

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NEW YORK'S CLAIMS FOR FEDERAL  
REIMBURSEMENT FOR PAYMENTS TO  
HEALTH HOME PROVIDERS ON BEHALF  
OF BENEFICIARIES DIAGNOSED WITH  
SERIOUS MENTAL ILLNESS OR  
SUBSTANCE USE DISORDER GENERALLY  
MET MEDICAID REQUIREMENTS BUT IT  
STILL MADE \$6 MILLION IN IMPROPER  
PAYMENTS TO SOME PROVIDERS**

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**Amy J. Frontz  
Deputy Inspector General  
for Audit Services**

**July 2021  
A-02-19-01007**

# ***Office of Inspector General***

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## Report in Brief

Date: July 2021

Report No. A-02-19-01007

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



### Why OIG Did This Audit

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 based on the idea that several providers can work together to coordinate and manage beneficiaries’ care at a reasonable cost.

A recent OIG audit found that New York claimed more than \$65 million in unallowable Federal Medicaid reimbursement for health home services provided to beneficiaries diagnosed with certain chronic health conditions, including asthma, diabetes, heart disease, and obesity.

Our objective for this audit was to determine whether New York’s claims for Federal Medicaid reimbursement for payments made to health home providers on behalf of beneficiaries diagnosed with serious mental illness and/or substance use disorder complied with Federal and State requirements.

### How OIG Did This Audit

Our audit covered 1 million payments made to health home providers for services provided during calendar years 2016 through 2018, totaling approximately \$186 million (Federal share). We selected and reviewed a statistical sample of 150 payments. For each payment, we reviewed the health home providers’ service documentation and beneficiaries’ health records.

## New York’s Claims for Federal Reimbursement for Payments to Health Home Providers on Behalf of Beneficiaries Diagnosed With Serious Mental Illness or Substance Use Disorder Generally Met Medicaid Requirements But It Still Made \$6 Million in Improper Payments to Some Providers

### What OIG Found

Of the 150 payments in our random sample, New York properly claimed reimbursement for 141 payments but improperly claimed reimbursement for the remaining 9 payments. Specifically, New York’s health home providers did not provide a comprehensive patient-centered care plan covering the sampled date of service for enrolled beneficiaries (five payments) and did not document health home services (four payments). The improper payments 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.

Health home providers’ failure to develop comprehensive patient-centered care plans and provide health home services could have resulted in beneficiaries not getting the services that they needed and may have put their health and safety at risk. On the basis of our sample results, we estimated that New York improperly claimed at least \$6 million in Federal Medicaid reimbursement for payments made to health home providers for services provided to beneficiaries diagnosed with serious mental illness or substance use disorder.

### What OIG Recommends and New York’s Comments

We recommend that New York refund \$6 million to the Federal Government. New York should also strengthen 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 comprehensive patient-centered care plan and (2) maintaining documentation to support services billed.

In written comments on our draft report, the State agency did not indicate concurrence or non-concurrence with our recommendations; however, it described actions that it has taken to address them. After reviewing the State agency’s comments, we maintain that our findings and recommendations are valid. In addition, we acknowledge the State agency’s efforts to expand and strengthen its oversight of its health home program.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

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 December 2020, 21 States and the District of Columbia had implemented Medicaid health home programs. More than one million Medicaid beneficiaries have been enrolled in health homes.

This audit is part of a series of audits to determine whether selected States complied with Federal and State requirements when claiming Federal Medicaid reimbursement for payments made to health home providers. Also, a recent Office of Inspector General (OIG) audit found that New York claimed more than \$65 million in unallowable Federal Medicaid reimbursement for health home program services provided to beneficiaries diagnosed with certain chronic health conditions, including asthma, diabetes, heart disease, and obesity.<sup>1</sup> The current audit covered health home services provided to beneficiaries diagnosed with serious mental illness or substance use disorder (SUD).

### OBJECTIVE

Our objective was to determine whether the New York State Department of Health’s (State agency’s) claims for Federal Medicaid reimbursement for payments made to health home providers on behalf of beneficiaries diagnosed with serious mental illness and/or SUD 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 a SPA, States can establish a health home program

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<sup>1</sup> *New York Claimed Federal Reimbursement for Some Payments to Health Home Providers That Did Not Meet Medicaid Requirements* ([A-02-17-01004](#)) July 1, 2019.

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 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/follow-up, 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 operates a Medicaid health home program which provides comprehensive care management for beneficiaries with at least two chronic conditions or a single qualifying condition (e.g., serious mental illness).<sup>2</sup> Health home providers directly provide, or contract for the provision of, health home services to eligible beneficiaries.<sup>3, 4</sup> 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<sup>5</sup> or active care management status.

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.<sup>6</sup> The State agency's monitoring activities include surveys in the areas of

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<sup>2</sup> SUDs are considered chronic conditions and do not, by themselves, qualify a beneficiary for health home services. Beneficiaries with a SUD must have another chronic condition to qualify.

<sup>3</sup> 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).

<sup>4</sup> During our audit period, health home providers that billed Medicaid (billing providers) included health homes, care management agencies, and managed care organizations.

<sup>5</sup> Effective October 2017, payments for case-finding activities are available for two consecutive months after a beneficiary was assigned or referred to a health home provider. Two additional months of case-finding activities may be billed within a rolling 12-month period (New York SPA #17-0053, Attachment 4.19-B).

<sup>6</sup> 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.

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 service per service period.<sup>7</sup> The State agency claimed Medicaid reimbursement totaling \$341,936,568 (\$193,238,148 Federal share) for payments made to health home providers for services provided to beneficiaries diagnosed with serious mental illness and/or SUD during the period January 2016 through December 2018 (audit period).<sup>8</sup>

### **Federal and State Requirements**

The Act requires Medicaid providers to maintain records necessary to disclose the extent of the services provided to beneficiaries.<sup>9</sup> 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.” Health home providers must provide a minimum of one health home service per service period to meet minimum billing requirements.

### **HOW WE CONDUCTED THIS AUDIT**

Our audit covered 1,089,857 payments, totaling \$322,418,184 (\$185,780,758 Federal share), that the State agency made to health home providers for services provided to beneficiaries diagnosed with serious mental illness or SUD during the audit period.<sup>10</sup> We audited a simple random sample of 150 of these payments. Specifically, we audited the health home providers’ service documentation and beneficiaries’ health records associated with the sampled payments.<sup>11</sup>

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.

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<sup>7</sup> A unit of service is defined as a billable unit per service month. In order to be reimbursed for a billable unit of service per month, health home providers must provide at least one of the core health home services per month.

<sup>8</sup> These were the most recent data available at the start of our audit.

<sup>9</sup> The Act §1902(a)(27).

<sup>10</sup> See Appendix A for a complete description of the payments covered by this audit.

<sup>11</sup> The service documentation reviewed included the service notes prepared by each beneficiary’s care manager.



Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains a list of related OIG reports.

## **FINDINGS**

The State agency's claims for Federal Medicaid reimbursement for payments made to health home providers on behalf of beneficiaries diagnosed with serious mental illness or SUD generally complied with Federal and State requirements. Of the 150 payments in our random sample, the State agency properly claimed reimbursement for 141 payments but improperly claimed reimbursement for the remaining 9 payments. Specifically, for five sampled payments, the health home provider did not provide a comprehensive patient-centered care plan covering the sampled date of service and, for four other sampled payments, the health home provider billed for services not documented in its service records. 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.

Health home providers' failure to develop comprehensive patient-centered care plans and provide health home services could have resulted in beneficiaries not getting the services that they needed and may have put their health and safety at risk. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$6,027,566 in Federal Medicaid reimbursement for payments made to health home providers for services provided to beneficiaries diagnosed with serious mental illness or SUD.<sup>12</sup>

### **NO COMPREHENSIVE PATIENT-CENTERED CARE PLAN FOR SAMPLED DATE OF SERVICE**

New York Medicaid State Plan, Attachment 3.1-H requires a comprehensive, patient-centered care plan for all beneficiaries enrolled in the health home program. The care manager develops the care plan based on the information obtained from a comprehensive health risk assessment used to identify the beneficiary's physical, mental health, chemical dependency and social service needs. The care plan must include goals and timeframes for improving the beneficiary's health, his/her overall health care status, and the interventions that will produce this effect. The care manager is required to make sure that the beneficiary (or their guardian) plays a central and active part in the development and execution of their plan of care, and that he/she is in agreement with the goals, interventions, and time frames contained in the plan.

For five sampled payments, the health home provider did not provide a comprehensive patient-centered care plan covering the sampled date of service. Specifically, providers did not prepare

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<sup>12</sup> 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 are designed to be less than the actual overpayment total 95 percent of the time.

a care plan that covered the sampled date of service (four payments)<sup>13</sup> or develop a care plan that addressed the beneficiary's needs and other required elements (one payment).<sup>14</sup>

### **NO DOCUMENTATION TO SUPPORT SERVICES BILLED**

The Act requires Medicaid providers to maintain records necessary to disclose the extent of the services provided to beneficiaries (The Act §1902(a)(27)). 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 four sampled payments, the health home provider billed for services not documented in its service records. Specifically, for two sampled payments, the health home provider did not document case-finding activities to locate and enroll potentially eligible beneficiaries during the sampled payment period for which it billed. For two other sampled payments, the health home provider did not document any billable services provided to the enrolled beneficiary during the sampled payment period.

### **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 comprehensive patient-centered care plan and (2) maintaining documentation to support services billed.

### **RECOMMENDATIONS**

We recommend that the New York State Department of Health:

- refund \$6,027,566 to the Federal Government and
- strengthen its monitoring of the health home program to ensure that health home providers comply with Federal and State requirements for (1) providing services

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<sup>13</sup> Specifically, for two payments, the care plan was developed *after* the sampled payment period (one plan was developed approximately 4 years after the sampled payment period and, for another payment, the care plan was developed approximately 1 year after the sampled payment period). In addition, for one payment, the provider did not document a care plan (i.e., there was no care plan for the beneficiary in the provider's service documentation), and for another payment, the provider indicated that it did not prepare a care plan.

<sup>14</sup> Specifically, the care plan provided did not address the beneficiary's needs (i.e., physical, mental health, chemical dependency, and social services), goals, and timeframes for improving the beneficiary's overall health.

according to a comprehensive patient-centered care plan and (2) maintaining documentation to support services billed.

### **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the State agency did not indicate concurrence or non-concurrence with our recommendations; however, it described actions it has taken to address them. Specifically, the State agency stated that its Office of the Medicaid Inspector General has initiated audits that overlap with our audit scope and will refund the Federal share of any identified overpayments. The State agency also described actions it has taken to expand and strengthen its oversight of the health homes program, including the issuance of a policy in June 2017 requiring health home providers to implement quality management programs and enhancements it made in 2020 to a performance management system. The State agency's comments are included in their entirety as Appendix E.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. In addition, we acknowledge the State agency's efforts to expand and strengthen its oversight of its health home program.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our audit covered 1,089,857 payments totaling \$322,418,184 (\$185,780,758 Federal share) that the State agency made to health home providers on behalf of beneficiaries diagnosed with serious mental illness or SUD for services provided during the audit period. We audited a simple random sample of 150 of these payments. Specifically, we reviewed the health home providers' service documentation and beneficiaries' health records associated with the sampled payments.

Our audit 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 conducted our audit from September 2019 to May 2021.

### **METHODOLOGY**

To accomplish our audit 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 to beneficiaries diagnosed with serious mental illness or SUD during the audit period;<sup>15</sup>
- created a sampling frame of 1,089,857 payments made to health home providers for services provided to beneficiaries diagnosed with serious mental illness and/or SUD, totaling \$322,418,184 (\$185,780,758 Federal share);<sup>16</sup>
- selected from the sampling frame a simple random sample of 150 payments and for each payment determined whether:
  - the beneficiary was Medicaid eligible,<sup>17</sup>
  - 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 case-finding activity or other health home service during the billable 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 1,089,857 payments; and

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<sup>15</sup> The data files contained 1,160,751 payments made to health home providers totaling \$341,936,568 (\$193,238,148 Federal share).

<sup>16</sup> The sampling frame included payments, valued at \$50 or more, for health home services provided during calendar years 2016 through 2018. The sampling frame did not include claims for two providers who were terminated from New York’s health home program and for one provider who was under investigation by New York’s Medicaid Fraud Control Unit.

<sup>17</sup> We determined, based on State enrollment data, whether the beneficiary was enrolled in Medicaid on the date of service associated with the sampled payment.

- summarized the results of our audit 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 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**

### **SAMPLING FRAME**

The sampling frame consisted of an Access database of 1,089,857 payments to health home providers for Medicaid beneficiaries diagnosed with serious mental illness or substance use disorder totaling \$322,418,184 (\$185,780,758 Federal share).<sup>18</sup> The sampling frame included payments, valued at \$50 or more, for health home services provided during the audit period, by providers enrolled in New York's health home program.

### **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 150 payments.

### **SOURCE OF RANDOM NUMBERS**

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

### **METHOD OF SELECTING SAMPLE UNITS**

We consecutively numbered the payments within the sampling frame. After generating 150 random numbers, we selected the corresponding frame items for audit.

### **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 in the sampling frame. To be conservative, we recommend recovery of unallowable payments at the lower limit of the two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

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<sup>18</sup> The data for payments to health home providers were extracted from New York's MMIS.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Table 1: Sample Details and Results**

<b>Frame Size</b>	<b>Value of Frame (Federal Share)</b>	<b>Sample Size</b>	<b>Value of Sample (Federal Share)</b>	<b>Number of Unallowable Payments</b>	<b>Value of Unallowable Payments (Federal Share)</b>
1,089,857	\$185,780,758	150	\$25,937	9	\$2,041

**Table 2: Estimated Value of Unallowable Payments (Federal Share) in the Sampling Frame  
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$14,827,105
Lower limit	6,027,566
Upper limit	23,626,644



**APPENDIX D: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>North Carolina Received \$30 Million in Excess Federal Funds Related to Improperly Claimed Health Home Expenditures</i>	<a href="#"><u>A-04-18-00120</u></a>	04-29-2020
<i>Iowa Inadequately Monitored Its Medicaid Health Home Providers, Resulting in Tens of Millions in Improperly Claimed Reimbursement</i>	<a href="#"><u>A-07-18-04109</u></a>	04-07-2020
<i>New York Claimed Federal Reimbursement for Some Payments to Health Home Providers That Did Not Meet Medicaid Requirements</i>	<a href="#"><u>A-02-17-01004</u></a>	07-01-2019

## APPENDIX E: STATE AGENCY COMMENTS



**ANDREW M. CUOMO**  
Governor

**Department  
of Health**

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

**LISA J. PINO, M.A., J.D.**  
Executive Deputy Commissioner

June 17<sup>th</sup>, 2021

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

Ref. No: A-02-19-01007

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-02-19-01007 entitled, "New York's Claims for Federal Reimbursement for Payments to Health Home Providers on Behalf of Beneficiaries Diagnosed With Serious Mental Illness or Substance Use Disorder Generally Met Medicaid Requirements But It Still Made \$6 Million in Improper Payments to Some Providers".

Thank you for the opportunity to comment.

Sincerely,

Theresa Egan  
Deputy Commissioner for Administration

Enclosure

cc: Diane Christensen  
Frank Walsh  
Brett Friedman  
Geza Hrazdina  
Daniel Duffy  
Erin Ives  
Timothy Brown  
Amber Rohan  
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 Final Audit Report A-02-19-01007  
entitled, “New York’s Claims for Federal Reimbursement for Payments  
to Health Home Providers on Behalf Of Beneficiaries Diagnosed With  
Serious Mental Illness or Substance Use Disorder Generally Met  
Medicaid Requirements But It Still Made \$6 Million in Improper  
Payments to Some Providers”**

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The following are the responses from the New York State Department of Health (Department) to Draft Audit Report A-02-19-01007 entitled, “New York’s Claims for Federal Reimbursement for Payments to Health Home Providers on Behalf Of Beneficiaries Diagnosed With Serious Mental Illness or Substance Use Disorder Generally Met Medicaid Requirements But It Still Made \$6 Million in Improper Payments to Some Providers” by the Department of Health and Human Services, Office of Inspector General (OIG).

**Recommendation #1:**

Refund \$6,027,566 to the Federal Government.

**Response #1:**

The Department notes that the survey results indicate a very low billing error rate among Health Home Payments during the three-year audit period. This minimal error rate validates the efficacy of the quality monitoring and performance improvement protocols that the Department implemented as part of its response to OIG’s Audit Report A-02-17-01004.

The Office of the Medicaid Inspector General (OMIG) has initiated Health Home audits that overlap with the OIG audit scope and will continue its reviews in this area. The Federal share of any identified overpayments will be refunded to the Federal government. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider’s right to due process.

**Recommendation #2:**

Strengthen 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 comprehensive patient-centered care plan and (2) maintaining documentation to support services billed.

**Response #2:**

The Department, in partnership with the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS), issued the Health Home Quality Monitoring and Oversight Policy in June 2017, which required Health Homes to implement a Quality Management Program that monitored end-to-end Health Home operations, including providing services according to the patient-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.

The Department implemented a stringent site survey protocol and weighted performance standards to determine a Health Home’s overall performance score that dictates the length of designation.

The Health Home Redesignation Site Visit Standards and Chart Review Tools are available for review on the Department's website:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/performance/index.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/performance/index.htm)

The length of designation is directly related to site survey outcomes and due to stringent administrative requirements implemented in 2017, four additional Health Homes will terminate operations by July 1, 2021.

Additionally, an enhancement to the Medicaid Analytics Provider Portal-Health Home Tracking System (MAPP-HHTS) implemented in 2020 prevents billing instances when there is no Plan of Date in the record, or when the attestation that a core service is incomplete.

Based on these efforts, the Department, OMH, and OASAS reflect their acknowledgement of the necessity of continuous quality improvement, monitoring and oversight.