DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

June 13, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Services That Were Not Family Planning (A-04-10-01089)

Attached, for your information, is an advance copy of our final report on family planning reimbursement to North Carolina's Division of Medicaid Assistance (State agency). We will issue this report to the State agency within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Lori S. Pilcher, Regional Inspector General for Audit Services, Region IV, at (404) 562-7795 or through email at Lori.Pilcher@oig.hhs.gov. Please refer to report number A-04-10-01089.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION IV
61 FORSYTH STREET, SW, SUITE 3T41
ATLANTA, GA 30303

June 15, 2012

Report Number: A-04-10-01089

Craigan L. Gray, M.D., M.B.A., J.D.
Director
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699-2501

Dear Dr. Gray:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Services That Were Not Family Planning*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Truman Mayfield, Audit Manager, at (850) 942-8900, extension 22, or through email at Truman.Mayfield@oig.hhs.gov. Please refer to report number A-04-10-01089 in all correspondence.

Sincerely,

/Lori S. Pilcher/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NORTH CAROLINA INCORRECTLY CLAIMED ENHANCED FEDERAL REIMBURSEMENT FOR SOME MEDICAID SERVICES THAT WERE NOT FAMILY PLANNING

Daniel R. Levinson
Inspector General

June 2012
A-04-10-01089

Office of Inspector General

http://oig.hhs.gov

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), 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. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In North Carolina, the Division of Medical Assistance (State agency) is responsible for administering the Medicaid program.

The amount of funding that the Federal Government reimburses to State Medicaid agencies, known as the Federal share, is determined by the Federal medical assistance percentage (FMAP). The State agency's FMAP ranged from 63.49 percent to 64.52 percent for claims paid from October 1, 2004, through September 30, 2007.

Section 1905(a)(4)(C) of the Act requires States to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and who desire such services and supplies.

Pursuant to section 1903(a)(5) of the Act and Federal regulations (42 CFR § 433.10(c)(1)), the amount the Federal Government is authorized to reimburse the State for expenditures in family planning services is calculated at an FMAP of 90 percent (enhanced rate). North Carolina's Administrative Code (10A NCAC § 13J.1402(a)(2)(C)) requires that providers adequately document services.

From October 1, 2004, through September 30, 2007, the Federal Government reimbursed the State agency at the enhanced rate $52,305,271 (Federal share) for Medicaid family planning services for pharmacy, sterilization, and clinic and practitioner claims.

OBJECTIVE

Our objective was to determine whether the State agency claimed Medicaid family planning reimbursement in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency did not always claim Medicaid family planning reimbursement in accordance with Federal and State requirements. Of 104 pharmacy claims in our stratified random sample, 75 claims totaling $10,116 (Federal share) met requirements and 8 claims totaling $229 (Federal share) were beyond the North Carolina Administrative Code's 5-year records retention period. However, the remaining 21 claims totaling $4,672 (Federal share) did not meet requirements, resulting in an overpayment of $4,315 (Federal share). Based on our sample results, we estimated that the State agency improperly claimed $1,383,713 (Federal share) in Medicaid reimbursement for pharmacy claims from October 1, 2004, through September 30, 2007.

Of 126 sterilization and clinic and practitioner claims that we reviewed in our judgmental sample, we found that 73 of the sterilization claims and all 50 of the clinic and practitioner claims qualified for reimbursement at the enhanced rate. However, three sterilization claims did not qualify for reimbursement at the enhanced rate because the claims were not supported by consent forms that met Federal requirements. As a result, the State agency improperly claimed $3,665 (Federal share) in Federal Medicaid funds for sterilization claims.

The State agency made these improper claims because it did not have adequate controls to ensure that it claimed only Medicaid family planning services at the enhanced rate.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,383,713 to the Federal Government for non-family-planning pharmacy claims that were reimbursed at the enhanced rate,
- refund $3,665 to the Federal Government for non-family-planning sterilization claims that were reimbursed at the enhanced rate,
- improve controls to ensure that the State agency claims the enhanced rate only for contraceptive drugs that physicians prescribe for family planning purposes,
- reemphasize to providers that only services clearly provided for family planning purposes should be billed as family planning, and
- improve controls to ensure sterilization consent forms are completed in accordance with Federal regulations.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency generally did not concur with four of our five recommendations. The State agency concurred with our second recommendation to refund $3,665 to the Federal Government to the extent that the State agency may have claimed enhanced Federal financial participation (FFP) for non-family planning sterilization claims.

In response to our first recommendation to return FFP for family planning pharmacy claims that neither the pharmacy nor the prescriber could produce supporting documentation for, the State agency did not agree that it should refund the majority of the estimated pharmacy claims to the Federal Government. (We had recommended that the State agency return to the Federal Government the estimated $2,467,222 in pharmacy claims because the pharmaceuticals on 29 of the 104 sampled claims may have been prescribed for purposes other than family planning.) The State agency noted that some of the claims selected for review were beyond North Carolina's 5-year record retention period. In addition, the State agency maintained that "all pharmaceuticals in the contraceptive therapeutic class should be eligible for the enhanced family planning matching rate." Further, the State agency stated that the only way to ensure that

pharmaceuticals in the contraceptive therapeutic class are prescribed only for family planning purposes would require implementing a methodology that is inconsistent with current medical practice and that would place an undue, disproportionate burden on prescribers of contraceptive drugs and pharmacies alike. For the same reasons, the State generally disagreed with our third and fourth recommendations.

The State provided a comment on our fifth recommendation, but it did not relate to the actual recommendation.

The State agency also stated that we were inconsistent in our interpretation of Federal requirements for claiming enhanced FFP for family planning services and supplies and that our findings were therefore not consistent with other issued Office of Inspector General (OIG) reports. The State agency's comments appear in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we modified our first recommendation by removing eight claims that were beyond the North Carolina Administrative Code's 5-year record retention period and adjusting our estimated overpayments for pharmacy claims accordingly. Nothing in the State agency's comments caused us to change our other findings or recommendations. We correctly applied Federal requirements to each of the reviewed claims.

Furthermore, the State agency's statement that our interpretation of Federal requirements during this audit is inconsistent with that of OIG audits of other States is inaccurate. OIG audits vary in objective, scope, and methodology. Therefore, OIG applies only those elements specific to the circumstances of the State it is auditing.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), 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. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Pursuant to section 1902(a)(27) of the Act and implementing Federal regulations (42 CFR § 433.32), Medicaid providers must maintain documentation that fully discloses the extent of the services provided to the beneficiary. In addition, Federal regulations (42 CFR § 441.253) require States to maintain documentation indicating that all Medicaid sterilization patients (1) were at least 21 years old at the time of the procedure; (2) were not mentally incompetent; and (3) voluntarily gave informed consent at least 30 days, but no more than 180 days, before the date of sterilization.

State of North Carolina Medicaid Program

In North Carolina, the Division of Medical Assistance (State agency) is responsible for administering the Medicaid program. The State agency contracts with HP Enterprise Services (formerly Electronic Data Systems) to maintain its Medicaid Management Information System, a computerized payment and information reporting system that processes and pays Medicaid claims.

North Carolina's Administrative Code (10A NCAC § 13J.1402(a)(2)(C)) complements 42 CFR § 433.32 by requiring that providers adequately document services. Specifically, the beneficiary's service record must contain a record of all services provided, including dates and times of the service(s), with entries dated and signed by the individual providing the service.

Medicaid Coverage of North Carolina Family Planning Services

Section 1905(a)(4)(C) of the Act requires States to furnish family planning services and supplies to individuals of childbearing age (including minors who can be considered sexually active) who are eligible under the State plan and who desire such services and supplies.

Pursuant to section 1903(a)(5) of the Act and Federal regulations (42 CFR § 433.10(c)(1)), the amount the Federal Government is authorized to reimburse the State for expenditures in family planning services is calculated at a Federal medical assistance percentage (FMAP) of 90 percent (enhanced rate).

The State agency's FMAP ranged from 63.49 percent to 64.52 percent (standard rate) for claims paid from October 1, 2004, through September 30, 2007.

According to section 4270 of the CMS *State Medicaid Manual* (the manual), family planning services are those that prevent or delay pregnancy or otherwise control family size. That provision of the manual generally permits the enhanced rate for the following family planning services and items: counseling services and patient education, examination and treatment by medical professionals according to each State's requirements, devices to prevent conception, and infertility services (including sterilization reversals). The manual provides that only items and procedures clearly furnished or provided for family planning purposes may be claimed at the enhanced rate.

From October 1, 2004, through September 30, 2007, the Federal Government reimbursed the State agency at the enhanced rate for 847,663 claims totaling $52,305,271 (Federal share) for Medicaid family planning services for pharmacy, sterilization, and clinic and practitioner claims.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Medicaid family planning reimbursement in accordance with Federal and State requirements.

Scope

Our audit covered certain Medicaid family planning claims for which the Federal Government reimbursed the State agency at the enhanced rate for the period October 1, 2004, through September 30, 2007. We did not review the overall internal control structure of the State agency or the Medicaid program. We limited our review to internal controls directly related to our objective.[1] We performed fieldwork at the State agency in Raleigh, North Carolina, from November 2010 through May 2011.

Methodology

To accomplish our objective, we:

- reviewed Federal laws, regulations, and the manual;

- interviewed State agency officials to understand the State's policies, procedures, guidance, and methodology for claiming Medicaid reimbursement for family planning services;

[1] We are reviewing family planning claims reimbursed under the State agency's Medicaid waiver program in an ongoing audit.

- obtained claim data from the State agency for family planning services consisting of 847,663 pharmacy, sterilization, and clinic and practitioner claims totaling $52,305,271 (Federal share) with dates of service from October 1, 2004, through September 30, 2007;

- selected a stratified random sample of 104 pharmacy claims ($15,018 Federal share) from 542,721 family planning pharmacy claims and:

    - contacted providers to obtain medical record information for each sampled claim,

    - contacted pharmacies that filled the prescriptions for sampled pharmacy claims in which the prescribing physician was not known,

    - reviewed the written physician notes in the corresponding medical records to determine whether the drugs were prescribed for family planning purposes, and

    - obtained an independent medical review of all medical records for which we determined the drugs may not have been prescribed for family planning purposes;

- selected judgmental samples of 30 beneficiaries of sterilization services and 30 beneficiaries of clinic and practitioner services from 304,942 family planning sterilization and clinic and practitioner claims and:

    - requested and reviewed the medical records for 76 sterilization claims ($145,535 Federal share) for the 30 sampled beneficiaries[2] to verify that all documentation was completed in accordance with 42 CFR §§ 441.258(a) and 441.258(b) and

    - requested and reviewed the medical records for 50 clinic and practitioner claims ($58,372 Federal share) for the 30 sampled beneficiaries to verify that all documentation was completed in accordance with 42 CFR §§ 433.32 and 441.253;

- followed up with providers to obtain additional information when supporting documentation was inadequate or missing; and

- calculated the improper payment amount for each error identified.

For our stratified random sample of pharmacy claims, we estimated the total overpayment in the sample frame. (See Appendix A for our sample design and methodology and Appendix B for our sample results and estimates.) We did not estimate the total overpayment in the population we reviewed for the 126 claims associated with the 60 judgmentally selected beneficiaries of sterilization and clinic and practitioner services.

[2] A single beneficiary sterilization often resulted in multiple claims (e.g., preliminary visits and postoperative followup).

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 objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not always claim Medicaid family planning reimbursement in accordance with Federal and State requirements. Of 104 pharmacy claims in our stratified random sample, 75 claims totaling $10,116 (Federal share) met requirements and 8 claims totaling $229 (Federal share) were beyond the North Carolina Administrative Code's 5-year records retention period. However, the remaining 21 claims totaling $4,672 (Federal share) did not meet requirements, resulting in an overpayment of $4,315 (Federal share). Based on our sample results, we estimated that the State agency improperly claimed $1,383,713 (Federal share) in Medicaid reimbursement for pharmacy claims from October 1, 2004, through September 30, 2007.

Of 126 sterilization and clinic and practitioner claims that we reviewed in our judgmental sample, we found that 73 of the sterilization claims and all 50 of the clinic and practitioner claims qualified for reimbursement at the enhanced rate. However, three sterilization claims did not. As a result, the State agency improperly claimed $3,665 (Federal share) in Federal Medicaid funds for sterilization claims.

The State agency made these improper claims because it did not have adequate controls to ensure that it claimed only Medicaid family planning services at the enhanced rate.

FEDERAL AND STATE REQUIREMENTS

Family Planning

Section 4270 of the manual generally permits an enhanced rate of Federal reimbursement for medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception. Pursuant to section 4270(B)(2) of the manual, "[o]nly items and procedures clearly provided or performed for family planning purposes may be matched at the 90 percent rate."

Adequate Documentation

Pursuant to section 1902(a)(27) of the Act and implementing Federal regulations (42 CFR § 433.32), Medicaid providers must maintain documentation that fully discloses the extent of the services provided to the beneficiary. The beneficiary's service record must contain a record of all services provided, including dates and times of the service, with entries dated and signed by the individual providing the service (10A North Carolina Administrative Code § 13J.1402(a)(2)(C)). Therefore, for a claim to be valid for Medicaid reimbursement, it must be adequately documented.

Federal regulations (42 CFR § 441.253) require States to maintain documentation indicating that all Medicaid sterilization patients (1) were at least 21 years old at the time of the procedure;

(2) were not mentally incompetent; and (3) voluntarily gave informed consent at least 30 days, but no more than 180 days, before the date of sterilization. In addition, § 441.256(a) states that Federal Medicaid reimbursement "… is not available in expenditures for any sterilization or hysterectomy unless the Medicaid agency, before making payment, obtained documentation showing that the requirements of this subpart were met." Federal regulations (42 CFR § 441.258(a)) require a sterilization consent form to be the same as the Appendix to subpart F of part 441 or another form approved by the Secretary of the U.S. Department of Health and Human Services (HHS). Pursuant to 42 CFR § 441.258(b), the form must include signatures of the patient, the physician performing the procedure, and the person securing the consent form.

Section 4270(B)(1) of the manual states that the cost of a sterilization is reimbursable at the enhanced rate if a properly completed sterilization consent form is submitted in accordance with the requirements of 42 CFR part 441, subpart F, Appendix.

PHARMACY CLAIMS

The State agency did not always properly claim Federal reimbursement at the enhanced rate for pharmacy claims of contraceptive drugs. Of 104 pharmacy claims in our stratified random sample, 75 claims totaling $10,116 (Federal share) qualified for reimbursement at the enhanced rate, and 8 claims totaling $229 (Federal share) were beyond the North Carolina Administrative Code's 5-year records retention period. However, of the other 21 pharmacy claims, 13 claims totaling $502 (Federal share) were for drugs prescribed for purposes other than family planning, resulting in an overpayment of $145 (Federal share). The remaining eight claims totaling $4,170 (Federal share) did not have adequate documentation, resulting in an overpayment.

For 13 sampled claims, independent medical reviewers determined that doctors prescribed the drugs for other than family planning purposes, such as hormone treatment, acne, excessive bleeding, and weight control. Although doctors may prescribe these drugs for family planning purposes, the medical records for these claims indicated that doctors had prescribed them for other purposes.

Eight sampled claims were not adequately documented to be eligible for Federal reimbursement at the enhanced rate. For six of these eight claims, doctors were unable to identify the patient or provide medical records supporting the pharmacy claims. For the remaining two of the eight claims, we were unable to locate the prescribing physician using the information provided by the State agency, even after multiple attempts.

For the 13 claims, which were for drugs that were not clearly prescribed for family planning purposes, we questioned the difference between the enhanced rate and the State agency's standard rate. For the eight claims with inadequate or no documentation, we questioned the entire amount claimed.

See Appendix A for our sampling methodology for pharmacy claims and Appendix B for our sample results and estimates.

STERILIZATION CLAIMS

The State agency did not always properly claim Federal reimbursement at the enhanced rate for sterilization claims. Of the 76 sterilization claims that we reviewed, 73 claims totaling $141,870 (Federal share) qualified for reimbursement at the enhanced rate. However, three claims totaling $3,665 (Federal share) did not have adequate documentation. Specifically:

- two claim-consent forms did not satisfy the Federal requirement (42 CFR § 441.258(a)) that the consent form be the same as the Appendix to subpart F of part 441 or another form approved by the Secretary of HHS and

- one claim was missing a consent form entirely.

INADEQUATE CONTROLS

The State agency made improper claims, resulting in overpayments, because it did not have adequate controls to ensure that it claimed only allowable family planning services. Specifically, the State agency did not have sufficient policies and procedures to:

- ensure that pharmacy claims for contraceptive drugs were prescribed for family planning purposes and

- ensure that it obtained consent forms that met all of the mandatory requirements, such as having the proper consent form required by 42 CFR part 441, subpart F.

UNALLOWABLE AMOUNT

Based on our sample of pharmacy claims, we estimated that the State agency improperly claimed $1,383,713 (Federal share) in Federal Medicaid reimbursement for contraceptive drugs. In addition, the State agency improperly claimed $3,665 (Federal share) in Federal Medicaid reimbursement for sterilization claims.

We did not estimate the total amount of overpayments for the population of all sterilization claims.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,383,713 to the Federal Government for non-family-planning pharmacy claims that were reimbursed at the enhanced rate,

- refund $3,665 to the Federal Government for non-family-planning sterilization claims that were reimbursed at the enhanced rate,

- improve controls to ensure that the State agency claims the enhanced rate only for contraceptive drugs that physicians prescribe for family planning purposes,

- reemphasize to providers that only services clearly provided for family planning purposes should be billed as family planning, and

- improve controls to ensure sterilization consent forms are completed in accordance with Federal regulations.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency generally did not concur with four of our five recommendations. The State agency concurred with our second recommendation to refund $3,665 to the Federal Government to the extent that the State agency may have claimed enhanced Federal financial participation (FFP) for non-family planning sterilization claims.

In response to our first recommendation to return FFP for family planning pharmacy claims that neither the pharmacy nor the prescriber could produce supporting documentation for, the State agency did not agree that it should refund the majority of the estimated pharmacy claims to the Federal Government. (We had recommended that the State agency return to the Federal Government the estimated $2,467,222 in pharmacy claims because the pharmaceuticals on 29 of the 104 sampled claims may have been prescribed for purposes other than family planning.) The State agency noted that some of the claims selected for review were beyond North Carolina's 5-year record retention period. In addition, the State agency maintained that "all pharmaceuticals in the contraceptive therapeutic class should be eligible for the enhanced family planning matching rate." Further, the State agency stated that the only way to ensure that pharmaceuticals in the contraceptive therapeutic class are prescribed only for family planning purposes would require implementing a methodology that is inconsistent with current medical practice and that would place an undue, disproportionate burden on prescribers of contraceptive drugs and pharmacies alike. For the same reasons, the State generally disagreed with our third and fourth recommendations.

The State provided a comment on our fifth recommendation, but it did not relate to the actual recommendation.

The State agency also stated that we were inconsistent in our interpretation of Federal requirements for claiming enhanced FFP for family planning services and supplies and that our findings were therefore not consistent with other issued Office of Inspector General (OIG) reports. The State agency's comments appear in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we modified our first recommendation by removing eight claims that were beyond the North Carolina Administrative Code's 5-year record retention period and adjusting our estimated overpayments for pharmacy claims accordingly. Nothing in the State agency's comments caused us to change our other findings or recommendations. We correctly applied Federal requirements to each of the reviewed claims. Furthermore, the State agency's statement that our interpretation of Federal requirements during this audit is inconsistent with that of OIG audits of other States is inaccurate. OIG audits vary in objective, scope, and methodology. Therefore, OIG applies only those elements specific to the circumstances of the State it is auditing.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was all Medicaid prescribed drug line items billed as regular State plan family planning services by North Carolina Division of Medical Assistance at a Federal medical assistance percentage of 90 percent during the period October 1, 2004, through September 30, 2007.

SAMPLING FRAME

We obtained from the State agency 586,631 line items totaling $21,895,893 (Federal share) from the Medicaid Management Information System paid claims files. From this population, we eliminated all negative (credit) adjustment line items and all corresponding positive (debit) line items for the same person, date of service, and dollar amount. The resulting sampling frame was 542,721 unique prescription drug line items totaling $21,898,629 (Federal share). Each line item is a unique claim.

SAMPLE UNIT

The sample unit was a claim.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into two strata: (1) Medicaid prescribed drug claims with a Federal paid amount ranging from $.01 to $449.99 and (2) Medicaid prescribed drug claims with a Federal paid amount ranging from $450 to $6,450.

Stratum	Range	No. of Claims	Federal Share
1	$.01 to $449.99	542,717	$21,887,837
2	450 to 6,450	4	10,792
	Total	**542,721**	**$21,898,629**

SAMPLE SIZE

We selected a sample of 104 claims consisting of 100 claims from stratum 1 and all 4 claims from stratum 2.

SOURCE OF THE RANDOM NUMBERS

A Region IV statistical specialist generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software, RAT-STATS 2010, Version 1, Random Number Generator.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the prescription drug claims from 1 to 542,717 in stratum 1. After generating 100 random numbers for stratum 1, we selected the corresponding line items. We selected all four line items in stratum 2.

ESTIMATION METHODOLOGY

We used OIG/OAS statistical software to estimate the amount of unallowable payments in the sample frame.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results: Federal Share Amounts

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Claims With Errors	Overpayments
1	542,717	$21,887,837	100	$4,226	20	$443
2	4	10,792	4	10,791	1	3,872
Total	**542,721**	**$21,898,629**	**104**	**$15,017**	**21**	**$4,315**

Estimates of Overpayments
(*Limits Calculated for a 90-Percent Confidence Interval*)

	Federal Share
Point estimate	$2,403,982
Lower limit	1,383,713
Upper limit	3,424,251

North Carolina Department of Health and Human Services
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Beverly Eaves Perdue, Governor

Albert A. Delia, Acting Secretary

March 7, 2012

Lori S. Pilcher
Regional Inspector General for Audit Services
US DHHS Office of Inspector General
61 Forsyth Street SW
Suite 3T41
Atlanta, GA 30303

Re: North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Services That Were Not Family Planning
CIN A-04-10-01089

Dear Ms. Pilcher:

The North Carolina Department of Health and Human Services (NCDHHS) received your January 5, 2012 letter and draft report entitled "*North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Services That Were Not Family Planning*" [Audit A-04-10-01089].

OIG Recommendation 1:

The recommendations were for the State agency to:

- Refund $2,467,333 to the Federal Government for non-family planning pharmacy claims that were reimbursed at the enhanced rate,
- Refund $3,665 to the Federal Government for non-family planning sterilization claims that were reimbursed at the enhanced rate,
- Improve controls to ensure that the State agency claims the enhanced rate only for contraceptive drugs that physicians prescribe for family planning purposes,
- Reemphasize to providers that only services clearly provided for family planning purposes should be billed as family planning, and
- Improve controls to ensure that sterilization consent forms are completed in accordance with Federal regulations.

DHHS Response – Recommendation 1:

NC DHHS partially concurs:

To the extent that the Department may have claimed FFP for family planning pharmacy claims for which neither the pharmacy nor the prescriber can produce supporting documentation that the pharmaceutical was prescribed at all, and the provider has not declared bankruptcy or gone out of business, the Department concurs that such FFP should be returned.

The Department respectfully disagrees with the Office of the Inspector General's (OIG's) recommendation that the majority of the estimated $2,467,222 be returned to the federal government because the pharmaceuticals on 29 of the 104 sampled claims may have been prescribed for purposes other than family planning. There are three primary reasons for the disagreement.

(1) North Carolina State law 10A NCAC 22F.0107 which went into effect on April 1, 1988, requires that Medicaid billing records be retained for only five years. (The law can be viewed at http://ncrules.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2022%20-%20medical%20assistance%20eligibility/subchapter%20f/10a%20ncac%2022f%20.0107.pdf http://www.ncdhhs.gov/dma/plan/sp.pdf.) In some sampled claims, the five year period had already expired before a records request could be made. Nevertheless, these claims were considered unallowable in the audit due to "no documentation". The Department asserts that the provider is not obligated to retain records for a period longer than contractually required.

The Department also asserts that the only way to ensure that claims for pharmaceuticals in the contraceptive therapeutic classification are only claimed at the enhanced match rate when prescribed specifically for the purposes of family planning would be to require pharmacies to include a diagnosis code on the claim. Pharmacies would be unable to do this unless the prescriber included the diagnosis code on the prescription. Requiring the diagnosis code on the prescription is not consistent with current medical practice and places an undue, disproportionate burden on prescribers of contraception and pharmacies alike and unfairly segregates a certain class of medication to be processed differently.

(2) The Department wishes to address the issue of the stigma that some women associate with discussing and requesting contraception. It is not uncommon for individuals to withhold sensitive and deeply personal information from health care providers, especially regarding sexual activity. Some women may feel more comfortable requesting contraceptives to manage dysmenorrhea or menorrhagia rather than for birth control. Further, at the client's request, providers may document a non-family planning purpose as the primary reason for the prescription in order to allay fears a client may have regarding privacy. Also, for all of the 29 claims in question, the patient was a female of child bearing age. No clinical records were observed that the patients in question were unable to conceive. So while a client may request contraception for another reason, it still could prevent a pregnancy despite the client's medical records not accurately reflecting the client's sexual activity and/or reasons for taking a contraceptive drug. Finally, Section 4270 of the State Medicaid Manual allows States to establish a way to identify family planning services and apply for the enhanced match. Therefore, the Department maintains that all pharmaceuticals in the contraceptive therapeutic class should be eligible for the enhanced family planning matching rate.

(3) Lastly, the Department believes that OIG is not consistent across state audits in its interpretation and application of the guidance in the Centers for Medicare and Medicaid Services (CMS)

Financial Management Review Guide #20 regarding states' claiming of enhanced federal financial participation (FFP)for family planning services and supplies. Nor does the Department believe that the OIG is consistent across state audits in its interpretation and application of Section 4270 of the State Medicaid Manual or the cited 1992 Departmental Appeals Board administrative law ruling.

During the course of the audit, the Department explained to the OIG that North Carolina's enhanced claiming for family planning pharmacy claims was governed by therapeutic classification code. It appears that many other states use this methodology for claiming the enhanced family planning match on pharmacy claims. In other audits conducted by the OIG of states' enhanced family planning pharmacy claiming, the Department found that in only one of these audits were the specific prescription diagnoses questioned. In the majority of these audits, the OIG found no issue with states claiming enhanced FFP on all claims for prescriptions with drugs that had been appropriately assigned to the contraceptive therapeutic classification code. Specifically, in one audit report released on February 28, 2011 (A-09-09-00049), the OIG specifically states, "***We reviewed $19 million (Federal share) for family planning services and supplies that did not contain approved diagnosis codes or approved therapeutic classification codes.***" [Emphasis added]. All of the 104 sampled claims in North Carolina's audit contained the appropriate classification codes by using the 'family planning indicator' that First Data Bank (national drug file compendia) sends to us, and this indicator results in identification of contraceptive therapeutic classification codes. Thus, the Department again disagrees with the OIG's recommendation to return the enhanced FFP for more than a quarter of its family planning pharmacy claims.

North Carolina has been using an automated approach through their MMIS system to restrict claims for enhanced FFP on family planning to only those claims with a pharmaceutical classified as family planning by a nationally recognized organization with expertise in the classification of pharmaceuticals.

An apparently very similar process was proposed by the State of Kansas as quoted in the OIG report A-07-09-04146 where the Kansas responded to the OIG recommendations stating:

"As a result, the policy changes implemented on June 18, 2010 ...add new system logic to remove the provider from the process of identifying family planning services eligible for enhanced FFP. The identification of family planning services takes place in the coding and editing of the MMIS claims process, which has the advantage of preventing claims of enhanced FFP for services the provider could have misidentified as being related to family planning."

The OIG responded as follows to the above comments:

"The corrective actions that the State agency described in its comments, **should, when fully implemented, adequately address our findings.**" [Emphasis added].

The North Carolina MMIS has had system edits in place for over a decade in this regard. All of the 104 sampled claims in North Carolina's audit contained the appropriate therapeutic classification codes and pharmaceuticals that were appropriately assigned to those therapeutic classification codes. As such, the Department respectfully disagrees with OIG's recommendation to return the enhanced FFP for a quarter of its family planning pharmacy claims, especially since the OIG has already informed at least one State agency that these controls are considered adequate by the OIG (Report A-07-09-04146, August 18, 2010 – "*The corrective actions that*

the State agency [Kansas Health Policy Authority] described in its comments should, when fully implemented, adequately address our findings...". .

OIG Recommendation #2

We recommend that the State Agency:

Refund $3,665 to the Federal Government for non-family planning sterilization claims that were reimbursed at the enhanced rate.

DHHS Response – Recommendation 2:

NC DHHS partially concurs.

To the extent that the Department may have claimed enhanced FFP for non-family planning sterilization claims, the Department concurs that such FFP should be returned. The Department is still in the process of researching the necessary medical records from the providers.

OIG Recommendation #3:

We recommend that the State Agency:

Strengthen internal controls to ensure that prescribed drug costs submitted for Federal reimbursement appropriately identify claims that are eligible for reimbursement at the 90-percent rate.

DHHS Response – Recommendation 3:

NC DHHS partially concurs.

For patients unable to conceive (e.g. male or too old), the Department concurs that enhanced match is not appropriate. However, the Department's procedures are very similar to those of other States where the OIG has allowed such procedures (e.g. A-07-09-04146).

The Department believes that its internal controls for appropriate claiming of enhanced match for family planning pharmaceuticals are adequate and exceed that of other states. As noted above, 100 percent of sampled claims included the appropriate therapeutic classification codes and pharmaceuticals that were appropriately assigned to those therapeutic classification codes as opposed to several other states. As discussed in its response to Recommendation #1, the Department asserts that the only way to ensure that claims for pharmaceuticals in the contraceptive therapeutic classification are only claimed at the enhanced match rate when prescribed specifically for the purposes of family planning would be to require pharmacies to include a diagnosis code on the claim. Pharmacies would not be able to do this unless the prescriber included the diagnosis code on the prescription. Requiring the diagnosis code on the prescription is not consistent with current medical practice and places an undue disproportionate burden on prescribers of contraception and pharmacies alike.

OIG Recommendation #4

Reemphasize to providers that only services clearly provided for family planning purposes should be billed as family planning.

DHHS Response – Recommendation 4

Medicaid providers in North Carolina bill services using standard medical codes. Pharmaceuticals are billed based upon National Drug Code (NDC). Neither of these codes provide for the explicit description of the services provided. As previously stated, the Department claims the enhanced rate only for pharmaceuticals classified with the appropriate therapeutic classification codes. The Department asserts that the only way to ensure that claims for pharmaceuticals in the contraceptive therapeutic classification are only claimed at the enhanced match rate when prescribed specifically for the purposes of family planning would be to require pharmacies to include a diagnosis code on the claim. Pharmacies would not be able to do this unless the prescriber included the diagnosis code on the prescription. Requiring the diagnosis code on the prescription is not consistent with current medical practice and places an undue disproportionate burden on prescribers of contraception and pharmacies alike.

OIG Recommendation #5

Improve controls to ensure that the State agency claims the enhanced rate only for contraceptive drugs that physicians prescribe for family planning purposes,

NC DHHS Response – Recommendation 5

As previously stated, the Department claims the enhanced rate only for pharmaceuticals classified with the appropriate therapeutic classification codes. The Department asserts that the only way to ensure that claims for pharmaceuticals in the contraceptive therapeutic classification are only claimed at the enhanced match rate when prescribed specifically for the purposes of family planning would be to require pharmacies to include a diagnosis code on the claim. Pharmacies would not be able to do this unless the prescriber included the diagnosis code on the prescription. Requiring the diagnosis code on the prescription is not consistent with current medical practice and places an undue disproportionate burden on prescribers of contraception and pharmacies alike.

We appreciate the assistance and professionalism provided by your staff in the performance of this audit. If you need any additional information, please contact Monica Hughes at (919) 855-3720.

Sincerely,

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