

Report in Brief

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



Why OIG Did This Review

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

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

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

How OIG Did This Review

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

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

What OIG Found

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

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

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

What OIG Recommends and New York’s Comments

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

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