

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**IOWA INADEQUATELY MONITORED
ITS MEDICAID HEALTH HOME
PROVIDERS, RESULTING IN
TENS OF MILLIONS IN IMPROPERLY
CLAIMED REIMBURSEMENT**

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Office of Inspector General

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Report in Brief

Date: April 2020

Report No. A-07-18-04109

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 healthcare model in which providers work together to coordinate and manage beneficiaries’ care at a reasonable cost.

For Federal fiscal year 2016, States claimed Federal Medicaid reimbursement for health home services totaling \$750 million (\$431 million Federal share). Iowa’s program accounted for 3 percent of the Federal share.

Our objective was to determine whether Iowa’s claims for Medicaid reimbursement for payments made to health home providers complied with Federal and State requirements.

How OIG Did This Audit

Our audit covered 795,000 payments made to health home providers for services provided during calendar years 2013 through 2016, totaling approximately \$107 million (\$92 million Federal share). We selected and reviewed a stratified random sample of 130 payments. For each sampled payment, we reviewed the health home providers’ documentation and beneficiaries’ medical records or other documentation.

Iowa Inadequately Monitored Its Medicaid Health Home Providers, Resulting in Tens of Millions in Improperly Claimed Reimbursement

What OIG Found

For 62 of the 130 payments, Iowa improperly claimed Federal Medicaid reimbursement for payments made to health home providers that did not comply with Federal and State requirements. These 62 improper payments primarily involved deficiencies in documentation. Specifically, Iowa’s health home providers did not document core services, integrated health home outreach services, diagnoses, and enrollment with providers. In addition, Iowa’s providers did not maintain documentation to support higher payments for intense integrated health home services and did not ensure that beneficiaries had full Medicaid benefits.

The improper payments occurred because Iowa did not adequately monitor providers for compliance with certain Federal and State requirements.

On the basis of our sample results, we estimated that Iowa improperly claimed at least \$37.1 million in Federal Medicaid reimbursement for payments made to health home providers.

What OIG Recommends and Iowa’s Response

We recommend that Iowa refund \$37.1 million to the Federal Government. Iowa should also improve its monitoring of the health home program to ensure that health home providers comply with Federal and State requirements for documenting the services for which the providers billed and received payments. We also recommend that Iowa revise its State Medicaid plan to define documentation requirements and that Iowa educate providers on these requirements.

Iowa concurred with our second, third, and fourth recommendations and described corrective actions that it had taken or planned to take. Iowa said that it was improving its monitoring of the health home program and that it was revising the State plan. Iowa did not concur with our first recommendation and disagreed with most of our findings. After reviewing Iowa’s comments and the additional documentation it provided, we revised some of our findings for this final report. These revisions reduced the dollar amount in our first recommendation. Otherwise, we maintain that our findings and recommendations remain valid.

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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 healthcare 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 March 2019, Iowa was among 23 States and the District of Columbia to implement Medicaid health home programs. For Federal fiscal year 2016, States claimed Federal Medicaid reimbursement for health home services totaling approximately \$750 million (\$431 million Federal share). Iowa accounted for approximately 3 percent of the Federal share.

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.¹ We reviewed payments made to Iowa’s Medicaid health home providers for services furnished to enrolled beneficiaries under the State’s health home programs.

OBJECTIVE

Our objective was to determine whether the Iowa Department of Human Services, Iowa Medicaid Enterprise’s (State agency’s), claims for Medicaid reimbursement for payments made to health home providers complied with Federal and State requirements.

BACKGROUND

Medicaid Health Home Services

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. In Iowa, the State agency administers the Medicaid program. During our audit period (January 2013 through December 2016), Iowa’s Federal Medicaid Assistance Percentage (FMAP, or Federal share) ranged from 54.91 percent to 59.93 percent.

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. In practice, States can submit, and receive CMS approval

¹ *New York Claimed Federal Reimbursement for Some Payments to Health Home Providers That Did Not Meet Medicaid Requirements* (A-02-17-01004), Jul. 1, 2019.

for, one or more SPAs to establish a health home program through a care management service model in which all parties involved in an enrolled 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 health home services, they must provide six core health home services (core services) specified in the Act: comprehensive care management, care coordination, health promotion, comprehensive transitional care and followup, patient and family support, and referral to community and social support services, if relevant (the Act § 1945(h)(4)(B)). (See more detailed discussion of core services in "Iowa's Medicaid Health Home Program" below.)

To be eligible for health home services, an individual must be a Medicaid beneficiary diagnosed with the following: two chronic conditions, one chronic condition and risk for a second, or a serious mental illness (the Act § 1945(h)(1)(A)). The Act directs that States specify, in relevant SPAs, the methodologies they will use to determine payment for health home services (the Act § 1945(c)(2)(A)). Beneficiaries enrolled in a health home program receive services through a network of providers, health plans, and community-based organizations.

Federal and State Requirements

Federal reimbursement is available only for allowable actual Medicaid expenditures for which there is adequate supporting documentation.² Requirements for Iowa's health home program (including the relevant SPAs) are detailed in its Medicaid State plan, which requires health home providers to document, in each enrolled beneficiary's medical record or other documentation, that the beneficiary met all applicable requirements identified in the SPAs. Specifically, to enroll in a health home program, a beneficiary must meet the qualifying condition requirements of one of the two health home programs discussed below. To bill for and receive payment from the State agency for a beneficiary, a health home provider must ensure that the beneficiary (1) has full Medicaid benefits, (2) has enrolled with the designated health home provider, and (3) received care management monitoring for treatment gaps defined as health home services in the State plan (e.g., one of the core services discussed below).

Iowa's Medicaid Health Home Program

Iowa has operated a Medicaid health home program since calendar year (CY) 2012. Health home providers directly provide, or contract for the provision of, health home services to eligible and enrolled beneficiaries.³ The State agency is primarily responsible for monitoring and overseeing the health home program. The State agency's monitoring activities include determining whether health home providers have documentation that enrolled beneficiaries

² CMS *State Medicaid Manual* § 2497.1.

³ During our audit period, health home providers that billed the State agency included health home providers and a contractor.

met the eligibility requirements discussed above and that the beneficiaries received health home services as defined in the relevant SPAs.

The State agency administers two health home programs: a chronic condition health home (CCHH) program and a serious mental illness health home program, which the State agency refers to as the Integrated Health Home (IHH) program. Iowa established the CCHH program in CY 2012 and the IHH program in CY 2013. Both programs require health home providers to furnish at least one core service (discussed below) to enrolled beneficiaries.

The State agency made payments to health home providers using a payment model that allowed those providers to bill the State agency and receive a per member-per month (PMPM) payment for providing at least one health home service to a Medicaid beneficiary for a month.⁴

Core Health Home Services

Health home providers must furnish at least one of the six core services per month to receive a PMPM payment (SPA IA-12-004, SPA IA-13-023, SPA IA-14-002, and SPA IA-16-012; SPA IA-13-002, SPA IA-14-003, SPA IA-14-009, and SPA IA-16-013):⁵

- comprehensive care management, which includes arranging care with other qualified professionals for all stages of life, developing and maintaining a continuity of care document, and implementing a formal screening tool to assess behavioral health;
- care coordination, which includes assisting members with medication adherence, appointments, referral scheduling, understanding health insurance coverage, reminders, transition of care, wellness education, health support and lifestyle modification, and behavior changes;
- health promotion, which includes coordinating or providing behavior modification interventions aimed at supporting health management, improving disease outcomes, preventing disease, and promoting safety and an overall healthy lifestyle;
- comprehensive transitional care from inpatient care to other settings, which includes the services for ongoing care coordination and followup;
- patient and family support, which includes communicating with the beneficiary, family, and caregivers in a culturally appropriate manner to assess care decisions, including the identification of authorized representatives; and

⁴ Although many of the policies and guidelines the State agency uses to administer the Medicaid program, including the PMPM acronym, refer to its beneficiaries as “members,” this report uses the term “beneficiaries.”

⁵ These are the eight relevant SPAs that address both of Iowa’s health home programs. For the remainder of this report, we will refer to criteria citations that encompass all eight SPAs as “health home SPAs.”

- referrals to community and social support services, which include coordinating or providing recovery services and social health services available in the community, to include assisting in the understanding of eligibility for various healthcare programs, disability benefits, and housing programs.

Chronic Condition Health Home Program

The CCHH program defines qualifying chronic conditions as mental health conditions; substance abuse disorder; asthma; diabetes; heart disease; a body mass index (BMI) over 25, or, for children, a BMI over the 85th percentile; and hypertension. Enrolled beneficiaries are considered at risk for developing another qualifying chronic condition if they have a documented family history of a verified heritable condition, a diagnosed medical condition with an established comorbidity, or a verified environmental exposure to an agent or condition known to be causative of a qualifying condition (SPA IA-12-004, SPA IA-13-023, SPA IA-14-002, and SPA IA-16-012).⁶

A health home provider receives a CCHH PMPM payment on behalf of an enrolled beneficiary based on the number of chronic conditions with which that beneficiary has been diagnosed.

Integrated Health Home Program

The IHH program covers enrolled beneficiaries who have a serious mental illness (SMI) or serious emotional disturbance (SED). An SMI is a diagnosis of psychotic disorder, schizophrenia, schizoaffective disorder, major depression, bipolar disorder, delusional disorder, obsessive-compulsive disorder, or an approved exception. An SED is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of mental disorders published by the American Psychiatric Association or its most recent International Classification of Diseases equivalent that result in functional impairment. An SED may co-occur with substance use disorders, learning disorders, or intellectual disorders that may be a focus of clinical attention (SPA IA-13-002, SPA IA-14-003, SPA IA-14-009, and SPA IA-16-013).⁷

Generally, health home providers can receive three different categories of IHH PMPM payments. The first of these involves payment for the performance of outreach services to enroll beneficiaries in the program.⁸ For the other two categories, providers receive different payments for enrolled adult beneficiaries than they do for enrolled child beneficiaries. IHH PMPM payments in these two categories are also based on the enrolled beneficiaries' needs;

⁶ These are the four SPAs that are applicable to the CCHH program. For the remainder of this report, we collectively refer to these four SPAs as "CCHH SPAs."

⁷ These are the four SPAs that are applicable to the IHH program. For the remainder of this report, we collectively refer to these four SPAs as "IHH SPAs."

⁸ Outreach services can include contacting potential beneficiaries by phone calls, letters, and home visits.

providers receive higher payments for beneficiaries (both adults and children) who require more intense community service case management (intense IHH services). For this report, we refer to IHH services that do not involve intense IHH services, and that therefore receive lower payments, as “basic IHH services.”

HOW WE CONDUCTED THIS AUDIT

Our audit covered 795,499 PMPM payments, totaling \$106,964,714 (\$92,071,172 Federal share), that the State agency made to health home providers for services furnished during CYs 2013 through 2016.^{9,10} We reviewed a stratified random sample of 130 of these payments (30 CCHH payments and 100 IHH payments). Specifically, we reviewed the health home providers’ documentation and beneficiaries’ medical records or other documentation associated with the sampled payments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

FINDINGS

The State agency claimed Federal Medicaid reimbursement for payments made to health home providers that did not comply with Federal and State requirements. Of the 130 PMPM payments in our stratified random sample, the State agency properly claimed reimbursement for 68 payments but improperly claimed reimbursement for the remaining 62 payments. These 62 improper payments primarily involved deficiencies in the documentation that providers were required to maintain. The documentation requirements are necessary to ensure that health home services were performed for Medicaid beneficiaries who were eligible and enrolled in the Health Home program and that the beneficiaries received the minimum service required to receive a PMPM payment. Table 1 summarizes the deficiencies noted and the number of payments related to each type of deficiency.

⁹ Over the course of our audit period, the State agency did not receive the regular FMAP rates of 54.91 percent to 59.93 percent but received enhanced Federal funding (90 percent Federal share, plus an additional 2 percent Federal share after being awarded a State Balancing Incentive Payment Program grant under section 10202 of the Patient Protection and Affordable Care Act of 2010, P.L. No. 111-148 (Mar. 23, 2010)). By the end of our audit period, Federal funding to the State agency had begun to revert to the regular FMAP rate. We used the correct FMAP rate for all of the PMPM payments that we reviewed.

¹⁰ See Appendix B for a complete description of the payments covered by this audit.

Table 1: Summary of Deficiencies in Sampled Payments

Deficiency	No. of Unallowable Payments^a
Core health home services not documented	37
Integrated health home outreach services not documented	18
Diagnoses not documented	9
Enrollment with health home provider not documented	10
Documentation to support higher payments for intense integrated health home services not maintained	4
Integrated health home providers did not ensure that beneficiaries had full Medicaid benefits	2

^a The total exceeds 62 because 12 payments related to more than 1 deficiency.

The improper payments occurred because the State agency did not adequately monitor health home providers for compliance with certain Federal and State requirements. The State agency had issued policy guidance to health home providers requiring them to support the PMPM payments they received by documenting the health home services they furnished. The State agency also conducted reviews to determine whether health home providers had documentation that enrolled beneficiaries met the eligibility requirements and received health home services as defined in the relevant SPAs. However, despite the State agency’s monitoring efforts, some health home providers did not always comply with Federal and State requirements.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$37,132,109 in Federal Medicaid reimbursement for payments made to health home providers.¹¹

CORE HEALTH HOME SERVICES NOT DOCUMENTED

To be eligible for a PMPM payment on behalf of an enrolled beneficiary, a health home provider must ensure that the beneficiary received the minimum service requirement of care management monitoring for treatment gaps as defined in the State plan. A health home provider must provide at least one of six core services per month to that beneficiary. The core services are comprehensive care management, care coordination, health promotion, comprehensive transitional care and followup, patient and family support, and referral to community and social support services (the Act § 1945(h)(4)(B)). The State agency requires that health home providers document the core service(s) provided to each beneficiary (health home SPAs).

¹¹ 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.

For 37 sampled payments (30 of which were IHH payments and 7 of which were CCHH payments), the health home providers billed for health home services furnished to beneficiaries. However, the providers could not provide any documentation that the beneficiaries had received care management monitoring for treatment gaps or were furnished any core services in the months associated with those sampled payments.

INTEGRATED HEALTH HOME OUTREACH SERVICES NOT DOCUMENTED

Federal requirements state that providers must maintain records fully to disclose the extent of the services provided to individuals receiving Medicaid services authorized under the State plan (the Act § 1902(a)(27)).

For 18 sampled IHH payments, the health home providers billed for outreach services (to locate and contact potential beneficiaries by phone calls, letters, and home visits) but could not provide any documentation to support that they had performed these services. Some providers stated that they had performed outreach services but acknowledged that they had not retained documentation of those activities.

DIAGNOSES NOT DOCUMENTED

To be eligible for an IHH PMPM payment on behalf of an enrolled beneficiary, the health home provider must maintain documentation showing that the beneficiary was diagnosed with one or more SMIs or SEDs (IHH SPAs).

For nine sampled payments, the health home providers billed but did not maintain documentation to support the payments. Specifically, for all nine of these payments, the health home providers informed us that they could not provide any documentation to support that the enrolled beneficiaries were diagnosed with one or more SMIs or SEDs.

ENROLLMENT WITH HEALTH HOME PROVIDER NOT DOCUMENTED

The State agency requires health home providers to document each beneficiary's enrollment with the designated health home provider (health home SPAs).

For 120 of the sampled payments, beneficiary records maintained by the health home providers included documentation showing that the beneficiary had agreed to enroll in the health home program. For 10 sampled payments (8 of which were IHH payments and 2 of which were CCHH payments), the health home providers did not maintain documentation supporting the beneficiaries' enrollment with the designated health home providers.

DOCUMENTATION TO SUPPORT HIGHER PAYMENTS FOR INTENSE INTEGRATED HEALTH HOME SERVICES NOT MAINTAINED

Federal requirements state that providers must maintain records fully to disclose the extent of the services provided to individuals receiving Medicaid services authorized under the State plan (the Act § 1902(a)(27)).

PMPM payments are based on the enrolled beneficiaries' needs; health home providers receive higher payments for beneficiaries (both adults and children) who require intense IHH services than for beneficiaries who receive only basic IHH services (IHH SPAs). For example, if a beneficiary needs intense IHH services, the Act would require the health home provider to maintain documentation that such intense IHH services were provided. In the absence of that documentation, only the lower PMPM payments (for the basic IHH services that would result from a beneficiary having been diagnosed with one SMI or one SED) would be allowable.

For four sampled IHH payments, the health home providers could not provide any documentation to support the higher payments, such as documenting that the beneficiary received habilitation services.¹² Specifically, the health home providers did not maintain documentation that the enrolled beneficiaries received intense IHH services; this documentation was necessary to support the higher payments. However, the providers did provide documentation that each beneficiary had one or more SMIs or SEDs; this documentation supported payments for that basic IHH service. Therefore, these four sampled payments should have been paid at the basic IHH service rate. We questioned only the costs claimed above the basic IHH service rate.

INTEGRATED HEALTH HOME PROVIDERS DID NOT ENSURE THAT BENEFICIARIES HAD FULL MEDICAID BENEFITS

Health home providers must ensure that each beneficiary had full Medicaid benefits at the time the PMPM payment was made on that beneficiary's behalf (health home SPAs).

For two sampled payments (both of which were IHH payments), the health home providers did not use the latest Medicaid eligibility file to ensure that the beneficiaries had full Medicaid benefits at the time the payments were made. Although the beneficiaries associated with these two payments were enrolled in the IHH program, and although providers billed and received payments for services furnished to these beneficiaries, the beneficiaries in question were not, according to the Medicaid eligibility data file we obtained from the State agency (Appendix A), eligible for full Medicaid benefits.

¹² According to State agency officials, intense IHH services include habilitation services, which are healthcare services that help beneficiaries keep, learn, or improve skills and functioning for daily living.

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. The State agency had issued policy guidance to health home providers requiring them to support the PMPM payments they received by documenting the health home services they provided. The State agency also conducted reviews to determine whether health home providers had documentation that enrolled beneficiaries met the eligibility requirements and received health home services as defined in the relevant SPAs. However, despite the State agency's monitoring efforts, some health home providers did not always comply with Federal and State requirements.

An example of the inadequacies on the parts of both the State agency and the health home providers involves our finding on beneficiaries for whom providers received payments for intense IHH services. The Act (§ 1902(a)(27)) and the SPAs require health home providers to maintain documentation of services furnished to enrolled beneficiaries, but the SPA requirements do not articulate the need for providers to maintain additional documentation to support the higher PMPM payments for intense IHH services.

Furthermore, the SPAs are silent on the administration of the health home program as it pertains to our finding on IHH outreach services. The Act (§ 1902(a)(27)) requires health home providers to maintain documentation of services furnished to enrolled beneficiaries. However, the State agency has not included a specific requirement in the SPAs that health home providers maintain documentation that these outreach services were performed. In this regard, some providers told us that they were not aware of a requirement to maintain documentation of outreach services.

COSTS ASSOCIATED WITH PAYMENTS NOT MADE IN ACCORDANCE WITH REQUIREMENTS

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$37,132,109 in Federal Medicaid reimbursement for payments made to health home providers.

RECOMMENDATIONS

We recommend that the Iowa Department of Human Services, Iowa Medicaid Enterprise:

- refund \$37,132,109 to the Federal Government;
- improve its monitoring of the health home program to ensure that health home providers comply with Federal and State requirements for maintaining documentation to support the services for which the providers billed and received PMPM payments;

- revise the State plan to define the documentation requirements that health home providers must follow to bill and receive the higher IHH PMPM payments for intense IHH services, and educate providers on these requirements; and
- revise the State plan to define the documentation requirements that health home providers must follow to bill and receive IHH PMPM payments for outreach services, and educate providers on these requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our second, third, and fourth recommendations and described corrective actions that it had taken or planned to take. The State agency said that it was improving monitoring and training and had begun to develop a provider self-assessment to ensure that the health home providers have policies and processes in place to ensure compliance with Federal and State requirements. The State agency also said that it was revising the State plan, would educate providers on the SPA requirements, and is planning face-to-face training opportunities to educate providers on core services documentation.

The State agency did not concur with our first recommendation and disagreed with most of our findings. The State agency listed several steps it has taken to correct issues which it said it had identified and corrected prior to our audit. The State agency also stated that our audit “did not take into account the understanding of the intent of the State Plan Amendment (SPA) language.” A summary of the State agency’s comments and our response, which we have structured to mirror the order of our findings, follows.

After reviewing the State agency’s comments and the additional documentation it provided, we revised some of our findings for this final report; these revisions, in turn, reduced the dollar amount in our first recommendation.¹³ Otherwise, we maintain that our findings and recommendations are valid.

The State agency’s comments appear as Appendix D. We have removed four attachments because of their volume, and we have redacted provider-specific information. We are providing the State agency’s comments in their entirety to CMS.

CORE HEALTH HOME SERVICES NOT DOCUMENTED

State Agency Comments

The State agency contested 8 of the 39 payments that our draft report had identified regarding the lack of provider documentation related to core health home services. The State agency said

¹³ Specifically, we reduced the number of payments in error from 70 to 62. By adjusting the associated dollar amounts, we also reduced our first recommendation’s estimate of the Federal Health Home payments from \$45,267,552 to \$37,132,109.

that six of the eight payments were made to health home providers for outreach services. The State agency stated that according to SPA IA-13-002, “a passive enrollment or opt-out model was adopted” in which a beneficiary was considered to be in the outreach phase until he or she was engaged with an individual health home. The State agency added that it and CMS anticipated that the PMPM would be paid for beneficiaries in the outreach phase and therefore, “a core service need not be documented.”

For one of the remaining payments that the State agency contested, it provided us with additional documentation that the beneficiary was enrolled with a different health home provider during our sample month as well as documentation supporting that the beneficiary had received an allowable core service. For the last payment, the State agency provided clarification regarding the date of service, and the service itself, listed on the documentation.

Office of Inspector General Response

After reviewing the State agency’s comments and the additional documentation that it separately provided for the two payments discussed just above, we reduced the number of payments in error in our first finding from 39 to 37.

We disagree with the State agency that outreach services need not be documented. As the State agency notes in its comments, SPA IA-13-002 states that eligible beneficiaries for integrated health homes will be notified by U.S. Mail and through conversations with providers. The SPA also states that the State agency “will use outreach efforts to identify potential enrollees based on program criteria.” The Act § 1902(a)(27) states that providers must maintain records fully to disclose the extent of the services provided to individuals receiving Medicaid services authorized under the State plan. Iowa Administrative Code (IAC) states that a provider “shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program” (441 IAC § 79.3(2)). In our review of the documentation submitted by health home providers and the State agency for the six payments that we continue to regard as improper, we found that there were no records to support that outreach services were performed or that a core health home service was provided.

INTEGRATED HEALTH HOME OUTREACH SERVICES NOT DOCUMENTED

State Agency Comments

The State agency contested 17 of the 18 payments related to IHH outreach services not being documented. The State agency referred again to the passive enrollment or opt-out model, here in the context of SPA IA-14-003 and SPA IA-14-009, and added that it and CMS anticipated that the PMPM would be paid for beneficiaries in the outreach phase; therefore, according to the State agency, “a core service need not be documented.” Further, the State agency stated that there was no requirement in the SPAs that outreach activities be documented.

Office of Inspector General Response

We maintain that our findings related to these 17 payments are correct, as Federal requirements state that providers must maintain records fully to disclose the extent of the services provided to individuals receiving Medicaid services authorized under the State plan (the Act § 1902(a)(27)). In addition, 441 IAC § 79.3(2) states: “A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program.” The service records must include information necessary to substantiate that the service was provided (441 IAC § 79.3(2)(c)(3)).

Health home providers did not have documentation supporting the outreach services and could not support that any such services were provided. During our review, some providers told us that they received payments for outreach services and attempted to enroll beneficiaries in the health home program. However, these providers stated that they did not maintain any documentation or records supporting that the outreach services were performed for the beneficiaries in our samples.

DIAGNOSES NOT DOCUMENTED¹⁴

State Agency Comments

The State agency contested 12 of the 16 payments that our draft report had identified regarding the maintenance of documentation showing that beneficiaries had been diagnosed with 1 or more SMIs or SEDs or with chronic conditions. Our draft report had identified 13 payments for which the health home providers did not document that the beneficiaries were diagnosed with at least 1 SMI or SED; the State agency contested 9 of the 13 payments. Specifically:

- For three of the nine contested payments, the State agency identified areas in the providers’ internal documentation where the diagnoses of SMIs or SEDs were mentioned.
- For one payment, the State agency provided additional documentation showing that the beneficiary was diagnosed with at least one SMI or SED.
- For five payments, the State agency said that under SPA IA 13-002, beneficiaries with SMIs or SEDs are eligible for services. The State agency also referred to the passive enrollment or opt-out model and said that the beneficiaries were in the outreach phase

¹⁴ Our draft report included in this finding three sampled payments involving documentation of chronic conditions. The State agency’s written comments included material about these three payments. As explained below, we reviewed documentation associated with these three payments in the context of the State agency’s comments and, for this final report, removed the three payments—and thus a mention of chronic conditions—from this finding.

and therefore “would not have a diagnosis documented in a record of the IHH because they were not engaged with an IHH at the time.”

The State agency also contested all 3 of the payments (of the 16 payments that our draft report had identified for this finding) involving a lack of documentation of chronic conditions. The State agency identified areas in the providers’ internal documentation where the diagnoses of chronic conditions were mentioned.

Office of Inspector General Response

After reviewing the State agency’s comments and the additional documentation that it separately provided, we reduced the number of payments in error in our third finding from 16 to 9. Specifically, we determined that four payments involving diagnoses of SMIs or SEDs and the three payments involving diagnoses of chronic conditions (footnote 14) were adequately supported.

However, there is still not adequate documentation to fully support the nine payments that remain in this finding. For the five payments that the State agency contested because the beneficiaries were in the outreach phase, the individuals would still need to meet the eligibility requirements for health home services (i.e., individuals with one or more SMIs or SEDs), but there was no documentation supporting that the individuals had the requisite conditions. The State agency did not contest the other four payments, which involved lack of documentation of SMIs or SEDs, that remain in this finding.

The health home SPAs require that for a health home provider to receive a monthly payment for services rendered to a beneficiary, the beneficiary must meet the eligibility requirements as identified by the provider and documented in that individual’s health record. Eligible individuals are those with one or more SMIs or SEDs. The Act § 1902(a)(27) states that providers must maintain records fully to disclose the extent of the services provided to individuals receiving Medicaid services authorized under the State plan. In addition, 441 IAC § 79.3(2) states: “A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program.” The service records must include information necessary to substantiate that the service was provided (441 IAC § 79.3(2)(c)(3)).

ENROLLMENT WITH HEALTH HOME PROVIDER NOT DOCUMENTED

State Agency Comments

The State agency contested 9 of the 10 payments related to health home providers not maintaining documentation supporting the relevant beneficiaries’ enrollment with those designated providers. For four of these payments, the State agency said that the beneficiaries were enrolled with particular providers. For the other five payments, the State agency stated

that the beneficiaries were passively enrolled and therefore “would not have a record that noted the individual health home provider until engagement was complete.”

Office of Inspector General Response

We maintain that our findings are correct for all nine of these payments. The CCHH SPAs state: “the member has agreed and enrolled with the designated health home provider” to receive a monthly payment. The IHH SPAs require that the member has enrolled with the IHH provider. For the four payments about which the State agency said that the beneficiaries had enrolled with health home providers, the providers did not have documentation showing that the beneficiaries were enrolled with the particular providers during the month that we reviewed. For example, some of the documentation was signed after our sample month; other documentation did not have a date indicating when the beneficiary enrolled in the program. For the five payments in which the State agency stated that the beneficiaries were passively enrolled and not engaged with an individual health home provider, we maintain that no documentation was maintained by health home providers or the State agency that supported that outreach services were performed or that these beneficiaries were enrolled with a health home provider.

DOCUMENTATION TO SUPPORT HIGHER PAYMENTS FOR INTENSE INTEGRATED HEALTH HOME SERVICES NOT MAINTAINED

State Agency Comments

The State agency contested three of the six payments that our draft report had identified regarding the lack of documentation supporting that the relevant beneficiaries had received intense IHH services (that qualified for higher payments).¹⁵ The State agency cited the SPAs to refer to those “services with more instance community service case management. These members are those that have Children’s Mental Health (CMH) Waiver or habilitation services.” [See footnote 12.] The State agency provided additional information and clarification about the services that were provided and how the higher services were documented in the beneficiary records.

Office of Inspector General Response

After reviewing the State agency’s comments and the additional documentation that it provided, we reduced the number of payments in error in our fifth finding from six to four. However, there is still not adequate documentation to fully support the other payment that the State agency contested. The State agency did not contest the other three payments that remain in this finding.

¹⁵ In its written comments on this finding, the State agency said that it disagreed with four payments. However, only three of the payments it contested were among the payments that this finding had identified. The fourth payment to which the State agency referred here was actually part of our finding on Core Health Home payments; we took those comments into account in our response to that earlier finding.

INTEGRATED HEALTH HOME PROVIDERS DID NOT ENSURE THAT BENEFICIARIES HAD FULL MEDICAID BENEFITS

State Agency Comments

The State agency contested both of the payments related to health home providers that did not use the latest Medicaid eligibility file to ensure that the relevant beneficiaries had full Medicaid benefits at the time the payments were made. The State agency said that no payments were received.

Office of Inspector General Response

We maintain that our findings are correct for both of these payments. The health home SPAs state that “providers must ensure that each beneficiary had full Medicaid benefits at the time the PMPM payment was made” on behalf of the beneficiary. Based on our review of the documentation, these two beneficiaries did not have Medicaid benefits during our sample month. In our reconciliation of the Quarterly Medicaid Statement of Expenditures for the Medicaid Program (Standard Form CMS-64), we determined that these payments were included in the amounts that the State agency reported on the Standard Form CMS-64 and that the State agency received Federal reimbursement for these payments.

STATISTICAL SAMPLING ISSUE

State Agency Comments

The State agency disagreed with our use of two strata in our statistical sampling. The State agency said that we based our calculated overpayment on a statistical methodology that combined the two strata (Appendices B and C) into a single overall calculation. The State agency requested that we apply our calculations separately for each stratum.

Office of Inspector General Response

We maintain that our calculation of an overall overpayment from the two strata is proper. We used well-accepted equations for calculating a confidence interval from a stratified design.¹⁶ In a stratified design, the overall estimate is more precise than the individual stratum estimates. Therefore, as we see in the current audit, the confidence interval for the overall estimate is narrower than what would be achieved by summing the upper and lower limits for each stratum.

¹⁶ See *e.g.*, Levy, Paul S., and Stanley Lemeshow. 2008. *Sampling of Populations: Methods and Applications*, 4th edition, pp 135. New York: John Wiley & Sons.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 795,499 PMPM payments, totaling \$106,964,714 (\$92,071,172 Federal share), that the State agency made to health home providers for services provided during CYs 2013 through 2016 (Appendix B). We reviewed a stratified random sample of 130 of these payments (30 CCHH payments and 100 IHH payments). Specifically, we reviewed the health home providers' documentation and beneficiaries' medical records or other documentation 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.¹⁷ We also established reasonable assurance of the completeness of the data by reconciling the claim data in the MMIS to the State agency's claims for reimbursement on the Form CMS-64.

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

We performed fieldwork at the State agency in Des Moines, Iowa. We reviewed Iowa's health home providers through desk reviews, site visits, or both.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- met with CMS financial and program management officials to gain an understanding of, and obtain information on, Iowa's health home program;
- met with State agency officials to gain an understanding of the State agency's administration and monitoring of the health home program;
- interviewed health home provider officials associated with the sampled payments to gain an understanding of their health home program policies and procedures, including determining beneficiary eligibility and enrollment, furnishing core services, and documenting health home services;

¹⁷ The MMIS is a computerized payment and information reporting system that the State agency uses to process and pay Medicaid claims and to manage information about Medicaid beneficiaries and services.

- requested and received, from the State agency’s MMIS data files, details on all payments to health home providers for which the State agency claimed Medicaid reimbursement for health home services furnished during CYs 2013 through 2016;¹⁸
- reconciled the claim data in the MMIS to the State agency’s claims for reimbursement on the Form CMS-64;
- removed payments with a Federal share of \$0 or less (Appendix B);¹⁹
- created a sampling frame of 795,499 payments made to health home providers totaling \$106,964,714 (\$92,071,172 Federal share) (Appendix B);
- requested and received the State agency’s Medicaid eligibility data file and used it in our review of the sampled payments;
- selected a stratified random sample of 130 PMPM payments and, for each payment, determined whether:
 - o the beneficiary received at least 1 of the 6 core services per month,
 - o the beneficiary, if enrolled in the CCHH program, either was diagnosed with at least 2 qualifying chronic conditions or was diagnosed with 1 qualifying chronic condition and was at risk of developing another qualifying condition,
 - o the beneficiary, if enrolled in the IHH program, was diagnosed with 1 or more SMIs or SEDs,
 - o the beneficiary had enrolled with the designated health home provider,
 - o the beneficiary, according to the Medicaid eligibility data file, had full Medicaid benefits at the time the PMPM payment was made, and
 - o the health home provider complied with all Federal and State documentation requirements for health home services, including outreach services;
- used the results of the sample to estimate the unallowable Federal Medicaid reimbursement to the State agency for our audit period; and
- summarized the results of our audit and discussed these results with State agency officials on August 15, 2019.

¹⁸ The data files contained 800,075 payments totaling \$106,964,250.

¹⁹ Payments of \$0 or less are for claims with a credit adjustment.

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 795,499 CCHH and IHH PMPM payments totaling \$106,964,714 (\$92,071,172 Federal share) for which the State agency claimed Federal Medicaid reimbursement for services provided during CYs 2013 through 2016.²⁰ We requested and received, from the State agency's MMIS data files, details on all of these payments to health home providers.

SAMPLE UNIT

The sample unit was one PMPM payment made to a health home provider.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample consisting of two strata. We divided the strata based on the health home program (CCHH or IHH) associated with each sample item, as follows:

Table 2: Sample Strata

Stratum	Stratum Description	Payments in Frame	Value of Frame (Federal Share)	Sample Size
1	CCHH PMPM payments	179,647	\$3,628,083	30
2	IHH PMPM payments	615,852	88,443,089	100
	Total	795,499	\$92,071,172	130

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the sample units in each stratum. After generating 30 random numbers for stratum 1 and 100 for stratum 2, we selected the corresponding frame items.

²⁰The sampling frame does not include 4,576 PMPM payments with a Federal share of \$0 or less.

ESTIMATION METHODOLOGY

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

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Details and Results

Stratum	Payments in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Unallowable Payments	Value of Unallowable Payments (Federal Share)
1	179,647	\$3,628,083	30	\$543	8	\$91
2	615,852	88,443,089	100	15,380	54	7,225
Total	795,499	\$92,071,172	130	\$15,923	62	\$7,316

Table 4: Estimated Value of Unallowable Payments (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$45,038,825
Lower limit	37,132,109
Upper limit	52,945,542



Kim Reynolds, Governor

Adam Gregg, Lt. Governor

Kelly Garcia, Director

January 21, 2020

Patrick J. Cogley
 Regional Inspector General for Audit Services
 HHS-OIG-Office of Audit Services
 Region VII
 601 East 12th Street, Room 0429
 Kansas City, MO 64106

The Iowa Medicaid Enterprise (IME) has prepared a response to the Office of Inspector General (OIG) draft report issued November 21, 2019, "Iowa Inadequately Monitored Its Medicaid Health Home Providers, Resulting in Tens of Millions in Improperly Claimed Reimbursement, Draft Report, A-07-18-04109." This audit is related to the Integrated Health Home (IHH) and the Chronic Condition Health Home (CCHH) programs. The OIG's findings state that Iowa improperly claimed reimbursement.

The OIG review identifies four areas of concern and corresponding recommendations. The IME concurs with the second, third and fourth recommendations. IME is improving monitoring and training and we are updating our State Plan Amendments (SPAs) to provide clear direction and rules for lead entities. However, the first recommendation is the primary focus and area of concern in the OIG audit, and IME identified and corrected this concern several years ago.

It is important to understand the historical context, and the steps IME has taken to correct the issues, which IME identified prior to the OIG's review.

- July 2012: IME initiated CCHH statewide, which utilized an opt-in approach. IME piloted IHH, which was implemented in phases between July 2013, and July 2014, and utilized an opt-out model. The Phase 1 IHH program did not have a timeframe associated with required outreach.
- February 2014: IME began identifying and disenrolling IHH members who were not engaged in Phase 1. This was done because IME observed there were members that were still not engaged with IHH outreach.
- April 2014: IME implemented Phase 2, which provided a three month timeframe for the lead entities to conduct outreach and connect members to services.
- July 2014: IME implemented Phase 3, which mirrored Phase 2.
- Early 2015: IME began updating SPAs in preparation for the implementation of managed care. In this process, IME built in additional oversight of IHH and converted the system to an opt-in model.

The primary concern related to ensuring services are provided to members enrolled in an IHH has been addressed through the changes made to the IHH program in 2014 and 2015. Requiring members to opt-in ensures they are actively seeking and utilizing the services being paid for.

In addition, the IME continues to evaluate the efficacy of the Health Home programs. In early 2018, IME assembled a workgroup, including providers and stakeholders, to evaluate compliance and the efficacy of programs. IME submitted a report to the legislature in December 2018. The evaluation of the programs continue. IME is committed to ensuring the appropriate use of Medicaid funding, and that our programs are successful and continually evaluated for programmatic improvements.

Sincerely,

Michael Randol /s/
Medicaid Director

Attachments



Department of
HUMAN SERVICES

***Response to Office of Inspector
General's Iowa Medicaid Enterprise
2019 Health Home Audit***

January 2020

Response to Office of Inspector General’s Health Home Audit

Response to Office of Inspector General’s (OIG) Findings

The Iowa Medicaid Enterprise (IME) has prepared a response to the Office of Inspector General (OIG) draft report issued November 21, 2019, “Iowa Inadequately Monitored Its Medicaid Health Home Providers, Resulting in Tens of Millions in Improperly Claimed Reimbursement, Draft Report, A-07-18-04109.” As part of the audit process, OIG sampled 130 of a possible 795,499 records. Of the 130 records reviewed, 100 were related to the Integrated Health Home (IHH) and the remaining 30 were related to the Chronic Condition Health Home (CCHH) records. OIG’s findings state that Iowa improperly claimed reimbursement for 70 of those records and the Iowa Medicaid Enterprise (IME) contests 52 of those records. The OIG external review did not take into account the understanding of the intent of the State Plan Amendment (SPA) language.

OIG Recommendation #1 Part One: IME Requests Separate Stratum Methodology Be Used

The OIG’s calculation of an overpayment of \$45,267,552 is based on a statistical methodology combining the two stratum examined into a single “overall” calculation. The OIG’s calculations also include separate analysis of each stratum resulting in an overpayment calculation in Stratum 1 of \$313,052 and an overpayment calculation in Stratum 2 of \$44,556,565 totaling \$44,869,617. The IME requests that the OIG apply the calculations for each separate stratum.

OIG Recommendation #1 Part Two: IME Contests OIG Findings

I. Finding One: Health Home Core Service Documentation (39 Deficiencies; Eight Contested).

OIG reported the health home provider did not document that an eligible service was provided in the sample month for 39 records. IME contests eight of the 39 identified deficiencies.

p

A. IME Contests Two of the 39 on Specific Grounds.

Health Home Core Service Documentation	
ST2_21	The member was enrolled with [REDACTED] ²⁰ for the month reviewed. OIG asked for records from [REDACTED] (a different provider) to determine if core services were documented. Because OIG requested documentation from incorrect provider, the deficiency is not supported. Documentation from [REDACTED] showing that the member received an eligible service is attached to this response.
ST2_37	There is a quarterly survey (assessment) on page seven that was

²⁰ Office of Inspector General Note—The deleted text in this Appendix has been redacted because it identifies individual facilities.

	completed in the month reviewed. This assessment documentation falls under Health Home Service Care Coordination – a core service.
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B. IME contests six of the 39 on grounds that core service documentation was not required during the outreach phase for IHH members under SPA IA 13-002.

Under SPA IA-13-002, a passive enrollment or opt-out model was adopted in which identified eligible members for integrated Serious Persistent Mental Illness (SPMI) Health Home (also known as IHH) were to be notified of the program via U.S. mail and through conversations with the IHH providers. A member was considered to be in the outreach phase until that member was engaged with an individual IHH. The State and the Centers for Medicare and Medicaid Services (CMS) anticipated that the per member per month (PMPM) would be paid for members in the outreach phase (that is, passively enrolled, but not engaged with an individual IHH) and, therefore, a core service need not be documented.

Phase One Members	
ST2_04	These members were phase one, were passively enrolled, were in the outreach phase, and core service documentation was not required.
ST2_08	
ST2_33	
ST2_38	
ST2_43	
ST2_45	

II. Finding Two: Integrated Health Home Outreach Services Not Documented. (17 Deficiencies; 17 Contested)

For 17 sampled payments, OIG reported that the health home provider did not have support for the outreach service. IME contests 17 of the 17 identified deficiencies.

Under SPA IA-14-003 and SPA IA-14-009, a passive enrollment or opt-out model was adopted in which identified eligible members for integrated SPMI Health Home were to be notified of the program via U.S. mail and through conversations with the IHH providers. A member was considered to be in the outreach phase until that member was engaged with an individual IHH. The State and CMS anticipated that the PMPM would be paid for members in the outreach phase (that is, passively enrolled, but not engaged with an individual IHH) and, therefore, a core service need not be documented. There was no requirement that outreach activities be documented.

Did Not Have Support for the Outreach Service ¹	
ST2_24	These members were passively enrolled, were in the outreach phase, and outreach documentation was not required.
ST2_30	
ST2_31 ²	
ST2_40	
ST2_46	
ST2_56	
ST2_60	
ST2_62	
ST2_65	
ST2_67	
ST2_68	
ST2_71	
ST2_74	
ST2_84	
ST2_85	
ST2_86	
ST2_91	

III. Finding Three: Diagnoses and Chronic Conditions Not Documented (16 Deficiencies; 12 Contested).

A. Failure to Support Beneficiary Diagnosed with at Least One SMI or SED.

For 13 sampled payments, the OIG found that the health home provider did not have support for the beneficiary being diagnosed with at least one serious mental illness (SMI) or serious emotional disturbance (SED).

1. IME contests four of the 13 on specific grounds.

Did Not Have Support for the Beneficiary Being Diagnosed with at Least One SED/SMI for IHH.	
ST2_23	In the notes the member is identified as having a diagnosis that meets the qualifications of being enrolled in the IHH. Page one is the Person-Centered plan developed for a habilitation (HAB) member. The

¹ IME also believes that ST2-35 falls within this contest. However, ST2-35 is not contested under Finding Six. Therefore, ST2-35 is not listed in this contest.

² Also note the discussion under VI below contesting ST2-31 on another ground.

	member must be in an IHH if they have HAB. Member receives psychiatric services (page one). Please see attached documentation containing a 2007 diagnosis of schizophrenia.
ST2_66	On page seven of the notes, the member is identified as having current diagnoses of anxiety and depression, which are sufficient for the member to enroll in the IHH. (While the attention-deficit/hyperactivity disorder (ADHD) diagnosis is highlighted, there are additional qualifying diagnoses.)
ST2_80	On page three of the notes, in the Risk Stratification Assessment, the member is identified as having primary diagnoses of anxiety, depression, and ADHD, which are sufficient for the member to enroll in the IHH. On page three of the [REDACTED] documents, the member is diagnosed with anxiety.
ST2_48	On page three of the [REDACTED] document, the care coordination plan notes the member has paranoid schizophrenia and psychosis.

2. IME contests five of the 13 on the ground that SPAs 14-003 and 14-009 did not require documentation of the diagnosis during the outreach phase.

SPA IA 13-002 indicates that members with SMI or SED are eligible. Further, under the SPA a passive enrollment or opt-out model was adopted in which identified eligible members for integrated SPMI Health Home would be notified of the program via U.S. mail and through conversations with the IHH providers. A member was considered to be in the outreach phase until that member was engaged with an individual IHH. These members would not have a diagnosis documented in a record of the IHH because they were not engaged with an IHH at the time. Documentation of a diagnosis for an eligible member can be found in the claims that were used to passively enroll for the IHH program and was documented in Iowa Medicaid Portal Access (IMPA). Copies of the IMPA documents are attached.

Health Home Provider Did Not Have Support for the Beneficiary Being Diagnosed with at Least One SMI or SED	
ST2_04	These members were passively enrolled, were in the outreach phase, and had not been engaged by the IHH. Therefore, no diagnosis documentation would appear in the IHH record until engagement. Documentation of diagnosis is found in the attached IMPA documents.
ST2_33	
ST2_38	
ST2_43	
ST2_45	

B. Chronic Conditions Not Documented.

For three sampled payments, the OIG found that the health home provider did not have the support for the beneficiary being diagnosed with two chronic conditions or one chronic condition and at risk for another. IME contests all three of the sampled payments.

Did Not Have Support for the Beneficiary Being Diagnosed with Two Chronic Conditions or One Chronic Condition and at Risk for Another	
ST1_13	In the notes, the member is identified as having diagnoses that meet the qualifications of being enrolled in the CCHH. Member is a smoker (page two), has suicidal thoughts (page two), anxiety (page two), and diabetes (page three). Member has diagnoses documented to qualify based on mental health and diabetes.
ST1_14	In the notes, the member is identified as having diagnoses that meet the qualifications of being enrolled in the CCHH. Member has depression and hypertension both noted on page six. Member has diagnosis documented to qualify based on mental health and hypertension.
ST1_15	In the notes, the member is identified as having diagnoses that meet the qualifications of being enrolled in the CCHH. Member has hypertension, heart disease, and depression all noted on page four. Member has diagnosis documented qualify based on mental health, heart disease and hypertension.

IV. Finding Four: Beneficiary Enrolled with Health Home Provider (10 Deficiencies; Nine Contested).

OIG reported that the health home provider did not document that the beneficiary was enrolled with the health home provider or the beneficiary did not opt-out of the program in 10 sampled payments. IME contests nine of those records.

A. IME Contests Four of the 10 Deficiencies on Specific Grounds.

██████████ Portal identifies which specific health home provider in the community was assigned to the member.

Health Home Provider Did Not Document that the Beneficiary was Enrolled with the Health Home Provider	
ST1_13	In the notes it identifies the member is enrolled with the health home provider. Page one identifies that the member is enrolled with ██████████.
ST1_15	The notes identify the member is enrolled with the health home provider. Page one identifies that the member is enrolled with ██████████.
ST2_39	This member has an Authorization for Use and Disclosure (AUD) (page one), contact notes that show that ██████████ was the IHH, they were unable to contact the mother, and disenrolled the following month.
ST2_80	In the notes it identifies the member is enrolled with the health home provider. On page one, the AUD shows enrollment in ██████████.

[REDACTED]

B. IME Contests Five of the 10 Deficiencies because Beneficiaries Were Enrolled with [REDACTED] as IHH During Passive Enrollment.

Under the SPAs, beneficiaries were passively enrolled with [REDACTED] as the IHH provider. That passive enrollment with [REDACTED] continued until the beneficiary was engaged with an individual IHH provider. Passive enrollment with [REDACTED] as the Integrated Health Home Provider was tracked in IMPA and is the source of truth. [REDACTED] is identified in IMPA as the IHH provider. The passive enrolled or opt-out members would not have a record that noted the individual health home provider until engagement was complete. The attached IMPA records reflect passive enrollment with [REDACTED] – the IHH provider until engagement.

Health Home Provider Did Not Document that the Beneficiary was Enrolled with the Health Home Provider	
ST2_04	IMPA documentation shows passive enrollment with [REDACTED] as the IHH provider.
ST2_33	
ST2_38	
ST2_43	
ST2_45	

V. Finding Five: IHH: No Support for Tier Seven or Eight (Six or Seven Deficiencies; four Contested).

OIG reported that for six sampled payments, the health home provider did not provide documentation showing the beneficiary received a service that would support the higher PMPM rate. The OIG concluded that the provider did provide documentation for the beneficiaries having one SMI or SED to support the lower PMPM rate for the six sampled payments.

The supplemental excel spreadsheet provided by OIG identified seven deficiencies but the report states there are only six. OIG identified deficiencies in six of those records. IME contests four out of the seven in the excel spreadsheet.

The SPAs note that category three is for those actively engaged members needing IHH services with more intense community service case management (CM). These members are those that have Children’s Mental Health (CMH) Waiver or habilitation services.

Health Home Provider Did Not Provide Documentation Showing the Beneficiary Received a Service that Would Support the Higher PMPM Rate

ST2_19	Documentation of quarterly face-to-face is only required for ICM members The member must be in an IHH if they have HAB. See the additional files from [REDACTED] to support the HAB authorization. In the documentation provided, the HAB services are documented on page 12.
ST2_21	The member was enrolled with [REDACTED] for the month reviewed. OIG asked for records from [REDACTED] to determine if there was support for ICM documented. IME contests that OIG doesn't have the evidence to determine that this service was not documented. According to the [REDACTED] Portal snapshot, the member was not disenrolled from [REDACTED] until July 31, 2014 and enrolled with [REDACTED] the following month (under Health Home Participation Info).
ST2_63	The record indicates the member is receiving HAB, which qualifies the member for ICM IHH Services. Page nine "Psych pharm" note indicates Supported Community Living (SCL) services. Documentation reflects a face to face contact on March 31, 2015 wherein the IHH discusses SCL with the member
ST2_82	The record indicates the member is receiving habilitation which qualifies the member for ICM IHH Services. Member was receiving Home-Based Habilitation services. [REDACTED] and [REDACTED] are listed as providers. Page one notes dated October 2015 discuss member changing homes. Pages three, five and seven under social history [REDACTED] is indicated as Habilitation Services provider.

VI. Finding Six: Beneficiary Medicaid Eligible (Two Deficiencies; Two Contested).

For two sampled payments, OIG reported that the health home provider did not ensure the beneficiary had full Medicaid benefits at the time the PMPM was made. IME contests both of the two sampled payments because no payments were received.

On the OIG spreadsheet, the two identified claims are identified as Tier 0. Tier 0 means that the beneficiary is not eligible for an IHH payment and the system automatically does not pay when a Tier 0 is entered.

In addition, IME requested that data warehouse pull a report of all health home claims during the audited time frame and these two claims did not appear. The data warehouse pull is attached.

Health Home Provider Did Not Ensure the Beneficiary Had Full Medicaid Benefits at the Time the PMPM was Made	
ST2_31	We do not find a paid claim for this member on this month.
ST2_25	We do not find a paid claim for this member on this month.

OIG Recommendation #2: Improve monitoring of the health homes program to ensure that the health home providers comply with Federal and State requirements for maintaining documentation.

IME concurs with this recommendation. IME is improving its monitoring of the health homes program through a more comprehensive file review shared by the Managed Care Organizations (MCOs) and the IME.

IME has worked with the MCOs to ensure that a member is eligible, enrolled, and provided a Health Home Service in order to bill a PMPM.

- IME developed an ongoing chart audit process completed by the IME and the MCOs that ensures confidence that Health Home Services are appropriately documented.
- IME hosted an IHH face-to-face training and planning additional face-to-face training opportunities to re-educate the health home providers on core services, and core services documentation.
- IME and the MCOs are in the beginning stages of a provider self-assessment to ensure the health home providers have policies and processes in place to ensure health homes are in compliance with Federal and State requirements.

OIG Recommendation #3: Revise the State plan to define the documentation requirements that health home providers must follow to bill and receive higher IHH PMPM payments for intense IHH services and educate providers on these requirements

IME concurs with this recommendation. IME is revising the State Plan to define the documentation requirements providers must follow to bill and receive higher IHH PMPM payments for intense IHH services and will educate providers on the revised SPA requirements.

IME has worked with the MCOs to ensure that a member is eligible, enrolled, and provided a Health Home Service in order to bill a PMPM.

- IME developed an ongoing chart audit process between the IME and the MCOs that ensures confidence that Health Home Services were appropriately documented.
- IME hosted an IHH face-to-face training and planning additional face-to-face training opportunities to re-educate the health home providers on core services, and core services documentation.
- IME and the MCOs are in the beginning stages of a provider self-assessment to ensure the health home has policies and processes in place to ensure compliance with Federal and State requirements.

OIG Recommendation #4: Revise the State plan to define the documentation requirements that health home providers must follow to bill and receive IHH PMPM payments for outreach services and educate providers on these requirements.

IME concurs with this recommendation. IME is revising the State Plan to define the documentation requirements providers must follow to bill and receive PMPM payments for outreach services and educate providers on these requirements.

The current audit results were significantly impacted by findings related members who were enrolled with a Health Home during the period of time that the State used an “opt out” method of enrollment. Iowa removed the opt-out option from the IHH SPA in 2016.

IME has worked with the MCOs to ensure that a member is eligible, enrolled, and provided a Health Home Service in order to bill a PMPM. This work has included updating the SPAs to ensure there is clear direction in roles and responsibilities of the health home providers and the MCOs as lead entities.

Summary

In summary, the IME contests the first recommendation made based on the findings of this OIG audit. Of the 130 record reviews, OIG found 91 deficiencies, resulting in a finding that the State agency claimed 70 improper payments for Health Home services.³ In response, our internal review of the records identified that 52 of these deficiencies are not applicable and therefore contests OIG findings.⁴

IME concurs with recommendations two, three and four and has begun to take action as noted above to address the findings contained in these recommendations.

³ As noted in the OIG Report (p. 5, Table 1, fn a), the total deficiencies exceeds the total asserted improper payments because 13 payments were related to more than one deficiency.

⁴ The State’s claim of 52 deficiencies corresponds to a claim of 51 correct payments out of the 70 claims identified by OIG as improperly claimed for reimbursement. Where a deficiency was noted in more than one area, if the State did not contest the deficiency on one ground, it did not include that deficiency in its contest on another ground even where contest would have been appropriate.

Attachments

1. ST2-21 – Finding 1(A): [REDACTED] support for Health Home Core service documentation.
2. ST2-23 – Finding 3(A)(1): Documentation supporting diagnosis.
3. Finding III(A)(2): IMPA screenshots documenting passive enrollment with [REDACTED].
4. Finding VI: Data Warehouse pull (electronic copy only) showing no payments made for two members.