New York State Medical Assistance Requirements
Home Health Providers and Verification Organizations

<u>Background</u>

This document is meant to serve as an overview for providers of Home Health services to the New York State (NYS) Medical Assistance (Medicaid) program which are subject to the Verification Organization (VO) requirements outlined in Chapter 59 of the Laws of 2011 as amended in 2014 (see attachment 1). In addition, the document provides guidance on how participating providers are determined, the role of the VO, and details the requirements participating providers and their VO vendor must meet.

Should you have any questions regarding this document, please contact OMIG at vo@omig.ny.gov.

.

Providers Meeting Statutory Threshold

<u>The statute states that a participating pr</u>ovider is a certified home health agency, long term home health agency or personal care provider with total Medicaid reimbursements including reimbursements through the Medicaid managed care program exceeding fifteen million dollars ($15,000,000) per calendar year.

To assist the Medicaid provider community, OMIG will develop a list of participating providers required to contract with a VO. As billing practices can change, this list will be updated on an annual basis and made available to the participating provider community annually. However, it should be noted that the ultimate responsibility in determining if a provider meets, or continues to meet, the requirements set forth in the statute lies with the Medicaid provider. If you have any questions regarding your eligibility for this program, please contact OMIG at (518) 402-0045.

In accordance with the statute, participating providers are required to contract with a VO vendor which uses electronic means including but not limited to contemporaneous telephone verification or contemporaneous verified electronic data to verify whether a service or item was provided to an eligible Medicaid recipient. It is not a requirement that the VO and Electronic Visit Verification (EVV) is the same vendor. The EVV vendor is not required to enroll in the Medicaid system while the VO is required to enroll as a Medicaid Service Bureau, COS 0080 with VO designation of COS 0039.
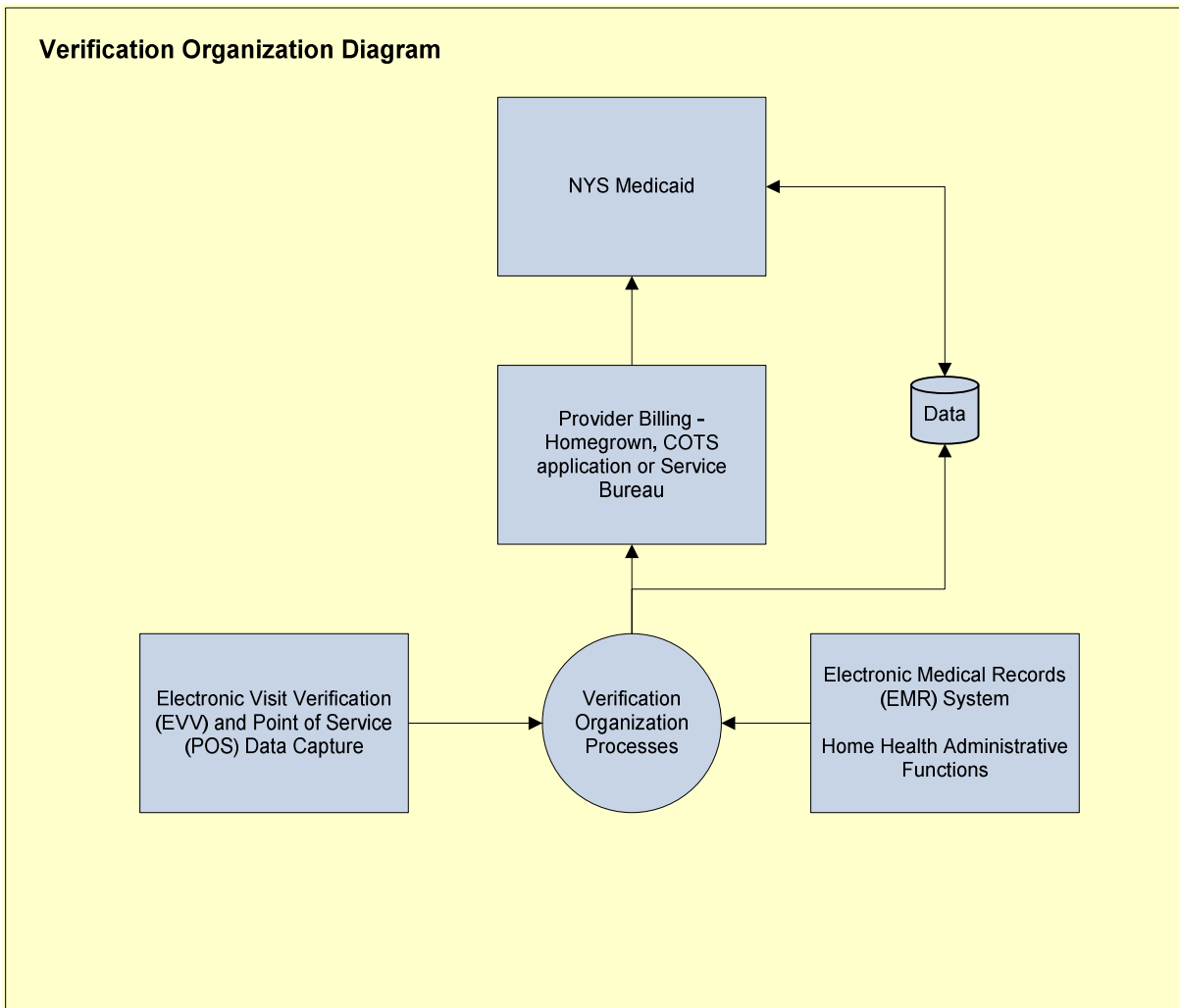
Defining the Verification Organization

<u>In New York State (NYS), especially in N</u>ew York City (NYC), many providers are familiar with EVV technology. For a number of years, NYC Human Resources Administration (HRA) stipulated the use of this technology for Medicaid Personal Care Level 2 providers. Though EVV is an important component for meeting the requirements of a VO, there are a number of key components beyond what's currently mandated (in NYC) for provision of personal care services. The diagram below gives an overview of the main components which a VO must ensure are in place for each provider installation.

A VO is an entity that uses data captured by EVV software to verify whether a service, or item, was provided to an eligible Medicaid beneficiary across all their participating providers.

EVV is an electronic means used to capture the services provided to a Medicaid beneficiary at the point of service.

Verification Organization Diagram

Electronic Visit Verification (EVV) and Point of Service (POS) Data Capture is meant to illustrate the controls and data gathering which occur at the point of service – the home of the Medicaid recipient. This data includes the identity of the recipient, the identity of the individual providing services and the date, time, duration, location and type of services being delivered. Critical to this gathering is the additional capacity to ensure the presence of the care provider at the patient's home by using technologies such as telephony or GPS.

Electronic Medical Records (EMR) System and Home Health Administrative Functions illustrates central office functions and tracking, including, but not limited to, scheduling, recipient records and duty rosters. This component must be integrated with the VO's pre-billing checks in order to meet a number of the program's requirements.

Provider Billing illustrates the function where a provider's software or its agent (which can be the same VO) prepares claims and sends them to the Medicaid claims system. A VO must ensure and attest to a complete integration such that only claims which have passed all requirements can be billed to the NYS Medicaid Program.

Data illustrates the need for one or more data stores to enable the collection of the data from the various components and to store the results of processing, any exceptions and the tracking of any resolution steps. Note that the diagram shows a single provider instance. In reality, there will be as many data stores as there are VOs. Though not an initial requirement, OMIG will be working with DOH and VO's to develop protocols and processes to aggregate the data in the Medicaid Data Warehouse.

Verification Organization Processes illustrates the role of the VO in comparing the information from POS Data Capture with the information from the Administrative Functions and only allowing billing to occur when there are no exceptions or, any which may have existed have been successfully corrected.

While it is required that a participating provider contracts with a VO, a participating provider is not required to utilize the VO's EVV product line for all outlined requirements. What is essential is that the VO ensures that all components are in place for a participating provider installation and the VO must attest to their proper integration and that all requirements have been met.

Requirements for Verification Organizations

A detailed list of VO requirements can be found later in this document.

If a VO will be submitting claims on behalf of a participating provider, the VO will be required to obtain an Electronic Transmitter Identification Number (ETIN) from the Medicaid Claims processing vendor. The application for the Service Bureau/VO ETIN can be found at: https://www.emedny.org/info/providerenrollment/allforms.aspx. Providers must select the "Service Bureau Electronic/Paper Transmitter Identification Number (ETIN)" application.

Additionally, each participating provider that intends to have a VO submit claims on their behalf must complete a "Certification Statement/Instruction for Existing ETIN" form. This form can be found at: https://www.emedny.org/info/providerenrollment/allforms.aspx.

New York State Medical Assistance Requirements
Home Health Providers and Verification Organizations

Attachment 1:   Home Health Exception Reporting Statute
         Bold add to denote revisions to Laws of 2011

Paragraph f of Subsection 38 of §2 of the Social Services Law:
(f) "Verification organization" means an entity, operating in a manner consistent with applicable federal and state confidentiality and privacy laws and regulations, which uses electronic means including but not limited to contemporaneous telephone verification or contemporaneous verified electronic data to verify whether a service or item was provided to an eligible medicaid recipient. For each service or item the verification organization shall capture:
(i) the identity of the individual providing services or items to the medicaid recipient;
(ii) the identity of the medicaid recipient; and
(iii) the date, time, duration, location and type of service or item.

A list of verification organizations shall be jointly developed by the department of health and the office of the medicaid inspector general.

(g) "Exception report" means an electronic report containing all the data fields in paragraph (f) of this subdivision for conflicts between services or items on the basis of the identity of the person providing the service or item to the medicaid recipient, the identity of the medicaid recipient, and/or time, date, duration or location of service;

(h) "Conflict report" means an electronic report containing all of the data fields in paragraph (f) of this subdivision detailing incongruities in services or items between scheduling and/or location of service when compared to a duty roster.

(i) "Participating provider" means a certified home health agency, long term home health agency or personal care provider with total medicaid reimbursements, **including reimbursements through the managed care program established pursuant to section three hundred sixty-four-j of this chapter,** exceeding fifteen million dollars per calendar year.

§363-e*2 of the Social Services Law:
§ 363-e. Preclaim review for participating providers of medical assistance program services and items. **The department of health and the office of the Medicaid inspector general shall jointly develop requirements for preclaim review.** Every service or item within a claim **or encounter** submitted by a participating provider shall be reviewed and verified by a verification organization prior to submission of a claim **or encounter** to the department of health **or to a managed care provider as defined in paragraph (b) of subdivision one of section three hundred sixty-four-j of this title.** The verification organization shall declare each service or item to be verified or unverified. Each participating provider shall receive and maintain reports from the verification organization which shall contain data on:

1. verified services or items, including whether a service appeared on a conflict or exception report before verification and how that conflict or exception was resolved; and
2. services or items that were not verified, including conflict and exception report data for these services.

New York State Medical Assistance Requirements
Home Health Providers and Verification Organizations

Requirements for Verification Organizations

1. A VO does not need to provide each of the components outlined in the Verification Organization Diagram. In fact, the only absolute function that a VO must provide are those pictured as Verification Organization Processes. However, it is the VO's responsibility to ensure that all of the functions exist, and meet all of the requirements described herein. For each participating provider that employs the services of the VO, the VO must review and attest to the requirements being met in that particular implementation.

2. A VO must ensure that EVV is employed and all resulting data is collected and stored in a VO provider neutral repository which can be accessed by DOH, the OMIG and their respective agents.

3. A VO must ensure that all employed EVV systems validate that all caregivers are properly registered, credentialed and matched against exclusion and sanction lists.

4. A VO must ensure that all employed EVV systems validate that the recipient has proper authorization, both for enrollment and any utilization limits, that the service scheduled is consistent with the plan of care and has had proper authorization and sign off.

5. A VO must ensure that all employed EVV systems have all required system compliance checks and edits, checks and edits are properly working and cannot be altered or bypassed by the provider.

6. A VO must ensure that a claim cannot be submitted when an exception and/or conflict exists. The VO must ensure that the exception and/or conflict have been resolved before claim submission.

7. A VO must track all exception resolutions and at a minimum, must capture the identity of the individual attesting to the resolution and capture an explanation for why the exception occurred and why it is a legitimate claim for Medicaid reimbursed services.

8. Where a provider uses a sub-contractor for Home Care Aide (HCA)/Personal Care Aide (PCA) staffing, the sub-contractor's employees must use EVV (provided by the provider or the contractor). If the sub-contractor's EVV system is used, the sub-contractor's EVV data must be used and integrated with the VO's process to ensure that required edits and checks are performed.

9. Where a claim is billed in time units, and where the duration of the visit is captured electronically, the billed duration must not exceed the duration of the service as indicated by the electronic time stamps.

10. The VO must be able to identify any instances of caregiver location conflicts (caregiver is at two locations at the same time) across its entire customer base prior to any claim submission.

11. The VO must perform an export of data to NYS, sufficient for NYS to retroactively perform analysis to identify any instances of caregiver location conflicts across VOs. The exact format and transport mechanism can be worked out between the VO and NYS. It is expected that the first transfer will be batch; however, the long term goal is to provide a messaging transfer to the NYS Data Warehouse in as close to real time as possible.

12. VOs must enroll in NYS Medicaid as Service Bureau with a special designation as a VO.

13. VOs must use their own ETIN and include the ETIN on any Medicaid claim when submitting claims on behalf of a participating provider.

14. A VO must ensure that the EVV system(s) validates each visit that occurs is scheduled.

15. A VO must ensure that the EVV system(s) creates an exception when a scheduled visit does not have a matching visit.

16. A VO must ensure that the EVV system(s) creates an exception for late/missed visits.

17. A VO must ensure that the EVV system(s) creates an exception when visit duration exceeds the authorized scheduled duration.

18. For each participating provider EVV installation, the VO must file a compliance summary upon EVV installation and yearly thereafter. The VO must attest to the installation of an EVV system, that the EVV is functioning properly, that all system requirements are being met and the EVV will be maintained as a condition to submit claims as a participating provider.

19. Chapter 59 of the LAWS of 2011 as amended in 2014 was developed to assist in ensuring participating provider claims are being accurately reported. A VO validating Medicaid claims is essential to an independent verification and, in some cases, submission of claims on behalf of participating providers. As this is vital to an objective verification of Medicaid claims, a VO may not perform VO services for any participating provider rendering services to a Medicaid beneficiary where the VO has a controlling interest, is the owner or is in any way affiliated with that provider.

20. VO's must provide electronic reports including "trending analysis" across their entire Medicaid participating provider customer base. These reports, at a minimum, should provide the capability to trend by participating provider, caregiver, and the individual authorized to validate that a service was provided when an exception or conflict is identified by EVV.

21. At present HHA and PCA are the only required verifiable services. Participating providers and VO's are encouraged to work toward including EVV for all services as a best practice.