OHIO AUDITOR OF STATE
KEITH FABER

Ohio Department of Medicaid

ELECTRONIC VISIT VERIFICATION

Auditor of State Report

November 2024

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OHIO AUDITOR OF STATE
KEITH FABER

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Letter from the Auditor

To the Governor's Office, General Assembly, Director and Staff of the Ohio Department of Medicaid, Ohio Taxpayers and Interested Citizens:

Congress passed the 21st Century Cures Act (the Act) in 2016, and amended it in 2018 to extend compliance deadlines, to address vulnerabilities for fraud, waste and abuse in home health services. Section 12006(a) of the Act required states to implement an Electronic Visit Verification (EVV) system to verify Personal Care Services (PCS) by January 1, 2020, and Home Health Care Services (HHCS), by January 1, 2023. The Ohio Department of Medicaid (the Department) began a three-phase implementation of EVV in 2018 and completed the process in 2021.

Pursuant to Ohio Rev. Code §117.11, we conducted this audit in the public interest to assess the Department's compliance with implementation of the Act's EVV requirements by analyzing EVV data for the period January 1, 2022, through December 31, 2022, to determine whether payments for services were supported by EVV data and to identify barriers to the use of EVV for data pre-payment or post-payment.

The audit found that EVV was utilized for 44 percent of provider paid PCS and HHCS claims in 2022. Stakeholders indicate low compliance rates will continue until there is more of an incentive such as EVV data being required to be submitted as a condition of payment. Ohio spent approximately $2 billion for personal care and home health care services in 2022. Ohio is one of 34 states that did not require an EVV data match for claims paid prior to the December 31, 2022. Also, the Department spent approximately $146 million to design, implement, test, and support the EVV system. This audit report contains recommendations, supported by a detailed analysis and feedback from stakeholders. This report has been provided to the Department and its contents have been discussed with the appropriate staff and leadership within the Department. It is the Auditor's hope that the Department will use the results of this audit as a resource for future changes to its EVV system.

This audit report can be accessed by visiting the Auditor of State's website at OhioAuditor.gov and choosing the "Search" option.

Sincerely,

Keith Faber
Auditor of State
Columbus, Ohio

November 1, 2024

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EXECUTIVE SUMMARY

Home health care services reimbursed through the Medicaid program have been identified as high risk for fraud, waste, and abuse. Nationwide investigations completed by the HHS-OIG for the period 2011 to 2015 over home health services resulted in $975 million in Medicare recovered funds[1]. These earlier reports (dating back to 2006) raised concerns about fraud, waste, and abuse in Medicaid-funded Personal Care Services (PCS) and culminated in a 2016 HHS OIG investigative advisory recommending the Centers for Medicare and Medicaid (CMS) issue regulations to "more fully and effectively use its authorities to improve oversight and monitoring of PCS programs across all states."[2]

Section 12006(a) of the 21st Century Cures Act (the Act) mandates that states implement Electronic Visit Verification (EVV) for all Medicaid PCS and Home Health Care Services (HHCS) that require an in-home visit by a provider. This applies to PCS provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and Section 1115; and HHCS provided under 1905(a)(7) of the Social Security Act or under a waiver. Otherwise, the state is subject to incremental Federal Medicaid Assistance Percentage (FMAP) reductions up to 1% unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays."

Pursuant to Ohio Rev. Code §117.11, we conducted this audit in the public interest to assess the Ohio Department of Medicaid's (the Department) compliance with the implementation of the Act's EVV requirements. As part of this audit, we analyzed EVV data for the period January 1, 2022, through December 31, 2022, the most recent full year data available, to determine whether payments for services were supported by EVV data and to identify barriers to the use of EVV data pre-payment or post-payment. During the audit period, approximately $2 billion in paid claims were processed which should have been matched to an EVV visit. The audit found that EVV was utilized for 44 percent of provider paid PCS and HHCS claims in 2022. Ohio is one of 34 states that did not require EVV data as a condition of payment prior to December 31, 2022. The following factors may have attributed to the low compliance:

- Lack of an incentive by providers to enter EVV data as it was not required as a condition of payment;
- the administrative burden related to the matching process between EVV, claims data, and manual adjustments; and
- reluctance by beneficiaries to participate in EVV due to privacy concerns or a general misunderstanding of EVV.

In addition, the Department spent approximately $146 million to design, implement, test, and support the EVV system. We selected a sample of 100 providers including home health care agencies, non-agency nurses and non-agency personal care aides. For each provider selected, we compared the number of paid services by procedure code to the number of EVV processed[3] visits in calendar year 2022 to determine the percent of services paid but not processed in EVV.

We found that approximately 56 percent of all services paid were not processed in the EVV system indicating the paid services were not matched to a verified EVV entry. The non-agency personal care aides had the highest percent of paid services without a matching processed visit at 62 percent.

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[1] The HHS-OIG report entitled, *Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases,* by Thomas Komaniecki, Regional Inspector General for Evaluation and Inspections, June 2016 (OEI-05-16-00031) is available at Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases.

[2]University of California San Francisco Health Workforce Research Center on Long-Term Care report entitled, *Impact of Electronic Visit Verification (EVV) on Personal Care Services Workers and Consumers in the United States,* by Jacqueline Miller, Mary Lou Breslin, and Susan Chapman, RN, PhD, July 2021 is available at UCSF Health Workforce study.

[3] A processed visit is when an EVV visit has been matched to a claim.

We found that 37 of the 100 providers in our sample did not submit any EVV data at all. We also found that approximately 34 percent of all EVV entries were manually adjusted.

Based on our sample results, more than 56% of PCS and HHCS services were paid without a matching EVV entry during our audit period.

Based on our analysis and feedback from stakeholders, we recommend that the Department:

- Communicate with beneficiaries to address common misconceptions about EVV and consider if reconvening the Stakeholder Advisory Group or similar committees to ensure beneficiaries and providers have an opportunity to provide input and feedback;
- Create a statewide scorecard to be shared among all EVV stakeholders to improve reporting on the effectiveness of the EVV system;
- Evaluate its implementation plan and timeline for requiring EVV as a condition of payment for all required services and take into account feedback from the various stakeholders. The Department should consider establishing a standard for percentage of auto-verified EVV data matches that providers must achieve. The Department should also proactively reach out to non-compliant providers to offer technical assistance and additional training.

BACKGROUND

21st Century Cures Act

The 21st Century Cures Act (the Act) was passed to address vulnerabilities of fraud, waste and abuse in home health care services; therefore, requiring states to implement an EVV system for Medicaid personal care services (PCS)[4] and home health care services (HHCS)[5] that require an in-home visit by a provider.

The Congressional Budget Office projected EVV would save an estimated $290 million over a 10-year period once fully implemented. Section 12006 of the Act requires that an EVV system must be implemented by January 1, 2019, for PCS and January 1, 2023, for HHCS[6].

The EVV system in place must be able to electronically verify the following:

- The individual receiving the service;
- the individual providing the service;
- type of service performed;
- date of service;
- location of the service; and
- the time the service begins and ends.

[4] The definition of PCS services is not uniform across all the authorities which it can be covered as a Medicaid benefit, but generally consists of services supporting activities of daily living (ADL), such as movement, bathing, dressing, toileting, personal hygiene, meal preparation, money management, shopping and telephone use.

[5] The Medicaid home health benefit is defined through federal regulation and includes (a) nursing services, (b) home health aide services, (c) medical supplies, equipment, and appliances. At the state's option, the benefit may also include physical therapy, occupational therapy, speech pathology and audiology services. Note: home health services are not subject to EVV if no in-home visit was required (i.e. medical supplies delivered through the mail).

[6] The federal authorization for the types of service required in EVV are Section 1905(a)(7) for home health services and Section 1915(c) for home and community-based services (HCBS) waiver program.

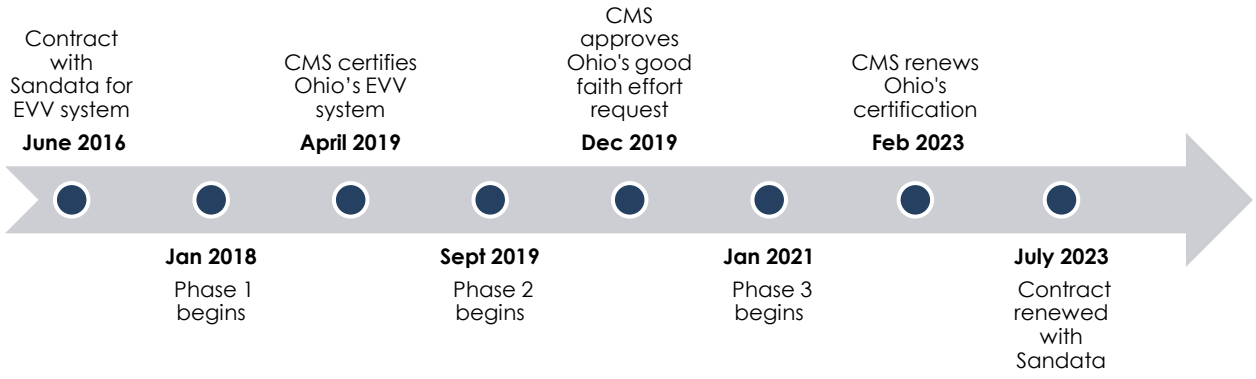
Section 12006 also indicates states should consult with providers/agencies in order to ensure requirements for EVV are minimally burdensome. States should consider current best practices or existing systems adhere to privacy and security guidelines[7], gather stakeholder input from beneficiaries and those providing services, and ensure those providing services have opportunities for training on the new system put in place. A failure to comply would result in a decrease in Federal Medical Assistance Percentage (FMAP) rate. Section 12006 specifies there is no particular or uniform electronic visit system required, giving states the flexibility in developing and implementing EVV systems to meet compliance requirements.

Ohio's Implementation of EVV

The development of Ohio's EVV system began in January 2016 when Sandata Technologies (Sandata) responded to a Request for Competitive Sealed Proposal (RFP) to develop an EVV service and training system. On June 30, 2016, the Department contracted with Sandata as the EVV vendor for the State of Ohio. The Department selected both a provider choice model and state mandated external vendor model for EVV. The provider choice model (or alternative EVV model) allows agencies to select their vendor of choice and self-fund EVV implementation. In the state mandated external vendor model, the Department contracted with Sandata to implement a single EVV solution. In addition, the Department formed the EVV Stakeholder Advisory Group to solicit input regarding the Ohio Medicaid EVV Project. Participation included individuals, advocacy organizations, providers, trade associations, Medicaid managed care plans and other state agencies. The group met regularly through 2021 to address issues related to the EVV implementation.

The Department's EVV implementation for PCS and HHCS began in 2018 and it self-reported[8] their EVV implementation status as fully compliant in 2021. The following timeline details the dates and steps associated with Ohio's EVV implementation:

EVV Implementation Timeline



The implementation of Phase 1 began in January 2018 and coincided with the codification of Ohio Admin. Code 5160-1-40. This rule requires providers to utilize EVV for the following services reimbursed by the Department through fee-for-service (FFS): home health nursing, home health aide, private duty nursing, registered nurse assessments and Ohio Home Care waiver nursing, personal care aide and home care attendant services. The Centers for Medicare & Medicaid Services (CMS) certified Ohio's EVV system in April 2019 based on the Department's EVV Compliance Survey submission outcome statements, meeting

[7] HIPPA privacy and security law as defined in section 83009 of The Public Health Service Act.
[8] States and territories were required to self-report their EVV implementation status using a web-based survey, which the Centers for Medicare & Medicaid Services (CMS) used to determine compliance with the EVV requirements.

five key performance indicators (KPIs[9]), and other evaluation criteria such as system functionality. The Department implemented Phase 2 in September 2019 and mandated providers enter managed care[10], MyCare Ohio waiver, PASSPORT[11] waiver nursing, PCS, home care attendant services, Ohio Department of Developmental Disabilities (DODD)[12] waiver homemaker personal care, and nursing services in EVV. In December 2019 CMS approved Ohio's good faith effort exemption request and determined Ohio encountered unavoidable delays.

The Department self-reported it was fully compliant with EVV requirements for PCS and CMS acknowledged their compliance in January 2021. At the same time, the Department also began implementation for Phase 3 requiring providers to utilize EVV for participant directed services and home health therapies to utilize the EVV system. Based on the Department's attestation, CMS acknowledged in February 2023 that Ohio's certification meets EVV requirements of the Act for home health and Home and Community Based Services (HCBS) waiver services.

The Department entered into contracts and amendments (as needed) from state fiscal year 2016 through 2022 totaling approximately $174 million. The table below shows Ohio's payments to Sandata from calendar year 2016 through 2022.

Total Payments to Sandata	
Calendar Year	**Amount Paid**
2016	$735,632
2017	$9,244,709
2018	$22,703,089
2019	$21,642,625
2020	$31,612,477
2021	$31,231,154
2022	$28,928,499
Total	**$146,098,185**

The Department's contract with Sandata includes the following components and requirements for training and support:

- Mobile Visit Verification: global positioning system (GPS) mobile application installed on the GPS device that captures visit data. This mobile application can be downloaded onto a Sandata-provided device, a caregiver owned device, or a beneficiary owned device to submit visits to the EVV system;

[9] The five KPIs include association of EVV record to claims/encounter; EVV record match against approved services, providers and units; EVV records without manual edits; EVV system availability; EVV privacy and security.
[10] Medicaid managed care entities (MCE) provide healthcare benefits to individuals enrolled in Ohio's Medicaid program. Individuals chose a managed care plan to manage benefits.
[11] Ohio's PASSPORT (Pre-Admission Screening Providing Options and Resource Today) program helps Medicaid-eligible older Ohioans get the long-term services and supports they need to stay in their homes or other community settings, rather than enter nursing homes.
[12] Ohio Department of Developmental Disabilities (DODD) oversees a statewide system of supportive services that focus on ensuring health and safety, supporting access to community participation, and increasing opportunities for meaningful employment.

- Telephonic Visit Verification: For individuals unable to record visit data on the GPS device, they can use a home phone to record visit data, and will include a voice recording for individual verification of services received;
- Provider Portal: Providers can use this portal to make corrections to visit data;
- EVV Aggregator: The aggregator collects data in near real-time from all approved systems, in addition to receiving claims data. It also includes a notification program for alerts;
- Aggregator Portal: This portal allows providers, the Department and third parties to view visit data;
- Claims Exchange: Provides near real time connectivity to the claims adjudication process for providers and the Department to show if claims have properly verified visits identified and are acceptable to be paid. Managed Care Entities (MCE) can also integrate with the exchange to validate claims before paying;
- Jurisdictional View: Gives the Department and MCEs the capability to run reports on visit data collected in the system;
- GPS Device: The contract recommends a smart phone as the primary data collection device in the home of each individual receiving services subject to EVV; and
- Training and Support: The Sandata contract requires the contractor to train users on an on-going basis and provide 24-7 technical support via telephone and on-line.

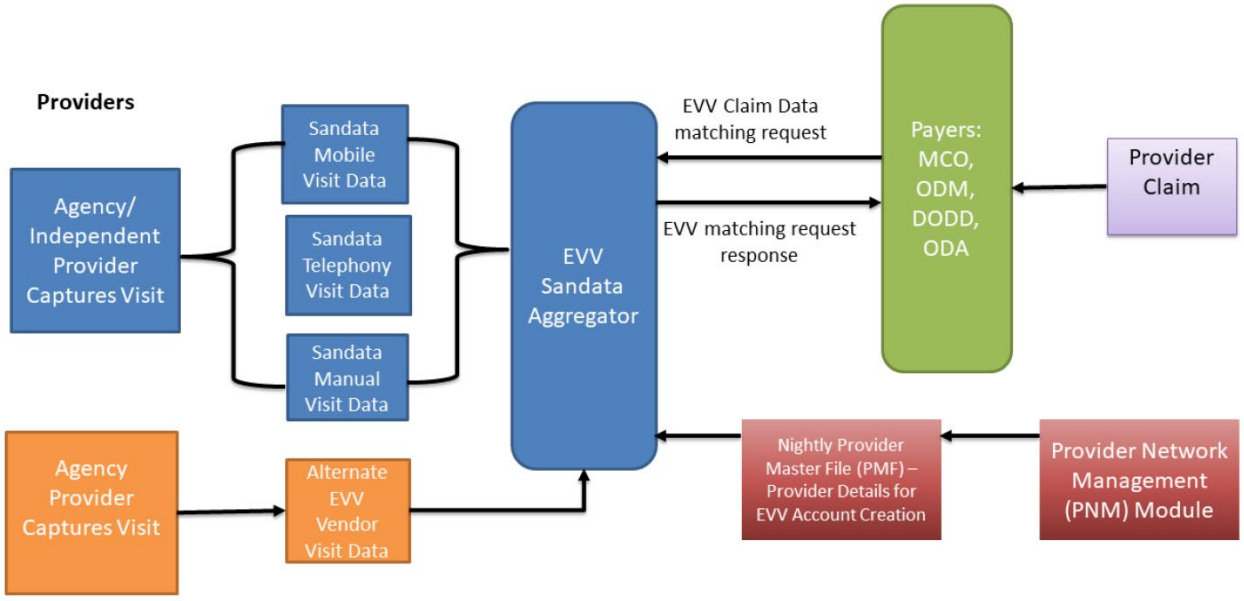
The Department requires EVV for both agency and non-agency providers. Along with the Sandata components that include mobile application and telephony system, agency providers also can elect to use an alternative EVV system to capture visit data. Providers also have the ability to enter and adjust visits manually from a computer within the Sandata EVV system. The Department's policy allows for manual visit entry only in the event verification through a device with an application or telephony is not available or appropriate based on the immediate needs of the individual and is not to be used for routine visit verification. All providers subject to EVV services are required to complete overview and security training modules by a representative of an agency or non-agency providers prior to receiving log-in credentials. The Department provides training modules for specific functionality and additional training resources such as fact sheets, reference guides, and webinars.

The Department's contract with the MCEs require utilization of the EVV system and that claims are validated against EVV data. MCEs must inform providers of how they will use data collected from the system and provide appropriate assistance to providers along with direct caregivers. The MCEs are also responsible for reviewing the monthly visit report identifying any trends, providing outreach and education to providers and identifying fraud, waste, and abuse as necessary.

Visit Processing and Claim Match Flowchart

The chart below describes the EVV process based on Sandata and on an alternate EVV system:

Source: Ohio Department of Medicaid's website



The agency and non-agency home health providers use the Sandata or Alternate EVV system to capture the visit using one of the allowable submission methods which flows into the EVV Sandata Aggregator[13]. The provider sends the claim to the payor source (MCE, the Department, DODD, or Ohio Department of Aging (ODA)) and a data matching request is sent to the aggregator for verification against EVV data. The five data elements used for matching are: date of service; payer, program, service provided; billing provider; recipient; and units[14]. A visit is processed when there is a successful match between an EVV visit record and the claim. The system categorizes a visit as verified, incomplete, or omitted. A visit is verified if the five data elements are present but there is not yet a successful match with the claims record, incomplete if there are exceptions with the five data elements that must be corrected before submitting the claim, and omitted means the service has been marked do not bill.

Monitoring of EVV is a collaborative process between the Department, Sandata, MCEs, CMS, providers, and stakeholders. The Department monitors dashboards and meets with Sandata on a regular basis to review visit data and provider utilization. An example of a data element which can be monitored includes reviewing manual adjustments of start and ending times, which could indicate the times do not reflect actual times services were rendered. CMS requires quarterly submission of five KPIs.

Recent Rule and Program Changes

Effective July 1, 2024, the Department instituted key policy changes and separated the comprehensive rule into four focused rules under Ohio Admin. Code 5160-32-01 through 5160-32-04. These changes were to increase privacy and security for individuals, reduce the administrative burden on providers and align with federal requirements. Key changes include:

- GPS functionality may only be used after obtaining the signed consent of individuals receiving the service.

[13] The Provider Network Management (PNM) Module Nightly Provider Master File (PMF): the PNM is system used as of October 1, 2022, to access data for enrolled Ohio Medicaid providers or to apply as a newly enrolled Medicaid provider; The PMF is a file generated from PNM containing information on provider enrollment.
[14] The Act requires states to capture the place where services are delivered. The Department uses GPS to record the location at the start and end of the visit only.

- Direct care workers who reside in the same household as the individual receiving services are exempt from EVV requirements upon approval.
- EVV devices will no longer be kept in the home of the person receiving services. EVV devices will be sent directly to providers, and they are responsible for maintenance and distributing to care workers.
- The person receiving the service is no longer required to validate the visit via a signature.

The Department is continuing to evaluate when the first phase of the claims adjudication process with home health service claims billed through the State Plan for FFS will commence. If the claim information submitted does not match a verified EVV visit record, claims may be denied, or a post payment review penalty levied. The Department will continue to phase in additional services to the claims adjudication process after communicating with effected providers at least three months in advance as required by Ohio Admin. Code 5160-32-02.

Feedback from Providers and Stakeholders

We interviewed four agency providers, one non-agency nurse, one non-agency personal care aide, five MCEs and two trade associations to gain an understanding of their experience with the Sandata Aggregator (or alternate EVV system), utilization of EVV, barriers to the use of EVV, and utilization of training and online resources.

Interview Results

Electronic Visit Verification System

All four agency providers interviewed indicated the interface between their alternative EVV system and Sandata creates downtime for staff. Specifically, one agency provider indicated downtime is created due to the time it takes Sandata to populate the data entered from the alternative EVV system.

Utilization of EVV

Based on information received from the agency providers, the average EVV utilization was approximately 77 percent, ranging from approximately 60 percent to approximately 100 percent. The non-agency nurse indicated an EVV utilization rate of 30 to 40 percent and the non-agency personal care aide did not provide a utilization rate.

As a result of these interviews, the following reasons for low EVV utilization were discussed:

- The claim should be assessed for accuracy and completeness prior to payment.
- Providers should not be allowed to enter visits after a claim has been submitted or make manual adjustments to visits as part of the reconciliation process with Sandata.
- This results in an ineffective use of administrative time adjusting the claims or visit data.

Additionally, one trade association indicated that when payment is not dependent upon accurate EVV visit data, this results in confusion among providers concerning compliance with EVV. There may be inconsistency among provider compliance with EVV, with compliant providers unfairly penalized because they are using additional resources to become compliant, while there are no consequences to providers who are not compliant with EVV.

Barriers
Three of four home health agencies[15] and both non-agency providers stated that internet connection issues are a barrier to fully utilizing EVV. Poor internet connection results in additional time logging in and out of EVV, and staff re-entering visit information.

Education and Training
One agency provider and two trade associations remarked that additional education and outreach would be helpful. The agency indicated that educating recipients via a video or other means with tailored content for a rural population would be beneficial. The tailored content should emphasize EVV is mandatory and highlight why utilizing the system is important.

Work Groups and Communication
Both trade associations indicated regular meetings and sharing more information with providers and stakeholders would be beneficial. In addition to sending letters to passively obtain feedback from providers, directly meeting with providers was suggested as one way for the Department to gain a better understanding of the impact of EVV on provider operations. One trade association indicated that the advisory work group no longer meets; therefore, there is not a clear way to bring up issues. A trade association did indicate the Department has recently been more responsive to receiving feedback from stakeholders. Clearly communicating any changes to rules and policies regarding EVV and explaining why changes are made would increase acceptance by agency staff and non-agency providers, potentially increasing utilization of the EVV system and accuracy of EVV data.

Monitoring
One trade association suggested a statewide scorecard could use data to improve EVV reporting on the effectiveness of the EVV system. The scorecard could show EVV utilization and accuracy of claims matching so providers are informed of compliance with EVV. One MCE utilizes a dashboard in a similar way stating that it allowed them to give personalized feedback to providers and identifying anomalies in the data to better educate providers.

Best Practices from Arizona

We interviewed representatives from Arizona's Medicaid Agency (Arizona Health Care Cost Containment system (AHCCCS)) to identify best practices for EVV implementation. Some of their challenges prior to implementing prepayment review to match to an EVV entry included alternative systems not communicating with the aggregator and nonparticipation of providers. In addition, a difficulty was encountered in ensuring all codes and modifiers were in the system correctly to calculate payment, particularly codes paid on a per-diem or per visit basis.

AHCCCS recommended providers should prepare at least six months in advance to ensure preparedness for prepayment match to a verified EVV entry. Providers should also perform visit maintenance to correct any errors such as inaccurately entered time before claims are processed.

AHCCCS recommended the following additional practices to consider for EVV implementation:

- Prioritize responding to providers in a timely manner to address concerns;
- Build close relationships with partners including trade associations;
- Educate providers on the impact of EVV implementation;
- Develop guidance such as a billing checklist and troubleshooting guide prior to implementation of prepayment; and
- Ensure validation rules for pre-payment align with service code units of measure rules.

[15] Home health agencies are defined as provider type 16, Other Accredited Home Health Agency; type 45, Waivered Services Organization; and type 60, Medicare Certified Home Health Agency.

Analysis of Claims Paid to Verified EVV Entries

Scope and Methodology

The scope of this audit included an analysis of PCS and HHCS claims between January 1, 2022, and December 31, 2022, to determine whether payments made to the provider were supported by a verified EVV entry. During this period, home health agencies and non-agency providers were paid approximately $2 billion for services that are required to be entered in EVV[16]. See **Appendix A** for a list of the services and procedure codes required to be entered in EVV.

Data Reliability

We obtained provider paid claims data from the Medicaid database of services billed to and paid by Ohio's Medicaid program. We performed validity and integrity tests on the data including (1) testing for blank fields, (2) looking for services outside of our audit period, (3) removing providers that were not paid for any services during the audit period and (4) checking data fields for validity errors. Based on these procedures, we determined that claims data was sufficiently reliable for the purpose of this audit.

Sampling Approach

From the total population of providers, we extracted all home health agencies (provider types 16, 45 and 60), non-agency personal care aides (provider type 25) and non-agency nurses (provider type 38) into separate files. We selected a random sample of 100 providers. The table below details the sample from each of the three subpopulations.

Sample Summary

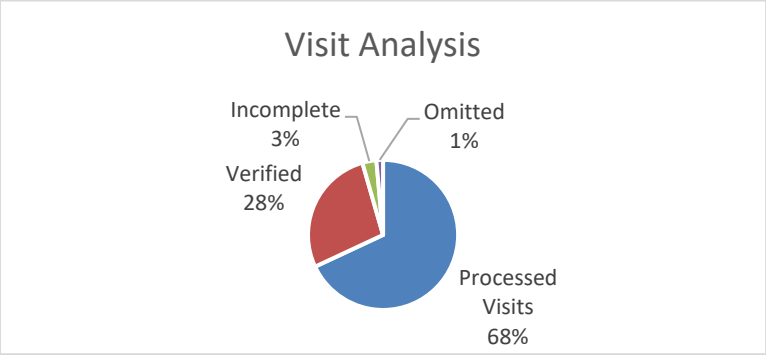
Provider Type	Number of Providers Sampled	Number of Providers in Population	Total Provider Payments
Home Health Agencies	60	2,479	$1,789,342,222
Non-Agency Nurses	20	755	$31,268,231
Non-Agency Personal Care Aides	20	6,966	$158,206,566
Total	**100**	**10,200**	**$1,978,817,019**

[16] Based on claims data from the Medicaid Information Technology System.

Work Performed

We extracted detailed paid claims data from the Department's database for each of the 100 sampled providers. We summarized the data by procedure code for each provider. We also obtained EVV data from Sandata's EVV Aggregator[17] for each of the providers and summarized by service type.

For each provider sampled, we compared the number of services by procedure code to the number of processed EVV entries to determine the percent of paid claims that were not entered into EVV. Instances where EVV contained more processed visits than were paid, we considered the provider to be 100 percent compliant with the requirement to use EVV. We also identified the number of entries for each of the 100 sampled providers with a verified, incomplete or omitted visit status, and the number of manual entries; see the chart below for the breakdown by visit status and breakout by provider type in **Appendix C**.



Note: We found that approximately 34 percent of EVV entries were manually adjusted.

RESULTS

The following table details the results of the sample for each population:

Results			
Provider Type	**Number of Services Paid**	**EVV Processed Visits**	**Percent of Services Not Processed in EVV[18]**
Home Health Agencies	558,540	258,351	56%
Non-Agency Nurses	3,859	1,845	54%
Non-Agency Personal Care Aides	7,266	2,861	62%
Totals	**569,665**	**263,057**	**56%**

[17] For agencies with more than one Sandata agency number, we obtained EVV data for the provider number that was selected for the sample.

[18] DODD allows providers to roll-up their visits for each calendar day into one claim detail. Therefore, Sandata does not take into account the number of units on the DODD visits and claims when changing the visit status from Verified to Processed. In addition, the percent of processed EVV visits (68%) was adjusted to remove instances in which the number of visits exceeded the number of services in the Department's database; as a result, 56% of processed visits were not processed in the EVV system.

Approximately 56 percent[18] of claims processed selected for testing did not match an EVV visit as required during the audit period. The Department had edits in place to identify claims that were not supported by EVV visits; however, payments were not denied. This resulted in approximately $1.1 billion in claims not supported by an EVV visit. See **Appendix B** for a detailed breakdown of the estimated results by procedure code.

RECOMMENDATIONS

This report includes the following recommendations to the Department to improve the EVV process. These recommendations are limited to the results of procedures performed during this audit and may not reflect all deficiencies or weaknesses.

Recommendation 1: Communication

In our interviews we learned that some beneficiaries are reluctant to allow the provider to use an EVV device in their home for fear of privacy breaches and a general misunderstanding of its need. We recommend the Department continue to develop informational public service announcements that providers can share with beneficiaries to address common misconceptions. We also recommend the Department consider if reconvening the Stakeholder Advisory Group or similar committee is appropriate to ensure beneficiaries and providers have an opportunity to provide input and feedback. This could also include being available for more one-on-one discussions and conducting targeted training/technical assistance to ensure providers maintain compliance with laws and regulations.

Recommendation 2: Statewide EVV Scorecard

We recommend the Department consider creating a statewide scorecard to be shared among all EVV stakeholders to improve reporting on the effectiveness of the EVV system. As one trade association suggested, a statewide scorecard could be shared to show EVV utilization and the accuracy of matching as a way stakeholders and the public are informed of compliance with EVV and where EVV utilization is not meeting expectations. The process of creating a statewide scorecard could be tied into the Department's EVV monitoring processes and could be an effective tool to educate and advocate to providers on the importance of EVV utilization as the Department moves forward in implementing EVV data matches as a condition of payment. We also recommend the Department evaluate and identify how often a statewide EVV scorecard should be updated and made available to all stakeholders.

Recommendation 3: EVV Match as a Condition of Payment

As outlined under the Recent Rule and Program Changes section, feedback received from stakeholders indicates provider utilization of EVV is low because claim payments are not tied to verified EVV entry. The Department is continuing to evaluate when the first phase of the claims adjudication process with home health service claims billed through the State Plan for FFS will commence. We recommend the Department continue to evaluate the implementation plan and timeline for requiring EVV as a condition of payment for all required services. This plan should include feedback/input from the various stakeholders over the amount of time before and during the initial claims denial effective date to allow technical assistance and a smooth transition.

In addition, the Department should consider establishing a standard for percentage of auto-verified EVV data matches that providers must achieve. The Department should proactively reach out to non-compliant providers to offer technical assistance and additional training.

Conclusion

The Department provided a response to the results of this audit which can be found in Appendix D. In its response, the Department indicated that "that throughout the report, the term "home health agency" seems to be used in a way that is inconsistent with typical program usage. The term "home health agency" is most often used for agencies that deliver care through the state plan home health service. In the report, home health agency is used to include what is often referred to as a "waiver agency." This difference could cause confusion for providers and individuals." We updated our report to define the term "home health agencies" which includes type 45, waivered services organization.

We reviewed the Department's response and except as noted above, made no additional changes, and maintain that our results and recommendations are valid.

Appendix A: Procedure Codes Requiring EVV

The following table shows the Current Procedural Terminology (CPT) codes, and service descriptions for services required to entered in EVV.

CPT CODE	SERVICE DESCRIPTION
DD250	IOW Comp Based HPC, 15 Minutes
DD251	IOW Comp Based HPC-Staff 2,15 Minutes
DD252	IOW Comp Based HPC-Staff,15 Minutes
DD253	IOW Comp Based HPC-Staff 4,15 Minutes
DD254	IOW Comp Based HPC -Staff 5,15 Minutes
DD255	L1W Comp Based HPC, 15 Minutes
DD256	L1W Comp Based HPC-Staff 2,15 Minutes
DD257	L1W Comp Based HPC-Staff 3,15 Minutes
DD258	L1W Comp Based HPC-Staff 4,15 Minutes
DD259	L1W Comp Based HPC-Staff 5,15 Minutes
DD260	L1WE Comp Based HPC, 15 Minutes
DD261	L1WE Comp Based HPC-Staff 2,15 Minutes
DD262	L1WE Comp Based HPC-Staff 3,15 Minutes
DD263	L1WE Comp Based HPC-Staff 4,15 Minutes
DD264	L1WE Comp Based HPC-STAFF 5,15 Minutes
G0156	HH/Hospice Aide Svc/Hospice Settings 15 Minutes
G0299	Home Health RN Nursing 15 Minutes
G0300	Home Health LPN Nursing 15 Minutes
MR816	IOW HPC-Staff 2,15 Minute Unit
MR817	IOW HPC-Staff 3,15 Minute Unit
MR818	IOW HPC-Staff 4,15 Minute Unit
MR819	IOW HPC-Staff 5,15 Minute Unit
MR820	L1W HPC-Staff 2,15 Minute Unit
MR821	L1W HPC-Staff 3,15 Minute Unit
MR822	L1W HPC-Staff 4,15 Minute Unit
MR823	L1W HPC-Staff 5,15 Minute Unit
MR824	L1WE HPC-Staff 2,15 Minute Unit
MR825	L1WE HPC-Staff 3,15 Minute Unit
MR826	L1WE HPC-Staff 4,15 Minute Unit
MR827	L1WE HPC-Staff 5,15 MINUTE UNIT
MR940	IOW HPC, 15 Minute Unit
MR970	L1W HPC, 15 Minute Unit
MR980	L1WE HPC, 15 Minute Unit
PT530	Waiver Nursing – RN (Passport)

CPT CODE	SERVICE DESCRIPTION
PT531	Waiver Nursing – LPN (Passport)
PT624	Personal Care Service, Per 15 minutes (Passport)
PT680	Home Care Attendant– Nursing (Passport)
PT681	Home Care Attendant – Personal Care (Passport)
S5125	Attendant Care Services, Per 15 Minutes
T1000	Licensed Private Duty Nursing, 15 Minutes
T1001	RN Nursing Assessment/Evaluation
T1002	RN Services, Up to 15 Minutes
T1003	LPN/LVN Services, Up to 15 Minutes
T1019	Personal Care Service, PER 15 Minutes

Appendix B: Results by Procedure Code

The following table is detailed breakdown of the estimated results by procedure code showing the percent of services not processed in EVV.

Procedure Code	Percent of Services Not Processed in EVV[18]
MRDD	44%
G0156	48%
G0299	72%
G0300	59%
PT531	100%
PT624	49%
T1000	71%
T1001	62%
T1002	69%
T1003	44%
T1019	65%
Provider Agency Total	56%
MRDD	55%
T1019	65%
Non-Agency Aide Total	54%
MRDD	76%
T1000	39%
T1001	100%
T1002	73%
T1003	77%
T1019	100%
Non-Agency Nursing Total	62%
Grand Total	56%

Appendix C: Results by Visit Status and Provider Type

The following table represents the 100 sampled providers by visit status and provider type.

Visit Analysis						
Provider Type	**Processed**	**Verified**	**Incomplete**	**Omitted**	**Total**	**Manual**
Agency	258,351 68.4%	104,470 27.2%	11,429 3.0%	5,433 1.4%	379,683	128,413 33.8%
Non-Agency Aide	2,861 91.7%	200 6.4%	25 .8%	35 1.1%	3,121	1,109 35.5%
Non-Agency Nursing	1,845 90.3%	120 5.9%	63 3.1%	15 .7%	2,043	144 7.0%
Total	263,057 68.4%	104,790 27.2%	11,517 3.0%	5,483 1.4%	384,847	129,666

Appendix D: The Department's Response

Via Electronic Mail

November 1, 2024

Keith Faber, Auditor of State of Ohio
Attn: Samuel Long, Assistant Chief Auditor
Medicaid Contract Audit Section
65 East State Street
Columbus, OH 43215

Re: Ohio Department of Medicaid Response to Auditor of State Report on Electronic Visit Verification

Dear Auditor of State Faber:

We are in receipt of your recent public interest audit of the Ohio Department of Medicaid (ODM) Electronic Visit Verification (EVV) program. We appreciate your review of this program from its inception to its most recent full year of operation.

Since early this year, ODM has been preparing to implement EVV visit validation as a condition of payment, ensuring a thoughtful and measured approach. We are committed to implementing it with care, taking all necessary considerations into account. ODM is currently on track to begin its phased approach to the claims adjudication process on or about January 1, 2025. We are pleased that ODM's implementation plan is in alignment with your recommendations and appreciate that your insights will help us ensure a successful implementation of the next phase of the EVV program.

A significant portion of the life of this program has operated under the COVID-19 public health emergency (PHE), which limited ODM's ability and efforts to encourage provider compliance due to PHE era funding and program requirements. Also, please note that throughout the report, the term "home health agency" seems to be used in a way that is inconsistent with typical program usage. The term "home health agency" is most often used for agencies that deliver care through the state plan home health service. In the report, home health agency is used to include what is often referred to as a "waiver agency." This difference could cause confusion for providers and individuals. That said, the findings of this public interest audit do comport with the agency's experience to date, and the recommendations proposed within the audit report mirror many of ODM's current activities. To that end, ODM reports the following work, based on each of your three recommendations.

AOS Recommendation 1: Communication

In our interviews we learned that some beneficiaries are reluctant to allow the provider to use an EVV device in their home for fear of privacy breaches and a general misunderstanding of its need. We recommend the Department continue to develop informational public service announcements that providers can share with beneficiaries to address common misconceptions. We also recommend the Department consider if reconvening the Stakeholder Advisory Group or similar committee is appropriate to ensure beneficiaries and providers have an opportunity to provide input and feedback. This could also include being available for more one-on-one discussions and

conducting targeted training/technical assistance to ensure providers maintain compliance with laws and regulations.

ODM Response:

ODM agrees with the AOS recommendation related to communication. ODM has carefully considered and taken stakeholder input into account throughout the development and implementation of the EVV program. We understand the importance of the stakeholder perspective and remain committed to integrating valuable feedback into our decision-making process. In preparation for the July 2023 EVV procurement, ODM engaged in a comprehensive stakeholder engagement process. We formed the EVV Stakeholder Advisory Group to solicit input regarding the Ohio Medicaid EVV Program. This group included individuals, advocacy organizations, providers, trade associations, Medicaid managed care organizations, and other state agencies. ODM met with five small group forums to gather stakeholder feedback. The topics for the forums included "EVV and Individuals Receiving services", "Support for Providers Using EVV", "Alternate EVV Systems", "Technical Issues", and "EVV and Home Health." ODM additionally solicited feedback via the Request for Information (RFI) process, which allowed us to gather valuable insights, expertise, and data from a wide range of stakeholders. Partner state agencies and managed care entities as well as oversight entities were engaged during the process. There are several methods for stakeholders to remain actively engaged with the EVV program, which include, but are not limited to:

- Monthly EVV newsletters.
- Subscribe to one of five ODM EVV listserv mailing lists (EVV stakeholders; EVV alt vendors; EVV agency providers; EVV non-agency providers; Home- and Community-Based Waiver Programs).
- Visit the recently modernized ODM EVV website to stay up to date on program changes and announcements.
- Attend trade association meetings where the ODM EVV team is in attendance. Most recently the EVV team attended the annual conference for the Ohio council for Home Care and Hospice in September 2024.

Targeted training and technical assistance are a priority as we continuously aim to equip stakeholders with specific skills and knowledge needed for success. Training on the program and system have been offered since the initial phase 1 implementation of EVV. The following educational opportunities continue to be offered to providers:

- Online support includes system manuals with step-by-step instructions and screenshots.
- Provider training and outreach materials translated to various languages.
- Online video library.
- Monthly EVV newsletter.
- Access to slides of past monthly webinars.
- Frequently asked question and fact sheet resource documents.
- Sandata Technical Support is available to troubleshoot and answer questions 7 days a week by phone, through email, and through a chat function.
- ODM operates a designated EVV mailbox where providers can send questions regarding program operations and policy.

By offering focused stakeholder feedback and learning opportunities, we demonstrate our commitment to providing comprehensive support and increasing provider compliance with the program. ODM will continue investment in these efforts as recommended by AOS to ensure

providers have the necessary tools and resources to succeed. ODM will also continue to evaluate whether the feedback options available to providers and individuals are sufficient.

Recommendation 2: Statewide EVV Scorecard

We recommend the Department consider creating a statewide scorecard to be shared among all EVV stakeholders to improve reporting on the effectiveness of the EVV system. As one trade association suggested, a statewide scorecard could be shared to show EVV utilization and the accuracy of matching as a way stakeholders and the public are informed of compliance with EVV and where EVV utilization is not meeting expectations. The process of creating a statewide scorecard could be tied into the Department's EVV monitoring processes and could be an effective tool to educate and advocate to providers on the importance of EVV utilization as the Department moves forward in implementing EVV data matches as a condition of payment. We also recommend the Department evaluate and identify how often a statewide EVV scorecard should be updated and made available to all stakeholders.

ODM Response:

ODM has been developing an EVV Provider Lookup Dashboard as a one-stop shop for providers to see a summary view of their claims in one place. Providers will be able to see if their claims were validated against a visit or if the visit record needs to be updated in the Sandata EVV system. The dashboard also includes a 'Diagnostics' view which tells providers specific error reasons they may be receiving on claims related to EVV and an 'Information' view which provides additional detail on the error and how to resolve. The provider lookup dashboard offers numerous benefits for providers by enhancing transparency, accessibility, and efficiency. By displaying EVV data, providers can easily track progress related to their EVV compliance and identify areas for improvement. ODM aims to provide most current data that is accessible on the dashboard, as that is most beneficial for providers. We plan to adjust the dashboard as we progress to best meet the needs of providers.

Recommendation 3: EVV Match as a Condition of Payment

As outlined under the Recent Rule and Program Changes section, feedback received from stakeholders indicates provider utilization of EVV is low because claim payments are not tied to verified EVV entry. The Department is continuing to evaluate when the first phase of the claims adjudication process with home health service claims billed through the State Plan for FFS will commence. We recommend the Department continue to evaluate the implementation plan and timeline for requiring EVV as a condition of payment for all required services. This plan should include feedback/input from the various stakeholders over the amount of time before and during the initial claims denial effective date to allow technical assistance and a smooth transition.

In addition, the Department should consider establishing a standard for percentage of auto-verified EVV data matches that providers must achieve. The Department should proactively reach out to non-compliant providers to offer technical assistance and additional training.

ODM Response:

ODM agrees with the AOS recommendation related to EVV match as a condition of payment. On July 1, 2024, ODM announced a policy update to the EVV program requiring payment to be tied to a validated EVV visit. ODM shared that this change will be introduced in phases, by service type. The first phase of the claims adjudication change will begin with home health services claims billed through State Plan Fee for Service (FFS) to ODM. On August 27, 2024, ODM released an update that the effective date of the first phase will take place on or about January 1, 2025. ODM plans to phase in the changes over time to allow a smooth transition by giving providers time to prepare and adjust, minimizing disruptions to their operations and access to care for individual's receiving services.

ODM has organized an internal workgroup that meets regularly, focused on planning for the above-mentioned policy change that includes diverse perspectives. The collective input has led to various workstreams focused on data, provider outreach and education, system changes, leadership reviews, and compliance. This approach ensures decisions are informed by a wide range of expertise and experience. Proactive outreach to providers is crucial to this effort. Outbound calls and communications are underway offering providers assistance and training. ODM will be conducting targeted 1:1 outreach to providers that are significantly not in compliance, and subsequently monitoring for the effectiveness of the outreach campaign. ODM intends on continuing these efforts to implement the workgroup's strategy for subsequent phases.

ODM appreciates the Auditor of State's review and recommendations. Thank you for the opportunity to provide comments on the draft report. Please let me know if you have any questions or need additional information.

Sincerely,

Julie Babtist
Chief Legal Counsel and Deputy Director
Bureau of Program Integrity
Office of Legal Counsel
The Ohio Department of Medicaid

OHIO AUDITOR OF STATE
KEITH FABER

OHIO DEPARTMENT OF MEDICAID - ELECTRONIC VISIT VERIFICATION

FRANKLIN COUNTY

AUDITOR OF STATE OF OHIO CERTIFICATION

This is a true and correct copy of the report, which is required to be filed pursuant to Section 117.26, Revised Code, and which is filed in the Office of the Ohio Auditor of State in Columbus, Ohio.

Certified for Release 11/26/2024

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