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

Washington State Did Not Comply With Federal and State Requirements for Claiming Enhanced Federal Reimbursement for Medicaid Managed-Care Health Home Service Expenditures

Why OIG Did This Audit

A health home is a designated provider or a team of health care providers that coordinates health care services for Medicaid beneficiaries with chronic medical conditions at a reasonable cost. States were authorized to receive Federal reimbursement at an enhanced Federal Medical Assistance Percentage (FMAP) of 90 percent (enhanced FMAP) for health home service payments they made to providers during the first eight quarters their programs were in effect.

Our objective was to determine whether Washington State complied with Federal and State requirements for claiming health home service expenditures under Medicaid managed care at the enhanced FMAP.

How OIG Did This Audit

Our audit covered the $1,957,622 ($1,770,860 Federal share) that Washington claimed as managed-care health home expenditures at the enhanced FMAP from April 1, 2017, through March 31, 2019. We reviewed the journal vouchers that Washington used to assign the enhanced FMAP to its managed-care health home expenditures, the managed-care encounter data that it used to support the claimed amount, and its capitation rate documentation that identified the portion of the managed-care capitation payments that was attributable to health home services.

What OIG Found

Washington did not comply with Federal and State requirements for claiming health home service expenditures under Medicaid managed care at the enhanced FMAP. Specifically, Washington improperly used fee-for-service health home reimbursement rates instead of the portion of the managed-care capitation payments that was specifically attributable to health home services to calculate and claim enhanced Federal reimbursement for its managed-care health home expenditures, totaling $1,770,860. In addition, of the $1,770,860 that Washington claimed, $374,579 was not supported by encounter data, and $29,161 was claimed for encounters that exceeded the number of encounters that managed-care organizations were allowed to report for a beneficiary. These issues occurred because Washington did not follow its State plan or Federal guidance and lacked adequate procedures and Medicaid Management Information System (MMIS) edits.

What OIG Recommends and Washington Comments

We recommend that Washington: (1) refund to the Federal Government $374,579 for the encounters that were no longer supported and the $29,161 that exceeded the number of allowable encounters; (2) determine the portion of the remaining $1,367,120 that should have been claimed based on the portion of the managed-care capitation rate attributable to health home services and refund any unallowable amounts; (3) review all managed-care health home encounters from July 1, 2013, through March 31, 2017, to determine the amount that should have been claimed based on the portion of the managed-care capitation rate attributable to health home services; (4) implement a procedure to identify whether encounters used to support journal vouchers have been removed from the encounter data; and (5) strengthen its MMIS edits to ensure that encounters comply with State reporting requirements. The full text of our recommendations is shown in the report.

Washington concurred with all of our recommendations and described corrective actions it had taken or planned to take, such as implementing MMIS edits to prevent multiple payments within a single calendar month. However, the corrective actions that Washington described did not fully address our first, second, and fifth recommendations. Therefore, we continue to recommend that Washington implement those recommendations.

The full report can be found at https://oig.hhs.gov/oas/reports/region9/92002008.asp.