Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW YORK CLAIMED FEDERAL REIMBURSEMENT FOR SOME PAYMENTS TO HEALTH HOME PROVIDERS THAT DID NOT MEET MEDICAID REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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July 2019
A-02-17-01004

Office of Inspector General

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Report in Brief
Date: July 2019
Report No. A-02-17-01004

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

New York Claimed Federal Reimbursement for Some Payments to Health Home Providers That Did Not Meet Medicaid Requirements

Why OIG Did This Review

The Medicaid "health home" option allows States to create programs that provide care coordination and care management for beneficiaries with chronic health conditions. Health homes are not physical spaces. Rather, they are a health care model in which providers work together to coordinate and manage beneficiaries' care at a reasonable cost.

For Federal fiscal year 2016, States claimed Federal Medicaid reimbursement for health home services totaling $750 million ($431 million Federal share). New York's program accounted for 62 percent of the Federal share.

Our objective was to determine whether New York's claims for Federal Medicaid reimbursement for certain payments made to health home providers complied with Federal and State requirements.

How OIG Did This Review

Our review covered 4.9 million payments made to health home providers for services provided during calendar years 2012 through 2016, totaling approximately $850 million ($523 million Federal share). We selected and reviewed a statistical sample of 100 payments. For each sampled payment, we reviewed the health home providers' service documentation and beneficiaries' health records.

What OIG Found

For 22 of 100 sampled payments, New York improperly claimed Federal Medicaid reimbursement for payments made to health home providers that did not comply with Federal and State requirements. Specifically, New York's health home providers did not provide services according to a comprehensive individualized patient-centered care plan, ensure that beneficiaries participated in the development and execution of their care plan, maintain documentation to support services billed, bill correctly for services, and bill only for services actually provided. New York also claimed reimbursement for services that duplicated similar ones provided under a different Medicaid-funded program.

The deficiencies occurred because New York did not adequately monitor health home providers for compliance with certain Federal and State requirements for providing, documenting, and billing services.

Based on our sample results, we estimated that New York improperly claimed at least $65.5 million in Federal Medicaid reimbursement for payments made to health home providers.

What OIG Recommends and New York's Comments

We recommend that New York refund $65.5 million to the Federal Government. New York should also improve its monitoring of the health home program to ensure that providers comply with Federal and State requirements for (1) providing services according to a care plan and ensuring beneficiary participation in the development and execution of the care plan, (2) maintaining documentation to support services billed, (3) billing correctly for services, (4) billing only for services actually provided, and (5) not billing for services that duplicate those provided under a different Medicaid-funded program.

In written comments on our draft report, New York did not indicate concurrence or nonconcurrence with our recommendations and indicated that it has taken multiple steps to ensure that health home providers comply with Federal and State requirements. New York also disagreed with our statistical sampling methodology and stated that it had already identified and was reviewing 7 of the 22 unallowable payments as problematic. After reviewing New York's comments, we maintain that our sampling methodology, findings, and recommendations are valid.

The full report can be found at https://oig.hhs.gov/oas/reports/region2/21701004.asp.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Medicaid "health home" option allows States to create programs that provide care coordination and care management for Medicaid beneficiaries with chronic health conditions. Health homes are not physical spaces. Rather, they are a health care model based on the idea that several providers can work together to coordinate and manage beneficiaries' care and, in doing so, provide quality care at a reasonable cost. As of September 2018, New York was among 23 States to implement Medicaid health home programs. For Federal fiscal year 2016, States claimed Federal Medicaid reimbursement for health home services totaling approximately $750 million ($431 million Federal share). New York accounted for approximately 62 percent of the Federal share.

This review is the first in a series of reviews to determine whether selected States complied with Federal and State requirements when claiming Federal Medicaid reimbursement for payments made to health home providers. We reviewed payments made to New York's Medicaid health home providers for services billed under rate codes for beneficiaries diagnosed with certain chronic health conditions, including asthma, diabetes, heart disease, and obesity.[1]

OBJECTIVE

Our objective was to determine whether the New York State Department of Health's (State agency's) claims for Federal Medicaid reimbursement for certain payments made to health home providers complied with Federal and State requirements.

BACKGROUND

Medicaid Health Home Services

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. In New York, the State agency administers the Medicaid program.

Effective January 2011, section 1945 of the Social Security Act (the Act) was amended to include an option for States to establish a health home program through a Medicaid State plan amendment (SPA) approved by CMS. Under an SPA, States can establish a health home program through a care management service model in which all parties involved in a beneficiary's care communicate with one another so that medical, behavioral health, and social

[1] We did not review payments for services billed under rate codes for beneficiaries diagnosed with serious mental illness, substance use disorder, or HIV/AIDS. We plan to review these payments in a separate audit.

needs are addressed in a comprehensive manner. While States have flexibility to define the core health home services, they must provide all core services required in the Act. Specifically, the Act requires that health home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care/followup, patient and family support, and referral to community and social support services. Beneficiaries enrolled in a health home program receive services through provider networks, health plans, and community-based organizations.

New York's Medicaid Health Home Program

New York has operated a Medicaid health home program since 2012. Health home providers directly provide, or contract for the provision of, health home services to eligible beneficiaries.[2, 3] Core health home services provided include engaging and retaining beneficiaries enrolled in the program, coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating beneficiaries' needs. New York relies on its health home providers to locate and enroll potentially eligible beneficiaries identified by the State agency or through community-based referrals (case-finding). Beneficiaries enrolled with a health home provider are assigned a dedicated care manager to assist them with obtaining medical, behavioral, and social services (referred to by the State agency as active care management). New York's health home program provides for a per member per month (PMPM) payment for beneficiaries in case-finding or active care management status. For most of the audit period, the case-finding PMPM payment was 80 percent of the active care management PMPM payment.[4]

The State agency is primarily responsible for monitoring and overseeing the health home program and works with its interagency partners to monitor the program and review providers' performance.[5] The State agency's monitoring activities include surveys in the areas of outcomes and quality, delivery of services, and governance and operational integrity. In addition, the State agency has issued policy and billing guidance to health home providers.

The State agency made payments to health home providers using a payment model that allowed providers to claim a PMPM payment for providing a minimum of one health home

[2] The eligible population includes Medicaid beneficiaries diagnosed with at least two qualifying chronic health conditions or one single qualifying condition (i.e., HIV/AIDS, serious mental illness, serious emotional disturbance, and complex trauma) (New York Medicaid State plan, Attachment 3.1-H).

[3] During our audit period, health home providers that billed Medicaid (billing providers) included health homes, care management agencies, and managed care organizations (MCOs).

[4] Effective September 2016, New York's health home providers received a uniform fee of $135 per month for case-finding activities (New York SPA #15-0002, Attachment 3.1-H).

[5] Interagency partners include New York State's Office of Mental Health, Office of Alcoholism and Substance Abuse Services, and Office of Children and Family Services.

service during the service period.[6] The State agency claimed Federal Medicaid reimbursement totaling $1,588,671,306 ($1,021,582,464 Federal share) for payments made to health home providers for services provided during the audit period (January 2012 through December 2016).[7]

Federal and State Requirements

Federal reimbursement is available only for allowable actual Medicaid expenditures for which there is adequate supporting documentation.[8] Requirements for New York's health home program are detailed in its Medicaid State plan, which requires a "comprehensive individualized patient-centered care plan [care plan] for all health home enrollees." In its Medicaid State plan, the State agency also assured CMS that health home services would not duplicate similar Medicaid services. Health home providers must provide a minimum of one health home service per service period[9] to meet minimum billing requirements.

HOW WE CONDUCTED THIS REVIEW

Our review covered 4,907,430 payments, totaling $850,112,633 ($523,370,133 Federal share), that the State agency made to health home providers for services provided during calendar years (CYs) 2012 through 2016.[10] We reviewed a simple random sample of 100 of these payments. Specifically, we reviewed the health home providers' service documentation and beneficiaries' health records associated with the sampled payments.[11]

We conducted this 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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

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[6] For January 2012 through December 2015, the service period was 1 calendar quarter. Beginning in January 2016, the service period was 1 month (New York Medicaid State plan, Attachment 4.19-B).

[7] The Federal Medicaid reimbursement rate for health home program services was 50 or 90 percent during our audit period. Generally, New York was reimbursed at the 90-percent rate for the first 2 years of a beneficiary's enrollment in the program.

[8] CMS *State Medicaid Manual* § 2497.1.

[9] See footnote 5.

[10] See Appendix B for a complete description of the payments covered by this review.

[11] The service documentation reviewed included the service notes prepared by each beneficiary's care manager.

FINDINGS

The State agency improperly claimed Federal Medicaid reimbursement for some payments made to health home providers that did not comply with Federal and State requirements. Of the 100 payments in our random sample, the State agency properly claimed reimbursement for 78 payments but improperly claimed reimbursement for the remaining 22 payments. Table 1 summarizes the deficiencies noted and the number of payments related to each type of deficiency.

Table 1: Summary of Deficiencies in Sampled Payments

Deficiency	No. of Unallowable Payments[a]
Care plan not documented or provided, or no beneficiary participation in care plan development	13
Services not documented	5
Services billed incorrectly	4
Services not provided	1
Duplicate services billed	1

[a] The total exceeds 22 because 2 payments related to more than 1 deficiency.

The improper payments occurred because the State agency did not adequately monitor health home providers for compliance with certain Federal and State requirements for providing, documenting, and billing services.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $65,468,943 in Federal Medicaid reimbursement for payments made to health home providers.[12]

CARE PLAN NOT DOCUMENTED OR PREPARED, OR NO BENEFICIARY PARTICIPATION IN CARE PLAN DEVELOPMENT

A comprehensive individualized patient-centered care plan is required for all health home enrollees. The care manager develops the care plan based on information obtained from a comprehensive health risk assessment used to identify the beneficiary's needs (i.e., physical, mental health, chemical dependency, and social services). Goals and timeframes for improving the beneficiary's health, their overall health care status, and the interventions that will produce this effect must also be included in the care plan. The care manager is required to ensure that the beneficiary (or his/her guardian) plays a central and active part in the development and execution of the care plan and that they are in agreement with the goals, interventions, and timeframes contained in the plan (Medicaid State plan, Attachment 3.1-H).

[12] To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

For 13 sampled payments, the health home provider either did not document the associated beneficiary's care plan, prepare a care plan for the beneficiary, or ensure that the beneficiary or his/her guardian participated in the development and execution of the care plan. Specifically:

- For seven payments, the provider did not document a care plan for the beneficiary. Specifically, for five payments, no care plan was found for the beneficiary in the provider's service documentation, and for the remaining two payments,[13] the care plan was prepared after the date of service for the sampled payment.

- For four payments, the provider did not prepare a care plan for the beneficiary. The provider's service documentation indicated that its care manager had not met or spoken with the beneficiary or his/her guardian to prepare a care plan.

- For two payments, the provider prepared a care plan without the beneficiary's participation or information obtained from a comprehensive health risk assessment. Specifically, although the provider documented a care plan for the beneficiary, the provider's service documentation indicated that its care manager had not met or spoken with the beneficiary or his/her guardian to prepare a care plan based on a comprehensive health risk assessment.

SERVICES NOT DOCUMENTED

Federal reimbursement is available only for allowable actual Medicaid expenditures. Medicaid expenditures are allowable only to the extent that, when a claim is filed, there is adequate supporting documentation to assure that all applicable Federal requirements have been met (CMS State Medicaid Manual § 2497.1). Health home providers must provide a minimum of one health home service per service period to meet minimum billing requirements (Medicaid State plan, Attachment 4.19-B).

For five sampled payments, the health home provider billed for services but did not document its case-finding activities and other health home services. Specifically, for three payments, the health home provider billed for case-finding activities but did not document its activities to locate and enroll potentially eligible beneficiaries or any other outreach and engagement during the service period, and for two payments, the provider billed for health home services for the enrolled beneficiary but did not document any billable services during the service period.

[13] For one of the two payments for which the care plan was prepared after the date of service for the sampled payment, the care plan was prepared 3 months after the date of enrollment with the provider and 2 months after the date of service for the sampled payment. For the remaining payment, the care plan was prepared 10 months after the date of enrollment with the provider and 7 months after the date of service for the sampled payment.

SERVICES BILLED INCORRECTLY

Health home providers receive a reduced payment for case-finding activities that is 80 percent of the payment for active care management (Medicaid State plan, Attachment 4.19-B).

For four sampled payments, the health home provider did not bill correctly for case-finding activities. Specifically, the providers documented case-finding activities to locate and enroll potentially eligible beneficiaries and then billed as they would for active care management services provided to enrolled beneficiaries. The providers should have billed at 80 percent of the payment rate for active care management provided to enrolled beneficiaries.[14]

SERVICES NOT PROVIDED

Health home providers must provide at least one health home service per service period to meet minimum billing requirements (Medicaid State plan, Attachment 4.19-B).

For one sampled payment, the health home provider did not provide any services. Specifically, the provider billed for active care management services. However, the provider had no record of this beneficiary's enrollment in the program or services provided during the sample payment period.

DUPLICATE SERVICES BILLED

The State agency assured CMS that health home services would not duplicate services and payments for similar services provided under other Medicaid authorities (Medicaid State plan, Attachment 3.1-H, effective January 2014).

For one sampled payment (for services provided in May 2016), the health home provider billed for comprehensive care management services that duplicated services provided under another Medicaid authority. Specifically, the beneficiary was enrolled in New York's Medicaid waiver for developmentally disabled beneficiaries and had been receiving case management services under the waiver that were similar to services provided under the health home program.[15] Both the health home provider and waiver services provider billed for services provided during the sample payment period.

[14] We questioned only the difference between the two rates for each of the four payments. The services related to these payments were provided prior to the September 2016 implementation of the uniform case-finding fee described in footnote 3.

[15] The State agency restricts beneficiaries who receive services through its Medicaid waiver for the developmentally disabled from enrolling in the health home program. If waiver participants elect to receive care management through the health home program, they must first disenroll from the waiver program (State agency's *Guide to Restriction Exception (RE Codes) and Health Home Services*, RE codes 46 and 48).

INADEQUATE STATE AGENCY MONITORING

The improper payments occurred because the State agency did not adequately monitor health home providers for compliance with certain Federal and State requirements for providing, documenting, and billing services. The State agency has issued policy and billing guidance to health home providers and conducts health home monitoring surveys in the areas of outcomes and quality, delivery of services, and governance and operational integrity. However, despite these monitoring efforts, some health home providers did not comply with Federal and State requirements for (1) providing services according to a care plan and ensuring beneficiary participation in the development and execution of the care plan, (2) maintaining documentation to support services billed, (3) billing correctly for services, (4) billing only for services actually provided, and (5) not billing for similar services that duplicate those provided under other Medicaid authorities.

RECOMMENDATIONS

We recommend that the New York State Department of Health:

- refund $65,468,943 to the Federal Government and

- improve its monitoring of the health home program to ensure that health home providers comply with Federal and State requirements for (1) providing services according to a care plan and ensuring beneficiary participation in the development and execution of the care plan, (2) maintaining documentation to support services billed, (3) billing correctly for services, (4) billing only for services actually provided, and (5) not billing for services that duplicate those provided under other Medicaid authorities.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not indicate concurrence or nonconcurrence with our recommendations and indicated that it has taken multiple steps to ensure that health home providers comply with Federal and State requirements. It also disagreed with our statistical sampling methodology used to estimate the State agency's improper claims for Federal Medicaid reimbursement for payments made to health home providers. Further, the State agency indicated that it had already identified 7 of the 22 unallowable sampled payments identified in our draft report as problematic and that these payments had been under active review and investigation.

After reviewing the State agency's comments, we maintain that our sampling methodology, findings, and recommendations are valid. We acknowledge the State agency's efforts to provide oversight of its health home program, including issuing policy requiring health home providers to implement quality management programs that address the areas of noncompliance described in our draft report. The State agency's comments are included in their entirety as Appendix D.

STATISTICAL SAMPLING METHODOLOGY

State Agency Comments

The State agency strongly disagreed with our sample and extrapolation methodology used to determine a potential overpayment of $65,468,943. It also indicated that an extrapolation based on a sample of 100 payments over a 5-year period did not represent a fair distribution of payments for New York's 34 health homes or its 400 care management agencies within the health home network.

Office of Inspector General Response

We disagree with the State agency's assertions regarding our sampling and extrapolation methods. Our methods fully account for the distribution of payments to home health providers. Specifically, we properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software to apply the correct formulas for the extrapolation.

In addition, we recommended recovery at the lower limit. If we knew that the distribution of the sample matched the distribution of the sampling frame, we would recommend recovery using the unbiased point estimate, which in this audit was over $37 million more than the lower limit. Our use of the lower limit ensures that our methods generally favor the State agency, regardless of the number of payments sampled or the differences between the sample and the sampling frame. Therefore, we maintain that our sampling and estimation methods are valid.

CLAIMS UNDER ACTIVE REVIEW AND INVESTIGATION

State Agency Comments

The State agency stated that of the 22 unallowable sampled payments identified in our draft report, it had already identified 7 that were problematic and under active review and investigation. It further stated that six of these payments were associated with a single health home provider. The State agency stated that one provider "had already been terminated due to its poor performance issues." Finally, the State agency indicated that it will continue to

collaborate with its Office of Medicaid Inspector General to further review the identified payments and determine an appropriate course of action.

Office of Inspector General Response

We disagree that six of the unallowable sampled payments were associated with a single health home provider. We sampled payments made to all billing providers, and the unallowable sampled payments that we identified were made to 17 different billing providers, none of which was associated with more than 2 unallowable payments.[16] We provided the State agency with details for all sampled payments, including information on billing providers associated with unallowable payments, prior to discussing the results of our review with State agency officials.

Regarding providers under active review and investigation, we note that we excluded from our review payments for claims made by any billing providers that the State agency informed us were the subject of ongoing investigations. We acknowledge the State agency's efforts to identify and terminate poor-performing providers and to review the unallowable payments we identified.

[16] The billing providers comprised 9 care management agencies associated with 11 unallowable payments, 5 MCOs associated with 7 unallowable payments, and 3 health homes associated with 4 unallowable payments.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 4,907,430 payments totaling $850,112,633 ($523,370,133 Federal share) that the State agency made to health home providers for services provided during CYs 2012 through 2016. We reviewed a simple random sample of 100 of these payments. Specifically, we reviewed the health home providers' service documentation and beneficiaries' health records associated with the sampled payments.

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the State agency's Medicaid Management Information System (MMIS) for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claim data in the MMIS to the State agency's claim for reimbursement on the CMS-64, Quarterly Medicaid Statement of Expenditures for the Medicaid Program.

We did not assess the State agency's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our audit objective.

We performed our fieldwork at the State agency's offices in Albany, New York, and at the health home providers' offices located throughout New York.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- met with CMS financial and program management officials to gain an understanding of and to obtain information on New York's health home program;
- met with State agency officials to gain an understanding of the State agency's administration and oversight of the health home program;
- interviewed health home providers' representatives regarding their health home programs' policies and procedures, including those for determining eligibility, assessments and enrollments, care planning, case-finding activities, documentation of services, and billing;
- obtained from the State agency's MMIS data files containing all payments for which the State agency claimed Medicaid reimbursement for health home services provided during CYs 2012 through 2016; [17]

[17] The data files contained 6,696,628 payments made to health home providers totaling $1,588,671,306 ($1,021,582,464 Federal share).

- removed payments billed under certain rate codes that were outside the scope of our review, payments with a Federal share less than $20, and payments to one health home provider that was under investigation;[18]

- created a sampling frame of 4,907,430 payments made to health home providers totaling $850,112,633 ($523,370,133 Federal share);

- selected from the sampling frame a simple random sample of 100 payments and for each payment determined whether:

    - the beneficiary was Medicaid eligible,

    - the beneficiary was eligible for health home services,

    - the beneficiary was enrolled with a health home provider,

    - the health home provider documented a care plan for the beneficiary,

    - the health home provider ensured that the beneficiary participated in the development and execution of the care plan,

    - the health home provider documented at least one health home service during the service period,

    - the health home provider billed for case-finding activities using the correct rate code, and

    - the health home provider billed for services that did not duplicate services provided under other Medicaid authorities;

- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 4,907,430 payments; and

- summarized the results of our review and discussed these results with State agency officials.

Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

We conducted this 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

[18] See Appendix B for additional details of the payments removed.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of payments made to health home providers for beneficiaries with certain chronic health conditions for which the State agency claimed Federal Medicaid reimbursement for services provided during CYs 2012 through 2016.[19]

SAMPLING FRAME

The sampling frame was 3 Access database files containing 4,907,430 payments totaling $850,112,633 ($523,370,133 Federal share) for which the State agency claimed Federal Medicaid reimbursement for services provided during CYs 2012 through 2016.[20] The data for payments made to health home providers were obtained from the State agency's MMIS.

SAMPLE UNIT

The sample unit was a payment for health home services.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 payments.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OAS), statistical software.

[19] We reviewed payments for health home services provided to beneficiaries diagnosed with multiple chronic conditions, including asthma, diabetes, heart disease, and obesity. These services were reimbursed under 13 rate codes (active care management reimbursed under rate codes 1386, 1857, 1858, 1859, 1864, 1865, 1866, 1869, 1870, and 1871; and case finding services reimbursed under rate codes 1387, 1862, and 1863).

[20] We excluded 1,707,780 payments totaling $726,511,694 ($491,079,303 Federal share) for health home services billed under certain codes that were outside the scope of our review and payments with a Federal share less than $20. We also excluded 81,418 payments totaling $12,046,979 ($7,133,028 Federal share) made to 1 health home provider that was under investigation.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the payments within the sampling frame. After generating 100 random numbers, we selected the corresponding claims in the frame for our sample.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of unallowable health home payments for which the State agency claimed reimbursement at the lower limit of the two-sided 90-percent confidence interval. We also used the software to calculate the corresponding point estimate and upper limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Details and Results

Payments in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Unallowable Payments	Value of Unallowable Payments (Federal Share)
4,907,430	$523,370,133	100	$10,822	22	$2,091

Table 3: Estimated Value of Unallowable Payments (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$102,608,207
Lower limit	65,468,943
Upper limit	139,747,472

APPENDIX D: STATE AGENCY COMMENTS

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

April 24, 2019

Ms. Brenda Tierney
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-17-01004

Dear Ms. Tierney:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-17-01004 entitled, "New York Claimed Federal Reimbursement for Some Payments to Health Home Providers That Did Not Meet Medicaid Requirements."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner
Donna Frescatore
Dennis Rosen
Erin Ives
Brian Kiernan
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New York State Department of Health Comments on the Department of Health and Human Services Office of Inspector General Draft Audit Report A-02-17-01004 entitled "New York Claimed Federal Reimbursement for Some Payments to Health Home Providers That Did Not Meet Medicaid Requirements"

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-17-01004 entitled, "New York Claimed Federal Reimbursement for Some Payments to Health Home Providers That Did Not Meet Medicaid Requirements."

Recommendation #1:

Refund $65,468,943 to the Federal Government.

Response #1:

The Department of Health strongly disagrees with the OIG's sample and extrapolation methodology that was used to determine a potential overpayment of $65,468,943. The OIG sampled a total of 100 payments over a five-year period and found that 22 claims failed to comply with Federal and State requirements. The extrapolation of these claims did not represent a fair distribution of payments for New York's 34 Health Homes or its 400 care management agencies within the Health Home network. Of the 22 claims identified, 7 claims (6 of which were from a single health home) were already identified by the State as problematic and were already under active review and investigation. Because of the State's robust compliance efforts, one of the Health Homes in question had already been terminated due to its poor performance issues.

In order to continue to ensure that the State's health homes are complying with Federal and State requirements, the Office of the Medicaid Inspector General will continue to collaborate with the Department to further review the identified payments and determine an appropriate course of action.

Recommendation #2:

Improve its monitoring of the health home program to ensure that health home providers comply with Federal and State requirements for (1) providing services according to a care plan and ensuring beneficiary participation in the development and execution of the care plan, (2) maintaining documentation to support services billed, (3) billing correctly for services, (4) billing only for services actually provided, and (5) not billing for services that duplicate those provided under other Medicaid authorities.

Response #2:

The Department has robust policies and protocols in place to ensure that New York's health home providers comply with all Federal and State requirements. Since the creation of the health home program in 2012, New York State has taken a multitude of actions to safeguard health home compliance, including educational webinars, billing and policy guidance documents, the creation of billing tracking systems, and on-site desk reviews to ensure health home compliance with Federal and State requirements.

First, the Department has taken concrete steps to ensure that Health Homes are providing services according to a care plan and ensuring beneficiary participation in the development and execution of the care plan. In an effort to enhance previous on-site reviews, since August 2015,

onsite re-designation surveys were initiated, which included more in-depth review of network management and compliance with Health Home standards and requirements. The lessons learned from the data gathered from these onsite surveys resulted in substantive policy revisions to improve comprehensive assessment and plan of care development. In addition, the Department required that all Health Homes, regardless of their designation outcome, participate in Technical Assistance and Quality Monitoring with the Department. This process provided in depth review of policies and procedures, quality management activities and performance improvement planning and implementation.

Second, the Department has instituted statewide Health Home tracking system to monitor billing and claims in order to ensure that health homes are complying with billing requirements. In April 2016, the Department launched the Medicaid Analytics Provider Portal-Health Home Tracking System (MAPP-HHTS) which substantially improved how Health Home and Managed Care Organizations track member assignments. The MAPP-HHTS has greatly improved the unintended duplication of services, as well as outreach and enrollment. The MAPP-HHTS has also improved the accuracy of billing to ensure that Health Homes are billing correctly for services. Each month, Health Homes attest to the core service provision within the tracking system, which populates a billing support download file to assist in determining what is or is not a valid billing service. The billing support download identifies the payor, rate determination and core service attestation. Health Homes submit claims to the appropriate payor if and only if a core service was provided. Health Homes are required to audit claims routinely to ensure accurate billing.

Third, the Department has instituted additional guidance documents to further strengthen health homes compliance with Federal and State requirements. In June 2017, the Department issued the Health Home Quality Monitoring and Oversight Policy. This policy requires Health Homes to implement a Quality Management Program that monitors end-to-end Health Home operations including: providing services according to the person-centered care plan; maintaining documentation to support services billed; billing correctly for services; billing only for services provided; and not billing for services that duplicate those provided.

In addition to the above-mentioned actions, the Department has developed several quality and compliance protocols. These include: populating performance measures accessible through a Health Home Dashboard to track actionable data to improve Health Home operations; and collecting data on interventions, assessments and plans of care through the Health Home Care Management Assessment Reporting Tool.

Lastly, it is important to note that the launch of New York's Health Home program has been extremely successful in providing needed assistance to the highest-risk, high-need Medicaid members with severe mental illness, HIV/AIDS, or two or more chronic conditions. There has been a measurable reduction in avoidable hospitalizations and increased access to primary care, clinic services needed medication for chronic disease management. Likewise, the Health Home program has been central in New York's efforts to end the HIV/AIDS epidemic by improving viral load suppression, as well as providing essential care management activities to address the State's opioid epidemic. On federally required standardized measures of quality, the State's health home program exceeds statewide performance for all Medicaid members statewide on 18 of 25 key performance measures despite the much more complex needs of the health home population.