. Data may be Null unless a mobile method approved by HHSC was used.	Ex00071A	Format Edit	EVV Learned Location on the EVV visit is not a valid value.	1	Varchar	Y,N	Y,N
File record	72	EVV_LAT_LONG_MATCH_IN	Latitude Longitude Match In: System assigned. Indicates that the Visit clock in latitude and longitude match the Member Home Geo-location.	Ex00072A	Format Edit	EVV Latitude Longitude Match In on the EVV visit is not a valid value.	1	Boolean	Y,N	Y,N
File record	73	EVV_INPUTMETHOD_IN	Electronic Visit Verification Input Method In: The data input method for call In.	Ex00073A	Format Edit	EVV Input Method In on the EVV visit is not a valid value.	50	Varchar	Preselected list of valid values.	Landline Alternative Device Mobile Method GUI
				Ex00073B	Required Field Edit	The EVV Input Method In on the EVV visit is missing.				
File record	74	EVV_INPUTMETHOD_OUT	Electronic Visit Verification Input Method Out: The data input method for call out.	Ex00074A	Format Edit	EVV Input Method Out on the EVV visit is not a valid value.	50	Varchar	Preselected list of valid values.	Landline Alternative Device Mobile Method GUI
				Ex00074B	Required Field Edit	The EVV Input Method Out on the EVV visit is missing.				
File record	75	EVV_ALTERNATIVEDEVICEID	Electronic Visit Verification Alternative Device Identification: The serial number or device identifier for an alternative device.	Ex00075A	Format Edit	EVV Alternative Device ID on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	76	EVV_REASONCODE1	Electronic Visit Verification Reason Code 1: The first reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00076A	Format Edit	The EVV Reason Code1 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	77	EVV_REASONCODE1DESC	Electronic Visit Verification Reason Code 1 Description: A narrative description of the EVV Reason Code 1 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00077A1	Format Edit	EVV Reason Code1 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex00077A2	Format Edit	The EVV Reason Code1 Description on the EVV visit is not valid for the EVV Reason Code1 on the visit.				
				Ex00077B	Required Field Edit	The EVV Reason Code1 Description on the EVV visit is required if EVV Reason Code1 is populated.				
File record	78	EVV_REASONCODE1COMMENT	Electronic Visit Verification Reason Code 1 Comment: Additional comments regarding the EVV Reason Code 1 value.	Ex00078A	Format Edit	EVV Reason Code1 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	79	EVV_REASONCODE2	Electronic Visit Verification Reason Code 2: The second reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00079A	Format Edit	The EVV Reason Code2 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	80	EVV_REASONCODE2DESC	Electronic Visit Verification Reason Code 2 Description: A narrative description of the EVV Reason Code 2 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00080A1	Format Edit	EVV Reason Code2 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
File record				Ex00080A2	Format Edit	The EVV Reason Code2 Description on the EVV visit is not valid for the EVV Reason Code2 on the visit.				
				Ex00080B	Required Field Edit	The EVV Reason Code2 Description on the EVV visit is required if EVV Reason Code2 is populated.				
File record	81	EVV_REASONCODE2COMMENT	Electronic Visit Verification Reason Code 2 Comment: Additional comments regarding the EVV Reason Code 2 value.	Ex00081A	Format Edit	EVV Reason Code2 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	82	EVV_REASONCODE3	Electronic Visit Verification Reason Code 3: The third reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00082A	Format Edit	The EVV Reason Code3 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	83	EVV_REASONCODE3DESC	Electronic Visit Verification Reason Code 3 Description: A narrative description of the EVV Reason Code 3 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00083A1	Format Edit	EVV Reason Code3 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00083A2	Format Edit	The EVV Reason Code3 Description on the EVV visit is not valid for the EVV Reason Code3 on the visit.				
				Ex00083B	Required Field Edit	The EVV Reason Code3 Description on the EVV visit is required if EVV Reason Code3 is populated.				
File record	84	EVV_REASONCODE3COMMENT	Electronic Visit Verification Reason Code 3 Comment: Additional comments regarding the EVV Reason Code 3 value.	Ex00084A	Format Edit	EVV Reason Code3 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	85	EVV_REASONCODE4	Electronic Visit Verification Reason Code 4: The fourth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00085A	Format Edit	The EVV Reason Code4 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	86	EVV_REASONCODE4DESC	Electronic Visit Verification Reason Code 4 Description: A narrative description of the EVV Reason Code 4 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00086A1	Format Edit	EVV Reason Code4 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex00086A2	Format Edit	The EVV Reason Code4 Description on the EVV visit is not valid for the EVV Reason Code4 on the visit.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00086B	Required Field Edit	The EVV Reason Code4 Description on the EVV visit is required if EVV Reason Code4 is populated.				
File record	87	EVV_REASONCODE4COMMENT	Electronic Visit Verification Reason Code 4 Comment: Additional comments regarding the EVV Reason Code 4 value.	Ex00087A	Format Edit	EVV Reason Code4 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	88	EVV_REASONCODE5	Electronic Visit Verification Reason Code 5: The fifth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00088A	Format Edit	The EVV Reason Code5 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	89	EVV_REASONCODE5DESC	Electronic Visit Verification Reason Code 5 Description: A narrative description of the EVV Reason Code 5 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00089A1	Format Edit	EVV Reason Code5 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex00089A2	Format Edit	The EVV Reason Code5 Description on the EVV visit is not valid for the EVV Reason Code5 on the visit.				
				Ex00089B	Required Field Edit	The EVV Reason Code5 Description on the EVV visit is required if EVV Reason Code5 is populated.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	90	EVV_REASONCODE5COMMENT	Electronic Visit Verification Reason Code 5 Comment: Additional comments regarding the EVV Reason Code 5 value.	Ex00090A	Format Edit	EVV Reason Code5 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	91	EVV_REASONCODE6	Electronic Visit Verification Reason Code 6: The sixth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00091A	Format Edit	The EVV Reason Code6 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	92	EVV_REASONCODE6DESC	Electronic Visit Verification Reason Code 6 Description: A narrative description of the EVV Reason Code 6 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00092A1	Format Edit	EVV Reason Code6 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex00092A2	Format Edit	The EVV Reason Code6 Description on the EVV visit is not valid for the EVV Reason Code6 on the visit.				
				Ex00092B	Required Field Edit	The EVV Reason Code6 Description on the EVV visit is required if EVV Reason Code6 is populated.				
File record	93	EVV_REASONCODE6COMMENT	Electronic Visit Verification Reason Code 6 Comment: Additional comments regarding the EVV Reason Code 6 value.	Ex00093A	Format Edit	EVV Reason Code6 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	94	EVV_REASONCODE7	Electronic Visit Verification Reason Code 7: The seventh reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00094A	Format Edit	The EVV Reason Code7 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	95	EVV_REASONCODE7DESC	Electronic Visit Verification Reason Code 7 Description: A narrative description of the EVV Reason Code 7 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00095A1	Format Edit	EVV Reason Code7 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex00095A2	Format Edit	The EVV Reason Code7 Description on the EVV visit is not valid for the EVV Reason Code7 on the visit.				
				Ex00095B	Required Field Edit	The EVV Reason Code7 Description on the EVV visit is required if EVV Reason Code7 is populated.				
File record	96	EVV_REASONCODE7COMMENT	Electronic Visit Verification Reason Code 7 Comment: Additional comments regarding the EVV Reason Code 7 value.	Ex00096A	Format Edit	EVV Reason Code7 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	97	EVV_REASONCODE8	Electronic Visit Verification Reason Code 8: The eighth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00097A	Format Edit	The EVV Reason Code8 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	98	EVV_REASONCODE8DESC	Electronic Visit Verification Reason Code 8 Description: A narrative description of the EVV Reason Code 8 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00098A1	Format Edit	EVV Reason Code8 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex00098A2	Format Edit	The EVV Reason Code8 Description on the EVV visit is not valid for the EVV Reason Code8 on the visit.				
				Ex00098B	Required Field Edit	The EVV Reason Code8 Description on the EVV visit is required if EVV Reason Code8 is populated.				
File record	99	EVV_REASONCODE8COMMENT	Electronic Visit Verification Reason Code 8 Comment: Additional comments regarding the EVV Reason Code 8 value.	Ex00099A	Format Edit	EVV Reason Code8 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	100	EVV_REASONCODE9	Electronic Visit Verification Reason Code 9: The ninth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex000100A	Format Edit	The EVV Reason Code9 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	101	EVV_REASONCODE9DESC	Electronic Visit Verification Reason Code 9 Description: A narrative description of the EVV Reason Code 9 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex000101A1	Format Edit	EVV Reason Code9 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex000101A2	Format Edit	The EVV Reason Code9 Description on the EVV visit is not valid for the EVV Reason Code9 on the visit.				
				Ex000101B	Required Field Edit	The EVV Reason Code9 Description on the EVV visit is required if EVV Reason Code9 is populated.				
File record	102	EVV_REASONCODE9COMMENT	Electronic Visit Verification Reason Code 9 Comment: Additional comments regarding the EVV Reason Code 9 value.	Ex000102A	Format Edit	EVV Reason Code9 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	103	EVV_REASONCODE10	Electronic Visit Verification Reason Code 10: The tenth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex000103A	Format Edit	The EVV Reason Code10 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	104	EVV_REASONCODE10DESC	Electronic Visit Verification Reason Code 10 Description: A narrative description of the EVV Reason Code 10 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex000104A1	Format Edit	EVV Reason Code10 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex000104A2	Format Edit	The EVV Reason Code10 Description on the EVV visit is not valid for the EVV Reason Code10 on the visit.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex000104B	Required Field Edit	The EVV Reason Code10 Description on the EVV visit is required if EVV Reason Code10 is populated.				
File record	105	EVV_REASONCODE10COMMENT	Electronic Visit Verification Reason Code 10 Comment: Additional comments regarding the EVV Reason Code 10 value.	Ex000105A	Format Edit	EVV Reason Code10 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	106	EVV_OVERALLREASONCODE	HHSC no longer uses the Overall Reason Code field. This field should be populated as Null. If a value is captured, it must be a "P" or "NP".’	Ex000106A	Format Edit	EVV Overall Reason Code on the EVV visit is not a valid value.	2	Varchar	Preselected list of valid values.	Null, P, NP
File record	107	EVV_VISITNOTES	Visit Notes: Additional information (if any) related to the visit, needs to be added to the Visit Notes field.	Ex000107A	Format Edit	EVV Visit Notes on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	108	EVV_LASTVISITMAINT	Last Visit Maintenance: The most recent date a change to one or more fields identified as impacting the last visit maintenance date in the HHSC EVV Policy Handbook are saved to the EVV visit transaction after the system User/Service Provider has documented the visit.	Ex000108A	Format Edit	The EVV Last Visit Maintenance on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM/PM.	
				Ex000108B	Required Field Edit	The EVV Last Visit Maintenance on the EVV visit is required if the visit is not Auto Confirmed.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	109	EVV_UPLOADINDICATOR	Electronic Visit Verification Upload Indicator: An indicator that specifies if a visit was finalized and uploaded (transferred) to the EVV Aggregator.	Ex000109A	Format Edit	EVV Upload Indicator on the EVV Visit has exceeded the maximum allowed length for that field.	2	Varchar		
File record	110	EVV_LASTUPLOAD	Electronic Visit Verification Last Upload: The last date a visit was finalized and uploaded (transferred) to the EVV Aggregator.	Ex000110A	Format Edit	The EVV Last Upload date on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM/PM.	
File record	111	EVV_VENDORID	Electronic Visit Verification Vendor Identification: EVV System name. EVV_VendorID is assigned by MES service providers. EVV_VendorID must match the EVV System ID of the submitter of the batch file. EVV_VendorID is first part of the incoming file name.	Ex000111A	Format Edit	EVV Vendor ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex000111B	Required Field Edit	The EVV Vendor ID on the EVV visit is missing.				
				Ex000111C	Business Edit	The EVV Vendor ID does not match the vendor that submitted the EVV Visit file.				
File record	112	EVV_FILEEXPORTID	Electronic Visit Verification File Export Identification: A specific upload identifier assigned to each data file export by the EVV System.	Ex000112A	Format Edit	EVV File Export ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex000112B	Required Field Edit	The EVV File Export ID on the EVV visit is missing.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	113	EVV_DONOTEXPORTINDICATOR	Electronic Visit Verification Do Not Export Indicator: An indicator that specifies if a visit has been manually flagged by a Program Provider or Financial Management Services Agency (FMSA) to not export to the EVV Aggregator.	Ex000113A	Format Edit	EVV Do Not Export Indicator on the EVV Visit has exceeded the maximum allowed length for that field.	1	Varchar		
File record	114	EVV_AUTOCONFIRMFLAG	Electronic Visit Verification Auto Confirm Flag: An indicator that specifies if a visit was auto-verified by the EVV System and no visit maintenance was required.	Ex000114A	Format Edit	EVV Auto Confirm Flag on the EVV visit is not a valid value.	2	Varchar	Preselected list of valid values.	Y,N
				Ex000114B	Required Field Edit	The EVV Auto Confirm Flag on the EVV visit is missing.				
File record	115	EVV_VISITRECORDINDICATOR	Electronic Visit Verification Visit Record Indicator: An indicator that specifies the status of the EVV visit transaction.	Ex000115A	Format Edit	The Visit Record Indicator is not a valid code.	30	Varchar	Preselected list of valid values.	NEW UPDATED CANCELLED
				Ex000115B	Required Field Edit	The EVV Visit Record Indicator on the EVV visit is missing.				
File record	116	EVV_VISIT_LATITUDE_OUT	Electronic Visit Verification Visit Latitude Out: The latitude of the visit location using the GPS location on a mobile method for the call out time. Data may be Null unless a mobile method was used.	Ex000116A	Format Edit	Invalid GPS data format. Numeric fields must contain only numeric digits and not exceed length allowed. GPS must be in decimal degree format only.	50	Varchar	decimal degree format Java BigDecimal Precision and Scale PRECISION=50; SCALE up to 47;	

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	117	EVV_VISIT_LONGITUDE_OUT	Electronic Visit Verification Visit Longitude Out: The longitude of the visit location using the GPS location on a mobile method for the call out time. Data may be Null unless a mobile method was used.	Ex000117A	Format Edit	Invalid GPS data format. Numeric fields must contain only numeric digits and not exceed length allowed. GPS must be in decimal degree format only.	50	Varchar	decimal degree format Java BigDecimal Precision and Scale PRECISION=50; SCALE up to 47;	
File record	118	EVV_MATERIAL_VM_CHANGE	Visit Maintenance Material Change: Indicates if a Material visit maintenance change was made. Required if a material field was changed during visit maintenance	Ex000118A	Format Edit	EVV Material VM Change on the EVV Visit has exceeded the maximum allowed length for that field.	1	Varchar	Y,N	Y,N
File record	119	EVV_MATERIAL_VM_FIELD_ID	Visit Maintenance Material Change Field Identification: Lists the Field identifier of each 'material change' field that was updated during visit maintenance, delimited by a comma. Required if Field EVV_MATERIAL_VM_CHANGE = Y.	Ex000119A	Format Edit	EVV Material VM Field ID on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Material change Requirements include: First time GUI input Methods, Provider_TIN Provider_NPI Provider_API 007 Provider_ContractNumber 035 IndvMbr_MedicaidID EVV_SvcCode EVV_HCPCS Code EVV_Modifier EVV_VisitDate EVV_CreatedDateTime EVV_CallInTime EVV_CallOutTime EVV_ActualHours EVV_PayHours EVV_Units

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	120	EVV_LAT_LONG_MATCH_OUT	Latitude Longitude Match: System assigned. Indicates that the Visit clock out latitude and longitude match the Member Home Geo-location.	Ex000120A	Format Edit	EVV Latitude Longitude Match Out on the EVV visit is not a valid value.	1	Varchar	Y,N	Y,N

Appendix N – EVV Data Transfer Guide

HHSC Electronic Visit Verification (EVV) Technical Documentation

Appendix N1 - EVV Member Information File Layout

Published Date: 02/25/2022

Effective Date: 05/31/2022

Data File transfers will be in Pipe-Delimited ("|") format .txt files

Authorization Data Fields				
Field Name	**Type**	**Description**	**Required**	**Data_Example**
EVV_LANDLINE_PHONE1	Number (10)	Member Landline Phone number		1234567890
PHONE2	Number (10)	Member Alternate Phone number		1234567890
PHONE_TYPE2	Varchar (10)	Type of Alternate Phone number		Cell Phone
PHONE3	Number (10)	Member Alternate Phone number		1234567890
PHONE_TYPE3	Number (10)	Type of Alternate Phone number		Cell Phone
DOB	Date (MM/DD/YYYY)	Member Date of birth	Yes	2/13/2000
MEDICAID	Number (9)	Member ID	Yes	987654321
EVV_LAND_LINE_2	Number (10)	Member Alternate Landline Phone number		1234567890
EVV_LAND_LINE_3	Number (10)	Member Alternate Landline Phone number		1234567890

HHSC Electronic Visit Verification (EVV)
Technical Documentation
Appendix N2 - EVV Service Attendant Information File Layout
Published Date: 02/25/2022
Effective Date: 05/31/2022
Data File transfers will be in Pipe-Delimited ("|") format .txt files

Service Provider Data Fields					
Field Name	**Type**	**Description**	**Required**	**Data_Example**	**Comments**
EMPNUMBER	Number(30)	An identifier assigned to the Service Provider by his or her employer for HR and payroll		100002	
SOCIALSEC	Number (4)	First 4 digits of Attendant SSN	Yes	6789	This could be the last four of the passport number as well, if there is no SSN.
STATUS	Varchar	Employment Status. Acceptable values are: Active,Inactive,Suspend		ACTIVE	
LASTNAME	Varchar (30)	Attendant Last Name	Yes	Smith	
FIRSTNAME	Varchar (30)	Attendant First Name	Yes	John	
ADDRESS	Varchar (50)	Attendant Address		123 Standard Dr.	
CITY	Varchar (50)	Attendant City		Harlingen	
STATE	Varchar (2)	Attendant State		TX	
ZIP	Number (5)	Attendant Zip Code		78550	
PHONE1	Number (10)	Attendant Phone		123-456-7890	
PHONE_TYPE1	Number (10)	Attendant additional Phone		Cell Phone	
EVV_ID	Varchar (30)	The Service Provider EVV System identifier number. This Identifier is assigned by the EVV System.		71238	
PROFTITLE	Varchar	Service Provider Title. Acceptable values are : Attendant, Nurse, CNA, PT, OT, SLP, Other	Yes	Attendant	
DOH	Date (MM/DD/YYYY)	Attendant Date of Hire	Yes	2/1/2020	
BRANCH	Varchar (30)	Attendant Branch		RIO HONDO	
EMAIL	Varchar (100)	Attendant Email Address		JOHNSMITH@ATTENDANT.COM	

HHSC Electronic Visit Verification (EVV) Technical Documentation

Appendix N3 - EVV Authorization Information File Layout

Published Date: 02/25/2022, Effective Date: 05/31/2022

Data File transfers will be in Pipe-Delimited ("|") format .txt files

Authorization Data Fields

Field Name	Type	Description	Applicable Payer(s) (HHSC, LTC, MCO, ALL)	Data_Example	Comments
INDV_MBR_PAYOR	Varchar (30)	Payor: A unique ID assigned to the payor.	ALL	SHP	HHSC (Acute Care FFS), LTC (LTC FFS)
MCO Provider_ID	Varchar (25)	MCO System Unique Servicing Provider ID	MCO	P12354987987	
Provider_ContractNumber	Number (9)	Provider Contract Number: A unique number assigned by DADS when a provider agency/FMSA contracts with DADS to provide Long Term Services and Supports (LTSS) program services.	LTC	123456789	
Provider_TIN	Number (11)	Provider Tax Identification Number: TIN Assigned by Comptroller that includes mail code. First digit will always be a "1"	ALL	123456789	9 digits
Provider_NPI	Varchar (30)	Provider National Provider Identifier (NPI): A HIPAA mandated unique ID assigned by the Centers for Medicare and Medicaid Services (CMS) to a healthcare provider.	ALL	1234567890	10 digits
Provider_API	Varchar (30)	Provider Atypical Provider Identifier (API): A unique ID assigned to a provider who does not provide healthcare services (ie. Respite, transportation).	ALL	123456789	10 digits
Provider_TPI	Number (11)	Provider Texas Provider Identifier (TPI): A unique ID assigned by the Claims Administrator to a provider who performs services in Texas.	HHSC, MCO	999999999	9 digits
MCO_Mbr_ID	Number (25)	MCO System Unique Member ID	MCO	123456879	9 digits
IndvMbr_MedicaidID	Number (9)	Invoice Individual/Member Medicaid Identification: The individual's/member's Medicaid ID number.	ALL	999999999	
IndvMbr_FirstName	Varchar (30)	Individual/Member First Name: The first name of the member receiving services.	ALL	JOAN	
IndvMbr_LastName	Varchar (30)	Individual/Member Last Name: The last name of the member receiving services.	ALL	DOE	
IndvMbr_MemberDOB	Date (MMDDYYYY)	Individual/Member Date of Birth: The member's date of birth.	ALL	12011950	
IndvMbr_Program	Varchar (20)	STAR, STAR+PLUS, STAR HEALTH, CLASS, CFC, MDCP, PHC/FC/CAS, PCS	ALL	STAR+PLUS, STAR HEALTH, CLASS, CFC, MDCP, PHC/FC/CAS, PCS	
MCO_Mbr_SDA	Varchar (2)	Managed Care Organization Member Service Delivery Area: The MCO service delivery area assigned to the member.	MCO	8A	PlanCode associated to MCO
Provider_Region	Number (2)	DADS Provider Region: The location of where the Provider Agency or Financial Management Services Agency (FMSA) is located. DADS has 11 regions.	HHSC, LTC	11	
Auth_Svc_Group	Number (3)	Electronic Visit Verification Service Group: A code that identifies the type of LTSS program for which the member is eligible.	LTC	18	
EVV_SvcCode	Varchar (6)	DADS Service Code- Specific services provided within a program (Svc Grp 7+Svc Code 17C = Family Care, but Svc Grp 7+ Svc Code 17CV = Family Care in the Consumer Directed Services (CDS) option)	LTC	17C, 27A, 11, etc.	
EVV_HCPCS Code	Varchar (30)	HCPCS Code: A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes.	HHSC, MCO	T1019	
EVV_Modifier	Varchar (30)	HCPCS Modifier: A two digit numeric or alphanumeric characters that are appended to CPT and HCPCS Level II codes. A modifier provides a means to indicate that a service or procedure was altered by specific circumstances, without changing the definition of the code.	HHSC, MCO	U3:U3	
Auth_Number	Varchar (30)	Authorization Number	ALL	OP1234567890	
IndvMbr_StartDate	Date (MMDDYYYY)	Individual/Member Start Date: The start date of when the member became eligible.	ALL	12012012	
IndvMbr_EndDate	Date (MMDDYYYY)	Individual/Member End Date: The end date of when the member became eligible.	ALL	12012013	
IndvMbr_Total_AuthUnits	Number (8,2)	Individual/Member Total Authorized Units: The total number of units authorized for a member for a service to be delivered for a given time period.	ALL		
Auth_Units Type	Varchar (10)	Individual/Member Authorized Units Type: The type of units authorized. Can be daily, weekly, monthly or per auth.	ALL		
Auth_Notes	Varchar (255)	Freetext notes context for authorization detail	ALL		

Appendix O – Visit Maintenance

HHSC Electronic Visit Verification (EVV) Technical Documentation Appendix
O - Visit Maintenance
Published Date: 02/25/2022 Effective Date: 05/31/2022

Field #	Extract Data Element	Length	Description	Can Provider or FMSA Edit After Visit Created? (Visit Data)	Additional Details for 'Can Provider or FMSA Edit After Visit Created? (Visit Data) '	Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)	Additional Details for 'Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)'	Can CDS Employer Edit/Enter After Visit Created? (Visit Data)	Additional Details for 'Can CDS Employer Edit/Enter After Visit Created? (Visit Data)'
60	EVV_VISITDATE	8	Actual Visit Date: The date the visit occurred. Note: EVV_VisitDate (actual visit) must be on or after Visit_VisitDate (scheduled visit)	No	The Actual Visit Date cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The Actual Visit Date cannot be modified by the CDS Employer.
61	EVV_CREATEDDATETIME	17	Created Date/Time: The date/time stamp assigned by the EVV system on the date of a valid clock in and clock out or the date a manual visit is created in the EVV System.	No	The Actual Visit creation date cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The Actual Visit creation date cannot be modified by the CDS Employer.
63	EVV_CALLINTIME	17	Actual Call In Time: The date/time (MMDDYYYY HH:MM AM/PM) that the Service Provider actually called in indicating service delivery started. Must be captured from an HHSC approved electronic verification method (Landline, Mobile or Alternative device). Must be Null for manually entered (GUI) visits.	No	The Actual Call In Time cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The Call In Time cannot be modified by the CDS Employer.
64	EVV_CALLOUTTIME	17	Actual Call Out Time: The date/time (MMDDYYYY HH:MM AM/PM) that the Service Provider actually called in indicating service delivery ended. Must be captured from an HHSC approved electronic verification method (Landline, Mobile or Alternative device). Must be Null for manually entered (GUI) visits.	No	The Actual Call Out Time cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The Call Out Time cannot be modified by the CDS Employer.
65	EVV_ACTUALHOURS	5	Actual Hours: EVV System calculated duration in Hours and Minutes (NN.NN) Difference between electronically captured EVV_CALLINTIME and EVV_CALLOUTTIME. Must be Null for manually entered (GUI) visits.	No	The Actual Hours cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The Actual Hours cannot be modified by the CDS Employer.
66	EVV_PAYHOURS	5	Pay Hours: (also referred to as Bill Hours). Calculated by EVV System by rounding EVV_ActualHours, when present. Entered by Provider/FMSA for manual visit.	Yes	The Pay Hours (Bill Hours) can be adjusted by the Provider/FMSA. EVV_PAYHOURS may be adjusted but cannot be greater than EVV_ACTUALHOURS.	N/A	This is not related to the Profile Data.	Yes	The Pay hours can be downward adjusted by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
67	EVV_UNITS	11	Electronic Visit Verification Units: The number of units calculated by the EVV system using the EVV_PAYHOURS and the Unit Type in the Bill Code Table for the service on the visit.	No	The EVV Units cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Units cannot be modified by the CDS Employer.
69	EVV_VISIT_LATITUDE_IN	50	Electronic Visit Verification Visit Latitude In: The latitude of the visit location using the GPS location on a mobile method for the call in time. Data may be blank unless a mobile method approved by HHSC was used.	No	The EVV Visit Latitude cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Visit Latitude cannot be modified by the CDS Employer.
70	EVV_VISIT_LONGITUDE_IN	50	Electronic Visit Verification Visit Longitude In: The longitude of the visit location using the GPS location on a mobile method for the call in time. Data may be blank unless a mobile method approved by HHSC was used.	No	The EVV Visit Longitude cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Visit Longitude cannot be modified by the CDS Employer.

Field #	Extract Data Element	Length	Description	Can Provider or FMSA Edit After Visit Created? (Visit Data)	Additional Details for 'Can Provider or FMSA Edit After Visit Created? (Visit Data) '	Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)	Additional Details for 'Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)'	Can CDS Employer Edit/Enter After Visit Created? (Visit Data)	Additional Details for 'Can CDS Employer Edit/Enter After Visit Created? (Visit Data)'
71	EVV_LEARNED_LOCATION	1	Electronic Visit Verification Learned Location: An indicator that specifies if an EVV location was learned via mobile method coordinates. This is usually the coordinates of the individual's/member's home. Data may be Null unless a mobile method approved by HHSC was used.	No	The EVV Visit Learned location cannot be modified by the Provider/FMSA.	Yes	System User can modify Learned Location by updating the Member Home Geo-location.	No	The EVV Visit Learned location cannot be modified by the CDS Employer.
72	EVV_LAT_LONG_MATCH_IN	1	Latitude Longitude Match: System assigned. Indicates that the Visit clock in latitude and longitude match the Member Home Geo-location.	No	The EVV Latitude Longitude Match cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Latitude Longitude Match cannot be modified by the CDS Employer.
76	EVV_REASONCODE1	3	Electronic Visit Verification Reason Code 1: The first reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE1 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
77	EVV_REASONCODE1DESC	50	A narrative description of the EVV Reason Code 1 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE1 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
78	EVV_REASONCODE1COMMENT	500	Free Text regarding the EVV Reason Code 1 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE1 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
79	EVV_REASONCODE2	3	Electronic Visit Verification Reason Code 2: The second reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE2 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
80	EVV_REASONCODE2DESC	50	Electronic Visit Verification Reason Code 2 Description: A narrative description of the EVV Reason Code 2 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE2 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
81	EVV_REASONCODE2COMMENT	500	Electronic Visit Verification Reason Code 2 Comment: Additional comments regarding the EVV Reason Code 2 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE2 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
82	EVV_REASONCODE3	3	Electronic Visit Verification Reason Code 3: The third reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE3 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
83	EVV_REASONCODE3DESC	50	Electronic Visit Verification Reason Code 3 Description: A narrative description of the EVV Reason Code 3 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE3 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
84	EVV_REASONCODE3COMMENT	500	Electronic Visit Verification Reason Code 3 Comment: Additional comments regarding the EVV Reason Code 3 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE3 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
85	EVV_REASONCODE4	3	Electronic Visit Verification Reason Code 4: The fourth reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE4 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.

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86	EVV_REASONCODE4DESC	50	Electronic Visit Verification Reason Code 4 Description: A narrative description of the EVV Reason Code 4 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE4 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
87	EVV_REASONCODE4COMMENT	500	Electronic Visit Verification Reason Code 4 Comment: Additional comments regarding the EVV Reason Code 4 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE4 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
88	EVV_REASONCODE5	3	Electronic Visit Verification Reason Code 5: The fifth reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE5 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
89	EVV_REASONCODE5DESC	50	Electronic Visit Verification Reason Code 5 Description: A narrative description of the EVV Reason Code 5 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE5 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
90	EVV_REASONCODE5COMMENT	500	Electronic Visit Verification Reason Code 5 Comment: Additional comments regarding the EVV Reason Code 5 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE5 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
91	EVV_REASONCODE6	3	Electronic Visit Verification Reason Code 6: The sixth reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE6 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
92	EVV_REASONCODE6DESC	50	Electronic Visit Verification Reason Code 6 Description: A narrative description of the EVV Reason Code 6 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE6 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
93	EVV_REASONCODE6COMMENT	500	Reason Code Full Comment Text field - full text entry Electronic Visit Verification Reason Code 6 Comment: Additional comments regarding the EVV Reason Code 6 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE6 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
94	EVV_REASONCODE7	3	Electronic Visit Verification Reason Code 7: The seventh reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE7 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
95	EVV_REASONCODE7DESC	50	Electronic Visit Verification Reason Code 7 Description: A narrative description of the EVV Reason Code 7 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE7 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
96	EVV_REASONCODE7COMMENT	500	Electronic Visit Verification Reason Code 7 Comment: Additional comments regarding the EVV Reason Code 7 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE7 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
97	EVV_REASONCODE8	3	Electronic Visit Verification Reason Code 8: The eighth reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE8 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
98	EVV_REASONCODE8DESC	50	Electronic Visit Verification Reason Code 8 Description: A narrative description of the EVV Reason Code 8 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE8 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
99	EVV_REASONCODE8COMMENT	500	Electronic Visit Verification Reason Code 8 Comment: Additional comments regarding the EVV Reason Code 8 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE8 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
100	EVV_REASONCODE9	3	Electronic Visit Verification Reason Code 9: The ninth reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE9 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.

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101	EVV_REASONCODE9DESC	50	Electronic Visit Verification Reason Code 9 Description: A narrative description of the EVV Reason Code 9 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE9 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
102	EVV_REASONCODE9COMMENT	500	Reason Code Full Comment Text field - full text entry Electronic Visit Verification Reason Code 9 Comment: Additional comments regarding the EVV Reason Code 9 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE9 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
103	EVV_REASONCODE10	3	Electronic Visit Verification Reason Code 10: The tenth reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE10 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
104	EVV_REASONCODE10DESC	50	Electronic Visit Verification Reason Code 10 Description: A narrative description of the EVV Reason Code 10 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE10 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
105	EVV_REASONCODE10COMMENT	500	Electronic Visit Verification Reason Code 10 Comment: Additional comments regarding the EVV Reason Code 10 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE10 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
106	EVV_OVERALLREASONCODE	2	HHSC no longer uses the Overall Reason Code field. This field should be populated as Null. If a value is captured, it must be a "P" or "NP".	N/A	HHSC no longer uses the Overall Reason Code field. This field should be populated as Null. If a value is captured, it must be a "P" or "NP".	N/A	This is not related to the Profile Data.	Yes	The Overall Reason Code can be modified when the CDS Employer does Visit Maintenance and selects a different reason code. This field is system assigned based on reason code(s) selected by the CDS Employer. If reason code(s) selected are all P, then this field will list P. If any reason code selected is NP, then the field would be assigned as NP. If the CDS Employer has chosen Option 1 in the 1722 form.
108	EVV_LASTVISITMAINT	17	Last Visit Maintenance: System assigned date of last date visit maintenance was performed on critical data elements per HHSC EVV Policy.	No	The Last Visit Maintenance Date is not a field that can be edited by the provider/FMSA. However, if the provider/FMSA does Visit Maintenance on some fields (please refer to the Last Visit Maintenance Policy for the list of fields), then the Last Visit Maintenance Date will change.	N/A	This is not related to the Profile Data.	Yes	The Last Visit Maintenance Date is not a field that can edited by the CDS Employer. However, if the CDS Employer does Visit Maintenance on some fields (please refer to the Last Visit Maintenance Policy for the list of fields), then the Last Visit Maintenance Date will change. If the CDS Employer has chosen Option 1 in the 1722 form.
111	EVV_VENDORID	30	Electronic Visit Verification Vendor Identification: EVV System name. EVV_VendorID is assigned by MES service providers. EVV_VendorID must match the EVV system ID of the submitter of the batch file. EVV_VendorID is first part of the incoming file name.	No	EVV Vendor ID cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	EVV Vendor ID cannot be modified by the CDS Employer.
116	EVV_VISIT_LATITUDE_OUT	50	Electronic Visit Verification Visit Latitude: The latitude of mobile verified visit for the time out. Data may be blank unless mobile app is approved by HHSC.	No	Visit Latitude Out cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	Visit Latitude Out cannot be modified by the CDS Employer.
117	EVV_VISIT_LONGITUDE_OUT	50	Electronic Visit Verification Visit Longitude: The longitude of mobile verified visit for the time out. Data may be blank unless mobile app is approved by HHSC.	No	Visit Longitude Out cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	Visit Longitude Out cannot be modified by the CDS Employer.
120	EVV_LAT_LONG_MATCH_OUT	1	Latitude Longitude Match: System assigned. Indicates that the Visit clock out latitude and longitude match the Member Home Geo-location.	No	Visit Latitude Longitude Match Out cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	Visit Latitude Longitude Match Out cannot be modified by the CDS Employer.
1	PROVIDER_TIN	30	Provider Tax Identification Number: TIN Assigned by Comptroller that includes mail code. First digit will always be a "1"	N/A	Derived from Profile Data on the EVV System.	Yes	The TIN information is retrieved using the Provider Web Service from MES service providers, by providing an NPI. This cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.
2	PROVIDER_NPI	10	Provider National Provider Identifier (NPI): A HIPAA mandated unique ID assigned by the Centers for Medicare and Medicaid Services (CMS) to a healthcare provider.	N/A	Derived from Profile Data on the EVV System.	Yes	The NPI is entered by the provider/FMSA and validated using the Provider Web Service from MES service providers.	No	The CDS Employers are not responsible for the profile setup.

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3	PROVIDER_API	10	Provider Atypical Provider Identifier (API): A unique ID assigned to a provider who does not provide healthcare services (i.e.. Respite, transportation). Medicaid or State Issued API number.	N/A	Derived from Profile Data on the EVV System.	Yes	The API is entered by the provider/FMSA and validated using the Provider Web Service from MES service providers.	No	The CDS Employers are not responsible for the profile setup.
4	PROVIDER_TPI	9	Texas Provider Identifier (TPI): A unique identifier assigned by the Claims Administrator to a Program Provider or Financial Management Services Agency (FMSA) delivering Acute Care fee-for-service services in Texas.	N/A	Derived from Profile Data on the EVV System.	Yes	The TPI information is retrieved using the Provider Web Service from MES service providers, by providing an NPI. This cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.
5	PROVIDER_LEGALNAME	50	Provider Legal Name: Provider Agency or Financial Management Services Agency (FMSA) legal name.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider Legal Name is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
6	PROVIDER_DBA	50	Provider Doing Business As Name: Provider Agency or Financial Management Services Agency (FMSA) Doing Business As name.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider DBA Name is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
7	PROVIDER_CONTRACTNUMBER	9	Provider Contract Number: A unique number assigned by HHSC when a provider agency/FMSA contracts with DADS to provide Long Term Services and Supports (LTSS) program services	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider Contract Number is retrieved using the Provider Web Service from MES service providers, by providing an NPI. This cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.
8	PROVIDER_ADDRESS1	50	Provider Address Line 1: Mailing address for the provider. This address may be the same for many different office locations.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider Address 1 is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
9	PROVIDER_ADDRESS2	50	Provider Address Line 2: Additional mailing address information for the provider. This address may be the same for many different office locations.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider Address 2 is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
10	PROVIDER_CITY	50	Provider City: The city where the provider's office is located.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider City is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
11	PROVIDER_STATE	2	Provider State: The state where the provider's office is located.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider State is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
12	PROVIDER_ZIP	5	Provider Zip: The zip code for which the provider's office is located.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider Zip is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
13	PROVIDER_LOCATIONID	30	A value assigned to the provider agency or FMSA for a particular physical address from which services are provided.	N/A	Derived from Profile Data on the EVV System.	No	Location ID is system generated for a provider/FMSA and this cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.
14	PROVIDER_REGION	2	HHSC Provider Region: The location where the Program Provider or Financial Management Services Agency (FMSA) Business Unit is located. HHSC Medicaid LTC has 11 regions.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider Region is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
15	PROVIDER_EVVEFFDATE	8	Provider Electronic Visit Verification Effective Date: The date the provider became effective in the EVV system.	N/A	Derived from Profile Data on the EVV System.	No	When a provider/FMSA profile is created during the onboard process, the EVV System enters the provider/FMSAs effective date and this cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.

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16	PROVIDER_EVVENDDATE	8	Provider Electronic Visit Verification End Date: The date the provider terminates from the EVV system.	N/A	Derived from Profile Data on the EVV System.	No	When a provider/FMSA transfers from the current EVV System to another, then the EVV System enters the end date and this cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.
17	EMPLOYEE_EMPLOYEEID	30	Employee Identification: An ID assigned to the Service Provider by his or her employer for HR and payroll purposes.	N/A	Derived from Profile Data on the EVV System.	No	Employee ID is generated systematically for each Employee. This cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.
18	EMPLOYEE_SOCSEC_VISA_PASSPOR	T 54	Employee Social Security Visa Passport: The last four digits of an employee's SSN or passport and last name.	N/A	Derived from Profile Data on the EVV System.	YES	The Provider/FMSA may edit this data field at anytime on the EVV System. Changes to the SSN will impact the Texas EVV Attendant ID.	No	The CDS Employers are not responsible for the profile setup.
19	EMPLOYEE_EMPLOYEEDISCIPLINE	30	Employee Discipline: Credentials of the person providing services.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider/FMSA may edit the Employee Discipline field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
20	EMPLOYEE_FIRSTNAME	50	Employee First Name: The Service Provider first name.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider/FMSA may edit the Employee First Name field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
21	EMPLOYEE_LASTNAME	50	Employee Last Name: The Service Provider last name.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider/FMSA may edit the Employee Last Name field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
22	EMPLOYEE_EVVID	30	Service Provider EVV System ID.	Yes	This is the Employee ID that is captured when the service is provided. The provider will be able to choose from a list of active Employee ID's linked to that provider, during Visit Maintenance. However a new Employee ID cannot be entered on the Visit, without going though the profile setup.	No	Employee ID is generated systematically for each Employee. This cannot be manually entered into the EVV System. The provider/FMSA can add a new Employee to the profile which will systematically create a new Employee ID.	Yes	This is the Employee ID that is captured when the service is provided. The CDS Employer will be able to choose from a list of active Employee ID's linked to that provider, during Visit Maintenance. The CDS Employers are not responsible for the profile setup of the Employee's. If the CDS Employer has chosen Option 1 in the 1722form.
23	EMPLOYEE_STARTDATE	8	Employee Start Date: The Service Provider start date.	N/A	Derived from Profile Data on the EVV System.	YES	The Provider/FMSA may edit the Employee Start Date field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
24	EMPLOYEE_ENDDATE	8	Employee End Date: The Service Provider end date.	N/A	Derived from Profile Data on the EVV System.	YES	The Provider/FMSA may edit the Employee End Date field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
25	EMPLOYEE_EVVUSERID	30	Service Provider EVV System User ID.	Yes	The User ID of the provider system user who conducted Visit Maintenance cannot be changed. However if there was Visit Maintenance conducted, then this field will be populated with the user ID of the person who conducted Visit Maintenance.	YES	The User ID for the Employee can be created by the Provider/FMSA.	Yes	The User ID of the CDS Employer who conducted Visit Maintenance cannot be changed. However if there was Visit Maintenance conducted, then this field will be populated with the user ID of the person who conducted Visit Maintenance.If the CDS Employer has chosen Option 1 in the 1722 form.
26	EMPLOYEE_EVVUSERFIRSTNAME	50	Electronic Visit Verification User First Name: The first name of the person associated with the EVV User ID.	N/A	Derived from Profile Data on the EVV System.	YES	The Employee First Name is editable by the provider/FMSA. This is the provider/FMSA staff conducting Visit Maintenance.	No	The CDS Employers are not responsible for the profile setup.
27	EMPLOYEE_EVVUSERLASTNAME	50	Electronic Visit Verification User Last Name: The last name of the person associatedwith the EVV User ID.	N/A	Derived from Profile Data on the EVV System.	YES	The Employee Last Name is editable by the provider/FMSA. This is the provider/FMSA staff conducting Visit Maintenance.	No	The CDS Employers are not responsible for the profile setup.
28	EMPLOYEE_CDSEMPLOYEREVVID	30	Consumer Directed Services Employer Electronic Visit Verification Identification: CDS employer ID (if different from the individual receiving services e.g. a parent or guardian).	N/A	Derived from Profile Data on the EVV System.	No	This is System Generated and cannot be manually entered.	No	The CDS Employers are not responsible for the profile setup.
29	EMPLOYEE_CDSEMPLOYERFIRSTNA	M 50	Consumer Directed Services Employer First Name: CDS employer first name (if different from the individual receiving services- e.g. a parent or guardian).	N/A	Derived from Profile Data on the EVV System.	YES	The CDS Employer First Name is editable by the FMSA.	No	The CDS Employers are not responsible for the profile setup.
30	EMPLOYEE_CDSEMPLOYERLASTNAM	50	Consumer Directed Services Employer Last Name: CDS employer last name (if different from the individual receiving services- e.g. a parent or guardian).	N/A	Derived from Profile Data on the EVV System.	YES	The CDS Employer Last Name is editable by the FMSA.	No	The CDS Employers are not responsible for the profile setup.
31	INDVMBR_PAYOR	4	Individual/Member Payor: A unique identifier assigned to the payor, which is obtained through the Payer Plan Code Web Service.	N/A	Derived from Profile Data on the EVV System.	Yes	The Payer associated with the Member can be updated by the provider/FMSA.	No	The CDS Employers are not responsible for the profile setup.
32	INDVMBR_FIRSTNAME	50	Individual/Member First Name: The first name of the member receiving services.	N/A	Derived from Profile Data on the EVV System.	Yes	The Member First name can be entered and edited by the provider/FMSA.	No	The CDS Employers are not responsible for the profile setup.

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33	INDVMBR_LASTNAME	50	Individual/Member Last Name: The last name of the member receiving services.	N/A	Derived from Profile Data on the EVV System.	Yes	The Member Last name can be entered and edited by the provider/FMSA.	No	The CDS Employers are not responsible for the profile setup.
34	INDVMBR_MEDICAIDID	9	Invoice Individual/Member Medicaid Identification: The individual's/member's Medicaid ID number.	N/A	Derived from Profile Data on the EVV System.	Yes	The Member Medicaid ID can be entered and edited by the provider/FMSA. An incorrect Medicaid ID will prevent the EVV System from requesting and posting 270/271 Eligibility data.	No	The CDS Employers are not responsible for the profile setup.
35	INDVMBR_MEMBERDOB	8	Individual/Member Date of Birth: The member's date of birth.	N/A	Derived from Profile Data on the EVV System.	Yes	The Member Date of Birth can be entered and edited by the provider/FMSA.	No	The CDS Employers are not responsible for the profile setup.
36	INDVMBR_MEMBEREVVID	30	Individual/Member Electronic Visit Verification Identification: The member's EVV System ID number.	No	This is captured by the IVR or Mobile App and cannot be edited by the Provider/FMSA during Visit Maintenance.	No	This is System Generated and cannot be manually entered.	No	This is captured by the IVR or Mobile App and cannot be edited by the CDS Employer during Visit Maintenance.
37	INDVMBR_STARTDATE	8	Individual/Member Start Date: The start date of when the member became eligible.	N/A	Derived from Profile Data on the EVV System.	YES	The Provider/FMSA may enter and edit the Member Start Date field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
38	INDVMBR_ENDDATE	8	Individual/Member End Date: The end date of when the member became eligible.	N/A	Derived from Profile Data on the EVV System.	YES	The Provider/FMSA may enter and edit the Member End Date field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
39	INDVMBR_PRIORITY	1	Individual/Member Priority: A numerical value assigned to the individual/member by the Program Provider or Financial Management Services Agency (FMSA) based on their level of need. https://hhs.texas.gov/laws-regulations/handbooks/hcs/section-5000-level-care-level-need	N/A	Derived from Profile Data on the EVV System.	Yes	Yes, the Provider/FMSA may indicate on the member profile if the member is priority.	No	The CDS Employers are not responsible for the profile setup.
40	INDVMBR_PHONE	10	Individual/Member Phone: The primary phone number registered for EVV phone calls for the member receiving services.	N/A	Derived from Profile Data on the EVV System.	Yes	The provider/FMSA may enter/edit the phone number of the Member.	No	The CDS Employers are not responsible for the profile setup.
41	INDVMBR_ALTPHONE	10	Individual/Member Alternative Phone: A secondary (additional) phone number registered for EVV telephone calls to the member receiving services.	N/A	Derived from Profile Data on the EVV System.	Yes	The provider/FMSA may enter/edit the Alt phone number one of the Member.	No	The CDS Employers are not responsible for the profile setup.
42	INDVMBR_ALTPHONE2	10	Individual/Member Alternative Phone 2: Another secondary (additional) phone number registered for EVV telephone calls to the member receiving services.	N/A	Derived from Profile Data on the EVV System.	Yes	The provider/FMSA may enter/edit the Alt phone number two of the Member.	No	The CDS Employers are not responsible for the profile setup.
43	MCO_MBR_SDA	2	Managed Care Organization (MCO) Plan code for which the member is enrolled. Member MCO Plan Code is available in the Payer Plan Code Web Service.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider/FMSA may enter and edit the Member Plan Code field at anytime on the EVV System. The Plan Code can be derived using the Payer Plan Code Web Service from MES service providers.	No	The CDS Employers are not responsible for the profile setup.
44	INDVMBR_ADDRESS_LATITUDE	50	Individual/Member Address Latitude: The latitude of the member's address.	N/A	Derived from Profile Data on the EVV System.	Yes	If the provider/FMSA edits the Member's address, then the Member Address Latitude will change.	No	The CDS Employers are not responsible for the profile setup.
45	INDVMBR_ADDRESS_LONGITUDE	50	Individual/Member Address Longitude: The longitude of the member's address.	N/A	Derived from Profile Data on the EVV System.	Yes	If the provider/FMSA edits the Member's address, then the Member Address Longitude will change.	No	The CDS Employers are not responsible for the profile setup.
46	INDVMBR_TOTAL_AUTHUNITS	11	Individual/Member Total Authorized Units: The total number of units authorized for a member for a service to be delivered for a given time period.	N/A	Derived from Profile Data on the EVV System.	Yes	The provider/FMSA may edit the units entered in the Authorization area of the EVV System	No	The CDS Employers are not responsible for the profile setup.
47	AUTH_UNITS_TYPE	10	Individual/Member Authorized Units Type: The type of units authorized. Can be daily, weekly, monthly or per auth.	N/A	Derived from Profile Data on the EVV System.	Yes	The provider/FMSA may edit the unit type entered in the Authorization area of the EVV System	No	The CDS Employers are not responsible for the profile setup.
48	INDVMBR_TOTAL_AUTHUNITSREMA	11	Individual/Member Total Authorized Units Remaining: The total number of units remaining for a member for a service to be delivered for a given time period. This is the value after the delivery of the units of service.	N/A	Derived from Profile Data on the EVV System.	Yes	The provider/FMSA may edit the Total Authorized Units entered in the Authorization area of the EVV System	No	The CDS Employers are not responsible for the profile setup.

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49	VISIT_VISITID	30	Electronic Visit Verification Visit Identification: A unique ID number assigned to the EVV visit by the EVV system.	No	Provider/FMSA cannot create or edit the Visit ID. This is systematically generated.	No	Provider/FMSA cannot create or edit the Visit ID. This is systematically generated.	No	The CDS Employers cannot create or edit the Visit ID. This is systematically generated.
50	VISIT_SCHEDULEID	30	Schedule Identification: A unique ID number assigned to the scheduled visit by the EVV system.	N/A	Derived from Schedule data on the EVV System.	No	Provider/FMSA cannot create or edit the Visit Schedule ID. This is systematically generated.	No	The CDS Employers are not responsible for the schedule setup.
51	VISIT_VISITDATE	8	Scheduled Visit Date: The date that the Service Provider was scheduled to perform services for the individual/member. Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Weekly Variable Schedule Begin Date is populated for Weekly Variable Schedule. Null for No Schedule.	No	Provider/FMSA cannot modify the schedule information after the Visit is created (Matching that schedule). Derived from Schedule data on the EVV System.	YES	Provider/FMSA can create or edit the Visit Schedule date.	No	The CDS Employers are not responsible for the schedule setup.
52	VISIT_VISITTIMEIN	17	Scheduled Visit Time In: Scheduled service delivery start time in date/time format (MMDDYYYY HH:MM AM/PM). Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Null for Weekly Variable Schedule or No Schedule.	No	Provider/FMSA cannot modify the schedule information after the Visit is created (Matching that schedule). Derived from Schedule data on the EVV System.	YES	Provider/FMSA can create or edit the Visit Time In field.	No	The CDS Employers are not responsible for the schedule setup.
53	VISIT_VISITTIMEOUT	17	Scheduled Visit Time Out: Service delivery stop time in date/time format (MMDDYYYY HH:MM AM/PM). Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Null for Weekly Variable Schedule or No Schedule.	No	Provider/FMSA cannot modify the schedule information after the Visit is created (Matching that schedule). Derived from Schedule data on the EVV System.	YES	Provider/FMSA can create or edit the Visit Time Out field.	No	The CDS Employers are not responsible for the schedule setup.
54	VISIT_VISITHOURS	5	Scheduled Visit Hours: Duration of services provided to the individual/member, shown as a decimal (Example: 1.25). Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Total Weekly Scheduled Hours is populated for Weekly Variable Schedule. Null for No Schedule.	No	Provider/FMSA cannot modify the schedule information after the Visit is created (Matching that schedule). Derived from Schedule data on the EVV System.	YES	Provider/FMSA can create or edit the Visit hours field.	No	The CDS Employers are not responsible for the schedule setup.
55	VISIT_VISITLOCATION	50	Scheduled Visit Location: The scheduled location where services are to be provided.	No	Provider/FMSA cannot modify the schedule information after the Visit is created (Matching that schedule). Derived from Schedule data on the EVV System.	YES	Provider/FMSA can create or edit the Visit Location field.	No	The CDS Employers are not responsible for the schedule setup.
56	VISIT_SVCGRP	3	A code that identifies the type of LTC FFS program for which the member is eligible.	Yes	Provider/FMSA can select the Service information during Visit Maintenance. New Service associated with the Member has to be created through the Profile area.	Yes	The providers/FMSA may update service information related to the Member.	Yes	CDS Employer can select the Service information during Visit Maintenance. The CDS Employer cannot create new Service information related to the member. If the CDS Employer has chosen Option 1 in the 1722 form.
57	EVV_SVCCODE	50	Visit Service Code: A code to denote a specific service or category of service within the Long Term Services and Supports (aka Long Term Care) fee-for-service program at HHSC. Example: HHSC Service Code- Specific services provided within a program (Svc Grp 7+Svc Code 17C = Family Care, but Svc Grp 7+ Svc Code 17CV = Family Care in the Consumer Directed Services (CDS) option)	Yes	Provider/FMSA can select the Service information during Visit Maintenance. New Service associated with the Member has to be created through the Profile area.	Yes	The providers/FMSA may update service information related to the Member.	Yes	CDS Employer can select the Service information during Visit Maintenance. The CDS Employer cannot create new Service information related to the member. If the CDS Employer has chosen Option 1 in the 1722 form.
58	EVV_HCPCS_CODE	30	HCPCS Code: A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes.	Yes	Provider/FMSA can select the Service information during Visit Maintenance. New Service associated with the Member has to be created through the Profile area.	Yes	The providers/FMSA may update service information related to the Member.	Yes	CDS Employer can select the Service information during Visit Maintenance. The CDS Employer cannot create new Service information related to the member. If the CDS Employer has chosen Option 1 in the 1722 form.

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59	EVV_MODIFIER	30	The Healthcare Common Procedure Coding System (HCPCS) Modifier: Two alphanumeric characters that are appended to the HCPCS codes to differentiate between services. A modifier provides a means to indicate that a service or procedure was altered by specific circumstances, without changing the definition of the code. There may be none or up to four modifiers for the HCPCS codes.	Yes	Provider/FMSA can select the Service information during Visit Maintenance. New Service associated with the Member has to be created through the Profile area.	Yes	The providers/FMSA may update service information related to the Member.	Yes	CDS Employer can select the Service information during Visit Maintenance. The CDS Employer cannot create new Service information related to the member. If the CDS Employer has chosen Option 1 in the 1722 form.
62	EVV_PHONE	10	Electronic Visit Verification Phone: The phone number used in the EVV transaction.	No	The EVV Phone cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Phone cannot be modified by the CDS Employer.
68	EVV_VISITLOCATION	50	Actual Visit Location: The location where services are being provided.	Yes	The Service Location can be modified by the Provider/FMSA. This needs to be restricted to only Mobile Method.	N/A	This is not related to the Profile Data.	Yes	The Service Location can be modified by the CDS Employer. This needs to be restricted to only Mobile Method. If the CDS Employer has chosen Option 1 in the 1722 form.
73	EVV_INPUTMETHOD_IN	50	Electronic Visit Verification Input Method In: The data input method for call In.	No	The EVV Input Method In cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Input Method In cannot be modified by the CDS Employer.
74	EVV_INPUTMETHOD_OUT	50	Electronic Visit Verification Input Method Out: The data input method for call out.	No	The EVV Input Method Out cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Input Method Out cannot be modified by the CDS Employer.
75	EVV_ALTERNATIVEDEVICEID	50	Electronic Visit Verification Alternative Device Identification: The serial number or device identifier alternative device assigned to the Member.	No	The Alternative Device ID cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The Alternative Device ID cannot be modified by the CDS Employer
107	EVV_VISITNOTES	500	Visit Notes: Information entered into memo or note(s) fields related to the visit.	Yes	The Visit Notes can be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	Yes	The Visit Notes can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
109	EVV_UPLOADINDICATOR	2	Electronic Visit Verification Upload Indicator: An indicator that specifies if a visit was finalized and uploaded (transferred) to the EVV Aggregator.	No	Electronic Visit Verification Upload Indicator cannot be modified by the Provider/FMSA. This is System Generated.	N/A	This is not related to the Profile Data.	No	Electronic Visit Verification Upload Indicator cannot be modified by the CDS Employer. This is System Generated.
110	EVV_LASTUPLOAD	17	Electronic Visit Verification Last Upload: The last date any information was uploaded or updated in the EVV System.	Yes	Electronic Visit Verification Last Upload cannot be modified by the Provider/FMSA. This is System Generated. However when Visit Maintenance is conducted and the visit is saved, this Last Upload date gets modified.	N/A	This is not related to the Profile Data.	No	Electronic Visit Verification Last Upload cannot be modified by the CDS Employer. This is System Generated. However when Visit Maintenance is conducted and the visit is saved, this Last Upload date gets modified.
112	EVV_FILEEXPORTID	30	Electronic Visit Verification File Export Identification: A specific upload identifier assigned to each data file exported by the EVV System.	No	EVV File Export ID cannot be modified by the Provider/FMSA. This is System Generated.	N/A	This is not related to the Profile Data.	No	EVV File Export ID cannot be modified by the CDS Employer. This is System Generated.
113	EVV_DONOTEXPORTINDICATOR	1	Electronic Visit Verification Do Not Export Indicator: An indicator that specifies if a visit has been manually flagged by a provider to not export to the billing system for payment.	Yes	The Provider/FMSA can mark the visit not to be exported.	N/A	This is not related to the Profile Data.	No	Do Not Export Indicator cannot be modified by the CDS Employer.
114	EVV_AUTOCONFIRMFLAG	2	Electronic Visit Verification Auto Confirm Flag: An indicator that specifies if a visit was auto- verified by the EVV System and no visit maintenance was required.	No	Auto Confirm Flag cannot be modified by the Provider/FMSA. This is System Generated.	N/A	This is not related to the Profile Data.	No	Auto Confirm Flag cannot be modified by the CDS Employer. This is System Generated.

Field #	Extract Data Element	Length	Description	Can Provider or FMSA Edit After Visit Created? (Visit Data)	Additional Details for 'Can Provider or FMSA Edit After Visit Created? (Visit Data) '	Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)	Additional Details for 'Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)'	Can CDS Employer Edit/Enter After Visit Created? (Visit Data)	Additional Details for 'Can CDS Employer Edit/Enter After Visit Created? (Visit Data)'
115	EVV_VISITRECORDINDICATOR	30	Electronic Visit Verification Visit Record Indicator: An indicator that specifies the status of the EVV visit transaction.	No	Visit Record Indicator cannot be modified by the Provider/FMSA. This is System Generated.	N/A	This is not related to the Profile Data.	No	Visit Record Indicator cannot be modified by the CDS Employer. This is System Generated.
118	EVV_MATERIAL_VM_CHANGE	1	Indicates if a Material visit maintenance change was made. Assigned by the EVV System if a material field was changed during visit maintenance.	No	EVV Material VM Change field cannot be modified by the Provider/FMSA. This is System Generated. However when Visit Maintenance is conducted and the visit is saved, this Material VM Change field gets modified.	N/A	This is not related to the Profile Data.	Yes	EVV Material VM Change field cannot be modified by the CDS Employer. This is System Generated. However when Visit Maintenance is conducted and the visit is saved, this Material VM Change field gets modified. If the CDS Employer has chosen Option 1 in the 1722 form.
119	EVV_MATERIAL_VM_FIELD_ID	50	Presents Field ID of all material changes delimited by a comma. Required if Field EVV_MATERIAL_VM_CHANGE = Y	No	EVV Material VM field ID cannot be modified by the Provider/FMSA. This is System Generated. However when Visit Maintenance is conducted and the visit is saved, this Material VM field ID gets modified.	N/A	This is not related to the Profile Data.	Yes	EVV Material VM field ID cannot be modified by the CDS Employer. This is System Generated. However when Visit Maintenance is conducted and the visit is saved, this Material VM field ID gets modified. If the CDS Employer has chosen Option 1 in the 1722 form.

Appendix P – Auto Verification

HHSC Electronic Visit Verification (EVV) Vendors Documentation
Appendix P - Auto Verification
Published Date: 02/25/2022
Effective Date: 05/31/2022

EVV Schedule Types Summary		
Schedule Type	**Auto-Verification Criteria**	**24-hour Call Matching Window enabled?**
Daily Variable Schedule	• Visit must occur on the scheduled date. • Visit duration must match scheduled duration within 7 minutes.	Yes
Daily Variable Schedule +Optional Expanded Time for Auto-verification	• Visit must occur on the scheduled date. • Visit duration must match scheduled duration within 22 minutes (.25 bill hours over or under).	Yes
Daily Variable Schedule +Optional Expanded Time for Auto-verification +Automatic Downward Adjustment	• Visit must occur on the scheduled date. • Visit duration must match scheduled duration within 22 minutes (.25 bill hours). • The EVV System will automatically downward adjust the Bill Hours to the scheduled duration if the visit duration is no more than .25 Bill Hours over.	Yes
Weekly Variable Schedule	• Visit must occur within the Weekly Schedule Begin Date and Weekly Schedule End Date. • Bill Hours of visit must not exceed hours remaining on Total Weekly Scheduled Hours • Visit duration is not considered for auto verification.	No
Daily Fixed Schedule	• Visit must occur on the scheduled date. • Visit clock in time must match scheduled begin time within 7 minutes and visit clock out time must match scheduled end time within 7 minutes. • Visit duration must match scheduled duration within 7 minutes. (8 minutes under or 8 minutes over will not auto-verify)	No
Daily Fixed Schedule +Optional Expanded Time for Auto-verification	• Visit must occur on the scheduled date. • Visit clock in time must match scheduled begin time within 7 minutes and visit clock out time must match scheduled end time within 7 minutes. • Visit duration must match scheduled duration within 14 minutes.	No

EVV Schedule Types Summary		
Daily Fixed Schedule +Optional Expanded Time for Auto-verification +Automatic Downward Adjustment	• Visit must occur on the scheduled date. • Visit clock in time must match scheduled begin time within 7 minutes and visit clock out time must match scheduled end time within 7 minutes. • Visit duration must match scheduled duration within 14 minutes. • The EVV System will automatically downward adjust the Bill Hours to the scheduled duration if the visit duration is within 14 minutes.	No

Below is Auto Verification Criteria to be used by the EVV System. The criteria are listed for with a Schedule (Daily Fixed, Daily Variable, Weekly Variable) and without a Schedule.

EVV Method	Field on the EVV Visit Transaction	Field on the Schedule	Auto Verification with Schedule (*'Daily Fixed Schedule', 'Daily Variable Schedule' and 'Weekly Variable Schedule'*)	Auto Verification without Schedule
ALL METHOD TYPES	EMPLOYEE_EVVID	ATTENDANT EVV ID	The EVV System must match the Employee EVV ID (EMPLOYEE_EVVID) on the EVV Visit Transaction with the Primary Service Provider Employee EVV ID or the Backup Service Provider Employee EVV ID on the Schedule. If the Employee EVV ID (EMPLOYEE_EVVID) on the EVV Visit Transaction does not match to Primary or Backup Service Provider Employee EVV ID, the EVV Visit Transaction must not Auto-verify.	The EVV System must validate the Employee EVV ID (EMPLOYEE_EVVID) on the EVV Visit Transaction is found in the EVV System. If Employee EVV ID (EMPLOYEE_EVVID) is not found, then the EVV Visit Transaction must not Auto-verify.
	INDVMBR_MEMBEREVVID	MEMBER EVV ID	The EVV System must match the Member EVV ID (INDVMBR_MEMBEREVVID) from the EVV Visit Transaction with the Member EVV ID on the Schedule. If Member EVV ID (INDVMBR_MEMBEREVVID) on the EVV Visit Transaction does not match with the Member EVV ID on the Schedule, the EVV Visit Transaction must not Auto-verify.	The EVV System must validate the Member EVV ID (INDVMBR_MEMBEREVVID) on the EVV Visit Transaction is found in the EVV System. If Member EVV ID(INDVMBR_MEMBEREVVID) on the EVV Visit Transaction is not found, then the EVV Visit Transaction must not Auto-verify.
	EVV_PAYHOURS (rounded actual hours)	VISIT_VISITHOURS	**Criteria 1 – Daily Variable Schedule, Daily Fixed Schedule (up to 7 Minutes Expanded Time)** Optional Expanded Time for Auto-Verification - **OFF** Optional Automatic Downward Adjustment - **OFF** The EVV System must compare Bill Hours (EVV_PAYHOURS) with Schedule Hours (VISIT_VISITHOURS) for the date of service. If the difference between Bill Hours (EVV_PAYHOURS) and Scheduled HOURS is greater than 7 minutes, the EVV Visit Transaction must not Auto-verify. **Criteria 2: Daily Variable Schedule (up to 22 Min Expanded Time (.25 hours), Billable hours are not**	The EVV System must validate the Bill Hours (EVV_PAYHOURS) on the EVV Visit Transaction is populated and is in the correct format. If the Bill Hours (EVV_PAYHOURS) is not populated and in the correct format, the EVV Visit Transaction must not Auto-verify.

			adjusted) Optional Expanded Time for Auto-Verification - **ON** Optional Automatic Downward Adjustment - **OFF** The EVV System must compare Bill Hours (EVV_PAYHOURS) with Schedule Hours (VISIT_VISITHOURS) for the date of service. If the difference between Bill Hours (EVV_PAYHOURS) and Scheduled HOURS is greater than 22 minutes, the EVV Visit Transaction must not Auto-verify. **Criteria 3: Daily Variable Schedule (up to 22 Min Expanded Time (.25 hours), Billable hours are downward adjusted)** Optional Expanded Time for Auto-Verification - **ON** Optional Automatic Downward Adjustment - **ON** The EVV System must compare Bill Hours (EVV_PAYHOURS) with Schedule Hours (VISIT_VISITHOURS) for the date of service. If the difference between Bill Hours (EVV_PAYHOURS) and Scheduled HOURS is greater than 22 minutes, the EVV Visit Transaction must not Auto-verify. In this criteria Bill Hours are downward adjusted to match the Scheduled hours. **Criteria 4: Daily Fixed Schedule (up to 14 Min Expanded Time (.25 hours), Billable hours are not adjusted)** Optional Expanded Time for Auto-Verification - **ON** Optional Automatic Downward Adjustment - **OFF** The EVV System must compare Bill Hours (EVV_PAYHOURS) with Schedule Hours (VISIT_VISITHOURS) for the date of service. If the difference between Bill Hours (EVV_PAYHOURS) and	

			Scheduled HOURS is greater than 14 minutes, the EVV Visit Transaction must not Auto-verify. **Criteria 5: Daily Variable Schedule (up to 14 Min Expanded Time (.25 hours), Billable hours are downward adjusted)** Optional Expanded Time for Auto-Verification - **ON** Optional Automatic Downward Adjustment - **ON** The EVV System must compare Bill Hours (EVV_PAYHOURS) with Schedule Hours (VISIT_VISITHOURS) for the date of service. If the difference between Bill Hours (EVV_PAYHOURS) and Scheduled Hours (VISIT_VISITHOURS) is greater than 14 minutes, the EVV Visit Transaction must not Auto-verify. In this criteria Bill Hours are downward adjusted to match the Scheduled hours. **Criteria 6: Weekly Variable Schedule** The EVV System must compare Bill Hours (EVV_PAYHOURS) with the remaining Total Weekly Scheduled Hours. If the Bill Hours (EVV_PAYHOURS) exceeds the remaining Total Weekly Scheduled Hours, the EVV Visit Transaction must not Auto-verify.	
	SERVICE (EVV_HCPCS_CODE, EVV_MODIFIER)	AUTHORIZED SERVICE	The EVV System must match the Service information on the EVV Visit Transaction with the Service Information on the active Authorization for the linked to the Schedule. If Service information does not match with the active Authorization, the EVV Visit Transaction must not Auto-verify.	The EVV System must match the Service information on the EVV Visit Transaction with the Service Information on the active Authorization. If Service information does not match with the active Authorization, the EVV Visit Transaction must not Auto-verify.
	EVV_VISITDATE (actual visit date of service)	VISIT_VISITDATE (Schedule Date for Daily Fixed and Daily Variable Schedule Types)	**Daily Fixed Schedule Type:** The EVV System must match actual visit date of service (EVV_VISITDATE) on the EVV Visit Transaction with date on the Schedule (VISIT_VISITDATE). If the actual visit date of service (EVV_VISITDATE) does not	The EVV System must validate the visit date of service (EVV_VISITDATE) on the EVV Visit Transaction is populated and is in the correct format. If the visit date of service (EVV_VISIT

		OR Weekly Schedule Begin Date and Weekly Schedule End Date for Weekly Variable Schedule Type	match with the date on the Schedule (VISIT_VISITDATE), the EVV Visit Transaction must not Auto-verify. **Daily Variable Schedule Types:** The EVV System must match actual visit date of service (EVV_VISITDATE) on the EVV Visit Transaction with date on the Schedule (VISIT_VISITDATE). If the actual visit date of service (EVV_VISITDATE) does not match with the date on the Schedule (VISIT_VISITDATE), the EVV Visit Transaction must not Auto-verify. For Daily Variable Schedule Type, the EVV System may only Auto-verify one visit within the 24-hour Call Matching Window, any additional visits in the same day for the same service must not Auto-verify. **Weekly Variable Schedule Type:** If the actual visit date of service (EVV_VISITDATE) on the EVV Visit Transaction is not within the Active Weekly Variable Schedule, then the Visit must not Auto-verify.	DATE) is not populated and in the correct format, the EVV Visit Transaction must not Auto-verify.
	EVV_CALLINTIME EVV_CALLOUTTIME (Actual Time In and Actual Time Out)	VISIT_VISITTIMEIN VISIT_VISITTIMEOUT (Schedule Time In and Schedule Time Out)	The EVV System must validate that the actual time in (EVV_CALLINTIME) and actual time out (EVV_CALLOUTTIME) are both populated on the EVV Visit Transaction and in the correct data format. If the actual time in (EVV_CALLINTIME) or actual time out (EVV_CALLOUTTIME) are missing, the visit must not Auto-verify. **Daily Variable Schedule Type** The EVV System must validate the actual time in (EVV_CALLINTIME) and actual time out (EVV_CALLOUTTIME) occur within 12:00 AM and	The EVV System must validate the actual time in (EVV_CALLINTIME) or actual time out (EVV_CALLOUTTIME) are both populated on the EVV Visit Transaction and in the correct data format EVV System must validate the actual time in (EVV_CALLINTIME) and actual time out (EVV_CALLOUTTIME) occur within 12:00 AM and 11:59 PM of the same date of service (EVV_VISITDATE). If the actual time in (EVV_CALLINTIME) or actual time out (EVV_CALLOUTTIME) fail validation, the EVV Visit Transaction must not Auto-verify.

			11:59 PM of the same date of service (EVV_VISITDATE). If the actual time in (EVV_CALLINTIME) or actual time out (EVV_CALLOUTTIME) fail validation, then the EVV Visit Transaction must not Auto-verify. **Daily Fixed Schedule Type** The EVV System must compare actual time in (EVV_CALLINTIME) on the EVV Visit Transaction with Scheduled Time In (VISIT_VISITTIMEIN) and compare actual time out (EVV_CALLOUTTIME) on the EVV Visit Transaction with Scheduled Time Out (VISIT_VISITTIMEOUT). If the variance of actual time in (EVV_CALLINTIME) and schedule time in (VISIT_VISITTIMEIN) is greater than 7 minutes OR the variance of actual time out (EVVCALLOUTTIME) and schedule time out (VISIT_VISITTIMEOUT) is greater than 7 minutes, the EVV Visit Transaction must not Auto-verify.	
LANDLINE METHOD	EVV_PHONE	N/A	The EVV System must match the EVV_PHONE number with the Member's primary landline phone number or alternate landline phone numbers (INDVMBR_PHONE or INDVMBR_ALTPHONE or INDVMBR_ALTPHONE2). If the phone number does not match to Member's primary or alternate phone numbers, the EVV Visit Transaction must not Auto-verify.	The EVV System must match the EVV_PHONE number with the Member's primary landline phone number or alternate landline phone numbers (INDVMBR_PHONE or INDVMBR_ALTPHONE or INDVMBR_ALTPHONE2). If the phone number does not match to Member's primary or alternate phone numbers, the EVV Visit Transaction must not Auto-verify.

MOBILE METHOD	EVV_VISIT_LATITUDE_IN EVV_VISIT_LONGITUDE_IN EVV_VISIT_LATITUDE_OUT EVV_VISIT_LONGITUDE_OUT	N/A	The EVV System must validate that the GPS Coordinates for the clock in and clock out are both populated on the EVV Visit Transaction and in the correct data format. If the GPS Coordinates fail validation, the EVV Visit Transaction must not Auto-verify. The EVV System must match the GPS Coordinates from the EVV Visit Transaction to the Geo-location of the Member's address based on the Geo Fencing that is approved per HHSC EVV Policy. If the 'Geo- Location' is not within the 'EVV Allowed Geo- perimeter' with 'Service Delivery Location' as 'Member Home', the EVV Visit Transaction must not Auto-verify.	The EVV System must validate that the GPS Coordinates for the clock in and clock out are both populated on the EVV Visit Transaction and in the correct data format. If the GPS Coordinates fail validation, the EVV Visit Transaction must not Auto-verify. The EVV System must match the GPS Coordinates from the EVV Visit Transaction to the Geo-location of the Member's address based on the Geo Fencing that is approved per HHSC EVV Policy. If the 'Geo-Location' is not within the 'EVV Allowed Geo-perimeter' with 'Service Delivery Location' as 'Member Home', the EVV Visit Transaction must not Auto-verify.
ALTERNATIVE DEVICE METHOD	ALTERNATIVE DEVICE TOKEN ID	N/A	The EVV System must match the Alternative Device Token ID from the EVV Visit Transaction to the Alternative Device that is linked to the Member. If the Token ID does not match to the Alternate Device linked to the member, the EVV Visit Transaction must not Auto-verify.	The EVV System must match the Alternative Device Token ID from the EVV Visit Transaction to the Alternative Device that is linked to the Member. If the Token ID does not match to the Alternate Device linked to the member, the EVV Visit Transaction must not Auto-verify.

Appendix Q – CDS Process Flow

EVV Visit Maintenance Process Flow for FMSAs/CDS Employers

Option 1: CDS Employer will perform visit maintenance and approve the time worked by their CDS employees in the EVV system.

EVV System

Start

Did Visit Auto Verify?

The EVV system performs visit validation edits

Did Visit(s) Pass EVV System Validations?

The EVV system returns reason(s) for rejection

Does CDS Employer need to adjust visit?

CDS Employer (or DR)

Does CDS employer approve time worked?

CDS employer (or DR) performs visit maintenance to: add clock in or clock out; adjust bill hours, add reason codes, select reason code description(s), and enter required free text

FMSA

The FMSA reviews the visit(s) using the CDS Service Delivery Log; compares to budget

Do Visits Match Budget?

Errors in time worked or time does not match budget; FMSA notifies CDS employer of VM adjustments required

FMSA makes corrections to pass the validation (No changes to clock in or clock out, bill hours or reason codes)

EVV Aggregator

Visit received by the EVV Aggregator and the Aggregator performs Business edits

Is EVV Visit Transaction Accepted or Rejected by Aggregator?

Accepted

The accepted EVV visit transactions are ready for EVV claims matching.

End

Rejected

The EVV Aggregator returns reason(s) for rejection to the EVV system. Visit maintenance must be performed.

Yes

No

Yes

No

Yes

No

Yes

No

Yes

No

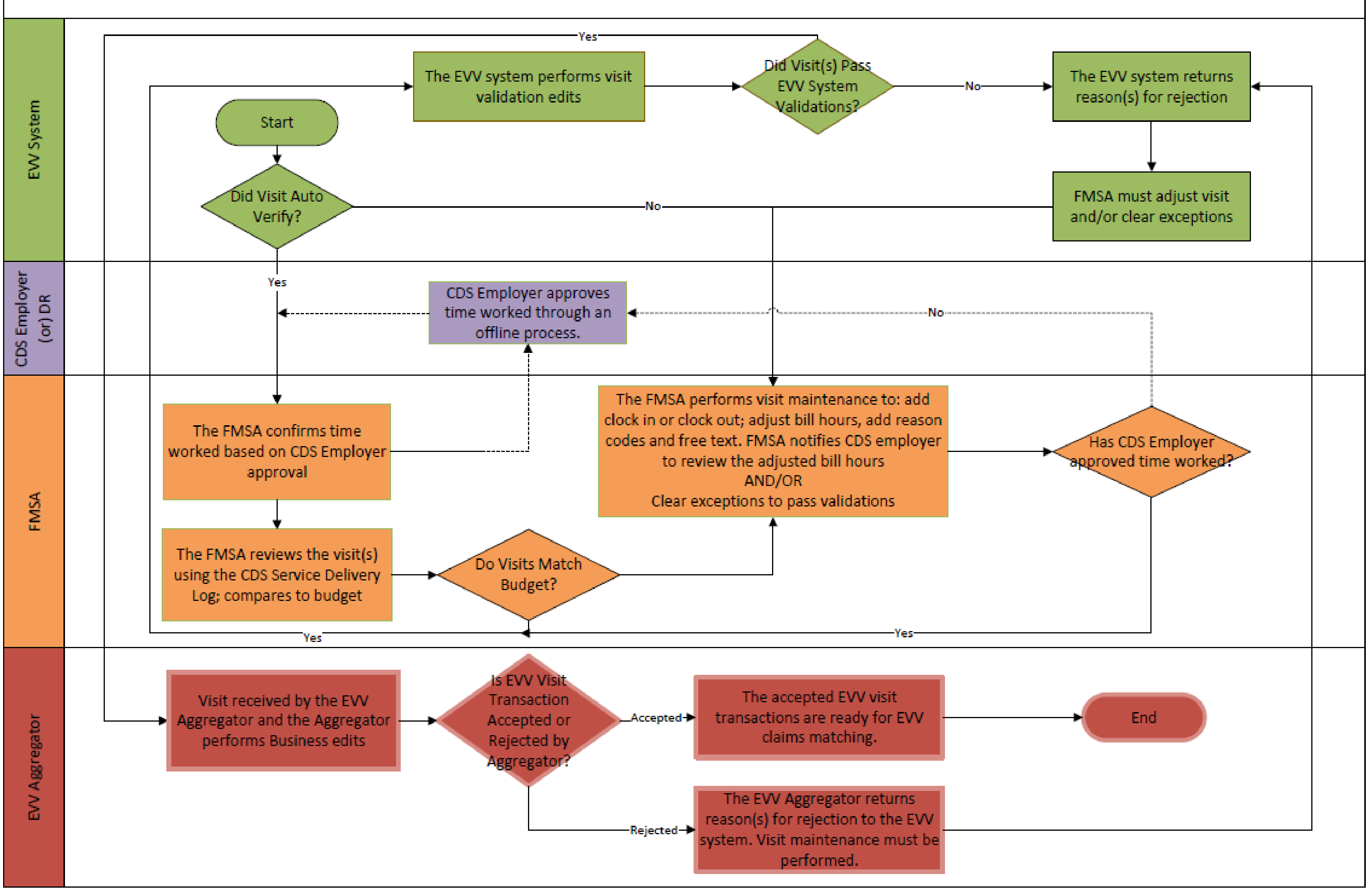
EVV Visit Maintenance Process Flow for FMSAs/CDS Employers
Option 3: The CDS Employer elects to delegate the performance of EVV visit maintenance to the FMSA. The FMSA will confirm the employee's time worked in the EVV system based on approval documentation from the CDS employer.
EVV System
CDS Employer (or) DR
FMSA
EVV Aggregator
Start
Did Visit Auto Verify?
Yes
No
The EVV system performs visit validation edits
Did Visit(s) Pass EVV System Validations?
Yes
No
The EVV system returns reason(s) for rejection
FMSA must adjust visit and/or clear exceptions
CDS Employer approves time worked through an offline process.
No
The FMSA confirms time worked based on CDS Employer approval
The FMSA performs visit maintenance to: add clock in or clock out; adjust bill hours, add reason codes and free text. FMSA notifies CDS employer to review the adjusted bill hours AND/OR Clear exceptions to pass validations
Has CDS Employer approved time worked?
The FMSA reviews the visit(s) using the CDS Service Delivery Log; compares to budget
Do Visits Match Budget?
Yes
Yes
Visit received by the EVV Aggregator and the Aggregator performs Business edits
Is EVV Visit Transaction Accepted or Rejected by Aggregator?
Accepted
The accepted EVV visit transactions are ready for EVV claims matching.
End
Rejected
The EVV Aggregator returns reason(s) for rejection to the EVV system. Visit maintenance must be performed.

Exhibit S: HHSC EVV Business Rules for Proprietary Systems

This document provides the HHSC EVV Business Rules for Proprietary Systems version 2.0, which is the current version as of September 2021. A proprietary system (referred to as "EVV system" within this document) must comply with the HHSC EVV Business Rules for Proprietary Systems. Contractor shall utilize this document in performing Proprietary System Management and Oversight. HHSC regularly updates the business rules and will provide the most current version to the awarded Contractor upon the Contract Effective Date or as otherwise agreed between the Parties.

Version 2.0

EVV System Management Services
RFO No. HHS0011055

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Proprietary System Operator (PSO) Compliance and Processing Guidelines

This document outlines the set of standards that any Proprietary System Operator (PSO) must adhere to as a condition of participation in the Texas Medicaid EVV Program. The standards cover the processing guidelines for business processes related to EVV, and compliance with them is critical to producing successful outcomes for the program.

The guidelines govern the system set up (onboarding) for PSOs, the documentation and verification of services requiring EVV, the maintenance of the visit data, and transmission of the data to the EVV Aggregator.

If a PSO does not act as a Financial Management Services Agency (FMSA) and does not serve any Consumer Directed Services (CDS) Employers, the references to CDS Employer and FMSA in the business rules do not apply to the PSO's EVV System.

Onboarding

The following business rules address onboarding requirements that include features within the EVV System to assist with verification against Medicaid data available from the MES service providers. HHSC acknowledges that a specific PSO may choose to not implement these features within the EVV System. HHSC will waive the rules related to the unused features for the PSO implementation of their chosen EVV System.

Program Provider or FMSA Profile Set-Up and Data Elements Validation

If a PSO does not implement the EVV Master Provider Web Service feature, HHSC will waive those rules marked by an '*'.

Id	Program Provider or FMSA Profile Set-Up and Data Elements Validation Business Rule
PAO-3P	EVV System must create a unique profile for each distinct Business Unit the Program Provider or FMSA will use to submit EVV Visit Transactions to the EVV Aggregator. This includes distinct profiles for each type of System User and their security access.
PAO-4P*	EVV System must electronically document identification data elements for each Program Provider or FMSA Business Unit through the EVV Master Provider web service described in Appendix D.

Id	Program Provider or FMSA Profile Set-Up and Data Elements Validation Business Rule
PAO-5P*	EVV System must validate identification data entered by the System User against Texas Medicaid data using the EVV Master Provider web service. The EVV System must communicate an error to the System User for any required data elements that do not match and creation of the Program Provider or FMSA Business Unit profile must not occur until the System User corrects the errors. See Appendix D for details on the EVV Master Provider web service.
PAO-6P	EVV System must allow System Users with appropriate security access to initiate Program Provider or FMSA Business Unit profile updates.
PAO-30P	EVV System must allow the following relationships, at a minimum: • A Program Provider or FMSA can be associated with multiple Members. • A Program Provider or FMSA can be associated with multiple Service Providers. • A Program Provider or FMSA can be associated with multiple Subcontracted Providers. • A Program Provider or FMSA Business Unit can be associated with multiple CDS Employers. • A CDS Employer can be associated with multiple Members. • A CDS Employer can be a Member. • A CDS Employer can be associated with multiple Service Providers.
PAO-31P	EVV System must allow an FMSA to capture the designation by the CDS Employer, to identify a Designated Representative (DR) to perform all system actions on behalf of a CDS Employer. EVV System must adhere to HHSC EVV Policy regarding the CDS Employer's appointment of a DR.

Service Provider Profile Set-Up and Data Elements Validation

Id	Service Provider Profile Set-Up and Data Elements Validation Business Rule
PAO-8P	EVV System must create a unique profile for each Service Provider containing the Service Provider identification information listed in PAO-9P (at a minimum). This includes CDS Employees.
PAO-9P	EVV System must electronically document the following data elements for the Service Provider's identification information: • Texas EVV Service Provider Identification Number • Legal Name (Last, First, MI)

Id	Service Provider Profile Set-Up and Data Elements Validation Business Rule
	• Permanent address (Street, City, State, ZIP+4)
PAO-10P	EVV System must allow System Users with the appropriate security access to update Service Provider profiles.
PAO-32P	EVV System must allow the following relationships, at a minimum: • A Service Provider can be associated with multiple Program Provider or FMSA Business Units. • A Service Provider can be associated with multiple CDS Employers. • A Service Provider can be associated with both Program Providers or FMSAs and CDS Employers. • A Service Provider can be associated with multiple Members.

Member Profile and Data Elements Validation

Id	Member Profile and Data Elements Validation Business Rule
PAO-14P	EVV System must create a unique profile for each Member receiving services containing the identification information listed in PAO-15P (at a minimum).
PAO-15P	EVV System must electronically document the following data elements for the Member's identification information: • Texas Medicaid Identification Number • Legal Name (Last, First, MI) • Date of Birth • Medicaid Eligibility start date • Medicaid Eligibility end date • Managed Care Eligibility start date • Managed Care Eligibility end date • Member Home Address (Street, City, State, ZIP+4) • Member Home Phone Number Conditional data elements depending on selected electronic verification method(s): When the Member selects Landline Method: • Member Home Phone Landline Number • Member Alternate Phone Landline Number(s) When the Member selects mobile method: • Member Home Geo-Location (system assigned) When the Member selects Alternative Device: • Member Alternative Device identifier
PAO-16P*	EVV System must validate any Member data entered by the System User against the Texas Medicaid data using the x12 270/271 exchange. EVV System may notify the System User of an exception for any required data elements that do not match but must not prevent the creation of the profile. See Appendix E – Member Eligibility Companion Guides for details on the X12 270/271.
PAO-17P	EVV System must allow the System Users with appropriate security access to initiate Member profile updates.
PAO-33P	EVV System must allow the following relationships, at a minimum: • A Member can be associated with multiple Program Providers or FMSA Business Units.

Id	Member Profile and Data Elements Validation Business Rule
	• A Member can be associated with only one CDS Employer. • A Member can be associated with both Program Provider and FMSA Business Units, and a CDS Employer. • A Member can be associated with multiple Service Providers.
PAO-34P	EVV System must allow a System User with the appropriate security access to adjust the Member Home Geo-location in the Member profile.

EVV System Training

Id	EVV System Training Business Rule
PAO-21P	The PSO must provide initial and ongoing system training, as needed, to HHSC and MCO staff. The training must include access to, and use of, the EVV System for demonstration of full system functionality.

Establishing Service

Service Authorizations

If a PSO does not implement the EVV Provider Authorization Web Service feature, HHSC will waive those rules marked by an '*'.

Id	Service Authorizations Business Rule
ESA-2P*	EVV System must request, receive and store available electronic Fee for Service authorization data from the MES service providers using the standardized file format found in Appendix F. EVV System must conduct this activity at least once daily, when used.
ESA-3P*	EVV System must allow the System User to confirm Member Service Authorization when using the authorization data received from the MES service providers in the standardized file format found in Appendix F. The EVV System must reject a Service Authorization not confirmed by the System User unless it matches what the System User created manually.
ESA-4P*	EVV System must alert the System User to changes in Service Authorization data when using the standardized file format found in Appendix F to receive authorization data from the MES service providers.
ESA-7P	EVV System must verify the accuracy of the EVV Visit Transaction, prior to confirmation and transmission to the EVV Aggregator, to ensure it matches the Service Authorization data. The verification must ensure that the relationship between the Provider ID (NPI, API, TIN, Provider Number), the Medicaid ID for the Member and the Service Codes match the Service Authorization data. If they do not match then the EVV System must notify the System User and, if within the Visit Maintenance Time Frame, and allow the System User to make corrections prior to transmission of the Visit to the EVV Aggregator.
ESA-15P	EVV System must allow the System User to manually create a Service Authorization for a Member. A Service Authorization from the payer will take precedence unless the Service Authorization matches what the System User created manually.

Id	Service Authorizations Business Rule
ESA-16P	EVV System must validate manually entered Service Authorization data against existing profile data in the system.
ESA-17P*	EVV System must validate electronic Service Authorization data received from the MES service providers when using the standardized file format in Appendix F to ensure that the data format is correct, and that the payer populated all required fields. See Appendix F for technical specifications.

Schedules - No Schedule

ESA-9P	EVV System must allow a Service Provider to clock in and clock out for a Visit that the Service Provider delivers without a Schedule.
ESA-52P	EVV System must allow a System User to manually document a Visit that the Service Provider delivered without a Schedule and did not use an electronic verification method to clock in or clock out.
ESA-53P	If the System User does not choose a Schedule Type for a Member, then the EVV System must default to no Schedule.
ESA-54P	The EVV System must Auto-verify a Visit with no Schedule if no critical exceptions are present on the Visit. Refer to Appendix P for Auto-verification specifications.

Schedules - General

The following business rules address Schedule Types for implementation within the EVV System. HHSC acknowledges that a PSO may choose to implement alternate Schedule Type(s) not described in the HHSC EVV Business Rules for Proprietary Systems or may choose not to implement any Schedule Types in the EVV System. HHSC will waive the rules related to the unused Schedule Type(s) for the PSO implementation of their chosen EVV System. PSOs are responsible for meeting any Medicaid program requirements related to the use of a service delivery schedule.

Id	Schedules Business Rule
ESA-8P	EVV System must provide a scheduling function, giving the System Users the option to enter and maintain any of the Schedule Types for planned Service delivery.
ESA-18P	EVV System must allow the System User to choose any of the Schedule Types for each of the Member's services.
ESA-19P	EVV System must allow the System User to choose only one Schedule Type per service per Member at a time.
ESA-20P	The EVV System must allow the System User to create a Recurring Weekly Variable Schedule, Daily Variable Schedule, or Daily Fixed Schedule.
ESA-21P	EVV System must alert the System User when a change in the Member's Schedule Type will cause the EVV System to delete all Member Schedules associated with the previous Schedule Type. The System User must acknowledge the alert to proceed with the change or may cancel the change.

Schedules – Daily Variable

Id	Schedules Business Rule

ESA-22P	EVV System must allow the System User to set up a Daily Variable Schedule for a specific Member, Service (HCPCS/Modifier), Service Provider, Service Delivery Location, Visit Duration and Visit Date.
ESA-23P	EVV System must match the Member, Service (HCPCS/Modifier) and Service Provider from a Visit to the specified data elements on the Daily Variable Schedule to Auto-verify the EVV Visit Transaction. Refer to Appendix P for Auto-verification specifications.
ESA-24P	EVV System must match the Visit date to the Scheduled Visit Date to Auto-verify the EVV Visit Transaction for a Member on a Daily Variable Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-25P	EVV System must match the Visit Duration within 7 minutes of the Scheduled Visit Duration to Auto-verify the Visit. Refer to Appendix P for Auto-verification specifications.
ESA-26P	EVV System must match the Visit Duration to the Scheduled Visit Duration using a 24-hour Call Matching Window to Auto-verify the Visit for a Member on a Daily Variable Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-27P	EVV System must allow the System User to apply the Optional Expanded Time for Auto-verification feature by Member when using a Daily Variable Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-28P	EVV System must allow the System User to apply the Optional Automatic Downward Adjustment feature by Member when using a Daily Variable Schedule. Refer to Appendix P for Auto-verification specifications.

Schedules – Weekly Variable

Id	Schedules Business Rule
ESA-29P	EVV System must allow the System User to set up a Weekly Variable Schedule for a seven-calendar day period (Sunday through Saturday) for a specific Member, Service (HCPCS/Modifier), Service Provider and Service Delivery Location.
ESA-30P	EVV System must allow the System User to select any Sunday as the Weekly Variable Schedule Begin Date for a Weekly Variable Schedule.
ESA-31P	EVV System must allow the System User to set the Total Weekly Scheduled Hours equal to or less than 168 hours for the Weekly Variable Schedule.
ESA-32P	EVV System must set the Weekly Variable Schedule End Date to be a Saturday that is six calendar days after the Weekly Variable Schedule Begin Date.
ESA-33P	EVV System must allow the System User to delete a Weekly Variable Schedule at any point prior to the Auto-verification of a Visit against that Schedule.
ESA-34P	EVV System must match the Member, Service (HCPCS/Modifier) and Service Provider data from a Visit to the specified data elements on the Weekly Variable Schedule to Auto-verify the EVV Visit Transaction. Refer to Appendix P for Auto-verification specifications.
ESA-35P	EVV System must Auto-verify a Visit for a Weekly Variable Schedule when the Visit Date is between the Weekly Variable Schedule Begin Date and the Weekly Variable Schedule End Date and the Visit Duration does not exceed the Remaining Weekly Scheduled Hours.
ESA-36P	EVV System must track and report the Remaining Weekly Scheduled Hours based on the decrementing of Bill Hours of Visits that Auto-verify against a Weekly Variable Schedule.
ESA-37P	EVV System must update the Remaining Weekly Scheduled Hours of a Weekly Variable Schedule when the System User adjusts the Bill Hours during Visit Maintenance for a Visit previously Auto-verified against the Weekly Variable Schedule.

ESA-38P	During a Member's Weekly Variable Schedule, the EVV System must allow the System User to increase or decrease the Total Weekly Scheduled Hours of the Weekly Variable Schedule prior to the Weekly Variable Schedule End Date. The Total Weekly Scheduled Hours adjusted amount must be equal to or greater than the Remaining Weekly Scheduled Hours.
ESA-39P	During a Member's Weekly Variable Schedule, the EVV System must allow the System User to make changes to the Service Provider data associated with the Weekly Variable Schedule for future Visit Schedule dates.
ESA-40P	EVV System must not enable the 24-hour Call Matching Window when the System User chooses a Weekly Variable Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-41P	EVV System must not enable the Optional Expanded Time for Auto-verification feature when using a Weekly Variable Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-42P	EVV System must not enable the Optional Automatic Downward Adjustment feature when using a Weekly Variable Schedule. Refer to Appendix P for Auto-verification specifications.

Schedules – Daily Fixed

Id	Schedules Business Rule
ESA-43P	EVV System must allow the System User to set up a Daily Fixed Schedule for a specific Member, Service (HCPCS/Modifier), Service Provider, Service Delivery Location, Visit clock in time and Visit clock out time, and Visit Date.
ESA-44P	EVV System must match the Member, Service (HCPCS/Modifier) and Service Provider from a Visit to the specified data elements on the Daily Fixed Schedule to Auto-verify the Visit. Refer to Appendix P for Auto-verification specifications.
ESA-45P	EVV System must match the Visit Date to the Scheduled Visit Date to Auto-verify the Visit for a Member on a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-46P	EVV System must match the Visit clock in time within 7 minutes of the scheduled clock in time to Auto-verify the Visit for a Member on a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-47P	EVV System must match the Visit clock out time within 7 minutes of the scheduled clock out time to Auto-verify the Visit or a Member on a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-48P	EVV System must match the Visit Duration within 7 minutes of the Scheduled Visit Duration to Auto-verify the Visit for a Member on a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-49P	EVV System must not enable the 24-hour Call Matching Window when the System User chooses a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-50P	EVV System must allow the System User to apply the Optional Expanded Time for Auto-verification feature by Member when using a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.
ESA-51P	EVV System must allow the System User to apply the Optional Automatic Downward Adjustment feature by Member when using a Daily Fixed Schedule. Refer to Appendix P for Auto-verification specifications.

Electronic Verification Methods

The following business rules address multiple electronic verification methods. HHSC acknowledges that a specific EVV System may not include all approved methods. HHSC will waive the rules related to the unused method(s) for the PSO implementation of their chosen EVV System.

General

Id	**Alternative Methods/Devices Business Rule**
EVM-16P	EVV System must only collect data specifically required to verify the EVV Visit Transaction. The EVV System must not capture personal data on the Service Provider's mobile device other than that required for the clock in and clock out.

Home Phone Landline

Id	**Home Phone Landline Business Rule**
EVM-3P	EVV System must accept clock in and clock out data via the Member home phone landline or a Member alternate phone landline number identified in the Member profile.
EVM-4P	EVV System must verify Member Home phone landline number, or Member alternate phone landline number, on EVV Visit Transaction is associated with the Member profile. If the EVV System finds a mismatch, the EVV System must flag the EVV Visit Transaction' and alert the System User.
EVM-22P	EVV System must assign the value 'Member Home' to the Service Delivery Location when the EVV System verifies the clock in or clock out method used for the Visit matches the Member home phone landline number in the Member profile.

Alternative Methods/Devices

Id	**Alternative Methods/Devices Business Rule**
EVM-5P	The PSO must provide HHSC-approved alternatives for clock in and clock out in the event a Member does not have a home phone landline, or a Member is unwilling to allow the Service Provider use of the home phone landline.
EVM-6P	EVV System must identify Service Provider use of Alternative Methods/Devices used for clock in and clock out and confirm association to a Member profile. If the EVV System finds a mismatch, the EVV System must flag the EVV Visit Transaction' and alert the System User.
EVM-23P	EVV System must assign the value 'Member Home' to Service Delivery Location when the EVV System verifies the clock in or clock out method used for the Visit matches the Alternative Device in the Member profile.

Mobile Method

Id	Mobile Method Business Rule
EVM-7P	The PSO must allow clock in and clock out through mobile methods. The PSO must provide the mobile methods at no charge to the Member.
EVM-8P	Proprietary System Operator must receive consent from the Service Provider when the Service Provider uses their personal cell phone for clock in and clock out using a mobile method.
EVM-9P	EVV System must verify that the mobile method used for clock in, and clock out is associated with the Service Provider delivering services to the Member. If the EVV System finds a mismatch, the EVV System must flag the EVV Visit Transaction and alert the System User.
EVM-10P	EVV System must capture Geo-location only at clock in and clock out through mobile methods. Mobile method must not allow for persistent tracking. EVV System must not allow a System User to alter Geo-location data captured through the mobile method.
EVM-11P	EVV System must allow the Service Providers to access the mobile method.
EVM-12P	EVV System must not utilize minutes from the Service Providers cellular plan or require significant data usage through cellular network for the mobile method when the cost associated with that data use is the responsibility of the Service Provider.
EVM-17P	EVV mobile method provided by the Proprietary System Operator must allow multiple users to use the same device but must require logon credentials unique to each Service Provider.
EVM-18P	EVV mobile method provided by the PSO must allow the user to download, set up and begin using the mobile method without hands on interaction by the PSO or System User.
EVM-19P	The EVV System must only use the Geo-location data to document the location of the service delivery visit. The PSO must not sell, share, or allow use of the Geo-location data by a third party for any reason.
EVM-20P	EVV System must not restrict usage of the mobile method based on the proximity of the home address of the Service Provider and the Member Home Geo-location of Member receiving services.
EVM-21P	EVV System must assign the value Member Home to Service Delivery Location when the EVV System verifies the Geo-location captured using the mobile method is within the EVV Allowed Geo-perimeter.
EVM-25P	The EVV mobile method must restrict the selection of Service Delivery Location during clock in and clock out to the allowable values identified in Appendix J – Service Delivery Locations.

Service Delivery Verification

Service Delivery (EVV Visit) Transaction Documentation

Id	Service Delivery (EVV Visit) Transaction Documentation Business Rule
SDV-1P	EVV System must capture and verify the following visit data for each EVV visit: • Member receiving the service • Service Provider providing the service • PSO Business Unit the Service Provider is performing the service on behalf of • Service Delivery Location • Date Service Provider delivered the service

Id	Service Delivery (EVV Visit) Transaction Documentation Business Rule
	• Time Service Provider delivered the service (start and end) • Type of service delivered The system must capture this visit data even in the absence of verification. See specific data elements required to support this data capture and validation in Appendix C and Appendix J.
SDV-2P	EVV System must capture the clock in and clock out method used for each EVV visit transaction.
SDV-64P	EVV System must capture the Service Delivery Location during clock in and clock out using the values listed in Appendix J. The EVV System will record the Service Delivery Location as the EVV_VISITLOCATION when transmitting the EVV Visit Transaction to the EVV Aggregator.
~~SDV-3P~~	** Business Rule Removed ** ~~'EVV System' must allow log in as well as the capture of clock-in/clock-out data when using a mobile method in instances when internet connection or cellular data is unavailable. This must not require manual entry of data by the 'System User'.~~
SDV-4P	EVV System must allow for manual data entry of EVV Visit Transactions only within the Visit Maintenance Time Frame. All EVV Visit Transactions created using this manual method must identify the input method and output method as "GUI" (manual entry). EVV System must require extra certification that supporting documentation is available when the System User creates a manual Visit.
SDV-64	EVV System must only allow for manual data entry of EVV Visit Transactions outside of the Visit Maintenance Time Frame when the payer has approved the creation of visits via the HHSC-approved process.
SDV-5P	EVV System must calculate service delivery time using clock in and clock out time in standard format (MMDDYYYY HH:MM AM/PM).
SDV-6P	EVV System must round actual service delivery time to the nearest quarter hour increment where program rules require and submit this separately as billed hours.
SDV-7P	EVV System must allow the System User the ability to adjust Bill Hours in cases where the Service Provider clock in and clock out was not appropriate. The System User may not adjust Bill Hours to an amount greater than the rounded actual hours recorded by the EVV System.
SDV-8P	EVV System must allow for multiple Service Providers to deliver the same service at the same Service Delivery Location, same date, and time with the same Member.
SDV-9P	EVV System must support overnight shifts in a way that does not require the Service Provider to clock in and clock out multiple times per shift. The EVV System must split the overnight shift into two separate EVV Visit Transactions for the two affected days. The EVV System must not require the use of a Schedule to implement this business rule.
SDV-10P	EVV System must allow the System User or may optionally allow the Service Provider, to document the amount of time associated with non-EVV relevant services that the Service Provider delivered during an EVV service delivery period. The EVV System must not use the non-EVV relevant service time in the calculation of the units.
SDV-11P	EVV System must identify duplicate EVV Visit Transactions and not allow transmission of the duplicate transaction to the EVV Aggregator. EVV System must alert the System Users when the EVV System identifies a duplicate and allow the System User to correct the EVV Visit Transaction.
SDV-58P	EVV System must not allow the System User to create a new EVV Visit Transaction to replace an existing EVV Visit Transaction. Instead, the System User must perform Visit Maintenance to make changes to the existing EVV Visit Transaction as

Id	Service Delivery (EVV Visit) Transaction Documentation Business Rule
	needed. If after the Visit Maintenance Time Frame, the System User must receive payer approval to proceed with the change.
SDV-42P	EVV System must identify service delivery to multiple Members at the same time at separate Service Delivery Locations by the same Service Provider, and not allow transmission of those transactions to the EVV Aggregator. EVV System must alert the System User when the EVV System identifies these EVV Visit Transactions and allow for correction or attestation that the service delivery was accurate using the most appropriate EVV Reason Code, if allowed by program rules. EVV System must allow transactions with one Service Provider that provides service to multiple members at the same Service Delivery Location and transmit those transactions to the EVV Aggregator. EVV System must capture the service delivery in a user-friendly and efficient manner to reduce input by the Service Provider.

Service Delivery (EVV Visit) Transaction Validation

Id	Service Delivery (EVV Visit) Transaction Validation Business Rule
SDV-12P	**Business Rule Removed – replaced by SDV-60** ~~'EVV System' must auto-verify a service delivery transaction received via approved method (except 'GUI') that matches to a previously entered 'Schedule' when applicable.~~
SDV-13P	**Business Rule Removed – replaced by SDV-60** ~~'EVV System' must auto-verify a service delivery transaction received that matches Texas Medicaid EVV program criteria, in lieu of a 'Schedule', without the 'System User' performing 'Visit Maintenance'.~~
SDV-60P	EVV System must adhere to HHSC EVV Policy regarding Auto-Verification of EVV Visit Transactions and must comply with Appendix P – Auto Verification Specifications.
SDV-14P*	EVV System may verify Member data using the client Medicaid eligibility data available from MES service providers for the Texas Medicaid program prior to verifying service delivery transaction. The EVV System may complete this validation using the x12 270/271. When used, the EVV System must notify the System User and allow the System User to correct exceptions prior to transmission of the EVV visit data to the EVV Aggregator. See Appendix E for details on the x12 270/271 Companion Guides.
SDV-55P	EVV System may verify payer and plan code using the Payer Plan Code web service prior to verifying service delivery transaction. If used, the EVV System must allow the System User to correct exceptions. See Appendix L for details on the Payer Plan Code web service.
SDV-15P	EVV System must verify PSO Business Unit profile prior to verifying service delivery transaction. The EVV System must notify the System User and allow the System User to correct exceptions.
SDV-16P	EVV System must accept only Texas Medicaid EVV program valid HCPCS (procedure codes) and modifier(s). The EVV System must allow the System User to correct exceptions. The EVV System must use the EVV Service Bill Codes Table to identify these valid codes, see Appendix B.
SDV-19P	EVV System must adhere to HHSC EVV Policy regarding Call Matching Window if the PSO chooses to implement this optional Visit Maintenance reduction solution.

Id	Service Delivery (EVV Visit) Transaction Validation Business Rule
SDV-49P	EVV System must adhere to HHSC EVV Policy regarding Optional Expanded Time for Auto-Verification if the PSO chooses to implement this optional Visit Maintenance reduction solution.
SDV-50P	EVV System must adhere to HHSC EVV Policy regarding Optional Automatic Downward Adjustment if the PSO chooses to implement this optional Visit Maintenance reduction solution which only applies to the Daily Variable Schedule or Daily Fixed Schedule types.
SDV-51P	EVV System must alert the System User when the Member units used are reaching the authorized units on the Service Authorization.

Visit Maintenance

Id	Visit Maintenance Business Rule
SDV-20P	EVV System must allow System Users to complete Visit Maintenance within the Visit Maintenance Time Frame.
SDV-65P	EVV System must only allow the System Users to complete Visit Maintenance outside of the Visit Maintenance Time Frame when the payer has approved Visit Maintenance via the HHSC-approved process.
SDV-21P	EVV System must restrict the System User from performing Visit Maintenance on the following fields: • Actual service delivery date • Actual service delivery clock in time • Actual service delivery clock out time • Actual hours worked • Auto-populated data fields • GPS coordinates See Appendix O for Visit Maintenance rules.
SDV-46P	EVV System must identify the input method on the EVV Visit Transaction as “GUI” when the clock in time for a Visit is missing (missed clock in) and the System User manually completes the Visit.
SDV-47P	EVV System must identify the input method on the EVV Visit Transaction as “GUI” when the clock out time for a Visit is missing (missed clock out) and the System User manually completes the Visit.
SDV-61P	EVV System must adhere to HHSC EVV Policy regarding Visit Maintenance of EVV Visit Transactions and must comply with technical specifications for Visit Maintenance. Refer to Appendix O for the Visit Maintenance specifications.
SDV-48P	EVV System must require the System User to entera EVV Reason Code and required free text when the System User makes changes to the EVV Visit Transaction after the System User/ Service Provider has documented the visit. EVV system must adhere to the HHSC EVV Policy regarding EVV Reason Codes.
SDV-22P	EVV System must record changes made to the EVV Visit Transaction by the System User after the System User/Service Provider has documented the Visit. The EVV System must collect the following audit trail data at a minimum: • Data elements changed (including the before and after values) • Name of the System User making the changes • Date and time the System User made the changes • EVV Reason Code(s) added with or without associated free text

Id	Visit Maintenance Business Rule
SDV-56P	EVV System must update the last visit maintenance date in the EVV Visit Transaction to the current date, whenever the EVV System identifies a change to one or more fields impacting the last visit maintenance date as listed in HHSC EVV Policy. The EVV System must save the last visit maintenance date to the EVV Visit Transaction after the System User/Service Provider has documented the EVV visit.
SDV-23P	EVV System must compare data elements from the original EVV Visit Transaction to the updated EVV Visit Transaction according to HHSC EVV Policy to confirm the EVV System made updates, prior to establishing the last visit maintenance date value for the field EVV_LASTVISITMAINT in the EVV Visit Transaction.
SDV-24P	EVV System must re-validate service delivery details, when the System User has updated the EVV Visit Transaction, using the same validations as an initial EVV Visit Transaction. Should the EVV System identify any exceptions, the EVV System must notify the System User that the System User must correct the exceptions before the EVV System will transmit changes to the EVV Aggregator. When re-validating service delivery details for multiple EVV Visit Transactions at a time, the EVV System should alert the System User of only those EVV Visit Transactions with exceptions.
SDV-25P	EVV System must allow the System Users to confirm an EVV Visit Transaction after completing Visit Maintenance prior to transmitting to the EVV Aggregator.
SDV-26P	EVV System must not allow the System User to delete delivered/documented services from the EVV System. This includes instances of Visit Maintenance where the System User has added an EVV Reason Code to an EVV Visit Transaction. The EVV System must not allow the System User to delete an EVV Reason Code and associated free text.
SDV-44P	EVV System must allow an FMSA to capture the designation provided by the CDS Employer to complete Visit Maintenance on behalf of a CDS Employer associated with that FMSA. EVV System must adhere to HHSC EVV Policy regarding the CDS Employer's Selection for Electronic Visit Verification Responsibilities. See Appendix Q for CDS Process Workflow.
SDV-45P	EVV System must allow an FMSA to capture the designation provided by the CDS Employer to confirm visit approval and complete Visit Maintenance. Note that if the CDS Employer designates the FMSA to confirm visit approval they must also designate the FMSA Contracted or Subcontracted Provider to complete Visit Maintenance. EVV System must adhere to HHSC EVV Policy regarding the CDS Employer's selection for Electronic Visit Verification Responsibilities.
SDV-52P	EVV System must allow the System User to modify billed hours by either entering bill time in and bill time out, or by directly modifying the billed hours, to reflect that the Program Provider or FMSA will not bill actual visit hours in full.
SDV-53P	EVV System may use two fields for data entry of bill time in and bill time out to assist System Users, when adjusting Bill Hours during Visit Maintenance. The EVV System must use the bill time in and bill time out when entered to calculate Bill Hours in the same manner as the calculation of actual hours from the actual time in and actual time out. The EVV System will not transmit data for the bill time in and bill time out fields to the EVV Aggregator.

EVV Reason Codes

Id	EVV Reason Codes Business Rule
SDV-27P	EVV System must only accept valid EVV Reason Codes as defined in HHSC EVV Policy. See Appendix A.

Id	EVV Reason Codes Business Rule
SDV-28P	EVV System must allow the System User to select multiple EVV Reason Codes for a single visit.
SDV-29P	EVV System must allow for modification of the EVV Reason Codes as directed by HHSC. Modifications may include adding new EVV Reason Codes, discontinuing EVV Reason Codes, changing EVV Reason Code usage guidelines, or changing EVV Reason Code text.
SDV-30P	EVV System must capture free text/comments to allow further explanation by the System User regarding the reason for Visit Maintenance. HHSC EVV Policy may require free text/comments when using certain EVV Reason Codes.
SDV-57P	** Business Rule Removed ** ~~*'EVV System' must alert the 'System User' when the same 'Reason Code' number and description combination is used on a Members visits for occurrences 10 through 14 during a calendar month, to notify the 'System User' that 'Reason Code' usage is approaching the limit specified in the HHSC EVV Policy Handbook.*~~
SDV-63P	EVV System Reason Code table must list all EVV Reason Codes as defined in the HHSC EVV Policy. See Appendix A.

Transmission of Service Delivery (EVV Visit) Transactions

Id	Transmission of Service Delivery (EVV Visit) Transactions Business Rule
SDV-31P	EVV System must transmit Confirmed EVV Visit Transactions to the EVV Aggregator in the standard format found in Appendix C.
SDV-32P	EVV System must transmit Confirmed EVV Visit Transactions to the EVV Aggregator. The PSO must ensure that 98% of initial EVV Visit Transactions submitted to the EVV Aggregator contain complete and accurate data elements and that 100% of subsequent EVV Visit Transactions submitted to the EVV Aggregator must contain complete and accurate data elements. For the purpose of this rule, "complete and accurate" is defined as no file-level errors, no field formatting errors, and all required fields populated, per the EVV Visit Data Layout Edits Crosswalk, found in Appendix M.
SDV-33P	EVV System must process responses from the EVV Aggregator and alert the System Users to the status (acceptance or rejection) of each EVV Visit Transaction within 24 hours of response receipt. EVV System must notify the System User of rejection alerts, including the reason for the rejection.
SDV-34P	EVV System must allow the System User to correct exceptions in allowable data elements on the EVV Visit Transactions previously submitted to the EVV Aggregator. Once complete, the EVV System must allow the System User to indicate that the EVV System can re-transmit the EVV visit transaction to the EVV Aggregator.
SDV-35P	The PSO must collaborate with Contractor and MES service providers to correct any format/file errors as well as any business errors received from the EVV Aggregator.
SDV-37P	EVV System must require CDS Employer or designated FMSA to approve an EVV Visit Transaction prior to export to the EVV Aggregator, even if the visit is Auto-verified. For the sequence of events of the CDS service delivery model refer to the CDS Process Flow diagram, found in Appendix Q.
SDV-59P	EVV System must allow the FMSA to review EVV Visit Transactions approved by the CDS Employer prior to export to the EVV Aggregator. For the sequence of events of the CDS service delivery model refer to the CDS Process Flow diagram, found in Appendix Q.

Reporting Requirements

Standard System Reports

Id	Standard System Reports Business Rule
EVR-1P	EVV System must provide reporting to support program requirements and monitoring. The EVV System must make the following standard reports available on demand, when applicable, based on data native to the EVV System. See Appendix G: • EVV CDS Service Delivery Log • EVV Landline Phone Verification Report • EVV Service Delivery Exception Report • Non-EVV Relevant Time Logged
EVR-8P	EVV System must provide reporting to CDS Employers to support program requirements and monitoring. The EVV System must make the following standard reports available on demand to CDS Employers (as applicable) based on data retrieved from the EVV Standard System Reports web service provided by the MES service providers. Program Providers, FMSAs, HHSC and MCOs will access these reports from the EVV Portal. See Appendix G: • EVV Attendant History Report • EVV CDS Employer Usage Report • EVV Clock In/Clock Out Usage Report • EVV Reason Code Usage and Free Text Report • EVV Units of Service Summary Report
EVR-4P	** Business Rule Removed – See Appendix G** ~~EVV System must provide the Service Delivery Exception Report in support of program requirements and monitoring for the System User. This report must include the following data points at a minimum:~~ ~~• Service Scheduled but not delivered~~ ~~• Service delivered but not Scheduled~~ ~~• Service delivered but not authorized~~ ~~• Service authorized but not delivered~~ ~~• Service delivered but not approved/confirmed~~ ~~This data must include services regardless of Service Delivery Location. See Appendix G for details.~~
EVR-7P	All standard system reports must comply with the specifications provided in Appendix G – EVV Standard System Reports.

EVV Proprietary System Specifications

EVV Proprietary System Specifications

Id	EVV Proprietary System Specifications Business Rule
VSS-2P	EVV System must adhere to the accessibility standards contained in state and federal laws and regulations, including Americans With Disabilities Act and Section 508 of the Federal Rehabilitation Act. This includes providing accessibility for System Users, Service Providers and Members with disabilities, such as hearing or visual disabilities (e.g., ability to use a text telephone (TTY) or telecommunication device for the deaf (TDD), or use of interactive voice response (IVR), screen readers, text to speech, etc.).
VSS-4P	EVV System must create a unique profile for individual HHSC and MCO users.
VSS-5P	EVV System must provide read-only access to HHSC and MCO staff to view the same information that the System User can access and view. The EVV System must limit individual MCO access to view only the data of the Members contracted with the MCO.
VSS-23P	The PSO must maintain a mapping of Texas-specific terms to the terms visible to users in the EVV System User Interface (UI). Refer to Appendix K for a list of Texas-EVV specific terms.
VSS-9P	The PSO must establish an Issue Resolution Process. The process must include PSO steps to respond to and resolve any complaints or issues with product(s) or service(s) as well as Root Cause Analysis and Corrective Action (RCCA) information. The RCCA must include the following at a minimum: • steps to prevent re-occurrence • the number of Members affected by the issue • impacted stakeholders including MCOs and HHSC
VSS-11P	The PSO must have a documented EVV System change management process in place.
VSS-12P	EVV System must support the requirements in this “HHSC EVV Business Rules for Proprietary Systems” document in their entirety, unless HHSC waived a portion of a rule or an entire rule as not applicable to the PSOs current situation. If that changes in the future, the EVV System must support each waived portion of the rule or the entire rule, as applicable.

Audit Trail & Quality

Id	Audit Trail & Quality Business Rule
VSS-13P	EVV System must maintain an audit trail for all data entered and updated in the EVV System, including the following data at a minimum: • EVV Visit Transaction data elements • Program Provider or FMSAFMSA Business Unit profile • Service Provider profile • Member profile • Prior Authorization/Service Authorization data • Service Schedule, if applicable • System User credentials

System Security

Id	System Security Business Rule
VSS-16P	The PSO must give System Users secure access to the EVV System in a way that creates unique login credentials which allows for the identification of users accessing the EVV System.
VSS-17P	The PSO must disable System User accounts within 24 hours of notification or action taken by the Program Provider or FMSA EVV administrator.
VSS-18P	EVV System must comply with the Health Insurance Portability and Accountability Act (HIPAA) related to physical security and privacy. The PSO must notify HHSC within 24 hours of any privacy breach or suspected breach.
VSS-19P	EVV System must meet secure data standards, especially those related to Confidential and Personal Information to protect it from unauthorized access, use, or disclosure. The PSO must notify HHSC of any breach or suspected breach within 24 hours and follow up with a RCCA.

Operational Readiness

Proprietary System Operator Testing/Preparedness

Id	Proprietary System Operator Testing/Preparedness Business Rule
OPR-1P	EVV System must successfully execute an Operational Readiness Review conducted by HHSC or its designee to confirm adherence to guidelines included in this document prior to participation in the Texas Medicaid EVV program.
OPR-2P	EVV System must conduct and successfully execute a Trading Partner Testing process with MES service providers and the EVV Aggregator prior to implementing any system modification impacting these entities.

Glossary

The terms defined in this glossary, when used in this document, have the following meanings.

Acronym/Term	Definition
Alternative Device	HHSC-approved electronic device provided at no cost by an EVV Vendor that allows the Service Provider or CDS Employee to clock in and clock out of the EVV System from the Member's home. The alternative device produces codes or information that display the precise date and time service delivery begins and ends.
Auto-Verified	EVV Visit Transactions that match a planned Schedule, include all required data elements, and have no exceptions; or EVV Visit Transactions with no planned Schedule that include all required data elements and have no exceptions. Refer to Appendix P for Auto-verification specifications.
Bill Hours	This refers to EVV_PAYHOURS in the EVV Visit Transaction file, calculated as the difference between the electronically captured EVV_CALLOUTTIME and the electronically captured EVV_CALLINTIME rounded to the nearest quarter hour increment. May be downward adjusted; used to bill the associated claim.
Business Unit	A distinct entity within a Program Provider or FMSA, as identified by a unique National Provider Identifier (NPI) or Atypical Provider Identifier (API), that will submit EVV Visit Transactions to the EVV Aggregator.
Call Matching Window	A visit maintenance reduction feature only applicable to the Daily Variable Schedule Type and when enabled allows the duration of an EVV visit to match to the Scheduled Visit Duration within a 24-hour time period, therefore not creating an alert to the System User.
CDS	Consumer Directed Services. A service delivery option in which a Member or Legally Authorized Representative employs and retains Service Providers and directs the delivery of program Services. This is an option given to Members to coordinate their Texas Medicaid program services.
CDS Employee	A Service Provider aged 18 years or older who meets eligibility requirements of the Member's program, is not prohibited by relationship from being a CDS Employee and delivers services to the Member as directed by the CDS Employer.
CDS Employer	An adult Member with no legally appointed guardian who is receiving services; or the parent or guardian of a minor Member, the Legally Authorized Representative (LAR) of a Member, or a foster parent authorized by DFPS to be the CDS Employer, who coordinates the Member's services within the Texas Medicaid program.
Confirmed EVV Visit Transaction	EVV Visit Transaction to which the System User has completed visit maintenance or otherwise verified.
Contracted Provider	A Program Provider or FMSA that is contracted by the State of Texas to provide Fee For Service (FFS) EVV services in Texas.

Acronym/Term	Definition
Daily Fixed Schedule	A Schedule Type in the EVV System that a System User may choose to plan Member Service visits. This Schedule Type allows Auto-verification of an EVV Visit Transaction on the Scheduled Visit Date when the clock in time matches the scheduled begin time within 7 minutes or less and the clock out time matches the scheduled end time within 7 minutes or less. The Daily Fixed Schedule does not use a Call Matching Window. The System User can use this Schedule Type in conjunction with other Visit Maintenance Reduction Options.
Daily Variable Schedule	A Schedule Type in the EVV System that a System User may choose to plan Member Service Visits. This Schedule Type allows Auto-verification of an EVV Visit Transaction when the Visit occurs within the Call Matching Window on the Scheduled Visit Date and the Visit Duration (rounded actual hours) matches the Scheduled Visit Duration on the Schedule. The System User can use this Schedule Type in conjunction with other Visit Maintenance Reduction Options.
Daylight Savings Time (DST)	Daylight Savings Time (DST) is the practice of advancing standard time by one hour in the spring ("spring forward") of each year and of setting it back by one hour in the fall ("fall back") to gain an extra period of daylight during the early evening.
Designated Representative (DR)	A willing adult appointed by the CDS Employer to assist with or perform the CDS Employer's required responsibilities to the extent approved by the CDS employer.
Electronic Visit Verification (EVV)	Electronic documentation and verification of Service delivery to a Member through an EVV System.
EVV Aggregator	A centralized database that collects, validates, and stores statewide EVV visit data transmitted by the EVV System(s).
EVV Allowed Geo-perimeter	A 250-foot perimeter around the Member Home Geo-location.
EVV Proprietary System	An HHSC-approved EVV System that a Program Provider or FMSA may opt to use instead of an EVV vendor system from the state vendor pool, that: (A) is purchased or developed by a Program Provider or FMSA; (B) is used to exchange EVV information with the EVV Aggregator (C) complies with the requirements of Texas Government Code §531.024172 or its successors.
EVV Reason Code	A standardized, HHSC-approved three-digit number and associated description used during Visit Maintenance to explain the specific reason a System User made a change to an EVV Visit Transaction.
EVV System	Electronic Visit Verification system that: (A) allows a service provider to electronically report: (i) the service recipient's identity; (ii) the service provider's identity; (iii) the date and time the service provider begins and ends the delivery of services; (iv) the Service Delivery Location; and (v) tasks performed by the service provider

Acronym/Term	Definition
	The system includes applications and tools used to clock in/clock out such as toll-free numbers, interactive voice response applications, mobile methods, and web applications. The system also includes mechanisms to complete Visit Maintenance and interact with the EVV Aggregator.
EVV Visit Transaction	A complete, verified visit consisting of all required data elements (visit data and identification data) needed to verify a service delivery visit. EVV Visit Transactions can receive any of the following statuses: • Unsubmitted – visit received by the EVV System but not yet transmitted to the EVV Aggregator. • Submitted – visit received by the EVV System and transmitted to the EVV Aggregator but which the EVV Aggregator has not returned as accepted or rejected. • Accepted – visit submitted to the EVV Aggregator from an HHSC-approved EVV System and has successfully passed the EVV Aggregator validation edits. • Rejected – visit submitted to the EVV Aggregator from an HHSC-approved EVV System that the EVV Aggregator did not accept because it did not pass the EVV Aggregator validation edits.
FMSA	Financial Management Services Agency is an entity that contracts with HHSC or an MCO to provide financial management services to a Member, CDS Employer or Designated Representative.
Geo-Location	Geographic location as determined by the GPS (latitude/longitude) coordinates.
GPS	Global Positioning System (GPS) is a satellite-based navigation system used to determine an exact location in latitude/longitude coordinates.
GUI	Graphical User Interface. A term used in the Texas Medicaid EVV program to identify manually entered EVV Visit Transactions using an EVV System.
HCPCS	Healthcare Common Procedure Coding System is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).
HHSC	Texas Health and Human Services Commission. When used in this document, the term also refers to HHSC's designees, identified by HHSC as needed, on a case-by-case basis.
HHSC EVV Policy	A set of HHSC standards for organizations to adhere to regarding the EVV program. HHSC EVV policy documents are posted on the HHSC EVV website.
IVR	Interactive Voice Response
Legally Authorized Representative (LAR)	A natural parent, legal/adopted parent, stepparent and/or a court-appointed guardian of a Member, or the legally appointed guardian of a Member of any age.
MCO	Managed Care Organization. An entity that contracts with the State of Texas to provide health benefits and additional services and accepts a set capitation payment per Member, per month, for such services.

Acronym/Term	Definition
Member	A person enrolled in Medicaid FFS (Individual) or MCO (Member) and receiving services through Texas Medicaid.
Member Home	The physical address where a Member who receives EVV services resides, which aligns with the address on file with Medicaid.
MES service providers	The MES service providers are a group of contractors charged with administering Texas Medicaid and other state health-care programs on behalf of the Texas Health and Human Services Commission.
Optional Automatic Downward Adjustment	A visit maintenance reduction solution offered to System Users for use with Schedules whereby the EVV System will downward adjust Bill Hours by .25 to match the planned scheduled hours, so the EVV System can still consider the visit a match to the Schedule, therefore not creating an alert to the System User. The EVV System must only allow System Users to apply this feature to the Daily Variable Schedule and the Daily Fixed Schedule Types.
Optional Expanded Time for Auto-Verification	A visit maintenance reduction solution offered to System Users for use with Schedules whereby the EVV System expands the auto-verified time frame by .25 rounded Bill Hours (22 minutes) so the EVV System can still consider the Visit a match to the Schedule, therefore not creating an alert to the System User. The EVV System must only allow System Users to apply this feature to the Daily Variable Schedule and the Daily Fixed Schedule Types.
Pending Visit	An EVV Visit Transaction that the EVV System has not confirmed and has not submitted to the EVV Aggregator.
Program Provider	An entity that contracts with HHSC or an MCO to provide an EVV service.
Proprietary System Operator	A Program Provider or FMSA that uses an EVV Proprietary System to meet HHSC EVV Business Rules for Proprietary Systems.
RCCA	Root Cause Analysis and Corrective Action (RCCA) is a process where the Proprietary System Operator reviews and analyzes an incident or deficiency to determine root cause. Corrective action defines the actions put in place to prevent re-occurrence.
Recurring	Indicates the planned service delivery event (Scheduled Visit) is to occur on a regular basis for a prescribed number of days or weeks.
Remaining Weekly Scheduled Hours	The number of hours that are available for Visit Auto-verification within a Weekly Variable Schedule after decrementing the Bill Hours of Visits that Auto-verify against the Weekly Variable Schedule and applying adjustments made by the System User to the Bill Hours of Auto-verified Visits.
Schedule	Planned time recorded in the EVV System when the service delivery (EVV visit) is to occur.
Schedule Type	A distinct method the System User can choose for planning future Member visits in the EVV System. Schedule Types include Daily Variable Schedule, Daily Fixed Schedule, and Weekly Variable Schedule.
Scheduled Visit Date	The date the System User scheduled the Service Provider to perform Services for the Member. The System User enters the Scheduled Visit Date into the EVV System prior to a Visit as part of

Acronym/Term	Definition
	a Daily Fixed Schedule or Daily Variable Schedule. Recorded as VISIT_VISITDATE in the EVV Visit Transaction.
Scheduled Visit Duration	The amount of time the System User scheduled the Service Provider to spend performing Services for the Member. The System User enters the Scheduled Visit Duration into the EVV System prior to a Visit as part of a Daily Fixed Schedule or Daily Variable Schedule. Recorded as VISIT_VISITHOURS in the EVV Visit Transaction.
Schedule Maintenance	Actions performed by a System User to adjust a Scheduled Visit or Visits in the EVV System.
Service	An in-home personal care service or home health care service required to use EVV as identified in Appendix B EVV Bill Code Services Table.
Service Authorization	Documentation of the Services a payer authorized for a Member, including the authorized units for the Services, the Program Provider or FMSA authorized to provide the Services, the bill codes for the Service and the effective dates during which the payer has authorized the Service. May be known by other names such as “prior authorization” in some Medicaid programs.
Service Delivery Location	The physical location where the Member received EVV services during a scheduled or unscheduled visit. See Appendix J for allowable values.
Service Provider	The person employed by the Program Provider or CDS Employer to deliver services directly to the Member.
Subcontracted Provider	An agency or individual contracted by a Program Provider or FMSA to provide EVV Services in Texas.
System User	An individual who the program provider or FMSA has authorized to have access to the Proprietary System. The individual can be a program provider or FMSA or CDS Employer or Subcontract Provider. CDS Employer
Texas EVV Service Attendant Identification Number	A unique identifier generated by the EVV System for each Service Provider. The number should be the last 4 digits of the Service Provider SSN or passport number plus Service Provider last name.
Total Weekly Scheduled Hours	The total hours scheduled by the System User for a Member Service on a Weekly Variable Schedule.
Visit	Electronic documentation of a completed EVV service delivery event.
Visit Approval	The process the System User (CDS Employer or FMSA) uses to confirm that the CDS Employee time worked in the EVV system accurately reflects the delivery of Services.
Visit Date	The calendar date when (MMDDYYYY) the Service Provider delivers Services to the Member.
Visit Duration	The total time a Service Provider spends with a Member during a service delivery Visit.

Acronym/Term	Definition
Visit Maintenance	The action the System User takes to create a Visit or correct data elements in an EVV Visit Transaction to accurately reflect Service delivery.
Visit Maintenance Time Frame	The number of days from the Visit Date when the System User can complete Visit Maintenance according to HHSC EVV Policy.
Weekly Variable Schedule	A Schedule Type in the EVV System that the System User may choose to plan Member Services for a set number of Service hours over the course of a 7-calendar day period (Sunday through Saturday). This Schedule Type will Auto-verify a Visit when the Visit is delivered on a date of service between the Weekly Variable Schedule Begin Date and the Weekly Variable Schedule End Date for a Visit Duration not to exceed the Remaining Weekly Scheduled Hours.
Weekly Variable Schedule Begin Date	The start date of a Weekly Variable Schedule set up by a System User for a Member. This is the first date (Sunday) of service during the Weekly Variable Schedule time frame when the EVV System will Auto- verify an EVV Visit Transaction if the Bill Hours of the EVV Visit do not exceed the Total Weekly Scheduled Hours.
Weekly Variable Schedule End Date	The last date of a Weekly Variable Schedule for a Member is set by the EVV System to be seven (7) calendar days from the Weekly Variable Schedule Begin Date. This is the last date of service during the Weekly Variable Schedule time frame when the EVV System will Auto verify an EVV Visit Transactions if the Bill Hours of the EVV Visit do not exceed the Total Weekly Scheduled Hours.

Appendices

Appendix A – HHSC EVV Reason Codes

Electronic Visit Verification

Reason Codes - Effective Jan. 1, 2021

Program providers, Financial Management Services Agencies (FMSAs) and consumer directed services (CDS) employers must select the most appropriate EVV Reason Code Number(s), EVV Reason Code Description option (e.g., A, B, C, etc.), and enter any required free text when completing visit maintenance in the EVV system. All EVV Reason Code Numbers, except EVV Reason Code Number 900, are preferred EVV Reason Code Numbers.

Reason Code	Number	Reason Code Description
Overnight Visit (If applicable)	000	This EVV Reason Code Number is a system-generated reason code used by the EVV system when the EVV system auto-generates a clock out at 11:59 p.m. and a clock in at 12:00 a.m. for overnight visits. This EVV Reason Code Number is not available for program provider, FMSA or CDS employer use.
Service Variation	100	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when service variations occur.
		A - Staff hours worked differ from schedule
		B - Downward adjustment of pay hours
		C - Authorized services provided outside of home
		D - Fill-in for regular attendant
		E - Member agreed or requested staff not work
		F - Attendant failed to show up for work
		G - Confirm visits with no schedule
		H - Overlap visits
		I - Split schedules
		J - In-home respite: used when an in-home respite visit occurs and there is no schedule in the EVV system
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Disaster	130	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when all or part of the scheduled visit could not be delivered due to a natural disaster.

Reason Code	Number	Reason Code Description
		A - Flood
		B - Hurricane
		C - Ice/snowstorm
		D - Tornado
		E - Wildfire
		F - Public Health Disaster
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Emergency	131	The program provider, FMSA or CDS employer will select this reason code when all or part of the scheduled visit could not be delivered due to an emergency with the member. Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system and describe the nature of the emergency.
Alternative Device	200	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when an assigned alternative device could not be used to clock in and/or clock out.
		A - Alt device ordered
		B - Alt device pending placement
		C - Alt device missing
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Mobile Device	201	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when an assigned mobile device could not be used to clock in and/or clock out.
		A - Mobile device ordered
		B - Mobile device pending placement
		C - Mobile device missing
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.

Reason Code	Number	Reason Code Description
Technical Issues	300	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when technical issues prevented staff from clocking in and/or clocking out of the EVV system.
		A – Phone lines not working
		B – Malfunctioning alternative device
		C – Incorrect alternative device value
		D – Incorrect employee ID entered
		E – Incorrect member EVV ID entered
		F – Malfunctioning mobile device/application
		G – Multiple calls for one visit
		H – Reversal of call in/out time
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Landline Not Accessible	400	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when the member's home phone landline was not accessible and prevented staff from clocking in and/or clocking out of the EVV system.
		A - Member does not have home phone
		B - Member phone unavailable
		C - Member refused staff use of phone
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.
Service Suspension	500	The program provider, FMSA or CDS employer will select this EVV Reason Code Number when the member's services are suspended due to a lapse in eligibility.
Other	600	The program provider, FMSA or CDS employer will select this EVV Reason Code Number when an exception cannot be addressed using any other EVV Reason Code Number and EVV Reason Code Description. Free text is required: The program provider, FMSA or CDS employer must explain the reason for using this code and provide any missing clock in or clock out time not electronically captured by the EVV system.

Reason Code	Number	Reason Code Description
Non-Preferred	900	The program provider, FMSA or CDS employer will select this EVV Reason Code Number and the appropriate EVV Reason Code Description when staff have failed to clock in and/or clock out of the EVV system.
		A – Failure to call in
		B – Failure to call out
		C – Failure to call in and out
		D – Wrong phone number
		Free text is required: The program provider, FMSA or CDS employer must provide any missing clock in or clock out time not electronically captured by the EVV system.

Appendix B – EVV Service Bill Codes Table

March 1, 2022 v10.0 Legend

Column Title	Column Description
Claims Code Qualifier	Procedure code for the service used by HCS & TxHmL program providers and FMSAs in the CARE system.
Claims Modifier	A modifier provides how the reporting physician or provider can indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. Used by HCS & TxHmL program providers and FMSAs in the CARE system.
Claims Place of Service	A set of codes used to identify the physical location where services were provided. Used by HCS & TxHmL program providers and FMSAs in the CARE system. **Note: HHSC is only including the claims place of service code 12 (Home Location) because EVV is only required to capture services that require an in-home visit**.
Claims Procedure Code	A collection of codes that represent procedures and services provided to individuals. Used by HCS & TxHmL program providers and FMSAs in the CARE system.
Claims Revenue Code	A revenue code is a code set that groups services into distinct cost centers. Used by HCS & TxHmL program providers and FMSAs in the CARE system.
Effective Date for EVV Claim Denial for No Matching Visit	The begin date (based on date of service) that a claim for an EVV-relevant service will be denied when there isn't an accepted EVV visit transaction that matches the claim. The EVV visit transaction must be accepted in the EVV Portal prior to billing the claim.
End Date for EVV Claim Denial for No Matching Visit	The end date (based on date of service) that a claim for an EVV-relevant service will be denied when there isn't an accepted EVV visit transaction that matches the claim. The EVV visit transaction must be accepted in the EVV Portal prior to billing the claim.
Healthcare Common Procedure Coding System (HCPCS)	A collection of codes that represent procedures and services provided to individuals.
Mod 1-4	A modifier provides how the reporting physician or provider can indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. There can be up to 4 modifiers associated with a HCPCS code.
Payer	The organization that processes the claim for payment or denial. Payers include: The Texas Health and Human Services Commission (HHSC) - Claims are for EVV Acute Care services in Fee-for-Service (FFS) and processed by the Compass21 system on behalf of HHSC. Long-Term Care (LTC) - Organization that processes claims for LTC services in FFS. Managed Care Organization (MCO) - Organization that processes claims for services in Managed Care. By Oct. 1, 2020 all EVV claims for Managed Care services must be submitted to the HHSC-designated system for claims matching. Once the claims matching result is obtained, the claim will be forwarded to the MCO with whom the individual member is enrolled at the time of service delivery for final processing.
Proc Code Qualifier	Procedure code for the service.
Procedure Effective Begin Date	The date when the service billing code became available for use in the Texas Medicaid Program. The date corresponds to the service delivery date, not the claim submission date.
Procedure Effective End Date	The date when the service billing code is no longer to be used. The date corresponds to the service delivery date, not the claim submission date. If the date is 12/31/9999 this means that there is no effective end date.
Program	The name of the program which services are available.
Service	The name of the service.

Column Title	Column Description
Service Code	A code that identifies the LTC service within the program and is only used in the FFS programs for LTC.
Service Group	A code that identifies the LTC program for the service and is only used in the FFS programs for LTC.
Unit Type	The amount of time assigned to a single unit when delivering the service to a member e.g. 15 minute increments, one hour increments.
Units Matched During EVV Claims Matching?	A 'Yes' or 'No' in this column indicates if the number of Units on the EVV-relevant claim is matched to the number of Units on the EVV visit transaction. Some services are not designed for this type of match.

March 1, 2022 v10.0 Acronyms

Acronym	Description
AC	Acute Care
BH	Behavioral Health
C21	Compass 21
CAS	Community Attendant Services
CARE	Client Assignment and Registration
CDS	Consumer Directed Services
CFC	Community First Choice
CLASS	Community Living Assistance and Support Services
CMBHS	Clinical Management for Behavioral Health Services
CMS	Claims Management System
DBMD	Deaf-Blind with Multiple Disabilities
DSA	Direct Services Agency
EVV	Electronic Visit Verification
FC	Family Care
FFS	Fee-for-Service
FFSS	Flexible Family Support Services
FMSA	Financial Management Services Agency
HAB	Habilitation
HCBS-AMH	Home and Community-Based Services–Adult Mental Health
HCPCS	Healthcare Common Procedure Coding System
HCS	Home and Community-based Services
HHSC	Health and Human Services Commission
LOC	Level of Care
LON	Level of Need
LTC	Long-term Care
MCO	Managed Care Organization
MDCP	Medically Dependent Children Program
MMP	Medicare-Medicaid Plan
N/A	Not Applicable
PAS	Personal Assistance Services
PCS	Personal Care Services
PHC	Primary Home Care
RN	Registered Nurse
SRO	Service Responsibility Option
STAR	State of Texas Access Reform
TxHmL	Texas Home Living
YES	Youth Empowerment Services

March 1, 2022 v10.0 Revision History

Effective Dates	Revision Description
6/1/2019 - 7/2/2019	Created for the 6/1/2019 release of the EVV Aggregator.
7/3/2019 - 7/15/2019	Updated based on TMHP SR 6861292.
7/16/2019 - 8/18/2019	Updated for publication on the HHSC EVV Website: - Added columns in orange. - Updated the Unit Match on all CDS and SRO services to reflect a bypass on the claims matching process for units of service due to inconsistencies with other programs. All other critical data elements will be matched.
8/19/2019 - 10/7/2019	**Formatting Changes:** - Added a column 'Bypass Claim Units Match?' to indicate when units are bypassed in the EVV Aggregator claims match. - Removed the column called 'Short Description' since it duplicates the 'Service' column. - Added a tab 'Acronyms' to list acronyms and their descriptions used in the EVV Service Bill Code tables. **Service Changes:** - Updated all LTC CLASS services (Service Group 2) to indicate that units on the claim will not be matched to units on the visit transaction. - Updated HCS/TxHmL service for Respite and Day Habilitation to indicate that claims will not be matched for EVV until new bill codes can be established to distinguish in-home service delivery from out-of-home service delivery. Note: EVV Clock-in and Clock-out is required when these services begin or end in the home. - Corrected an error in the HCPCS/Modifiers for Texas Home Living CFC PAS/HAB CDS service (Service Group 15, Service Code 10CFV).
10/8/2019 - 6/14/2020	**Formatting Changes:** - Added a column 'Bypass EVV Claim Match and Apply EVV07?' to indicate when the EVV claims matching process is bypassed in the EVV Aggregator (EVV Claims Match Result Code EVV07). **Service Changes:** - Updated the EVV Aggregator Claims Match Begin Effective Date for all programs, services, and service delivery options affected by the 21st Century Cures Act due to the delayed EVV start date from 1/1/2020 to 1/1/2021. - Updated all LTC CLASS (Service Group 2) and LTC DBMD (Service Group 16) services to indicate these services are bypassing EVV units matching in the EVV Aggregator claims match. - Updated LTC CLASS CFC PAS/HAB service (Service Group 2, Service Code 10CFC T2026) column 'Bypass EVV Claim Match and Apply EVV07' to a yes to indicate that this service is bypassing EVV claims matching in the EVV Aggregator until new bill codes can be established to distinguish between EVV services and non-EVV services. Note: When billing for EVV services, an EVV Clock-in and Clock-out is required when services begin and/or end in the home. This bypass will avoid unnecessary EVV claim denials due to an EVV visit transaction never having been created for a non-EVV service. This is a temporary solution until new billing codes can be created to distinguish between EVV-required and non-EVV required services. - Updated LTC DBMD CFC PAS/HAB service (Service Group 16, Service Code 10CFC T2026) column 'Bypass EVV Claim Match and Apply EVV07' to a yes to indicate that this service is bypassing EVV claims matching in the EVV Aggregator until new bill codes can be established to distinguish between EVV services and non-EVV services. Note: EVV is not currently required for DBMD. This bypass will avoid unnecessary EVV claim denials due to an EVV visit transaction never having been created for a non-EVV service. This is a temporary solution until new billing codes can be created to distinguish between EVV-required and non-EVV required services. - Updated all LTC HCS (Service Group 12) and TxHmL (Service Group 15) procedure effective end dates from 2/29/2020 to 12/31/9999.

Effective Dates	Revision Description
6/15/2020 - 9/30/2020	**Formatting Changes:** Added new column 'EVV Claim Denial for No Matching Visit Effective Date' to the MCO, C21 AC FFS, CMS LTC FFS, and CARE LTC FFS tabs to indicate the begin date a claim for an EVV-required service will be denied if there isn't an accepted EVV visit transaction in the EVV Portal that matches the claim. Services with an effective date of 12/1/2020 are part of the Cures Act EVV Expansion and included in the EVV Practice Period beginning 7/1/2020 and ending 11/30/2020. See the TMHP article for more information about the practice period: http://www.tmhp.com/News_Items/2020/05-May/05-26-20%20Cures%20Act%20EVV%20The%20EVV%20Practice%20Period%20Begins%20July%201.pdf. Added new tab 'CARE LTC FFS EVV Services' to include HCS & TxHmL program services requiring EVV beginning 12/1/2020. Added new column 'Effective Date for EVV Claim Denial for No Matching Visit' to the MCO, C21 AC FFS, CMS LTC FFS, and CARE LTC FFS tabs to indicate the begin date a claim for an EVV-required service will be denied if there isn't an accepted EVV visit transaction in the EVV Portal that matches the claim. Renamed column 'Bypass Claim Units Match' to 'Units Matched During EVV Claims Matching?' to clarify when units on the claim are matched to units on the EVV visit transaction during the EVV claims matching process. The following columns have been removed from the MCO, C21 AC FFS, and CMS LTC FFS tabs: Unit Conversion Factor EVV Aggregator Claims Match Begin Effective Date EVV Aggregator Claims Match Begin Effective End Date Bypass EVV Claim Match and Apply EVV07? Bill Code Changed for 9/1/2019? EVV Service (Required or Optional) for 9/1/2019? EVV Services Required Starting 1/1/2021? Note: New column 'Effective Date EVV Claim Denial for No Matching Visit' has replaced this column and the date has been updated to align with the HHSC Cures Act EVV Expansion timeline. See the HHSC Cures Act EVV webpage for more information https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/21st-century-cures-act. In the 'Revision History' tab, replaced the 'Version' column with 'Effective Dates'. Minor changes to font size and color. **Service Changes:** Updated the following services to indicate units on the claim will be matched to units on the EVV visit transaction during the EVV claims matching process: Long-Term Care Services: CLASS CFC PAS/HAB (Service Group 2, Service Code 10CFC) DBMD CFC PAS/HAB (Service Group 16, Service Code 10CFC) Updated the following services to indicate units on the claim will not be matched to units on the EVV visit transaction during the EVV claims matching process: Acute Care Services: HCBS-AMH Supported Home Living (HCPCS S5130) YES Waiver Respite (In-Home) (HCPCS T2027) Long-Term Care Services: HCS CFC PAS/HAB (Service Group 12, Service Code 10CFC) TxHmL CFC PAS/HAB (Service Group 15, Service Code 10CFC) Added LTC CAS SRO service (Service Group 7, Service Code 17DS) because this service will require EVV by Dec. 1, 2020, but was not included in the previous version of the bill code table.

Effective Dates	Revision Description
10/1/2020	**Formatting Changes:** Certain program and service names were updated in all applicable tabs to be more consistent with the "EVV-Required Programs, Services, and Service Delivery Options" document on the HHS EVV webpage at: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification#programs-and-services-required-to-use-evv CMBHS was added to the 'C21 AC FFS EVV Services' tab. The STAR+PLUS/MMP bill codes with an 'Effective End Date' of 8/31/2019 were removed from the 'MCO EVV Services' tab. The 'Effective Date for EVV Claim Denial for No Matching Visit' was corrected for LTC CLASS CFC PAS/HAB (Service Group 2, Service Code 10CFC T2026) and In-Home Respite (Service Group 2, Service Code 11 G0100) from 11/1/2019 to 12/1/2020. The 'Claims Place of Service' column in the 'CARE LTC FFS EVV Services' tab was updated to only display the code relevant to EVV services: 12 (Home Location). This change was made because EVV is only required to capture services that require an in home visit. **Service Changes:** Effective Oct. 1, billed units on claims for the following EVV-required services will be matched to the billable units on the EVV visit transaction during the EVV claims matching process: All services delivered through the service responsibility option listed in the 'MCO EVV Services' tab; LTC CAS Personal Attendant Services - Level 1 and Level 2 (Service Group 7, Service Code 17DS G0755 and G0756); and LTC CLASS CFC PAS/HAB (Service Group 2, Service Code 10CFC T2026). The 'Units Matched During EVV Claims Matching?' columns in the 'MCO EVV Services' and 'CMS LTC FFS EVV Services' tabs were updated to 'Yes' to indicate this change. Program providers and FMSAs can practice units matching on EVV claims during the Cures Act EVV practice period and these claims will not be denied for an EVV mismatch. The practice period ends on Nov. 30. Read more about the practice period at
11/9/2020	**Formatting Changes:** The service names in the 'CARE LTC FFS EVV Services' tab for Day Habilitation and In-Home Respite in the HCS program were updated to match the HCS and TxHmL Bill Code Crosswalk. Additional information has been added to the bottom of the table noting that for HCS these services only require EVV when provided in own home or family home settings. The Claims Place of Service column in the 'CARE LTC FFS EVV Services' tab for CFC PAS/HAB added the community setting locations which require EVV. **Service Changes:** The Effective Date for EVV Claim Denial for No Matching Visit has been updated for services impacted by the Cures Act expansion to reflect the extension of the new EVV implementation date to Jan. 1, 2021. More information is available in the Cures Act EVV Practice Period Extended Through Dec 31 article on the HHS EVV webpage at https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification.

Effective Dates	Revision Description
5/1/2021	**Service Changes:** HCBS-AMH In Home Respite Unit type changed from Per Day to Per 15 Min Change HCPCS from S9125 (Respite care, in the home, per diem) to T1005 (Respite care services, up to 15 minutes) No change to HK and HE modifiers HCBS-AMH Supported Home Living - Habilitative Support Unit type changed from Per Hour to Per 15 Min No change to HCPCS S5130 (Homemaker service, nos; per 15 minutes) No change to HK and HE modifiers
11/1/2021	**Service Changes:** **Add to STAR Health PCS** New service combination T1019 UA (PCS BH Condition - Agency Model) New service combination T1019 U7 (PCS - CDS Model) New service combination T1019 UB (PCS BH Condition - CDS Model) **Remove from STAR Health PCS** T1019 UA, U6 (PCS BH Condition - Agency Model) T1019 UC (PCS - CDS Model) T1019 UA, UC (PCS BH Condition - CDS Model)

Effective Dates	Revision Description
3/1/2022	**Version 10.0 Service Changes:** **Updates to CARE LTC FFS Services table:** Ended HCS (Service Group 12) and TxHmL (Service Group 15) services effective 4/30/2022. Added a new column for End Date for EVV Claim Denial for No Matching Visit to reflect that Service Group 12 and Service Group 15 claims will not be denied for an EVV mismatch for dates of services after 2/28/2022.* *Program providers and FMSAs may view informational claims matching results in the EVV Portal for dates of service 3/1/2022 - 4/30/2022. **Updates to CMS LTC FFS Services table:** Added HCS (Service Group 21) and TxHmL (Service Group 22) services effective 3/1/2022. The following services include new Code Qualifier, HCPCS, Modifiers: HCS CDS Hourly Respite - LC 1, 8 - In-Home TxHmL CDS Day Habilitation - LC 1 - In-Home TxHmL CDS Hourly Respite - LC 1 - In Home The following services include an updated Unit Type (per 15 min): HCS CFC PAS/HAB - LOC 1, 8 HCS Hourly Respite - LC 1, 8 - In-Home TxHmL CFC PAS/HAB TxHmL Hourly Respite - LC 1 - In-Home The following services include an Effective Date for EVV Claim Denial for No Matching Visit of 6/1/2022*: HCS Day Habilitation - LN 1, 5, 6, 8 ,9 - In-Home HCS CFC PAS/HAB - LOC 1, 8 HCS CDS CFC PAS/HAB - LOC 1, 8 HCS Hourly Respite - LC 1, 8 - In-Home HCS CDS Hourly Respite - LC 1, 8 - In-Home TxHmL Day Habilitation - LC 1 - In-Home TxHmL CDS Day Habilitation - LC 1 - In-Home TxHmL CFC PAS/HAB TxHmL Hourly Respite - LC 1 - In-Home TxHmL CDS Hourly Respite - LC 1 - In Home *Program providers and FMSAs may view informational claims matching results in the EVV Portal for dates of service 5/1/2022 - 5/31/2022 Updates to the Legend Tab: Updated column description for: Effective Date for EVV Claim Denial for No Matching Visit Added new column title and column description for End Date for EVV Claim Denial for No Matching Visit

EVV Service Bill Codes - March 1, 2022 v10.0 Managed Care

Payer	Program	Service	Proc Code Qualifier	HCPCS	mod 1	mod 2	mod 3	mod 4	Unit Type	Units Matched During EVV Claims Matching?	Procedure Effective Begin Date	Procedure Effective End Date	Effective Date for EVV Claim Denial for No Matching Visit
MCO	STAR Health, STAR Kids	CFC HAB - Agency Model	HC	T1019	U9				per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	CFC HAB - CDS Model	HC	T1019	U4				per 15 min	No	3/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	CFC HAB - SRO Model	HC	T1019	U2				per 15 min	Yes	3/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	CFC PCS Only - Agency Model	HC	T1019	UD				per 15 min	Yes	3/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	CFC PCS Only - CDS Model	HC	T1019	U3				per 15 min	No	3/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	CFC PCS Only - SRO Model	HC	T1019	U1				per 15 min	Yes	3/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant - Agency Model	HC	H2015	99	U1			per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant - CDS Model	HC	H2015	99	U1	UC		per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant - SRO Model	HC	H2015	99	U1	US		per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant with RN Delegation - Agency Model	HC	H2015	99	U1	UA		per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant with RN Delegation - CDS Model	HC	H2015	99	U1	UA	UC	per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant with RN Delegation - SRO Model	HC	H2015	99	U1	UA	US	per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant - Agency Model	HC	H2015	U1				per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant - CDS Model	HC	H2015	U1	UC			per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant - SRO Model	HC	H2015	U1	US			per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant with RN Delegation - Agency Model	HC	H2015	U1	UA			per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant with RN Delegation - CDS Model	HC	H2015	U1	UA	UC		per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant with RN Delegation - SRO Model	HC	H2015	U1	UA	US		per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	PCS - Agency Model	HC	T1019	U6				per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Kids	PCS - CDS Model	HC	T1019	UC				per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health	PCS - CDS Model	HC	T1019	U7				per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	PCS - SRO Model	HC	T1019	US				per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Kids	PCS, BH Condition - Agency Model	HC	T1019	UA	U6			per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health	PCS, BH Condition - Agency Model	HC	T1019	UA				per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Kids	PCS, BH Condition - CDS Model	HC	T1019	UA	UC			per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health	PCS, BH Condition - CDS Model	HC	T1019	UB				per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	PCS, BH Condition - SRO Model	HC	T1019	UA	US			per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC HAB - Agency Model (HCBS)	HC	T2017	U3	U7			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	CFC HAB - Agency Model (Non-HCBS)	HC	T2017	U5	U7			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	CFC HAB - CDS Model (HCBS)	HC	T2017	U3	UC	U7		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC HAB - CDS Model (Non-HCBS)	HC	T2017	U5	UC	U7		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC HAB - SRO Model (HCBS)	HC	T2017	U3	UD	U7		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC HAB - SRO Model (Non-HCBS)	HC	T2017	U5	UD	U7		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC PAS - Agency Model (HCBS)	HC	S5125	U3	U7			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	CFC PAS - Agency Model (Non-HCBS)	HC	S5125	U5	U7			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	CFC PAS - CDS Model (HCBS)	HC	S5125	U3	UC	U7		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC PAS - CDS Model (Non-HCBS)	HC	S5125	U5	UC	U7		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC PAS - SRO Model (HCBS)	HC	S5125	U3	UD	U7		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	CFC PAS - SRO Model (Non-HCBS)	HC	S5125	U5	UD	U7		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	In-Home Respite - Agency Model (HCBS)	HC	T1005	U3				per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	In-Home Respite - CDS Model (HCBS)	HC	T1005	U3	UC			per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	In-Home Respite - SRO Model (HCBS)	HC	T1005	U3	UD			per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	PAS - Agency Model (HCBS)	HC	S5125	U3				per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	PAS - Agency Model (Non-HCBS)	HC	S5125	U5				per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	PAS - CDS Model (HCBS)	HC	S5125	U3	UC			per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	PAS - CDS Model (Non-HCBS)	HC	S5125	U5	UC			per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	PAS - SRO Model (HCBS)	HC	S5125	U3	UD			per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	PAS - SRO Model (Non-HCBS)	HC	S5125	U5	UD			per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	Protective Supervision - Agency Model (HCBS)	HC	S5125	U3	U1			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/MMP	Protective Supervision - CDS Model (HCBS)	HC	S5125	U3	UC	U1		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/MMP	Protective Supervision - SRO Model (HCBS)	HC	S5125	U3	UD	U1		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021

EVV Service Bill Codes - March 1, 2022 v10.0 Acute Care Fee-for-Service

Payer	Program	Service	Proc Code Qualifier	HCPCS	mod 1	mod 2	mod 3	mod 4	Unit Type	Units Matched During EVV Claims Matching?	Procedure Effective Begin Date	Procedure Effective End Date	Effective Date for EVV Claim Denial for No Matching Visit
HHSC	CFC	CFC - HAB (Non-FMSA)	HC	T1019	U9				per 15 min	Yes	6/1/2015	12/31/9999	11/1/2019
HHSC	CFC	CFC - HAB CDS (FMSA)	HC	T1019	U4				per 15 min	No	6/1/2015	12/31/9999	1/1/2021
HHSC	CFC	CFC - PCS Only (Non-FMSA)	HC	T1019	UD				per 15 min	Yes	6/1/2015	12/31/9999	11/1/2019
HHSC	CFC	CFC - PCS Only CDS (FMSA)	HC	T1019	U3				per 15 min	No	6/1/2015	12/31/9999	1/1/2021
HHSC	HCBS-AMH	In-Home Respite	HC	S9125	HK	HE			per day	No	8/1/2016	4/30/2021	1/1/2021
HHSC	HCBS-AMH	In-Home Respite	HC	T1005	HK	HE			per 15 min	No	5/1/2021	12/31/9999	5/1/2021
HHSC	HCBS-AMH	Supported Home Living - Habilitative Support	HC	S5130	HK	HE			per hour	No	8/1/2016	4/30/2021	1/1/2021
HHSC	HCBS-AMH	Supported Home Living - Habilitative Support	HC	S5130	HK	HE			per 15 min	No	5/1/2021	12/31/9999	5/1/2021
HHSC	PCS	PCS (non-FMSA)	HC	T1019	U6				per 15 min	Yes	9/1/2015	12/31/9999	11/1/2019
HHSC	PCS	PCS - CDS (FMSA)	HC	T1019	U7				per 15 min	No	9/1/2015	12/31/9999	1/1/2021
HHSC	PCS	PCS BH Condition (non-FMSA)	HC	T1019	UA				per 15 min	Yes	9/1/2011	12/31/9999	11/1/2019
HHSC	PCS	PCS BH Condition - CDS (FMSA)	HC	T1019	UB				per 15 min	No	9/1/2011	12/31/9999	1/1/2021
HHSC	YES	In-Home Respite	HC	T2027	U9				per 15 min	No	6/30/2010	12/31/9999	1/1/2021

EVV Service Bill Codes - March 1, 2022 v10.0 Long-term Care Fee-for-Service

Payer	Program	Service	Proc Code Qualifier	HCPCS	mod 1	mod 2	mod 3	mod 4	Unit Type	Units Matched During EVV Claims Matching?	Procedure Effective Begin Date	Procedure Effective End Date	Service Group	Service Code	Effective Date for EVV Claim Denial for No Matching Visit
LTC	CAS	Personal Attendant Services (1929B) - Level 1, 2	HC	S5125					per hour	Yes	10/16/2003	12/31/2199	7	17D	11/1/2019
LTC	CAS	Personal Attendant Services (1929B) - Level 1 (Non-Priority) - CDS	ER	G0749					per $1	No	1/1/1900	12/31/2199	7	17DV	1/1/2021
LTC	CAS	Personal Attendant Services Level 1 (Non-Priority) - SRO	ER	G0756					per hour	Yes	1/2/2006	12/31/2199	7	17DS	1/1/2021
LTC	CAS	Personal Attendant Services (1929B) - Level 2 (Priority) - CDS	ER	G0748					per $1	No	1/1/1900	12/31/2199	7	17DV	1/1/2021
LTC	CAS	Personal Attendant Services Level 2 (Priority) - SRO	ER	G0755					per hour	Yes	1/2/2006	12/31/2199	7	17DS	1/1/2021
LTC	CLASS	CFC PAS/HAB	HC	T2026					per hour	Yes	6/1/2015	12/31/2199	2	10CFC	1/1/2021
LTC	CLASS	CFC PAS/HAB - CDS	HC	T2016					per $1	No	6/1/2015	12/31/2199	2	10CFV	1/1/2021
LTC	CLASS	In-Home Respite - DSA	ER	G0100					per day	No	1/1/1900	12/31/2199	2	11	1/1/2021
LTC	CLASS	In-Home Respite - CDS	HC	S9125					per $1	No	3/1/2008	12/31/2199	2	11PV	1/1/2021
LTC	DBMD	CFC PAS/HAB	HC	T2026					per hour	Yes	6/1/2015	12/31/2199	16	10CFC	1/1/2021
LTC	DBMD	CFC PAS/HAB - CDS	HC	T2016	UC				per $1	No	6/1/2015	12/31/2199	16	10CFV	1/1/2021
LTC	DBMD	In-Home Respite	ER	G0100					per day	No	1/1/1900	12/31/2199	16	11	1/1/2021
LTC	DBMD	In-Home Respite - CDS	HC	S9125					per $1	No	12/01/2008	12/31/2199	16	11PV	1/1/2021
LTC	FC	Personal Attendant Services	HC	S5125					per hour	Yes	10/16/2003	12/31/2199	7	17C	11/1/2019
LTC	FC	Personal Attendant Services - Level 1 (Non-Priority) - CDS	ER	G0746					per $1	No	1/1/1900	12/31/2199	7	17CV	1/1/2021
LTC	FC	Personal Attendant Services - Level 2 (Priority) - CDS	ER	G0745					per $1	No	1/1/1900	12/31/2199	7	17CV	1/1/2021
LTC	PHC	Personal Attendant Services - Level 1, 2	HC	S5125					per hour	Yes	10/16/2003	12/31/2199	7	17	11/1/2019
LTC	PHC	Personal Attendant Services - CDS	HC	S5125	UB				per $1	No	6/1/2015	12/31/2199	7	17V	1/1/2021
LTC	HCS	Day Habilitation - LN 1, 5, 6, 8 ,9 - In-Home	HC	T2020					per day	No	3/1/2022	12/31/2199	21	10C	6/1/2022
LTC	HCS	CFC PAS/HAB - LOC 1, 8	HC	T2016					per hour	No	3/1/2022	12/31/2199	21	10CFC	6/1/2022
LTC	HCS	CDS CFC PAS/HAB - LOC 1, 8	HC	T2016	UC				per $1	No	3/1/2022	12/31/2199	21	10CFV	6/1/2022
LTC	HCS	Hourly Respite - LC 1, 8 - In-Home	HC	S5150					per hour	No	3/1/2022	12/31/2199	21	11X	6/1/2022
LTC	HCS	CDS Hourly Respite - LC 1, 8 - In-Home	HC	S9125					per $1	No	3/1/2022	12/31/2199	21	11XV	6/1/2022
LTC	TxHmL	Day Habilitation - LC 1 - In-Home	HC	T2020					per day	No	3/1/2022	12/31/2199	22	10C	6/1/2022
LTC	TxHmL	CDS Day Habilitation - LC 1 - In-Home	HC	T2020	UC				per $1	No	3/1/2022	12/31/2199	22	10CV	6/1/2022
LTC	TxHmL	CFC PAS/HAB	HC	T2016					per hour	No	3/1/2022	12/31/2199	22	10CFC	6/1/2022
LTC	TxHmL	CDS CFC PAS/HAB	HC	T2016	UC				per $1	No	3/1/2022	12/31/2199	22	10CFV	6/1/2022
LTC	TxHmL	Hourly Respite - LC 1 - In-Home	HC	S5150					per hour	No	3/1/2022	12/31/2199	22	11X	6/1/2022
LTC	TxHmL	CDS Hourly Respite - LC 1 - In Home	HC	S9125					per $1	No	3/1/2022	12/31/2199	22	11XV	6/1/2022

More Information for HCS Day Habilitation and Respite
EVV is only required for HCS Day Habilitation and HCS Respite when services are provided in own home or family home settings.

EVV Service Bill Codes - March 1, 2022 v10.0 HCS and TxHmL Long-term Care Fee-for-Service															
Payer	**Program**	**Service**	**Claims Code Qualifier**	**Claims Procedure Code**	**Claims Modifier**	**Claims Revenue Code**	**Claims Place of Service**	**Unit Type**	**Units Matched During EVV Claims Matching?**	**Procedure Effective Begin Date**	**Procedure Effective End Date**	**Service Group**	**Service Code**	**Effective Date for EVV Claim Denial for No Matching Visit**	**End Date for EVV Claim Denial for No Matching Visit**
LTC	HCS	CFC PAS/HAB - LOC 1, 8	HC	T2016			3, 11, 12, 22, 49, 99	per 15 min	No	6/1/2015	4/30/2022	12	10CFC	1/1/2021	2/28/2022
LTC	HCS	CFC PAS/HAB - LOC 1, 8 - CDS	HC	T2016	UC		3, 11, 12, 22, 49, 99	per $1	No	6/1/2015	4/30/2022	12	10CFV	1/1/2021	2/28/2022
LTC	HCS	Day Habilitation - LON 1, 5, 6, 8, 9	HC	T2020		0942	12	per day	No	9/1/2011	4/30/2022	12	10C	N/A	N/A
LTC	HCS	Hourly Respite LOC 1, 8	HC	S5150		0660	12	per 15 min	No	2/1/2008	4/30/2022	12	11X	N/A	N/A
LTC	HCS	CDS Hourly Respite LOC 1	ZZ	M0145			12	per $1	No	2/1/2008	4/30/2022	12	11XV	N/A	N/A
LTC	HCS	CDS Hourly Respite LOC 8	ZZ	M0146			12	per $1	No	2/1/2008	4/30/2022	12	11XV	N/A	N/A
LTC	TxHmL	CFC PAS/HAB	HC	T2016			3, 11, 12, 22, 49, 99	per 15 min	No	6/1/2015	4/30/2022	15	10CFC	1/1/2021	2/28/2022
LTC	TxHmL	CFC PAS/HAB - CDS	HC	T2016	UC		3, 11, 12, 22, 49, 99	per $1	No	6/1/2015	4/30/2022	15	10CFV	1/1/2021	2/28/2022
LTC	TxHmL	In-Home Day Habilitation - LOC 1	HC	T2020		0942	12	per day	No	2/1/2011	4/30/2022	15	10C	N/A	N/A
LTC	TxHmL	In-Home Day Habilitation - LOC 1 - CDS	ZZ	M0202			12	per $1	No	2/1/2011	4/30/2022	15	10CV	N/A	N/A
LTC	TxHmL	In-Home Respite (Hourly) - LOC 1	HC	S5150		0660	12	per 15 min	No	2/1/2008	4/30/2022	15	11X	N/A	N/A
LTC	TxHmL	In-Home Respite (Hourly) - LOC 1 - CDS	ZZ	M0241			12	per $1	No	2/1/2008	4/30/2022	15	11XV	N/A	N/A

More Information for HCS Day Habilitation and Respite

EVV is only required for HCS Day Habilitation and HCS Respite when services are provided in own home or family home settings.

Appendix C – EVV Visit Transaction File

HHSC Electronic Visit Verification (EVV) Technical Documentation Appendix C - EVV Visit Transaction Layout
Published Date: 02/25/2022 Effective Date: 05/31/2022

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
Header record	1	This header record contains HHSC approved EVV vendor data transfer headers for all extract data elements contained in this file.	0	0	0				
File record	1	PROVIDER_TIN	30	1	30	Varchar			Provider Taxpayer Identification Number: A unique Identifier assigned by the Social Security Administration or Internal Revenue Service (IRS) to a Program Provider or Financial Management Services Agency (FMSA) for tax purposes.
File record	2	PROVIDER_NPI	10	31	40	Varchar			Provider National Provider Identifier (NPI): A Health Insurance Portability and Accountability Act (HIPAA) mandated unique identifier assigned by the Centers for Medicare and Medicaid Services (CMS) to a healthcare Program Provider or Financial Management Services Agency (FMSA).
File record	3	PROVIDER_API	10	41	50	Varchar			Provider Atypical Provider Identifier (API): A unique identifier assigned to a Program Provider or Financial Management Services Agency (FMSA) who does not provide healthcare services (i.e. Respite, transportation). Medicaid or State Issued API number.
File record	4	PROVIDER_TPI	9	51	59	Varchar			Texas Provider Identifier (TPI): A unique identifier assigned by the Claims Administrator to a Program Provider or Financial Management Services Agency (FMSA) delivering Acute Care fee-for-service services in Texas.
File record	5	PROVIDER_LEGALNAME	50	1	50	Varchar			Provider Legal Name: Provider Agency or Financial Management Services Agency (FMSA) legal name.
File record	6	PROVIDER_DBA	50	51	100	Varchar			Provider Doing Business As Name: Program Provider or Financial Management Services Agency (FMSA) Doing Business As name. This is a name that a person or business uses, other than their official name, in order to transact business.
File record	7	PROVIDER_CONTRACTNUMBER	9	101	109	Number			Provider Contract Number: A unique number assigned by HHSC when a Program Provider/FMSA contracts directly with HHSC to provide Long Term Services and Supports (aka Long Term Care) program services.
File record	8	PROVIDER_ADDRESS1	50	110	159	Varchar			Provider Address Line 1: Mailing address for the Program Provider or Financial Management Services Agency (FMSA). This address may be the same for many different office locations.

File record	9	PROVIDER_ADDRESS2	50	160	209	Varchar			Provider Address Line 2: Additional mailing address information for the Program Provider or Financial Management Services Agency (FMSA). This address may be the same for many different office locations.
File record	10	PROVIDER_CITY	50	1	50	Varchar			Provider City: The city where the Program Provider or Financial Management Services Agency (FMSA) address is located.
File record	11	PROVIDER_STATE	2	51	52	Varchar			Provider State: The state where the Program Provider or Financial Management Services Agency (FMSA) address is located.
File record	12	PROVIDER_ZIP	5	53	57	Number			Provider Zip: The zip code for which the Program Provider or Financial Management Services Agency (FMSA) address is located.

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	13	PROVIDER_LOCATIONID	30	58	87	Varchar			Provider Location Identification: A number assigned by the Program Provider or Financial Management Services Agency (FMSA) for a particular physical address from which services are provided.
File record	14	PROVIDER_REGION	2	88	89	Number			HHSC Provider Region: The location of where the Program Provider or Financial Management Services Agency (FMSA) is located. HHSC Medicaid LTC has 11 regions.
File record	15	PROVIDER_EVVEFFDATE	8	90	97	Date	MMDDYYYY		Provider Electronic Visit Verification Effective Date: The date the Program Provider or Financial Management Services Agency (FMSA) became effective in the EVV System. This is the first verified visit date by the Program Provider or FMSA.
File record	16	PROVIDER_EVVENDDATE	8	1	8	Date	MMDDYYYY		Provider Electronic Visit Verification End Date: The date the Program Provider or Financial Management Services Agency (FMSA) terminates from the EVV System.
File record	17	EMPLOYEE_EMPLOYEEID	30	9	38	Varchar			Employee Identification: An identifier assigned to the Service Provider by his or her employer for HR and payroll purposes.
File record	18	EMPLOYEE_SOCSEC_VISA_PASSPORT	54	39	92	Varchar			Employee Social Security Visa Passport: It consists of the last four digits of a Service Provider’s SSN or passport number concatenated with the Service Provider's last name.
File record	19	EMPLOYEE_EMPLOYEEDISCIPLINE	30	93	122	Varchar		Attendant, Nurse, CNA, PT, OT, SLP, Other	Employee Discipline: Credentials of the Service Provider.
File record	20	EMPLOYEE_FIRSTNAME	50	123	172	Varchar			Employee First Name: The Service Provider's first name.
File record	21	EMPLOYEE_LASTNAME	50	173	222	Varchar			Employee Last Name: The Service Provider's last name.
File record	22	EMPLOYEE_EVVID	30	223	252	Varchar			Electronic Visit Verification Identification: The Service Provider EVV System identifier number. This Identifier is assigned by the EVV System.
File record	23	EMPLOYEE_STARTDATE	8	253	260	Date	MMDDYYYY		Employee Start Date: The Service Provider start date. This is the date when the Service Provider became active on the EVV System.
File record	24	EMPLOYEE_ENDDATE	8	261	268	Date	MMDDYYYY		Employee End Date: The Service Provider end date. This is the date when the Service Provider was terminated on the EVV System.
File record	25	EMPLOYEE_EVVUSERID	30	269	298	Varchar			Electronic Visit Verification Identification: This is an account name or login identifier, used by the Service Provider to log onto the EVV System. This is assigned by the EVV System. The EVV User identifier and Password are required credentials for logging onto the EVV System.
File record	26	EMPLOYEE_EVVUSERFIRSTNAME	50	299	348	Varchar			Electronic Visit Verification User First Name: The first name of the person associated with the EVV User ID.
File record	27	EMPLOYEE_EVVUSERLASTNAME	50	349	398	Varchar			Electronic Visit Verification User Last Name: The last name of the person associated with the EVV User ID.
File record	28	EMPLOYEE_CDSEMPLOYEREVVID	30	399	428	Varchar			Consumer Directed Services Employer Electronic Visit Verification Identification: CDS employer identifier (if different from the individual receiving services e.g., a parent or guardian) assigned by the EVV System.
File record	29	EMPLOYEE_CDSEMPLOYERFIRSTNAME	50	429	478	Varchar			Consumer Directed Services Employer First Name: CDS employer first name (if different from the individual receiving services- e.g. a parent or guardian).
File record	30	EMPLOYEE_CDSEMPLOYERLASTNAME	50	479	528	Varchar			Consumer Directed Services Employer Last Name: CDS employer last name (if different from the individual receiving services- e.g. a parent or guardian).

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	31	INDVMBR_PAYOR	4	529	532	Varchar		AGP, BCB, CHS, CKC, CMC, LTC, HHSC, MOL, SHP, UHC	Individual/Member Payor: A unique identifier assigned to the payor, which is obtained through the Payer Plan Code Web Service.
File record	32	INDVMBR_FIRSTNAME	50	533	582	Varchar			Individual/Member First Name: The first name of the individual/member receiving services.
File record	33	INDVMBR_LASTNAME	50	583	632	Varchar			Individual/Member Last Name: The last name of the individual/member receiving services.
File record	34	INDVMBR_MEDICAIDID	9	633	641	Varchar			Invoice Individual/Member Medicaid Identification: The individual's/member's Medicaid ID number.
File record	35	INDVMBR_MEMBERDOB	8	642	649	Date	MMDDYYYY		Individual/Member Date of Birth: The individual's/member's date of birth.
File record	36	INDVMBR_MEMBEREVVID	30	650	679	Varchar			Individual/Member Electronic Visit Verification Identification: The individual /member's EVV System identifier number. This identifier is assigned by the EVV System.
File record	37	INDVMBR_STARTDATE	8	680	687	Date	MMDDYYYY		Individual/Member Start Date: The start date of when the individual/member became Medicaid eligible.
File record	38	INDVMBR_ENDDATE	8	688	695	Date	MMDDYYYY		Individual/Member End Date: The end date of when the individual/member became Medicaid eligible.
File record	39	INDVMBR_PRIORITY	1	696	696	Varchar			Individual/Member Priority: A numerical value assigned to the individual/member by the Program Provider or Financial Management Services Agency (FMSA) based on their level of need. https://hhs.texas.gov/laws-regulations/handbooks/hcs/section-5000-level-care-level-need
File record	40	INDVMBR_PHONE	10	697	706	Varchar			Individual/Member Phone: The primary phone number registered for EVV phone calls for the individual/member receiving services.
File record	41	INDVMBR_ALTPHONE	10	707	716	Varchar			Individual/Member Alternative Phone: A secondary (additional) phone number registered for EVV telephone calls to the individual/member receiving services.
File record	42	INDVMBR_ALTPHONE2	10	717	726	Varchar			Individual/Member Alternative Phone 2: Another secondary (additional) phone number registered for EVV telephone calls to the individual/member receiving services.
File record	43	MCO_MBR_SDA	2	727	728	Varchar			Managed Care Organization (MCO) Plan code for which the member is enrolled. Member MCO Plan Code is available in the Payer Plan Code Web Service.
File record	44	INDVMBR_ADDRESS_LATITUDE	50	729	778	Varchar			Individual/Member Address Latitude: The latitude of the individual's/member's address. This is pre saved information in the EVV System (Based on the individual/member's address)
File record	45	INDVMBR_ADDRESS_LONGITUDE	50	779	828	Varchar			Individual/Member Address Longitude: The longitude of the individual's/member's address. This is pre saved information in the EVV System (Based on the individual/member's address)
File record	46	INDVMBR_TOTAL_AUTHUNITS	11	829	839	Number	NNNNNNNN.NN		Individual/Member Total Authorized Units: The total number of units authorized for an individual/member for a service to be delivered for a given time period.
File record	47	AUTH_UNITS_TYPE	10	840	849	Varchar			Individual/Member Authorized Units Type: The type of units authorized. Can be daily, weekly, monthly or per auth.

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	48	INDVMBR_TOTAL_AUTHUNITSREMAINING	11	850	860	Number	NNNNNNNN.NN		Individual/Member Total Authorized Units Remaining: The total number of units remaining for an individual/member for a service to be delivered for a given time period. This is the value after the delivery of the units of service.
File record	49	VISIT_VISITID	30	861	890	Varchar			Electronic Visit Verification Visit Identification: A unique ID number assigned to the EVV visit by the EVV System.
File record	50	VISIT_SCHEDULEID	30	891	920	Varchar			Schedule Identification: A unique identifier number assigned to the scheduled visit by the EVV System.
File record	51	VISIT_VISITDATE	8	921	928	Date	MMDDYYYY		Scheduled Visit Date: The date that the System User scheduled the Service Provider to perform services for the individual/member. Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Weekly Variable Schedule Begin Date is populated for Weekly Variable Schedule. Null for No Schedule.
File record	52	VISIT_VISITTIMEIN	17	929	945	Date	MMDDYYYY HH:MM AM		Scheduled Visit Time In: Scheduled service delivery start time in date/time format.
File record	53	VISIT_VISITTIMEOUT	17	946	962	Date	MMDDYYYY HH:MM AM		Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Null for Weekly Variable Schedule or No Schedule.
File record	54	VISIT_VISITHOURS	5	963	967	Number	NN.NN		Scheduled Visit Time Out: Service delivery stop time in date/time format. Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Total Weekly Scheduled Hours is populated for Weekly Variable Schedule. Null for No Schedule.
File record	55	VISIT_VISITLOCATION	50	968	1017	Varchar			Scheduled Visit Location: The scheduled location where services are to be provided.
File record	56	VISIT_SVCGRP	3	1018	1020	Number		Full list can be found on HHSC Service Group/Service Code List	Visit Service Group: A code assigned by HHSC for the Long Term Services and Supports (aka Long Term Care) fee-for-service program through which the Individual is receiving services.
File record	57	EVV_SVCCODE	50	1021	1070	Varchar			Visit Service Code: A code to denote a specific service or category of service within the Long Term Services and Supports (aka Long Term Care) fee-for-service program at HHSC. Example: HHSC Service Code- Specific services provided within a program (Svc Grp 7+Svc Code 17C = Family Care, but Svc Grp 7+ Svc Code 17CV = Family Care in the Consumer Directed Services (CDS) option)
File record	58	EVV_HCPCS_CODE	30	1071	1100	Varchar			The Healthcare Common Procedure Coding System (HCPCS) Code: A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes.
File record	59	EVV_MODIFIER	30	1101	1130	Varchar			The Healthcare Common Procedure Coding System (HCPCS) Modifier: Two alphanumeric characters that are appended to the HCPCS codes to differentiate between services. There may be none or up to four modifiers for the HCPCS codes.
File record	60	EVV_VISITDATE	8	1131	1138	Date	MMDDYYYY		Actual Visit Date; EVV_VisitDate (actual visit) must be on or after Visit_VisitDate (scheduled visit)
File record	61	EVV_CREATEDDATETIME	17	1139	1155	Date	MMDDYYYY HH:MM AM		Created Date/Time: The date/time stamp assigned by the EVV System on the date a valid clock in and clock out or the date a manual visit is created in the EVV System.

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	62	EVV_PHONE	10	1156	1165	Varchar			Electronic Visit Verification Phone: The phone number used in the EVV Electronically Generated Call transaction.
File record	63	EVV_CALLINTIME	17	1166	1182	Date	MMDDYYYY HH:MM AM		Actual Call In Time: The date/time the Service Provider actually called in indicating service delivery started. Must be captured from an HHSC approved electronic verification method (Landline, Mobile or Alternative device). Must be Null for manually entered (GUI) visits.
File record	64	EVV_CALLOUTTIME	17	1183	1199	Date	MMDDYYYY HH:MM AM		Actual Call Out Time: The date/time the Service Provider actually called in indicating service delivery ended. Must be captured from an HHSC approved electronic verification method (Landline, Mobile or Alternative device). Must be Null for manually entered (GUI) visits.
File record	65	EVV_ACTUALHOURS	5	1200	1204	Number	NN.NN		Actual Hours: EVV System calculated duration in Hours and Minutes (NN.NN) Difference between electronically captured EVV_CALLINTIME and EVV_CALLOUTTIME. Must be Null for manually entered (GUI) visits.
File record	66	EVV_PAYHOURS	5	1205	1209	Number	NN.NN		Pay Hours: (also referred to as Bill Hours). Calculated by EVV System by rounding EVV_ActualHours, when present. Entered by Provider/FMSA for manual visit.
File record	67	EVV_UNITS	11	1210	1220	Number	NNNNNNNN.NN		Electronic Visit Verification Units: The number of units calculated by the EVV System using the EVV_PAYHOURS and the Unit Type in the Bill Code Table for the service on the visit.
File record	68	EVV_VISITLOCATION	50	1221	1270	Varchar			Actual Visit Location: The location where services are being provided.
File record	69	EVV_VISIT_LATITUDE_IN	50	1271	1320	Varchar			Electronic Visit Verification Visit Latitude In: The latitude of the visit location using the GPS location on a mobile method for the call in time. Data may be Null unless a mobile method approved by HHSC was used.
File record	70	EVV_VISIT_LONGITUDE_IN	50	1321	1370	Varchar			Electronic Visit Verification Visit Longitude In: The longitude of the visit location using the GPS location on a mobile method for the call in time. Data may be Null unless a mobile method approved by HHSC was used.
File record	71	EVV_LEARNED_LOCATION	1	1371	1371	Varchar			Electronic Visit Verification Learned Location: An indicator that specifies if an EVV location was learned via mobile method coordinates. This is usually the coordinates of the individual's/member's home. Data may be Null unless a mobile method approved by HHSC was used.
File record	72	EVV_LAT_LONG_MATCH_IN	1	1372	1372	Boolean	Y,N	Y,N	Latitude Longitude Match In: System assigned. Indicates that the Visit clock in latitude and longitude match the Member Home Geo-location.
File record	73	EVV_INPUTMETHOD_IN	50	1373	1422	Varchar			Electronic Visit Verification Input Method In: The data input method for call In.
File record	74	EVV_INPUTMETHOD_OUT	50	1423	1472	Varchar			Electronic Visit Verification Input Method Out: The data input method for call out.
File record	75	EVV_ALTERNATIVEDEVICEID	50	1473	1522	Varchar			Electronic Visit Verification Alternative Device Identification: The serial number or device identifier for an alternative device.
File record	76	EVV_REASONCODE1	3	1523	1525	Number			Electronic Visit Verification Reason Code 1: The first reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	77	EVV_REASONCODE1DESC	50	1526	1575	Varchar			Electronic Visit Verification Reason Code 1 Description: A narrative description of the EVV Reason Code 1 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	78	EVV_REASONCODE1COMMENT	500	1576	2075	Varchar			Electronic Visit Verification Reason Code 1 Comment: Additional comments regarding the EVV Reason Code 1 value.
File record	79	EVV_REASONCODE2	3	2076	2078	Number			Electronic Visit Verification Reason Code 2: The second reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	80	EVV_REASONCODE2DESC	50	2079	2128	Varchar			Electronic Visit Verification Reason Code 2 Description: A narrative description of the EVV Reason Code 2 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	81	EVV_REASONCODE2COMMENT	500	2129	2628	Varchar			Electronic Visit Verification Reason Code 2 Comment: Additional comments regarding the EVV Reason Code 2 value.
File record	82	EVV_REASONCODE3	3	2629	2631	Number			Electronic Visit Verification Reason Code 3: The third reason code that explains why maintenance occurred on an EVV transaction.
File record	83	EVV_REASONCODE3DESC	50	2632	2681	Varchar			Electronic Visit Verification Reason Code 3 Description: A narrative description of the EVV Reason Code 3 value. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	84	EVV_REASONCODE3COMMENT	500	2682	3181	Varchar			Electronic Visit Verification Reason Code 3 Comment: Additional comments regarding the EVV Reason Code 3 value.
File record	85	EVV_REASONCODE4	3	3182	3184	Number			Electronic Visit Verification Reason Code 4: The fourth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	86	EVV_REASONCODE4DESC	50	3185	3234	Varchar			Electronic Visit Verification Reason Code 4 Description: A narrative description of the EVV Reason Code 4 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	87	EVV_REASONCODE4COMMENT	500	3235	3734	Varchar			Electronic Visit Verification Reason Code 4 Comment: Additional comments regarding the EVV Reason Code 4 value.
File record	88	EVV_REASONCODE5	3	3735	3737	Number			Electronic Visit Verification Reason Code 5: The fifth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	89	EVV_REASONCODE5DESC	50	3738	3787	Varchar			Electronic Visit Verification Reason Code 5 Description: A narrative description of the EVV Reason Code 5 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	90	EVV_REASONCODE5COMMENT	500	3788	4287	Varchar			Electronic Visit Verification Reason Code 5 Comment: Additional comments regarding the EVV Reason Code 5 value.
File record	91	EVV_REASONCODE6	3	4288	4290	Number			Electronic Visit Verification Reason Code 6: The sixth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	92	EVV_REASONCODE6DESC	50	4291	4340	Varchar			Electronic Visit Verification Reason Code 6 Description: A narrative description of the EVV Reason Code 6 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	93	EVV_REASONCODE6COMMENT	500	4341	4840	Varchar			Reason Code Full Comment Text field - full text entry Electronic Visit Verification Reason Code 6 Comment: Additional comments regarding the EVV Reason Code 6 value.
File record	94	EVV_REASONCODE7	3	4841	4843	Number			Electronic Visit Verification Reason Code 7: The seventh reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	95	EVV_REASONCODE7DESC	50	4844	4893	Varchar			Electronic Visit Verification Reason Code 7 Description: A narrative description of the EVV Reason Code 7 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	96	EVV_REASONCODE7COMMENT	500	4894	5393	Varchar			Electronic Visit Verification Reason Code 7 Comment: Additional comments regarding the EVV Reason Code 7 value.
File record	97	EVV_REASONCODE8	3	5394	5396	Number			Electronic Visit Verification Reason Code 8: The eighth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	98	EVV_REASONCODE8DESC	50	5397	5446	Varchar			Electronic Visit Verification Reason Code 8 Description: A narrative description of the EVV Reason Code 8 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	99	EVV_REASONCODE8COMMENT	500	5447	5946	Varchar			Electronic Visit Verification Reason Code 8 Comment: Additional comments regarding the EVV Reason Code 8 value.
File record	100	EVV_REASONCODE9	3	5947	5949	Number			Electronic Visit Verification Reason Code 9: The ninth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	101	EVV_REASONCODE9DESC	50	5950	5999	Varchar			Electronic Visit Verification Reason Code 9 Description: A narrative description of the EVV Reason Code 9 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	102	EVV_REASONCODE9COMMENT	500	6000	6499	Varchar			Reason Code Full Comment Text field - full text entry Electronic Visit Verification Reason Code 9 Comment: Additional comments regarding the EVV Reason Code 9 value.
File record	103	EVV_REASONCODE10	3	6500	6502	Number			Electronic Visit Verification Reason Code 10: The tenth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	104	EVV_REASONCODE10DESC	50	6503	6552	Varchar			Electronic Visit Verification Reason Code 10 Description: A narrative description of the EVV Reason Code 10 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.
File record	105	EVV_REASONCODE10COMMENT	500	6553	7052	Varchar			Electronic Visit Verification Reason Code 10 Comment: Additional comments regarding the EVV Reason Code 10 value.

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	106	EVV_OVERALLREASONCODE	2	7053	7054	Varchar		Null, P, NP	HHSC no longer uses the Overall Reason Code field. This field should be populated as Null. If a value is captured, it must be a "P" or "NP".’
File record	107	EVV_VISITNOTES	500	7055	7554	Varchar			Visit Notes: Additional information (if any) related to the visit, needs to be added to the Visit Notes field.
File record	108	EVV_LASTVISITMAINT	17	7555	7571	Date	MMDDYYYY HH:MM AM		Last Visit Maintenance: The most recent date a change to one or more fields identified as impacting the last visit maintenance date in the HHSC EVV Policy Handbook are saved to the EVV visit transaction after the system User/Service Provider has documented the visit.
File record	109	EVV_UPLOADINDICATOR	2	7572	7573	Varchar			Electronic Visit Verification Upload Indicator: An indicator that specifies if a visit was finalized and uploaded (transferred) to the EVV Aggregator.
File record	110	EVV_LASTUPLOAD	17	7574	7590	Date	MMDDYYYY HH:MM AM		Electronic Visit Verification Last Upload: The last date a visit was finalized and uploaded (transferred) to the EVV Aggregator.
File record	111	EVV_VENDORID	30	7591	7620	Varchar			Electronic Visit Verification Vendor Identification: EVV System name. EVV_VendorID is assigned by MES service providers. EVV_VendorID must match the EVV System ID of the submitter of the batch file. EVV_VendorID is first part of the incoming file name.
File record	112	EVV_FILEEXPORTID	30	7621	7650	Varchar			Electronic Visit Verification File Export Identification: A specific upload identifier assigned to each data file export by the EVV System.
File record	113	EVV_DONOTEXPORTINDICATOR	1	7651	7651	Varchar			Electronic Visit Verification Do Not Export Indicator: An indicator that specifies if a visit has been manually flagged by a Program Provider or Financial Management Services Agency (FMSA) to not export to the EVV Aggregator.
File record	114	EVV_AUTOCONFIRMFLAG	2	7652	7653	Varchar			Electronic Visit Verification Auto Confirm Flag: An indicator that specifies if a visit was auto-verified by the EVV System and no visit maintenance was required.
File record	115	EVV_VISITRECORDINDICATOR	30	7654	7683	Varchar		New, Update, Cancel	Electronic Visit Verification Visit Record Indicator: An indicator that specifies the status of the EVV visit transaction.
File record	116	EVV_VISIT_LATITUDE_OUT	50	7684	7733	Varchar			Electronic Visit Verification Visit Latitude Out: The latitude of the visit location using the GPS location on a mobile method for the call out time. Data may be Null unless a mobile method was used.
File record	117	EVV_VISIT_LONGITUDE_OUT	50	7734	7783	Varchar			Electronic Visit Verification Visit Longitude Out: The longitude of the visit location using the GPS location on a mobile method for the call out time. Data may be Null unless a mobile method was used.
File record	118	EVV_MATERIAL_VM_CHANGE	1	7784	7784	Varchar	Y,N	Y,N	Visit Maintenance Material Change: Indicates if a Material visit maintenance change was made. Required if a material field was changed during visit maintenance

Type of Record	Position of Data Element	Extract Data Element	Length	Beginning Position	Ending Position	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Comments
File record	119	EVV_MATERIAL_VM_FIELD_ID	50	7785	7834	Varchar		include: First time GUI input Methods, Provider_TIN Provider_NPI Provider_API 007 Provider_ContractNumber 035 IndvMbr_MedicaidID EVV_SvcCode EVV_HCPCS Code EVV_Modifier EVV_VisitDate EVV_CreatedDateTime EVV_CallInTime EVV_CallOutTime EVV_ActualHours EVV_PayHours EVV_Units	Visit Maintenance Material Change Field Identification: Lists the Field identifier of each 'material change' field that was updated during visit maintenance, delimited by a comma. Required if Field EVV_MATERIAL_VM_CHANGE = Y.

Appendix D – EVV Master Provider Web Service

HHSC Electronic Visit Verification (EVV) Technical Documentation Appendix D - EVV Master Provider Web Service
Published Date: 02/25/2022 Effective Date: 05/31/2022

EVV Master Provider Web Service layout:

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic
Input	1	npiOrApi	10	STRING		
Input	2	asOfDate	19	STRING		
Output	3	errorMessage	N/A	STRING	Unexpected System Error	Return 'Unexpected System Error' if there is a system error when trying to match on the input parameters and build a return object.
Output	4	validationErrors	N/A	STRING		<u>**Format validation for NPI/API**</u> **Validation:** If the NPI/API field is a 10-digit string. Then the system passes the validation Else the system throws a Validation Error Message **Validation Error Message:** The NPI/API field is not in a valid format. <u>**Range validation for AsOfDate**</u> **Validation:** If the AsOfDate field is >= '04/01/2015' Then the system passes the validation Else the system throws a Validation Error Message **Validation Error Message:** The AsOfDate field needs to be greater than or equal to

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic
						04/01/2015. **<u>* Validate NPI/API and AsOfDate Combination</u>** **Validation:** If the search using the input parameters (As defined in the Values column of the input parameters) yield results in LongTermCareProviderResult OR AcuteCareProviderResult OR LTSSProviderResult Then the system passes the validation Else the system throws a Validation Error Message **Validation Error Message:** Provider cannot be validated/found for the NPI/API and AsOfDate Combination.
Output	5	providerResultType	26	STRING	AcuteCareProviderResult, LongTermCareProviderResult, LTSSProviderResult	
Output	6	tin	9	STRING		
Output	7	tpi	9	STRING		Required when ProviderResultType = AcuteCareProviderResult
Output	8	taxonomy	10	STRING		Required when ProviderResultType = AcuteCareProviderResult
Output	9	contractNumber	9	INTEGER		Required if the ProviderResultType = LongTermCareProviderResult

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic
Output	10	serviceGroup	5	STRING		Required if the ProviderResultType = LongTermCareProviderResult
Output	11	serviceCode	5	STRING		Required if the ProviderResultType = LongTermCareProviderResult
Output	12	fromDate	19	DATETIME		
Output	13	toDate	19	DATETIME		Required if the ProviderResultType = LongTermCareProviderResult (OR) LTSSProviderResult
Output	14	legalName	50	STRING		
Output	15	dbaName	50	STRING		Required if the ProviderResultType = LongTermCareProviderResult (OR) AcuteCareProviderResult
Output	16	address1	150	STRING		
Output	17	address2	150	STRING		
Output	18	city	100	STRING		
Output	19	state	2	STRING		
Output	20	zip	10	STRING		

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic
Output	21	region	2	STRING		Required if the ProviderResultType = LongTermCareProviderResult (OR) AcuteCareProviderResult
Output	22	badAddressIndicato r	5	BOOLEAN	TRUE, FALSE	**AcuteCareProviderResult:** BAD_ADDRESS_IND = 'N' , then FALSE BAD_ADDRESS_IND = 'Y', then TRUE **LongTermCareProviderResult:** 'FALSE' **LTSSProviderResult:** 'FALSE'
Output	23	pendingIndicator	5	BOOLEAN	TRUE, FALSE	**AcuteCareProviderResult:** ACUTEMBR.PRV_PRACTICE_LOC.PENDING_IND = 'A' and ACUTEMBR.PRV_PROVIDER.PENDING = 'A', then FALSE else TRUE **LongTermCareProviderResult:** 'FALSE' **LTSSProviderResult:** 'FALSE'
Output	24	sanctionIndicator	5	BOOLEAN	TRUE, FALSE	**AcuteCareProviderResult:** Have ACUTEMBR.PRV_PL_IMP_SANCT.FK_PROV_SANC_CODE <> (63, 67) and (ACUTEMBR.PRV_PL_IMP_SANCT.EFFECTIVE_DATE <= AsOfDate <= ACUTEMBR.PRV_PL_IMP_SANCT.TERMINATE_DATE), then 'TRUE' else, FALSE **LongTermCareProviderResult:** 'FALSE' **LTSSProviderResult:** 'FALSE'

Below is the list of Required, Conditionally Required and Informational provider fields and which may be edited in the EVV System UI:

Field	EVV System UI	Web Service Result
tin	Required - Not Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
tpi	Conditionally Required - Not Editable (This is Conditionally required only when the Payer is HHSC and not when the Payer is MCO or LTC)	AcuteCareProviderResult: Populated LongTermCareProviderResult: Default Blank LTSSProviderResult: Default Blank
taxonomy	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Default Blank LTSSProviderResult: Populated
contractNumber	Conditionally Required - Not Editable	AcuteCareProviderResult: Default Blank LongTermCareProviderResult: Populated LTSSProviderResult: Default Blank
serviceGroup	Conditionally Required - Not Editable	AcuteCareProviderResult: Default Blank LongTermCareProviderResult: Populated LTSSProviderResult: Default Blank
serviceCode	Conditionally Required - Not Editable	AcuteCareProviderResult; Default Blank LongTermCareProviderResult: Populated LTSSProviderResult; Default Blank
fromDate	Required - Not Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
toDate	Conditionally Required - Not Editable	AcuteCareProviderResult Default Blank LongTermCareProviderResult: Populated LTSSProviderResult: Populated
legalName	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
dbaName	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Default Blank
address1	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
address2	Informational - Editable	AcuteCareProviderResult: Optional LongTermCareProviderResult: Optional LTSSProviderResult: Optional

city	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
state	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
zip	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Populated
region	Informational - Editable	AcuteCareProviderResult: Populated LongTermCareProviderResult: Populated LTSSProviderResult: Default Blank
badAddressIndicator	INTERNAL USE ONLY DO NOT SHOW PROVIDER Conditionally Required - Not Editable	AcuteCareProviderResult: Populated (‘TRUE’ OR ‘FALSE’) LongTermCareProviderResult: default 'FALSE' LTSSProviderResult: default 'FALSE'
pendingIndicator	INTERNAL USE ONLY DO NOT SHOW PROVIDER Conditionally Required - Not Editable	AcuteCareProviderResult: Populated (‘TRUE’ OR ‘FALSE’) LongTermCareProviderResult: default 'FALSE' LTSSProviderResult: default 'FALSE'
sanctionIndicator	INTERNAL USE ONLY DO NOT SHOW PROVIDER Conditionally Required - Not Editable	AcuteCareProviderResult: Populated (‘TRUE’ OR ‘FALSE’) LongTermCareProviderResult: default 'FALSE' LTSSProviderResult: default 'FALSE'

Appendix E – Member Eligibility Companion Guides

HHSC Electronic Visit Verification (EVV) Technical Documentation Appendix E - Member Eligibility Companion Guides
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Below are links to the published X12 270/271 Eligibility Request and Response transaction companion guides.

Recommendation is for EVV systems to use of Eligibility as a Service (EaaS) X12 270/271 process over existing legacy Acute Care X12 270/271 process. EaaS better supports MCO only enrolled LTSS providers and the EaaS response returns the HHSC TIERS eligibility member residential address. The legacy Acute Care X12 270/271 response returns HHSC TIERS eligibility member mailing address which may include a PO Box address.

Eligibility as a Service (EaaS) X12 270/271 Companion Guide * Returns TIERS member residential address when available otherwise returns TIERS member mailing address	https://www.tmhp.com/topics/edi
X12 270/271 Long Term Care Companion Guide	https://www.tmhp.com/sites/default/files/file-library/edi/270-271%20Long%20Term%20Care%20Companion%20Guide.pdf
X12 270/271 Acute Care Companion Guide * NPI must be enrolled with TMHP and only returns TIERS member mailing address which may include PO Box Address.	https://www.tmhp.com/sites/default/files/file-library/edi/270-271%20Acute%20Care%20Companion%20Guide.pdf

Following fields are required to complete a member profile in the EVV System.

Field	**EVV System UI**
Medicaid ID	Required – Not Editable
Member Last Name	Required – Not Editable
Member First Name	Required – Not Editable
Gender	Required – Not Editable
Date of Birth	Required – Not Editable
Address	Required – Editable
City	Required – Editable
State	Required – Editable
Zip + 4	Required – Editable

Appendix F – EVV Prior Authorization File

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Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Table Name	Field Name
Input	1	medicaidID	9	STRING				
Input	2	asOfDate	19	DATETIME				
Output	3	errorMessage	N/A	STRING	Unexpected System Error	Return 'Unexpected System Error' if there is a system error when trying to match on the input parameters and build a return object.		
Output	4	validationErrors	N/A	STRING		* **Format validation for MedicaidID** Validation: 9 digit numerical Then the system passes validation Else the system sets Validation Error Message Validation Error Message: The Medicaid ID is not in a valid format. **Range validation for AsOfDate** Validation: If the AsOfDate field is >= '04/01/2015' Then the system passes the validation Else the system throws a Validation Error Message Validation Error Message:		

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Table Name	Field Name
						The AsOfDate field needs to be greater than or equal to 04/01/2015. **Validate MedicaidID and AsOfDate Combination** Validation: If the search using the input parameters (As defined in the Values column of the input parameters) yield result(s) in AuthorizationResult Then the system passes the validation Else the system throws a Validation Error Message Validation Error Message: Authorization cannot be found for MedicaidID and AsOfDate Combination.		
authorizationResultType CAN REPEAT MULTIPLE TIMES								
Output	5	authorizationResultType	25	STRING	LongTermCareAuthorization, AcuteCareAuthorization			
Output	6	indvMbrPayor	4	STRING	HHSC,LTC	**AcuteCareAuthorization:** HHSC **LongTermCareAuthorization:** LTC		
Output	7	indvMbrMedicaidID	9	STRING			**AcuteCareAuthorization:** ELG_CLIENT **LongTermCareAuthorization:** SRVC_AUTH	**AcuteCareAuthorization:** PATIENT_CONTROL_NO **LongTermCareAuthorization:** FK CL CLIENT ID
Output	8	indvMbrFirstName	15	STRING			**AcuteCareAuthorization:** ELG_CLIENT **LongTermCareAuthorization:** CLIENT	**AcuteCareAuthorization:** FIRST_NAME **LongTermCareAuthorization:**NM FIRST
Output	9	indvMbrLastName	25	STRING			**AcuteCareAuthorization:** ELG_CLIENT	**AcuteCareAuthorization:** LAST_NAME

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Table Name	Field Name
							LongTermCareAuthorization: CLIENT	**LongTermCareAuthorization:** LAST NM
Output	10	indvMbrMemberDOB		DATETIME			**AcuteCareAuthorization:** ELG_CLIENT **LongTermCareAuthorization:** CLIENT	**AcuteCareAuthorization:** BIRTH_DATE **LongTermCareAuthorization:** BIRTH DT
Output	11	indvMbrProgram	4	STRING	HHSC,LTC	**AcuteCareAuthorization:** HHSC **LongTermCareAuthorization:** LTC		
Output	12	mcoMbrPlanCode	2	STRING		Blank		
Output	13	providerTIN	9	STRING		**LongTermCareAuthorization:** When CONTRACT.PAYEE_ID_NBR digit 1 is not equal to 2, save digits 2-10 as TIN, else blank	**AcuteCareAuthorization:** PRV_PL_PGM_ASG_TAX **LongTermCareAuthorization:** CONTRACT	**AcuteCareAuthorization:** FK_PROV_IRS_NO **LongTermCareAuthorization:** PAYEE_ID_NBR
Output	14	providerNPI	10	STRING		**AcuteCareAuthorization:** If FK_PROVIDER_NPI first character is digit then save as NPI, else blank **LongTermCareAuthorization:** If NATIONAL_PROV_NBR first character is digit then save as NPI, else blank	**AcuteCareAuthorization:** AUT_AUTH_DETAIL **LongTermCareAuthorization:**CONTRACT	**AcuteCareAuthorization:** FK_PROVIDER_NPI **LongTermCareAuthorization:** NATIONAL_PROV_NBR
Output	15	providerAPI	10	STRING		**AcuteCareAuthorization:** If FK_PROVIDER_NPI first character is digit then save as NPI, else blank **LongTermCareAuthorization:** If NATIONAL_PROV_NBR first character is digit then save as NPI, else blank	**AcuteCareAuthorization:** AUT_AUTH_DETAIL **LongTermCareAuthorization:**CONTRACT	**AcuteCareAuthorization:** FK_PROVIDER_NPI **LongTermCareAuthorization:**NATIONAL_PR OV_NBR
Output	16	providerTPI	9	STRING		Required if AuthorizationResultType = AcuteCareAuthorization	**AcuteCareAuthorization:** AUT_AUTH_DETAIL	**AcuteCareAuthorization:** FK_PROVIDER_TPI+FK_PRAC_LOC_CODE

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Table Name	Field Name
Output	17	evvhcpcsCode	7	STRING		Required if AuthorizationResultType = AcuteCareAuthorization	**AcuteCareAuthorization:** AUT_AUTH_DETAIL	**AcuteCareAuthorization:** FK_PROC_CODE_SUB
Output	18	evvModifier	5	STRING		Required if AuthorizationResultType = AcuteCareAuthorization	**AcuteCareAuthorization:** AUT_AUTH_DETAIL	**AcuteCareAuthorization:** FK_SUB1_MOD_CD:FK_SUB2_MOD_CD
Output	19	authNumber	10	STRING		Required if AuthorizationResultType = AcuteCareAuthorization	**AcuteCareAuthorization:** AUT_AUTH_HEADER	**AcuteCareAuthorization:** AUTHORIZATION_NUM
Output	20	indvMbrAuthStartDate	19	DATETIME			**AcuteCareAuthorization:** AUT_AUTH_DETAIL **LongTermCareAuthorization:** SRVC_AUTH	**AcuteCareAuthorization:** FROM_SERVICE_DT **LongTermCareAuthorization:** BEGIN DT
Output	21	indvMbrAuthEndDate	19	DATETIME			**AcuteCareAuthorization:** AUT_AUTH_DETAIL **LongTermCareAuthorization:** SRVC_AUTH	**AcuteCareAuthorization:** THRU_SERVICE_DT **LongTermCareAuthorization:** END DT
Output	22	indvMbrTotalAuthUnits	11	STRING			**AcuteCareAuthorization:** AUT_AUTH_DETAIL **LongTermCareAuthorization:** SRVC_AUTH	**AcuteCareAuthorization:** APP_SRV_UNIT_NUM_H **LongTermCareAuthorization:** AUTH_UNITS
Output	23	remainingServiceUnits	11	STRING		Blank		

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Table Name	Field Name
Output	24	authUnitsType	8	STRING	DAILY,WEEKLY,MONTHLY,YEARLY,PER AUTH	**AcuteCareAuthorization:** Database value "D" = Auth response value "DAILY" Dtabase value "W" = Auth response value "WEEKLY" Database value "M" = Auth response value "MONTHLY" Database value "Y" = Auth response value "YEARLY" Database value "Blank" = Auth response value "PER AUTH" **LongTermCareAuthorization:** Format: Database value - Auth response value Database value "D" = Auth response value "DAILY" Dtabase value "W" = Auth response value "WEEKLY" Database value "M" = Auth response value "MONTHLY"	**AcuteCareAuthorization:** AUT_DTL_PER_LIMIT **LongTermCareAuthorization:** SRVC_AUTH	**AcuteCareAuthorization:** FK_FREQ_PERIOD_CD **LongTermCareAuthorization:** FK_UTC_UNIT_TYPE
Output	25	contractNumber	9	STRING		Required if AuthorizationResultType = LongTermCareAuthorization	**LongTermCareAuthorization:** SRVC_AUTH	**LongTermCareAuthorization:** FK_CN_CONTRACT_NBR
Output	26	serviceGroup	5	STRING		Required if AuthorizationResultType = LongTermCareAuthorization	**LongTermCareAuthorization:** SRVC_AUTH	**LongTermCareAuthorization:** FK_SG_SRVC_GRP
Output	27	serviceCode	5	STRING		Required if AuthorizationResultType = LongTermCareAuthorization	**LongTermCareAuthorization:** SRVC_AUTH	**LongTermCareAuthorization:** FK_SC_SRVC_CD

Appendix G – EVV Standard System Reports

HHSC Electronic Visit Verification (EVV) Technical Documentation Appendix G - EVV Standard System Reports
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HHSC requires each EVV Vendor and Proprietary System Operator (PSO) to provide the On-Demand EVV Standard System Reports as listed in the HHSC EVV Business Rules unless specifically indicated. This document contains specifications for each report. The EVV System will generate some reports using a web service provided by MES service providers, as indicated in the Report Description, to maintain consistency with the EVV Portal since the CDS Employers do not have access to that system. Therefore, the EVV System will display these reports specifically for the CDS Employer. The Program Providers, Financial Management Services Agency (FMSA), HHSC and MCOs will view these reports through the EVV Portal. The EVV System will create other reports using data native to the EVV System. MES service providers will provide sample reports upon request. All standard system reports must comply with these report specifications at a minimum.

Report Name	Description	Report Source
EVV Alternative Device Order Status Report	The EVV System must produce this report for the System User to use when verifying Alternative Devices orders placed by the program provider, CDS Employer, or FMSA on behalf of the CDS Employer, and to track the status of those orders. The EVV System must create this report using data native to the EVV System.	Native to the EVV System Not required for PSOs
EVV Attendant History Report	This report shows the Service Providers identified on accepted EVV Visit Transactions that delivered services to a Member for a requested date range. The System User will request this report through and view the results in, the EVV System. The EVV System will provide this report using the EVV Standard System Reports web service provided by MES service providers.	EVV Standard System Reports Web Service
EVV CDS Service Delivery Log	This report shows EVV Visit Transactions for visits for a requested date range. The EVV System must create this report using data native to the EVV system and. View the current CDS Delivery Log (HHS Form 1745) at the link below: https://hhs.texas.gov/laws-regulations/forms/1000- 1999/form-1745-service-delivery-log-written-narrativewritten- summary	Native to the EVV System
EVV CDS Employer Usage Report	This report shows the EVV usage score for CDS Employers. It equals the number of total electronic (non-manual) visit transactions divided by the total number of accepted visit transactions by the EVV Aggregator for a Member and requested date range. The System User will request this report through and view the results in, the EVV System. The EVV System will provide this report using the EVV Standard System Reports web service provided by MES service providers.	EVV Standard System Reports Web Service
EVV Clock In/Clock Out Usage Report	This report shows the number of accepted EVV Visit Transactions by a Service Provider, the number of times a Service Provider used each method (Mobile, GUI, etc.) to clock-	EVV Standard System Reports Web Service

Report Name	Description	Report Source
	in or clock-out, as well as the number of visits that the EVV System auto-verified. The System User will request this report through, and view the results in, the EVV System. The EVV System will provide this report using the EVV Standard System Reports web service provided by.	
EVV Landline Phone Verification Report	This report shows the phone number, phone type and carrier used by a Service Provider to clock-in or clock-out using the home landline electronic verification method. The report allows the System User to monitor phone numbers and to identify the use of non-landline phone numbers. The EVV System must create this report using data native to the EVV system.	Native to the EVV System
EVV Reason Code Usage and Free Text Report	This report shows the count of Reason Code number and description combinations and associated free text/comments used on accepted EVV Visit Transactions for a Member and requested date range. The System User will request this report through, and view the results in, the EVV System. The EVV System will provide this report using the EVV Standard System Reports web service provided by MES service providers.	EVV Standard System Reports Web Service
EVV Service Delivery Exception Report	This report shows the number of visits that varied from the schedule or authorization, as well as the number of visits that the System User did not approve for a requested date range. This data must include services regardless of service delivery locations (home or community location, and GPS coordinates when the Service Provider used the mobile method to clock in/out). The EVV System must create this report using data native to the EVV system.	Native to the EVV System
EVV Units of Service Summary Report	This report displays a calendar view summary at the service level of the number of units delivered each day on accepted EVV Visit Transactions for a Member and requested date range. The System User will request the report through, and view the results in, the EVV System. The EVV System will provide the report using the EVV Standard System Reports web service provided by MES service providers.	EVV Standard System Reports Web Service
Non-EVV Relevant Time Logged Report	This report shows time the Service Provider spent on non-EVV services between clock in and clock out for a requested date range. The EVV System must create this report using data native to the EVV system.	Native to the EVV System

Standard Report Name: EVV Attendant History Report

Report Description

This report shows the Service Attendants identified on accepted EVV Visit Transactions that delivered services to a Member for a requested date range. The report will be requested through, and the results displayed in, the EVV System, using the EVV Standard System Reports web service provided by MES service providers.

Report Field Listing

EVV Attendant History Report Fields	Field Description	Associated EVV Visit Transaction Field
Texas EVV Attendant ID	The last four digits of the employee's social security number or passport number and last name of the person providing EVV services	EMPLOYEE_SOCSEC_VISA_PASSPORT
Attendant First Name	The first name of the person providing EVV services	EMPLOYEE_FIRSTNAME
Attendant Last Name	The last name of the person providing EVV services	EMPLOYEE_LASTNAME
Employee Discipline	The specialty of the person providing EVV services: attendant, nurse, certified nursing assistant (CNA), physical therapist (PT), occupational therapist (OT), speech-language pathologist (SLP), or other	EMPLOYEE_EMPLOYEEDISCIPLINE
Total Billable Units	The calculated sum of the Billable Units for the visits in the report.	N/A
Visit ID	A unique ID number assigned to the EVV visit transaction by the EVV system	VISIT_VISITID
Provider Name	The legal name of the program provider or Financial Management Services Agency (FMSA)	PROVIDER_LEGALNAME
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services	PROVIDER_NPI PROVIDER_API
TIN	The Tax Identification Number for the provider or FMSA	PROVIDER_TIN
Provider Number	The Long-Term Care (LTC) provider number if applicable	PROVIDER_CONTRACTNUMBER
TPI	The Texas Provider Identifier if applicable	PROVIDER_TPI
Payer Name	HHSC or name of MCO associated with the payer identifier submitted on visit transaction	INDVMBR_PAYOR (This field contains a 3–4-character identifier associated to a payer, the Payer Name should be displayed on the report)
Service Group	A code that identifies the LTC program when applicable	VISIT_SVCGRP

EVV Attendant History Report Fields	Field Description	Associated EVV Visit Transaction Field
Service Code	A code that identifies the service provided	EVV_SVCCODE
HCPCS	Identifies the service provided	EVV_HCPCS_CODE
Modifiers	The modifier associated with the HCPCS for the service if applicable	EVV_MODIFIER
Member Medicaid ID	Member's Medicaid Identification Number	INDVMBR_MEDICAIDID
Individual Last Name	Last Name of Member	INDVMBR_LASTNAME
Individual First Name	First Name of Member	INDVMBR_FIRSTNAME
Actual Visit Date	The date the EVV service occurred	EVV_VISITDATE
Actual Clock In	The time the attendant electronically clocked in when service delivery began: HH:MM AM/PM Null for manually entered (GUI) visits.	EVV_CALLINTIME
Actual Clock Out	The time the attendant electronically clocked out when service delivery ended: HH:MM AM/PM Null for manually entered (GUI) visits.	EVV_CALLOUTTIME
Actual Hours Worked	The total duration of service delivery based on electronic clock in and clock out times Null for manually entered (GUI) visits.	EVV_ACTUALHOURS
Billable Units	The billable units for the visit	EVV_UNITS
EVV System	Name of the EVV System	EVV_VENDORID

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer
Sort Order	N/A (Report Generated by MES service providers)
Default Filter (The system applies this filter)	Only Accepted EVV Transactions, Submitting EVV System

*Report Generation Criteria **

Field Name	Required/Optional
Texas EVV Attendant ID	Optional
Medicaid ID	Required and populated with all Medicaid Ids that are linked to the CDS Employer Profile. May only select one Medicaid Id.
Visit Begin Date	Required

Field Name	Required/Optional
Visit End Date	Required
Payer Name	Optional
Export Format	Required

Details of the Field Length, Field Validations and Validation Error Message will be provided with the JSON

Standard Report Name: EVV CDS Service Delivery Log

Report Description

This report shows EVV Visit Transactions for visits for a requested date range. This report is native to the EVV system and must be created by the EVV Vendor. The current CDS Delivery Log (HHS Form 1745) can be found at the link below:
https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-1745-service-delivery-log-written-narrativewritten-summary

Report Field Listing

EVV CDS Service Delivery Log Report Fields	Field Description	Associated EVV Visit Transaction Field
Pay Period (header)	Dates of service delivery for the pay period as determined by the Financial Management Services Agency (FMSA).	N/A
CDS Employer (header)	CDS Employer Id and name, if the report is generated for one CDS Employer, else “All”.	EMPLOYEE_CDSEMPLOYEREVVID, EMPLOYEE_CDSEMPLOYERFIRSTNAME, EMPLOYEE_CDSEMPLOYERLASTNAME
FMSA Legal Name	Legal name of the FMSA.	PROVIDER_LEGALNAME
FMSA DBA Name	Doing Business As name of the FMSA.	PROVIDER_DBA
NPI/API	NPI or API of the FMSA.	PROVIDER_NPI PROVIDER_API
TIN	Tax Identification Number of the FMSA.	PROVIDER_TIN
Location	Location of the FMSA, as documented in the EVV System.	N/A
Region	HHSC Region of the FMSA.	PROVIDER_REGION
SDA	Managed Care Service Delivery Area of the FMSA, as documented in the EVV System.	MCO_MBR_SDA
Contract Number	Long-Term Care (LTC) provider number, if applicable.	PROVIDER_CONTRACTNUMBER
CDS Employer ID	IRS-assigned Employer Identification Number (EIN) or EVV system-generated Id of the CDS Employer.	EMPLOYEE_CDSEMPLOYEREVVID
CDS Employer First Name	First name of the CDS Employer.	EMPLOYEE_CDSEMPLOYERFIRSTNAME
CDS Employer Last Name	Last name of the CDS Employer.	EMPLOYEE_CDSEMPLOYERLASTNAME
Member ID	Member's Texas Medicaid Identification Number.	INDVMBR_MEDICAIDID
Member First Name	First name of the person receiving services.	INDVMBR_FIRSTNAME
Member Last Name	Last name of the person receiving services.	INDVMBR_LASTNAME

EVV CDS Service Delivery Log Report Fields	Field Description	Associated EVV Visit Transaction Field
CDS Employee ID	Last four digits of the social security number or passport number and last name of the person providing EVV services.	EMPLOYEE_SOCSEC_VISA_PASSPORT
CDS Employee First Name	First name of the person providing EVV services.	EMPLOYEE_FIRSTNAME
CDS Employee Last Name	Last name of the person providing EVV services.	EMPLOYEE_LASTNAME
Visit ID	Unique number assigned to the EVV visit transaction by the EVV system.	VISIT_VISITID
HCPCS and Modifiers	Identifies the service provided (each HCPCS will have zero to four modifiers in the EVV_MODIFIER field).	EVV_HCPCS_CODE plus space plus EVV_MODIFIER
Service	Description of the service provided (Service Short Description value from the EVV Service Bill Codes Table (HHSC version).	N/A
Visit Date	Date on which the service was provided (in MM/DD/YYYY format).	EVV_VISITDATE
Actual Clock In Time	Time the service began (the time the attendant electronically clocked in when service delivery began). Null for manually entered (GUI) visits.	EVV_CALLINTIME
Actual Clock Out Time	Time the service ended (the time the attendant electronically clocked out when service delivery ended). Null for manually entered (GUI) visits.	EVV_CALLOUTTIME
Actual Hours	Actual number of hours the service was provided (NN.NN format, not rounded). Null for manually entered (GUI) visits.	EVV_ACTUALHOURS
Non-EVV Relevant Hours	Number of hours identified as Non-EVV Relevant by the CDS Employee during the EVV service delivery, if applicable (NN.NN format, rounded to the quarter hour).	N/A
Billable Hours	Billable number of hours for the service that was provided (NN.NN format, rounded to the quarter hour).	EVV_PAYHOURS
Place of Service	Location where the service was delivered (home or community location per the list of valid values in the HHSC EVV Business Rules for Proprietary Systems).	EVV_VISITLOCATION
Reason Code Number	Texas EVV Reason Code Number.	EVV_REASONCODE1 EVV_REASONCODE2 … EVV_REASONCODE10

EVV CDS Service Delivery Log Report Fields	Field Description	Associated EVV Visit Transaction Field
Reason Code	Texas EVV Reason Code (reason category name), as listed in the HHSC EVV Reason Codes list on the HHSC EVV website.	N/A
Reason Code Description	Texas EVV Reason Code Description.	EVV_REASONCODE1DESC EVV_REASONCODE2DESC … EVV_REASONCODE10DESC
Reason Code Free Text	Free text/comments (if any) entered during visit maintenance.	EVV_REASONCODECOMMENT1 EVV_REASONCODECOMMENT2 … EVV_REASONCODECOMMENT10
CDS Employee Daily Total Actual Hours	Calculated sum of the actual service delivery hours worked by the CDS Employee for the day.	N/A
CDS Employee Daily Total Non-EVV Relevant Hours	Calculated sum of the non-EVV relevant hours worked by the CDS Employee for the day.	N/A
CDS Employee Daily Total Billable Hours	Calculated sum of the billable hours for the CDS Employee for the day.	N/A
CDS Employee Pay Period Total Actual Hours	Calculated sum of the actual service delivery hours worked by the CDS Employee during the pay period.	N/A
CDS Employee Pay Period Total Non-EVV Relevant Hours	Calculated sum of the non-EVV relevant hours worked by the CDS Employee during the pay period.	N/A
CDS Employee Pay Period Total Billable Hours	Calculated sum of the billable hours worked by the CDS Employee during the pay period.	N/A
Member Pay Period Total Actual Hours	Calculated sum of the actual service delivery hours worked providing services to the Member by all CDS Employees during the pay period.	N/A
Member Pay Period Total Non-EVV Relevant Hours	The calculated sum of the non-EVV relevant hours worked providing services to the Member by all CDS Employees during the pay period.	N/A
Member Pay Period Total Billable Hours	Calculated sum of the billable hours worked providing services to the Member by all CDS Employees during the pay period.	N/A
CDS Employer Pay Period Total Actual Hours	Calculated sum of the actual service delivery hours worked for the CDS Employer by all CDS Employees providing services to the CDS Employer's Members during the pay period.	N/A

EVV CDS Service Delivery Log Report Fields	Field Description	Associated EVV Visit Transaction Field
CDS Employer Pay Period Total Non-EVV Relevant Hours	Calculated sum of the non-EVV relevant hours worked for the CDS Employer by all CDS Employees providing services to the CDS Employer's Members during the pay period.	N/A
CDS Employer Pay Period Total Billable Hours	Calculated sum of the billable hours worked for the CDS Employer by all CDS Employees providing services to the CDS Employer's Members during the pay period.	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer, FMSA, MCO, HHSC
Sort Order	CDS Employer ID, Member ID, CDS Employee ID, Visit ID
Default Filter (The system applies this filter)	N/A

Report Generation Criteria

Field Name	Required/Optional
CDS Employer ID	*When logged in user is a CDS Employer:* Required and populated with the CDS Employer Id that is associated with the user. *When logged in user is from an FMSA:* Optional (but restricted to CDS Employer Ids that are associated with the FMSA). *When logged in user is from an MCO:* Optional (but restricted to CDS Employer Ids that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional Note: Each CDS Employer Id starts a new report page.
Visit Begin Date	Required
Visit End Date	Required

Standard Report Name: EVV Clock In/Clock Out Usage Report

Report Description

This report shows the number of accepted EVV Visit Transactions by a Service Attendant, the number of times each method (Mobile, GUI, etc.) was used to clock in or clock out, as well as the number of visits that were auto-verified. The report will be requested through, and the results displayed in, the EVV System, using the EVV Standard System Reports web service provided by MES service providers.

Report Field Listing

EVV Clock In/Clock Out Report Fields	Field Description	Associated EVV Visit Transaction Field
Texas EVV Attendant ID	The last four digits of the employee's social security number or passport number and last name of the person providing EVV services	EMPLOYEE_SOCSEC_VISA_PASSPORT
Attendant Last Name	The first name of the person providing EVV services	EMPLOYEE_FIRSTNAME
Attendant First Name	The last name of the person providing EVV services	EMPLOYEE_LASTNAME
Medicaid ID	Member's Medicaid Identification Number	INDVMBR_MEDICAIDID
Provider Name	The legal name of the program provider or Financial Management Services Agency (FMSA)	PROVIDER_LEGALNAME
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services	PROVIDER_NPI PROVIDER_API
TIN	The Tax Identification Number for the provider or FMSA	PROVIDER_TIN
Provider Number	The Long-Term Care (LTC) provider number if applicable	PROVIDER_CONTRACTNUMBER
TPI	The Texas Provider Identifier if applicable	PROVIDER_TPI
Total Accepted Visits	The total number of visits accepted by the EVV Aggregator that meet the search criteria	N/A
Auto Verified Count	The number of Auto Verified visits accepted into the EVV Aggregator that meet the search criteria.	EVV_AUTOCONFIRMFLAG
% Auto Verified	The percentage of Auto Verified visits out of the Total Accepted Visits	N/A
GUI Count	Number of visits from the Total Accepted Visits where GUI was used as the Clock In Method or the Clock Out Method	EVV_INPUTMETHOD_IN EVV_INPUTMETHOD_OUT

EVV Clock In/Clock Out Report Fields	Field Description	Associated EVV Visit Transaction Field
% GUI	The percentage of GUI visits out of the Total Accepted Visits. GUI was entered as either the clock in method or the clock out method	N/A
Landline Count	Number of visits from the Total Accepted Visits where Landline was used as the Clock In Method or the Clock Out Method	EVV_INPUTMETHOD_IN EVV_INPUTMETHOD_OUT
% Landline	The percentage of Landline visits out of the Total Accepted Visits. Landline was entered as either the clock in method or the clock out method	N/A
Alternative Device Count	Number of visits from the Total Accepted Visits where Alternative Device was used as the Clock In Method or the Clock Out Method	EVV_INPUTMETHOD_IN EVV_INPUTMETHOD_OUT
% Alt Device	The percentage of Alternative Device visits out of the Total Accepted Visits. Alternative Device was entered as either the clock in method or the clock out method	N/A
Mobile Method Count	Number of visits from the Total Accepted Visits where Mobile Method was used as the Clock In Method or the Clock Out Method	EVV_INPUTMETHOD_IN EVV_INPUTMETHOD_OUT
% Mobile Method	The percentage of Mobile Method visits out of the Total Accepted Visits. Mobile Method was entered as either the clock in method or the clock out method	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer
Sort Order	N/A (Report Generated by MES service providers)
Default Filter (The system applies this filter)	Only Accepted EVV Transactions, Submitting EVV System

*Report Generation Criteria **

Field Name	Required/Optional
Texas EVV Attendant ID	Optional
Medicaid ID	Required and populated with all Medicaid Ids that are linked to the CDS Employer Profile. May only select one Medicaid Id.
Visit Begin Date	Required
Visit End Date	Required
Payer Name	Optional
Export Format	Required

Details of the Field Length, Field Validations and Validation Error Message will be provided with the JSON

Standard Report Name: EVV Landline Phone Verification Report

Report Description

This report shows the phone number, phone type and carrier used by a Service Attendant to clock-in or clock-out using the home landline electronic verification method. The report allows for monitoring of phone numbers, to identify the use of non-landline numbers. This report is native to the EVV system and must be created by the EVV Vendor.

Report Field Listing

EVV Landline Phone Verification Report Fields	Field Description	Associated EVV Visit Transaction Field
Service Delivery Date Range (header)	Visit begin and end dates covered by the report.	N/A
Payer (header)	Name of the Payer, if the report is generated for one Payer, else “All”.	INDVMBR_PAYOR
Provider (header)	NPI/API and legal name of the program provider or Financial Management Services Agency (FMSA), if the report is generated for one program provider or FMSA, else “All”.	PROVIDER_NPI, PROVIDER_API, PROVIDER_LEGALNAME
CDS Employer (header)	CDS Employer Id and name, if the report is generated for one CDS Employer, else “All”.	EMPLOYEE_CDSEMPLOYEREVVID, EMPLOYEE_CDSEMPLOYERFIRSTNAME, EMPLOYEE_CDSEMPLOYERLASTNAME
Member ID	Member's Texas Medicaid Identification Number.	INDVMBR_MEDICAIDID
Member First Name	First Name of Member.	INDVMBR_FIRSTNAME
Member Last Name	Last Name of Member.	INDVMBR_LASTNAME
Phone Number	Phone number that was used to clock in or clock out via IVR for a visit (listed only once for a Member during a calendar month, regardless of the number of times the number was used for that Member during the month).	EVV_PHONE
Listed Phone Type	Phone type of the phone number (such as Landline, Mobile, Fixed VoIP, Non-Fixed VoIP, etc.) from a 3rd party validation service.	N/A
Listed Carrier	Registered carrier for the phone number such as AT&T, Verizon, etc., per 3rd party validation.	N/A
Month	The calendar month and year during which the phone number was used.	N/A
NPI/API	NPI or API of the program provider or FMSA.	PROVIDER_NPI PROVIDER_API
Provider Name	Legal name of the program provider or FMSA.	PROVIDER_LEGALNAME

EVV Landline Phone Verification Report Fields	Field Description	Associated EVV Visit Transaction Field
Payer (detail)	HHSC (Acute Care), LTC (Fee For Service Long Term Care) or name of MCO, as identified on the visit transaction.	INDVMBR_PAYOR

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer, Program Provider or FMSA, MCO, HHSC
Sort Order	Member ID, Phone Number, Month
Default Filter (The system applies this filter)	Only Accepted EVV Transactions

Report Generation Criteria

Field Name	Required/Optional
CDS Employer ID	*When logged in user is a CDS Employer:* Required and populated with the CDS Employer Id that is associated with the user. *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to CDS Employer Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Optional (but restricted to CDS Employer Ids that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
NPI/API	*When logged in user is a CDS Employer:* N/A *When logged in user is from a Program Provider or FMSA:* Required and restricted to the NPIs/APIs that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to NPIs/APIs that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional

Field Name	Required/Optional
Payer Name	*When logged in user is a CDS Employer:* Optional (but restricted to Payers that are associated with Member Ids that are associated with the CDS Employer). *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to Payers that are associated with Member Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Required and populated with the Payer Name that is associated with the MCO. *When logged in user is from HHSC (or its designee):* Optional
Visit Begin Date	Required
Visit End Date	Required

Standard Report Name: EVV Reason Code Usage and Free Text Report

Report Description

This report shows the count of Reason Code number and description combinations and associated free text/comments used on accepted EVV Visit Transactions for a Member and requested date range. The report will be requested through, and the results displayed in, the EVV System, using the EVV Standard System Reports web service provided by MES service providers.

Report Field Listing

EVV Reason Code Usage and Free Text Report Fields	Field Description	Associated EVV Visit Transaction Field
Reason Code Summary Section	This report section shows a summary of the reason code counts by Payer	
Reason Code Number	The Texas EVV Reason Code Number	EVV_REASONCODE1 EVV_REASONCODE2 ... EVV_REASONCODE10
Reason Code	The Texas EVV Reason Code	Reference HHSC EVV Reason Codes on the HHSC EVV website.
Reason Code Description	The Texas EVV Reason Code Description	EVV_REASONCODE1DESC EVV_REASONCODE2DESC ... EVV_REASONCODE10DESC
Count	The count of each reason code, reason code number, and reason code description for accepted EVV Visit transactions during the time period selected	N/A
Summary of Reason Codes by Provider Identifiers	This report section shows a summary of the reason code counts by Provider	
Provider Name	The legal name of the program provider or Financial Management Services Agency (FMSA)	PROVIDER_LEGALNAME
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services	PROVIDER_NPI PROVIDER_API
TIN	The Tax Identification Number for the provider or FMSA	PROVIDER_TIN
Provider Number	The Long-Term Care (LTC) provider number if applicable	PROVIDER_CONTRACTNUMBER
TPI	The Texas Provider Identifier if applicable	PROVIDER_TPI
EVV System	Name of the EVV System	EVV_VENDORID

EVV Reason Code Usage and Free Text Report Fields	Field Description	Associated EVV Visit Transaction Field
Reason Code Number	The Texas EVV Reason Code Number	EVV_REASONCODE1 EVV_REASONCODE2 … EVV_REASONCODE10
Reason Code	The Texas EVV Reason Code	Reference HHSC EVV Reason Codes on the HHSC EVV website.
Reason Code Description	The Texas EVV Reason Code Description	EVV_REASONCODE1DESC EVV_REASONCODE2DESC … EVV_REASONCODE10DESC
Count	The count of each reason code, reason code number, and reason code description for accepted EVV Visit transactions during the time period selected	N/A
Reason Codes/Free Text Details for Provider Identifiers by Medicaid ID	This report section shows a listing of the reason codes used by visit with the associated reason code free text description	
Provider Name	The legal name of the program provider or Financial Management Services Agency (FMSA)	PROVIDER_LEGALNAME
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services	PROVIDER_NPI PROVIDER_API
TIN	The Tax Identification Number for the provider or FMSA	PROVIDER_TIN
Provider Number	The Long-Term Care (LTC) provider number if applicable	PROVIDER_CONTRACTNUMBER
TPI	The Texas Provider Identifier if applicable	PROVIDER_TPI
Medicaid ID	Member's Medicaid Identification Number	INDVMBR_MEDICAIDID
Individual Last Name	Last Name of Member	INDVMBR_LASTNAME
Individual First Name	First Name of Member	INDVMBR_FIRSTNAME
EVV System	Name of the Proprietary System Operator	EVV_VENDORID
Reason Code Number	The Texas EVV Reason Code Number	EVV_REASONCODE1 EVV_REASONCODE2 … EVV_REASONCODE10
Reason Code	The Texas EVV Reason Code	Reference HHSC EVV Reason Codes on the HHSC EVV website.

EVV Reason Code Usage and Free Text Report Fields	Field Description	Associated EVV Visit Transaction Field
Reason Code Description	The Texas EVV Reason Code Description	EVV_REASONCODE1DESC EVV_REASONCODE2DESC … EVV_REASONCODE10DESC
Count	The count of each reason code, reason code number, and reason code description for accepted EVV Visit transactions during the time period selected	N/A
Visit Date	The date the EVV service occurred	EVV_VISITDATE
Visit ID	A unique ID number assigned to the EVV visit transaction by the EVV system	VISIT_VISITID
Actual Call In	The time the attendant electronically clocked in when service delivery began: HH:MM AM/PM Null for manually entered (GUI) visits.	EVV_CALLINTIME
Actual Call Out	The time the attendant electronically clocked out when service delivery ended: HH:MM AM/PM Null for manually entered (GUI) visits.	EVV_CALLOUTTIME
Reason Code Number	The Texas EVV Reason Code Number	EVV_REASONCODE1 EVV_REASONCODE2 … EVV_REASONCODE10
Reason Code	The Texas EVV Reason Code	Reference HHSC EVV Reason Codes on the HHSC EVV website.
Reason Code Description	The Texas EVV Reason Code Description	EVV_REASONCODE1DESC EVV_REASONCODE2DESC … EVV_REASONCODE10DESC
Reason Code Free Text Description	The free text manually entered for the specific visit	EVV_REASONCODE1COMMENT EVV_REASONCODE2COMMENT … EVV_REASONCODE10COMMENT

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer
Sort Order	N/A (Report Generated by MES service providers)
Default Filter (The system applies this filter)	Only Accepted EVV Transactions, Submitting EVV System

*Report Generation Criteria **

Field Name	Required/Optional
Year	Required
Monthly Range	Required
Medicaid ID	Required and populated with all Medicaid Ids that are linked to the CDS Employer Profile. May only select one Medicaid Id.
Payer Name	Optional
Export Format	Required

Details of the Field Length, Field Validations and Validation Error Message will be provided with the JSON

Standard Report Name: EVV Service Delivery Exception Report

Report Description

This report shows the number of visits that varied from the schedule or authorization, as well as the number of visits that were not approved, for a requested date range. This Report must include the following data points at a minimum:
Service scheduled but not performed
Service performed but not scheduled
Service performed but not authorized
Service authorized but not performed
Service performed but not approved/confirmed
This data must include services regardless of service delivery locations (home or community location, and GPS coordinates when the mobile method is used to clock in/out). This report is native to the EVV system and must be created by the EVV Vendor.

Report Field Listing

EVV Service Delivery Exception Report Fields	Field Description	Associated EVV Visit Transaction Field
Service Delivery Date Range (header)	Visit begin and end dates covered by the report. The report must accommodate a Service Delivery Date Range of at least four months.	N/A
Payer (header)	Name of the Payer, if the report is generated for one Payer, else “All”.	INDVMBR_PAYOR
Provider (header)	NPI/API and legal name of the program provider or Financial Management Services Agency (FMSA), if the report is generated for one program provider or FMSA, else “All”.	PROVIDER_NPI, PROVIDER_API, PROVIDER_LEGALNAME
CDS Employer (header)	CDS Employer Id and name, if the report is generated for one CDS Employer, else “All”.	EMPLOYEE_CDSEMPLOYEREVVID, EMPLOYEE_CDSEMPLOYERFIRSTNAME, EMPLOYEE_CDSEMPLOYERLASTNAME
Generated Date (header)	The date the report was generated by the EVV System.	N/A
Service scheduled but not performed	The count of service delivery exceptions where the service was scheduled but not performed during each calendar month included in the service delivery date range. Daily Fixed Schedule Criteria: No visit exists matching the Schedule for Member, Service Provider, Service, Date, and Time In and Time Out	N/A

EVV Service Delivery Exception Report Fields	Field Description	Associated EVV Visit Transaction Field
	Daily Variable Schedule Criteria: No visit exists matching the Schedule for Member, Service Provider, Service, Date, and Duration Weekly Variable Schedule Criteria: No visit exists matching the Schedule for Member, Service Provider, Service, and Date within the Weekly Schedule Begin and End Date range.	
Service performed but not scheduled	The count of service delivery exceptions where the service was performed but not scheduled during each calendar month included in the service delivery date range.	N/A
Service performed but not authorized	The count of service delivery exceptions where the service was performed but not authorized during each calendar month included in the service delivery date range.	N/A
Service authorized but not performed	The count of service delivery exceptions where the service was authorized but not performed during each calendar month included in the service delivery date range.	N/A
Service performed but not approved/confirmed	The count of service delivery exceptions where the service was performed but not approved/confirmed during each calendar month included in the service delivery date range.	N/A
Total	The count of services listed in each service row of the report.	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer, Program Provider or FMSA, MCO, HHSC
Sort Order	N/A
Default Filter (The system applies this filter)	N/A

Report Generation Criteria

Field Name	Required/Optional
CDS Employer ID	*When logged in user is a CDS Employer:*

Field Name	Required/Optional
	Required and populated with the CDS Employer Id that is associated with the user. *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to CDS Employer Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Optional (but restricted to CDS Employer Ids that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
NPI/API	*When logged in user is a CDS Employer:* N/A *When logged in user is from a Program Provider or FMSA:* Required and restricted to the NPIs/APIs that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to NPIs/APIs that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
Payer Name	*When logged in user is a CDS Employer:* Optional (but restricted to Payers that are associated with Member Ids that are associated with the CDS Employer). *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to Payers that are associated with Member Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Required and populated with the Payer Name that is associated with the MCO. *When logged in user is from HHSC (or its designee):* Optional
Visit Begin Date	Required
Visit End Date	Required

Standard Report Name: EVV Units of Service Summary

Report Description

This report displays a calendar view summary at the service level of the number of units delivered each day on accepted EVV Visit Transactions for a Member and requested date range. The report will be requested through, and the results displayed in, the EVV System, using the EVV Standard System Reports web service provided by MES service providers.

Report Field Listing

EVV Units of Service Summary Report Fields	Field Description	Associated EVV Visit Transaction Field
EVV Units of Service Summary	This report shows the summary information,	
Provider Legal Name	The legal name of the program provider or Financial Management Services Agency (FMSA)	PROVIDER_LEGALNAME
Provider DBA	Provider Doing Business As Name	PROVIDER_DBA
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services	PROVIDER_NPI PROVIDER_API
TIN	The Tax Identification Number for the program provider or FMSA	PROVIDER_TIN
Provider Number	The Long-Term Care (LTC) provider number if applicable	PROVIDER_CONTRACTNUMBER
Member Medicaid ID	Member's Medicaid Identification Number	INDVMBR_MEDICAIDID
Individual Last Name	Last Name of Member	INDVMBR_LASTNAME
Individual First Name	First Name of Member	INDVMBR_FIRSTNAME
Payer	HHSC or name of MCO associated with the payer identifier submitted on visit transaction	INDVMBR_PAYOR (This field contains a 3-4 character identifier associated to a payer, the payer name should be displayed on the report)
Total Units Verified on Report	Blank field used by HHSC Contract Monitoring	N/A
Total Units Authorized on Report	Blank field used by HHSC Contract Monitoring	N/A
Total Units Eligible for Payment on Report	Blank field used by HHSC Contract Monitoring	N/A
Total Units Paid on Report	Blank field used by HHSC Contract Monitoring	N/A
Total Units Disallowed on Report	Blank field used by HHSC Contract Monitoring	N/A

EVV Units of Service Summary Report Fields	Field Description	Associated EVV Visit Transaction Field
Service Group	A code that identifies the LTC program when applicable	VISIT_SVCGRP
Service Code	A code that identifies the service provided	EVV_SVCCODE
HCPCS	Identifies the service provided	EVV_HCPCS_CODE
Modifier(s)	The modifier associated with the HCPCS for the service if applicable	EVV_MODIFIER
EVV Units of Service by Month	This report section shows the daily, weekly, and monthly totals of service unit's delivery for a specific Medicaid ID.	
Month/Year	The name of the month and the year in long date format for the report	N/A
Priority Status	Blank field used by HHSC Contract Monitoring	N/A
Non Priority Status	Blank field used by HHSC Contract Monitoring	N/A
Fixed Schedule	Blank field used by HHSC Contract Monitoring	N/A
Variable Schedule	Blank field used by HHSC Contract Monitoring	N/A
SUN	The date for the month with the daily count of EVV service units delivered for the specific Medicaid ID for that day. The field is repeated for each week of the month.	EVV_UNITS (sum of all units for all visits on the day for the above criteria)
MON	The date for the month with the daily count of EVV service units delivered for the specific Medicaid ID for that day. The field is repeated for each week of the month.	EVV_UNITS (sum of all units for all visits on the day for the above criteria)
TUE	The date for the month with the daily count of EVV service units delivered for the specific Medicaid ID for that day. The field is repeated for each week of the month.	EVV_UNITS (sum of all units for all visits on the day for the above criteria)
WED	The date for the month with the daily count of EVV service units delivered for the specific Medicaid ID for that day. The field is repeated for each week of the month.	EVV_UNITS (sum of all units for all visits on the day for the above criteria)
THU	The date for the month with the daily count of EVV service units delivered for the specific Medicaid ID for that day. The field is repeated for each week of the month.	EVV_UNITS (sum of all units for all visits on the day for the above criteria)
FRI	The date for the month with the daily count of EVV service units delivered for the specific Medicaid ID for that day. The field is repeated for each week of the month.	EVV_UNITS (sum of all units for all visits on the day for the above criteria)
SAT	The date for the month with the daily count of EVV service units delivered for the specific	EVV_UNITS (sum of all units for all visits on the day for the above criteria)

EVV Units of Service Summary Report Fields	Field Description	Associated EVV Visit Transaction Field
	Medicaid ID for that day. The field is repeated for each week of the month.	
A. Units Verified	Sum of the EVV Service units for each week	N/A
B. Authorized Weekly Units	Blank field used by HHSC Contract Monitoring	N/A
C. Lesser Amt = Verified Units	Blank field used by HHSC Contract Monitoring	N/A
D. Units Paid	Blank field used by HHSC Contract Monitoring	N/A
E. Units Disallowed	Blank field used by HHSC Contract Monitoring	N/A
F. Service Interrupt (Y/N)	Blank field used by HHSC Contract Monitoring	N/A
Sum of Units Verified for the Month Reviewed	Sum of the EVV Service units for the month	N/A
Notes	Blank field used by HHSC Contract Monitoring	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF
Report Available To	CDS Employer
Sort Order	N/A (Report Generated by MES service providers)
Default Filter (The system applies this filter)	Only Accepted EVV Transactions, Submitting EVV System

*Report Generation Criteria **

Field Name	Required/Optional
Visit Begin Date	Required
Visit End Date	Required
Medicaid ID	Required and populated with all Medicaid Ids that are linked to the CDS Employer Profile. May only select one Medicaid Id.
Payer Name	Optional
Export Format	Required

Details of the Field Length, Field Validations and Validation Error Message will be provided with the JSON

Standard Report Name: Non-EVV Relevant Time Logged Report

Report Description

This report shows time that was spent on non-EVV services between clock in and clock out for a requested date range. This report is native to the EVV system and must be created by the EVV Vendor.

Report Field Listing

Non-EVV Relevant Time Logged Report Fields	Field Description	Associated EVV Visit Transaction Field
Service Delivery Date Range (header)	Visit begin and end dates covered by the report.	N/A
Provider (header)	NPI/API and legal name of the program provider or Financial Management Services Agency (FMSA), if the report is generated for one program provider or FMSA, else “All”.	PROVIDER_NPI, PROVIDER_API, PROVIDER_LEGALNAME
CDS Employer (header)	CDS Employer Id and name, if the report is generated for one CDS Employer, else “All”.	EMPLOYEE_CDSEMPLOYEREVVID, EMPLOYEE_CDSEMPLOYERFIRSTNAME, EMPLOYEE_CDSEMPLOYERLASTNAME
Member (header)	Member Id and name, if the report is generated for one Member, else “All”.	INDVMBR_MEDICAIDID, INDVMBR_FIRSTNAME, INDVMBR_LASTNAME
Provider Legal Name	Legal name of the program provider or Financial Management Services Agency (FMSA).	PROVIDER_LEGALNAME
Provider DBA Name	Doing Business As name of the program provider or FMSA.	PROVIDER_DBA
NPI/API	NPI or API of the program provider or FMSA.	PROVIDER_NPI PROVIDER_API
TIN	Tax Identification Number of the program provider or FMSA.	PROVIDER_TIN
Location	Location of the program provider or FMSA, as documented in the EVV System.	N/A
Region	HHSC Region of the program provider or FMSA, as documented in the EVV System.	N/A
SDA	Managed Care Service Delivery Area of the program provider or FMSA, as documented in the EVV System.	N/A
Contract Number	Long-Term Care (LTC) provider number, if applicable.	PROVIDER_CONTRACTNUMBER

Member ID	Member's Texas Medicaid Identification Number.	INDVMBR_MEDICAIDID
Member First Name	First Name of the Member.	INDVMBR_FIRSTNAME
Member Last Name	Last Name of the Member.	INDVMBR_LASTNAME
Texas EVV Attendant ID	Last four digits of the employee's social security number or passport number and last name of the person providing EVV services.	EMPLOYEE_SOCSEC_VISA_PASSPORT
Service Attendant First Name	First name of the person providing EVV services.	EMPLOYEE_FIRSTNAME
Service Attendant Last Name	Last name of the person providing EVV services.	EMPLOYEE_LASTNAME
Visit ID	Unique ID number assigned to the EVV visit transaction by the EVV System.	VISIT_VISITID
Visit Date	The date of the EVV service delivery during which the Non-EVV relevant service occurred (in MM/DD/YYYY format).	EVV_VISITDATE
Non-EVV Relevant Hours	Number of hours identified as Non-EVV Relevant by the Service Attendant during the EVV service delivery (in n.nn format).	N/A
Service Attendant Total Non-EVV Relevant Hours	Calculated sum of the non-EVV relevant hours worked by the Service Attendant during the period.	N/A
Member Total Non-EVV Relevant Hours	Calculated sum of the non-EVV relevant hours worked by all Service Attendants providing non-EVV relevant services to the Member during the period.	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer, Program Provider or FMSA, MCO, HHSC
Sort Order	Member ID, Texas EVV Attendant ID, Visit ID
Default Filter (The system applies this filter)	N/A

Report Generation Criteria

Field Name	Required/Optional
CDS Employer ID	*When logged in user is a CDS Employer:*

Field Name	Required/Optional
	Required and populated with the CDS Employer Id that is associated with the user. *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to CDS Employer Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Optional (but restricted to CDS Employer Ids that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
Member ID	*When logged in user is a CDS Employer:* Optional (but restricted to the Member Ids that are associated with the CDS Employer). *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to Member Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Optional (but restricted to Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
NPI/API	*When logged in user is a CDS Employer:* N/A *When logged in user is from a Program Provider or FMSA:* Required and restricted to the NPIs/APIs that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to NPIs/APIs that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
Visit Begin Date	Required
Visit End Date	Required

Standard Report Name: EVV Alternative Device Order Status Report

Report Description

This report is used to verify that Alternative Devices have been ordered by the program provider, CDS Employer, or Financial Management Services Agency (FMSA) on behalf of the CDS Employer, and to track the status of those orders. This report is native to the EVV system and must be created by the EVV Vendor. This report is not required for PSOs.

Report Field Listing

Report Fields	Field Description	Associated EVV Visit Transaction Field
Date Range (header)	Begin and end dates covered by the report, taking ***all date fields*** into account (AD Ordered Date, AD First Used Date, AD Returned Date, etc.). If one or more dates for an AD are covered, that AD is included in the report.	N/A
Payer (header)	Name of the Payer, if the report is generated for one Payer, else “All”.	INDVMBR_PAYOR
TIN (header)	TIN of the program provider or FMSA, if the report is generated for one TIN, else “All”.	PROVIDER_TIN
Provider (header)	NPI/API and legal name of the program provider or FMSA, if the report is generated for one program provider or FMSA, else “All”.	PROVIDER_NPI, PROVIDER_API, PROVIDER_LEGALNAME
Contract (header)	HHSC Contract Number of the program provider or FMSA, if the report is generated for one Contract Number, else “All”.	PROVIDER_CONTRACTNUMBER
CDS Employer (header)	CDS Employer Id and name, if the report is generated for one CDS Employer, else “All”.	EMPLOYEE_CDSEMPLOYEREVVID, EMPLOYEE_CDSEMPLOYERFIRSTNAME, EMPLOYEE_CDSEMPLOYERLASTNAME
Member (header)	Member Id and name, if the report is generated for one Member, else “All”.	INDVMBR_MEDICAIDID, INDVMBR_FIRSTNAME, INDVMBR_LASTNAME
AD ID (header)	The serial number or device identifier for the Alternative Device, if the report is generated for one Alternative Device, else “All”.	EVV_ALTERNATIVEDEVICEID
Provider Legal Name	The legal name of the program provider or FMSA.	PROVIDER_LEGALNAME
Provider DBA Name	Program provider or FMSA Doing Business As name. This is a name that a person or business uses, other than their official name, in order to transact business.	PROVIDER_DBA

Report Fields	Field Description	Associated EVV Visit Transaction Field
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services. A Health Insurance Portability and Accountability Act (HIPAA) mandated unique identifier assigned by the Centers for Medicare and Medicaid Services (CMS) to a program provider or FMSA.	PROVIDER_NPI PROVIDER_API
TIN (detail)	A unique identifier assigned by the Social Security Administration or Internal Revenue Service (IRS) to a program provider or FMSA for tax purposes.	PROVIDER_TIN
Location	Location of the program provider or FMSA, as documented in the EVV System.	N/A
Region	HHSC Region of the program provider or FMSA, as documented in the EVV System.	N/A
SDA	Managed Care Service Delivery Area of the program provider or FMSA, as documented in the EVV System.	N/A
Contract Number	A unique number assigned by HHSC when a program provider or FMSA contracts directly with HHSC to provide Long Term Services and Supports (aka Long-Term Care) program services.	PROVIDER_CONTRACTNUMBER
Member ID	The Member's Texas Medicaid identification number.	INDVMBR_MEDICAIDID
Member First Name	The first name of the person receiving services.	INDVMBR_FIRSTNAME
Member Last Name	The last name of the person receiving services.	INDVMBR_LASTNAME
AD ID (detail)	The serial number or device identifier for an Alternative Device.	EVV_ALTERNATIVEDEVICEID
AD Status	The status of the Alternative Device (Active or Inactive).	N/A
AD Ordered Date	The date when the Alternative Device was ordered.	N/A
AD Assigned Date	The date when the Alternative Device was assigned by the Vendor.	N/A
AD Shipped Date	The date when the Alternative Device was shipped. Will be blank if the Alternative Device was picked up in person (not shipped).	N/A
Shipping Carrier	Shipping Carrier used to ship the Alternative Device to the program provider or FMSA. Will be “in Person” if the Alternative Device was picked up in person (not shipped).	N/A
Tracking Number	Tracking number associated to the Alternative Device shipment. Will be blank if the Alternative Device was picked up in person (not shipped).	N/A
AD Received Date	The date when the Alternative Device was received.	N/A

Report Fields	Field Description	Associated EVV Visit Transaction Field
AD First Used Date	The date when the Alternative Device was first used.	N/A
AD Last Used Date	The date when the Alternative Device was last used.	N/A
AD Unassigned Date	The date when the Alternative Device was relinquished by the assigned Member and made available for assignment to, and use by, another Member.	N/A
AD Deactivated Date	The date when the Alternative Device was deactivated.	N/A
AD Returned Date	The date when the Alternative Device was returned to the Vendor.	N/A
AD Returned Reason	The reason Alternative Device was return (Broken, Lost, Malfunctioning, etc.).	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF and Excel
Report Available To	CDS Employer, Program Provider or FMSA, MCO, HHSC
Sort Order	TIN, NPI/API, Contract Number, Member ID, AD Ordered Date
Default Filter (The system applies this filter)	N/A

Report Generation Criteria

Field Name	Required/Optional
CDS Employer ID	*When logged in user is a CDS Employer:* Required and populated with the CDS Employer Id that is associated with the user. *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to CDS Employer Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Optional (but restricted to CDS Employer Ids that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
Member ID	*When logged in user is a CDS Employer:* Optional (but restricted to the Member Ids that are associated with the CDS Employer).

Field Name	Required/Optional
	When logged in user is from a Program Provider or FMSA: Optional (but restricted to Member Ids that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
AD ID	*When logged in user is a CDS Employer:* Optional (but restricted to the AD Ids that are associated with the CDS Employer). *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to AD Ids that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to AD Ids that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
NPI/API	*When logged in user is a CDS Employer:* N/A *When logged in user is from a Program Provider or FMSA:* Required and restricted to the NPIs/APIs that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to NPIs/APIs that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional Note: Each NPI/API starts a new report page.
Contract Number	*When logged in user is a CDS Employer:* N/A *When logged in user is from a Program Provider or FMSA:* Required and restricted to Contract Numbers that are associated with the Program Provider or FMSA.

Field Name	Required/Optional
	When logged in user is from an MCO: Optional (but restricted to Contract Numbers that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
TIN	*When logged in user is a CDS Employer:* N/A *When logged in user is from a Program Provider or FMSA:* Required and restricted to the TINs that are associated with the Program Provider or FMSA. *When logged in user is from an MCO:* Optional (but restricted to TINs that are associated with Member Ids for which the MCO is the payer). *When logged in user is from HHSC (or its designee):* Optional
Payer Name	*When Logged in user is a CDS Employer:* Optional (but restricted to Payers that are associated with Member Ids that are associated with the CDS Employer). *When logged in user is from a Program Provider or FMSA:* Optional (but restricted to Payers that are associated with Member Ids that are associated with the Program Provider or FMSA). *When logged in user is from an MCO:* Required and populated with the Payer Name that is associated with the MCO. *When logged in user is from HHSC (or its designee):* Optional
Begin Date	Required
End Date	Required

Standard Report Name: EVV CDS Employer Usage Report

Report Description

This report shows the EVV usage score calculations for CDS Employers based on the percentage of total electronic EVV Visit Transactions and the total accepted EVV Visit Transactions for a Member and requested date range.

The report will be requested through, and the results displayed in, the EVV System using the EVV Standard System Reports web service provided by MES service providers.

Report Field Listing

Report Fields	Field Description	Associated EVV Visit Transaction Field
Payer	HHSC or name of MCO associated with the payer identifier submitted on visit transaction	INDVMBR_PAYOR (This field contains a 3–4-character identifier associated to a payer; the payer name should be displayed on the report)
EVV System	Name of the EVV System	EVV_VENDOR_ID
CDS Employer Name	CDS Employer Name	CDS_EMPLOYER_LAST_NAME CDS_EMPLOYER_FIRST_NAME
FMSA Name	The legal name of the program provider or Financial Management Services Agency (FMSA)	PROVIDER_LEGAL_NAME
Service Delivery Option	Agency: services are managed by a program provider CDS: services are self-directed	N/A
NPI/API	The NPI or API of the program provider or FMSA who provided EVV services	PROVIDER_NPI PROVIDER_API
Medicaid ID	Member's Medicaid Identification Number	INDV_MBR_MEDICAID_ID
EVV Usage Score	EVV usage score calculations for CDS Employers based on the percentage of total electronic EVV Visit Transactions and the total accepted EVV Visit Transactions for a Member For CDS Employers: Total Electronic EVV Visit Transactions / Total Accepted EVV Visit Transactions	N/A
Total Accepted Visit Transactions	Total Accepted EVV Visit Transactions	N/A

Report Fields	Field Description	Associated EVV Visit Transaction Field
Total Manual Visit Transactions	Total Manual EVV Visit Transactions	N/A
Total Electronic Visit Transactions	Total Electronic EVV Visit Transactions	N/A
EVV Implementation Group	Category identifying when an EVV service implemented in production to allow report to be filtered by: State-Required Personal Care Services CURES Act Personal Care Services (2021)	N/A

Report Parameters

Report Frequency	Ad-Hoc
Report Format	PDF, Excel and CSV
Report Available To	CDS Employer
Sort Order	N/A
Default Filter (The system applies this filter)	N/A

*Report Generation Criteria **

Field Name	Required/Optional
Fiscal Year	Required
Quarter	Required when Month is blank
Month	Required when Quarter is blank
Medicaid ID	Required
Payer Name	Optional
EVV Implementation Group	Optional
Export Format	Required

Details of the Field Length, Field Validations and Validation Error Message will be provided with the JSON

Appendix H – N/A

Appendix I – N/A

Appendix J – Service Delivery Locations

HHSC Electronic Visit Verification (EVV) Business Rules
Appendix J – Service Delivery Locations
Published Date: 02/25/2022
Effective Date: 05/31/2022

The EVV System must utilize the following list of allowable service delivery location values:

Member Home
Community
Family Home
Neighbor Home
Other

Appendix K – Texas-EVV Specific Terms

Electronic Visit Verification (EVV) Business Rules Appendix K - Texas-EVV Specific Terms
Published Date: 2/25/2022
Effective Date: 5/31/2022

Actual Hours
Acute Care
Alternative Device
Alternative Method
Bill(able) Hours
Clock In
Clock Out
Confirmed Visit
Consumer Directed Services (CDS) Employee
Consumer Directed Services (CDS) Employer
Designated Representative (DR)
Financial Management Services Agency (FMSA)
GUI/Manual Visit Transaction
Healthcare Common Procedure Coding System (HCPCS)
Last Visit Maintenance Date
Legally Authorized Representative (LAR)
Long-term Care (LTC)
Long-term Services and Supports (LTSS)
Managed Care Plan Code
Member
Mobile Method
National Provider Identifier (NPI)
Payer
Pending Visit
Prior/Service Authorization
Program Provider
Reason Code
Service Group
Service Attendant
Service Code
Sub-contracted Provider
Tax Identification Number (TIN)
Texas Provider Identifier (TPI)
Visit
Visit Maintenance
Visit Transaction
Visit/Service Location

Appendix L – Payer Plan Code Web Service

HHSC Electronic Visit Verification (EVV) Technical Documentation
Appendix L - Payer Plan Code Web Service
Published Date: 02/25/2022
Effective Date: 05/31/2022

Type of Record	Position of Data Element	Extract Data Element	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields	Transformation Logic	Comments	Table Name	Field Name	GUI Interface	WebService Name
Input		hcpcsCode	30	String				Required				hcpcsCode
Input		modifier	11	String				Conditionally Required modifier can be blank if the services are LTC				modifier
Input		serviceGroup	3	String				Conditionally Required serviceGroup and serviceCode is required when the payer is LTC.				serviceGroup
Input		serviceCode	50	String				Conditionally Required serviceGroup and serviceCode is required when the payer is LTC.				serviceCode
Input		medicaidID	9	Numeric				Required				medicaidID
Input		asOfDate	19	DateTime				Required This is the Date that the provider has selected the services for the individual. This could also be the date visits are scheduled in [State Pool System].				asOfDate
Output		errorMessage	N/A	String		Return 'Unexpected System Error' if there is a system error when trying to match on the input parameters and build a return object.						errorMessage
Output		validationErrors	N/A	String		**Format validation for all fields**- If doesn't match below Validation Error Message: The input was not valid. **Format validation for hcpcsCode** Validation: 30 digit Alphanumeric Then the system passes validation Else the system sets Validation Error Message Validation Error Message: The hcpcsCode is not in a valid format. *** Format validation for modifier** Validation: 11 digit Alphanumeric Then the system passes validation Else the system sets Validation Error Message Validation Error Message: The modifier is not in a valid format. *** Format validation for serviceGroup** Validation: 3 digit Numeric Then the system passes validation Else the system sets Validation Error Message Validation Error Message:						validationErrors
Output		payer	4	String					EVV.REF_EVV_PLAN_CODE_NEW	PLAN_CODE		payer
Output		planCode	2	String					EVV.REF_EVV_PLAN_CODE_NEW	PAYER ID		planCode

Appendix M – EVV Visit Data Layout Edits Crosswalk

HHSC Electronic Visit Verification (EVV) Business Rules Appendix M – EVV Visit Data Layout Edits Crosswalk

Published Date: 02/25/2022
Effective Date: 05/31/2022

Please Note: This file must be in pipe delimited format. Edits included in this document are executed when the EVV System transmits the EVV Visit Transaction to the EVV Aggregator.

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
Header record	1		This header record contains HHSC approved EVV System data transfer headers for all extract data elements contained in this file.	Ex00001	Business Edit	File error: file size is 0 KB, or file contains no transaction records or contains no Header record	0			
				Ex00002	Business Edit	File error: file format is incorrect			Pipe delimited	
				Ex00003	Business Edit	File error: file size is greater than the maximum allowable size.				
File record	1	PROVIDER_TIN	Provider Taxpayer Identification Number: A unique Identifier assigned by the Social Security Administration or Internal Revenue Service (IRS) to a Program Provider or Financial Management Services Agency (FMSA) for tax purposes.	Ex0001A	Format Edit	The Provider TIN on the EVV visit is not in a valid 9 digit TIN format.	30	Varchar	9 digit numeric NNNNNNNNN	Provider Web Service
				Ex0001B	Required Field Edit	The Provider TIN on the EVV visit is missing.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	2	PROVIDER_NPI	Provider National Provider Identifier (NPI): A Health Insurance Portability and Accountability Act (HIPAA) mandated unique identifier assigned by the Centers for Medicare and Medicaid Services (CMS) to a healthcare Program Provider or Financial Management Services Agency (FMSA).	Ex0002A	Format Edit	The Provider NPI on the EVV visit is not in a valid 10 character NPI format.	10	Varchar	10 digit numeric NNNNNNNNNN	
				Ex0002B	Required Field Edit	Provider NPI is required if Provider API is missing.				
				Ex0002C	Business Edit	Provider NPI cannot be validated as active for the visit date.				Provider Web Service
File record	3	PROVIDER_API	Provider Atypical Provider Identifier (API): A unique identifier assigned to a Program Provider or Financial Management Services Agency (FMSA) who does not provide healthcare services (i.e. Respite, transportation). Medicaid or State Issued API number.	Ex0003A	Format Edit	The Provider API on the EVV visit is not in a valid 10 character API format.	10	Varchar	10 character alphanumeric	
				Ex0003B	Required Field Edit	Provider API is required if Provider NPI is missing.				
				Ex0003C1	Business Edit	Provider API cannot be validated as active for the visit date.				
				Ex0003C2	Business Edit	Provider API cannot be sent in if Provider NPI is present on the visit file.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	4	PROVIDER_TPI	Texas Provider Identifier (TPI): A unique identifier assigned by the Claims Administrator to a Program Provider or Financial Management Services Agency (FMSA) delivering Acute Care fee-for-service services in Texas.	Ex0004A	Format Edit	Provider TPI on the EVV Visit is not in a valid 9 digit format.	9	Varchar	9 digit numeric NNNNNNNNN	Provider Web Service
				Ex0004C	Business Edit	The Provider TPI on the EVV visit is not associated with this provider NPI/API for the visit date.				
File record	5	PROVIDER_LEGALNAME	Provider Legal Name: Program Provider or Financial Management Services Agency (FMSA) legal name.	Ex0005A	Format Edit	Provider Legal Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Provider Web Service
				Ex0005B	Required Field Edit	The Provider Legal Name on the EVV visit is missing.				
File record	6	PROVIDER_DBA	Provider Doing Business As Name: Program Provider or Financial Management Services Agency (FMSA) Doing Business As name. This is a name that a person or business uses, other than their official name, in order to transact business.	Ex0006A	Format Edit	Provider DBA on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Provider Web Service
File record	7	PROVIDER_CONTRACT NUMBER	Provider Contract Number: A unique number assigned by HHSC when a Program Provider/FMSA contracts directly with HHSC to provide Long Term Services and Supports (aka Long Term Care) program services.	Ex0007A	Format Edit	The Provider Number on the EVV visit is not in a valid 9 digit format.	9	Number	9 digit numeric NNNNNNNNN	Provider Web Service

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex0007B	Required Field Edit	The Provider Number is a required field on the EVV visit if Service Group or Service Code is present on the EVV Visit File.				
				Ex0007C1	Business Edit	The Provider Number on the EVV visit is not associated with this provider NPI/API for the Visit Date.				
				Ex0007C2	Business Edit	Member on the EVV visit is not authorized for this Provider Number on this visit date in our records.				
File record	8	PROVIDER_ADDRESS1	Provider Address Line 1: Physical address for the Program Provider or Financial Management Services Agency (FMSA). This address may be the same for many different office locations.	Ex0008A	Format Edit	Provider Address 1 on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Provider Web Service
				Ex0008B	Required Field Edit	The Provider Address 1 on the EVV visit is missing.				
File record	9	PROVIDER_ADDRESS2	Provider Address Line 2: Additional mailing address information for the Program Provider or Financial Management Services Agency (FMSA). This address may be the same for many different office locations.	Ex0009A	Format Edit	Provider Address 2 on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Provider Web Service
File record	10	PROVIDER_CITY	Provider City: The city where the Program Provider or Financial Management Services Agency (FMSA) address is located.	Ex00010A	Format Edit	Provider City on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Provider Web Service

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00010B	Required Field Edit	The Provider City on the EVV visit is missing.				
File record	11	PROVIDER_STATE	Provider State: The state where the Program Provider or Financial Management Services Agency (FMSA) address is located.	Ex00011A	Format Edit	Provider State on the EVV Visit has exceeded the maximum allowed length for that field.	2	Varchar		Provider Web Service
				Ex00011B	Required Field Edit	The Provider State on the EVV visit is missing.				
File record	12	PROVIDER_ZIP	Provider Zip: The zip code for which the Program Provider or Financial Management Services Agency (FMSA) address is located.	Ex00012A	Format Edit	The Provider Zip on the EVV visit is not in a valid 5 digit format.	5	Number	5 digit numeric NNNNN	Provider Web Service
				Ex00012B	Required Field Edit	The Provider Zip on the EVV visit is missing.				
File record	13	PROVIDER_LOCATIONID	Provider Location Identification: A number assigned by the Program Provider or Financial Management Services Agency (FMSA) for a particular physical address from which services are provided.	Ex00013A	Format Edit	Provider Location ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
File record	14	PROVIDER_REGION	HHSC Provider Region: The location of where the Program Provider or Financial Management Services Agency (FMSA) is located. HHSC Medicaid LTC has 11 regions.	Ex00014A	Format Edit	The Provider Region on the EVV visit is not in a valid format.	2	Number	1 (or) 2 digit Numeric format	Provider Web Service
File record	15	PROVIDER_EVVEFFDATE	Provider Electronic Visit Verification Effective Date: The date the Program Provider or Financial Management Services Agency (FMSA) became effective in the EVV System. This is the first verified visit date by the Program Provider or FMSA.	Ex00015A	Format Edit	The Provider EVV Effective Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00015B	Required Field Edit	The Provider EVV Effective Date on the EVV visit is missing.				
File record	16	PROVIDER_EVVENDDATE	Provider Electronic Visit Verification End Date: The date the Program Provider or Financial Management Services Agency (FMSA) terminates from the EVV System.	Ex00016A	Format Edit	The Provider EVV End Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	
				Ex00016C	Business Edit	The Provider EVV End Date on the EVV visit file should be greater than or equal to the EVV Visit Date.				
File record	17	EMPLOYEE_EMPLOYEEID	Employee Identification: An identifier assigned to the Service Provider by his or her employer for HR and payroll purposes.	Ex00017A	Format Edit	Employee ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex00017B	Required Field Edit	The Employee ID on the EVV visit is missing.				
File record	18	EMPLOYEE_SOCSEC_VISA_PASSPORT	Employee Social Security Visa Passport: It consists of the last four digits of a Service Provider's SSN or passport number concatenated with the Service Provider's last name.	Ex00018A1	Format Edit	Texas EVV Attendant ID on the EVV Visit has exceeded the maximum allowed length for that field.	54	Varchar		
				Ex00018A2	Format Edit	Texas EVV Attendant ID on the EVV Visit is not in a valid format.			4 Numeric followed by up to 50 characters.	
				Ex00018B	Required Field Edit	Texas EVV Attendant ID on the EVV visit is missing.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	19	EMPLOYEE_EMPLOYEE DISCIPLINE	Employee Discipline: Credentials of the Service Provider.	Ex00019A	Format Edit	The Employee Discipline on the EVV visit must be one of the valid values.	30	Varchar	Preselected list of valid values.	Attendant, Nurse, CNA, PT, OT, SLP, Other
				Ex00019B	Required Field Edit	The Employee Discipline on the EVV visit is missing.				
File record	20	EMPLOYEE_FIRSTNAME	Employee First Name: The Service Provider's first name.	Ex00020A	Format Edit	Employee First Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		
				Ex00020B	Required Field Edit	The Employee First Name on the EVV visit is missing.				
File record	21	EMPLOYEE_LASTNAME	Employee Last Name: The Service Provider's last name.	Ex00021A	Format Edit	Employee Last Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		
				Ex00021B	Required Field Edit	The Employee Last Name on the EVV visit is missing.				
File record	22	EMPLOYEE_EVVID	Electronic Visit Verification Identification: The Service Provider EVV System identifier number. This Identifier is assigned by the EVV System.	Ex00022A	Format Edit	Employee EVV ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex00022B	Required Field Edit	The Employee EVV ID on the EVV visit is missing.				
File record	23	EMPLOYEE_STARTDATE	Employee Start Date: The Service Provider start date. This is the date when the Service Provider became active on the EVV System.	Ex00023A	Format Edit	The Employee Start Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00023B	Required Field Edit	The Employee Start Date on the EVV visit is missing.				
File record	24	EMPLOYEE_ENDDATE	Employee End Date: The Service Provider end date. This is the date when the Service Provider was terminated on the EVV System.	Ex00024A	Format Edit	The Employee End Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	
File record	25	EMPLOYEE_EVVUSERID	Electronic Visit Verification Identification: This is an account name or login identifier, used by the Service Provider to log onto the EVV System. This is assigned by the EVV System. The EVV User identifier and Password are required credentials for logging onto the EVV System.	Ex00025A	Format Edit	Employee EVV User ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex00025B	Required Field Edit	The Employee EVV User ID on the EVV visit is required if it is a visit maintenance.				
File record	26	EMPLOYEE_EVVUSERFIRSTNAME	Electronic Visit Verification User First Name: The first name of the person associated with the EVV User ID.	Ex00026A	Format Edit	The Employee EVV User First Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		
				Ex00026B	Required Field Edit	The Employee EVV User First Name on the EVV visit is required if Employee EVV User ID is populated.				
File record	27	EMPLOYEE_EVVUSERLASTNAME	Electronic Visit Verification User Last Name: The last name of the person associated with the EVV User ID.	Ex00027A	Format Edit	Employee EVV User Last Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00027B	Required Field Edit	The Employee EVV User Last Name on the EVV visit is required if Employee EVV User ID is populated.				
File record	28	EMPLOYEE_CDSEMPLOYEREVVID	Consumer Directed Services Employer Electronic Visit Verification Identification: CDS employer identifier (if different from the individual receiving services e.g., a parent or guardian) assigned by the EVV System.	Ex00028A	Format Edit	CDS Employer EVV ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
File record	29	EMPLOYEE_CDSEMPLOYERFIRSTNAME	Consumer Directed Services Employer First Name: CDS employer first name (if different from the individual receiving services- e.g. a parent or guardian).	Ex00029A	Format Edit	CDS Employer First Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		
				Ex00029B	Required Field Edit	The CDS Employer First Name on the EVV visit is required if CDS Employer EVV ID is populated.				
File record	30	EMPLOYEE_CDSEMPLOYERLASTNAME	Consumer Directed Services Employer Last Name: CDS employer last name (if different from the individual receiving services- e.g., a parent or guardian).	Ex00030A	Format Edit	CDS Employer Last Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		
				Ex00030B	Required Field Edit	The CDS Employer Last Name on the EVV visit is required if CDS Employer EVV ID is populated.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	31	INDVMBR_PAYOR	Individual/Member Payor: A unique identifier assigned to the payor, which is obtained through the Payer Plan Code Web Service.	Ex00031A	Format Edit	The Member's Payer on the EVV visit must be one of the valid values.	4	Varchar	Preselected list of valid values.	AET, AGP, BCB, CFC, CHS, CKC, CMC, DRC, HHSC, LTC, MOL, SHP, TXC, UHC From Payer Plan Code Web service.
				Ex00031B	Required Field Edit	The Member's Payer on the EVV visit is missing.				
				Ex00031C	Business Edit	The Member's Payer on the EVV visit does not match our records for this Member.				
File record	32	INDVMBR_FIRSTNAME	Individual/Member First Name: The first name of the individual/member receiving services.	Ex00032A	Format Edit	Member First Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		271 Response File
				Ex00032B	Required Field Edit	The Member First Name on the EVV visit is missing.				
File record	33	INDVMBR_LASTNAME	Individual/Member Last Name: The last name of the individual/member receiving services.	Ex00033A	Format Edit	Member Last Name on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		271 Response File
				Ex00033B	Required Field Edit	The Member Last Name on the EVV visit is missing.				
File record	34	INDVMBR_MEDICAIDID	Individual/Member Medicaid Identification: The individual's/member's Medicaid identifier number.	Ex00034A	Format Edit	Member Medicaid ID on the EVV Visit is not in a valid 9-digit Medicaid ID format.	9	Varchar		

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00034B	Required Field Edit	The Member Medicaid ID on the EVV visit is missing.				
				Ex00034C1	Business Edit	The Member Medicaid ID on the EVV visit is not found in our records.				
				Ex00034C2	Business Edit	The Member Medicaid ID on the EVV visit does not have active Medicaid eligibility for the visit date.				
File record	35	INDVMBR_MEMBERDOB	Individual/Member Date of Birth: The individual's/member's date of birth.	Ex00035A	Format Edit	The Member DOB on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	271 Response File
				Ex00035B	Required Field Edit	The Member DOB on the EVV visit is missing.				
File record	36	INDVMBR_MEMBEREVVID	Individual/Member Electronic Visit Verification Identification: The individual /member’s EVV System identifier number. This identifier is assigned by the EVV System.	Ex00036A	Format Edit	Member EVV ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex00036B	Required Field Edit	The Member EVV ID on the EVV visit is missing.				
File record	37	INDVMBR_STARTDATE	Individual/Member Start Date: The start date of when the individual/member became Medicaid eligible.	Ex00037A	Format Edit	The Member Start Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	271 Response File
				Ex00037B	Required Field Edit	The Member Start Date on the EVV visit is missing.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	38	INDVMBR_ENDDATE	Individual/Member End Date: The end date of when the individual/member became Medicaid eligible.	Ex00038A	Format Edit	The Member End Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	271 Response File
File record	39	INDVMBR_PRIORITY	Individual/Member Priority: A numerical value assigned to the individual/member by the Program Provider or Financial Management Services Agency (FMSA) based on their level of need. https://hhs.texas.gov/laws-regulations/handbooks/hcs/section-5000-level-care-level-need	Ex00039A	Format Edit	Member Priority on the EVV Visit has exceeded the maximum allowed length for that field.	1	Varchar		
File record	40	INDVMBR_PHONE	Individual/Member Phone: The primary phone number registered for EVV phone calls for the individual/member receiving services.	Ex00040A	Format Edit	The Member Phone on the EVV visit is not in a valid 10-digit numeric format.	10	Varchar	10-digit numeric format	
File record	41	INDVMBR_ALTPHONE	Individual/Member Alternative Phone: A secondary (additional) phone number registered for EVV telephone calls to the individual/member receiving services.	Ex00041A	Format Edit	The Member Alternate Phone on the EVV visit is not in a valid 10-digit numeric format.	10	Varchar	10-digit numeric format	
File record	42	INDVMBR_ALTPHONE2	Individual/Member Alternative Phone 2: Another secondary (additional) phone number registered for EVV telephone calls to the individual/member receiving services.	Ex00042A	Format Edit	The Member Alternate Phone 2 on the EVV visit is not in a valid 10-digit numeric format.	10	Varchar	10-digit numeric format	
File record	43	MCO_MBR_SDA	Managed Care Organization (MCO) Plan code for which the member is enrolled. Member MCO Plan Code is available in the Payer Plan Code Web Service.	Ex00043A	Format Edit	MCO Member SDA on the EVV Visit has exceeded the maximum allowed length for that field.	2	Varchar		Plan Code from Payer Plan Code Web service.

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00043B	Required Field Edit	The MCO Member SDA on the EVV visit is required if the Member's Payer is Managed Care.				Null for HHSC or LTC payer
				Ex00043C	Business Edit	The plan code on the visit is not associated with the Member's Payer.				Plan Code is not required for HHSC or LTC payer but if submitted must be the MCO plan code for which the member is enrolled.
File record	44	INDVMBR_ADDRESS_LATITUDE	Individual/Member Address Latitude: The latitude of the individual's/member's address. This is pre saved information in the EVV System (Based on the individual/member's address)	Ex00044A	Format Edit	Invalid GPS data format. Numeric fields must contain only numeric digits and not exceed length allowed. GPS must be in decimal degree format only.	50	Varchar	decimal degree format Java BigDecimal Precision and Scale PRECISION=50; SCALE up to 47;	Derived through geo-coding of member physical address
File record	45	INDVMBR_ADDRESS_LONGITUDE	Individual/Member Address Longitude: The longitude of the individual's/member's address. This is pre saved information in the EVV System (Based on the individual/member's address)	Ex00045A	Format Edit	Invalid GPS data format. Numeric fields must contain only numeric digits and not exceed length allowed. GPS must be in decimal degree format only.	50	Varchar	decimal degree format Java BigDecimal Precision and Scale PRECISION=50; SCALE up to 47;	Derived through geo-coding of member physical address
File record	46	INDVMBR_TOTAL_AUTHUNITS	Individual/Member Total Authorized Units: The total number of units authorized for an individual/member for a service to be delivered for a given time period.	Ex00046A	Format Edit	The Member Total Authorization units on the EVV visit is not in a valid numeric format.	11	Number	NNNNNNNN.NN	

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	47	AUTH_UNITS_TYPE	Individual/Member Authorized Units Type: The type of units authorized. Can be daily, weekly, monthly or per auth.	Ex00047A	Format Edit	Authorization Units Type on the EVV Visit has exceeded the maximum allowed length for that field.	10	Varchar		
File record	48	INDVMBR_TOTAL_AUTHUNITSREMAINING	Individual/Member Total Authorized Units Remaining: The total number of units remaining for an individual/member for a service to be delivered for a given time period. This is the value after the delivery of the units of service.	Ex00048A	Format Edit	The Member Total Authorization units remaining on the EVV visit is not in a valid numeric format.	11	Number	NNNNNNNN.NN	
File record	49	VISIT_VISITID	Electronic Visit Verification Visit Identification: A unique identifier number assigned to the EVV visit by the EVV System.	Ex00049A	Format Edit	Visit ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex00049B	Required Field Edit	The Visit ID on the EVV visit is missing.				
				Ex00049C1	Business Edit	Duplicate visit transaction found with this Visit ID.				
				Ex00049C2	Business Edit	No previous record found with this Visit ID for update.				
				Ex00049C3	Business Edit	This Visit ID was previously voided.				
File record	50	VISIT_SCHEDULEID	Schedule Identification: A unique identifier number assigned to the scheduled visit by the EVV System.	Ex00050A	Format Edit	Visit Schedule ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	51	VISIT_VISITDATE	Scheduled Visit Date: The date that the System User scheduled the Service Provider to perform services for the individual/member. Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Weekly Variable Schedule Begin Date is populated for Weekly Variable Schedule. Null for No Schedule.	Ex00051A	Format Edit	The Visit Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	The EVV System will populate this field with the Scheduled Visit Date from a Daily Fixed or Daily Variable Schedule Types and with the Weekly Variable Schedule Begin Date for a Weekly Variable Schedule Type.
File record	52	VISIT_VISITTIMEIN	Scheduled Visit Time In: Scheduled service delivery start time in date/time format. Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Null for Weekly Variable Schedule or No Schedule.	Ex00052A	Format Edit	The Visit Time in on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM/PM.	The EVV System will populate this field with the Scheduled Visit Time In from a Daily Fixed or Daily Variable Schedule, but Null for a Weekly Variable Schedule Type.
File record	53	VISIT_VISITTIMEOUT	Scheduled Visit Time Out: Service delivery stop time in date/time format. Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Null for Weekly Variable Schedule or No Schedule.	Ex00053A	Format Edit	The Visit Time Out on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM/PM.	The EVV System will populate this field with the Scheduled Visit Time Out from a Daily Fixed or Daily Variable Schedule but Null for a Weekly Variable Schedule Type.
File record	54	VISIT_VISITHOURS	Scheduled Visit Hours: Duration of services provided to the individual/member, shown as a decimal (Example: 1.25). Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Total Weekly Scheduled Hours is populated for Weekly Variable Schedule. Null for No Schedule.	Ex00054A	Format Edit	The Visit Hours on the EVV visit is not in a valid numeric format.	5	Number	NN.NN	The EVV System will populate this field with the Scheduled Visit Hours for a Daily Fixed or Daily Variable Schedule and with the Total Weekly Scheduled Hours for a Weekly Variable Schedule Type.

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	55	VISIT_VISITLOCATION	Scheduled Visit Location: The scheduled location where services are to be provided.	Ex00055A	Format Edit	Visit Location on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Appendix J
File record	56	VISIT_SVCGRP	Visit Service Group: A code assigned by HHSC for the Long Term Services and Supports (aka Long Term Care) fee-for-service program through which the Individual is receiving services.	Ex00056A	Format Edit	Service Group on the EVV Visit has exceeded the maximum allowed length for that field.	3	Number		HHSC EVV Service Bill Codes Table contains the full list of valid values
				Ex00056B1	Required Field Edit	The Service Group on the EVV visit is required when EVV Service Code is present in the EVV visit.				
				Ex00056B2	Required Field Edit	The Service Group on the EVV visit is required when Provider Number is present in the EVV visit.				
File record	57	EVV_SVCCODE	Visit Service Code: A code to denote a specific service or category of service within the Long Term Services and Supports (aka Long Term Care) fee-for-service program at HHSC. Example: HHSC Service Code- Specific services provided within a program (Svc Grp 7+Svc Code 17C = Family Care, but Svc Grp 7+ Svc Code 17CV = Family Care in the Consumer Directed Services (CDS) option)	Ex00057A	Format Edit	Service Code on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Service Bill Codes Table contains the full list of valid values

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00057B1	Required Field Edit	The Service Code on the EVV visit is required when Service Group is present in the EVV visit.				
				Ex00057B2	Required Field Edit	The Service Code on the EVV visit is required when Provider Number is present in the EVV visit.				
				Ex00057C1	Business Edit	The Service Group and Service Code combination on the EVV visit are not eligible for EVV.				
				Ex00057C2	Business Edit	The Service Group and Service Code combination on the EVV visit are not valid for the Provider number on the visit.				
				Ex00057C3	Business Edit	The Member on the EVV visit is not authorized for this service group/service code on this visit date in our records.				
File record	58	EVV_HCPCS_CODE	The Healthcare Common Procedure Coding System (HCPCS) Code: A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes.	Ex00058A	Format Edit	EVV HCPCS Code on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		HHSC EVV Service Bill Codes Table contains the full list of valid values
				Ex00058B	Required Field Edit	The EVV HCPCS Code on the EVV visit is missing.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	59	EVV_MODIFIER	The Healthcare Common Procedure Coding System (HCPCS) Modifier: Two alphanumeric characters that are appended to the HCPCS codes to differentiate between services. There may be none or up to four modifiers for the HCPCS codes.	Ex00059A1	Format Edit	EVV Modifier on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar	Alphanumeric characters are allowed and Colon (:) is the only special character allowed for this field. The EVV System must separate each 2-character modifier with a colon with no beginning or ending colon.	HHSC EVV Service Bill Codes Table contains the full list of valid values
				Ex00059A2	Format Edit	The EVV Modifier on the EVV visit is not in a valid format.				
				Ex00059C	Business Edit	The EVV HCPCS Code and EVV Modifier combination on the EVV visit is not eligible for EVV.				
File record	60	EVV_VISITDATE	Actual Visit Date: The date the visit occurred. Note: EVV_VisitDate (actual visit) must be on or after Visit_VisitDate (scheduled visit).	Ex00060A	Format Edit	The EVV Visit Date on the EVV visit is not in a valid date format.	8	Date	Dates must be in the format MMDDYYYY.	
				Ex00060B	Required Field Edit	The EVV Visit Date on the EVV visit is missing.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00060C	Business Edit	The actual visit date must be between 4/1/2015 and the date the EVV Visit batch is submitted.				
File record	61	EVV_CREATEDDATETIME	Created Date/Time: The date/time stamp assigned by the EVV System on the date a valid clock in and clock out or the date a manual visit is created in the EVV System.	Ex00061A	Format Edit	The EVV Created Date Time on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM.	
				Ex00061B	Required Field Edit	The EVV Created Date Time on the EVV visit is missing.				
File record	62	EVV_PHONE	Electronic Visit Verification Phone: The phone number used in the EVV Electronically Generated Call transaction.	Ex00062A	Format Edit	The EVV Phone on the EVV visit is not in a valid 10-digit numeric format.	10	Varchar	10-digit numeric format	
File record	63	EVV_CALLINTIME	Actual Call In Time: The date/time the Service Provider actually called in indicating service delivery started. Must be captured from an HHSC approved electronic verification method (Landline, Mobile or Alternative device). Must be Null for manually entered (GUI) visits.	Ex00063A	Format Edit	The EVV Call In Time on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM/PM.	System derived when a Service Provider clocks in using an electronic method. Null for manual entry.
File record	64	EVV_CALLOUTTIME	Actual Call Out Time: The date/time the Service Provider actually called in indicating service delivery ended. Must be captured from an HHSC approved electronic verification method (Landline, Mobile or Alternative device). Must be Null for manually entered (GUI) visits.	Ex00064A	Format Edit	The EVV Call Out Time on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM/PM.	System derived when a Service Provider clocks out using an electronic method. Null for manual entry.

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	65	EVV_ACTUALHOURS	Actual Hours: EVV System calculated duration in Hours and Minutes (NN.NN) Difference between electronically captured EVV_CALLINTIME and EVV_CALLOUTTIME. Must be Null for manually entered (GUI) visits.	Ex00065A	Format Edit	The EVV Actual Hours on the EVV visit is not in a valid hours and minutes format.	5	Number	Numeric and has to be in NN.NN format.	System derived
				Ex00065B	Required Field Edit	The EVV Actual Hours on the EVV visit is required if EVV Call In Time and EVV Call Out Time is present in the EVV visit.			Numeric and has to be in NN.NN format.	
				Ex00065C	Business Edit	The EVV Actual Hours calculation on the EVV visit is not correct for the Call In and Call Out time on the visit.			Numeric and has to be in NN.NN format.	
File record	66	EVV_PAYHOURS	Pay Hours: (also referred to as Bill Hours). Calculated by EVV System by rounding EVV_ActualHours, when present. Entered by Provider/FMSA for manual visit.	Ex00066A	Format Edit	The EVV Billed Hours on the EVV visit is not in a valid hours and minutes format.	5	Number	Numeric and has to be in NN.NN format.	
				Ex00066B	Required Field Edit	The EVV Billed Hours on the EVV visit is missing.				
File record	67	EVV_UNITS	Electronic Visit Verification Units: The number of units calculated by the EVV System using the EVV_PAYHOURS and the Unit Type in the Bill Code Table for the service on the visit.	Ex00067A	Format Edit	The EVV Units on the EVV visit is not in a valid numeric format.	11	Number	NNNNNNNN.NN	EVV Service Bill Codes Table

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00067B	Required Field Edit	The EVV Units on the EVV visit is missing.				
				Ex00067C	Business Edit	The EVV Units on the EVV visit do not match the EVV Billed Hours based on the Unit of Measurement.				
File record	68	EVV_VISITLOCATION	Actual Visit Location: The location where services are being provided.	Ex00068A	Format Edit	EVV Visit Location on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Appendix J
				Ex00068B	Required Field Edit	The EVV Visit Location on the EVV visit is missing.				
File record	69	EVV_VISIT_LATITUDE_IN	Electronic Visit Verification Visit Latitude In: The latitude of the visit location using the GPS location on a mobile method for the call in time. Data may be Null unless a mobile method approved by HHSC was used.	Ex00069A	Format Edit	Invalid GPS data format. Numeric fields must contain only numeric digits and not exceed length allowed. GPS must be in decimal degree format only.	50	Varchar	decimal degree format Java BigDecimal Precision and Scale PRECISION=50; SCALE up to 47;	
File record	70	EVV_VISIT_LONGITUDE_IN	Electronic Visit Verification Visit Longitude In: The longitude of the visit location using the GPS location on a mobile method for the call in time. Data may be Null unless a mobile method approved by HHSC was used.	Ex00070A	Format Edit	Invalid GPS data format. Numeric fields must contain only numeric digits and not exceed length allowed. GPS must be in decimal degree format only.	50	Varchar	decimal degree format Java BigDecimal Precision and Scale PRECISION=50; SCALE up to 47;	

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	71	EVV_LEARNED_LOCATION	Electronic Visit Verification Learned Location: An indicator that specifies if an EVV location was learned via mobile method coordinates. This is usually the coordinates of the individual's/member's home. Data may be Null unless a mobile method approved by HHSC was used.	Ex00071A	Format Edit	EVV Learned Location on the EVV visit is not a valid value.	1	Varchar	Y,N	Y,N
File record	72	EVV_LAT_LONG_MATCH_IN	Latitude Longitude Match In: System assigned. Indicates that the Visit clock in latitude and longitude match the Member Home Geo-location.	Ex00072A	Format Edit	EVV Latitude Longitude Match In on the EVV visit is not a valid value.	1	Boolean	Y,N	Y,N
File record	73	EVV_INPUTMETHOD_IN	Electronic Visit Verification Input Method In: The data input method for call In.	Ex00073A	Format Edit	EVV Input Method In on the EVV visit is not a valid value.	50	Varchar	Preselected list of valid values.	Landline Alternative Device Mobile Method GUI
				Ex00073B	Required Field Edit	The EVV Input Method In on the EVV visit is missing.				
File record	74	EVV_INPUTMETHOD_OUT	Electronic Visit Verification Input Method Out: The data input method for call out.	Ex00074A	Format Edit	EVV Input Method Out on the EVV visit is not a valid value.	50	Varchar	Preselected list of valid values.	Landline Alternative Device Mobile Method GUI
				Ex00074B	Required Field Edit	The EVV Input Method Out on the EVV visit is missing.				
File record	75	EVV_ALTERNATIVEDEVICEID	Electronic Visit Verification Alternative Device Identification: The serial number or device identifier for an alternative device.	Ex00075A	Format Edit	EVV Alternative Device ID on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	76	EVV_REASONCODE1	Electronic Visit Verification Reason Code 1: The first reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00076A	Format Edit	The EVV Reason Code1 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	77	EVV_REASONCODE1DESC	Electronic Visit Verification Reason Code 1 Description: A narrative description of the EVV Reason Code 1 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00077A1	Format Edit	EVV Reason Code1 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex00077A2	Format Edit	The EVV Reason Code1 Description on the EVV visit is not valid for the EVV Reason Code1 on the visit.				
				Ex00077B	Required Field Edit	The EVV Reason Code1 Description on the EVV visit is required if EVV Reason Code1 is populated.				
File record	78	EVV_REASONCODE1COMMENT	Electronic Visit Verification Reason Code 1 Comment: Additional comments regarding the EVV Reason Code 1 value.	Ex00078A	Format Edit	EVV Reason Code1 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	79	EVV_REASONCODE2	Electronic Visit Verification Reason Code 2: The second reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00079A	Format Edit	The EVV Reason Code2 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	80	EVV_REASONCODE2DESC	Electronic Visit Verification Reason Code 2 Description: A narrative description of the EVV Reason Code 2 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00080A1	Format Edit	EVV Reason Code2 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
File record				Ex00080A2	Format Edit	The EVV Reason Code2 Description on the EVV visit is not valid for the EVV Reason Code2 on the visit.				
				Ex00080B	Required Field Edit	The EVV Reason Code2 Description on the EVV visit is required if EVV Reason Code2 is populated.				
File record	81	EVV_REASONCODE2COMMENT	Electronic Visit Verification Reason Code 2 Comment: Additional comments regarding the EVV Reason Code 2 value.	Ex00081A	Format Edit	EVV Reason Code2 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	82	EVV_REASONCODE3	Electronic Visit Verification Reason Code 3: The third reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00082A	Format Edit	The EVV Reason Code3 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	83	EVV_REASONCODE3DESC	Electronic Visit Verification Reason Code 3 Description: A narrative description of the EVV Reason Code 3 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00083A1	Format Edit	EVV Reason Code3 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00083A2	Format Edit	The EVV Reason Code3 Description on the EVV visit is not valid for the EVV Reason Code3 on the visit.				
				Ex00083B	Required Field Edit	The EVV Reason Code3 Description on the EVV visit is required if EVV Reason Code3 is populated.				
File record	84	EVV_REASONCODE3COMMENT	Electronic Visit Verification Reason Code 3 Comment: Additional comments regarding the EVV Reason Code 3 value.	Ex00084A	Format Edit	EVV Reason Code3 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	85	EVV_REASONCODE4	Electronic Visit Verification Reason Code 4: The fourth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00085A	Format Edit	The EVV Reason Code4 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	86	EVV_REASONCODE4DESC	Electronic Visit Verification Reason Code 4 Description: A narrative description of the EVV Reason Code 4 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00086A1	Format Edit	EVV Reason Code4 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex00086A2	Format Edit	The EVV Reason Code4 Description on the EVV visit is not valid for the EVV Reason Code4 on the visit.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex00086B	Required Field Edit	The EVV Reason Code4 Description on the EVV visit is required if EVV Reason Code4 is populated.				
File record	87	EVV_REASONCODE4COMMENT	Electronic Visit Verification Reason Code 4 Comment: Additional comments regarding the EVV Reason Code 4 value.	Ex00087A	Format Edit	EVV Reason Code4 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	88	EVV_REASONCODE5	Electronic Visit Verification Reason Code 5: The fifth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00088A	Format Edit	The EVV Reason Code5 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	89	EVV_REASONCODE5DESC	Electronic Visit Verification Reason Code 5 Description: A narrative description of the EVV Reason Code 5 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00089A1	Format Edit	EVV Reason Code5 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex00089A2	Format Edit	The EVV Reason Code5 Description on the EVV visit is not valid for the EVV Reason Code5 on the visit.				
				Ex00089B	Required Field Edit	The EVV Reason Code5 Description on the EVV visit is required if EVV Reason Code5 is populated.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	90	EVV_REASONCODE5COMMENT	Electronic Visit Verification Reason Code 5 Comment: Additional comments regarding the EVV Reason Code 5 value.	Ex00090A	Format Edit	EVV Reason Code5 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	91	EVV_REASONCODE6	Electronic Visit Verification Reason Code 6: The sixth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00091A	Format Edit	The EVV Reason Code6 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	92	EVV_REASONCODE6DESC	Electronic Visit Verification Reason Code 6 Description: A narrative description of the EVV Reason Code 6 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00092A1	Format Edit	EVV Reason Code6 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex00092A2	Format Edit	The EVV Reason Code6 Description on the EVV visit is not valid for the EVV Reason Code6 on the visit.				
				Ex00092B	Required Field Edit	The EVV Reason Code6 Description on the EVV visit is required if EVV Reason Code6 is populated.				
File record	93	EVV_REASONCODE6COMMENT	Electronic Visit Verification Reason Code 6 Comment: Additional comments regarding the EVV Reason Code 6 value.	Ex00093A	Format Edit	EVV Reason Code6 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	94	EVV_REASONCODE7	Electronic Visit Verification Reason Code 7: The seventh reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00094A	Format Edit	The EVV Reason Code7 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	95	EVV_REASONCODE7DESC	Electronic Visit Verification Reason Code 7 Description: A narrative description of the EVV Reason Code 7 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00095A1	Format Edit	EVV Reason Code7 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex00095A2	Format Edit	The EVV Reason Code7 Description on the EVV visit is not valid for the EVV Reason Code7 on the visit.				
				Ex00095B	Required Field Edit	The EVV Reason Code7 Description on the EVV visit is required if EVV Reason Code7 is populated.				
File record	96	EVV_REASONCODE7COMMENT	Electronic Visit Verification Reason Code 7 Comment: Additional comments regarding the EVV Reason Code 7 value.	Ex00096A	Format Edit	EVV Reason Code7 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	97	EVV_REASONCODE8	Electronic Visit Verification Reason Code 8: The eighth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00097A	Format Edit	The EVV Reason Code8 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	98	EVV_REASONCODE8DESC	Electronic Visit Verification Reason Code 8 Description: A narrative description of the EVV Reason Code 8 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex00098A1	Format Edit	EVV Reason Code8 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex00098A2	Format Edit	The EVV Reason Code8 Description on the EVV visit is not valid for the EVV Reason Code8 on the visit.				
				Ex00098B	Required Field Edit	The EVV Reason Code8 Description on the EVV visit is required if EVV Reason Code8 is populated.				
File record	99	EVV_REASONCODE8COMMENT	Electronic Visit Verification Reason Code 8 Comment: Additional comments regarding the EVV Reason Code 8 value.	Ex00099A	Format Edit	EVV Reason Code8 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	100	EVV_REASONCODE9	Electronic Visit Verification Reason Code 9: The ninth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex000100A	Format Edit	The EVV Reason Code9 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	101	EVV_REASONCODE9DESC	Electronic Visit Verification Reason Code 9 Description: A narrative description of the EVV Reason Code 9 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex000101A1	Format Edit	EVV Reason Code9 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex000101A 2	Format Edit	The EVV Reason Code9 Description on the EVV visit is not valid for the EVV Reason Code9 on the visit.				
				Ex000101B	Required Field Edit	The EVV Reason Code9 Description on the EVV visit is required if EVV Reason Code9 is populated.				
File record	102	EVV_REASONCODE9CO MMENT	Electronic Visit Verification Reason Code 9 Comment: Additional comments regarding the EVV Reason Code 9 value.	Ex000102A	Format Edit	EVV Reason Code9 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	103	EVV_REASONCODE10	Electronic Visit Verification Reason Code 10: The tenth reason code that explains why maintenance occurred on an EVV transaction. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex000103A	Format Edit	The EVV Reason Code10 on the EVV visit is not a valid Reason Code.	3	Number		HHSC EVV Reason Codes Table
File record	104	EVV_REASONCODE10D ESC	Electronic Visit Verification Reason Code 10 Description: A narrative description of the EVV Reason Code 10 value. There is a preset combination of Reason Code and Reason Code Descriptions. Refer to the HHSC EVV Reason Codes Table for valid values.	Ex000104A 1	Format Edit	EVV Reason Code10 Description on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		HHSC EVV Reason Codes Table
				Ex000104A 2	Format Edit	The EVV Reason Code10 Description on the EVV visit is not valid for the EVV Reason Code10 on the visit.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
				Ex000104B	Required Field Edit	The EVV Reason Code10 Description on the EVV visit is required if EVV Reason Code10 is populated.				
File record	105	EVV_REASONCODE10COMMENT	Electronic Visit Verification Reason Code 10 Comment: Additional comments regarding the EVV Reason Code 10 value.	Ex000105A	Format Edit	EVV Reason Code10 Comment on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	106	EVV_OVERALLREASONCODE	HHSC no longer uses the Overall Reason Code field. This field should be populated as Null. If a value is captured, it must be a "P" or "NP".'	Ex000106A	Format Edit	EVV Overall Reason Code on the EVV visit is not a valid value.	2	Varchar	Preselected list of valid values.	Null, P, NP
File record	107	EVV_VISITNOTES	Visit Notes: Additional information (if any) related to the visit, needs to be added to the Visit Notes field.	Ex000107A	Format Edit	EVV Visit Notes on the EVV Visit has exceeded the maximum allowed length for that field.	500	Varchar		
File record	108	EVV_LASTVISITMAINT	Last Visit Maintenance: The most recent date a change to one or more fields identified as impacting the last visit maintenance date in the HHSC EVV Policy Handbook are saved to the EVV visit transaction after the system User/Service Provider has documented the visit.	Ex000108A	Format Edit	The EVV Last Visit Maintenance on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM/PM.	
				Ex000108B	Required Field Edit	The EVV Last Visit Maintenance on the EVV visit is required if the visit is not Auto Confirmed.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	109	EVV_UPLOADINDICATOR	Electronic Visit Verification Upload Indicator: An indicator that specifies if a visit was finalized and uploaded (transferred) to the EVV Aggregator.	Ex000109A	Format Edit	EVV Upload Indicator on the EVV Visit has exceeded the maximum allowed length for that field.	2	Varchar		
File record	110	EVV_LASTUPLOAD	Electronic Visit Verification Last Upload: The last date a visit was finalized and uploaded (transferred) to the EVV Aggregator.	Ex000110A	Format Edit	The EVV Last Upload date on the EVV visit is not in a valid date format.	17	Date	Date/Times must be in the format MMDDYYYY HH:MM AM/PM.	
File record	111	EVV_VENDORID	Electronic Visit Verification Vendor Identification: EVV System name. EVV_VendorID is assigned by MES service providers. EVV_VendorID must match the EVV System ID of the submitter of the batch file. EVV_VendorID is first part of the incoming file name.	Ex000111A	Format Edit	EVV Vendor ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex000111B	Required Field Edit	The EVV Vendor ID on the EVV visit is missing.				
				Ex000111C	Business Edit	The EVV Vendor ID does not match the vendor that submitted the EVV Visit file.				
File record	112	EVV_FILEEXPORTID	Electronic Visit Verification File Export Identification: A specific upload identifier assigned to each data file export by the EVV System.	Ex000112A	Format Edit	EVV File Export ID on the EVV Visit has exceeded the maximum allowed length for that field.	30	Varchar		
				Ex000112B	Required Field Edit	The EVV File Export ID on the EVV visit is missing.				

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	113	EVV_DONOTEXPORTINDICATOR	Electronic Visit Verification Do Not Export Indicator: An indicator that specifies if a visit has been manually flagged by a Program Provider or Financial Management Services Agency (FMSA) to not export to the EVV Aggregator.	Ex000113A	Format Edit	EVV Do Not Export Indicator on the EVV Visit has exceeded the maximum allowed length for that field.	1	Varchar		
File record	114	EVV_AUTOCONFIRMFLAG	Electronic Visit Verification Auto Confirm Flag: An indicator that specifies if a visit was auto-verified by the EVV System and no visit maintenance was required.	Ex000114A	Format Edit	EVV Auto Confirm Flag on the EVV visit is not a valid value.	2	Varchar	Preselected list of valid values.	Y,N
				Ex000114B	Required Field Edit	The EVV Auto Confirm Flag on the EVV visit is missing.				
File record	115	EVV_VISITRECORDINDICATOR	Electronic Visit Verification Visit Record Indicator: An indicator that specifies the status of the EVV visit transaction.	Ex000115A	Format Edit	The Visit Record Indicator is not a valid code.	30	Varchar	Preselected list of valid values.	NEW UPDATED CANCELLED
				Ex000115B	Required Field Edit	The EVV Visit Record Indicator on the EVV visit is missing.				
File record	116	EVV_VISIT_LATITUDE_OUT	Electronic Visit Verification Visit Latitude Out: The latitude of the visit location using the GPS location on a mobile method for the call out time. Data may be Null unless a mobile method was used.	Ex000116A	Format Edit	Invalid GPS data format. Numeric fields must contain only numeric digits and not exceed length allowed. GPS must be in decimal degree format only.	50	Varchar	decimal degree format Java BigDecimal Precision and Scale PRECISION=50; SCALE up to 47;	

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	117	EVV_VISIT_LONGITUDE_OUT	Electronic Visit Verification Visit Longitude Out: The longitude of the visit location using the GPS location on a mobile method for the call out time. Data may be Null unless a mobile method was used.	Ex000117A	Format Edit	Invalid GPS data format. Numeric fields must contain only numeric digits and not exceed length allowed. GPS must be in decimal degree format only.	50	Varchar	decimal degree format Java BigDecimal Precision and Scale PRECISION=50; SCALE up to 47;	
File record	118	EVV_MATERIAL_VM_CHANGE	Visit Maintenance Material Change: Indicates if a Material visit maintenance change was made. Required if a material field was changed during visit maintenance	Ex000118A	Format Edit	EVV Material VM Change on the EVV Visit has exceeded the maximum allowed length for that field.	1	Varchar	Y,N	Y,N
File record	119	EVV_MATERIAL_VM_FIELD_ID	Visit Maintenance Material Change Field Identification: Lists the Field identifier of each 'material change' field that was updated during visit maintenance, delimited by a comma. Required if Field EVV_MATERIAL_VM_CHANGE = Y.	Ex000119A	Format Edit	EVV Material VM Field ID on the EVV Visit has exceeded the maximum allowed length for that field.	50	Varchar		Material change Requirements include: First time GUI input Methods, Provider_TIN Provider_NPI Provider_API 007 Provider_ContractNumber 035 IndvMbr_MedicaidID EVV_SvcCode EVV_HCPCS Code EVV_Modifier EVV_VisitDate EVV_CreatedDateTime EVV_CallInTime EVV_CallOutTime EVV_ActualHours EVV_PayHours EVV_Units

Type of Record	Position of Data Element	Extract Data Element	Description	Edit Number	Edit Type	Edit Description	Length	Field Type	Format	Valid Values for Fields/ Derived Values for Fields
File record	120	EVV_LAT_LONG_MATCH_OUT	Latitude Longitude Match: System assigned. Indicates that the Visit clock out latitude and longitude match the Member Home Geo-location.	Ex000120A	Format Edit	EVV Latitude Longitude Match Out on the EVV visit is not a valid value.	1	Varchar	Y,N	Y,N

Appendix N – EVV Data Transfer Guide

HHSC Electronic Visit Verification (EVV) Technical Documentation

Appendix N1 - EVV Member Information File Layout

Published Date: 02/25/2022

Effective Date: 05/31/2022

Data File transfers will be in Pipe-Delimited ("|") format .txt files

Authorization Data Fields				
Field Name	**Type**	**Description**	**Required**	**Data_Example**
EVV_LANDLINE_PHONE1	Number (10)	Member Landline Phone number		1234567890
PHONE2	Number (10)	Member Alternate Phone number		1234567890
PHONE_TYPE2	Varchar (10)	Type of Alternate Phone number		Cell Phone
PHONE3	Number (10)	Member Alternate Phone number		1234567890
PHONE_TYPE3	Number (10)	Type of Alternate Phone number		Cell Phone
DOB	Date (MM/DD/YYYY)	Member Date of birth	Yes	2/13/2000
MEDICAID	Number (9)	Member ID	Yes	987654321
EVV_LAND_LINE_2	Number (10)	Member Alternate Landline Phone number		1234567890
EVV_LAND_LINE_3	Number (10)	Member Alternate Landline Phone number		1234567890

HHSC Electronic Visit Verification (EVV)
Technical Documentation
Appendix N2 - EVV Service Attendant Information File Layout

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Data File transfers will be in Pipe-Delimited ("|") format .txt files

Service Provider Data Fields					
Field Name	**Type**	**Description**	**Required**	**Data_Example**	**Comments**
EMPNUMBER	Number(30)	An identifier assigned to the Service Provider by his or her employer for HR and payroll		100002	
SOCIALSEC	Number (4)	First 4 digits of Attendant SSN	Yes	6789	This could be the last four of the passport number as well, if there is no SSN.
STATUS	Varchar	Employment Status. Acceptable values are: Active,Inactive,Suspend		ACTIVE	
LASTNAME	Varchar (30)	Attendant Last Name	Yes	Smith	
FIRSTNAME	Varchar (30)	Attendant First Name	Yes	John	
ADDRESS	Varchar (50)	Attendant Address		123 Standard Dr.	
CITY	Varchar (50)	Attendant City		Harlingen	
STATE	Varchar (2)	Attendant State		TX	
ZIP	Number (5)	Attendant Zip Code		78550	
PHONE1	Number (10)	Attendant Phone		123-456-7890	
PHONE_TYPE1	Number (10)	Attendant additional Phone		Cell Phone	
EVV_ID	Varchar (30)	The Service Provider EVV System identifier number. This Identifier is assigned by the EVV System.		71238	
PROFTITLE	Varchar	Service Provider Title. Acceptable values are : Attendant, Nurse, CNA, PT, OT, SLP, Other	Yes	Attendant	
DOH	Date (MM/DD/YYYY)	Attendant Date of Hire	Yes	2/1/2020	
BRANCH	Varchar (30)	Attendant Branch		RIO HONDO	
EMAIL	Varchar (100)	Attendant Email Address		JOHNSMITH@ATTENDANT.COM	

HHSC Electronic Visit Verification (EVV) Technical Documentation

Appendix N3 - EVV Authorization Information File Layout

Published Date: 02/25/2022, Effective Date: 05/31/2022

Data File transfers will be in Pipe-Delimited ("|") format .txt files

Authorization Data Fields

Field Name	Type	Description	Applicable Payer(s) (HHSC, LTC, MCO, ALL)	Data_Example	Comments
INDV_MBR_PAYOR	Varchar (30)	Payor: A unique ID assigned to the payor.	ALL	SHP	HHSC (Acute Care FFS), LTC (LTC FFS)
MCO Provider_ID	Varchar (25)	MCO System Unique Servicing Provider ID	MCO	P12354987987	
Provider_ContractNumber	Number (9)	Provider Contract Number: A unique number assigned by DADS when a provider agency/FMSA contracts with DADS to provide Long Term Services and Supports (LTSS) program services.	LTC	123456789	
Provider_TIN	Number (11)	Provider Tax Identification Number: TIN Assigned by Comptroller that includes mail code. First digit will always be a "1"	ALL	123456789	9 digits
Provider_NPI	Varchar (30)	Provider National Provider Identifier (NPI): A HIPAA mandated unique ID assigned by the Centers for Medicare and Medicaid Services (CMS) to a healthcare provider.	ALL	1234567890	10 digits
Provider_API	Varchar (30)	Provider Atypical Provider Identifier (API): A unique ID assigned to a provider who does not provide healthcare services (ie. Respite, transportation).	ALL	123456789	10 digits
Provider_TPI	Number (11)	Provider Texas Provider Identifier (TPI): A unique ID assigned by the Claims Administrator to a provider who performs services in Texas.	HHSC, MCO	999999999	9 digits
MCO_Mbr_ID	Number (25)	MCO System Unique Member ID	MCO	123456879	9 digits
IndvMbr_MedicaidID	Number (9)	Invoice Individual/Member Medicaid Identification: The individual's/member's Medicaid ID number.	ALL	999999999	
IndvMbr_FirstName	Varchar (30)	Individual/Member First Name: The first name of the member receiving services.	ALL	JOAN	
IndvMbr_LastName	Varchar (30)	Individual/Member Last Name: The last name of the member receiving services.	ALL	DOE	
IndvMbr_MemberDOB	Date (MMDDYYYY)	Individual/Member Date of Birth: The member's date of birth.	ALL	12011950	
IndvMbr_Program	Varchar (20)	STAR, STAR+PLUS, STAR HEALTH, CLASS, CFC, MDCP, PHC/FC/CAS, PCS	ALL	STAR+PLUS, STAR HEALTH, CLASS, CFC, MDCP, PHC/FC/CAS, PCS	
MCO_Mbr_SDA	Varchar (2)	Managed Care Organization Member Service Delivery Area: The MCO service delivery area assigned to the member.	MCO	8A	PlanCode associated to MCO
Provider_Region	Number (2)	DADS Provider Region: The location of where the Provider Agency or Financial Management Services Agency (FMSA) is located. DADS has 11 regions.	HHSC, LTC	11	
Auth_Svc_Group	Number (3)	Electronic Visit Verification Service Group: A code that identifies the type of LTSS program for which the member is eligible.	LTC	18	
EVV_SvcCode	Varchar (6)	DADS Service Code- Specific services provided within a program (Svc Grp 7+Svc Code 17C = Family Care, but Svc Grp 7+ Svc Code 17CV = Family Care in the Consumer Directed Services (CDS) option)	LTC	17C, 27A, 11, etc.	
EVV_HCPCS Code	Varchar (30)	HCPCS Code: A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes.	HHSC, MCO	T1019	
EVV_Modifier	Varchar (30)	HCPCS Modifier: A two digit numeric or alphanumeric characters that are appended to CPT and HCPCS Level II codes. A modifier provides a means to indicate that a service or procedure was altered by specific circumstances, without changing the definition of the code.	HHSC, MCO	U3:U3	
Auth_Number	Varchar (30)	Authorization Number	ALL	OP1234567890	
IndvMbr_StartDate	Date (MMDDYYYY)	Individual/Member Start Date: The start date of when the member became eligible.	ALL	12012012	
IndvMbr_EndDate	Date (MMDDYYYY)	Individual/Member End Date: The end date of when the member became eligible.	ALL	12012013	
IndvMbr_Total_AuthUnits	Number (8,2)	Individual/Member Total Authorized Units: The total number of units authorized for a member for a service to be delivered for a given time period.	ALL		
Auth_Units Type	Varchar (10)	Individual/Member Authorized Units Type: The type of units authorized. Can be daily, weekly, monthly or per auth.	ALL		
Auth_Notes	Varchar (255)	Freetext notes context for authorization detail	ALL		

Appendix O – Visit Maintenance

HHSC Electronic Visit Verification (EVV) Technical Documentation Appendix O - Visit Maintenance
Published Date: 02/25/2022 Effective Date: 05/31/2022

Field #	Extract Data Element	Length	Description	Can Provider or FMSA Edit After Visit Created? (Visit Data)	Additional Details for 'Can Provider or FMSA Edit After Visit Created? (Visit Data) '	Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)	Additional Details for 'Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)'	Can CDS Employer Edit/Enter After Visit Created? (Visit Data)	Additional Details for 'Can CDS Employer Edit/Enter After Visit Created? (Visit Data)'
60	EVV_VISITDATE	8	Actual Visit Date: The date the visit occurred. Note: EVV_VisitDate (actual visit) must be on or after Visit_VisitDate (scheduled visit)	No	The Actual Visit Date cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The Actual Visit Date cannot be modified by the CDS Employer.
61	EVV_CREATEDDATETIME	17	Created Date/Time: The date/time stamp assigned by the EVV system on the date of a valid clock in and clock out or the date a manual visit is created in the EVV System.	No	The Actual Visit creation date cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The Actual Visit creation date cannot be modified by the CDS Employer.
63	EVV_CALLINTIME	17	Actual Call In Time: The date/time (MMDDYYYY HH:MM AM/PM) that the Service Provider actually called in indicating service delivery started. Must be captured from an HHSC approved electronic verification method (Landline, Mobile or Alternative device). Must be Null for manually entered (GUI) visits.	No	The Actual Call In Time cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The Call In Time cannot be modified by the CDS Employer.
64	EVV_CALLOUTTIME	17	Actual Call Out Time: The date/time (MMDDYYYY HH:MM AM/PM) that the Service Provider actually called in indicating service delivery ended. Must be captured from an HHSC approved electronic verification method (Landline, Mobile or Alternative device). Must be Null for manually entered (GUI) visits.	No	The Actual Call Out Time cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The Call Out Time cannot be modified by the CDS Employer.
65	EVV_ACTUALHOURS	5	Actual Hours: EVV System calculated duration in Hours and Minutes (NN.NN) Difference between electronically captured EVV_CALLINTIME and EVV_CALLOUTTIME. Must be Null for manually entered (GUI) visits.	No	The Actual Hours cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The Actual Hours cannot be modified by the CDS Employer.
66	EVV_PAYHOURS	5	Pay Hours: (also referred to as Bill Hours). Calculated by EVV System by rounding EVV_ActualHours, when present. Entered by Provider/FMSA for manual visit.	Yes	The Pay Hours (Bill Hours) can be adjusted by the Provider/FMSA. EVV_PAYHOURS may be adjusted but cannot be greater than EVV_ACTUALHOURS.	N/A	This is not related to the Profile Data.	Yes	The Pay hours can be downward adjusted by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
67	EVV_UNITS	11	Electronic Visit Verification Units: The number of units calculated by the EVV system using the EVV_PAYHOURS and the Unit Type in the Bill Code Table for the service on the visit.	No	The EVV Units cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Units cannot be modified by the CDS Employer.
69	EVV_VISIT_LATITUDE_IN	50	Electronic Visit Verification Visit Latitude In: The latitude of the visit location using the GPS location on a mobile method for the call in time. Data may be blank unless a mobile method approved by HHSC was used.	No	The EVV Visit Latitude cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Visit Latitude cannot be modified by the CDS Employer.
70	EVV_VISIT_LONGITUDE_IN	50	Electronic Visit Verification Visit Longitude In: The longitude of the visit location using the GPS location on a mobile method for the call in time. Data may be blank unless a mobile method approved by HHSC was used.	No	The EVV Visit Longitude cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Visit Longitude cannot be modified by the CDS Employer.

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71	EVV_LEARNED_LOCATION	1	Electronic Visit Verification Learned Location: An indicator that specifies if an EVV location was learned via mobile method coordinates. This is usually the coordinates of the individual's/member's home. Data may be Null unless a mobile method approved by HHSC was used.	No	The EVV Visit Learned location cannot be modified by the Provider/FMSA.	Yes	System User can modify Learned Location by updating the Member Home Geo-location.	No	The EVV Visit Learned location cannot be modified by the CDS Employer.
72	EVV_LAT_LONG_MATCH_IN	1	Latitude Longitude Match: System assigned. Indicates that the Visit clock in latitude and longitude match the Member Home Geo-location.	No	The EVV Latitude Longitude Match cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Latitude Longitude Match cannot be modified by the CDS Employer.
76	EVV_REASONCODE1	3	Electronic Visit Verification Reason Code 1: The first reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE1 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
77	EVV_REASONCODE1DESC	50	A narrative description of the EVV Reason Code 1 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE1 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
78	EVV_REASONCODE1COMMENT	500	Free Text regarding the EVV Reason Code 1 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE1 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
79	EVV_REASONCODE2	3	Electronic Visit Verification Reason Code 2: The second reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE2 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
80	EVV_REASONCODE2DESC	50	Electronic Visit Verification Reason Code 2 Description: A narrative description of the EVV Reason Code 2 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE2 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
81	EVV_REASONCODE2COMMENT	500	Electronic Visit Verification Reason Code 2 Comment: Additional comments regarding the EVV Reason Code 2 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE2 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
82	EVV_REASONCODE3	3	Electronic Visit Verification Reason Code 3: The third reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE3 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
83	EVV_REASONCODE3DESC	50	Electronic Visit Verification Reason Code 3 Description: A narrative description of the EVV Reason Code 3 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE3 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
84	EVV_REASONCODE3COMMENT	500	Electronic Visit Verification Reason Code 3 Comment: Additional comments regarding the EVV Reason Code 3 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE3 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
85	EVV_REASONCODE4	3	Electronic Visit Verification Reason Code 4: The fourth reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE4 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.

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86	EVV_REASONCODE4DESC	50	Electronic Visit Verification Reason Code 4 Description: A narrative description of the EVV Reason Code 4 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE4 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
87	EVV_REASONCODE4COMMENT	500	Electronic Visit Verification Reason Code 4 Comment: Additional comments regarding the EVV Reason Code 4 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE4 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
88	EVV_REASONCODE5	3	Electronic Visit Verification Reason Code 5: The fifth reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE5 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
89	EVV_REASONCODE5DESC	50	Electronic Visit Verification Reason Code 5 Description: A narrative description of the EVV Reason Code 5 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE5 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
90	EVV_REASONCODE5COMMENT	500	Electronic Visit Verification Reason Code 5 Comment: Additional comments regarding the EVV Reason Code 5 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE5 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
91	EVV_REASONCODE6	3	Electronic Visit Verification Reason Code 6: The sixth reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE6 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
92	EVV_REASONCODE6DESC	50	Electronic Visit Verification Reason Code 6 Description: A narrative description of the EVV Reason Code 6 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE6 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
93	EVV_REASONCODE6COMMENT	500	Reason Code Full Comment Text field - full text entry Electronic Visit Verification Reason Code 6 Comment: Additional comments regarding the EVV Reason Code 6 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE6 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
94	EVV_REASONCODE7	3	Electronic Visit Verification Reason Code 7: The seventh reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE7 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
95	EVV_REASONCODE7DESC	50	Electronic Visit Verification Reason Code 7 Description: A narrative description of the EVV Reason Code 7 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE7 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
96	EVV_REASONCODE7COMMENT	500	Electronic Visit Verification Reason Code 7 Comment: Additional comments regarding the EVV Reason Code 7 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE7 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
97	EVV_REASONCODE8	3	Electronic Visit Verification Reason Code 8: The eighth reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE8 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
98	EVV_REASONCODE8DESC	50	Electronic Visit Verification Reason Code 8 Description: A narrative description of the EVV Reason Code 8 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE8 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
99	EVV_REASONCODE8COMMENT	500	Electronic Visit Verification Reason Code 8 Comment: Additional comments regarding the EVV Reason Code 8 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE8 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
100	EVV_REASONCODE9	3	Electronic Visit Verification Reason Code 9: The ninth reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE9 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.

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101	EVV_REASONCODE9DESC	50	Electronic Visit Verification Reason Code 9 Description: A narrative description of the EVV Reason Code 9 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE9 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
102	EVV_REASONCODE9COMMENT	500	Reason Code Full Comment Text field - full text entry Electronic Visit Verification Reason Code 9 Comment: Additional comments regarding the EVV Reason Code 9 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE9 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
103	EVV_REASONCODE10	3	Electronic Visit Verification Reason Code 10: The tenth reason code that explains why maintenance occurred on an EVV transaction.	No	Reason Codes can be added to a visit at any time, but once added, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE10 can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
104	EVV_REASONCODE10DESC	50	Electronic Visit Verification Reason Code 10 Description: A narrative description of the EVV Reason Code 10 value.	No	EVV System adds the Reason Code Description based on the Reason Code selection. See Appendix A.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE10 Description can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
105	EVV_REASONCODE10COMMENT	500	Electronic Visit Verification Reason Code 10 Comment: Additional comments regarding the EVV Reason Code 10 value.	No	Reason Code Comment, or Free Text, can be added, but once saved, cannot be modified.	N/A	This is not related to the Profile Data.	Yes	The EVV_REASONCODE10 Comment can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
106	EVV_OVERALLREASONCODE	2	HHSC no longer uses the Overall Reason Code field. This field should be populated as Null. If a value is captured, it must be a "P" or "NP".	N/A	HHSC no longer uses the Overall Reason Code field. This field should be populated as Null. If a value is captured, it must be a "P" or "NP".	N/A	This is not related to the Profile Data.	Yes	The Overall Reason Code can be modified when the CDS Employer does Visit Maintenance and selects a different reason code. This field is system assigned based on reason code(s) selected by the CDS Employer. If reason code(s) selected are all P, then this field will list P. If any reason code selected is NP, then the field would be assigned as NP. If the CDS Employer has chosen Option 1 in the 1722 form.
108	EVV_LASTVISITMAINT	17	Last Visit Maintenance: System assigned date of last date visit maintenance was performed on critical data elements per HHSC EVV Policy.	No	The Last Visit Maintenance Date is not a field that can be edited by the provider/FMSA. However, if the provider/FMSA does Visit Maintenance on some fields (please refer to the Last Visit Maintenance Policy for the list of fields), then the Last Visit Maintenance Date will change.	N/A	This is not related to the Profile Data.	Yes	The Last Visit Maintenance Date is not a field that can edited by the CDS Employer. However, if the CDS Employer does Visit Maintenance on some fields (please refer to the Last Visit Maintenance Policy for the list of fields), then the Last Visit Maintenance Date will change. If the CDS Employer has chosen Option 1 in the 1722 form.
111	EVV_VENDORID	30	Electronic Visit Verification Vendor Identification: EVV System name. EVV_VendorID is assigned by MES service providers. EVV_VendorID must match the EVV system ID of the submitter of the batch file. EVV_VendorID is first part of the incoming file name.	No	EVV Vendor ID cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	EVV Vendor ID cannot be modified by the CDS Employer.
116	EVV_VISIT_LATITUDE_OUT	50	Electronic Visit Verification Visit Latitude: The latitude of mobile verified visit for the time out. Data may be blank unless mobile app is approved by HHSC.	No	Visit Latitude Out cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	Visit Latitude Out cannot be modified by the CDS Employer.
117	EVV_VISIT_LONGITUDE_OUT	50	Electronic Visit Verification Visit Longitude: The longitude of mobile verified visit for the time out. Data may be blank unless mobile app is approved by HHSC.	No	Visit Longitude Out cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	Visit Longitude Out cannot be modified by the CDS Employer.
120	EVV_LAT_LONG_MATCH_OUT	1	Latitude Longitude Match: System assigned. Indicates that the Visit clock out latitude and longitude match the Member Home Geo-location.	No	Visit Latitude Longitude Match Out cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	Visit Latitude Longitude Match Out cannot be modified by the CDS Employer.
1	PROVIDER_TIN	30	Provider Tax Identification Number: TIN Assigned by Comptroller that includes mail code. First digit will always be a "1"	N/A	Derived from Profile Data on the EVV System.	Yes	The TIN information is retrieved using the Provider Web Service from MES service providers, by providing an NPI. This cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.
2	PROVIDER_NPI	10	Provider National Provider Identifier (NPI): A HIPAA mandated unique ID assigned by the Centers for Medicare and Medicaid Services (CMS) to a healthcare provider.	N/A	Derived from Profile Data on the EVV System.	Yes	The NPI is entered by the provider/FMSA and validated using the Provider Web Service from MES service providers.	No	The CDS Employers are not responsible for the profile setup.

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3	PROVIDER_API	10	Provider Atypical Provider Identifier (API): A unique ID assigned to a provider who does not provide healthcare services (i.e.. Respite, transportation). Medicaid or State Issued API number.	N/A	Derived from Profile Data on the EVV System.	Yes	The API is entered by the provider/FMSA and validated using the Provider Web Service from MES service providers.	No	The CDS Employers are not responsible for the profile setup.
4	PROVIDER_TPI	9	Texas Provider Identifier (TPI): A unique identifier assigned by the Claims Administrator to a Program Provider or Financial Management Services Agency (FMSA) delivering Acute Care fee-for-service services in Texas.	N/A	Derived from Profile Data on the EVV System.	Yes	The TPI information is retrieved using the Provider Web Service from MES service providers, by providing an NPI. This cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.
5	PROVIDER_LEGALNAME	50	Provider Legal Name: Provider Agency or Financial Management Services Agency (FMSA) legal name.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider Legal Name is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
6	PROVIDER_DBA	50	Provider Doing Business As Name: Provider Agency or Financial Management Services Agency (FMSA) Doing Business As name.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider DBA Name is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
7	PROVIDER_CONTRACTNUMBER	9	Provider Contract Number: A unique number assigned by HHSC when a provider agency/FMSA contracts with DADS to provide Long Term Services and Supports (LTSS) program services	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider Contract Number is retrieved using the Provider Web Service from MES service providers, by providing an NPI. This cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.
8	PROVIDER_ADDRESS1	50	Provider Address Line 1: Mailing address for the provider. This address may be the same for many different office locations.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider Address 1 is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
9	PROVIDER_ADDRESS2	50	Provider Address Line 2: Additional mailing address information for the provider. This address may be the same for many different office locations.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider Address 2 is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
10	PROVIDER_CITY	50	Provider City: The city where the provider's office is located.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider City is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
11	PROVIDER_STATE	2	Provider State: The state where the provider's office is located.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider State is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
12	PROVIDER_ZIP	5	Provider Zip: The zip code for which the provider's office is located.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider Zip is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
13	PROVIDER_LOCATIONID	30	A value assigned to the provider agency or FMSA for a particular physical address from which services are provided.	N/A	Derived from Profile Data on the EVV System.	No	Location ID is system generated for a provider/FMSA and this cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.
14	PROVIDER_REGION	2	HHSC Provider Region: The location where the Program Provider or Financial Management Services Agency (FMSA) Business Unit is located. HHSC Medicaid LTC has 11 regions.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider Region is provided by the Provider Web Service from MES service providers and the EVV System must allow the provider/FMSA to edit this information as needed.	No	The CDS Employers are not responsible for the profile setup.
15	PROVIDER_EVVEFFDATE	8	Provider Electronic Visit Verification Effective Date: The date the provider became effective in the EVV system.	N/A	Derived from Profile Data on the EVV System.	No	When a provider/FMSA profile is created during the onboard process, the EVV System enters the provider/FMSAs effective date and this cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.

Field #	Extract Data Element	Length	Description	Can Provider or FMSA Edit After Visit Created? (Visit Data)	Additional Details for 'Can Provider or FMSA Edit After Visit Created? (Visit Data) '	Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)	Additional Details for 'Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)'	Can CDS Employer Edit/Enter After Visit Created? (Visit Data)	Additional Details for 'Can CDS Employer Edit/Enter After Visit Created? (Visit Data)'
16	PROVIDER_EVVENDDATE	8	Provider Electronic Visit Verification End Date: The date the provider terminates from the EVV system.	N/A	Derived from Profile Data on the EVV System.	No	When a provider/FMSA transfers from the current EVV System to another, then the EVV System enters the end date and this cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.
17	EMPLOYEE_EMPLOYEEID	30	Employee Identification: An ID assigned to the Service Provider by his or her employer for HR and payroll purposes.	N/A	Derived from Profile Data on the EVV System.	No	Employee ID is generated systematically for each Employee. This cannot be manually entered into the EVV System.	No	The CDS Employers are not responsible for the profile setup.
18	EMPLOYEE_SOCSEC_VISA_PASSPOR	T 54	Employee Social Security Visa Passport: The last four digits of an employee's SSN or passport and last name.	N/A	Derived from Profile Data on the EVV System.	YES	The Provider/FMSA may edit this data field at anytime on the EVV System. Changes to the SSN will impact the Texas EVV Attendant ID.	No	The CDS Employers are not responsible for the profile setup.
19	EMPLOYEE_EMPLOYEEDISCIPLINE	30	Employee Discipline: Credentials of the person providing services.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider/FMSA may edit the Employee Discipline field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
20	EMPLOYEE_FIRSTNAME	50	Employee First Name: The Service Provider first name.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider/FMSA may edit the Employee First Name field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
21	EMPLOYEE_LASTNAME	50	Employee Last Name: The Service Provider last name.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider/FMSA may edit the Employee Last Name field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
22	EMPLOYEE_EVVID	30	Service Provider EVV System ID.	Yes	This is the Employee ID that is captured when the service is provided. The provider will be able to choose from a list of active Employee ID's linked to that provider, during Visit Maintenance. However a new Employee ID cannot be entered on the Visit, without going though the profile setup.	No	Employee ID is generated systematically for each Employee. This cannot be manually entered into the EVV System. The provider/FMSA can add a new Employee to the profile which will systematically create a new Employee ID.	Yes	This is the Employee ID that is captured when the service is provided. The CDS Employer will be able to choose from a list of active Employee ID's linked to that provider, during Visit Maintenance. The CDS Employers are not responsible for the profile setup of the Employee's. If the CDS Employer has chosen Option 1 in the 1722form.
23	EMPLOYEE_STARTDATE	8	Employee Start Date: The Service Provider start date.	N/A	Derived from Profile Data on the EVV System.	YES	The Provider/FMSA may edit the Employee Start Date field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
24	EMPLOYEE_ENDDATE	8	Employee End Date: The Service Provider end date.	N/A	Derived from Profile Data on the EVV System.	YES	The Provider/FMSA may edit the Employee End Date field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
25	EMPLOYEE_EVVUSERID	30	Service Provider EVV System User ID.	Yes	The User ID of the provider system user who conducted Visit Maintenance cannot be changed. However if there was Visit Maintenance conducted, then this field will be populated with the user ID of the person who conducted Visit Maintenance.	YES	The User ID for the Employee can be created by the Provider/FMSA.	Yes	The User ID of the CDS Employer who conducted Visit Maintenance cannot be changed. However if there was Visit Maintenance conducted, then this field will be populated with the user ID of the person who conducted Visit Maintenance.If the CDS Employer has chosen Option 1 in the 1722 form.
26	EMPLOYEE_EVVUSERFIRSTNAME	50	Electronic Visit Verification User First Name: The first name of the person associated with the EVV User ID.	N/A	Derived from Profile Data on the EVV System.	YES	The Employee First Name is editable by the provider/FMSA. This is the provider/FMSA staff conducting Visit Maintenance.	No	The CDS Employers are not responsible for the profile setup.
27	EMPLOYEE_EVVUSERLASTNAME	50	Electronic Visit Verification User Last Name: The last name of the person associatedwith the EVV User ID.	N/A	Derived from Profile Data on the EVV System.	YES	The Employee Last Name is editable by the provider/FMSA. This is the provider/FMSA staff conducting Visit Maintenance.	No	The CDS Employers are not responsible for the profile setup.
28	EMPLOYEE_CDSEMPLOYEREVVID	30	Consumer Directed Services Employer Electronic Visit Verification Identification: CDS employer ID (if different from the individual receiving services e.g. a parent or guardian).	N/A	Derived from Profile Data on the EVV System.	No	This is System Generated and cannot be manually entered.	No	The CDS Employers are not responsible for the profile setup.
29	EMPLOYEE_CDSEMPLOYERFIRSTNA	M 50	Consumer Directed Services Employer First Name: CDS employer first name (if different from the individual receiving services- e.g. a parent or guardian).	N/A	Derived from Profile Data on the EVV System.	YES	The CDS Employer First Name is editable by the FMSA.	No	The CDS Employers are not responsible for the profile setup.
30	EMPLOYEE_CDSEMPLOYERLASTNAM	50	Consumer Directed Services Employer Last Name: CDS employer last name (if different from the individual receiving services- e.g. a parent or guardian).	N/A	Derived from Profile Data on the EVV System.	YES	The CDS Employer Last Name is editable by the FMSA.	No	The CDS Employers are not responsible for the profile setup.
31	INDVMBR_PAYOR	4	Individual/Member Payor: A unique identifier assigned to the payor, which is obtained through the Payer Plan Code Web Service.	N/A	Derived from Profile Data on the EVV System.	Yes	The Payer associated with the Member can be updated by the provider/FMSA.	No	The CDS Employers are not responsible for the profile setup.
32	INDVMBR_FIRSTNAME	50	Individual/Member First Name: The first name of the member receiving services.	N/A	Derived from Profile Data on the EVV System.	Yes	The Member First name can be entered and edited by the provider/FMSA.	No	The CDS Employers are not responsible for the profile setup.

Field #	Extract Data Element	Length	Description	Can Provider or FMSA Edit After Visit Created? (Visit Data)	Additional Details for 'Can Provider or FMSA Edit After Visit Created? (Visit Data) '	Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)	Additional Details for 'Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)'	Can CDS Employer Edit/Enter After Visit Created? (Visit Data)	Additional Details for 'Can CDS Employer Edit/Enter After Visit Created? (Visit Data)'
33	INDVMBR_LASTNAME	50	Individual/Member Last Name: The last name of the member receiving services.	N/A	Derived from Profile Data on the EVV System.	Yes	The Member Last name can be entered and edited by the provider/FMSA.	No	The CDS Employers are not responsible for the profile setup.
34	INDVMBR_MEDICAIDID	9	Invoice Individual/Member Medicaid Identification: The individual's/member's Medicaid ID number.	N/A	Derived from Profile Data on the EVV System.	Yes	The Member Medicaid ID can be entered and edited by the provider/FMSA. An incorrect Medicaid ID will prevent the EVV System from requesting and posting 270/271 Eligibility data.	No	The CDS Employers are not responsible for the profile setup.
35	INDVMBR_MEMBERDOB	8	Individual/Member Date of Birth: The member's date of birth.	N/A	Derived from Profile Data on the EVV System.	Yes	The Member Date of Birth can be entered and edited by the provider/FMSA.	No	The CDS Employers are not responsible for the profile setup.
36	INDVMBR_MEMBEREVVID	30	Individual/Member Electronic Visit Verification Identification: The member's EVV System ID number.	No	This is captured by the IVR or Mobile App and cannot be edited by the Provider/FMSA during Visit Maintenance.	No	This is System Generated and cannot be manually entered.	No	This is captured by the IVR or Mobile App and cannot be edited by the CDS Employer during Visit Maintenance.
37	INDVMBR_STARTDATE	8	Individual/Member Start Date: The start date of when the member became eligible.	N/A	Derived from Profile Data on the EVV System.	YES	The Provider/FMSA may enter and edit the Member Start Date field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
38	INDVMBR_ENDDATE	8	Individual/Member End Date: The end date of when the member became eligible.	N/A	Derived from Profile Data on the EVV System.	YES	The Provider/FMSA may enter and edit the Member End Date field at anytime on the EVV System.	No	The CDS Employers are not responsible for the profile setup.
39	INDVMBR_PRIORITY	1	Individual/Member Priority: A numerical value assigned to the individual/member by the Program Provider or Financial Management Services Agency (FMSA) based on their level of need. https://hhs.texas.gov/laws-regulations/handbooks/hcs/section-5000-level-care-level-need	N/A	Derived from Profile Data on the EVV System.	Yes	Yes, the Provider/FMSA may indicate on the member profile if the member is priority.	No	The CDS Employers are not responsible for the profile setup.
40	INDVMBR_PHONE	10	Individual/Member Phone: The primary phone number registered for EVV phone calls for the member receiving services.	N/A	Derived from Profile Data on the EVV System.	Yes	The provider/FMSA may enter/edit the phone number of the Member.	No	The CDS Employers are not responsible for the profile setup.
41	INDVMBR_ALTPHONE	10	Individual/Member Alternative Phone: A secondary (additional) phone number registered for EVV telephone calls to the member receiving services.	N/A	Derived from Profile Data on the EVV System.	Yes	The provider/FMSA may enter/edit the Alt phone number one of the Member.	No	The CDS Employers are not responsible for the profile setup.
42	INDVMBR_ALTPHONE2	10	Individual/Member Alternative Phone 2: Another secondary (additional) phone number registered for EVV telephone calls to the member receiving services.	N/A	Derived from Profile Data on the EVV System.	Yes	The provider/FMSA may enter/edit the Alt phone number two of the Member.	No	The CDS Employers are not responsible for the profile setup.
43	MCO_MBR_SDA	2	Managed Care Organization (MCO) Plan code for which the member is enrolled. Member MCO Plan Code is available in the Payer Plan Code Web Service.	N/A	Derived from Profile Data on the EVV System.	Yes	The Provider/FMSA may enter and edit the Member Plan Code field at anytime on the EVV System. The Plan Code can be derived using the Payer Plan Code Web Service from MES service providers.	No	The CDS Employers are not responsible for the profile setup.
44	INDVMBR_ADDRESS_LATITUDE	50	Individual/Member Address Latitude: The latitude of the member's address.	N/A	Derived from Profile Data on the EVV System.	Yes	If the provider/FMSA edits the Member's address, then the Member Address Latitude will change.	No	The CDS Employers are not responsible for the profile setup.
45	INDVMBR_ADDRESS_LONGITUDE	50	Individual/Member Address Longitude: The longitude of the member's address.	N/A	Derived from Profile Data on the EVV System.	Yes	If the provider/FMSA edits the Member's address, then the Member Address Longitude will change.	No	The CDS Employers are not responsible for the profile setup.
46	INDVMBR_TOTAL_AUTHUNITS	11	Individual/Member Total Authorized Units: The total number of units authorized for a member for a service to be delivered for a given time period.	N/A	Derived from Profile Data on the EVV System.	Yes	The provider/FMSA may edit the units entered in the Authorization area of the EVV System	No	The CDS Employers are not responsible for the profile setup.
47	AUTH_UNITS_TYPE	10	Individual/Member Authorized Units Type: The type of units authorized. Can be daily, weekly, monthly or per auth.	N/A	Derived from Profile Data on the EVV System.	Yes	The provider/FMSA may edit the unit type entered in the Authorization area of the EVV System	No	The CDS Employers are not responsible for the profile setup.
48	INDVMBR_TOTAL_AUTHUNITSREMA	11	Individual/Member Total Authorized Units Remaining: The total number of units remaining for a member for a service to be delivered for a given time period. This is the value after the delivery of the units of service.	N/A	Derived from Profile Data on the EVV System.	Yes	The provider/FMSA may edit the Total Authorized Units entered in the Authorization area of the EVV System	No	The CDS Employers are not responsible for the profile setup.

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49	VISIT_VISITID	30	Electronic Visit Verification Visit Identification: A unique ID number assigned to the EVV visit by the EVV system.	No	Provider/FMSA cannot create or edit the Visit ID. This is systematically generated.	No	Provider/FMSA cannot create or edit the Visit ID. This is systematically generated.	No	The CDS Employers cannot create or edit the Visit ID. This is systematically generated.
50	VISIT_SCHEDULEID	30	Schedule Identification: A unique ID number assigned to the scheduled visit by the EVV system.	N/A	Derived from Schedule data on the EVV System.	No	Provider/FMSA cannot create or edit the Visit Schedule ID. This is systematically generated.	No	The CDS Employers are not responsible for the schedule setup.
51	VISIT_VISITDATE	8	Scheduled Visit Date: The date that the Service Provider was scheduled to perform services for the individual/member. Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Weekly Variable Schedule Begin Date is populated for Weekly Variable Schedule. Null for No Schedule.	No	Provider/FMSA cannot modify the schedule information after the Visit is created (Matching that schedule). Derived from Schedule data on the EVV System.	YES	Provider/FMSA can create or edit the Visit Schedule date.	No	The CDS Employers are not responsible for the schedule setup.
52	VISIT_VISITTIMEIN	17	Scheduled Visit Time In: Scheduled service delivery start time in date/time format (MMDDYYYY HH:MM AM/PM). Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Null for Weekly Variable Schedule or No Schedule.	No	Provider/FMSA cannot modify the schedule information after the Visit is created (Matching that schedule). Derived from Schedule data on the EVV System.	YES	Provider/FMSA can create or edit the Visit Time In field.	No	The CDS Employers are not responsible for the schedule setup.
53	VISIT_VISITTIMEOUT	17	Scheduled Visit Time Out: Service delivery stop time in date/time format (MMDDYYYY HH:MM AM/PM). Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Null for Weekly Variable Schedule or No Schedule.	No	Provider/FMSA cannot modify the schedule information after the Visit is created (Matching that schedule). Derived from Schedule data on the EVV System.	YES	Provider/FMSA can create or edit the Visit Time Out field.	No	The CDS Employers are not responsible for the schedule setup.
54	VISIT_VISITHOURS	5	Scheduled Visit Hours: Duration of services provided to the individual/member, shown as a decimal (Example: 1.25). Captured for a Daily Fixed Schedule or a Daily Variable Schedule. Total Weekly Scheduled Hours is populated for Weekly Variable Schedule. Null for No Schedule.	No	Provider/FMSA cannot modify the schedule information after the Visit is created (Matching that schedule). Derived from Schedule data on the EVV System.	YES	Provider/FMSA can create or edit the Visit hours field.	No	The CDS Employers are not responsible for the schedule setup.
55	VISIT_VISITLOCATION	50	Scheduled Visit Location: The scheduled location where services are to be provided.	No	Provider/FMSA cannot modify the schedule information after the Visit is created (Matching that schedule). Derived from Schedule data on the EVV System.	YES	Provider/FMSA can create or edit the Visit Location field.	No	The CDS Employers are not responsible for the schedule setup.
56	VISIT_SVCGRP	3	A code that identifies the type of LTC FFS program for which the member is eligible.	Yes	Provider/FMSA can select the Service information during Visit Maintenance. New Service associated with the Member has to be created through the Profile area.	Yes	The providers/FMSA may update service information related to the Member.	Yes	CDS Employer can select the Service information during Visit Maintenance. The CDS Employer cannot create new Service information related to the member. If the CDS Employer has chosen Option 1 in the 1722 form.
57	EVV_SVCCODE	50	Visit Service Code: A code to denote a specific service or category of service within the Long Term Services and Supports (aka Long Term Care) fee-for-service program at HHSC. Example: HHSC Service Code- Specific services provided within a program (Svc Grp 7+Svc Code 17C = Family Care, but Svc Grp 7+ Svc Code 17CV = Family Care in the Consumer Directed Services (CDS) option)	Yes	Provider/FMSA can select the Service information during Visit Maintenance. New Service associated with the Member has to be created through the Profile area.	Yes	The providers/FMSA may update service information related to the Member.	Yes	CDS Employer can select the Service information during Visit Maintenance. The CDS Employer cannot create new Service information related to the member. If the CDS Employer has chosen Option 1 in the 1722 form.
58	EVV_HCPCS_CODE	30	HCPCS Code: A medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes.	Yes	Provider/FMSA can select the Service information during Visit Maintenance. New Service associated with the Member has to be created through the Profile area.	Yes	The providers/FMSA may update service information related to the Member.	Yes	CDS Employer can select the Service information during Visit Maintenance. The CDS Employer cannot create new Service information related to the member. If the CDS Employer has chosen Option 1 in the 1722 form.

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59	EVV_MODIFIER	30	The Healthcare Common Procedure Coding System (HCPCS) Modifier: Two alphanumeric characters that are appended to the HCPCS codes to differentiate between services. A modifier provides a means to indicate that a service or procedure was altered by specific circumstances, without changing the definition of the code. There may be none or up to four modifiers for the HCPCS codes.	Yes	Provider/FMSA can select the Service information during Visit Maintenance. New Service associated with the Member has to be created through the Profile area.	Yes	The providers/FMSA may update service information related to the Member.	Yes	CDS Employer can select the Service information during Visit Maintenance. The CDS Employer cannot create new Service information related to the member. If the CDS Employer has chosen Option 1 in the 1722 form.
62	EVV_PHONE	10	Electronic Visit Verification Phone: The phone number used in the EVV transaction.	No	The EVV Phone cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Phone cannot be modified by the CDS Employer.
68	EVV_VISITLOCATION	50	Actual Visit Location: The location where services are being provided.	Yes	The Service Location can be modified by the Provider/FMSA. This needs to be restricted to only Mobile Method.	N/A	This is not related to the Profile Data.	Yes	The Service Location can be modified by the CDS Employer. This needs to be restricted to only Mobile Method. If the CDS Employer has chosen Option 1 in the 1722 form.
73	EVV_INPUTMETHOD_IN	50	Electronic Visit Verification Input Method In: The data input method for call In.	No	The EVV Input Method In cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Input Method In cannot be modified by the CDS Employer.
74	EVV_INPUTMETHOD_OUT	50	Electronic Visit Verification Input Method Out: The data input method for call out.	No	The EVV Input Method Out cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The EVV Input Method Out cannot be modified by the CDS Employer.
75	EVV_ALTERNATIVEDEVICEID	50	Electronic Visit Verification Alternative Device Identification: The serial number or device identifier alternative device assigned to the Member.	No	The Alternative Device ID cannot be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	No	The Alternative Device ID cannot be modified by the CDS Employer
107	EVV_VISITNOTES	500	Visit Notes: Information entered into memo or note(s) fields related to the visit.	Yes	The Visit Notes can be modified by the Provider/FMSA.	N/A	This is not related to the Profile Data.	Yes	The Visit Notes can be modified by the CDS Employer. If the CDS Employer has chosen Option 1 in the 1722 form.
109	EVV_UPLOADINDICATOR	2	Electronic Visit Verification Upload Indicator: An indicator that specifies if a visit was finalized and uploaded (transferred) to the EVV Aggregator.	No	Electronic Visit Verification Upload Indicator cannot be modified by the Provider/FMSA. This is System Generated.	N/A	This is not related to the Profile Data.	No	Electronic Visit Verification Upload Indicator cannot be modified by the CDS Employer. This is System Generated.
110	EVV_LASTUPLOAD	17	Electronic Visit Verification Last Upload: The last date any information was uploaded or updated in the EVV System.	Yes	Electronic Visit Verification Last Upload cannot be modified by the Provider/FMSA. This is System Generated. However when Visit Maintenance is conducted and the visit is saved, this Last Upload date gets modified.	N/A	This is not related to the Profile Data.	No	Electronic Visit Verification Last Upload cannot be modified by the CDS Employer. This is System Generated. However when Visit Maintenance is conducted and the visit is saved, this Last Upload date gets modified.
112	EVV_FILEEXPORTID	30	Electronic Visit Verification File Export Identification: A specific upload identifier assigned to each data file exported by the EVV System.	No	EVV File Export ID cannot be modified by the Provider/FMSA. This is System Generated.	N/A	This is not related to the Profile Data.	No	EVV File Export ID cannot be modified by the CDS Employer. This is System Generated.
113	EVV_DONOTEXPORTINDICATOR	1	Electronic Visit Verification Do Not Export Indicator: An indicator that specifies if a visit has been manually flagged by a provider to not export to the billing system for payment.	Yes	The Provider/FMSA can mark the visit not to be exported.	N/A	This is not related to the Profile Data.	No	Do Not Export Indicator cannot be modified by the CDS Employer.
114	EVV_AUTOCONFIRMFLAG	2	Electronic Visit Verification Auto Confirm Flag: An indicator that specifies if a visit was auto- verified by the EVV System and no visit maintenance was required.	No	Auto Confirm Flag cannot be modified by the Provider/FMSA. This is System Generated.	N/A	This is not related to the Profile Data.	No	Auto Confirm Flag cannot be modified by the CDS Employer. This is System Generated.
115	EVV_VISITRECORDINDICATOR	30	Electronic Visit Verification Visit Record Indicator: An indicator that specifies the status of the EVV visit transaction.	No	Visit Record Indicator cannot be modified by the Provider/FMSA. This is System Generated.	N/A	This is not related to the Profile Data.	No	Visit Record Indicator cannot be modified by the CDS Employer. This is System Generated.

Field #	Extract Data Element	Length	Description	Can Provider or FMSA Edit After Visit Created? (Visit Data)	Additional Details for 'Can Provider or FMSA Edit After Visit Created? (Visit Data) '	Can Provider & FMSA Enter & Maintain Data Elements? (Profile Data)	Additional Details for 'Can Provider & FMSA Enter& Maintain Data Elements? (Profile Data)'	Can CDS Employer Edit/Enter After Visit Created? (Visit Data)	Additional Details for 'Can CDS Employer Edit/Enter After Visit Created? (Visit Data)'
118	EVV_MATERIAL_VM_CHANGE	1	Indicates if a Material visit maintenance change was made. Assigned by the EVV System if a material field was changed during visit maintenance.	No	EVV Material VM Change field cannot be modified by the Provider/FMSA. This is System Generated. However when Visit Maintenance is conducted and the visit is saved, this Material VM Change field gets modified.	N/A	This is not related to the Profile Data.	Yes	EVV Material VM Change field cannot be modified by the CDS Employer. This is System Generated. However when Visit Maintenance is conducted and the visit is saved, this Material VM Change field gets modified. If the CDS Employer has chosen Option 1 in the 1722 form.
119	EVV_MATERIAL_VM_FIELD_ID	50	Presents Field ID of all material changes delimited by a comma. Required if Field EVV_MATERIAL_VM_CHANGE = Y	No	EVV Material VM field ID cannot be modified by the Provider/FMSA. This is System Generated. However when Visit Maintenance is conducted and the visit is saved, this Material VM field ID gets modified.	N/A	This is not related to the Profile Data.	Yes	EVV Material VM field ID cannot be modified by the CDS Employer. This is System Generated. However when Visit Maintenance is conducted and the visit is saved, this Material VM field ID gets modified. If the CDS Employer has chosen Option 1 in the 1722 form.

Appendix P – Auto Verification

HHSC Electronic Visit Verification (EVV) Vendors Documentation
Appendix P - Auto Verification
Published Date: 02/25/2022
Effective Date: 05/31/2022

EVV Schedule Types Summary		
Schedule Type	**Auto-Verification Criteria**	**24-hour Call Matching Window enabled?**
Daily Variable Schedule	• Visit must occur on the scheduled date. • Visit duration must match scheduled duration within 7 minutes.	Yes
Daily Variable Schedule +Optional Expanded Time for Auto-verification	• Visit must occur on the scheduled date. • Visit duration must match scheduled duration within 22 minutes (.25 bill hours over or under).	Yes
Daily Variable Schedule +Optional Expanded Time for Auto-verification +Automatic Downward Adjustment	• Visit must occur on the scheduled date. • Visit duration must match scheduled duration within 22 minutes (.25 bill hours). • The EVV System will automatically downward adjust the Bill Hours to the scheduled duration if the visit duration is no more than .25 Bill Hours over.	Yes
Weekly Variable Schedule	• Visit must occur within the Weekly Schedule Begin Date and Weekly Schedule End Date. • Bill Hours of visit must not exceed hours remaining on Total Weekly Scheduled Hours • Visit duration is not considered for auto verification.	No
Daily Fixed Schedule	• Visit must occur on the scheduled date. • Visit clock in time must match scheduled begin time within 7 minutes <u>and</u> visit clock out time must match scheduled end time within 7 minutes. • Visit duration must match scheduled duration within 7 minutes. (8 minutes under or 8 minutes over will not auto-verify)	No
Daily Fixed Schedule +Optional Expanded Time for Auto-verification	• Visit must occur on the scheduled date. • Visit clock in time must match scheduled begin time within 7 minutes <u>and</u> visit clock out time must match scheduled end time within 7 minutes. • Visit duration must match scheduled duration within 14 minutes.	No

EVV Schedule Types Summary		
Daily Fixed Schedule +Optional Expanded Time for Auto-verification +Automatic Downward Adjustment	• Visit must occur on the scheduled date. • Visit clock in time must match scheduled begin time within 7 minutes and visit clock out time must match scheduled end time within 7 minutes. • Visit duration must match scheduled duration within 14 minutes. • The EVV System will automatically downward adjust the Bill Hours to the scheduled duration if the visit duration is within 14 minutes.	No

Below is Auto Verification Criteria to be used by the EVV System. The criteria are listed for with a Schedule (Daily Fixed, Daily Variable, Weekly Variable) and without a Schedule.

EVV Method	Field on the EVV Visit Transaction	Field on the Schedule	Auto Verification with Schedule (*'Daily Fixed Schedule', 'Daily Variable Schedule' and 'Weekly Variable Schedule'*)	Auto Verification without Schedule
ALL METHOD TYPES	EMPLOYEE_EVVID	ATTENDANT EVV ID	The EVV System must match the Employee EVV ID (EMPLOYEE_EVVID) on the EVV Visit Transaction with the Primary Service Provider Employee EVV ID or the Backup Service Provider Employee EVV ID on the Schedule. If the Employee EVV ID (EMPLOYEE_EVVID) on the EVV Visit Transaction does not match to Primary or Backup Service Provider Employee EVV ID, the EVV Visit Transaction must not Auto-verify.	The EVV System must validate the Employee EVV ID (EMPLOYEE_EVVID) on the EVV Visit Transaction is found in the EVV System. If Employee EVV ID (EMPLOYEE_EVVID) is not found, then the EVV Visit Transaction must not Auto-verify.
	INDVMBR_MEMBEREVVID	MEMBER EVV ID	The EVV System must match the Member EVV ID (INDVMBR_MEMBEREVVID) from the EVV Visit Transaction with the Member EVV ID on the Schedule. If Member EVV ID (INDVMBR_MEMBEREVVID) on the EVV Visit Transaction does not match with the Member EVV ID on the Schedule, the EVV Visit Transaction must not Auto-verify.	The EVV System must validate the Member EVV ID (INDVMBR_MEMBEREVVID) on the EVV Visit Transaction is found in the EVV System. If Member EVV ID(INDVMBR_MEMBEREVVID) on the EVV Visit Transaction is not found, then the EVV Visit Transaction must not Auto-verify.
	EVV_PAYHOURS (rounded actual hours)	VISIT_VISITHOURS	**Criteria 1 – Daily Variable Schedule, Daily Fixed Schedule (up to 7 Minutes Expanded Time)** Optional Expanded Time for Auto-Verification - **OFF** Optional Automatic Downward Adjustment - **OFF** The EVV System must compare Bill Hours (EVV_PAYHOURS) with Schedule Hours (VISIT_VISITHOURS) for the date of service. If the difference between Bill Hours (EVV_PAYHOURS) and Scheduled HOURS is greater than 7 minutes, the EVV Visit Transaction must not Auto-verify. **Criteria 2: Daily Variable Schedule (up to 22 Min Expanded Time (.25 hours), Billable hours are not**	The EVV System must validate the Bill Hours (EVV_PAYHOURS) on the EVV Visit Transaction is populated and is in the correct format. If the Bill Hours (EVV_PAYHOURS) is not populated and in the correct format, the EVV Visit Transaction must not Auto-verify.

			adjusted) Optional Expanded Time for Auto-Verification - **ON** Optional Automatic Downward Adjustment - **OFF** The EVV System must compare Bill Hours (EVV_PAYHOURS) with Schedule Hours (VISIT_VISITHOURS) for the date of service. If the difference between Bill Hours (EVV_PAYHOURS) and Scheduled HOURS is greater than 22 minutes, the EVV Visit Transaction must not Auto-verify. **Criteria 3: Daily Variable Schedule (up to 22 Min Expanded Time (.25 hours), Billable hours are downward adjusted)** Optional Expanded Time for Auto-Verification - **ON** Optional Automatic Downward Adjustment - **ON** The EVV System must compare Bill Hours (EVV_PAYHOURS) with Schedule Hours (VISIT_VISITHOURS) for the date of service. If the difference between Bill Hours (EVV_PAYHOURS) and Scheduled HOURS is greater than 22 minutes, the EVV Visit Transaction must not Auto-verify. In this criteria Bill Hours are downward adjusted to match the Scheduled hours. **Criteria 4: Daily Fixed Schedule (up to 14 Min Expanded Time (.25 hours), Billable hours are not adjusted)** Optional Expanded Time for Auto-Verification - **ON** Optional Automatic Downward Adjustment - **OFF** The EVV System must compare Bill Hours (EVV_PAYHOURS) with Schedule Hours (VISIT_VISITHOURS) for the date of service. If the difference between Bill Hours (EVV_PAYHOURS) and	

			Scheduled HOURS is greater than 14 minutes, the EVV Visit Transaction must not Auto-verify. **Criteria 5: Daily Variable Schedule (up to 14 Min Expanded Time (.25 hours), Billable hours are downward adjusted)** Optional Expanded Time for Auto-Verification - **ON** Optional Automatic Downward Adjustment - **ON** The EVV System must compare Bill Hours (EVV_PAYHOURS) with Schedule Hours (VISIT_VISITHOURS) for the date of service. If the difference between Bill Hours (EVV_PAYHOURS) and Scheduled Hours (VISIT_VISITHOURS) is greater than 14 minutes, the EVV Visit Transaction must not Auto-verify. In this criteria Bill Hours are downward adjusted to match the Scheduled hours. **Criteria 6: Weekly Variable Schedule** The EVV System must compare Bill Hours (EVV_PAYHOURS) with the remaining Total Weekly Scheduled Hours. If the Bill Hours (EVV_PAYHOURS) exceeds the remaining Total Weekly Scheduled Hours, the EVV Visit Transaction must not Auto-verify.	
	SERVICE (EVV_HCPCS_CODE, EVV_MODIFIER)	AUTHORIZED SERVICE	The EVV System must match the Service information on the EVV Visit Transaction with the Service Information on the active Authorization for the linked to the Schedule. If Service information does not match with the active Authorization, the EVV Visit Transaction must not Auto-verify.	The EVV System must match the Service information on the EVV Visit Transaction with the Service Information on the active Authorization. If Service information does not match with the active Authorization, the EVV Visit Transaction must not Auto-verify.
	EVV_VISITDATE (actual visit date of service)	VISIT_VISITDATE (Schedule Date for Daily Fixed and Daily Variable Schedule Types)	**Daily Fixed Schedule Type:** The EVV System must match actual visit date of service (EVV_VISITDATE) on the EVV Visit Transaction with date on the Schedule (VISIT_VISITDATE). If the actual visit date of service (EVV_VISITDATE) does not	The EVV System must validate the visit date of service (EVV_VISITDATE) on the EVV Visit Transaction is populated and is in the correct format. If the visit date of service (EVV_VISIT

		OR Weekly Schedule Begin Date and Weekly Schedule End Date for Weekly Variable Schedule Type	match with the date on the Schedule (VISIT_VISITDATE), the EVV Visit Transaction must not Auto-verify. **Daily Variable Schedule Types:** The EVV System must match actual visit date of service (EVV_VISITDATE) on the EVV Visit Transaction with date on the Schedule (VISIT_VISITDATE). If the actual visit date of service (EVV_VISITDATE) does not match with the date on the Schedule (VISIT_VISITDATE), the EVV Visit Transaction must not Auto-verify. For Daily Variable Schedule Type, the EVV System may only Auto-verify one visit within the 24-hour Call Matching Window, any additional visits in the same day for the same service must not Auto-verify. **Weekly Variable Schedule Type:** If the actual visit date of service (EVV_VISITDATE) on the EVV Visit Transaction is not within the Active Weekly Variable Schedule, then the Visit must not Auto-verify.	DATE) is not populated and in the correct format, the EVV Visit Transaction must not Auto-verify.
	EVV_CALLINTIME EVV_CALLOUTTIME (Actual Time In and Actual Time Out)	VISIT_VISITTIMEIN VISIT_VISITTIMEOUT (Schedule Time In and Schedule Time Out)	The EVV System must validate that the actual time in (EVV_CALLINTIME) and actual time out (EVV_CALLOUTTIME) are both populated on the EVV Visit Transaction and in the correct data format. If the actual time in (EVV_CALLINTIME) or actual time out (EVV_CALLOUTTIME) are missing, the visit must not Auto-verify. **Daily Variable Schedule Type** The EVV System must validate the actual time in (EVV_CALLINTIME) and actual time out (EVV_CALLOUTTIME) occur within 12:00 AM and	The EVV System must validate the actual time in (EVV_CALLINTIME) or actual time out (EVV_CALLOUTTIME) are both populated on the EVV Visit Transaction and in the correct data format EVV System must validate the actual time in (EVV_CALLINTIME) and actual time out (EVV_CALLOUTTIME) occur within 12:00 AM and 11:59 PM of the same date of service (EVV_VISITDATE). If the actual time in (EVV_CALLINTIME) or actual time out (EVV_CALLOUTTIME) fail validation, the EVV Visit Transaction must not Auto-verify.

			11:59 PM of the same date of service (EVV_VISITDATE). If the actual time in (EVV_CALLINTIME) or actual time out (EVV_CALLOUTTIME) fail validation, then the EVV Visit Transaction must not Auto-verify. **Daily Fixed Schedule Type** The EVV System must compare actual time in (EVV_CALLINTIME) on the EVV Visit Transaction with Scheduled Time In (VISIT_VISITTIMEIN) and compare actual time out (EVV_CALLOUTTIME) on the EVV Visit Transaction with Scheduled Time Out (VISIT_VISITTIMEOUT). If the variance of actual time in (EVV_CALLINTIME) and schedule time in (VISIT_VISITTIMEIN) is greater than 7 minutes OR the variance of actual time out (EVVCALLOUTTIME) and schedule time out (VISIT_VISITTIMEOUT) is greater than 7 minutes, the EVV Visit Transaction must not Auto-verify.	
LANDLINE METHOD	EVV_PHONE	N/A	The EVV System must match the EVV_PHONE number with the Member's primary landline phone number or alternate landline phone numbers (INDVMBR_PHONE or INDVMBR_ALTPHONE or INDVMBR_ALTPHONE2). If the phone number does not match to Member's primary or alternate phone numbers, the EVV Visit Transaction must not Auto-verify.	The EVV System must match the EVV_PHONE number with the Member's primary landline phone number or alternate landline phone numbers (INDVMBR_PHONE or INDVMBR_ALTPHONE or INDVMBR_ALTPHONE2). If the phone number does not match to Member's primary or alternate phone numbers, the EVV Visit Transaction must not Auto-verify.

MOBILE METHOD	EVV_VISIT_LATITUDE_IN EVV_VISIT_LONGITUDE_IN EVV_VISIT_LATITUDE_OUT EVV_VISIT_LONGITUDE_OUT	N/A	The EVV System must validate that the GPS Coordinates for the clock in and clock out are both populated on the EVV Visit Transaction and in the correct data format. If the GPS Coordinates fail validation, the EVV Visit Transaction must not Auto-verify. The EVV System must match the GPS Coordinates from the EVV Visit Transaction to the Geo-location of the Member's address based on the Geo Fencing that is approved per HHSC EVV Policy. If the 'Geo- Location' is not within the 'EVV Allowed Geo- perimeter' with 'Service Delivery Location' as 'Member Home', the EVV Visit Transaction must not Auto-verify.	The EVV System must validate that the GPS Coordinates for the clock in and clock out are both populated on the EVV Visit Transaction and in the correct data format. If the GPS Coordinates fail validation, the EVV Visit Transaction must not Auto-verify. The EVV System must match the GPS Coordinates from the EVV Visit Transaction to the Geo-location of the Member's address based on the Geo Fencing that is approved per HHSC EVV Policy. If the 'Geo-Location' is not within the 'EVV Allowed Geo-perimeter' with 'Service Delivery Location' as 'Member Home', the EVV Visit Transaction must not Auto-verify.
ALTERNATIVE DEVICE METHOD	ALTERNATIVE DEVICE TOKEN ID	N/A	The EVV System must match the Alternative Device Token ID from the EVV Visit Transaction to the Alternative Device that is linked to the Member. If the Token ID does not match to the Alternate Device linked to the member, the EVV Visit Transaction must not Auto-verify.	The EVV System must match the Alternative Device Token ID from the EVV Visit Transaction to the Alternative Device that is linked to the Member. If the Token ID does not match to the Alternate Device linked to the member, the EVV Visit Transaction must not Auto-verify.

Appendix Q – CDS Process Flow

EVV Visit Maintenance Process Flow for FMSAs/CDS Employers

Option 1: CDS Employer will perform visit maintenance and approve the time worked by their CDS employees in the EVV system.

EVV System

Start

Did Visit Auto Verify?

No

The EVV system performs visit validation edits

Did Visit(s) Pass EVV System Validations?

Yes

No

The EVV system returns reason(s) for rejection

Does CDS Employer need to adjust visit?

CDS Employer (or DR)

Yes

No

Does CDS employer approve time worked?

CDS employer (or DR) performs visit maintenance to: add clock in or clock out; adjust bill hours, add reason codes, select reason code description(s), and enter required free text

Yes

No

FMSA

Yes

The FMSA reviews the visit(s) using the CDS Service Delivery Log; compares to budget

Do Visits Match Budget?

No

Errors in time worked or time does not match budget; FMSA notifies CDS employer of VM adjustments required

FMSA makes corrections to pass the validation (No changes to clock in or clock out, bill hours or reason codes)

Yes

EVV Aggregator

Visit received by the EVV Aggregator and the Aggregator performs Business edits

Is EVV Visit Transaction Accepted or Rejected by Aggregator?

Accepted

The accepted EVV visit transactions are ready for EVV claims matching.

End

Rejected

The EVV Aggregator returns reason(s) for rejection to the EVV system. Visit maintenance must be performed.

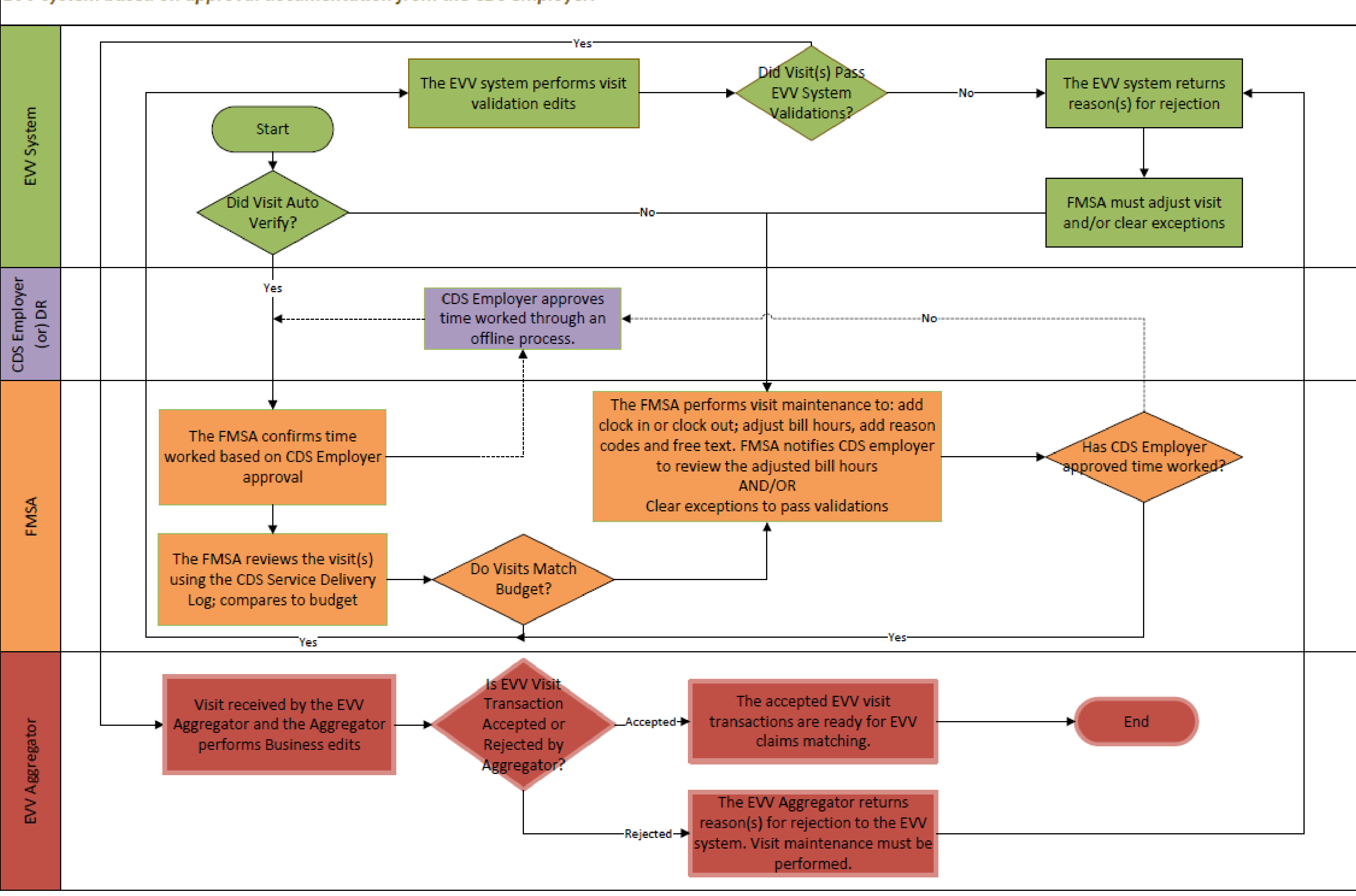
EVV Visit Maintenance Process Flow for FMSAs/CDS Employers
Option 3: The CDS Employer elects to delegate the performance of EVV visit maintenance to the FMSA. The FMSA will confirm the employee's time worked in the EVV system based on approval documentation from the CDS employer.
EVV System
CDS Employer (or) DR
FMSA
EVV Aggregator
Start
Did Visit Auto Verify?
Yes
No
The EVV system performs visit validation edits
Did Visit(s) Pass EVV System Validations?
Yes
No
The EVV system returns reason(s) for rejection
FMSA must adjust visit and/or clear exceptions
CDS Employer approves time worked through an offline process.
No
The FMSA confirms time worked based on CDS Employer approval
The FMSA reviews the visit(s) using the CDS Service Delivery Log; compares to budget
Do Visits Match Budget?
Yes
The FMSA performs visit maintenance to: add clock in or clock out; adjust bill hours, add reason codes and free text. FMSA notifies CDS employer to review the adjusted bill hours
AND/OR
Clear exceptions to pass validations
Has CDS Employer approved time worked?
Yes
Visit received by the EVV Aggregator and the Aggregator performs Business edits
Is EVV Visit Transaction Accepted or Rejected by Aggregator?
Accepted
Rejected
The accepted EVV visit transactions are ready for EVV claims matching.
End
The EVV Aggregator returns reason(s) for rejection to the EVV system. Visit maintenance must be performed.

Exhibit T: EVV Standard Language Guide

The following document is a guide that should be referenced and adhered to when developing, reviewing, or engaging in EVV related presentations, documents, guidance, policies, training, notifications, website content, and additional materials, to ensure consistent EVV terminology is used.

HHSC regularly updates the EVV Standard Language Guide and will provide the most current version to the awarded Contractor upon the Contract Effective Date or as otherwise agreed between the Parties.

Version 3

Electronic Visit Verification (EVV) Standard Language Guide

Purpose: This guide should be referenced and adhered to when developing and/or reviewing presentations, documents, EVV guidance, EVV policies, EVV training, information letters, notifications, website content, etc. to ensure consistent EVV terminology is used.

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General Capitalization Rules

- Always capitalize EVV policy names (e.g. Data Collection Policy).
- When referring to EVV policy and EVV policy training in general, lowercase "policy" unless it's an official policy name or training name.

General Acronym Rule

- Always spell out terms on first instance; use acronym after that if it appears more than once in the document.

Common EVV Terms, Definitions, Acronyms, and Capitalization Rules

Sources: Texas Administrative Code (TAC), posted EVV policies, EVV Operations SMEs and management, HHSC website, EVV federal and state statutes and rules

Term	Definition	Acronym	Capitalization
21st Century Cures Act	The 21st Century Cures Act is a federal law enacted by the U.S. Congress in December 2016. This law requires all states to use EVV for Medicaid personal care services (PCS) and home health care services (HHCS) requiring an in-home visit that are provided under a State plan or under a waiver of the plan.	Cures Act	Capitalize Other instances: Cures Act implementation (implementation not capitalized)
21st Century Cures Act, Section 12006	The 21st Century Cures Act is a federal law enacted on December 13, 2016 that amends Section 1903 of the Social Security Act (42 USC 1396b). Section 12006 of the Cures Act describes electronic visit verification (EVV) requirements and federal financial matching participation to support the development of EVV systems for the delivery of all Medicaid personal care services (beginning January 1, 2020) and home health care services (beginning January 1, 2023).	Cures Act, Section 12006	Capitalize

Term	Definition	Acronym	Capitalization
alternative device	An HHSC-approved electronic device provided at no cost by an EVV vendor or Proprietary System Operator (PSO), if applicable, that allows the service provider to clock in and clock out of the EVV system from the member's home	N/A	Lowercase
Atypical Provider Identifier (API)	A unique number assigned to a program provider instead of a National Provider Identifier (NPI) number. The Centers for Medicare and Medicaid Services (CMS) defines atypical program providers as a program provider that does not provide health care. Respite services are an example of an atypical service.	API	Capitalize
auto-verified EVV visits	EVV visits that have no exceptions in the EVV system and are eligible for claims matching	N/A	Lowercase
Bill Hours	The quarter hour increments that represent the Actual Hours Worked ***Internal Note:*** *Use Bill Hours instead of Pay Hours per SG 4/12/21.*	N/A	Capitalize
Billable Hours	The hours that the EVV Aggregator systematically converts to EVV units	N/A	Capitalize
billing staff	Staff who submit Medicaid claims for an EVV-required service	N/A	Lowercase
business day	Monday through Friday, except national or state holidays listed in Texas Government Code, Section 662.003(a) or (b)	N/A	Lowercase
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs	CMS	Capitalize

Term	Definition	Acronym	Capitalization
claims administrator	The entity HHSC has designated to perform functions such as processing certain Medicaid program provider claims, managing the EVV Aggregator, and performing EVV vendor management functions	N/A	Lowercase
claims matching process	HHSC uses the claims matching process to identify one or more EVV visits that support a Medicaid claim.	N/A	Lowercase
Community Attendant Services (CAS) 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)	CAS *Pronounced "cass"*	Capitalize
Community First Choice (CFC)	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). This includes STAR members who receive these services through the traditional Medicaid service model also referred to as fee-for-service.	CFC	Capitalize
Community First Choice Habilitation (CFC HAB)	A Medicaid state plan service that provides habilitation through Community First Choice (CFC)	CFC HAB *Pronounced "CFC habb"*	Capitalize
Community First Choice Personal Assistance Services (CFC PAS)	A Medicaid state plan service that provides personal assistance services through Community First Choice (CFC)	CFC PAS *Pronounced "CFC pass"*	Capitalize
Community First Choice Personal Assistance Services/Habilitation (CFC PAS/HAB)	A Medicaid state plan service provided through CFC that provides both personal assistance services and habilitation combined into one service	CFC PAS/HAB *Pronounced "CFC pass habb"*	Capitalize

Term	Definition	Acronym	Capitalization
computer-based training (CBT)	A training method where participants access the training using a computer or a mobile device, with no live instructor	CBT	Lowercase
Community Living Assistance and Support Services (CLASS) Program	The Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in 40 TAC Chapter 45 (relating to Community Living Assistance and Support Services and Community First Choice (CFC) Services)	CLASS *Pronounced "class"*	Capitalize
Consumer Directed Services (CDS)	Consumer Directed Services allows people who receive services from Texas Health and Human Services Commission to hire and manage the people who provide their services	CDS	Capitalize
Consumer Directed Services (CDS) employee	*N/A - This is now included in the definition for **service provider** so not defining separately anymore*	CDS employee	Capitalize CDS, lowercase employee
Consumer Directed Services (CDS) employer	A member or Legally Authorized Representative (LAR) who chooses to participate in the CDS option. A CDS employer, the member or LAR, is responsible for hiring and retaining a service provider who delivers a service described in §354.4005 of Chapter 354, Subchapter O (relating to Applicability)	CDS employer	Capitalize CDS, lowercase employer
Consumer Directed Services (CDS) option	A service delivery option in which a member or LAR employs and retains a service provider and directs the delivery of a service described in §354.4005 of Chapter 354, Subchapter O (relating to Applicability)	CDS option	Capitalize CDS, lowercase option

Term	Definition	Acronym	Capitalization
critical data elements	Data an EVV system verifies related to the delivery of Medicaid services: • The type of service provided • The name of the recipient to whom the service is provided • The date and times the provider began and ended the service delivery visit • The location, including the address, at which the service was provided • The name of the individual who provided the service • Other information the commission determines is necessary to ensure the accurate adjudication of Medicaid claims	N/A	Lowercase
data validation	A process performed by the EVV system and EVV Aggregator to ensure the data complies with defined requirements	N/A	Lowercase
day	A calendar day, including weekends and holidays	N/A	Lowercase
Deaf Blind with Multiple Disabilities (DBMD) Program	The Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in 40 TAC Chapter 42 (relating to Deaf Blind with Multiple Disabilities (DBMD) Program and Community First Choice (CFC) Services)	DBMD	Capitalize
Designated Representative	If a Consumer Directed Services (CDS) employer (member or Legally Authorized Representative) needs support or assistance to meet employer responsibilities, they may choose to appoint a DR. A CDS employer can appoint a DR to assist or to perform EVV responsibilities in the CDS option.	DR *Pronounced "D-R"*	Capitalize

Term	Definition	Acronym	Capitalization
Electronic Visit Verification (EVV)	The documentation and verification of service delivery through an EVV system ***Internal Note:*** Source	EVV	Capitalize
EVV Aggregator	A centralized database that collects, validates, and stores statewide EVV service delivery data transmitted by an EVV system	N/A	Capitalize
EVV claim match result code	A code used to indicate if an EVV claim line item matched or did not match an accepted EVV visit transaction ***Internal Note:*** *See the* ***EVV Claim Match Result Code Descriptions*** *section in this document for definitions of EVV01-EVV08.*	N/A	Lowercase
EVV compliance oversight	A set of standards established by the Texas Health and Human Services Commission (HHSC) and managed care organizations (MCOs) to ensure EVV requirements and policies are being followed	N/A	Lowercase
EVV Compliance Oversight Reviews	Monitors the usage of an EVV system to electronically document authorized service delivery visits	N/A	Capitalize
EVV compliance oversight quarter	A period of three consecutive calendar months prior to the review month that occurs at least once within a calendar year, or more frequent as determined by the payer	N/A	Lowercase
EVV compliance oversight score	An EVV minimum score of 80 percent based on EVV compliance oversight reviews that must be achieved and maintained per review period; each quarter	N/A	Lowercase

Term	Definition	Acronym	Capitalization
EVV Implementation Groups	*Definition Placeholder (in progress):* • *Pre-Cures Act (9/1/19)* • *Cures Act Personal (1/1/21)* • *Cures Act Home Health (1/1/23)*	N/A	*TBD*
EVV mobile application	An application downloaded onto a mobile device that facilitates EVV user access to an EVV system	N/A	Lowercase
EVV mobile method	A mobile device (smart phone or tablet) used in the home or community to clock in when service delivery begins and clock out when service delivery ends	N/A	Lowercase
EVV Policy Handbook	The HHSC handbook that provides EVV standards and policy requirements	N/A	Capitalize
EVV Portal	An online system that allows users to perform searches and view reports associated with EVV visits in the EVV Aggregator	N/A	Capitalize
EVV Portal Registration	The establishing of access, including log on credentials, to the EVV Portal (operated by Texas Medicaid & Healthcare Partnership) for program providers and Financial Management Services Agencies (FMSAs)	N/A	Capitalize
EVV Portal Training	All required trainings created by [Contractor] for program providers and FMSAs to complete to understand how to access and use the EVV Portal.	N/A	Capitalize

Term	Definition	Acronym	Capitalization
EVV proprietary system	An HHSC-approved EVV system that a program provider or Financial Management Services Agency (FMSA) may opt to use instead of an EVV vendor system that: (A) is purchased or developed by a program provider or an FMSA; (B) is used to exchange EVV information with HHSC or a managed care organization (MCO); and (C) complies with the requirements of Texas Government Code §531.024172 or its successors	PS	Lowercase

EVV Proprietary System Operator (PSO)	A program provider or FMSA whose responsibilities for EVV include but are not limited to:
	• Adhering to all HHSC EVV proprietary system business rules for system operation
	• Following all EVV requirements such as:
	    ○ The HHSC EVV Policy Handbook and policies on the EVV website
	    ○ Texas Administrative Code Chapter 354 as it relates to EVV
	• Supporting one or more electronic verification methods required to use the EVV proprietary system
	• Providing EVV system training and technical support
		PSO	Capitalize

EVV Proprietary System Operator (PSO) Onboarding Process	The process when an EVV Proprietary System Operator (PSO) onboards their EVV proprietary system in the Texas EVV operating environment ***Internal Note:*** Source	PSO Onboarding Process	Capitalize

Term	Definition	Acronym	Capitalization
EVV Proprietary System Request Form	A form on the [CONTRACTOR] EVV Proprietary Systems webpage that must be completed and sent to [CONTRACTOR] to indicate the program provider or FMSA has made the decision to operate an EVV proprietary system in Texas	N/A	Capitalize
EVV Provider Onboarding Form	A form on the EVV vendor’s website that must be completed and sent to the EVV vendor to select the EVV vendor’s system and initiate the onboarding process	N/A	Capitalize
EVV Reason Code Number	A number selected in the EVV system that describes the purpose for completing visit maintenance on an EVV visit transaction	N/A	Capitalize
EVV Reason Code Description	A letter selected in the EVV system that describes the purpose for completing visit maintenance on an EVV visit transaction in more detail	N/A	Capitalize
EVV system	A vendor or proprietary system used to electronically document and verify critical data elements related to the delivery of EVV-required services	N/A	Always lowercase unless we're referring to EVV System training or a specific EVV system
EVV System Administrator	This person will administer access to the EVV system for agency personnel and ensure that the program provider or FMSA enters all necessary data into the system for EVV visit collection to begin	N/A	Capitalize
EVV system users	Staff who use an EVV system for their daily job functions	N/A	Lowercase
EVV Tool Kit	A collection of resources that will help prepare program providers, financial management services agencies (FMSAs), and Consumer Directed Services (CDS) employers in the use of EVV	N/A	Capitalize

Term	Definition	Acronym	Capitalization
EVV Usage	The standards created by HHSC to ensure program providers and FMSAs use the EVV system as documented in the EVV Policy Handbook	N/A	Capitalize
EVV Usage Score	The EVV Usage Score is equal to the manual visit score plus the rejected visit score for the quarter.	N/A	Capitalize
EVV vendor	An entity contracted with [CONTRACTOR], the state’s claims administrator, to provide a cost-free EVV system option for program providers and Financial Management Services Agencies (FMSAs) contracted with HHSC or a managed care organization (MCO)	N/A	Lowercase
EVV vendor system	An EVV system provided by an EVV vendor, selected by the claims administrator on behalf of HHSC, that a program provider or FMSA may opt to use instead of an EVV proprietary system	N/A	Lowercase
EVV visit	The time spent by a service provider providing services that require EVV to a member	N/A	Lowercase

Term	Definition	Acronym	Capitalization
EVV visit transaction	A data record generated by an EVV system that contains data elements for a visit conducted to provide an EVV service *Types of EVV visit transactions:* • **Electronic visit transactions:** visit transactions automatically generated when the service provider uses approved electronic verification methods to clock in and clock out • **Manual visit transactions:** visit transactions manually entered into the EVV system when the service provider fails to use an approved electronic verification method to clock in and/or clock out • **Exported visit transactions:** visit transactions sent from the EVV system to the EVV Aggregator • **Accepted visit transactions:** visit transactions accepted by the EVV Aggregator that are ready for the EVV claims matching process • **Rejected visit transactions:** visit transactions rejected by the EVV Aggregator because they did not pass visit validation edits	N/A	Lowercase
exception	Visits that varied from the schedule or authorization	N/A	Lowercase
Family Care (FC) Program	A program funded under Title XX, Subtitle A of the Social Security Act, as described in 40 TAC Chapter 47	FC	Capitalize

Term	Definition	Acronym	Capitalization
Fee-for-Service	Types of Medicaid services in which program providers are paid for each service performed and which the claims are processed through the claims administrator	FFS Note: Always pronounce it fee-for-service (not FFS)	Capitalize
Financial Management Services Agency (FMSA)	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)	FMSA	Capitalize
Free text	Additional information attached to an EVV Reason Code description that is required when a visit is missing a clock in/out time and/or when using specified reason code numbers outlined in the EVV Reason Code Policy	N/A	Lowercase
GovDelivery	A subscription management system used by HHSC to deliver new information through email or text message	N/A	Capitalize
HHSC	Texas Health and Human Services Commission	HHSC	Capitalize
Home and Community-Based Services (HCBS) 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).	HCBS-AMH	Capitalize per TAC
Home and Community-based Services (HCS) Program	A Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in 40 TAC Chapter 9, Subchapter D (relating to Home and Community-based Services [HCS] Program and Community First Choice [CFC]).	HCS	Capitalize per TAC

Term	Definition	Acronym	Capitalization
home health care services	Covered services, equipment, appliances and supplies which are provided to qualified Medicaid recipients at their place of residence by home health agency staff, providers of durable medical equipment, or expendable medical supplies under federal regulations 42 CFR §440.70 and §354.1037 of this title (relating to Written Plan of Care) and §354.1039 of this title (relating to Home Health Benefits and Limitations) ***Internal Notes:*** *Source: TAC RULE §354.1031; this definition was recommended by Dana Williamson*	HHCS	Lowercase
home phone landline	An approved method used to clock in and clock out of an EVV system using the member's home phone landline to call a toll-free number	N/A	Lowercase
identification data	Data program providers and Financial Management Services Agencies (FMSAs) must enter (or import) into the EVV system before service providers can clock in and clock out: • The type of service provided (Service Authorization Data) • The name of the recipient to whom the service is provided (Member Data) • The name of the individual who provided the service (Service Attendant Data) • Other information the commission determines is necessary to ensure the accurate adjudication of Medicaid claims (program provider or FMSA information)	N/A	Lowercase
instructor-led training	A method of delivering live, in-person training by an instructor	ILT	Lowercase

Term	Definition	Acronym	Capitalization
Learning Management System (LMS)	A software application used for the delivery and tracking of educational training courses	LMS	Capitalize
Legally Authorized Representative (LAR)	A person authorized by law to act on behalf of an individual, which may include a parent, guardian or managing conservator of a minor, of the guardian of an adult	LAR *Pronounce "larr"*	Capitalize
Long-term Care (LTC)	A range of services and supports provided to people who are older and require help with basic tasks of living; such as bathing, dressing, personal care, housekeeping, or preparing meals	LTC	Capitalize except for the "t" in "term"
Long-term Services and Supports (LTSS)	The services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications	LTSS	Capitalize
managed care	Quality initiatives under as determined by the commission based on data or other evidence provided by the organization or meets quality of care and cost-efficiency benchmarks	N/A	Lowercase

Term	Definition	Acronym	Capitalization
managed care organization (MCO)	A person that is authorized or otherwise permitted by law to arrange for or provide a managed care plan and contracts with the commission to provide health care services to Medicaid recipients. The term includes health maintenance organizations and exclusive provider organizations. ***Internal Note:*** *Sources include* • *https://statutes.capitol.texas.gov/Docs/GV/htm/GV.531.htm#531.024172* • *https://statutes.capitol.texas.gov/Docs/GV/htm/GV.533.htm#533.001*	MCO	Lowercase
managed care organization (MCO) Long-term Services and Supports (LTSS) provider	An MCO LTSS provider is any provider who provides LTSS services under a specific National Provider Identifier (NPI) and taxonomy combination and submits claims through Medicaid managed care. An MCO LTSS provider will have to enroll through this process when the NPI and taxonomy combination they bill LTSS services with does not have an active, associated Texas Provider Identifier (TPI) through [CONTRACTOR] or an Atypical Provider Identifier (API) through this process. ***Internal Note:*** *Effective 8/25/20, this term replaces "Managed care organization (MCO)-Only Enrolled Program Providers."*	MCO LTSS provider	managed care organization (MCO) Long-term Services and Supports (LTSS) provider

Term	Definition	Acronym	Capitalization
manual visit score	Equal to the number of non-Graphical User Interface (GUI) EVV visit transactions (visit transactions generated by electronic clock in and clock out), divided by the total accepted EVV visit transactions, multiplied by 60 percent	N/A	Lowercase
Medicaid	The medical assistance program established under Chapter 32 of the Human Resources Code; includes all of the health care and related services and benefits authorized or provided under federal law for needy individuals of this state ***Internal Note:*** *Source*	N/A	Capitalize
Medically Dependent Children Program (MDCP)	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)	MDCP	Capitalize per TAC
Medically Dependent Children Program STAR Health (MDCP STAR Health) covered service	A service provided to a member eligible to receive MDCP benefits under the STAR Health Program	MDCP STAR Health	Capitalize per TAC (but not "covered service")
Medically Dependent Children Program STAR Kids (MDCP STAR Kids) covered service	A service provided to a member eligible to receive MDCP benefits under the STAR Kids Program	MDCP STAR Kids	Capitalize per TAC (but not "covered service")
member	A person eligible to receive a Medicaid service federally required to use EVV	N/A	Lowercase
National Provider Identifier (NPI)	A unique 10-digit identification number issued to health care program providers	NPI	Capitalize

Term	Definition	Acronym	Capitalization
non-EVV service	An authorized service not required to use EVV, such as transportation and supported employment	N/A	Lowercase
Non-Preferred Reason Code	This EVV Reason Code Number and the appropriate EVV Reason Code Description should be selected when staff have failed to clock in and/or clock out of the EVV system	N/A	Capitalize
onboarding process	The process of establishing access to an EVV system	N/A	Lowercase
payer	An entity that pays a Medicaid claim, and includes HHSC and MCOs	N/A	Lowercase
personal care services (PCS)	Support services provided to a person eligible for Texas Health Steps Comprehensive Care Program (CCP) services who requires assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs) due to physical, cognitive, or behavioral limitations related to his or her disability or chronic health condition ***Internal Note:*** *Source: TAC RULE §363.602; Dana Williamson recommended this definition*	*PCS?*	Lowercase
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	N/A	Capitalize per TAC
program provider	An entity that contracts with HHSC or an MCO to provide a service required to use EVV	N/A	Lowercase
Program Provider/ Financial Management Services Agency (FMSA) EVV System Administrator	Administers access to the EVV system for agency personnel and ensures that the program provider or FMSA enters all necessary data into the system for EVV visit collection to begin	N/A	Capitalize

Term	Definition	Acronym	Capitalization
Readiness Review	A validation process conducted by HHSC for the approval of an EVV Proprietary System Operator to operate an EVV proprietary system. The approval process includes a series of tests designed to ensure the EVV proprietary system meets all HHSC requirements within an established timeline.	N/A	Capitalize
reason code	A standardized HHSC-approved code selected in an EVV system that explains the specific reason a change was made to an EVV visit transaction	N/A	Lowercase
rejected EVV claim	An EVV claim that fails the initial system edits and is returned to the program provider or Financial Management Services Agency (FMSA) for correction without being submitted for processing	N/A	Lowercase
rejected visit score	Equal to the number of non-rejected EVV visit transactions, divided by the total exported EVV visit transactions, multiplied by 40 percent ***Internal Note:*** *This may change in the future when compliance information is updated.*	N/A	Lowercase
service provider	A person who provides a service required to use EVV and who is employed or contracted by a program provider or a CDS employer ***Internal Note:*** *SRO should not be included here, even though it is currently in the TAC. In the next iteration of the TAC, it will be removed. - SG*	N/A	Lowercase

Term	Definition	Acronym	Capitalization
service delivery option	Options members can choose from for the delivery of services: • Agency option • Consumer Directed Services (CDS) option • Service Responsibility (SRO) option	N/A	Lowercase
Service Responsibility (SRO) option	A service delivery option in which a member or LAR 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	SRO	Capitalize (except "option")
Signature Authority	Responsible for maintaining accurate data within the EVV system, including information managed or maintained by a third party or sub-contractor	N/A	Capitalize
STAR	State of Texas Access Reform	STAR	Capitalize per TAC
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)	N/A	Capitalize per TAC
STAR Health Program	The 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)	N/A	Capitalize per TAC

Term	Definition	Acronym	Capitalization
STAR Kids Program	The 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)	N/A	Capitalize per TAC
STAR+PLUS Home and Community-Based Services Program (STAR+PLUS HCBS 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)	STAR+PLUS HCBS Program	Capitalize per TAC
STAR+PLUS Medicare-Medicaid Plan (STAR+PLUS MMP)	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 are contracted 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)	STAR+PLUS MMP	Capitalize per TAC

Term	Definition	Acronym	Capitalization
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)	N/A	Capitalize per TAC
state vendor pool	Cost-free EVV system options for program providers and FMSAs contracted with HHSC or an MCO	N/A	Lowercase
Statutes and rules	**State** • Texas Administrative Code, Title 1, Chapter 354, Subchapter O • Texas Administrative Code, Title 40, Part 1, Chapter 41 • Texas Administrative Code, Title 40, Part 1, Chapter 49 • Texas Government Code, Section 531.024172 • Texas Human Resources Code, Section 161.086 **Federal** • The 21st Century Cures Act, Section 12006	N/A	Capitalize
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 (relating to Personal Care Services). This includes STAR members who receive these services through the traditional Medicaid service model also referred to as fee-for-service	N/A	Capitalize per TAC

Term	Definition	Acronym	Capitalization
Texas Home Living (TxHmL) Program	A Medicaid waiver program approved by CMS under Title XIX, Section 1915(c) of the Social Security Act, as described in 40 TAC Chapter 9, Subchapter N (relating to Texas Home Living [TxHmL] Program and Community First Choice [CFC])	TxHmL Program	Capitalize per TAC
Texas Provider Identifier (TPI)	A nine-digit number issued to a program provider by the claims administrator that is used to identify the program provider when filing claims for reimbursement	TPI	Capitalize
[Contractor]	The state's claims administrator and is responsible for the Medicaid Management Information System (MMIS) where the EVV Aggregator resides	[CONTRACTOR]	Capitalize
third-party software system	A software program used to manage scheduling, billing and payroll	N/A	Lowercase
[CONTRACTOR] claims submission IDs	• Submitter ID • Receiver ID • Compass 21 (C21) Submitter ID • Claims Management System (CMS) Submitter ID • Long-term Services and Supports (LTSS) Submitter ID	• N/A • N/A • C21 Submitter ID • CMS Submitter ID • LTSS Submitter ID	• Submitter ID • Receiver ID • Compass 21 (C21) Submitter ID • Claims Management System (CMS) Submitter ID • Long-term Services and Supports (LTSS) Submitter ID

Term	Definition	Acronym	Capitalization
visit data	Data the EVV system captures when the service provider clocks in and clocks out of the EVV system: • The type of service provided (Service Authorization Data) • The name of the recipient to whom the service is provided (Member Data) • The date and times the provider began and ended the service delivery visit • The location, including the address, at which the service was provided • The name of the individual who provided the service (Service Attendant Data)	N/A	Lowercase
visit maintenance	A process that allows edits to certain data elements in an EVV visit transaction within an EVV system	N/A	Lowercase
Visit Maintenance Lockout	The inability to complete EVV visit maintenance in the EVV system within the standard EVV visit maintenance timeframe	N/A	Capitalize
Visit Maintenance Unlock Request	Allows program providers, FMSAs, and CDS employers the opportunity to correct data elements on an EVV visit transaction after the standard EVV visit maintenance timeframe	N/A	Capitalize
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])	YES	Capitalize per TAC

EVV Claims Matching Process and Claim Match Result Code Descriptions

Each EVV claim line item is matched to its corresponding item on the accepted EVV visit transaction during the EVV claims matching process. The result is the EVV claim match result code.

EVV Claim Line Item	Accepted EVV Visit Transaction	EVV Claim Match Result Code and Description	Type of Code
All	**All**	EVV01	Match
Medicaid ID	**Medicaid ID**	EVV02: Medicaid ID Mismatch	Mismatch
Date of Service	**EVV Visit Date**	EVV03: Visit Date Mismatch	Mismatch
National Provider Identifier (NPI) or Atypical Provider Identifier (API)	**NPI or API**	EVV04: Provider Mismatch (NPI/API)	Mismatch
Healthcare Common Procedure Coding System (HCPCS) code	**HCPCS Code**	EVV05: Service Mismatch – HCPCS/Modifier	Mismatch
HCPCS Modifiers	**HCPCS Modifiers**	EVV05: Service Mismatch – HCPCS/Modifier	Mismatch
Billed Units	**Billable Units**	EVV06: Units Mismatch	Mismatch
N/A	**N/A**	EVV07: Match Not Required	Informational
N/A	**N/A**	EVV08: Natural Disaster	Informational

EVV Claims Matching Process and Claim Match Result Code Descriptions – HCS/TxHmL

Note: As of May 2021, the claims matching process is a little different for HCS/TxHmL program providers and FMSAs submitting EVV claims for HCS/TxHmL services (see orange rows below). However, this will change when units are matched and when In-Home Respite and Day Habilitation service claims are matched later this year.

EVV Claim Line Item	Accepted EVV Visit Transaction	EVV Claim Match Result Code and Description	Type of Code
All	**All**	EVV01	Match
Medicaid ID	**Medicaid ID**	EVV02: Medicaid ID Mismatch	Mismatch
Date of Service	**EVV Visit Date**	EVV03: Visit Date Mismatch	Mismatch
National Provider Identifier (NPI) or Atypical Provider Identifier (API)	**NPI or API**	EVV04: Provider Mismatch (NPI/API)	Mismatch
Claims Procedure Code	**Claims Procedure Code**	EVV05: Service Mismatch	Mismatch
Claims Modifier, if Applicable	**Claims Modifier, if Applicable**	EVV05: Service Mismatch	Mismatch
N/A	**N/A**	EVV07: Match Not Required	Informational
N/A	**N/A**	EVV08: Natural Disaster	Informational

EVV Portal Search Tab Descriptions

Search Tool	Description
Accepted Visit Search tab	The Accepted Visit Search tab displays the most current accepted EVV visit transactions, including those that have been resubmitted, within a specific date range This tab is used to confirm that an EVV visit transaction has been accepted by the EVV Aggregator before submitting the associated EVV claim, which is a best practice to help avoid EVV claim mismatches.
Visit History Search tab	The Visit History Search tab displays all accepted and rejected EVV visit transactions and the visit history of EVV visit transactions, including all changes made through visit maintenance.
EVV Claim Search tab	The EVV Claim Search tab displays EVV claim match result codes and claim information for EVV claims submitted to [CONTRACTOR] and matched with EVV visit transactions.

EVV Portal and EVV System Report Descriptions

Report Name	Description	Report Location
EVV Alternative Device Order Status Report	Used to verify and track the status of alternative device orders	EVV System
EVV Attendant History Report	Displays which service providers (service attendants and CDS employees) provided services to a member for a requested date range	EVV Portal
EVV CDS Service Delivery Log	• Displays EVV visit data for CDS employers for a requested date range • Data is based only on completed and verified visits from the EVV system	EVV System
EVV Claim Match Reconciliation Report	Used to determine if there are visits that match EVV claims that received an informational mismatch code during EVV claim submission Note: The EVV01 version of this report shows EVV claims that received an EVV01 but at the time the report is run, the visit has been updated so the claim would no longer receive an EVV01 match on the report run date. It shows the new code the EVV claim would receive.	EVV Portal
EVV Clock In/Clock Out Usage Report	Displays the service provider's: • Use of EVV clock in and clock out methods. • Total accepted visits worked within a specific date range. • Percentage of total accepted visits worked for each clock in and clock out method within a specific date range.	EVV Portal

Report Name	Description	Report Location
EVV Landline Phone Verification Report	• Displays the phone number used for clocking in and clocking out of the EVV system to ensure the home phone landline number is an allowable phone type • Used to conduct EVV compliance oversight landline phone reviews; see the EVV Compliance Oversight Reviews Policy for more information	EVV System
EVV Provider Report	• Displays contract or enrollment data used by the program provider or FMSA during setup in the EVV system • Displays the program provider or FMSA EVV system onboarding date, start date and end date	EVV Portal
EVV Reason Code Usage and Free Text Report	• Displays the EVV Reason Code Number, Reason Code Description and any free text entered on accepted EVV visit transactions during a specified month, sorted by each program provider's or FMSA's unique identifier • Allows program providers, and FMSAs on behalf of CDS employers, to search reason code usage and entered free text by Medicaid ID • Used to conduct EVV compliance oversight reason code and required free text reviews; see the EVV Compliance Oversight Reviews policy for more information	EVV Portal
EVV Units of Service Summary Report	• Displays daily, weekly and monthly totals of services delivered for a member (Medicaid ID) • Identifies breaks in service for a member (Medicaid ID)	EVV Portal

Report Name	Description	Report Location
EVV Usage Report	• Displays the EVV Usage Score for each program provider and FMSA for the preceding quarter(s) • Used to conduct EVV compliance oversight usage reviews; see the EVV Compliance Oversight Reviews policy for more information	EVV Portal
EVV Visit Log Report	• Displays the visit details of the services delivered by the service provider to the member • Includes all accepted visit transactions for the report visit date range selected • Displays the: ○ Scheduled visit date (if applicable) ○ Time and location (if applicable) ○ Actual visit date ○ Clock in and clock out times ○ Actual hours and Bill hours ○ Units ○ Location ○ Clock in and clock out method used for each visit ○ All reason codes used during visit maintenance	EVV Portal
Non-EVV Relevant Time Report	Displays service provider time spent on non-EVV services during each visit for a requested date range	EVV System

EVV Vendors in the State Vendor Pool

Vendor	Contact Information	Clock In and Clock Out Method Names

EVV PSO Training Contact Information

EVV Proprietary System Access and Training Guide for MCO and State Staff

HHSC EVV Policy Training on the HHS Learning Portal

Always refer our training audiences to the EVV Policy Training page on the HHS Learning Portal:
https://learningportal.hhs.texas.gov/course/index.php?categoryid=26

Course Name on HHS Learning Portal	Course Audience	Certificate of Completion Available?	Training Method
Initial EVV Policy Training for CDS Employers	CDS employers required to use EVV who are new to EVV; also available in Spanish	Yes	Computer-based training (CBT)
As of June 2021: **Initial EVV Policy Training for Program Providers and FMSAs**	Program providers and FMSAs required to use EVV who are new to EVV	Yes	Computer-based training (CBT)
As of June 2021: **Annual EVV Policy Training for Program Providers and FMSAs**	Program providers and FMSAs required to use EVV who have completed initial EVV policy training and need to take an annual refresher training to satisfy the annual training requirement	Yes	Computer-based training (CBT)
EVV Policy Training - Webinar Recordings	• Program providers, FMSAs, and CDS employers required to use EVV who are new to EVV or need to take an annual refresher training to satisfy the annual training requirement • State staff	Yes	YouTube Video

Miscellaneous Phrasing Rules

- Use clock in, clock out, clocked-in, clocked-out, etc. (hyphenate past tense only)
- EVV claims: Always put “EVV” before claims to distinguish it from other types of claims
- Use “EVV claim line items” when referring to how EVV claim line items are matched to accepted EVV visit transactions in the EVV Aggregator

- EVV vendors in the state vendor pool are not "HHSC-approved;" [CONTRACTOR] approves them on behalf of HHSC

EVV Operations Email Addresses

- HHSC EVV Operations: Electronic_Visit_Verification@hhsc.state.tx.us

Resources – For EVV Training/Notifications/Webpage Developers

- HHSC Accessibility Center
  - Email the Accessibility mailbox if you need help making a document accessible.
  - Word Accessibility Process
- HHSC Templates
  - PPT Template used: HHS PowerPoint template 16:9 for external audiences (PowerPoint) (second layout branch with white background)
- HHSC Acronyms
- HHSC Brand Guide
- HHSC Forms (always refer to this website instead of linking to a specific form)
- HHSC EVV webpage
  - EVV GovDelivery

Exhibit U: EVV Service Bill Codes Table

The following document provides current billing codes for EVV-relevant services in Long-Term Care, Acute Care, and Managed Care programs.

HHSC regularly updates the EVV Service Bill Codes Table and will provide the most current version to the awarded Contractor upon the Contract Effective Date or as otherwise agreed between the Parties. The current EVV Service Bill Codes Table is located on the [HHSC EVV webpage]().

Version 9.5

Electronic Visit Verification

Service Bill Codes Table

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EVV Service Bill Codes: Legend

Column Title	Column Description
Claims Code Qualifier	Procedure code for the service used by HCS & TxHmL program providers and FMSAs in the CARE system.
Claims Modifier	A modifier provides how the reporting physician or provider can indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. Used by HCS & TxHmL program providers and FMSAs in the CARE system.
Claims Place of Service	A set of codes used to identify the physical location where services were provided. Used by HCS & TxHmL program providers and FMSAs in the CARE system. **Note: HHSC is only including the claims place of service code 12 (Home Location) because EVV is only required to capture services that require an in-home visit**.
Claims Procedure Code	A collection of codes that represent procedures and services provided to individuals. Used by HCS & TxHmL program providers and FMSAs in the CARE system.
Claims Revenue Code	A revenue code is a code set that groups services into distinct cost centers. Used by HCS & TxHmL program providers and FMSAs in the CARE system.
Effective Date for EVV Claim Denial for No Matching Visit	The begin date that a claim for an EVV-relevant service will be denied when there isn't an accepted EVV visit transaction that matches the claim. The EVV visit transaction must be accepted in the EVV Portal prior to billing the claim.
Healthcare Common Procedure Coding System (HCPCS)	A collection of codes that represent procedures and services provided to individuals.
Mod 1-4	A modifier provides how the reporting physician or provider can indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. There can be up to 4 modifiers associated with a HCPCS code.
Payer	The organization that processes the claim for payment or denial. Payers include: 1. The Texas Health and Human Services Commission (HHSC) - Claims are for EVV Acute Care services in Fee-for-Service (FFS) and processed by the Texas Medicaid & Healthcare Partnership (TMHP) Compass21 system on behalf of HHSC. 2. Long-Term Care (LTC) - Organization that processes claims for LTC services in FFS. 3. Managed Care Organization (MCO) - Organization that processes claims for services in Managed Care. By Oct. 1, 2020 all EVV claims for Managed Care services must be submitted to TMHP for claims matching. Once the claims matching result is obtained, the claim will be forwarded to the MCO with whom the individual member is enrolled at the time of service delivery for final processing.

EVV Service Bill Codes: Legend

Proc Code Qualifier	Procedure code for the service.
Procedure Effective Begin Date	The date when the service billing code became available for use in the Texas Medicaid Program. The date corresponds to the service delivery date, not the claim submission date.
Procedure Effective End Date	The date when the service billing code is no longer to be used. The date corresponds to the service delivery date, not the claim submission date. If the date is 12/31/9999 this means that there is no effective end date.
Program	The name of the program which services are available.
Service	The name of the service.
Service Code	A code that identifies the LTC service within the program and is only used in the FFS programs for LTC.
Service Group	A code that identifies the LTC program for the service and is only used in the FFS programs for LTC.
Unit Type	The amount of time assigned to a single unit when delivering the service to a member e.g. 15-minute increments, one-hour increments.
Units Matched During EVV Claims Matching?	A 'Yes' or 'No' in this column indicates if the number of Units on the EVV-relevant claim is matched to the number of Units on the EVV visit transaction. Some services are not designed for this type of match.

EVV Service Bill Codes: Acronyms

Acronym	Description
AC	Acute Care
BH	Behavioral Health
C21	Compass 21
CAS	Community Attendant Services
CARE	Client Assignment and Registration
CDS	Consumer Directed Services
CFC	Community First Choice
CLASS	Community Living Assistance and Support Services
CMBHS	Clinical Management for Behavioral Health Services
CMS	Claims Management System
DBMD	Deaf-Blind with Multiple Disabilities
DSA	Direct Services Agency
EVV	Electronic Visit Verification
FC	Family Care
FFS	Fee-for-Service
FFSS	Flexible Family Support Services
FMSA	Financial Management Services Agency
HAB	Habilitation
HCBS-AMH	Home and Community-Based Services–Adult Mental Health
HCPCS	Healthcare Common Procedure Coding System
HCS	Home and Community-based Services
HHSC	Health and Human Services Commission
LOC	Level of Care
LON	Level of Need
LTC	Long-Term Care
MCO	Managed Care Organization
MDCP	Medically Dependent Children Program
MMP	Medicare-Medicaid Plan
N/A	Not Applicable
PAS	Personal Assistance Services
PCS	Personal Care Services
PHC	Primary Home Care

EVV Service Bill Codes: Acronyms

RN	Registered Nurse
SRO	Service Responsibility Option
STAR	State of Texas Access Reform
TMHP	Texas Medicaid & Healthcare Partnership
TxHmL	Texas Home Living
YES	Youth Empowerment Services

EVV Service Bill Codes: Revision History

Effective Dates	Revision Description
6/1/2019 - 7/2/2019	Created for the 6/1/2019 release of the EVV Aggregator.
7/3/2019 - 7/15/2019	Updated based on TMHP SR 6861292.
7/16/2019 - 8/18/2019	Updated for publication on the HHSC EVV Website: - Added columns in orange. - Updated the Unit Match on all CDS and SRO services to reflect a bypass on the claims matching process for units of service due to inconsistencies with other programs. All other critical data elements will be matched.
8/19/2019 - 10/7/2019	**Formatting Changes:** - Added a column 'Bypass Claim Units Match?' to indicate when units are bypassed in the EVV Aggregator claims match. - Removed the column called 'Short Description' since it duplicates the 'Service' column. - Added a tab 'Acronyms' to list acronyms and their descriptions used in the EVV Service Bill Code tables. **Service Changes:** - Updated all LTC CLASS services (Service Group 2) to indicate that units on the claim will not be matched to units on the visit transaction. - Updated HCS/TxHmL service for Respite and Day Habilitation to indicate that claims will not be matched for EVV until new bill codes can be established to distinguish in-home service delivery from out-of-home service delivery. Note: EVV Clock-in and Clock-out is required when these services begin or end in the home. - Corrected an error in the HCPCS/Modifiers for Texas Home Living CFC PAS/HAB CDS service (Service Group 15, Service Code 10CFV).

10/8/2019 - 6/14/2020	**Formatting Changes:** - Added a column 'Bypass EVV Claim Match and Apply EVV07?' to indicate when the EVV claims matching process is bypassed in the EVV Aggregator (EVV Claims Match Result Code EVV07). **Service Changes:** - Updated the EVV Aggregator Claims Match Begin Effective Date for all programs, services, and service delivery options affected by the 21st Century Cures Act due to the delayed EVV start date from 1/1/2020 to 1/1/2021. - Updated all LTC CLASS (Service Group 2) and LTC DBMD (Service Group 16) services to indicate these services are bypassing EVV units matching in the EVV Aggregator claims match. - Updated LTC CLASS CFC PAS/HAB service (Service Group 2, Service Code 10CFC T2026) column 'Bypass EVV Claim Match and Apply EVV07' to a yes to indicate that this service is bypassing EVV claims matching in the EVV Aggregator until new bill codes can be established to distinguish between EVV services and non-EVV services. Note: When billing for EVV services, an EVV Clock-in and Clock-out is required when services begin and/or end in the home. This bypass will avoid unnecessary EVV claim denials due to an EVV visit transaction never having been created for a non-EVV service. This is a temporary solution until new billing codes can be created to distinguish between EVV-required and non-EVV required services. - Updated LTC DBMD CFC PAS/HAB service (Service Group 16, Service Code 10CFC T2026) column 'Bypass EVV Claim Match and Apply EVV07' to a yes to indicate that this service is bypassing EVV claims matching in the EVV Aggregator until new bill codes can be established to distinguish between EVV services and non-EVV services. Note: EVV is not currently required for DBMD. This bypass will avoid unnecessary EVV claim denials due to an EVV visit transaction never having been created for a non-EVV service. This is a temporary solution until new billing codes can be created to distinguish between EVV-required and non-EVV required services. - Updated all LTC HCS (Service Group 12) and TxHmL (Service Group 15) procedure effective end dates from 2/29/2020 to 12/31/9999.

6/15/2020 - 9/30/2020	**Formatting Changes:** - Added new column 'EVV Claim Denial for No Matching Visit Effective Date' to the MCO, C21 AC FFS, CMS LTC FFS, and CARE LTC FFS tabs to indicate the begin date a claim for an EVV-required service will be denied if there isn't an accepted EVV visit transaction in the EVV Portal that matches the claim. **Services with an effective date of 12/1/2020 are part of the Cures Act EVV Expansion and included in the EVV Practice Period beginning 7/1/2020 and ending 11/30/2020.** See the TMHP article for more information about the practice period: http://www.tmhp.com/News_Items/2020/05-May/05-26-20%20Cures%20Act%20EVV%20The%20EVV%20Practice%20Period%20Begins%20July%201.pdf. - Added new tab 'CARE LTC FFS EVV Services' to include HCS & TxHmL program services requiring EVV beginning 12/1/2020. - Added new column 'Effective Date for EVV Claim Denial for No Matching Visit' to the MCO, C21 AC FFS, CMS LTC FFS, and CARE LTC FFS tabs to indicate the begin date a claim for an EVV-required service will be denied if there isn't an accepted EVV visit transaction in the EVV Portal that matches the claim. - Renamed column 'Bypass Claim Units Match' to 'Units Matched During EVV Claims Matching?' to clarify when units on the claim are matched to units on the EVV visit transaction during the EVV claims matching process. - The following columns have been removed from the MCO, C21 AC FFS, and CMS LTC FFS tabs: - Unit Conversion Factor - EVV Aggregator Claims Match Begin Effective Date - EVV Aggregator Claims Match Begin Effective End Date - Bypass EVV Claim Match and Apply EVV07? - Bill Code Changed for 9/1/2019? - EVV Service (Required or Optional) for 9/1/2019? - EVV Services Required Starting 1/1/2021? Note: New column 'Effective Date EVV Claim Denial for No Matching Visit' has replaced this column and the date has been updated to align with the HHSC Cures Act EVV Expansion timeline. See the HHSC Cures Act EVV website for more information https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/21st-century-cures-act. - In the 'Revision History' tab, replaced the 'Version' column with 'Effective Dates'. - Minor changes to font size and color.

	Service Changes: - Updated the following services to indicate units on the claim will be matched to units on the EVV visit transaction during the EVV claims matching process: - Long-Term Care Services: - CLASS CFC PAS/HAB (Service Group 2, Service Code 10CFC) - DBMD CFC PAS/HAB (Service Group 16, Service Code 10CFC) - Updated the following services to indicate units on the claim will not be matched to units on the EVV visit transaction during the EVV claims matching process: - Acute Care Services: - HCBS-AMH Supported Home Living (HCPCS S5130) - YES Waiver Respite (In-Home) (HCPCS T2027) - Long-Term Care Services: - HCS CFC PAS/HAB (Service Group 12, Service Code 10CFC) - TxHmL CFC PAS/HAB (Service Group 15, Service Code 10CFC) - Added LTC CAS SRO service (Service Group 7, Service Code 17DS) because this service will require EVV by Dec. 1, 2020, but was not included in the previous version of the bill code table.

10/1/2020	**Formatting Changes:** - Certain program and service names were updated in all applicable tabs to be more consistent with the "EVV-Required Programs, Services, and Service Delivery Options" document on the HHS EVV webpage at: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification#programs-and-services-required-to-use-evv - CMBHS was added to the 'C21 AC FFS EVV Services' tab. - The STAR+PLUS/MMP bill codes with an 'Effective End Date' of 8/31/2019 were removed from the 'MCO EVV Services' tab. - The 'Effective Date for EVV Claim Denial for No Matching Visit' was corrected for LTC CLASS CFC PAS/HAB (Service Group 2, Service Code 10CFC T2026) and In-Home Respite (Service Group 2, Service Code 11 G0100) from 11/1/2019 to 12/1/2020. - The 'Claims Place of Service' column in the 'CARE LTC FFS EVV Services' tab was updated to only display the code relevant to EVV services: 12 (Home Location). This change was made because EVV is only required to capture services that require an in-home visit. **Service Changes:** - Effective Oct. 1, billed units on claims for the following EVV-required services will be matched to the billable units on the EVV visit transaction during the EVV claims matching process: - All services delivered through the service responsibility option listed in the 'MCO EVV Services' tab; - LTC CAS Personal Attendant Services - Level 1 and Level 2 (Service Group 7, Service Code 17DS G0755 and G0756); and - LTC CLASS CFC PAS/HAB (Service Group 2, Service Code 10CFC T2026). The 'Units Matched During EVV Claims Matching?' columns in the 'MCO EVV Services' and 'CMS LTC FFS EVV Services' tabs were updated to 'Yes' to indicate this change. Program providers and FMSAs can practice units matching on EVV claims during the Cures Act EVV practice period and these claims will not be denied for an EVV mismatch. The practice period ends on Nov. 30. Read more about the practice period at: http://www.tmhp.com/news/2020-06-27-update-cures-act-evv-evv-practice-period-begins-july-1

EVV Service Bill Codes: Revision History

11/9/2020	**Formatting Changes:** - The service names in the 'CARE LTC FFS EVV Services' tab for Day Habilitation and In-Home Respite in the HCS program were updated to match the HCS and TxHmL Bill Code Crosswalk. Additional information has been added to the bottom of the table noting that for HCS these services only require EVV when provided in own home or family home settings. - The Claims Place of Service column in the 'CARE LTC FFS EVV Services' tab for CFC PAS/HAB added the community setting locations which require EVV. **Service Changes:** - The Effective Date for EVV Claim Denial for No Matching Visit has been updated for services impacted by the Cures Act expansion to reflect the extension of the new EVV implementation date to Jan. 1, 2021. More information is available in the Cures Act EVV Practice Period Extended Through Dec 31 article on the HHS EVV webpage at https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification.
5/1/2021	**Service Changes:** **HCBS-AMH In Home Respite** - Unit type changed from Per Day to Per 15 Min - Change HCPCS from S9125 (Respite care, in the home, per diem) to T1005 (Respite care services, up to 15 minutes) - No change to HK and HE modifiers **HCBS-AMH Supported Home Living - Habilitative Support** - Unit type changed from Per Hour to Per 15 Min - No change to HCPCS S5130 (Homemaker service, nos; per 15 minutes) - No change to HK and HE modifiers

EVV Service Bill Codes: Managed Care

Payer	Program	Service	Proc Code Qualifier	HCPCS	mod 1	mod 2	mod 3	mod 4	Unit Type	Units Matched During EVV Claims Matching?	Procedure Effective Begin Date	Procedure Effective End Date	Effective Date for EVV Claim Denial for No Matching Visit
MCO	STAR Health, STAR Kids	CFC HAB - Agency Model	HC	T1019	U9				per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	CFC HAB - CDS Model	HC	T1019	U4				per 15 min	No	3/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	CFC HAB - SRO Model	HC	T1019	U2				per 15 min	Yes	3/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	CFC PCS Only - Agency Model	HC	T1019	UD				per 15 min	Yes	3/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	CFC PCS Only - CDS Model	HC	T1019	U3				per 15 min	No	3/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	CFC PCS Only - SRO Model	HC	T1019	U1				per 15 min	Yes	3/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant - Agency Model	HC	H2015	99	U1			per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant - CDS Model	HC	H2015	99	U1	UC		per 15 min	No	11/1/2016	12/31/9999	1/1/2021

MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant - SRO Model	HC	H2015	99	U1	US		per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant with RN Delegation - Agency Model	HC	H2015	99	U1	UA		per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant with RN Delegation - CDS Model	HC	H2015	99	U1	UA	UC	per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - FFSS - Attendant with RN Delegation - SRO Model	HC	H2015	99	U1	UA	US	per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant - Agency Model	HC	H2015	U1				per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant - CDS Model	HC	H2015	U1	UC			per 15 min	No	11/1/2016	12/31/9999	1/1/2021

EVV Service Bill Codes: Managed Care

MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant - SRO Model	HC	H2015	U1	US			per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant with RN Delegation - Agency Model	HC	H2015	U1	UA			per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant with RN Delegation - CDS Model	HC	H2015	U1	UA	UC		per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	MDCP - In-Home Respite - Attendant with RN Delegation - SRO Model	HC	H2015	U1	UA	US		per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	PCS - Agency Model	HC	T1019	U6				per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	PCS - CDS Model	HC	T1019	UC				per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	PCS - SRO Model	HC	T1019	US				per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021

EVV Service Bill Codes: Managed Care

MCO	STAR Health, STAR Kids	PCS, BH Condition - Agency Model	HC	T1019	UA	U6			per 15 min	Yes	11/1/2016	12/31/9999	9/1/2019
MCO	STAR Health, STAR Kids	PCS, BH Condition - CDS Model	HC	T1019	UA	UC			per 15 min	No	11/1/2016	12/31/9999	1/1/2021
MCO	STAR Health, STAR Kids	PCS, BH Condition - SRO Model	HC	T1019	UA	US			per 15 min	Yes	11/1/2016	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	CFC HAB - Agency Model (HCBS)	HC	T2017	U3	U7			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/ MMP	CFC HAB - Agency Model (Non-HCBS)	HC	T2017	U5	U7			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/ MMP	CFC HAB - CDS Model (HCBS)	HC	T2017	U3	UC	U7		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	CFC HAB - CDS Model (Non-HCBS)	HC	T2017	U5	UC	U7		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	CFC HAB - SRO Model (HCBS)	HC	T2017	U3	UD	U7		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	CFC HAB - SRO Model (Non-HCBS)	HC	T2017	U5	UD	U7		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	CFC PAS - Agency Model (HCBS)	HC	S5125	U3	U7			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019

MCO	STAR+PLUS/ MMP	CFC PAS - Agency Model (Non-HCBS)	HC	S5125	U5	U7			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/ MMP	CFC PAS - CDS Model (HCBS)	HC	S5125	U3	UC	U7		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	CFC PAS - CDS Model (Non-HCBS)	HC	S5125	U5	UC	U7		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	CFC PAS - SRO Model (HCBS)	HC	S5125	U3	UD	U7		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	CFC PAS - SRO Model (Non-HCBS)	HC	S5125	U5	UD	U7		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	In-Home Respite - Agency Model (HCBS)	HC	T1005	U3				per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/ MMP	In-Home Respite - CDS Model (HCBS)	HC	T1005	U3	UC			per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	In-Home Respite - SRO Model (HCBS)	HC	T1005	U3	UD			per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	PAS - Agency Model (HCBS)	HC	S5125	U3				per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019

MCO	STAR+PLUS/ MMP	PAS - Agency Model (Non-HCBS)	HC	S5125	U5				per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/ MMP	PAS - CDS Model (HCBS)	HC	S5125	U3	UC			per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	PAS - CDS Model (Non-HCBS)	HC	S5125	U5	UC			per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	PAS - SRO Model (HCBS)	HC	S5125	U3	UD			per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	PAS - SRO Model (Non-HCBS)	HC	S5125	U5	UD			per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	Protective Supervision - Agency Model (HCBS)	HC	S5125	U3	U1			per 15 min	Yes	9/1/2019	12/31/9999	9/1/2019
MCO	STAR+PLUS/ MMP	Protective Supervision - CDS Model (HCBS)	HC	S5125	U3	UC	U1		per 15 min	No	9/1/2019	12/31/9999	1/1/2021
MCO	STAR+PLUS/ MMP	Protective Supervision - SRO Model (HCBS)	HC	S5125	U3	UD	U1		per 15 min	Yes	9/1/2019	12/31/9999	1/1/2021

EVV Service Bill Codes: Acute Care Fee-For-Service

Payer	Program	Service	Proc Code Qualifier	HCPCS	mod 1	mod 2	mod 3	mod 4	Unit Type	Units Matched During EVV Claims Matching?	Procedure Effective Begin Date	Procedure Effective End Date	Effective Date for EVV Claim Denial for No Matching Visit
HHSC	CFC	CFC - HAB (Non-FMSA)	HC	T1019	U9				per 15 min	Yes	6/1/2015	12/31/9999	11/1/2019
HHSC	CFC	CFC - HAB CDS (FMSA)	HC	T1019	U4				per 15 min	No	6/1/2015	12/31/9999	1/1/2021
HHSC	CFC	CFC - PCS Only (Non-FMSA)	HC	T1019	UD				per 15 min	Yes	6/1/2015	12/31/9999	11/1/2019
HHSC	CFC	CFC - PCS Only CDS (FMSA)	HC	T1019	U3				per 15 min	No	6/1/2015	12/31/9999	1/1/2021
HHSC	HCBS-AMH	In-Home Respite	HC	S9125	HK	HE			per day	No	8/1/2016	4/30/2021	1/1/2021
HHSC	HCBS-AMH	In-Home Respite	HC	T1005	HK	HE			per 15 min	No	5/1/2021	12/31/9999	5/1/2021
HHSC	HCBS-AMH	Supported Home Living - Habilitative Support	HC	S5130	HK	HE			per hour	No	8/1/2016	4/30/2021	1/1/2021
HHSC	HCBS-AMH	Supported Home Living - Habilitative Support	HC	S5130	HK	HE			per 15 min	No	5/1/2021	12/31/9999	5/1/2021
HHSC	PCS	PCS (non-FMSA)	HC	T1019	U6				per 15 min	Yes	9/1/2015	12/31/9999	11/1/2019
HHSC	PCS	PCS - CDS (FMSA)	HC	T1019	U7				per 15 min	No	9/1/2015	12/31/9999	1/1/2021

HHSC	PCS	PCS BH Condition (non-FMSA)	HC	T1019	UA				per 15 min	Yes	9/1/2011	12/31/9999	11/1/2019
HHSC	PCS	PCS BH Condition - CDS (FMSA)	HC	T1019	UB				per 15 min	No	9/1/2011	12/31/9999	1/1/2021
HHSC	YES	In-Home Respite	HC	T2027	U9				per 15 min	No	6/30/2010	12/31/9999	1/1/2021

EVV Service Bill Codes: Long-Term Care Fee-For-Service

Payer	Program	Service	Proc Code Qualifier	HCPCS	mod 1	mod 2	mod 3	mod 4	Unit Type	Units Matched During EVV Claims Matching?	Proc Effec Begin Date	Proc Effec End Date	Service Group	Service Code	Effec Date for EVV Claim Denial for No Matching Visit
LTC	CAS	Personal Attendant Services (1929B) - Level 1, 2	HC	S5125					per hour	Yes	10/16/ 2003	12/31/ 2199	7	17D	11/1/ 2019
LTC	CAS	Personal Attendant Services (1929B) - Level 1 (Non-Priority) - CDS	ER	G0749					per $1	No	1/1/ 1900	12/31/ 2199	7	17DV	1/1/2021
LTC	CAS	Personal Attendant Services Level 1 (Non-Priority) - SRO	ER	G0756					per hour	Yes	1/2/ 2006	12/31/ 2199	7	17DS	1/1/2021
LTC	CAS	Personal Attendant Services (1929B) - Level 2 (Priority) - CDS	ER	G0748					per $1	No	1/1/ 1900	12/31/ 2199	7	17DV	1/1/2021
LTC	CAS	Personal Attendant Services Level 2 (Priority) - SRO	ER	G0755					per hour	Yes	1/2/ 2006	12/31/ 2199	7	17DS	1/1/2021

EVV Service Bill Codes: Long-Term Care Fee-For-Service

LTC	CLASS	CFC PAS/HAB	HC	T2026					per hour	Yes	6/1/ 2015	12/31/ 2199	2	10CFC	1/1/2021
LTC	CLASS	CFC PAS/HAB - CDS	HC	T2016					per $1	No	6/1/ 2015	12/31/ 2199	2	10CFV	1/1/2021
LTC	CLASS	In-Home Respite - DSA	ER	G0100					per day	No	1/1/ 1900	12/31/ 2199	2	11	1/1/2021
LTC	CLASS	In-Home Respite - CDS	HC	S9125					per $1	No	3/1/ 2008	12/31/ 2199	2	11PV	1/1/2021
LTC	DBMD	CFC PAS/HAB	HC	T2026					per hour	Yes	6/1/ 2015	12/31/ 2199	16	10CFC	1/1/2021
LTC	DBMD	CFC PAS/HAB - CDS	HC	T2016	UC				per $1	No	6/1/ 2015	12/31/ 2199	16	10CFV	1/1/2021
LTC	DBMD	In-Home Respite	ER	G0100					per day	No	1/1/ 1900	12/31/ 2199	16	11	1/1/2021
LTC	DBMD	In-Home Respite - CDS	HC	S9125					per $1	No	12/01/ 2008	12/31/ 2199	16	11PV	1/1/2021
LTC	FC	Personal Attendant Services	HC	S5125					per hour	Yes	10/16/ 2003	12/31/ 2199	7	17C	11/1/ 2019
LTC	FC	Personal Attendant Services - Level 1 (Non-Priority) - CDS	ER	G0746					per $1	No	1/1/ 1900	12/31/ 2199	7	17CV	1/1/2021
LTC	FC	Personal Attendant Services - Level 2 (Priority) - CDS	ER	G0745					per $1	No	1/1/ 1900	12/31/ 2199	7	17CV	1/1/2021
LTC	PHC	Personal Attendant Services - Level 1, 2	HC	S5125					per hour	Yes	10/16/ 2003	12/31/ 2199	7	17	11/1/ 2019

LTC	PHC	Personal Attendant Services - CDS	HC	S5125	UB				per $1	No	6/1/ 2015	12/31/ 2199	7	17V	1/1/2021

EVV Service Bill Codes: HCS/TxHmL Long-Term Care Fee-for-Service

Payer	Program	Service	Claims Code Qualifier	Claims Proc Code	Claims Modifier	Claims Revenue Code	Claims Place of Service	Unit Type	Units Matched During EVV Claims Matching?	Proc Effec Beg Date	Proc Effec End Date	Service Group	Service Code	Effec Date for EVV Claim Denial for No Match Visit
LTC	HCS	CFC PAS/HAB - LOC 1, 8	HC	T2016			3, 11, 12, 22, 49, 99	per 15 min	No	6/1/ 2015	12/31/ 9999	12	10CFC	1/1/ 2021
LTC	HCS	CFC PAS/HAB - LOC 1, 8 - CDS	HC	T2016	UC		3, 11, 12, 22, 49, 99	per $1	No	6/1/ 2015	12/31/ 9999	12	10CFV	1/1/ 2021
LTC	HCS	Day Habilitatio n - LON 1, 5, 6, 8, 9	HC	T2020		0942	12	per day	No	9/1/ 2011	12/31/ 9999	12	10C	N/A
LTC	HCS	Hourly Respite LOC 1, 8	HC	S5150		0660	12	per 15 min	No	2/1/ 2008	12/31/ 9999	12	11X	N/A
LTC	HCS	CDS Hourly Respite LOC 1	ZZ	M0145			12	per $1	No	2/1/ 2008	12/31/ 9999	12	11XV	N/A
LTC	HCS	CDS Hourly Respite LOC 8	ZZ	M0146			12	per $1	No	2/1/ 2008	12/31/ 9999	12	11XV	N/A
LTC	TxHmL	CFC PAS/HAB	HC	T2016			3, 11, 12, 22, 49, 99	per 15 min	No	6/1/ 2015	12/31/ 9999	15	10CFC	1/1/ 2021
LTC	TxHmL	CFC PAS/HAB - CDS	HC	T2016	UC		3, 11, 12, 22, 49, 99	per $1	No	6/1/ 2015	12/31/ 9999	15	10CFV	1/1/ 2021
LTC	TxHmL	In-Home Day Habilitatio n - LOC 1	HC	T2020		0942	12	per day	No	2/1/ 2011	12/31/ 9999	15	10C	N/A

EVV Service Bill Codes: HCS/TxHmL Long-Term Care Fee-for-Service

LTC	TxHmL	In-Home Day Habilitation - LOC 1 - CDS	ZZ	M0202			12	per $1	No	2/1/ 2011	12/31/ 9999	15	10CV	N/A
LTC	TxHmL	In-Home Respite (Hourly) - LOC 1	HC	S5150		0660	12	per 15 min	No	2/1/ 2008	12/31/ 9999	15	11X	N/A
LTC	TxHmL	In-Home Respite (Hourly) - LOC 1 - CDS	ZZ	M0241			12	per $1	No	2/1/ 2008	12/31/ 9999	15	11XV	N/A

Additional Information for HCS Day Habilitation and Respite: EVV is only required for HCS Day Habilitation and HCS Respite when services are provided in own home or family home settings.

Signature Document for HHSC Contract No. ___________

The **Health and Human Services Commission** ("**System Agency**"), an administrative agency within the executive branch of the state of Texas, and **<Contractor's Complete Legal Name - including any "DBA">** ("**Contractor**"), having its principal office at <Contractor's Complete Physical Address, not PO Box>, (each a "Party" and collectively the "Parties"), enter into the following Contract ("Contract") for Electronic Visit Verification system management services.

I. Legal Authority

This Contract is entered into pursuant to Tex. Gov't Code § 2157.068 (e-2) and 2157.006 (a)(2); and Tex. Admin. Code, Title 34, Part 1, Chapter 20, Subchapter H, Section 20.391. The governing authorities for EVV are: Tex. Gov't Code § 531.024172; Tex. Admin. Code Title 1, Part 15, Chapter 354, Subchapter O; and 42 U.S. Code § 1396b (l).

II. Duration

The Contract is effective on [Month spelled out DD, YYYY, **OR** the signature date of the latter of the Parties to sign this agreement] and terminates on Month spelled out DD, YYYY, unless sooner terminated or renewed or extended. System Agency, at its sole discretion, may renew or extend this Contract. However, in no event may the Contract term, including all renewals and extensions, exceed 7 years. Notwithstanding the limitation in the preceding sentence, System Agency, at its sole discretion, also may extend the Contract beyond 7 years as necessary to ensure continuity of service, for purposes of transition, or as otherwise determined by System Agency to serve the best interest of the State.

III. Statement of Work

The Statement of Work to which Contractor is bound is incorporated into and made a part of this Contract for all purposes and included as **Attachment A**.

IV. Budget

The total amount of this Contract will not exceed **[$X. XX]**. By executing this Contract, Contractor agrees to the contracted rates and budget for the Contract term, including the initial term, and all renewals and extensions exercised. However, at System Agency's sole discretion or by mutual agreement of the Parties as authorized under the Contract, the budget or Contract amounts may be amended. All expenditures under the Contract will be in accordance with **Attachment O, System Agency Solicitation No. <XX>** and **Attachment E, Budget**.

V. CONTRACTOR'S ABILITY TO CONTRACT WITH AN SPSO

"<CONTRACTOR> SHALL CONTRACT WITH AN SPSO TO OPERATE A STATE POOL SYSTEM IN COMPLIANCE WITH THE REQUIREMENTS STATED IN THIS SOLICITATION NO LATER THAN TWO (2) CALENDAR DAYS FOLLOWING THE CONTRACT EFFECTIVE DATE.

VI. CHANGE IN AND COMPLIANCE WITH HHSC EVV BUSINESS RULES, HHSC EVV BUSINESS RULES FOR PROPRIETARY SYSTEMS, HHSC EVV POLICIES, EVV STANDARD LANGUAGE GUIDE, AND EVV SERVICE BILL CODES TABLE

The Contractor Solution shall comply with the **HHSC EVV BUSINESS RULES, HHSC EVV BUSINESS RULES FOR PROPRIETARY SYSTEMS, HHSC EVV POLICIES, EVV STANDARD LANGUAGE GUIDE, AND EVV SERVICE BILL CODES TABLE** in their current versions and as amended, throughout the term of the Contract. System Agency will provide to Contractor the most current versions of the foregoing documents in this Article VI upon the Contract Effective Date or as otherwise agreed between the Parties. Any amended versions of the foregoing documents in this Article VI will be provided to the Contractor within a reasonable time after any amendment(s) thereto.

VII. CONTRACT REPRESENTATIVES

The following will act as the representative authorized to administer activities under this Contract on behalf of its respective Party.

System Agency Contract Representative	**Contractor Contract Representative**
[Contract Representative Name]	[Contract Representative Name]
[Agency Name]	[Contractor Name]
[Address]	[Address]
[City, State ZIP]	[City, State ZIP]
[Email Address]	[Email Address]

VIII. NOTICE REQUIREMENTS

A. All notices given by Contractor shall be in writing, include the Contract number, comply with all terms and conditions of the Contract, and be delivered to the System Agency's Contract Representative identified above.
B. Contractor shall send legal notices to System Agency at the address below and provide a copy to the System Agency's Contract Representative:

Health and Human Services Commission
Attn: Office of Chief Counsel
4601 W Guadalupe St. | Mail Code: 8067
Austin, Texas 78751

With copy to

Department of State Health Services
P.O. Box 149347 – Mail Code 1911
Austin, Texas 78714-9347
Attention: General Counsel

C. System Agency shall send legal notices to Contractor at the address below and provide a copy to the Contractor's Contract Representative:

D. Notices given by System Agency to Contractor may be emailed, mailed or sent by common carrier. Email notices shall be deemed delivered when sent by System Agency. Notices sent by mail shall be deemed delivered when deposited by the System Agency in the United States mail, postage paid, certified, return receipt requested. Notices sent by common carrier shall be deemed delivered when deposited by the System Agency with a common carrier, overnight, signature required.
E. Notices given by Contractor to System Agency shall be deemed delivered when received by System Agency.
F. Either Party may change its Contract Representative or Legal Notice contact by providing written notice to the other Party.

IX. CONTRACT DOCUMENTS

The following documents are incorporated by reference and made a part of this Contract for all purposes. In the event of a conflict, ambiguity, or inconsistency between the terms and conditions set forth in the documents that comprise this Contract, the controlling document shall be this Signature Document, then the remaining documents in the following list in the order stated:

ATTACHMENT A – STATEMENT OF WORK
ATTACHMENT B – CONTRACT AFFIRMATIONS (VERSION 2.1)
ATTACHMENT C – UNIFORM TERMS AND CONDITIONS (VERSION 3.2)
ATTACHMENT D – DATA USE AGREEMENT
ATTACHMENT E – BUDGET
ATTACHMENT F – ADDITIONAL PROVISIONS
ATTACHMENT G – HHSC EVV POLICIES LOCATED AT HTTPS://WWW.HHS.TEXAS.GOV/PROVIDERS/LONG-TERM-CARE-PROVIDERS/LONG-TERM-CARE-PROVIDER-RESOURCES/ELECTRONIC-VISIT-VERIFICATION
ATTACHMENT H – HHSC EVV BUSINESS RULES
ATTACHMENT I – HHSC EVV BUSINESS RULES FOR PROPRIETARY SYSTEMS
ATTACHMENT J – EVV STANDARD LANGUAGE GUIDE
ATTACHMENT K – EVV SERVICE BILL CODES TABLE
ATTACHMENT L – FEDERAL ASSURANCES
ATTACHMENT M – CERTIFICATION REGARDING LOBBYING

ATTACHMENT N – DISCLOSURE OF LOBBYING ACTIVITIES
ATTACHMENT O – SYSTEM AGENCY SOLICITATION NO. [INSERT RF* NO.], INCLUDING, BUT NOT LIMITED TO ALL ADDENDA
ATTACHMENT P – CONTRACTOR'S SOLICITATION RESPONSE

X. SIGNATURE AUTHORITY

Each Party represents and warrants that the person executing this Contract on its behalf has full power and authority to enter into this Contract. Any Services or Work performed by Contractor before this Contract is effective or after it ceases to be effective are performed at the sole risk of Contractor.

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE FOR SYSTEM AGENCY CONTRACT NO. ***

SYSTEM AGENCY	**CONTRACTOR*** **
______________________________	______________________________
[Insert Name]	Name: ______________________
[Insert Title]	Title: _________________________
Date of execution: _______________	Date of execution: _______________

HEALTH AND HUMAN SERVICES

Contract Number ________________________________

__ CONTRACT AFFIRMATIONS

For purposes of these Contract Affirmations, HHS includes both the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS). System Agency refers to HHSC, DSHS, or both, that will be a party to this Contract. These Contract Affirmations apply to all Contractors and Grantees (referred to as "Contractor") regardless of their business form (e.g., individual, partnership, corporation).

By entering into this Contract, Contractor affirms, without exception, understands, and agrees to comply with the following items through the life of the Contract:

1. Contractor represents and warrants that these Contract Affirmations apply to Contractor and all of Contractor's principals, officers, directors, shareholders, partners, owners, agents, employees, subcontractors, independent contractors, and any other representatives who may provide services under, who have a financial interest in, or otherwise are interested in this Contract and any related Solicitation.

2. Complete and Accurate Information

Contractor represents and warrants that all statements and information provided to HHS are current, complete, and accurate. This includes all statements and information in this Contract and any related Solicitation Response.

3. Public Information Act

Contractor understands that HHS will comply with the Texas Public Information Act (Chapter 552 of the Texas Government Code) as interpreted by judicial rulings and opinions of the Attorney General of the State of Texas. Information, documentation, and other material prepared and submitted in connection with this Contract or any related Solicitation may be subject to public disclosure pursuant to the Texas Public Information Act. In accordance with Section 2252.907 of the Texas Government Code, Contractor is required to make any information created or exchanged with the State pursuant to the Contract, and not otherwise excepted from disclosure under the Texas Public Information Act, available in a format that is accessible by the public at no additional charge to the State.

4. Contracting Information Requirements

Contractor represents and warrants that it will comply with the requirements of Section 552.372(a) of the Texas Government Code. Except as provided by Section 552.374(c) of the Texas Government Code, the requirements of Subchapter J (Additional Provisions Related to Contracting Information), Chapter 552 of the Government Code, may apply to the Contract and the Contractor agrees that the Contract can be terminated if the Contractor knowingly or intentionally fails to comply with a requirement of that subchapter.

5. Assignment

A. Contractor shall not assign its rights under the Contract or delegate the performance of its duties under the Contract without prior written approval from System Agency. Any attempted assignment in violation of this provision is void and without effect.

B. Contractor understands and agrees the System Agency may in one or more transactions assign, pledge, or transfer the Contract. Upon receipt of System Agency's notice of assignment, pledge, or transfer, Contractor shall cooperate with System Agency in giving effect to such assignment, pledge, or transfer, at no cost to System Agency or to the recipient entity.

6. Terms and Conditions

Contractor accepts the Solicitation terms and conditions unless specifically noted by exceptions advanced in the form and manner directed in the Solicitation, if any, under which this Contract was awarded. Contractor agrees that all exceptions to the Solicitation, as well as terms and conditions advanced by Contractor that differ in any manner from HHS' terms and conditions, if any, are rejected unless expressly accepted by System Agency in writing.

7. HHS Right to Use

Contractor agrees that HHS has the right to use, produce, and distribute copies of and to disclose to HHS employees, agents, and contractors and other governmental entities all or part of this Contract or any related Solicitation Response as HHS deems necessary to complete the procurement process or comply with state or federal laws.

8. Release from Liability

Contractor generally releases from liability and waives all claims against any party providing information about the Contractor at the request of System Agency.

9. Dealings with Public Servants

Contractor has not given, has not offered to give, and does not intend to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with this Contract or any related Solicitation, or related Solicitation Response.

10. Financial Participation Prohibited

Under Section 2155.004, Texas Government Code (relating to financial participation in preparing solicitations), Contractor certifies that the individual or business entity named in this Contract and any related Solicitation Response is not ineligible to receive this Contract and acknowledges that this Contract may be terminated and payment withheld if this certification is inaccurate.

11. Prior Disaster Relief Contract Violation

Under Sections 2155.006 and 2261.053 of the Texas Government Code (relating to convictions and penalties regarding Hurricane Rita, Hurricane Katrina, and other disasters), the Contractor certifies that the individual or business entity named in this Contract and any related Solicitation Response is not ineligible to receive this Contract

and acknowledges that this Contract may be terminated and payment withheld if this certification is inaccurate.

12. Child Support Obligation

Under Section 231.006(d) of the Texas Family Code regarding child support, Contractor certifies that the individual or business entity named in this Contract and any related Solicitation Response is not ineligible to receive the specified payment and acknowledges that the Contract may be terminated and payment may be withheld if this certification is inaccurate.

13. Suspension and Debarment

Contractor certifies that it and its principals are not suspended or debarred from doing business with the state or federal government as listed on the *State of Texas Debarred Vendor List* maintained by the Texas Comptroller of Public Accounts and the *System for Award Management (SAM*) maintained by the General Services Administration. This certification is made pursuant to the regulations implementing Executive Order 12549 and Executive Order 12689, Debarment and Suspension, 2 C.F.R. Part 376, and any relevant regulations promulgated by the Department or Agency funding this project. This provision shall be included in its entirety in Contractor's subcontracts, if any, if payment in whole or in part is from federal funds.

14. Excluded Parties

Contractor certifies that it is not listed in the prohibited vendors list authorized by Executive Order 13224, *"Blocking Property and Prohibiting Transactions with Persons Who Commit, Threaten to Commit, or Support Terrorism,"* published by the United States Department of the Treasury, Office of Foreign Assets Control.'

15. Foreign Terrorist Organizations

Contractor represents and warrants that it is not engaged in business with Iran, Sudan, or a foreign terrorist organization, as prohibited by Section 2252.152 of the Texas Government Code.

16. Executive Head of a State Agency

In accordance with Section 669.003 of the Texas Government Code, relating to contracting with the executive head of a state agency, Contractor certifies that it is not (1) the executive head of an HHS agency, (2) a person who at any time during the four years before the date of this Contract was the executive head of an HHS agency, or (3) a person who employs a current or former executive head of an HHS agency.

17. Human Trafficking Prohibition

Under Section 2155.0061 of the Texas Government Code, Contractor certifies that the individual or business entity named in this Contract is not ineligible to receive this Contract and acknowledges that this Contract may be terminated and payment withheld if this certification is inaccurate.

18. Franchise Tax Status

Contractor represents and warrants that it is not currently delinquent in the payment of any franchise taxes owed the State of Texas under Chapter 171 of the Texas Tax Code.

19. Debts and Delinquencies

Contractor agrees that any payments due under this Contract shall be applied towards any debt or delinquency that is owed to the State of Texas.

20. Lobbying Prohibition

Contractor represents and warrants that payments to Contractor and Contractor's receipt of appropriated or other funds under this Contract or any related Solicitation are not prohibited by Sections 556.005, 556.0055, or 556.008 of the Texas Government Code (relating to use of appropriated money or state funds to employ or pay lobbyists, lobbying expenses, or influence legislation).

21. Buy Texas

Contractor agrees to comply with Section 2155.4441 of the Texas Government Code, requiring the purchase of products and materials produced in the State of Texas in performing service contracts.

22. Disaster Recovery Plan

Contractor agrees that upon request of System Agency, Contractor shall provide copies of its most recent business continuity and disaster recovery plans.

23. Computer Equipment Recycling Program

If this Contract is for the purchase or lease of computer equipment, then Contractor certifies that it is in compliance with Subchapter Y, Chapter 361 of the Texas Health and Safety Code related to the Computer Equipment Recycling Program and the Texas Commission on Environmental Quality rules in 30 TAC Chapter 328.

24. Television Equipment Recycling Program

If this Contract is for the purchase or lease of covered television equipment, then Contractor certifies that it is compliance with Subchapter Z, Chapter 361 of the Texas Health and Safety Code related to the Television Equipment Recycling Program.

25. Cybersecurity Training

A. Contractor represents and warrants that it will comply with the requirements of Section 2054.5192 of the Texas Government Code relating to cybersecurity training and required verification of completion of the training program.

B. Contractor represents and warrants that if Contractor or Subcontractors, officers, or employees of Contractor have access to any state computer system or database, the Contractor, Subcontractors, officers, and employees of Contractor shall complete cybersecurity training pursuant to and in accordance with Government Code, Section 2054.5192.

26. Restricted Employment for Certain State Personnel

Contractor acknowledges that, pursuant to Section 572.069 of the Texas Government Code, a former state officer or employee of a state agency who during the period of state service or employment participated on behalf of a state agency in a procurement or contract negotiation involving Contractor may not accept employment from Contractor before the second anniversary of the date the Contract is signed or the procurement is terminated or withdrawn.

27. No Conflicts of Interest

A. Contractor represents and warrants that it has no actual or potential conflicts of interest in providing the requested goods or services to System Agency under this Contract or any related Solicitation and that Contractor's provision of the requested goods and/or services under this Contract and any related Solicitation will not constitute an actual or potential conflict of interest or reasonably create an appearance of impropriety.

B. Contractor agrees that, if after execution of the Contract, Contractor discovers or is made aware of a Conflict of Interest, Contractor will immediately and fully disclose such interest in writing to System Agency. In addition, Contractor will promptly and fully disclose any relationship that might be perceived or represented as a conflict after its discovery by Contractor or by System Agency as a potential conflict. System Agency reserves the right to make a final determination regarding the existence of Conflicts of Interest, and Contractor agrees to abide by System Agency's decision.

28. Fraud, Waste, and Abuse

Contractor understands that HHS does not tolerate any type of fraud, waste, or abuse. Violations of law, agency policies, or standards of ethical conduct will be investigated, and appropriate actions will be taken. Pursuant to Texas Government Code, Section 321.022, if the administrative head of a department or entity that is subject to audit by the state auditor has reasonable cause to believe that money received from the state by the department or entity or by a client or contractor of the department or entity may have been lost, misappropriated, or misused, or that other fraudulent or unlawful conduct has occurred in relation to the operation of the department or entity, the administrative head shall report the reason and basis for the belief to the Texas State Auditor's Office (SAO). All employees or contractors who have reasonable cause to believe that fraud, waste, or abuse has occurred (including misconduct by any HHS employee, Grantee officer, agent, employee, or subcontractor that would constitute fraud, waste, or abuse) are required to immediately report the questioned activity to the Health and Human Services Commission's Office of Inspector General. Contractor agrees to comply with all applicable laws, rules, regulations, and System Agency policies regarding fraud, waste, and abuse including, but not limited to, HHS Circular C-027.

A report to the SAO must be made through one of the following avenues:

- SAO Toll Free Hotline: 1-800-TX-AUDIT
- SAO website: http://sao.fraud.state.tx.us/

All reports made to the OIG must be made through one of the following avenues:

- OIG Toll Free Hotline 1-800-436-6184
- OIG Website: ReportTexasFraud.com
- Internal Affairs Email: InternalAffairsReferral@hhsc.state.tx.us
- OIG Hotline Email: OIGFraudHotline@hhsc.state.tx.us.
- OIG Mailing Address: Office of Inspector General
  Attn: Fraud Hotline
  MC 1300
  P.O. Box 85200
  Austin, Texas 78708-5200

29. Antitrust

The undersigned affirms under penalty of perjury of the laws of the State of Texas that:

A. in connection with this Contract and any related Solicitation Response, neither I nor any representative of the Contractor has violated any provision of the Texas Free Enterprise and Antitrust Act, Tex. Bus. & Comm. Code Chapter 15;

B. in connection with this Contract and any related Solicitation Response, neither I nor any representative of the Contractor has violated any federal antitrust law; and

C. neither I nor any representative of the Contractor has directly or indirectly communicated any of the contents of this Contract and any related Solicitation Response to a competitor of the Contractor or any other company, corporation, firm, partnership or individual engaged in the same line of business as the Contractor.

30. Legal and Regulatory Actions

Contractor represents and warrants that it is not aware of and has received no notice of any court or governmental agency proceeding, investigation, or other action pending or threatened against Contractor or any of the individuals or entities included in numbered paragraph 1 of these Contract Affirmations within the five (5) calendar years immediately preceding execution of this Contract or the submission of any related Solicitation Response that would or could impair Contractor's performance under this Contract, relate to the contracted or similar goods or services, or otherwise be relevant to System Agency's consideration of entering into this Contract. If Contractor is unable to make the preceding representation and warranty, then Contractor instead represents and warrants that it has provided to System Agency a complete, detailed disclosure of any such court or governmental agency proceeding, investigation, or other action that would or could impair Contractor's performance under this Contract, relate to the contracted or similar goods or services, or otherwise be relevant to System Agency's consideration of entering into this Contract. In addition, Contractor acknowledges this is a continuing disclosure requirement. Contractor represents and warrants that Contractor shall notify System Agency in writing within five (5) business days of any changes to the representations or warranties in this clause and understands that failure to so timely update System Agency shall constitute breach of contract and may result in immediate contract termination.

31. No Felony Criminal Convictions

Contractor represents that neither Contractor nor any of its employees, agents, or representatives, including any subcontractors and employees, agents, or representative of such subcontractors, have been convicted of a felony criminal offense or that if such a conviction has occurred Contractor has fully advised System Agency in writing of the facts and circumstances surrounding the convictions.

32. Unfair Business Practices

Contractor represents and warrants that it has not been the subject of allegations of Deceptive Trade Practices violations under Chapter 17 of the Texas Business and Commerce Code, or allegations of any unfair business practice in any administrative hearing or court suit and that Contractor has not been found to be liable for such practices in such proceedings. Contractor certifies that it has no officers who have served as officers of other entities who have been the subject of allegations of Deceptive Trade Practices violations or allegations of any unfair business practices in an administrative hearing or court suit and that such officers have not been found to be liable for such practices in such proceedings**.**

33. Entities that Boycott Israel

Contractor represents and warrants that (1) it does not, and shall not for the duration of the Contract, boycott Israel or (2) the verification required by Section 2271.002 of the Texas Government Code does not apply to the Contract. If circumstances relevant to this provision change during the course of the Contract, Contractor shall promptly notify System Agency.

34. E-Verify

Contractor certifies that for contracts for services, Contractor shall utilize the U.S. Department of Homeland Security's E-Verify system during the term of this Contract to determine the eligibility of:

1. all persons employed by Contractor to perform duties within Texas; and
2. all persons, including subcontractors, assigned by Contractor to perform work pursuant to this Contract within the United States of America.

35. Former Agency Employees – Certain Contracts

If this Contract is an employment contract, a professional services contract under Chapter 2254 of the Texas Government Code, or a consulting services contract under Chapter 2254 of the Texas Government Code, in accordance with Section 2252.901 of the Texas Government Code, Contractor represents and warrants that neither Contractor nor any of Contractor's employees including, but not limited to, those authorized to provide services under the Contract, were former employees of an HHS Agency during the twelve (12) month period immediately prior to the date of the execution of the Contract.

36. Disclosure of Prior State Employment – Consulting Services

If this Contract is for consulting services,

A. In accordance with Section 2254.033 of the Texas Government Code, a Contractor providing consulting services who has been employed by, or employs an individual who has been employed by, System Agency or another State of Texas agency at any time during the two years preceding the submission of Contractor's offer to provide services must disclose the following information in its offer to provide services. Contractor hereby certifies that this information was provided and remains true, correct, and complete:

   1. Name of individual(s) (Contractor or employee(s));
   2. Status;
   3. The nature of the previous employment with HHSC or the other State of Texas agency;
   4. The date the employment was terminated and the reason for the termination; and
   5. The annual rate of compensation for the employment at the time of its termination.

B. If no information was provided in response to Section A above, Contractor certifies that neither Contractor nor any individual employed by Contractor was employed by System Agency or any other State of Texas agency at any time during the two years preceding the submission of Contractor's offer to provide services.

37. Abortion Funding Limitation

Contractor understands, acknowledges, and agrees that, pursuant to Article IX of the General Appropriations Act (the Act), to the extent allowed by federal and state law, money appropriated by the Texas Legislature may not be distributed to any individual or entity that, during the period for which funds are appropriated under the Act:

1. performs an abortion procedure that is not reimbursable under the state's Medicaid program;
2. is commonly owned, managed, or controlled by an entity that performs an abortion procedure that is not reimbursable under the state's Medicaid program; or
3. is a franchise or affiliate of an entity that performs an abortion procedure that is not reimbursable under the state's Medicaid program.

The provision does not apply to a hospital licensed under Chapter 241, Health and Safety Code, or an office exempt under Section 245.004(2), Health and Safety Code. Contractor represents and warrants that it is not ineligible, nor will it be ineligible during the term of this Contract, to receive appropriated funding pursuant to Article IX.

38. Funding Eligibility

Contractor understands, acknowledges, and agrees that, pursuant to Chapter 2272 (eff. Sept. 1, 2021, Ch. 2273) of the Texas Government Code, except as exempted under that Chapter, HHSC cannot contract with an abortion provider or an affiliate of an abortion provider. Contractor certifies that it is not ineligible to contract with HHSC under the terms of Chapter 2272 (eff. Sept. 1, 2021, Ch. 2273) of the Texas Government Code.

39. Prohibition on Certain Telecommunications and Video Surveillance Services or Equipment (2 CFR 200.216)

Contractor certifies that the individual or business entity named in this Response or Contract is not ineligible to receive the specified Contract or funding pursuant to 2 CFR 200.216.

40. COVID-19 Vaccine Passports

Pursuant to Texas Health and Safety Code, Section 161.0085(c), Contractor certifies that it does not require its customers to provide any documentation certifying the customer's COVID-19 vaccination or post-transmission recovery on entry to, to gain access to, or to receive service from the Contractor's business. Contractor acknowledges that such a vaccine or recovery requirement would make Contractor ineligible for a state-funded contract.

41. Entities that Boycott Energy Companies

In accordance with Senate Bill 13, Acts 2021, 87th Leg., R.S., pursuant to Section 2274.002 of the Texas Government Code (relating to prohibition on contracts with companies boycotting certain energy companies), Contractor represents and warrants that: (1) it does not, and will not for the duration of the Contract, boycott energy companies or (2) the verification required by Section 2274.002 of the Texas Government Code does not apply to the Contract. If circumstances relevant to this provision change during the course of the Contract, Contractor shall promptly notify System Agency.

42. Entities that Discriminate Against Firearm and Ammunition Industries

In accordance with Senate Bill 19, Acts 2021, 87th Leg., R.S., pursuant to Section 2274.002 of the Texas Government Code (relating to prohibition on contracts with companies that discriminate against firearm and ammunition industries), Contractor verifies that: (1) it does not, and will not for the duration of the Contract, have a practice, policy, guidance, or directive that discriminates against a firearm entity or firearm trade association or (2) the verification required by Section 2274.002 of the Texas Government Code does not apply to the Contract. If circumstances relevant to this provision change during the course of the Contract, Contractor shall promptly notify System Agency.

43. Security Controls for State Agency Data

In accordance with Senate Bill 475, Acts 2021, 87th Leg., R.S., pursuant to Texas Government Code, Section 2054.138, Contractor understands, acknowledges, and agrees that if, pursuant to this Contract, Contractor is or will be authorized to access, transmit, use, or store data for System Agency, Contractor is required to meet the security controls the System Agency determines are proportionate with System Agency's risk under the Contract based on the sensitivity of System Agency's data and that Contractor must periodically provide to System Agency evidence that Contractor meets the security controls required under the Contract.

44. Cloud Computing State Risk and Authorization Management Program

In accordance with Senate Bill 475, Acts 2021, 87th Leg., R.S., pursuant to Texas Government Code, Section 2054.0593, Contractor acknowledges and agrees that, if providing cloud computing services for System Agency, Contractor must comply with the requirements of the state risk and authorization management program and that System Agency may not enter or renew a contract with Contractor to purchase cloud computing services for the agency that are subject to the state risk and authorization management program unless Contractor demonstrates compliance with program requirements. If providing cloud computing services for System Agency that are subject to the state risk and authorization management program, Contractor certifies it will maintain program compliance and certification throughout the term of the Contract.

45. Office of Inspector General Investigative Findings Expert Review

In accordance with Senate Bill 799, Acts 2021, 87th Leg., R.S., if Texas Government Code, Section 531.102(m-1)(2) is applicable to this Contract, Contractor affirms that it possesses the necessary occupational licenses and experience.

46. Contract for Professional Services of Physicians, Optometrists, and Registered Nurses

In accordance with Senate Bill 799, Acts 2021, 87th Leg., R.S., if Texas Government Code, Section 2254.008(a)(2) is applicable to this Contract, Contractor affirms that it possesses the necessary occupational licenses and experience.

47. Foreign-Owned Companies in Connection with Critical Infrastructure

If Texas Government Code, Section 2274.0102(a)(1) (relating to prohibition on contracts with certain foreign-owned companies in connection with critical infrastructure) is applicable to this Contract, pursuant to Government Code Section 2274.0102, Contractor certifies that neither it nor its parent company, nor any affiliate of Contractor or its parent company, is: (1) majority owned or controlled by citizens or governmental entities of China, Iran, North Korea, Russia, or any other country designated by the Governor under Government Code Section 2274.0103, or (2) headquartered in any of those countries.

48. Critical Infrastructure Subcontracts

For purposes of this Paragraph, the designated countries are China, Iran, North Korea, Russia, and any countries lawfully designated by the Governor as a threat to critical infrastructure. Pursuant to Section 113.002 of the Business and Commerce Code, Contractor shall not enter into a subcontract that will provide direct or remote access to or control of critical infrastructure, as defined by Section 113.001 of the Texas Business and Commerce Code, in this state, other than access specifically allowed for product warranty and support purposes to any subcontractor unless (i) neither the subcontractor nor its parent company, nor any affiliate of the subcontractor or its parent company, is majority owned or controlled by citizens or governmental entities of a designated country; and (ii) neither the subcontractor nor its parent company, nor any affiliate of the subcontractor or its parent company, is headquartered in a designated country. Contractor will notify the System Agency before entering into any subcontract that will provide direct or remote

access to or control of critical infrastructure, as defined by Section 113.001 of the Texas Business & Commerce Code, in this state.

49. Enforcement of Certain Federal Firearms Laws Prohibited

In accordance with House Bill 957, Acts 2021, 87th Leg., R.S., if Texas Government Code, Section 2.101 is applicable to Contractor, Contractor certifies that it is not ineligible to receive state grant funds pursuant to Texas Government Code, Section 2.103.

50. Prohibition on Abortions

Contractor understands, acknowledges, and agrees that, pursuant to Article II of the General Appropriations Act, (1) no funds shall be used to pay the direct or indirect costs (including marketing, overhead, rent, phones, and utilities) of abortion procedures provided by contractors of HHSC; and (2) no funds appropriated for Medicaid Family Planning, Healthy Texas Women Program, or the Family Planning Program shall be distributed to individuals or entities that perform elective abortion procedures or that contract with or provide funds to individuals or entities for the performance of elective abortion procedures. Contractor represents and warrants that it is not ineligible, nor will it be ineligible during the term of this Contract, to receive appropriated funding pursuant to Article II.

51. False Representation

Contractor understands, acknowledges, and agrees that any false representation or any failure to comply with a representation, warranty, or certification made by Contractor is subject to all civil and criminal consequences provided at law or in equity including, but not limited to, immediate termination of this Contract.

52. False Statements

Contractor represents and warrants that all statements and information prepared and submitted by Contractor in this Contract and any related Solicitation Response are current, complete, true, and accurate. Contractor acknowledges any false statement or material misrepresentation made by Contractor during the performance of this Contract or any related Solicitation is a material breach of contract and may void this Contract. Further, Contractor understands, acknowledges, and agrees that any false representation or any failure to comply with a representation, warranty, or certification made by Contractor is subject to all civil and criminal consequences provided at law or in equity including, but not limited to, immediate termination of this Contract.

53. Permits and License

Contractor represents and warrants that it will comply with all applicable laws and maintain all permits and licenses required by applicable city, county, state, and federal rules, regulations, statutes, codes, and other laws that pertain to this Contract.

54. Drug-Free Workplace

Contractor represents and warrants that it shall comply with the applicable provisions of the Drug-Free Work Place Act of 1988 (41 U.S.C. §701 et seq.) and maintain a drug-free work environment.

55. Equal Employment Opportunity

Contractor represents and warrants its compliance with all applicable duly enacted state and federal laws governing equal employment opportunities.

56. Federal Occupational Safety and Health Law

Contractor represents and warrants that all articles and services shall meet or exceed the safety standards established and promulgated under the Federal Occupational Safety and Health Act of 1970, as amended (29 U.S.C. Chapter 15).

57. Signature Authority

Contractor represents and warrants that the individual signing this Contract Affirmations document is authorized to sign on behalf of Contractor and to bind the Contractor.

Signature Page Follows

Authorized representative on behalf of Contractor must complete and sign the following:

____
Legal Name of Contractor

____
Assumed Business Name of Contractor, if applicable (d/b/a or 'doing business as')

____
Texas County(s) for Assumed Business Name (d/b/a or 'doing business as')
Attach Assumed Name Certificate(s) filed with the Texas Secretary of State and Assumed Name Certificate(s), if any, for each Texas County Where Assumed Name Certificate(s) has been filed.

Signature of Authorized Representative	**Date Signed**
Printed Name of Authorized Representative **First, Middle Name or Initial, and Last Name**	**Title of Authorized Representative**
Physical Street Address	**City, State, Zip Code**
Mailing Address, if different	**City, State, Zip Code**
Phone Number	**Fax Number**
Email Address	**DUNS Number**
Federal Employer Identification Number	**Texas Identification Number (TIN)**
Texas Franchise Tax Number	**Texas Secretary of State Filing Number**
SAM.gov Unique Entity Identifier (UEI)	