Department of Health

Medicaid Program: Provider Compliance With the Electronic Visit Verification Program

Report 2022-S-31 | November 2024

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine whether Medicaid made payments for personal care and home health care services that were not supported by required electronic visit verification records. We examined paid personal care services with service dates from January 2021 through March 2023 and paid home health care services with service dates from January 2023 through March 2023.

About the Program

The Department of Health (DOH) administers the Medicaid program. In accordance with the federal 21st Century Cures Act (Cures Act), New York State implemented an electronic visit verification (EVV) program for all Medicaid personal care (PC) services in January 2021 and home health care (HHC) services in January 2023. EVV systems must capture the provider, recipient, service type, date, location, and begin and end times. For example, caregivers can use an application on their mobile phone to submit this information while in the home providing services. To implement the EVV program, DOH selected the "Choice Model," which allows PC and HHC providers to select and fund their own EVV system for submitting EVV records to DOH. A major goal of the EVV program is to validate service delivery by allowing entities to match EVV information to Medicaid claims to identify improper services charged to the Medicaid program.

In addition, New York State Social Services Law required PC and HHC providers with Medicaid reimbursements that exceeded $15 million a year to use a verification organization (VO) to conduct pre-claim reviews (using EVV records as well as other information) to verify PC and HHC services on claims prior to submission of the claims to Medicaid. The Office of the Medicaid Inspector General (OMIG) was required to develop a list of providers that met the VO requirement and notify them of the requirements.

Medicaid paid over $31.5 billion for PC services from January 2021 through March 2023, and about $109.8 million for HHC services from January 2023 through March 2023.

Key Findings

- Medicaid paid claims totaling $14.5 billion for 82 million PC services and $97.6 million for over 400,000 HHC services that did not have matching EVV records. This equated to matches of only 56% of PC services and 11% of HHC services. The audit identified a range of oversight and internal control deficiencies that contributed to the high volume of unmatched services.
- Medicaid paid claims totaling $11.6 million for 54,833 PC services that did not indicate valid services because they were too short in duration (under 8 minutes) to be billable under Medicaid rules. In addition, PC and HHC services should be suspended while a recipient is hospitalized; however, we found 65,626 PC and HHC services, totaling $9.7 million, occurred while recipients were hospitalized.
- OMIG did not take steps to help ensure providers that were required to use a VO for pre-claim reviews actually obtained a VO for that purpose. OMIG only notified 32 providers in 2015 of the requirement. We identified an additional 153 providers that, based on PC payments made to them during calendar year 2021, met the VO requirement. For example, of six providers we sampled that met the $15 million threshold, five were not notified by OMIG and did not obtain a VO for pre-claim reviews. The VO requirement ended in January 2024. Despite the numerous control

deficiencies we identified in the audit, DOH planned on relying on the EVV program to offset the lack of required VO pre-claim review.

Key Recommendations

- Review the $14.5 billion in PC services and $97.6 million in HHC services with no matching EVV records and take steps to ensure these services are properly supported with EVV data.
- Improve oversight of the EVV program and establish key controls to ensure EVV compliance, including developing controls that prevent payment of claims for PC and HHC services that lack supporting EVV records.
- Review the $11.6 million for PC services under 8 minutes and the $9.7 million for PC and HHC services provided during hospital stays and recover overpayments, as appropriate.

Office of the New York State Comptroller
Division of State Government Accountability

November 13, 2024

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. McDonald:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Provider Compliance With the Electronic Visit Verification Program*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
DOH	Department of Health	*Auditee*
Aggregator	System that collects and houses EVV records	*System*
API	Application programming interface	*Key Term*
CMA	Currier McCabe and Associates, Inc.	*Contractor*
CMS	Centers for Medicare & Medicaid Services	*Federal Agency*
Cures Act	Federal 21st Century Cures Act	*Law*
eMedNY	Medicaid claims processing and payment system	*System*
Encounter	Record of health care service provided to a managed care recipient	*Key Term*
EVV	Electronic visit verification	*Key Term*
EVV Crosswalk Table	Claim EVV Transaction Crosswalk Table	*Key Term*
EVV History Table	EVV Transaction History Table	*Key Term*
EVV Manual	EVV Program Guidelines and Requirements	*Key Term*
FI	Fiscal intermediary	*Key Term*
GDIT	General Dynamics Information Technology, Inc.	*Contractor*
GPS	Global Positioning System	*Key Term*
HHC	Home health care	*Key Term*
MCO	Managed care organization	*Key Term*
MDW	Medicaid Data Warehouse	*Key Term*
OMIG	Office of the Medicaid Inspector General	*Agency*
PC	Personal care	*Key Term*
Submitter	An entity (e.g., provider, FI) that sends EVV records to the Aggregator	*Key Term*
VO	Verification organization	*Key Term*

Background

The New York State Medicaid program is a federal, State, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Department of Health (DOH) administers the Medicaid program in New York. For the State fiscal year ended March 31, 2023, New York's Medicaid program had approximately 8.4 million recipients and Medicaid claim costs totaled about $80.2 billion (comprising $30.2 billion in fee-for-service health care payments and $50 billion in managed care premium payments). The federal government funded about 56.9% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.1%.

The Medicaid program pays health care providers through either the fee-for-service method or managed care. Under fee-for-service, DOH makes Medicaid payments directly to health care providers for services rendered to Medicaid recipients. Under managed care, DOH pays managed care organizations (MCOs) a monthly premium for each Medicaid recipient enrolled in the MCOs. The MCOs are then responsible for ensuring recipients have access to a comprehensive range of health care services. The MCOs make payments to health care providers for the services provided to recipients and are required to submit encounter claims to inform DOH about each medical service provided.

In New York State, Medicaid recipients may be eligible for personal care (PC) and home health care (HHC) services. These in-home services, which may include housekeeping, meal preparation, bathing, toileting, and personal grooming, are provided to promote, maintain, or restore health or lessen the effects of illness and disability and help individuals stay in their own homes and communities rather than live in institutional settings, such as nursing homes.

Pursuant to the federal 21st Century Cures Act (Cures Act) – which was enacted in 2016 – states are required to implement an electronic visit verification (EVV) system for all Medicaid PC and HHC services, whereby providers are required to submit records that detail certain information about the services delivered by their caregivers (providers can contract with a third party to submit EVV records on their behalf). The Cures Act requires that EVV systems capture six data points: service type, service recipient, service date, service provider, location of service delivery, and service begin and end times. The provider – or their fiscal intermediary (FI) that performs administrative services (e.g., maintaining time records) for caregivers – is responsible for ensuring that EVV data is captured in a compliant manner. States can validate the delivery of services by matching Medicaid reimbursement claims with EVV records to identify unsupported and improper services charged to the Medicaid program. Notwithstanding appropriate exemptions, payments for services without corresponding EVV records are questionable. Exemptions, for example, would include situations with live-in caregivers.

The Cures Act did not specify an EVV design model that states should implement, but the federal Centers for Medicare & Medicaid Services (CMS) identified five EVV design models for states to consider. The EVV design models vary mostly in terms of state involvement in vendor selection. For example, the "Choice Model" allows each

service provider to select their EVV vendor and fund their own EVV system, while the "State Mandated External Vendor Model" allows states to contract with a single EVV vendor that all providers must use. Of the five options, DOH selected the "Choice Model" to implement its EVV program.

DOH's EVV Program Guidelines and Requirements (EVV Manual) provides information and guidance about the EVV Program. According to the EVV Manual, the goals of EVV are to:

- Ensure timely service delivery for Medicaid recipients
- Reduce the administrative burden associated with paper time sheet processing
- Validate the delivery of services
- Generate cost savings from the prevention of fraud, waste, and abuse

Under New York State Social Services Law, providers, such as certified home health agencies, long-term home health agencies, and personal care providers, exceeding $15 million in Medicaid fee-for-service and MCO reimbursements were required to use a verification organization (VO) to perform a pre-claim review. The VO verifies the home health service within the claim prior to submission of the claim to Medicaid. For instance, a VO would compare a claimed Medicaid service against other data sources, including EVV records. Such data could include, but not be limited to, staff schedules, recipient records, and date/time/location/type of service delivered. The Office of the Medicaid Inspector General (OMIG) was responsible for periodically developing a list of the providers required to contract with a VO and notifying them by letter. These requirements continued until January 2024.

DOH contracted with General Dynamics Information Technology, Inc. (GDIT) to maintain the EVV Data Aggregator (Aggregator), which collects and houses EVV records in eMedNY (DOH's Medicaid claims processing and payment system). Providers are required to submit EVV data to the Aggregator either directly or through third parties contracted by the providers, such as a VO.

DOH contracted with Currier McCabe and Associates, Inc. (CMA) to maintain the Medicaid Data Warehouse (MDW), which stores Medicaid information such as recipient and claim data. CMA is also responsible for matching EVV records to the paid claim data for PC and HHC services. EVV records are stored in two primary data tables in the MDW: the EVV Transaction History Table (EVV History Table) and the Claim EVV Transaction Crosswalk Table (EVV Crosswalk Table). According to CMA staff, the EVV History Table contains all EVV records accepted by the Aggregator. The most current EVV record transaction is copied to the EVV Crosswalk Table to be linked to a paid claim (even if a matching paid claim is not in the table).

The Cures Act and subsequent legislation established EVV implementation deadlines of January 2020 and January 2023 for PC and HHC services, respectively. States could request from CMS a one-time 1-year good faith effort extension. New York State received an extension from CMS through January 2021 to meet the

requirements for PC services; the January 2023 deadline for HHC services remained unchanged (with the exception of services provided by sole practitioner private duty nurses, who are subject to data submission requirements beginning January 1, 2024). States that fail to comply are subject to reductions in federal medical assistance percentages.

Audit Findings and Recommendations

For the audit period, we determined the Medicaid program made payments totaling $14.5 billion for 82 million PC services and $97.6 million for 400,557 HHC services that were not supported by required EVV records.

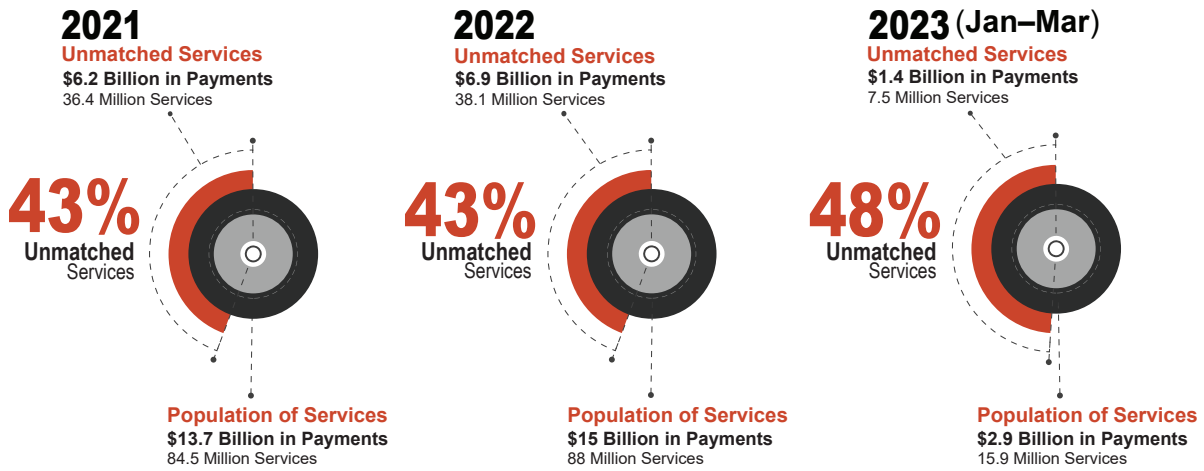
Although DOH issued the EVV Manual containing the EVV program guidelines, it did not establish adequate internal controls to ensure its own and providers' compliance with EVV requirements. For instance, we found DOH did not use all EVV records to match with services reported on claims for reimbursement, did not identify or consistently monitor provider non-compliance, and did not take administrative actions against providers' non-compliance. We also found certain EVV data quality and quantity issues that should have been identified and addressed to increase match rates between EVV records and Medicaid claims and allow for better program oversight. OMIG also did not take steps to help ensure that providers that met the requirement for a pre-claim review by a VO actually used a VO for that purpose, which could have reduced some of the EVV data issues cited in this report.

Medicaid Payments Without Matching EVV Records

A major goal of DOH's EVV program is to strengthen quality assurance through validation of service delivery by matching Medicaid claims to corresponding EVV records. Currently, PC and HHC services are paid for by Medicaid fee-for-service or MCOs even if there are no matching EVV records. DOH officials informed us that DOH has a goal to match over 90% of paid services to EVV records. DOH officials do not expect 100% of all services to match EVV records for multiple reasons – for instance, in situations that may require manual submission of timekeeping information.

To determine whether PC and HHC services were paid without the required supporting EVV records, we compared EVV records from the MDW (sourced from the Aggregator) to paid claim data from the MDW. First, we identified, across fee-for-service and managed care claims, approximately 188.4 million PC services totaling over $31.5 billion that had dates of services from January 2021 through March 2023. Of these, approximately 106.4 million services (56%), totaling $17 billion, had a matching EVV record, as shown in Figure 1. The remaining 82 million PC services (44%), with payments totaling $14.5 billion, did not have a matching EVV record.

Figure 1 – Results of Match Between EVV Records and Fee-for-Service/Encounter Claims for PC Services for the Period January 2021 Through March 2023



We also identified 449,235 HHC services, totaling almost $109.8 million, with dates of services from January 2023 through March 2023. Of these, only 48,678 services (11%), totaling approximately $12.2 million, had a matching EVV record. The remaining 400,557 HHC services (89%), with payments totaling $97.6 million, did not have a matching EVV record.

DOH did not meet its EVV goal to strengthen quality assurance through the validation of delivery of services, as evidenced by PC and HHC service match rates – 56% and 11%, respectively – that fell far below DOH's goal of over a 90% match rate between EVV records and paid services.

According to the EVV Manual, DOH is responsible for implementing quality control measures. Toward this end, DOH should have effective controls in place to ensure that quality data is being submitted in a timely manner so DOH meets the EVV goals. We identified several deficiencies in controls and issues that weakened the quality and timing of EVV data submissions and likely contributed to the high number of paid claims without a matching EVV record, which are discussed throughout the remainder of the report.

Recommendation

1. Review the $14.5 billion and $97.6 million in PC and HHC paid services, respectively, with no matching EVV records and take appropriate steps to ensure services are properly supported with EVV data.

Lack of Denial of Claims Without Matching EVV Records

DOH and GDIT officials stated eMedNY has a feature that will prevent payment of fee-for-service claims that do not have a matching EVV record, but this feature was

not turned on. Therefore, payments for PC and HHC services were processed even in the absence of the required corresponding EVV record, hampering DOH's goal to validate the delivery of PC and HHC services and reduce the risk of improper payments. According to DOH officials, to date, no providers have had claims pended or denied, nor have any been issued a letter seeking recoupment for lack of EVV data. However, officials stated DOH plans to implement a compliance program, including regulations to allow for the pending, denial, or recoupment of payments to providers that are not compliant with the EVV requirements.

Recommendation

2. Establish an EVV compliance program that will allow for the denial of improper claims and recoupment of improper payments.

EVV-Exempt Live-In Caregiver Services

According to DOH's EVV Manual, live-in caregivers – defined as caregivers who provide services to a recipient where the recipient and the caregiver have the same permanent place of residence – are exempt from EVV requirements. In these cases, DOH does not require the submission of EVV records. However, caregivers who do not meet this definition are not considered EVV-exempt live-in caregivers and must comply with EVV requirements. The EVV Manual also states that providers and FIs are responsible for compiling, maintaining, and validating all records justifying the status of each EVV-exempt live-in caregiver.

We found that neither DOH nor OMIG conducts reviews or audits of the residence status of EVV-exempt live-in caregivers to ensure that claims submitted with a live-in caregiver code truly meet the exemption criterion.

For the audit period, PC claims with a live-in caregiver code accounted for 5.6 million PC services (of 188.4 million) and $1.8 billion (of $31.5 billion) in Medicaid payments. Of the 5.6 million PC services, 5.4 million services did not have a matching EVV record. HHC service claims with a live-in caregiver code accounted for 1,342 services (of 449,235) and $488,724 (of $109.8 million) in Medicaid payments. None of these 1,342 services had a matching EVV record. Because no reviews or audits of caregivers' residence status were conducted, it is uncertain whether all these services were truly EVV-exempt, increasing the risk of providers' non-compliance with the EVV program.

While providers and FIs are responsible for compiling, maintaining, and validating all records justifying the status of each EVV-exempt live-in caregiver, the lack of reviews or audits of this information compromises DOH's oversight of this process.

Recommendation

3. Verify the residence status of live-in caregivers for assurance that they are exempt from the EVV requirement.

Records Not Copied From EVV History Table to EVV Crosswalk Table

According to CMA staff, EVV records accepted by the Aggregator and moved into the MDW are copied from the EVV History Table to the EVV Crosswalk Table for linking to paid PC and HHC claims. However, of more than 151 million active records in the EVV History Table with dates of service spanning January 2021 through March 2023, we identified approximately 8 million records (5%) that did not get copied to the EVV Crosswalk Table. DOH officials could not explain why the records were not copied to the EVV Crosswalk Table and stated they needed to review them to make a determination.

Procedure/Modifier Code Combinations not in the EVV Manual

We observed almost 7.4 million (92%) of the 8 million records not copied to the EVV Crosswalk Table appeared to be for PC services that did not conform to the procedure/modifier billing code combinations detailed in the EVV Manual. A procedure code identifies the service provided to a recipient. A modifier code provides additional information about the services rendered, such as whether a service was performed on the weekend or a holiday. DOH officials stated the Aggregator allows providers to submit EVV records regardless of which procedure and modifier billing codes are used. However, the EVV matching algorithm would not match EVV records to paid PC and HHC claims that have non-applicable or incorrect billing codes.

The EVV Manual lists 32 distinct PC procedure/modifier code combinations that can be used to identify services on PC encounter claims. We reviewed procedure/modifier code combinations on paid PC encounters with service dates from January 2021 through August 2022 and identified 125 distinct code combinations. Of those 125, we identified 96 (77%) that did not match the list of EVV-applicable codes in the EVV Manual. For example, procedure code T1019 with modifier code U1 is defined in the EVV Manual as “Personal Care Service Level II Basic – 15 minutes.” However, we identified over 1.6 million paid services with procedure code T1019 and both modifier codes U1 and TV (TV indicates the service was on the weekend or a holiday), a combination that is not in the EVV Manual.

We determined not all appropriate combinations are listed in the EVV Manual. For example, the EVV Manual lists allowed modifier code combinations under PC procedure code T1019; however, it does not list T1019 without a modifier code as an EVV-applicable option. This appeared to be an oversight in the EVV Manual. We sent the list of reported procedure/modifier code combinations on the paid PC encounters to DOH for review, and DOH officials verified that most combinations were valid with the exception of nine. However, these remaining nine combinations also appeared to be for EVV-applicable services.

In 2017, DOH issued standards for procedure and procedure/modifier code reporting. In these standards, certain modifier codes did not appear to be applied consistently and appeared for some, but not all, procedures. For example, providers can report modifier code U4 when delivering PC services to hard-to-serve clients. However, when the same services are delivered by a live-in caregiver to the same type of recipient, there is no procedure/modifier code. DOH should review its current list of PC procedure codes and modifier codes to ensure all appropriate combinations are identified.

The number of EVV records with procedure/modifier code combinations not listed in the EVV Manual is significant. Of the entire population of EVV records in the EVV History Table, totaling approximately 185.4 million as of October 2023, almost 33 million (18%) had procedure/modifier code combinations that did not match any in the EVV Manual. Without an adequate list of all appropriate code combinations, providers can enter code combinations that do not conform to the EVV Manual, potentially representing increased risks of errors and failed match attempts between EVV records and paid services.

Recommendations

4. Review the 8 million EVV records identified in the EVV History Table that were not in the EVV Crosswalk Table, identify the reason(s) EVV records do not transfer to the EVV Crosswalk Table, take remediation steps, and match the 8 million EVV records to paid claims, if possible.
5. Update the EVV Manual and procedure standards with all allowed combinations of procedure and modifier codes.

Data Quality Issues on Required Data Points

According to the EVV Manual, providers and FIs are responsible for ensuring EVV data is collected and verified prior to a claim or encounter being submitted. To understand the process, we reviewed EVV data submissions for a judgmental sample of seven providers and two EVV vendors used by the seven providers. Both EVV vendors provided EVV submission services and/or pre-claim review.

We found DOH did not provide adequate oversight of EVV submissions to ensure EVV data complied with Cures Act data point requirements and did not establish adequate controls to ensure all required EVV data points were accurately reported.

Service Location Data

The Cures Act requires service location to be captured by the EVV system. Providers that we interviewed indicated that service location can be captured by the recipient's landline phone or by an application on the caregiver's mobile phone.

Although providers have the ability to capture the exact service address, DOH does not require this to be sent to the Aggregator and only requires submitters (e.g., providers, FIs) to make a general indication whether the service was rendered in the

home or outside the home. DOH officials stated that federal EVV guidelines do not require service location to be captured through GPS (Global Positioning System), and GPS information was noted as a privacy concern among providers, caregivers, and recipients.

There are ways for providers to capture the service address location that do not involve GPS (e.g., landline phones and fixed object devices). Lacking more specific location data, such as the address of the recipient rather than a notation of "home," DOH cannot ensure that the in-home service took place at the address contained in DOH's recipient records. DOH officials explained that providers are expected to ensure the addresses in EVV records match where care was actually provided.

Dates of Service

The Cures Act requires EVV systems to capture date of service. DOH officials and GDIT staff stated the Aggregator's system controls for entering dates only checked for formatting, not whether the date entered was reasonable.

Of the entire population of EVV records in the EVV History Table, consisting of over 151 million active EVV records as of June 2023, there were 703,251 with service start dates from 2015 up to 2020 (before the EVV requirement was established in 2021), and 1,430 with nonsensical service start dates – for example, start dates of January 1, 1900 and January 1, 0001, and an EVV service start date of December 31, 1969 and an end date of August 21, 2021. The lack of control on data quality resulted in records with service dates that spanned decades.

Recommendations

6. Improve oversight of providers' compliance with EVV requirements, including but not limited to ensuring service locations and services dates are accurate.
7. Improve controls in the Aggregator to validate both format and accuracy of EVV fields, such as service date.

Lax Monitoring

Inadequate Monitoring of Rejected EVV Submissions

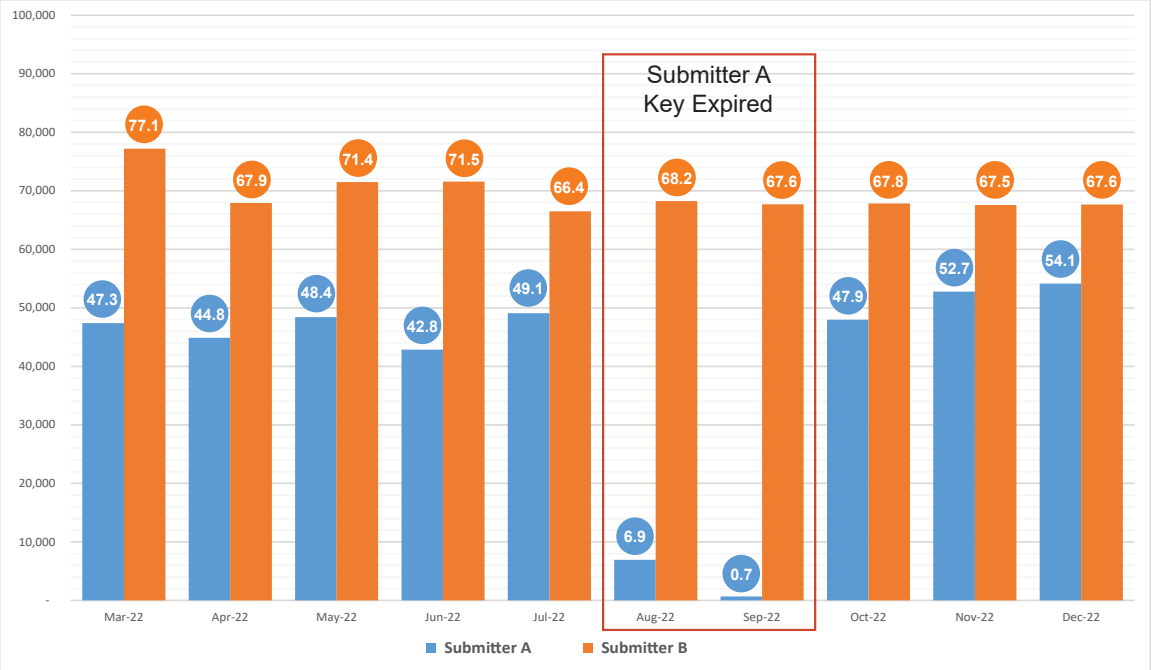
The Aggregator rejects EVV records that do not meet certain data requirements (rejected submissions). Rejected submissions can result from errors in the submitted EVV data, such as if the service end time comes before the service start time. When an EVV record is rejected, the Aggregator sends an error message to the submitter, which can review the reasons for the rejection and resubmit the record. However, DOH does not keep error messages past 90 days, nor does it review error message reports that could be generated from the system – reports that would provide DOH with valuable insight on sources of error and enable DOH to proactively address issues that otherwise result in delayed acceptance of EVV records and contribute to its low claim–EVV record matching rate.

For example, according to one of the EVV submitters we sampled, of the nearly 105 million EVV records it had submitted to the Aggregator as of February 2023, about 11 million records (10%) were not accepted. Because error message reports were not tracked by DOH, DOH was unable to identify the common reasons for the rejected submissions, which could have reduced the number of future rejected EVV submissions. DOH officials agreed to take steps to implement and utilize error message reports to review trends and provide outreach to providers and EVV submitters as needed.

Application Programming Interface Problems

We also found there were other technical reasons why EVV records were not uploaded to the Aggregator. A submitter must have an active application programming interface (API) key to submit EVV records. However, we identified one submitter that had an expired API key, which prevented it from submitting EVV records. To understand the impact of this issue, we analyzed its monthly EVV submissions (referred to as Submitter A) for the period from March 2022 through December 2022. For context, we compared Submitter A's submission data with data from another submitter, Submitter B, that had a valid API key. Results are shown in Figure 2.

Figure 2 – Comparison of Submitters' Monthly Submissions, March–December 2022



Submitter A's EVV submissions were fairly steady for the first 5 months, and then decreased significantly, from 49,084 submissions in July 2022 to about 700 in September 2022, because of the expired API key. (Submitter A explained its EVV submissions did not go down to zero because some of the EVV data was submitted through a different EVV system used by an MCO.) In contrast, Submitter B's EVV

submissions remained relatively constant throughout the period. DOH officials should routinely monitor the volume of EVV submissions so they can take prompt corrective action if submissions appear lower than usual.

Underutilization of EVV Reports for Monitoring

DOH officials have the ability to review reports on providers' EVV compliance. These reports identify which providers have submitted EVV records compared to their service claims and which providers have not. They also identify how long it takes providers to submit supporting EVV records. In June 2023, when asked how they review these reports, DOH officials responded that the program staff do not have access to the reports, but some staff are able to view the information in a data analysis application. DOH officials also stated that the staff plan to review the EVV data to determine which providers are submitting EVV records, in addition to reviewing specific claims to determine compliance. DOH officials further responded that they plan to document those providers that received outreach, and as the compliance program develops, DOH will keep documentation of those reviews.

DOH officials also stated they conduct high-level monthly reviews of EVV data in the data analysis application, including a check of how many EVV records match to paid services. The review is based on a live feed and is not documented. We requested that DOH officials provide a demonstration of the EVV reports in the data analysis application; however, no demonstration was provided.

Another report, from OMIG, identifies instances of caregivers reported as working in multiple locations based on key data points. Upon our request, OMIG provided the report for one of the seven providers we sampled. The report lists the caregivers, the recipients, the dates and times the recipients were seen, as well as the conflicting agency the caregiver was working under along with those dates and hours reported. We asked OMIG to detail actions taken based on the exceptions reported; however, OMIG did not provide any details. Therefore, we have no assurance of what, if any, actions are taken in response to these reports.

DOH should utilize the available EVV reports, as they are important tools for monitoring the quality and quantity of EVV submissions and taking action to address non-compliance. DOH officials stated they plan to incorporate monitoring of the EVV reports into the compliance program to help ensure providers are submitting EVV data and verifying claims.

Recommendations

8. Monitor EVV submission error message logs and take corrective actions as necessary to reduce the volume of rejected EVV records.
9. Develop and implement procedures to utilize all EVV reports as a monitoring tool for EVV compliance, including identifying variances between the number of EVV records accepted by the Aggregator and the volume of claims from providers.

Transparency of Adjustments to EVV Records

EVV data can be manually adjusted by the provider or the submitter (such as FIs) before sending the EVV records to the Aggregator. Manual adjustments to EVV records were not transparent to DOH because only the adjusted records were sent to the Aggregator, and the adjusted records did not include the reasons for the adjustments or if they were even adjusted. DOH has not established controls to identify when any manual adjustments have been made. According to an EVV vendor, when EVV data, such as shift times, are manually adjusted on an EVV record, only the adjusted values are sent to the Aggregator. Further, the EVV vendor does not identify manually adjusted data on the records or provide an explanation because DOH does not require it. There is a risk that the integrity of the EVV records is compromised when submitters can manually adjust the records before submitting them without DOH's knowledge or providing a reason.

Recommendation

10. Develop controls to identify manual adjustments made to EVV records before they are initially sent to the Aggregator.

Questionable Payments

Short Personal Care Segments

Medicaid allows providers to bill for a 15-minute service if the service was at least 8 minutes in length. For the period January 2021 through March 2023, we identified 54,833 PC services, with payments totaling approximately $11.6 million, where the matching EVV record showed a service duration of less than 8 minutes. In one case, for example, a provider billed for a 15-minute service, at a cost of $207, whereas the EVV record showed a 1-second service duration.

These payments are questionable because the EVV records do not indicate valid services based on the service durations. We encourage DOH to review these services and determine if inappropriate payments were made.

Services Provided During Hospital Stays

When a recipient is admitted to the hospital, PC and HHC services should be suspended. However, we found this does not always happen, resulting in questionable Medicaid payments. Our analysis of EVV data identified 65,626 PC and HHC services provided to 19,935 recipients while they were hospitalized (excluding admission and discharge days). These claims resulted in payments totaling about $9.7 million (see Table 1).

Table 1 – Payments for PC and HHC Services During Periods of Hospitalization

Payment Type	Service Count	Number of Recipients	Questionable Payments
Fee-for-service	3,669	1,115	$875,465
Encounter	61,957	18,835	8,801,570
Totals	**65,626**	**19,950***	**$9,677,035**

*Includes 15 recipients who had both fee-for-service and encounters

For example, one recipient was admitted to a hospital on January 13, 2021 and discharged on January 21, 2021. During that period, home health providers billed, and Medicaid paid, $4,454 for services rendered on January 14 through January 20. DOH officials stated they are not aware of any circumstances under which PC and HHC services during hospitalization would be appropriate.

DOH's eMedNY system has a control to identify when a PC service is claimed during an inpatient stay. However, we identified 3,669 services that were paid despite this control. Furthermore, this control only addresses claims directly processed by DOH as fee-for-service claims and not those processed by MCOs as encounter claims. MCOs reported 61,957 PC services when a recipient was hospitalized.

Services With Overlapping Time Frames

Records that show overlapping services provided by one or more caregivers to the same recipient could be inappropriate. We analyzed data from the EVV History Table as of June 2023 and identified nearly 3.7 million active EVV records of services with overlapping time frames (excluding records with service durations of less than 8 minutes).

According to DOH officials, there may be specific situations, such as positioning or bathing services, that could require the services of more than one caregiver for a given recipient at a given time. However, they do not analyze data to identify records with overlapping services and assess them for appropriateness. DOH officials further told us that there are no specific regulations that state recipients cannot have more than one caregiver working at the same time if the caregivers do not exceed their authorized hours. However, there were no codes in the EVV Manual that could be used to indicate that an overlapping service took place and whether it was appropriate.

To identify questionable payments, we reviewed EVV Crosswalk Table records with service dates from January 2021 through March 2023 where service time frames overlapped for at least 8 minutes. As shown in Table 2, we identified 5,677 EVV records with overlapping services, with payments totaling $339,372.

Table 2 – Payments for Services With Overlapping Time Frames

Service Overlap in Minutes	Service Count	Questionable Payments
Less than 60	2,946	$33,492
60–119	813	32,770
120–299	1,153	119,698
300–479	523	92,402
480 or more	242	61,010
Totals	**5,677**	**$339,372**

For example, we identified one recipient who received overlapping services from two different caregivers on March 2, 2022. The first caregiver clocked in about 6 a.m. and clocked out about 9 p.m., and the second caregiver clocked in at 7:30 a.m. and clocked out at 11:30 p.m., resulting in an overlap of about 13.5 hours.

Lacking a process to evaluate EVV data with overlapping services and detect those that are questionable, DOH has no assurance that Medicaid payments are appropriate.

Recommendations

11. Improve controls to identify and prevent payment of PC and HHC services that do not meet the 8-minute minimum requirement for payment. Review the $11.6 million in corresponding payments and ensure recoveries are made, as appropriate.
12. Improve controls to identify and prevent payment of PC and HHC services claimed during hospital stays. Review the $9.7 million in corresponding payments and ensure recoveries are made, as appropriate.
13. Review the $339,372 in payments for services provided by multiple caregivers to a single recipient with same-day overlapping time frames and ensure recoveries are made, as appropriate.

Verification Organization Program

Pursuant to New York State Social Services Law, providers, such as certified home health agencies, long-term home health agencies, and personal care providers, with total Medicaid fee-for-service and/or managed care reimbursements that exceeded $15 million per calendar year were required to contract with a VO to perform pre-claim reviews. Pre-claim reviews involve verification of PC and HHC services prior to submission of the claims to DOH or the encounters to MCOs by taking steps such as comparing to authorized staff schedules, recipient records, and EVV records (e.g., to verify date, time, recipient, procedure). In addition to pre-claim reviews, VOs can also be used to submit EVV records to the Aggregator.

According to the EVV Manual, OMIG was responsible for periodically developing a list of the providers required to contract with a VO and notifying them of the requirement by letter.

In August 2022, we requested from OMIG a list of the providers required to have a VO. The list, which OMIG gave to us 2 months later, included 106 providers. Of those, only 32 had been notified by OMIG (which last sent letters in May 2015). Therefore, any other providers that met the requirement since then had not received a formal notification from OMIG as required. We reviewed all providers that submitted EVV-applicable claims and encounters during calendar year 2021 and identified 153 providers that met the $15 million requirement (after removing the 32 providers that OMIG sent notification letters to in May 2015).

According to OMIG, even though not all providers on its list of 106 were notified they needed a VO, 100 providers' EVV records were submitted to the Aggregator by third parties that also provide VO services. Nevertheless, OMIG's list does not distinguish between providers that use a VO to perform the required pre-claim review and those that use a VO only to submit EVV records to the Aggregator. This distinction is important because a provider that meets the requirement for a VO might use the VO only for EVV data submission services, in which case there is no assurance that the required pre-claim reviews are performed, as the law intended.

For example, one provider on OMIG's list stated to us, and the VO confirmed, that it was not receiving pre-claim reviews. We also note that six of the seven providers in our judgmental sample met the VO requirement (exceeded $15 million in reimbursements) during calendar year 2021, yet five providers did not receive a letter from OMIG (one received a letter in 2015) and did not obtain a VO for pre-claim review services. Because OMIG and DOH had not taken appropriate steps to ensure that providers that met the VO requirement were notified of such, services were not always verified, which could have led to fraud, waste, or abuse of Medicaid funds.

In response, DOH officials stated that the VO requirement ended in January 2024 and that current EVV procedures are sufficient to meet the goals of the EVV program. Nevertheless, particularly in light of the numerous other deficiencies in oversight that we identified in this report, we strongly encourage DOH to improve its controls and monitoring of the EVV program to help offset the lack of required pre-claim reviews as a consequence of the VO requirement ending in 2024.

Recommendation

14. Improve controls and monitoring of the EVV program that will help offset the lack of required VO pre-claim reviews.

Audit Scope, Objective, and Methodology

The objective of the audit was to determine whether Medicaid made payments for PC and HHC services that were not supported by required EVV records. We examined paid PC services with service dates from January 2021 through March 2023 and paid HHC services with service dates from January 2023 through March 2023.

To accomplish our audit objective and assess related internal controls, we interviewed officials from DOH, CMA, and GDIT, and examined DOH's relevant EVV policies and procedures as well as applicable federal and State laws. We also interviewed and obtained information about the EVV submission process from a judgmental sample of seven home health providers, as follows: four of 744 providers with fee-for-service claims and three of 1,113 providers with encounter claims. The providers were selected based on high payments from Medicaid and MCOs and other risk factors. Because the providers were judgmentally selected, the results cannot be projected to the population as a whole. In addition, we interviewed and obtained information from the two EVV vendors that provided services to the seven sampled providers.

In June 2023 and July 2023, we obtained fee-for-service and encounter data from the MDW and eMedNY to identify paid PC services (January 2021–March 2023) and HHC services (January 2023–March 2023) that were not supported by EVV records in the MDW. This data was also used to test DOH's oversight of the EVV program (additional EVV records as of June 2023 and October 2023 were used as well), as described in the body of the report. We relied on data from the MDW and eMedNY that, based on reviewing existing policies, interviewing DOH officials and providers knowledgeable about the systems, reviewing existing reports regarding encounter data, and performing electronic testing, is sufficiently reliable for the purposes of this audit.

We shared our methodology and findings with officials from DOH and OMIG during the audit for their review. We took their comments into consideration and adjusted our analyses as appropriate.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgement, these duties do not affect our ability to conduct this independent performance audit of DOH's oversight and administration of the EVV program.

Reporting Requirements

We provided a draft copy of this report to DOH officials for their review and formal comment. We considered DOH's comments in preparing this final report and have included them in their entirety at the end of it. In their response, DOH officials generally agreed with most of the audit recommendations and indicated certain actions have been and will be taken to address them. Our responses to certain DOH remarks are embedded within DOH's response as State Comptroller's Comments.

Within 180 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

September 25, 2024

Andrea Inman
Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2022-S-31 entitled, "Medicaid Program: *Provider Compliance With the Electronic Visit Verification Program*."

Thank you for the opportunity to comment.

Sincerely,

Johanne E. Morne

Johanne E. Morne, M.S.
Executive Deputy Commissioner

Enclosure

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Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2022-S-31 entitled, "Medicaid Program: Provider Compliance With the Electronic Visit Verification Program"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2022-S-31 entitled, "Medicaid Program: *Provider Compliance With the Electronic Visit Verification Program*." Included in the Department's response are the Office of the Medicaid Inspector General's (OMIG) replies to applicable recommendations. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers, fiscal intermediaries, and recipients to ensure they are complying with the laws and regulations.

General Comments:

Electronic Visit Verification (EVV) uses technology to verify home and community-based service visits in real-time, including the date, location, type of service, individual(s) providing and receiving services, and the duration of service(s). It also validates hours worked by caregivers. The caregiver completes the Electronic Visit Verification by entering all the required information while at the recipient's home or community-based service visit using a mobile application on their smart phone or tablet, a fixed object (called a fob) placed in the home where services are provided, or a landline phone.

OSC's audit included the following Electronic Visit Verification services Medicaid recipients may receive in their homes:

- Personal Care Services, which include services such as housekeeping, meal preparation, bathing, toileting, and personal hygiene starting **January 1, 2021**.
- Home Health Services, which may include nursing care, speech, physical and occupational therapists, home health aide services, and personal care services starting **January 1, 2023.**

OSC focused their audit on Electronic Visit Verification data entered by caregivers for personal care services and home health services from the very beginning of each program, January 1, 2021 and January 1, 2023, respectively. It is also important to note that the Electronic Visit Verification was implemented during the COVID-19 pandemic.

Responses to the Audit Recommendations:

Recommendation #1:
Review the $14.5 billion and $97.6 million in PC and HHC paid services, respectively, with no matching EVV records and take appropriate steps to ensure these services are properly supported with EVV data.

Recommendation #2:

Establish an EVV compliance program that will allow for the denial of improper claims and recoupment of improper payments.

Response #1 & #2:

The absence of Electronic Visit Verification data alone may not indicate that the underlying claim was inappropriate and that a recovery should be made. OMIG's initial analysis of the claims determined that about $2.7 billion should not be included in the OSC-identified payments as detailed below.

Reason	Amount
Paid service has matching EVV submission in the crosswalk table.	$1,843,483,607
Paid service does not have EVV specific modifiers in any of the four modifier fields for EVV applicable rate/procedure codes.	$391,254,482
PCS codes under HCBS Childrens Respite Program need to have both the specific modifier associated with the procedure code as well as modifier 96 indicating it's a claim that meets the three mandatory conditions which make it an EVV applicable HCBS Children's Respite Waiver claim.	$244,042,280
If an EVV applicable procedure/rate code has a modifier associated with it, that modifier should be in the first modifier field. If it is not listed in that first placement, regardless of whether it's in a different modifier field, this would not be considered an EVV applicable claim.	$90,227,158
OSC unmatched claims that were no longer the latest transaction in Claim Transaction.	$69,267,637
PDN codes S9123, S9124, T1002, T1003 are not required to submit EVV.	$38,542,723
OSC-identified paid amounts were different from the Claim Transaction paid amounts.	$6,532,747
Claims that have already been recovered.	$6,051,148
OSC-identified unmatched claims that have $0 in Claim Transaction	$2,482,477
PCS codes under HCBS Children's program where the member is under 21.	$446,331
TOTAL	**$2,692,330,590**

State Comptroller's Comment – The numbers in the audit report are accurate. We captured the available EVV data for our audit period over a year before OMIG's response, and OMIG acknowledged its analysis included matching *additional* EVV documentation. This corresponded to about $1.9 billion of OMIG's analysis. We note that, when EVV records are submitted late (as shown by OMIG's review), the EVV system is ineffective. In order for EVV to be successful and to verify services in the home and validate hours worked by caregivers, EVV records should be submitted timely and contemporaneously with their corresponding claims for Medicaid reimbursement, not over a year after the fact.

Regarding the remainder of OMIG's analysis, DOH generally agreed with the procedure/rate codes and modifiers in our findings population. Further, we remind OMIG that DOH's EVV Manual did not contain all applicable codes and modifiers (see p. 13 of the audit report). Lastly, relying on the order of code modifiers rather than if the applicable modifier was reported could reduce DOH's ability to match EVV records to claims for services and create burdens for providers reporting EVV records.

We are pleased OMIG is taking prompt action to address the audit findings and recommendations.

OMIG's analysis included matching additional Electronic Visit Verification documentation and reviewing claims data that does not meet Electronic Visit Verification requirements or was not supported by Electronic Visit Verification submissions. In collaboration with the Department,

OMIG will continue to perform analysis on the identified claims to determine an appropriate course of action.

The Department and OMIG meet monthly to discuss Electronic Visit Verification compliance, including analysis of Aggregator data. OMIG has been issuing compliance letters to identified providers and fiscal intermediaries who appear to be non-compliant to address barriers and facilitate compliance. The Department is addressing provider and fiscal intermediary responses to the compliance letters through outreach and education, so providers and fiscal intermediaries have a better understanding of the Electronic Visit Verification program and its requirements. For example, providers and fiscal intermediaries submit claims under their Medicaid Management Information System Identification Number, but the Electronic Visit Verification data is submitted under their National Provider Identification Number. Another example is that providers and fiscal intermediaries shouldn't assume their Electronic Visit Verification vendor is submitting data on their behalf.

The Department is in the process of drafting regulations to ensure Electronic Visit Verification data is submitted to the State's data Aggregator more timely - after the service is rendered but before the claim is billed. Claims without matching Electronic Visit Verification data will be pended. Failure of a provider or fiscal intermediary to cure a pended claim will result in a denial and non-payment. The regulations will also allow for program integrity activities.

The Department and OMIG will continue to evaluate and update Electronic Visit Verification requirements, as appropriate, to improve service delivery, oversight of Medicaid payments, and implementation of these requirements by the provider community.

Recommendation #3:

Verify the residence status of live-in caregivers for assurance that they are exempt from the EVV requirement.

Response #3:

The Department requires that providers and fiscal intermediaries be responsible for compiling, maintaining, and validating all records justifying the status of each Electronic Visit Verification exempt live-in caregiver. The Department will issue reminders to providers and fiscal intermediaries to review the instructions and their responsibilities to verify live-in caregiver addresses for Electronic Visit Verification exemptions.

State Comptroller's Comment – Without steps taken by DOH and/or OMIG, there is no assurance that the status of live-in caregivers – and the exemption from submitting EVV Records – will be accurate.

Recommendation #4:

Review the 8 million EVV records identified in the EVV History Table that were not in the EVV Crosswalk Table, identify the reason(s) EVV records do not transfer to the EVV Crosswalk Table, take remediation steps, and match the 8 million EVV records to paid claims, if possible.

Response #4:

The Department will continue to work with its contractor to ensure all appropriate Electronic Visit Verification records will be re-processed to the Electronic Visit Verification Crosswalk table.

Recommendation #5:

Update the EVV Manual and procedure standards with all allowed combinations of procedure and modifier codes.

Response #5:

The Department will review and make any necessary updates to the current Electronic Visit Verification Manual and procedure standards.

Recommendation #6:

Improve oversight of providers' compliance with EVV requirements, including but not limited to ensuring service locations and services dates are accurate.

Response #6:

The Department will issue a Medicaid Update article to remind providers of their obligations to ensure that Electronic Visit Verification data and claims data match and that service locations are accurate.

Recommendation #7:

Improve controls in the Aggregator to validate both format and accuracy for EVV fields, such as service date.

Response #7:

The Department has enhanced system data validation requirements built into the Aggregator. The Department will continue to monitor and work with its contractor to ensure the appropriate enhancements are implemented to meet the Cures Act standards.

Recommendation #8:

Monitor EVV submission error message logs and take corrective actions as necessary to reduce the volume of rejected EVV records.

Response #8:

Once error message logs have been implemented, the Department will review error message logs for trends and provide outreach to providers, fiscal intermediaries, and Electronic Visit Verification submitters as needed.

Recommendation #9:

Develop and implement procedures to utilize all EVV reports as a monitoring tool for EVV compliance, including identifying variances between the number of EVV records accepted by the Aggregator and the volume of claims from providers.

Response #9:

The Department plans to incorporate monitoring of the Electronic Visit Verification reports into its compliance program to help ensure providers and fiscal intermediaries are submitting Electronic Visit Verification data and verifying claims. The Department will work with providers, fiscal intermediaries, managed care organizations, and Local Departments of Social Services to resolve Electronic Visit Verification compliance issues, including location conflicts.

Variances between the number of claims and the number of Electronic Visit Verification records in the Aggregator may occur due to providers and fiscal intermediaries using different provider identification numbers when submitting their claims and their Electronic Visit Verification data. For example, providers and fiscal intermediaries submit claims under their Medicaid Management Information System Identification Number, but the Electronic Visit Verification data is submitted under their National Provider Identification Number. To help remedy this situation, the Department will conduct a review of where this has occurred and provide outreach and education to providers and fiscal intermediaries to remind them to use the same identification number for both claims and Electronic Visit Verification to provide the Department better matching outcomes. Additionally, once implemented, the unique identifier for home care service workers and personal care aides required by statute (and referenced in Response #14) will assist in the identification of issues involving providers, fiscal intermediaries, and caregivers. As is standard practice, if the Department identifies potential fraud, waste, or abuse in the course of its monitoring activities, referrals will be made to OMIG for review and appropriate actions.

OMIG will also utilize data and reports from the Department to support its own program integrity initiatives – including investigations and audits.

Recommendation #10:

Develop controls to identify manual adjustments made to EVV records before they are initially sent to the Aggregator.

Response #10:

The Department will work with its contractor and pursue changes to the Aggregator that will allow for identification of Electronic Visit Verification records that were manually adjusted before they are initially sent to the Aggregator. The Department will submit a Change Request to implement changes to improve controls.

Recommendation #11:

Improve controls to identify and prevent payment of PC and HHC services that do not meet the 8-minute minimum requirement for payment. Review the $11.6 million in corresponding payments and ensure recoveries are made, as appropriate.

Response #11:

The Department will review controls currently in place to detect and flag these instances for review. Additionally, once implemented, the unique identifier for home care service workers and personal care aides required by statute (and referenced in Response #14), will assist in the identification of issues involving providers, fiscal intermediaries, and caregivers.

OMIG is performing analysis on the OSC-identified payments and will perform its own extraction of data from the Medicaid Data Warehouse to confirm the accuracy of the claims detail for use in future OMIG audit activities.

Recommendation #12:

Improve controls to identify and prevent payment of PC and HHC services claimed during hospital stays. Review the $9.7 million in corresponding payments and ensure recoveries are made, as appropriate.

Response #12:

The Department will work with OMIG to identify any improper payments for home care services that occurred when a recipient was hospitalized, and recoup payments where appropriate. However, this type of incorrect billing is typically monitored through existing controls and is not an Electronic Visit Verification related procedure.

OMIG's analysis determined that more than $1 million should not be included in the OSC-identified payments due to the following reasons:

Reason	Amount
The OSC-identified inpatient claim or encounter shows $0 paid:	$610,734
The home health service start date was before the first inpatient start date:	$362,389
The latest transaction on the home health encounter shows $0 paid:	$121,714
TOTAL	**$1,094,837**

State Comptroller's Comment – Regarding the "$0 paid" claims, OMIG's response was over a year after our audit period ended and that claim information would not reflect the payment claim information used at the time of the audit (see State Comptroller's Comment on p. 26). Also, our analysis only considered home health services when the services were claimed at the same time the Medicaid recipient was hospitalized.

Recommendation #13:

Review the $339,372 in payments for services provided by multiple caregivers to a single recipient with same-day overlapping time frames and ensure recoveries are made, as appropriate.

Response #13:

Records with overlapping time spans will be reviewed by the Department for appropriateness. Records that are determined to be inaccurate will be referred to OMIG for overpayment recoupment or other necessary action, if appropriate. Additionally, once implemented, the unique identifier for home care service workers and personal care aides required by statute (and referenced in Response #14), will assist in the identification of issues involving providers and fiscal intermediaries.

OMIG is performing analysis on the OSC-identified payments. OMIG will perform its own extraction of data from the Medicaid Data Warehouse to confirm the accuracy of the claims detail for use in future OMIG audit activities.

Recommendation #14:

Improve controls and monitoring of the EVV program that will help offset the lack of required VO pre-claim reviews.

Response #14:

While the law previously required OMIG and the Department to jointly develop a list of Verification Organizations, the law did not explicitly state that OMIG was required to send providers and fiscal intermediaries notification that they met the Verification Organizations requirement. It should be noted that it is the responsibility of the Medicaid provider to determine if they met or continued to meet the requirements set forth in statute.

State Comptroller's Comment – OMIG is mistaken. DOH's EVV Manual states, "Only providers who receive notification from OMIG are required to have their services verified by a VO." The EVV Manual further states that OMIG will notify providers by "certified letter." There are many requirements that providers must follow, and DOH and OMIG have a responsibility to ensure providers comply.

There was an overlap in roles between the Verification Organizations and Electronic Visit Verification which caused confusion in the provider community. Verification Organizations and Electronic Visit Verification were created to facilitate verification of certain home care services provided to Medicaid members. The Verification Organizations requirement only applied to providers and fiscal intermediaries reimbursed $15 million or more in Medicaid and/or Medicaid Managed Care funded services and applied to qualifying personal care and home health care services. However, the federally required Electronic Visit Verification program is a more robust system which allows the comparison of all Medicaid home care claims in NYS.

One of the initial goals of the Verification Organizations program was to compare conflicting services, captured by their verification system, to Medicaid and Managed Care billed services. Unfortunately, the enrollment of multiple Verification Organizations created silos of data and information. Key data points were not available in the Verification Organizations portals (like Medicaid Management Information System Identification Numbers for recipients, providers, and fiscal intermediaries). Verification Organizations often listed recipients and providers and fiscal intermediaries only by name. The data was not standardized across portals for comparison, such as for identifying and comparing caregivers. It was challenging to compare providers' and fiscal intermediaries' Electronic Visit Verification data amongst each individual Verification Organizations enrolled vendor, and there was not enough identifying elements to accurately compare to rendered services. Therefore, upon statewide conversion to Electronic Visit Verification requirements, the decision was made to repeal the authorization of Verification Organizations.

The statewide Electronic Visit Verification system created by the Department collects all required Electronic Visit Verification data in one area with standardized file formats. This includes collecting key data elements such as recipient Medicaid Management Information System Identification Numbers for recipients, providers, and fiscal intermediaries. The statewide

Electronic Visit Verification system collected data is stored in the Medicaid Data Warehouse, which in partnership with the standardized format and key data elements, provides the capability for comparison to claims data to identify potential fraud, waste, and abuse.

The statewide Electronic Visit Verification system is also prepared to include the Unique Identifier, once implemented, for home care service workers and personal care assistants. The inclusion of the Unique Identifier on Electronic Visit Verification submissions and claims will allow OMIG to perform more enhanced reviews. The Unique Identifier will allow for pre-payment reviews by OMIG and the Managed Care Plans. The Unique Identifier would allow staff to perform data analysis using the following criteria to identify outliers:

- the total hours worked per caregiver,
- the number of agencies or Fiscal Intermediaries submitting billing for that caregiver,
- the location of services,
- the eligibility status of a caregiver,
- the number of recipients per caregiver, and ultimately,
- uncovering unusual or impossible billing patterns.

Upon the implementation of the Unique Identifier, OMIG would commence pre-payment reviews to identify conflicts (i.e., the same caregiver being listed on claims for overlapping timeframes or same time/different location, missing identifier, etc.), which would give the provider and fiscal intermediary the opportunity to correct and resubmit the claim.

The Department's implementation of the statewide Electronic Visit Verification system and the addition of the Unique Identifier have greater capabilities to realize the intended goal of the Verification Organizations program.

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