DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

June 28, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Lori S. Pilcher/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Medicaid Family Planning Services Claimed Under the Oregon Health Plan During the Period October 1, 2006, Through September 30, 2009 (A-09-10-02043)

Attached, for your information, is an advance copy of our final report on Medicaid family planning services claimed under the Oregon Health Plan. We will issue this report to the Oregon Department of Human Services 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 A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360 or through email at Lori.Ahlstrand@oig.hhs.gov. Please refer to report number A-09-10-02043.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

June 29, 2011

Report Number: A-09-10-02043

Bruce Goldberg, M.D.
Director
Oregon Department of Human Services
500 Summer Street, NE
Salem, OR 97301

Dear Dr. Goldberg:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Family Planning Services Claimed Under the Oregon Health Plan During the Period October 1, 2006, Through September 30, 2009*. 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 Janet Tursich, Audit Manager, at (206) 615-2063 or through email at Janet.Tursich@oig.hhs.gov. Please refer to report number A-09-10-02043 in all correspondence.

Sincerely,

/Lori A. Ahlstrand/
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 & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID FAMILY PLANNING SERVICES CLAIMED UNDER THE OREGON HEALTH PLAN DURING THE PERIOD OCTOBER 1, 2006, THROUGH SEPTEMBER 30, 2009

Daniel R. Levinson
Inspector General

June 2011
A-09-10-02043

Office of Inspector General

http://oig.hhs.gov

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at http://oig.hhs.gov

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.

Pursuant to section 1905(a)(4)(C) of the Act, States are required to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and desire such services and supplies. Section 1903(a)(5) of the Act and Federal regulations (42 CFR § 433.10(c)(1)) authorize Federal reimbursement for family planning services at the enhanced Federal medical assistance percentage (FMAP) of 90 percent (90-percent rate). Family planning services prevent or delay pregnancy or otherwise control family size.

In Oregon, the Department of Human Services (State agency) administers the Medicaid program. The State agency provides Medicaid family planning services under the Oregon Health Plan and the Family Planning Expansion Project. This report focuses on fee-for-service claims for family planning services provided to those Oregon Health Plan beneficiaries who were not enrolled in a managed care plan or who elected to receive services outside such a plan. Another report (A-09-11-02010) will focus on family planning services provided under the Family Planning Expansion Project.

The Oregon Administrative Rules (OAR), § 410-130-0585, define family planning services as those services that are intended to prevent or delay pregnancy or otherwise control family size. The Oregon Health Plan covers family planning services for clients of childbearing age, including minors who are considered to be sexually active. Pursuant to OAR § 410-130-0585(6), for billing purposes, a family planning service must be coded with the most appropriate diagnosis code related to contraceptive management.

During the period October 1, 2006, through September 30, 2009, the State agency submitted fee-for-service claims totaling approximately $56 million ($51 million Federal share) for family planning services provided to Medicaid beneficiaries under the Oregon Health Plan. We reviewed $41 million (Federal share) of fee-for-service claims for family planning services that did not contain appropriate diagnosis codes related to contraceptive management.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal reimbursement at the 90-percent rate for family planning services provided under the Oregon Health Plan in accordance with Federal and State requirements.

SUMMARY OF FINDING

The State agency did not always claim Federal reimbursement at the 90-percent rate for family planning services provided under the Oregon Health Plan in accordance with Federal and State requirements. Specifically, the State agency claimed some medical services that were not related to family planning. Contrary to State requirements, the claims did not contain appropriate diagnosis codes related to contraceptive management and thus were ineligible for reimbursement at the 90-percent rate. However, these claims were eligible for reimbursement at Oregon's regular FMAP for the years in which the claims were paid. As a result, we calculated that the State agency was overpaid $1,487,974 (Federal share) for these claims.

The overpayment occurred because the State agency's Medicaid Management Information System (MMIS) controls did not properly distinguish claims eligible for reimbursement at the 90-percent rate from claims eligible for reimbursement at the regular FMAP rate. In December 2008, the State agency implemented a new MMIS and changed its internal controls to properly identify these claims.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,487,974 to the Federal Government and

- identify and refund any overpayments for family planning claims before October 1, 2006, that did not contain appropriate diagnosis codes identifying the claims as eligible for reimbursement at the 90-percent rate.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and provided information on actions that it had taken or planned to take to address the recommendations. The State agency's comments are included in their entirety as the Appendix.

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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. Section 1115 of the Act authorizes demonstration projects to assist in promoting the objectives of the Medicaid program.

Medicaid Coverage of Family Planning Services

Pursuant to section 1905(a)(4)(C) of the Act, States are required to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and desire such services and supplies. Section 1903(a)(5) of the Act and Federal regulations (42 CFR § 433.10(c)(1)) authorize Federal reimbursement for family planning services at the enhanced Federal medical assistance percentage (FMAP) of 90 percent (90-percent rate).

Section 4270 of the CMS *State Medicaid Manual* (the Manual) states that family planning services include those that prevent or delay pregnancy or otherwise control family size and may also include infertility treatments. The Manual indicates that States are free to determine which services will be covered as long as those services are sufficient in amount, duration, and scope to reasonably achieve their purpose. However, only services clearly furnished for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate.

Oregon's Medicaid Program

In Oregon, the Department of Human Services (State agency) administers the Medicaid program. The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims for payment by the Statewide Financial Management Application. The expenditures related to the claims are reported on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, for Federal reimbursement.

The Federal share of the Medicaid program is determined by the FMAP. During our audit period, the FMAP in Oregon was 61.07 percent (October 1, 2006, through September 30, 2007), 60.86 percent (October 1, 2007, through September 30, 2008), and between 71.58 and 72.61 percent (October 1, 2008, through September 30, 2009).

Oregon's Medicaid Family Planning Programs

The State agency provides Medicaid family planning services under the Oregon Health Plan and the Family Planning Expansion Project, both of which are section 1115 demonstration projects. This report focuses on fee-for-service claims for family planning services provided to those Oregon Health Plan beneficiaries who were not enrolled in a managed care plan or who elected to receive services outside such a plan. Another report (A-09-11-02010) will focus on family planning services provided under the Family Planning Expansion Project.

CMS approved a section 1115 waiver for the Oregon Health Plan beginning on February 1, 1994. The goal of the waiver was to expand eligibility, prioritize the list of health services provided to beneficiaries, and increase the use of managed care. Through the Oregon Health Plan, the State agency provides health care to Oregonians who have applied and been determined eligible with incomes up to 185 percent of the Federal poverty level.

State Requirements for the Oregon Health Plan

The Oregon Administrative Rules (OAR), § 410-130-0585, define family planning services as those services that are intended to prevent or delay pregnancy or otherwise control family size. The Oregon Health Plan covers family planning services for clients of childbearing age, including minors who are considered to be sexually active. Family planning services include annual exams; contraceptive education and counseling to address reproductive health issues; laboratory tests; radiology services; medical and surgical procedures, including tubal ligation and vasectomies; and pharmaceutical supplies and devices.

Pursuant to OAR § 410-130-0585(6), for billing purposes, a family planning service must be coded with the most appropriate International Classification of Diseases (ICD)[1] diagnosis code in the V25 series (Contraceptive Management).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Federal reimbursement at the 90-percent rate for family planning services provided under the Oregon Health Plan in accordance with Federal and State requirements.

Scope

During our audit period (October 1, 2006, through September 30, 2009), the State agency submitted fee-for-service claims totaling $56,176,373 ($50,551,310 Federal share) for family planning services provided to Medicaid beneficiaries under the Oregon Health Plan.

We reviewed $45,784,251 ($41,198,400 Federal share) of fee-for-service claims for family planning services that did not contain appropriate diagnosis codes within the V25 series. We did

[1] *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM).

not review the remaining $10,392,122 ($9,352,910 Federal share) because these claims contained appropriate diagnosis codes within the V25 series.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We conducted our audit from March to December 2010 and performed our fieldwork at the State agency's office in Salem, Oregon.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance and the approved State plan;
- reviewed the demonstration project requirements for the Oregon Health Plan;
- held discussions with CMS officials to gain an understanding of CMS guidance furnished to State agency officials concerning Medicaid family planning claims;
- held discussions with State agency officials to gain an understanding of State policies and procedures for claiming Federal reimbursement for family planning services;
- obtained family planning claim data from the State agency's MMIS;
- reconciled family planning claim data to Form CMS-64;
- identified claims for services that did not have the most appropriate diagnosis codes within the V25 series; and
- calculated the unallowable Federal reimbursement claimed by the State agency.

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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

The State agency did not always claim Federal reimbursement at the 90-percent rate for family planning services provided under the Oregon Health Plan in accordance with Federal and State requirements. Specifically, the State agency claimed some medical services that were not related to family planning. Contrary to State requirements, the claims for services did not contain appropriate diagnosis codes related to contraceptive management and thus were ineligible for reimbursement at the 90-percent rate. However, these claims were eligible for reimbursement at

Oregon's regular FMAP for the years in which the claims were paid. As a result, we calculated that the State agency was overpaid $1,487,974 (Federal share) for these claims.

The overpayment occurred because the State agency's MMIS controls did not properly distinguish claims eligible for reimbursement at the 90-percent rate from claims eligible for reimbursement at the regular FMAP rate. In December 2008, the State agency implemented a new MMIS and changed its internal controls to properly identify these claims.

FEDERAL REQUIREMENTS

Pursuant to section 4270.B of the Manual, States are free to determine which family planning services will be covered as long as they are sufficient in amount, duration, and scope to reasonably achieve their purpose. However, the Manual states that only services clearly furnished for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate.

STATE REQUIREMENTS

The State plan provides for family planning services for Medicaid-eligible individuals of childbearing age with limitations as specified.[2]

Pursuant to OAR § 410-130-0585(6), providers must "bill all family planning services with the most appropriate ICD-9-CM diagnosis code in the V25 series (Contraceptive Management) …."

SERVICES NOT RELATED TO FAMILY PLANNING

The State agency initially claimed $41,198,400 (Federal share) of medical services provided under the Oregon Health Plan that were not related to family planning. Contrary to State requirements, the claims for services did not contain appropriate V25 diagnosis codes and thus were not eligible for reimbursement at the 90-percent rate. Examples of these diagnosis codes were V20.2, routine infant or child health check; V22.1, supervision of other normal pregnancy; 465.9, acute respiratory infection of unspecified site; and 250.00, diabetes mellitus.

The claims for medical services were eligible for reimbursement at Oregon's regular FMAP for the years in which the claims were paid. We calculated that the State agency was overpaid $12,884,829 (Federal share) for these claims.

In January 2007, the State agency discovered that since 2005, the claimed amount of family planning services had increased from 4 percent to 40 percent of total physician services. The increase occurred because the State agency's MMIS controls did not properly distinguish claims eligible for reimbursement at the 90-percent rate from claims eligible for reimbursement at the regular FMAP rate. Before our audit, the State agency determined that it had overclaimed services unrelated to family planning and had been improperly reimbursed $11,396,855 (Federal

[2] Family planning services are provided subject to the rules and procedures set forth in OAR Division 130, "Medical-Surgical Services," and the billing instructions for Oregon Medical Assistance programs.

share) for the period October 1, 2006, through September 30, 2009. As a result, the State agency made adjustments for this amount on Form CMS-64.[3]

The difference between our calculated overpayment ($12,884,829) and the State agency's adjustments ($11,396,855) represents the remaining overpayment, totaling $1,487,974. The remaining overpayment exists because we analyzed final claim data, whereas the State agency analyzed quarterly expenditure data coded as family planning.

In December 2008, the State agency implemented a new MMIS and changed its internal controls to properly identify allowable family planning claims. State agency officials informed us that they had made changes to provider contracts to require providers to use specific diagnosis codes when claiming family planning services. In addition, the State agency plans to monitor the Form CMS-64 reporting process.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,487,974 to the Federal Government and

- identify and refund any overpayments for family planning claims before October 1, 2006, that did not contain appropriate diagnosis codes identifying the claims as eligible for reimbursement at the 90-percent rate.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and provided information on actions that it had taken or planned to take to address the recommendations. The State agency's comments are included in their entirety as the Appendix.

[3] We verified the State agency's adjustments for reimbursements unrelated to family planning services.

APPENDIX

APPENDIX: DEPARTMENT OF HUMAN SERVICES COMMENTS

DHS Oregon Department of Human Services

Office of the Director

Oregon Health Authority

John A. Kitzhaber, MD, Governor

500 Summer Street NE
Salem, OR 97301

April 21, 2011

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Re: Report Number A-09-10-02043

Dear Ms. Ahlstrand:

The Oregon Department of Human Services appreciates the opportunity to respond to the draft report entitled *Review of Family Planning Services Claimed Under the Oregon Health Plan During the Period October 1, 2006, Through September 30, 2009* from the U.S. Department of Health and Human Services, Office of Inspector General.

We concur with the recommendations made in the draft report and will correct the prior period claiming for family planning services. Below we have provided the department's responses to the recommendations found within the draft report.

We recommend that the State agency refund $1,487,974 to the Federal Government.

The department concurs with this recommendation.

The department has made an adjustment in our prior period claiming of family planning services in the amount of $1,487,974. This adjustment will be reflected in our CMS 64 reporting for the quarter ending March 31, 2011. The department will also determine the

amount of any adjustments necessary to reflect the appropriate match rates in the claiming rates for family planning services claimed under the Oregon Health Plan (OHP) for the periods since September 30, 2009. Further, the department has made adjustments to our information systems to correctly claim family planning services at the appropriate match rates going forward. These initial changes were implemented in late July and early August 2010. Further changes were made and verified in December 2010.

Department analysis of claims data during the audit revealed that the new Medicaid Management Information System (MMIS), due to its increased capacity, functionality and design, has more accurately captured family planning services eligible for 90% match since its implementation in December of 2008. As mentioned above, the analysis also revealed that there were small modifications still needed. Some of these modifications further reduce the likelihood services would be incorrectly categorized as family planning, and some of the modifications enable the department to claim the higher match rate on family planning services that we were previously missing.

Examples of changes made to the MMIS system include an audit and subsequent adjustment to the provider types we accept family planning claims from, adding drug IUD codes, restricting certain family planning procedure codes to specific diagnoses that must be billed in conjunction with those procedure codes, restricting diagnoses codes accepted for family planning services to the fifth digit of specificity, adding more procedure codes, restricting the age of the client for acceptance of claims as family planning services, adding J-code restrictions by age and diagnosis for injections to be accepted as family planning services, adjustments to the modifiers that are accepted as family planning services.

As part of the department's ongoing monitoring and internal controls, the CMS 64 reporting of claims expense for claiming of federal match at the family planning rate is being reviewed, going forward, by the Division of Medical Assistance Programs (DMAP), Policy and Program Management Section, and by others in the Budget Unit, to ensure any anomalies in amounts claimed as family planning are

discovered quickly, and can be corrected before submission, or adjusted in the next quarter.

We recommend that the State agency identify any overpayments for family planning claims before October 1, 2006, that did not contain appropriate diagnosis codes identifying the claims as eligible for reimbursement at the 90-percent rate.

The department concurs with the recommendation.

The department maintains financial data beginning January 2001, and claims data beginning December 2001, based on paid date, in our current Decision Support and Surveillance Utilization Review System (DSSURS). A majority of the data (prior to December 2008) is converted data from our prior legacy MMIS system. Further, we have prior legacy system data dating back to January 1998 in a searchable DB2 format.

We have hard copy CMS 64 information for most quarters dating back to the first quarter of Federal Fiscal Year 2001. We have also located hard copy Medicaid reporting information for a few quarters going back to September 1995. In addition, we have access to CMS 64 reporting information online through the Medicaid Budget and Expenditure System (MBES) through the first quarter of Federal Fiscal Year 1989.

The department does not have Statewide Financial Management Application (SFMA) detailed accounting data before July 1, 2005.

As was discussed during the audit, the department has historically monitored the expenditure and match rates for Family Planning Physicians' Services claims. This analysis goes back to July 1, 2003. For each month since July 2003, DMAP Budget Unit staff tracked information from the SFMA database records for expenditures and revenue. This data is contained in summary form in an Excel spreadsheet/database, which lists the monthly data by type of service; e.g., Fully Capitated Health Plan (managed care) and fee-for-service categories, including Physicians' Services. The achieved

match rate is calculated from this high-level information, by comparing the federal funds to the total funds spent by category.

In June 2007, the department made an adjustment resulting in a net $7.7 million federal fund reduction for family planning claims processed between July 1, 2005 and September 30, 2006. These adjustments were based on estimates from the DSSURS analysis. This analysis estimated that approximately 4.25% of the Physicians' Services claims processed to that point in the biennium qualified for the family planning enhanced rate.

Our available Budget Unit records indicate that at the time the 2003-2005 analysis was completed, the department claims data found that approximately 8.5% of the Physicians' Services claims qualified for enhanced funding under approved procedure codes. This analysis resulted in a prospective reduction of approximately $13 million in federal funds. However, this prospective adjustment was not made. Instead this prospective adjustment was offset by the prospective under claiming of federal funds for the Medicaid Buy-In program. During the period of October 2004 to January 2005, the majority of these eligible Buy-In program claims were expended at 100% state funds. This resulted in an estimated under claiming of approximately $13.5 million in federal funds. The department chose to not make either adjustment at that time.

Based on our review of the CMS 64 information for Federal Fiscal Years 2001, 2002 and the first three quarters of 2003, the level of Physicians' Services claims charged at the enhanced family planning rate appears relatively consistent with the average lower (post-adjustment) amounts for the other years discussed above. This expenditure level continued until the final quarter of Federal Fiscal Year 2003, when the Physicians' Services claims charged at the enhanced family planning rate increased substantially. We speculate this was the result of system coding changes that were made during June and July 2003. Given the information available, we believe the coding problem identified in the audit most likely began in late June or early July 2003.

Based on the above information, we will analyze our available DSSURS claims and financial data, CMS 64 reporting data, and Budget Unit and accounting documentation to determine and make appropriate adjustments for any net remaining amount owed to the federal government.

To accomplish this for the last three quarters of Federal Fiscal Year 2002 and first three quarters of Federal Fiscal Year 2003, we will use our DSSURS claims and financial data and CMS 64 reports to analyze the coding and reporting of OHP Family Planning services.

- This will allow for analysis of available claims and financial data from our current DSSURS.
- This will review claims for a period of 18 months prior to when we suspect the system coding problem began.

For the period of July 2003 through June 2005, we will review our DSSURS, CMS 64 and available Budget Unit documentation to determine the accuracy of our initial analysis addressed above. For the period of July 2005 through September 2006, we will review the original adjustments by analyzing available accounting, Budget Unit, DSSURS and CMS 64 information.

Once again, thank you for this opportunity to respond to the recommendations found within Report Number A-09-10-02043. If you have any questions or concerns with the department's responses, please feel free to contact me or contact Dave Lyda, the department's Chief Audit Officer at 503-945-6700 or through e-mail at dave.m.lyda@state.or.us.

Sincerely,

Jim Scherzinger

Jim Scherzinger
Deputy Director of Finance
Oregon Department of Human Services

cc: Dave Lyda, Chief Audit Officer