Department of Health

Medicaid Program – Oversight of Health Homes

Report 2023-S-8 | January 2026

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller
Division of State Government Accountability

Audit Highlights

Objective

To determine whether the Department of Health (DOH) has provided adequate oversight of Medicaid Health Homes to ensure that appropriate care was provided and that appropriate payments were made. The audit covered the period from January 2019 through June 2023, with analysis of selected performance measures extending through March 2024 and review of certain aspects of the redesignation process extending through October 2024.

About the Program

The Health Home Program (Program), implemented in New York in January 2012, is an optional benefit under the Medicaid State Plan that provides care coordination and case management to certain Medicaid members who have chronic health problems. The Program's goals include removing individuals' social and economic barriers to care, engaging people in the behavioral and general medical care needed to stay well, and reducing unnecessary services and costs.

Under New York State's approach to Program implementation, a Health Home is the central point for directing patient-centered care and is accountable for reducing unnecessary health care costs. A Health Home is not a physical place; it's a care management model that connects community and social supports with health care providers to ensure that all caregivers work together and focus on their clients' needs. Health Home providers render services to eligible members either directly or through contracts with Care Management Agencies that assign members a dedicated care manager to help with obtaining medical, behavioral, and social services.

DOH administers New York's Medicaid program and is responsible for overseeing the Program and ensuring Health Home providers comply with federal and State statutory, regulatory, and policy requirements and achieve intended results. DOH's monitoring activities include periodic audits called redesignation reviews, which are designed to assess administrative management, service delivery, and operational integrity of Health Homes. DOH also calculates Health Home performance measures (e.g., the rate of inpatient admissions for chronic conditions) to evaluate the effectiveness of the Program and to guide quality improvement efforts. Health Homes must also submit supporting information to DOH's Medicaid Analytics Performance Portal Health Home Tracking System (MAPP System) for each month a Medicaid member is enrolled in the Program, including an attestation that a billable service was provided. Based on the information submitted, the MAPP System determines whether a Health Home claim is warranted and calculates which rate code should be billed.

Key Findings

DOH has not consistently followed its monitoring and oversight guidelines for Health Homes to ensure effective delivery of services, nor has it used all available data and measurements to assess the Program's value and effectiveness. Additionally, Health Homes lacked compliance with Program policies and procedures, and certain payments made to Health Homes lacked the required support in the MAPP System. The following details our findings:

- DOH did not complete redesignation reviews for all Health Homes within the required time frames, allowing Health Homes to operate for periods without this key monitoring process. While DOH cited the COVID-19 public health emergency and the implementation of redesignation process changes in 2023 as reasons for delays with many reviews, of the 18 recent redesignation reviews due before October 2024, 10 were delayed by more than 6 months.

- Health Homes frequently did not comply with Medicaid policies and procedures. For example, the majority of Health Homes had poor compliance with updating members' care plans when needed.
- DOH's performance measure calculations do not include baseline measurements, a crucial point of reference for evaluating the progress and effectiveness of the Program and Health Home providers. Without a baseline, it is difficult to determine whether goals are being met or if improvements are needed.
- For the period from January 2019 through June 2023, we identified $19.7 million in payments across 67,026 claims that lacked proper support in the MAPP System.

Key Recommendations

- Ensure redesignation reviews are conducted timely in accordance with the redesignation policy.
- Formally evaluate whether to include baseline data calculations (such as Health Home member circumstances before enrollment) in the Health Home performance measures.
- Review the $19.7 million in payments that lacked proper support in the MAPP System attestations, and make recoveries, as appropriate.
- Ensure that Health Home claims are properly supported in the MAPP System and make recoveries on improper payments, as appropriate.

Office of the New York State Comptroller
Division of State Government Accountability

January 20, 2026

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. McDonald:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Oversight of Health Homes*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
DOH	Department of Health	*Auditee*
Agencies	Care Management Agencies	*Key Term*
AMB	Ambulatory Care Within the Emergency Department	*Key Term*
CMS	Centers for Medicare & Medicaid Services	*Agency*
eMedNY	Medicaid claims processing and payment system	*System*
IPU	Inpatient Utilization	*Key Term*
MAPP System	Medicaid Analytics Performance Portal Health Home Tracking System	*System*
MCO	Managed care organization	*Key Term*
PQI-92	Prevention Quality Indicator for Chronic Condition Hospital Admission	*Key Term*
Program	Health Home Program	*Key Term*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. During the State fiscal year ended March 31, 2025, New York's Medicaid program had approximately 8.4 million recipients and Medicaid claim costs totaled about $93 billion (comprising $49.2 billion in fee-for-service health care payments and $43.8 billion in managed care premium payments). The federal government funded about 55.7% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 44.3%.

The Department of Health (DOH) administers the Medicaid program in New York State. DOH uses two methods to pay for Medicaid services: fee-for-service and managed care. Under the fee-for-service method, DOH, through its Medicaid claims processing and payment system (eMedNY), pays providers directly for services delivered to Medicaid members. Under the managed care method, DOH pays managed care organizations (MCOs) a monthly premium for each enrolled Medicaid member and, in turn, the MCOs arrange for the provision of services and reimburse providers for those services. MCOs submit claims (referred to as encounter claims) to inform DOH of each service provided to their enrollees.

The Health Home Program (Program) created under the Affordable Care Act of 2010, Section 2703, provides care coordination and case management to children and adult Medicaid members who have certain health conditions and meet Program eligibility requirements. Under New York State's approach to Program implementation, a Health Home is the central point for directing patient-centered care and is accountable for reducing unnecessary health care costs, specifically preventable hospital admissions and readmissions and avoidable emergency room visits; providing timely post-discharge follow-up; and improving patient outcomes by addressing primary medical, specialist, and behavioral health care needs. A Health Home is not a physical place; it's a care management model that connects community and social supports with health care to ensure that all caregivers work together and focus on their client's needs.

The Program is available as an optional benefit for members who have at least two chronic conditions or a single qualifying condition (e.g., serious mental illness) and who have identified social risk factors, such as food insecurity. However, an individual can have two chronic conditions and be managing their own health and social care needs effectively, thereby not requiring Health Home care management assistance. Therefore, an individual must be assessed and found unable to manage their health conditions effectively due to significant behavioral, medical, physical, or social risk factors that require the intensive level of services provided by the Program. Health Home providers render services to eligible members either directly, or through contracts with Care Management Agencies (Agencies).

Core Health Home services include assessing preliminary needs of potentially eligible members, developing treatment plans, coordinating and arranging for the provision of services, supporting adherence to treatment recommendations, and monitoring and evaluating their health status. Members enrolled with a Health Home

are assigned a dedicated care manager to assist them with obtaining medical, behavioral, and social services. DOH requires Health Homes to provide at least one of the core services per month for each member for whom reimbursement is claimed. DOH requires Health Homes to use its Medicaid Analytics Performance Portal Health Home Tracking System (MAPP System), a web-based performance management system designed to house member information for those enrolled in the Program and to track and manage their care provided through the Program. Health Homes must submit various supporting information for every month members are enrolled in the Health Home, including attestations that billable services were provided.

Health Homes receive a set payment for each enrolled member each month, ranging from $200 to $877, and the payment amount is influenced by the member's age, the complexity of their health and social needs, and the intensity of care management services required. During the period from January 2019 through June 2023, Medicaid paid $3 billion for Health Home services provided to 431,155 Medicaid members.

DOH is responsible for overseeing the Program and ensuring Health Home providers comply with federal and State statutory, regulatory, and policy requirements and achieve intended results. DOH monitoring activities include periodic audits of Health Homes called redesignation reviews, which are designed to evaluate Health Homes' operations and performance to ensure they are in compliance. Additionally, DOH calculates various Health Home performance measures (e.g., the rate of inpatient admissions for chronic conditions among members enrolled in a Health Home) to evaluate the effectiveness of the Program and to guide quality improvement efforts.

Audit Findings and Recommendations

We determined that DOH did not adequately oversee Medicaid Health Homes to ensure appropriate care and payments. For example, DOH did not conduct redesignation reviews for all Health Homes as often as required, and these reviews lacked consistency prior to August 2023, when improvements were implemented. Additionally, Health Homes frequently did not comply with Medicaid policies and procedures. We also found that DOH's performance measure calculations did not include baseline measurements, a crucial point of reference for evaluating progress and the effectiveness of the Program and Health Home providers. Without a baseline, it is difficult to determine whether goals are being met or if improvements are necessary. Finally, from January 2019 through June 2023, we identified $19.7 million in payments across 67,026 Health Home claims that were not appropriately supported by information in the MAPP System.

Redesignation Reviews

Since 2019, DOH has monitored Health Homes through redesignation reviews, which are periodic audits of various aspects of operations and performance to ensure compliance with federal and State requirements. These reviews aim to provide assurance that Medicaid members in Health Homes receive necessary medical, behavioral health, and long-term services and support. Areas reviewed include administrative processes and documentation, Health Homes' performance against specific measures and processes, and evidence of positive interventions in member charts. Health Homes are required to have written documentation that clearly demonstrates how the requirements are being met. During the redesignation review, DOH reviews a list of questions and documentation for each area of compliance and reviews a sample of member charts to calculate compliance scores based on whether the Health Home provided sufficient documentation to meet the specific requirement.

DOH summarizes its findings for each Health Home in a redesignation report across three separate domains—Administrative Review Management (Domain 1), Performance and Process Measures (Domain 2), and Chart Review Analysis (Domain 3)—and assigns weighted numeric scores for each. The individual domain scores are then used to calculate the Health Home's total score. Health Homes that receive a high overall score get a maximum redesignation of 3 or 4 years, those with middle-range scores get a 2-year redesignation, and those that don't perform well get a provisional redesignation of 1 year or less. Health Homes that receive multiple low scores or one failing score can be removed from the Program. DOH has worked to improve the redesignation process since it was implemented in 2019. Round 1 of the redesignation reviews ran from 2019 to 2020, Round 2 ran from 2021 to 2022, and Round 3 started in 2023.

We determined that DOH did not adequately monitor Health Homes' compliance with certain requirements because it did not conduct redesignation reviews for all Health Homes within the required time frames and did not complete all elements of reviews consistently. Additionally, Health Homes frequently did not comply with DOH policies and procedures, such as patient chart documentation and proper billing support

requirements. We note that DOH has taken steps to improve the redesignation process to better ensure adequate care, including gradually increasing the scoring thresholds for determining the timing of the next redesignation review, improving the consistency of the record review process, and significantly increasing the number of members sampled for the reviews.

Health Home Redesignation Reviews Not Completed on Time

To assess the timeliness of DOH redesignation reviews, we reviewed the reports completed from January 2019 through October 2024. During this period, a total of 31 Health Homes serving adult and/or child members participated in the Medicaid program; however, some Health Homes closed or merged with other Health Homes. Reviews resulted in the following redesignations:

Round 1 (2019–2020): DOH reviewed 27 of the 31 Health Homes and granted a 2-year redesignation to 17 Health Homes, a 1-year redesignation to eight Health Homes, and a 6-month redesignation to two Health Homes. Of the remaining four Health Homes, two had no redesignation review performed, and two were new providers with an initial designation period of 2 or 3 years and were not yet due for a review. We did not have the due date for Round 1 reviews, so we were unable to assess the timeliness of these reviews.

Round 2 (2021–2022): During this round, six of the 31 Health Homes either closed or merged with another Health Home. DOH completed redesignation reviews for the remaining 25 Health Homes. Of these, 14 reviews were completed timely or with delays of 6 months or less, while 11 (44%) had delays of more than 6 months. DOH granted a 3-year redesignation period to one Health Home, a 2-year redesignation period to 20 Health Homes, and a year or less redesignation period to four Health Homes.

Round 3 (began in 2023): Of the 25 Health Homes still open after Round 2, six later closed or merged into another Health Home and, therefore, no redesignation review was done. In October 2024, we inquired about the status of the redesignation reviews for the 19 operational Health Homes. Eighteen of these were due to be reviewed before October 2024. DOH provided us with eight completed reports and stated 10 of the 18 were still ongoing. Of the 18 reports, we determined 10 (56%) were not completed timely; four of the eight completed reviews were delayed, with delays ranging from 8 to 15 months, and six of the 10 ongoing reviews were already over 6 months past the due date at the time of our inquiry. DOH officials stated redesignations were paused for all Health Homes after Round 2, until August 2023, because they were revamping the redesignation process. For example, one Health Home had a redesignation review completed in September 2020, and DOH granted a 6-month redesignation due to a low score. However, the next redesignation was not completed until 11 months later. This Health Home received a 1-year redesignation in September 2021 and September 2022, but no redesignation was performed in 2023. It ultimately closed in March 2024.

DOH noted that during the COVID-19 public health emergency, delays occurred because they were short-staffed and redesignation reviews moved from in-person to online. Over time, DOH stated it has added resources to ensure more timely redesignation reviews.

Notwithstanding, as of October 2024, after the end of the public health emergency and the changes to the redesignation process, 10 Health Homes were past due for completed redesignation reviews, which allowed these Health Homes to operate for periods without this key monitoring process. Conducting redesignation reviews according to DOH's prescribed time frames will help ensure Health Homes meet requirements and provide adequate care.

Lack of Compliance With Program Rules and Inconsistent Patient Chart Reviews

Patient chart review is Domain 3 of the redesignation reviews. In this domain, DOH reviews Health Home patient records for a sample of members, and DOH reviewers answer a set of predetermined questions to determine if Health Homes meet Program requirements. The patient chart review domain includes seven areas: comprehensive health assessment, forms and documentation, member plan of care, Health and Recovery Plans and Home and Community-Based Services, care coordination, MCO interaction, and member disenrollment. Each area has detailed questions. For example, in the member plan of care area, DOH evaluates whether Health Homes have met standards for specific elements in members' plans, such as establishing goals related to treatment, wellness, and recovery; determining functional needs related to the goals, including a description of planned interventions to achieve them; and tracking progress in meeting the goals.

A score is assigned to the domain based on whether the Health Home had sufficient documentation showing it met Program requirements. If the patient chart sufficiently supported that a specific function was performed—for example, verifying a member's eligibility and appropriately documenting it—DOH would assign a value of 1 to that element. If the documentation was insufficient, a value of 0 would be given, lowering the overall compliance score. Some questions are mandatory, while others are situational or not applicable.

To assess the completeness and consistency of DOH's review of patient charts during redesignation Round 2 (2021–2022), we selected redesignation reports for all 18 Health Homes where DOH's updated Round 2 report format was used, which included all questions that DOH used in its review. We did not assess the redesignation reviews for seven Health Homes in Round 2 that used an older report format, which did not consistently include all review questions.

For the 18 reports we analyzed, DOH sampled a total of 283 members and reviewed documentation for compliance with up to 66 questions for each member. We note that DOH requires a written Enhanced Oversight Plan—detailed later in this report—for each question with a rating below 90%. The redesignation process identified low compliance (below 90%) in several areas, as follows:

- Members' barriers to care were addressed and acted upon as needed (193 of 283 samples, or 68% compliant).
- Notice of Determination for Enrollment form was provided at the time of member enrollment or was found in the patient chart (200 of 283 samples, or 71% compliant).
- Member plan of care was updated as needed (211 of 283 samples, or 75% compliant).
- An initial comprehensive assessment was completed within 60 days of enrollment (211 of 283 samples, or 75% compliant).
- The initial plan of care was developed within 60 days of member enrollment (222 of 283 samples, or 78% compliant).

Generally, DOH found that Health Homes were not routinely compliant with patient chart requirements. We analyzed the results of DOH's compliance scores across 66 questions from the 18 redesignation reports we reviewed, finding the compliance rate was below 90% for 46 (of 66) questions across these Health Homes. For example, 16 of the 18 Health Homes had less than 90% compliance in including the Notice of Determination for Enrollment form in patient charts. Additionally, 13 of the 18 Health Homes had less than 90% compliance in updating members' plans of care when needed. DOH reviewers rated 1,188 questions across the 18 Health Homes, identifying a total of 478 instances where compliance was below 90%. Overall, 15 of the 18 Health Homes had less than 90% compliance on more than half of the 66 questions.

Furthermore, the redesignation process did not assess whether Health Homes, through the plan of care or other actions, addressed the underlying risk factors used to justify a member's Program eligibility. Many Medicaid members have Health Home-qualifying medical conditions, but simply meeting Medicaid eligibility and qualifying conditions does not automatically make someone eligible for Health Home enrollment. For example, an individual may have two chronic conditions and manage their own health and social care needs effectively, thus not requiring Health Home care management assistance. To qualify for enrollment and ongoing care management services in the Program, an individual must be assessed and found to have significant behavioral, medical, physical, or social risk factors that require the intensive level of care management services provided by a Health Home. Therefore, these risk factors should be a focus of the services delivered by Health Homes and of DOH redesignation reviews.

We also found that DOH redesignation review sheets were not filled out consistently and completely. For example, out of 283 sampled members at the 18 Health Homes, 51 members (18%) had no rating from DOH on whether the Health Home addressed and acted upon identified barriers to care—factors that hinder a member's ability to access and receive necessary services. DOH policy requires Health Homes to continuously evaluate members' health care and related needs, ensuring barriers to care are identified and addressed for every member. Additionally, DOH did not

rate 18 of 283 sampled members when checking if the Notice of Determination for Enrollment form was provided at the time of enrollment and on file.

Additionally, the "Assessment and Action Taken" section of the patient chart review domain focuses on whether certain health care and social needs were screened for during a member's comprehensive health assessment and whether the associated plan of care should include positive interventions to address the identified needs. Each member must be screened for 18 health care and social needs. DOH reviewers did not consistently record a value of 1 or 0 on the redesignation review sheets while rating compliance for the 283 sampled members, leaving many response cells blank. None of the 18 areas assessed were filled out completely for all members. For example, for 74 of the 283 members (26%), DOH did not record a response to the question about whether the member was screened for the need of a specialist in a particular field to address their specific needs or challenges. Additionally, DOH did not record a response for whether the member was screened for any educational needs for 48 of the 283 members (17%). The lack of response on DOH review sheets suggests members might not have been properly screened and that not all needs were documented in their patient charts. Members who are not consistently screened may be at risk of not receiving comprehensive and timely high-quality services to improve their health outcomes.

As mentioned, DOH has taken various steps to improve its oversight of Health Homes by improving the redesignation process, which may, in turn, help ensure Program rules are followed. For example, Round 3 of the redesignation reviews, which began in August 2023, included a revised patient chart review sheet that required a response to every question and a rating for each sampled member to prevent inconsistent results. We reviewed three of these completed redesignation reviews and found that the new review sheets were generally filled out more thoroughly and consistently.

Health Home Records Missing Components

We selected a judgmental sample of 50 adult and child members from six Health Homes that were among the top-paid providers in the 2019 and 2022 calendar years. We selected the Health Homes from different regions in the State (downstate and upstate) that served both adult and child members, and we selected the members who had been enrolled in the Health Home for over 6 months and did not have a history of corresponding medical claims during their enrollment. As with the DOH redesignation reviews, our review of Health Home patient records noted instances where members were not screened for all potential needs, and members' plans of care were deficient because they did not consistently document barriers to care, risk factors (characteristics that increase the likelihood of a negative health outcome), strengths, goals to achieve, and the timeline to achieve goals. For 34 of 50 members reviewed (68%), the plan of care did not document risk factors. Additionally, for 16 (of 34) members (47%), the plan of care did not identify any barriers to care. We also found 33 of 50 members (66%) were not screened for all required areas during the comprehensive health assessment. For example, one member wasn't

screened for food, home care, advanced directive, education, social support, and legal needs. Our review also showed that even when needs were identified, they were often not added as goals to the plan of care and the members were not always actively working to achieve the goals in their plan of care. In another example, a member assessed in March 2019 needed a primary care physician, stable housing, financial assistance, and assistance with daily living. However, Health Home records from 2019 and 2020 showed the member had goals on file but chose not to engage with providers during that time, and all goals were abandoned while the member remained in the program for over 2 years until their disenrollment from the Health Home in March 2021.

We note that, effective December 2023, DOH implemented a new assessment form, the Continued Eligibility for Services Tool, which must be filled out for certain Health Home members after 12 months of enrollment in the Program and every 6 months thereafter, to help ensure it is appropriate for those members to remain in the Program.

Inconsistent and Incomplete Enhanced Oversight Plans

Health Homes that did not meet compliance requirements based on the redesignation review are required to develop and implement a written Enhanced Oversight Plan, a detailed document outlining the reasons for the deficiencies identified, a plan to correct them, and specific timelines for implementation. Health Homes requiring these plans must complete and submit them to DOH within a set time frame of receiving their initial redesignation results.

In the patient chart review domain, DOH requires a written Enhanced Oversight Plan for each question with a rating below 90%. We checked whether these plans were submitted as required for the 18 Health Homes we reviewed for Round 2 of the redesignation process. We found that Enhanced Oversight Plans were submitted by Health Homes for 430 of 478 (90%) identified deficiencies where compliance was below 90%. For the plans we reviewed, we noted that the level of detail provided varied significantly. For example, regarding the question about whether the initial comprehensive assessment was completed within 60 days of enrollment, one Health Home stated it created reports and dashboards to ensure assessments were done in a timely manner and that it created supervisory chart review tools that collected data on assessment timeliness. However, another Health Home responded to the same question, stating it would review office hours and had implemented a “quality notebook.” We concluded that most of the actions listed in the plans contained detailed action plans (386 of 430, or 90%), while a small percentage of Enhanced Oversight Plans (44 of 430, or 10%) lacked detailed corrective measures.

We shared our observations from the analysis of the Round 2 redesignation reports and the reconciliation of the Enhanced Oversight Plans with DOH officials during the audit. They generally agreed that their previous redesignation process was less effective in identifying Health Home deficiencies. Additionally, DOH added an element within Domain 1 to its Round 3 redesignation reviews (which began

in 2023) regarding the implementation of Enhanced Oversight Plans to address previously identified deficiencies. Furthermore, DOH officials stated that for any Health Home that received less than a 2-year redesignation, they meet to assess the completion of each element from the approved Enhanced Oversight Plan prior to conducting another review in 6 months or 1 year. DOH officials stated they also have the discretion to conduct a focused review at any time if a Health Home has underperformed in the past or if an emerging issue raises concerns. When we asked DOH about focus reviews for three Health Homes that underperformed previously based on past redesignation results, DOH responded that they did not conduct such reviews for those Health Homes.

Performance Measures

According to DOH, Health Homes were expected to reduce unnecessary health care costs, specifically preventable hospital admissions, readmissions, and avoidable emergency room visits; lessen reliance on long-term care facilities; ensure needed care is received; and improve the quality of care for members. To drive improvement in care delivery and health outcomes, the Centers for Medicare & Medicaid Services (CMS) established performance and utilization measures for Health Homes. States were expected to report these measures to CMS to facilitate standardized reporting on a uniform set of performance measures and to encourage states to use the results to improve quality. Additionally, DOH established and defined performance measures to evaluate and assess individual Health Homes and the Program as a whole within New York's Medicaid program. DOH collects utilization and enrollment data from Medicaid claims and encounters, along with provider-submitted data from the MAPP System. Using the performance measure specifications and collected data, DOH calculates these measures quarterly.

DOH factors certain performance measures into its redesignation reviews. For its redesignation reports, DOH selected a subset of performance and process measures (Domain 2), and assigned points based on percentile rankings compared with other Health Homes. For example, if a Health Home's score on a given measure was in the 75th percentile, it would typically be given a score of 7.5. The total score for Domain 2 is calculated by aggregating the points for all measures, and this score is then combined with Domain 1 and Domain 3 scores—each based on DOH's determined weights—to calculate the redesignation score for the Health Home. As noted, higher overall scores during redesignation reviews result in longer intervals between reviews.

Use of Baseline Calculations to Assess Performance

We reviewed the performance measures calculated by DOH for the Health Home population and judgmentally selected three measures for further analysis based on relevance to key goals of the Program. The three measures selected were related to chronic health conditions, utilization of inpatient services, and utilization of emergency room services:

- Ambulatory Care Within the Emergency Department (AMB) – summarizes utilization of ambulatory care in outpatient emergency department visits (i.e., emergency department visits that don't result in an inpatient stay)
- Inpatient Utilization (IPU) – summarizes utilization of acute inpatient care and services in maternity, surgery, mental and behavioral health, and medicine
- Prevention Quality Indicator for Chronic Condition Hospital Admission (PQI-92) – assesses the rate of preventable hospitalizations for chronic conditions such as diabetes, asthma, and hypertension

Performance measures are calculated as the rate per applicable population.

Our analysis of the three selected performance measures was based on the query logic DOH uses to calculate these measures. For the period from April 1, 2021 to March 31, 2024, we identified members who were continuously enrolled in Medicaid for 12 months before Health Home enrollment and then maintained 12 months of continuous Health Home enrollment. This resulted in 29,168 member spans of 24 continuous months across 26 Health Homes. Additionally, using the query logic provided by DOH, we extracted Medicaid claims data in accordance with DOH's criteria for the three performance measures. This included identifying information such as certain hospital visits, inpatient admission types, and specific health conditions relevant to a measure's calculation. We then analyzed the performance measures at the Health Home level based on member enrollment information in the Medicaid Data Warehouse.

We analyzed the performance measure results before and after enrollment for each of the 26 Health Homes for the population of 29,168 members. As shown in Table 1, there was no significant change in the performance measures from the period before members enrolled in Health Homes to after their enrollment. A decrease in the rate is considered an improvement for AMB and PQI-92, while an increase in the rate of IPU is desired as it indicates needed care was received.

Table 1 – Changes in Performance Measures When Using a Baseline

Quality Measure	Performance Measure w/ Improved Rate (> 3%)	Performance Measure w/ No Relative Rate Change	Performance Measure w/ Worsened Rate (> 3%)	Number of Performance Measure Calculations
AMB	0	26	0	26
IPU	1	25	0	26
PQI-92	1	20	2	23*
Total	**2**	**71**	**2**	**75**

*PQI-92 does not apply to Health Homes that only serve children.

The pre- and post-enrollment rates for these performance measures show that 12 months of Health Home enrollment did not significantly impact members' inpatient admissions for chronic conditions, inpatient service utilization, or ambulatory emergency room services. Only four out of 75 (5%) Health Home performance measure calculations in our analysis showed a change of more than 3% after

enrollment (two with an improved rate and two with a worse rate), while the remaining 71 (95%) had a change of less than 3%.

Use of Baseline Calculations for Redesignation Scoring

To assess how not using baseline data calculations affects performance scores on redesignation reports, we reviewed redesignation reports from Round 3 (started in 2023) for two Health Homes. These Health Homes had scores within Domain 2 for PQI-92 that ranged from the 25th (lowest) to the 100th (highest) percentile (see Table 2). One Health Home located upstate had a DOH-calculated PQI-92 rate of 2,482 (meaning 2,482 preventable hospital admissions for chronic conditions per a composite of chronic conditions per 100,000 members) from October 2021 to September 2022. This score earned the maximum points (10) for this measure because its rate was in the 100th percentile. In contrast, another Health Home located downstate had a DOH calculated PQI-92 rate of 9,606 and received the minimum points (2.5) because its rate was in the 25th percentile in the same period. Based on this audit's calculations of PQI-92, using baseline data from April 1, 2021 to March 31, 2024 (with members having 12 months of Medicaid before enrollment and 12 months after enrollment), the lower rate for the upstate Health Home does not necessarily indicate better performance as the DOH percentiles and Domain 2 points given for PQI-92 would suggest. The upstate Health Home's PQI-92 rate was 3,205 before enrollment and increased to 4,360 during enrollment. The downstate Health Home's rate was 7,966 before enrollment and rose slightly to 8,108 during enrollment. These PQI-92 rates indicate significant differences in the circumstances of the respective member populations between the two providers. However, they do not indicate that the upstate Health Home significantly outperformed the downstate Health Home. Rather, both Health Homes' PQI-92 rates worsened slightly in the 12 months after enrollment, as shown in Table 2.

Table 2 – PQI-92 for Two Sampled Health Homes (Rates per 100,000)

Health Home	Prior to Enrollment (Using Baseline Data)	During Enrollment (Using Baseline Data)	DOH Calculated Rate (Domain 2)	DOH Calculated Percentile (Domain 2)
Upstate	3,205	4,360	2,482	100
Downstate	7,966	8,108	9,606	25

The current scoring for Domain 2 of the redesignation review does not incorporate baseline data calculations, so it does not account for differences in circumstances among each Health Home's members or accurately reflect improvements or declines in performance. As a result, performance measure scores in Domain 2 may be unnecessarily lower and higher, potentially leading to longer or shorter periods between redesignation reviews than what Health Homes might otherwise receive.

It is important to track performance measures before and after implementing changes and interventions to effectively measure Program performance, assess progress, and identify areas that need improvement. Without baseline data calculations, it is difficult to determine if and to what extent Health Homes are

improving health outcomes for their members. Performance measures that include baseline data—such as the circumstances before Health Home enrollment—are more likely to effectively identify areas of the Program that require improvement, high- or low-performing providers, and best practices. Additionally, DOH has not routinely or comprehensively calculated Program cost savings resulting from reduced use of unnecessary emergency department, inpatient, and nursing facility services.

DOH officials generally agreed that more can be done with performance measures to assess Program performance. However, during the audit, they disagreed that comprehensive baseline data, such as calculations of performance measures before Health Home enrollment, should be routinely used, primarily citing the complexity of doing so. However, we note that DOH presented slides it shared with the Health Home provider community in January 2025, which displayed results of a comparative analysis showing the performance of Health Home members across multiple performance measures compared with the rest of the Medicaid population not enrolled in Health Homes. The officials stated that these results suggested Health Home members generally performed better than their non-Health Home counterparts. We note that this analysis did not include any baseline measures of the actual individuals who elected to receive Health Home services, and therefore, DOH's conclusions might not be adequately supported. DOH officials also mentioned a separate analysis done by a third party that assessed utilization patterns of a small cohort of 3,887 Health Home members age 21 or older as of December 2023 who had been enrolled in Medicaid for at least 24 months and in the Program for at least 9 months. According to DOH, the results suggested a significant reduction in inpatient and nursing home costs and admission rates for this cohort compared with other Medicaid members not enrolled in the Program. However, DOH also noted a significant increase in outpatient and pharmacy utilization and costs. DOH officials explained that when chronically ill, newly enrolled members are reconnected with care through Program care coordination, an increase in costs is an expected outcome. The officials were unable to provide additional details that would enhance our understanding of the underlying data and methodologies used to generate the results presented in the tables. Nonetheless, providing this analysis suggests DOH recognizes the value of assessing the Program using baseline data calculations.

While reducing Medicaid costs related to avoidable inpatient admissions and emergency room use are important goals of the Program, DOH officials have been cautious about measuring utilization, citing the difficulty of setting realistic performance goals for utilization measures. However, establishing a baseline for the performance measures is a potential way to more accurately assess Program and Health Home provider performance, whether through utilization-based or other measures.

Claims Without Appropriate Support in the MAPP System

Health Homes are required to provide information to the MAPP System each month for all enrolled members. Prior to submitting claims for payment, Health Homes are expected to update the MAPP System with billing support information for each member attesting to the type of service provided, whether the member was a child or an adult, and any other relevant circumstances related to the needed care. Based on this information, the MAPP System determines if a claim is warranted and calculates the appropriate rate code for billing. Occasionally, if a Health Home determines that the initial submission was inaccurate, the submitted information is voided or replaced with another record.

To meet Program member needs, Health Homes or the contracted Agencies must provide core Health Home services on a consistent basis. However, members may occasionally become disengaged from the Program, such as when a member without stable housing misses scheduled appointments and cannot be located. Health Homes and their Agencies must take steps to locate and re-engage these members in their care, and in some cases, may need to intensify efforts beyond case management activities. These activities, known as diligent search efforts, can include actions like attempting a face-to-face visit to the member's last known address or reaching out to emergency contacts. DOH allows payments to Health Homes during the first 3 consecutive months of a diligent search, beginning from the month the member was considered disengaged. Members who cannot be located through diligent search efforts must be disenrolled from the Program.

We compared the MAPP System billing support records to Health Home fee-for-service and encounter claims in the Medicaid Data Warehouse from January 2019 through June 2023. We identified $19.7 million in payments across 67,026 claims that were not appropriately supported by the MAPP System's billing support records, as summarized in Table 3.

Table 3 – Summary of Data Match Results by Issue

Issue	Claim Count	Unsupported Amount
No core service was attested to	43,862	$12,749,783
MAPP indicated voided claims	14,558	4,987,834
Billed at a rate exceeding the MAPP-calculated rate	6,861	1,369,773
Diligent search billed for more than 3 consecutive months	1,231	364,266
No record of member in MAPP	514	186,736
Totals	**67,026**	**$19,658,392**

To better understand why Health Home claims were billed without proper billing support records as required by DOH, we contacted the eight Health Homes with the highest number of claims within our risk population and asked them to review a judgmental sample of 50 claims from our risk population with service dates in 2022. This review found that 35 claims were not justified, 13 claims had documentation of core services or diligent search efforts to justify the billing despite not updating MAPP

with the appropriate information, and two claims had been properly voided by the Health Homes before our audit. Further detail regarding the 35 claims follows:

- For 15 claims, the Health Homes determined that their claims were inappropriate and submitted voids to the MCO prior to our audit sample; however, the MCO erroneously paid these claims again when processing system-wide retroactive claim adjustments. These claims were paid, voided, and then re-paid by the MCO without proper justification within the MAPP System.
- For 12 claims, Health Homes stated that billing errors caused the improper claims, as they either failed to void the claim after the corresponding billing support record was voided in the MAPP System or they submitted a claim at the incorrect, higher rate.
- For five claims, the Agency initially submitted a billing support record indicating that a core service had been provided, and the Health Home billed a claim based on this record. Later, the Agency reviewed the member's case and determined the services provided were not sufficient to justify a claim, so it submitted an adjusted billing support record to the MAPP System indicating that no billable service had been provided. The Health Home was expected to void the corresponding claim, but failed to do so.
- For three claims, Health Homes billed for members who had already disenrolled from the Program or transferred to another Health Home, and their enrollment segment within the MAPP System did not have a corresponding billing support record where they could upload information about the services provided outside the member enrollment period. These Health Homes agreed that their claims were not justified and should not have been billed.

DOH allows billing for diligent search efforts for 3 consecutive months. For service dates prior to December 1, 2022, Health Homes, through their Agencies, had to ensure that they did not add more than three consecutive billing support records to the system while a member was in diligent search status. For service dates after December 1, 2022, the MAPP System only allows the submission of up to three consecutive billing support records during diligent search, then stops providers from adding additional records. However, DOH lacks effective mechanisms to prevent payments to Health Homes beyond 3 months.

While the responsibilities for claim submission and billing support records reporting to the MAPP System are shared between Health Homes and their contracted Agencies, Health Homes are ultimately responsible for ensuring Agencies comply with applicable DOH policies and procedures. Health Homes did not always follow the requirement to have appropriate billing support records in the MAPP System before requesting reimbursement from Medicaid. Additionally, Health Homes did not always void their claims after the Agency voided or adjusted billing support records indicating no reimbursable core service was provided. Closer monitoring of Agency submissions by Health Homes is needed to ensure all claims are properly supported.

DOH does not routinely monitor Health Home claims to identify those lacking proper support in the MAPP System. During the Health Home redesignation process, DOH reviews the MAPP billing support records by comparing claim rate codes with the MAPP System's calculated rates. However, the timing of the redesignation process varies greatly for each Health Home, which can allow some billing support issues at higher-scoring Health Homes to go undetected for longer periods of time.

Recommendations

1. Ensure redesignation reviews are conducted timely in accordance with the redesignation policy.
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.
3. Ensure that Health Homes submit Enhanced Oversight Plans timely, when required, and with adequate detail.
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.
5. Review the $19.7 million in payments that lacked proper support in the MAPP System attestations, and make recoveries, as appropriate.
6. Ensure that Health Home claims are properly supported in the MAPP System and make recoveries on improper payments, as appropriate.
7. Ensure the MCO identified in this report takes corrective actions to prevent erroneously paying voided Health Home claims due to retroactive rate changes.

Audit Objective, Scope, and Methodology

The objective of our audit was to determine whether DOH has provided adequate oversight of Medicaid Health Homes to ensure that appropriate care was provided and that appropriate payments were made. The audit covered the period from January 2019 through June 2023, with analysis of selected performance measures extending through March 2024 and review of certain aspects of the redesignation process extending through October 2024.

To accomplish our objective and assess related internal controls, we interviewed officials and gathered information from DOH, Health Homes, and MCOs. We examined the relevant DOH policies and procedures and reviewed applicable federal and State laws, rules, and regulations. We used the encounter system, eMedNY, the Medicaid Data Warehouse, and the MAPP System to identify Health Home claims.

We used a non-statistical sampling approach to provide conclusions on our audit objective and to test internal controls and compliance. We selected judgmental samples. However, because we used a non-statistical sampling approach for our tests, we cannot project the results to the respective population. Our samples, which are discussed in detail in the body of our report, include:

- We selected a judgmental sample of three of the 49 performance measures listed in the DOH Health Home Measure Specification and Reporting Manual, based on their availability, accessibility, and complexity, to evaluate performance on baseline calculations.
- We selected a judgmental sample of six top-paid Health Homes in 2019 and 2022 from the total population of 26 Health Homes. The Health Homes we selected represented different regions of the State (downstate and upstate) and served both adult and child members. We used the claims submitted by these Health Homes to test for missing record components.
- We asked the six top-paid Health Homes to review a judgmental sample of 50 of 399,767 records for adult or child members who had been enrolled in a Health Home for over 6 months and did not have a history of corresponding medical claims during the enrollment. We used the sample to test for missing record components.
- We selected a judgmental sample of eight top-paid Health Homes in 2022 to identify claims that were at risk of not being properly justified by billing support records in the MAPP System.
- We asked the eight top-paid Health Homes to review a judgmental sample of 50 of 5,632 claims with service dates in 2022 within the risk population of claims that were not properly justified by billing support records in the MAPP System. The sample was selected to proportionally represent each risk area identified within the population, relative to the size of the selected Health Homes, billed rate codes for adult and child members, and fee-for-service and encounter claims.

We relied on data from eMedNY and the Medicaid Data Warehouse that, based on work performed by OSC, is sufficiently reliable for the purposes of this audit. We also

relied on data from the MAPP System and assessed the reliability of that data by reviewing existing information, interviewing officials knowledgeable about the system, performing electronic testing, and tracing to and from source data. We determined that the data from this system was sufficiently reliable for the purposes of this report.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

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

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of DOH's oversight and administration of Medicaid Health Homes.

Reporting Requirements

We provided a draft copy of this report to DOH officials for their review and formal comment. We considered DOH's comments in preparing this report and have included them in their entirety at the end of the report. In their response, DOH officials generally concurred with the audit recommendations and indicated that certain actions have been and will be taken to address them. Our responses to certain DOH remarks are included in the report's State Comptroller's Comments, which are embedded in DOH's response.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

NEW YORK STATE | Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, MD, MPH
Commissioner

JOHANNE E. MORNE, MS
Executive Deputy Commissioner

December 3, 2025

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:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2023-S-8 entitled, "Medicaid program: Oversight of Health Homes."

Thank you for the opportunity to comment.

Sincerely,

Johanne E Morne

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

Enclosure

cc: Melissa Fiore
Amir Bassiri
Jacqueline McGovern
Jennifer Danz
James Dematteo
James Cataldo
Brian Kiernan
Timothy Brown
Amber Gentile
Michael Lewandowski
OHIP Audit
DOH Audit

Department of Health Comments on the Office of the State Comptroller's Draft 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) Draft 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 175,000 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 against inappropriate billing, tighter scrutiny of Plans of Care, and the adoption of consistent, objective standards for program admission and disenrollment.

The Department disagrees with OSC's general finding that not all needs identified in the assessment process are addressed in Plans of Care.

State Comptroller's Comment – The basis for DOH's disagreement is unclear. As stated on page 12 of the report, the audit sampled 50 members from six Health Homes and found that members' plans of care were deficient because they did not consistently document barriers to care, risk factors (characteristics that increase the likelihood of a negative outcome), strengths, goals to achieve, and the timeline to achieve goals.

We also found that DOH's redesignation process did not assess whether Health Homes, through the plan of care or other actions, addressed the underlying risk factors used to justify a member's Program eligibility. DOH's response to recommendation 2 (see Response #2 below) indicated that it agreed and took steps to fix this issue.

The Department also disagrees with the premise that the MAPP System is an appropriate indicator of 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 and 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 (73%) lacked justification.

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 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.

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 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 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. The Department denies reimbursement to a Health Home that has not met certain criteria, including a timely finalization of the Plan of Care, ensuring that those whose needs have been met do not remain in the Health Home program, and – although not mentioned in the Draft Report – ensuring there is objective justification for enrollment due to physical, behavioral, or social risks.

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 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 28 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 has thoughtfully considered multiple approaches to measuring the Health Home program and has chosen to implement evaluation strategies for the overall program and redesignation that do not regularly incorporate baseline data. The current approach is typical in quality measurement and used across New York and national programs. This widely utilized approach uses contemporaneous comparisons to peers using validated quality measures and leverages quality measures with stringent criteria to account for differing population eligibility. These measures were not chosen by OSC in their review but are crucial components of program evaluation for the Health Home. The Department's current approach addresses many of the concerns raised in OSC's audit which the inclusion of baseline data would not inherently address. Because members become eligible for and enroll in Health Homes primarily at a time of change, crisis, or need, which means their outcomes and utilization are expected to change, the Department has decided that the use of baseline data would be methodologically problematic and finds it more appropriate to compare performance across Health Homes.

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 spends increased over the same period.

State Comptroller's Comment – The use of baseline data could enhance DOH's current methods and provide valuable insights into the performance of Health Homes and specific program areas. As outlined on page 16 of the report, DOH's existing process—evaluating a Health Home's performance by comparing it to others—is limited and does not account for differences among each Health Home's members or accurately reflect improvements or declines in performance. Additionally, the annual analyses referenced in DOH's response (and on page 17 of the report) were based on a small group of adult members, representing about 2% of the entire Medicaid population enrolled in the program. During the audit, DOH was unable to provide details to support the analysis, so we could not verify the reductions in inpatient admissions and emergency department spending. Regardless, we encourage DOH to expand the review to include a larger population. We also urge DOH to consider establishing a baseline for performance metrics, which would add another measure—alongside existing measures—to better evaluate both the Program and Health Home provider performance.

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 the premise that the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System is intended to be the source of determinations of whether claims have or have not been paid appropriately. This reflects a continued inaccurate understanding of the purpose of the system.

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 and 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 (73%) lacked justification.

The MAPP Health Home Tracking System is not an appropriate audit tool. It was established to track enrollment and its relationship to billing is simply to provide the Health Homes with guidance regarding which acuity level ought to be billed. The MAPP Health Home Tracking System does not supplant the Health Home's responsibility to maintain records to support billing. The lack of MAPP Health Home Tracking System support of a claim does not definitively indicate that a claim/encounter was inappropriately paid. During the Redesignation process the Department regularly reviews and audits documentation within the Health Homes' Electronic Health Records (EHR) that constitutes the justification for claims submission.

Though it is not a reliable indicator, it is noted that the $19.7M in claims which OSC has identified as not matching MAPP Health Home Tracking System records represents less than one percent of the total spend for Health Home services provided in the review period. In the

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

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. Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process.

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.

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 and 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 (73%) lacked justification.

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.

Contributors to Report

Executive Team

Andrea C. Miller - *Executive Deputy Comptroller*

Tina Kim - *Deputy Comptroller*

Stephen C. Lynch - *Assistant Comptroller*

Audit Team

Andrea Inman - *Audit Director*

Christopher Morris - *Audit Director*

Mark Breunig - *Audit Manager*

Kate Merrill - *Audit Supervisor*

Emily Proulx - *Examiner-in-Charge*

Nareen Jarrett - *Examiner-in-Charge*

Benjamin Babendreier - *Senior Examiner*

Julissa Guzman - *Senior Examiner*

Misty Daiyan - *Senior Examiner*

Andrea Majot - *Supervising Editor*

Contact Information
(518) 474-3271
StateGovernmentAccountability@osc.ny.gov
Office of the New York State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

For more audits or information, please visit: www.osc.state.ny.us/state-agencies/audits