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

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

Why OIG Did This Audit

The Medicaid "health home" option allows States to create programs that provide care coordination and care management for beneficiaries with chronic health conditions. Health homes are not physical spaces. Rather, they are a health care model based on the idea that several providers can work together to coordinate and manage beneficiaries' care at a reasonable cost.

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

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

How OIG Did This Audit

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

What OIG Found

Of the 150 payments in our random sample, New York properly claimed reimbursement for 141 payments but improperly claimed reimbursement for the remaining 9 payments. Specifically, New York's health home providers did not provide a comprehensive patient-centered care plan covering the sampled date of service for enrolled beneficiaries (five payments) and did not document health home services (four payments). The improper payments occurred because New York did not adequately monitor health home providers for compliance with certain Federal and State requirements for providing, documenting, and billing services.

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

What OIG Recommends and New York's Comments

We recommend that New York refund $6 million to the Federal Government. New York should also strengthen its monitoring of the health home program to ensure that health home providers comply with Federal and State requirements for (1) providing services according to a comprehensive patient-centered care plan and (2) maintaining documentation to support services billed.

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

The full report can be found at https://oig.hhs.gov/oas/reports/region2/21901007asp.