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June 2, 2026

RE: AN ACT to amend the public health law, in relation to the submission of claims for services provided by home care agencies

A.1257 (Paulin)
S.3358 (Rivera)

MEMORANDUM IN OPPOSITION

Submitted on behalf of the Blue Cross and Blue Shield Plans

The New York State Conference of Blue Cross and Blue Shield Plans strongly opposes the enactment of this legislation, which would require claims from home care agencies and fiscal intermediaries to be only submitted and remitted on forms approved by the Centers for Medicare & Medicaid Services, require claims to be submitted to plans directly from home care agency's or fiscal intermediary's, and prohibit managed care plans from requiring the use of a specific billing entities for use by a home care agency or fiscal intermediary. This bill significantly inhibits a health plans' ability to ensure compliance with the Federal Cures Act and fulfill its obligations to detect and prevent fraud, waste, or abuse in Medicaid.

The 21st Century Cures Act ("Cures Act") required states to implement electronic visit verification ("EVV") for personal care services and home care services provided under Medicaid.[1] EVV is an electronic system that verifies when a home care visit occurs by capturing the date and time of the visit, the location of the visit, the person receiving the services, the person providing the services, and the services provided. For home care services, states were required under the Cures Act to have an EVV system in place by January 1, 2023, otherwise federal Medicaid funding would have decreased.[2] When implementing EVV, New York selected the Choice Model (meaning providers select their own EVV vendor), to give consumers EVV options to consider when selecting a provider, provide flexibility to home health care providers

[1] 42 U.S.C. § 1396b(k).
[2] *Id*.

to select an option that best meets their needs, and recognized that many providers had already implemented EVV before it was required.[3]

Health plans use entities to connect with providers to confirm EVV compliance and receive claims. These entities validate EVV information to ensure that there are no data issues or discrepancies before a claim is processed for payment. For example, review of EVV ensures that the home care worker was at the correct location and services are not being billed for the same worker in two different places at the same time.

This pre-adjudication claim process ensures that claims are verified using EVV before they are paid, preventing fraud, waste, and abuse. Requiring claims to go directly from the home care provider or fiscal intermediary to the health plan would eliminate this pre-claim review and would increase administrative costs. Health plans would be forced to perform their own validation when the claim is submitted, increasing the time between claim submission and payment. If plans pay the claims without validation, they will need to conduct post-payment reviews, meaning after the claim was paid. Post-payment reviews would force plans to chase providers for overpayment recovery, increasing administrative burdens and inefficiencies and causing friction between the plans and providers. Eliminating this pre-claim review using EVV would undermine the intent of the Cures Act to prevent fraud, waste, and abuse in home care services provided under the Medicaid program.

For the foregoing reasons, the New York State Conference of Blue Cross and Blue Shield Plans strongly opposes enactment of this legislation.

Respectfully submitted,

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Legislative Counsel for the Blue Cross and Blue Shield Plans

[3] N.Y. Dept. of Health, *Electronic Visit Verification – EVV Program Guidelines and Requirements*, April 14, 2022, *available at* https://www.health.ny.gov/health_care/medicaid/redesign/evv/repository/docs/evv_prog_guidelines.pdf.