NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

July 21, 2026

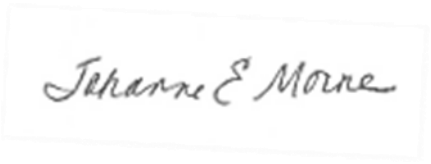
Christopher Morris, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Christopher Morris:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2023-S-8 entitled, "Medicaid Program – Oversight of Health Homes"

Please feel free to contact the Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,



Johanne E. Morne, M.S.
Executive Deputy Commissioner

Enclosures

cc: Melissa Fiore
DOH Audit

**Department of Health Comments on the Office of the State Comptroller's Final Audit Report 2023-S-8 entitled, "Medicaid Program – Oversight of Health Homes"**

---

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2023-S-8 entitled, "Medicaid Program – Oversight of Health Homes" Included in the Department's response is the Office of the Medicaid Inspector General's (OMIG) replies to applicable recommendations. OMIG conducts and coordinates the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations.

**Executive Summary**

Health Homes provide critical care management support to 180,000 chronically ill New Yorkers at risk of adverse outcomes such as death, disability, costly preventable hospitalizations, homelessness, or incarceration.

The Department agrees that improvements to oversight were necessary and is proud that over the last four years the Department has implemented enhancements that have addressed the majority of findings noted in OSC's Report. Oversight has improved, driven by a re-engineered Redesignation process, new technological safeguards to ensure appropriate billing, tighter scrutiny of Plans of Care, and the adoption of consistent, objective standards for program admission and disenrollment.

The Department urges OSC to acknowledge the limitations in its finding that not all needs identified in the assessment process are addressed in Plans of Care. Medicaid recipients have autonomy and the right to drive decisions about which of their needs are addressed, how goals are prioritized, and how activities are implemented to achieve these goals.

State Comptroller's Comment – We recognize that Medicaid members have the autonomy and the right to make decisions about their care needs. In our review of provider medical records, we assessed whether there was documentation showing that a member had specifically chosen to defer or not pursue a proposed goal in their Plan of Care. We found no clear evidence that members decided not to pursue certain goals. Furthermore, the DOH redesignation reports we examined also showed that Health Homes did not consistently address whether a member, in the absence of a positive intervention or goal for an identified need, had chosen not to pursue it.

**Audit Recommendation Responses:**

**Recommendation #1**

Ensure redesignation reviews are conducted timely in accordance with the redesignation policy.

**Response #1**

The Department agrees with the recommendation and has corrected this issue in August 2023. As OSC acknowledges in the report, despite being constrained by the limitations imposed by the COVID-19 pandemic including staff shortages, the need to switch to virtual reviews, and the many mounting priorities that came with ensuring members could continue to receive services and stay safe, the Department made significant progress in revising its Redesignation review tool and process. The Redesignation Process that was implemented in August of 2023, and currently operating, ensures that redesignation reviews are conducted timely and in accordance with the Redesignation policy. 100% of reviews conducted in the 2023-2025 Redesignation cycle were completed on time as per the plan for the cycle.

**Recommendation #2**

Formally evaluate whether the redesignation process should be improved to ensure that Health Homes (via the plan of care and other actions) are addressing the underlying risk factors members were identified to have upon enrollment in the Health Home program.

**Response #2**

The Department agrees with the recommendation and has corrected the issue in 2023. We appreciate OSC's acknowledgement that the Department has implemented significant improvements to its Round 3 redesignation process, starting in August of 2023, dramatically improving the oversight of the Health Homes. The additional information submitted to the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) verifies the presence of a person-centered Plan of Care that takes into account the Medicaid recipient's identification and prioritization of needs and goals.

A recent analysis by the Department of the Comprehensive Assessments and Plans of Care of 1792 case records reviewed during the 2023-2025 Redesignation Cycle indicates that 88% of needs identified in the Comprehensive Assessment process are carried over to the Plan of Care; and among those not carried over, a substantial portion were not addressed in the Care Plan due to the member's preference.

**Recommendation #3**

Ensure that Health Homes submit Enhanced Oversight Plans timely, when required, and with adequate detail.

**Response #3**

The Department agrees with the recommendation and has corrected the issue in August 2023. The Health Home Program has ensured the timeliness of submission of Enhanced Oversight Plans during the current (2023-2025) Redesignation Cycle. To date, Health Homes have been required to submit 35 Enhanced Oversight Plans, and all were submitted within the timeframes required by the Department, with adequate detail, and were reviewed and approved by the Department in a timely manner.

The Department appreciates that OSC acknowledged that *"most enhanced oversight plans contained detailed action plans."* The Department notes that the records reviewed by OSC were for Round 2 reviews. The redesignation tool was updated in August 2023 for Round 3 reviews and includes specific criteria related to implementation of Enhanced Oversight Plans to ensure even greater compliance. Evidence from the current Redesignation Round 3 demonstrates achievement of 100% timeliness. The Department also notes that while we expect Enhanced Oversight Plans to be provided timely, it is appropriate and within the Department's discretion to allow extensions, especially where it will yield a more thorough and detailed Enhanced Oversight Plan.

**Recommendation #4**

Formally evaluate whether to include baseline data calculations (such as Health Home member

circumstances before enrollment) in the Health Home performance measures to:

- More accurately score Domain 2 of Health Home redesignation reviews, and
- Effectively measure the overall performance of the Program.

**Response #4**

The Department considered multiple approaches for evaluating the Health Home program and believes contemporary comparisons of quality measures to evaluate the Health Home performance best achieves the goals of the redesignation process. The Department uses many methods and measures to periodically review and evaluate the program. While we have occasionally used baseline before and after comparisons as part of these program evaluations, we also use other methods to accommodate the methodological and feasibility limitations of baseline before and after comparisons.

The OSC report reviewed three utilization measures which operate differently than typical quality measures. Ambulatory Emergency Department visits and inpatient utilization were never included in redesignation and PQI-92 is no longer included in redesignation. Unadjusted utilization rates are highly subject to confounding as they have minimal inclusion and exclusion criteria. However, using baseline comparisons can be misleading as Health Home goals are to improve care connection and access which may result in increased utilization. Alternatively, most quality measures, including nine other redesignation measures not reviewed by OSC, are not utilization measures. Non-utilization quality measures include denominator exclusion criteria which enable fair contemporary comparisons across populations and providers. We have chosen quality measures and methodologies that align with other state programs and federal performance evaluations.

One of OSC's major concerns was that our current methods of performance measurement do not account for varying circumstances of the members. However, baseline data does not mitigate the confounding from differing member circumstances when those circumstances also impact the rate or likelihood of change. The same factors causing varying levels of Emergency Department use before Health Home enrollment also cause variation in the responsiveness and tractability of changing Emergency Department use after Health Home enrollment. Before and after comparisons also require rigorous inclusion and enrollment criteria which greatly limit the sample size and generalizability of the analysis, even in OSC's example.

The current redesignation process uses contemporaneous comparisons to peers using validated quality measures. This is a standard approach used across New York and national programs. We also specifically select quality measures for redesignation that have strict inclusion and exclusion criteria which enable fair comparisons across providers. These measures were not chosen by OSC in their review but are a crucial component of Health Home evaluation. OSC has asserted that baseline data calculations are crucial in measuring program performance, assessing progress, and identifying areas that need improvement. While the Department does use before and after analyses when appropriate, we strive to use the best evaluation methods for each circumstance and rely on other methods that avoid the limitations of baseline data comparisons.

**State Comptroller's Comment** – DOH lacks specificity when it states that it prefers other non-utilization measures for its contemporaneous comparisons. The additional performance

measures used by DOH for Health Homes were provided during the audit and include measures such as initiation or engagement in certain treatments, adherence to certain medications, and timeliness of follow-up care. Assessing members in these areas prior to enrollment in a Health Home for comparison to circumstances after enrollment in a Health Home would provide valuable insight into whether the Health Home program had any impact and, if so, the magnitude. We encourage DOH to formally assess the feasibility of doing this for any and all measures it uses and deems appropriate (as stated in our recommendation #4). The examples illustrated on pages 16–17 of the report explain why the contemporaneous scoring and comparison DOH cites are likely inadequate for assessing and comparing Health Home providers and for assessing the overall success of the Health Home program. Furthermore, as stated in the report on Page 14, Health Homes were expected to reduce unnecessary health care costs. DOH stated in the response that it relies on other program evaluation methods; however, it is unclear what analyses DOH is referring to. During the audit, DOH officials shared the results of a comparative analysis of Health Home-enrolled members versus those who were never enrolled, and mentioned a separate analysis done by a third party that assessed utilization patterns of a small cohort of Health Home members. The officials did not share any other analyses to assess whether the goals of the Health Home program are being met.

As noted in OSC's report, the Department performs an annual system wide analysis to inform its assessment of the program (as opposed to individual Health Home performance). For example, an analysis of 3,663 adults fully enrolled in Medicaid throughout Calendar Year 2021-2022 (24 months of enrollment) that had 9+ continuous months of health home enrollment in Calendar Year 2022 reflected Inpatient Admission spend reductions of 38.4%, and Emergency Department spend reductions of 27.6%. As would be predicted for members better connected to care, Outpatient, Professional, and Pharmacy spend increased over the same period.

**Recommendation #5**

Review the $19.7 million in payments that lacked proper support in the MAPP System attestations, and make recoveries, as appropriate.

**Response #5**

The Department agrees that paid claims must be reported, returned, and explained if they lack appropriate support. However, the Department disagrees with OSC's assertion that the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) is the appropriate source to determine whether claims have been paid appropriately.

**State Comptroller's Comment** – DOH's statement conflicts with its own policies. According to DOH guidance, Health Home providers must attest that a billable service occurred by adding the member's billing instance to the MAPP System and confirming it before submitting a monthly claim. Additionally, DOH officials acknowledged that they use the MAPP System billing support records to identify providers who submit improper claims. As explained on pages 18–19 of the report, our audit tests confirmed that the MAPP System could be a resource for identifying improper claims. We contacted eight Health Homes to review 50 claims lacking MAPP billing support records. We determined that two of the sampled claims had been properly voided by the Health Homes prior to our outreach. Of the remaining 48 claims, 35, or 73%, lacked justification.

In the first half of 2023, the Health Home program demonstrated a 99.6% accuracy rate of claims matching the MAPP HHTS.

The MAPP HHTS does not supplant Health Home's responsibility to maintain records to support billing; the Department asserts that the contents of those records are the determinants of the legitimacy of claims. OSC's own findings that 27% of a convenience sample of potentially inappropriate claims flagged in their analysis of the MAPP HHTS were not inappropriate reinforces the Department's assertion that while the MAPP HHTS could contribute to the identification of inappropriate claims it cannot and should not be the sole arbiter of claim appropriateness.

In collaboration with the Department, OMIG will perform analysis of the OSC-identified overpayments to determine an appropriate course of action, which will include recovery of any payment determined to be inappropriate in the upcoming OMIG audits of Health Home providers. Providers are authorized by regulation to adjust or void any claims or encounters up to two years after submission to NYS Medicaid. OMIG takes this into account when determining the start of the audit process. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

Additionally, the Department will develop and implement a procedure for periodic identification of records where MAPP HHTS does not match claims data and will provide the results of those periodic reviews to OMIG for further investigation.

**State Comptroller's Comment** – We commend DOH officials for taking steps to implement this recommendation.

**Recommendation #6**

Ensure that Health Home claims are properly supported in the MAPP System and make recoveries on improper payments, as appropriate.

**Response #6**

Please refer to the Department's response to Recommendation #5.

**Recommendation #7**

Ensure the MCO identified in this report takes corrective actions to prevent erroneously paying voided Health Home claims due to retroactive rate changes.

**Response #7**

The Department will advise Plans of necessary corrective action to avoid paying inappropriate Health Home claims.