Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CALIFORNIA IMPROPERLY CLAIMED ENHANCED FEDERAL REIMBURSEMENT FOR MEDICAID FAMILY PLANNING SERVICES PROVIDED IN SAN DIEGO COUNTY

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General

December 2012
A-09-11-02040

Office of Inspector General

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EXECUTIVE SUMMARY

California claimed approximately $5.7 million in unallowable enhanced Federal reimbursement for Medicaid family planning services provided in San Diego County.

WHY WE DID THIS REVIEW

Family planning services prevent or delay pregnancy or otherwise control family size. Federal law and regulations authorize Federal Medicaid reimbursement to States for family planning services at an enhanced Federal medical assistance percentage (FMAP) of 90 percent (90-percent rate). Previous Office of Inspector General reviews found that States improperly claimed reimbursement at the 90-percent rate for services that were eligible only for the regular FMAP or were ineligible for Federal reimbursement.

The objective of this review was to determine whether the California Department of Health Care Services (State agency) complied with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning services provided under the Family Planning, Access, Care, and Treatment (FPACT) program in San Diego County.

BACKGROUND

In California, the State agency administers the Medicaid program. The State agency's FPACT program, a demonstration project (waiver) under section 1115 of the Social Security Act, extends Medicaid eligibility for family planning services to individuals of childbearing age who reside in California and have incomes up to 200 percent of the Federal poverty level. Individuals eligible for the FPACT program are generally not otherwise eligible for Medicaid.

The section 1115 waiver for the FPACT program states that Federal reimbursement is available at the 90-percent rate for services whose primary purpose is family planning and that are provided in a family planning setting. Federal reimbursement is available at the regular FMAP (61.59 percent during our audit period) for services provided ancillary to a family planning service, such as followup visits, and that carry a diagnosis code indicating that they are related to a family planning service. The Centers for Medicare & Medicaid Services (CMS) approved a list of procedure codes eligible for reimbursement under the FPACT program and applicable Federal reimbursement rates.

HOW WE CONDUCTED THIS REVIEW

From October 1, 2008, through September 30, 2010, the State agency claimed approximately $96.8 million ($71.5 million Federal share) for family planning services, drugs, and supplies provided to FPACT clients in San Diego County, representing 2.5 million claim lines. (A claim line represented an individual service billed as part of a claim for an FPACT client.) Of these claim lines, we judgmentally selected for review 2,688 claim lines, totaling $88,748, that had no procedure codes or procedure codes that were not approved by CMS for reimbursement at the 90-percent rate. We did not review approximately 1 million claim lines, totaling $41.3 million, for drugs and supplies (to be reviewed in a future audit), pregnancy tests (a low risk of being

unallowable), and reimbursements determined to be immaterial. We reviewed a stratified random sample from the remaining 1.5 million claim lines, totaling $55.5 million, for family planning services.

WHAT WE FOUND

The State agency did not always comply with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning services provided under the FPACT program in San Diego County. As a result, the State agency claimed $5,671,216 in unallowable Federal reimbursement.

- Of the 110 sampled claim lines, 81 complied and 29 did not comply with requirements. Of the 29 claim lines, 23 were ineligible for reimbursement because the primary purpose of the visit was not family planning, 4 were eligible for reimbursement only at the regular FMAP because they were for followup visits, and 2 were ineligible for reimbursement because of insufficient documentation. On the basis of our sample results, we estimated that the State agency claimed $5,605,504 in unallowable Federal reimbursement.

- Of the $88,748 we reviewed separately, the State agency claimed $65,712 in unallowable Federal reimbursement for claim lines that contained either no procedure code or a procedure code that was not approved by CMS for reimbursement at the 90-percent rate.

The overpayment occurred because the State agency did not have billing procedures to ensure that it claimed reimbursement at the 90-percent rate only for services whose primary purpose was family planning. Also, the State agency's Medicaid Management Information System (MMIS) lacked edits to prevent followup services from being claimed at the 90-percent rate and to ensure that claims contained a CMS-approved procedure code.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $5,671,216 to the Federal Government,

- establish billing procedures to ensure that only services whose primary purpose is family planning are claimed for reimbursement at the 90-percent rate, and

- establish MMIS edits to ensure that family planning claims meet Federal and State requirements for reimbursement at the 90-percent rate and at the regular FMAP for followup visits.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations and provided information on actions that it had taken or planned to take to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Family planning services prevent or delay pregnancy or otherwise control family size. Federal law and regulations authorize Federal Medicaid reimbursement to States for family planning services at an enhanced Federal medical assistance percentage (FMAP) of 90 percent (90-percent rate). Previous Office of Inspector General (OIG) reviews found that States improperly claimed reimbursement at the 90-percent rate for services that were eligible only for the regular FMAP or were ineligible for Federal reimbursement.

OBJECTIVE

Our objective was to determine whether the California Department of Health Care Services (State agency) complied with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning services provided under the Family Planning, Access, Care, and Treatment (FPACT) program in San Diego County.

BACKGROUND

Medicaid Program

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 Social Security Act (the Act) authorizes demonstration projects (waiver) to assist in promoting the objectives of the Medicaid program.

Medicaid Coverage of Family Planning Services

According 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 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 and supplies will be covered as long as those services are sufficient in amount, duration, and scope to reasonably achieve their purpose. However, only services and supplies clearly furnished for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate.

California's Medicaid Family Planning Program

In California, the State agency administers the Medicaid program. The State agency's FPACT program, a section 1115 waiver, extends Medicaid eligibility for family planning services to individuals of childbearing age who reside in California and have incomes up to 200 percent of the Federal poverty level. Individuals eligible for the FPACT program are generally not otherwise eligible for Medicaid. California's Department of Public Health, Office of Family Planning, is responsible for administering the FPACT program.

The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims for payment. The expenditures related to the claims are reported on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, for Federal reimbursement. During our audit period, the regular FMAP for California was 61.59 percent.

State Requirements for the Family Planning Program

CMS approved the section 1115 waiver for the FPACT program effective December 1, 1999. The waiver period ended November 30, 2004, and operated on monthly extensions until family planning services were incorporated into the State plan through State Plan Amendment 10-014, effective July 1, 2010.

Section 6 of the Special Terms and Conditions of the section 1115 waiver for the FPACT program (Special Terms and Conditions) states that Federal reimbursement is available at the 90-percent rate for services whose primary purpose is family planning and that are provided in a family planning setting. Federal reimbursement is available at the regular FMAP for services that are provided ancillary to a family planning service, such as followup visits, and that carry a diagnosis code indicating that they are related to a family planning service. According to the State agency's *Family PACT Policies, Procedures, and Billing Instructions Manual,* the FPACT program requires family planning providers to bill for services using special diagnosis codes, called S-codes. The S-code is based on the family planning method selected by the FPACT client, such as oral contraceptive, contraceptive injection, or barrier method.

In accordance with the Special Terms and Conditions, CMS approved a list of procedure codes eligible for reimbursement under the FPACT program and their applicable Federal reimbursement rates.[1] To account for clients who receive family planning services but are not eligible for public benefits under Federal law,[2] such as nonqualified aliens, the State agency deducts a CMS-approved percentage from total FPACT expenditures for the applicable period before claiming reimbursement at the 90-percent rate (in accordance with section 24 of the Special Terms and Conditions). This percentage ranged from 13.95 to 24 percent during our audit period.

[1] CMS approved the original list on February 28, 2000, and an updated version on November 21, 2006.

[2] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 defines citizenship requirements for Federal public benefits.

HOW WE CONDUCTED THIS REVIEW

From October 1, 2008, through September 30, 2010, the State agency claimed approximately $96.8 million ($71.5 million Federal share) for family planning services, drugs, and supplies provided to FPACT clients in San Diego County, representing 2.5 million claim lines. (A claim line represented an individual service billed as part of a claim for an FPACT client.) Of these claim lines, we judgmentally selected for review 2,688 claim lines, totaling $88,748, that had no procedure codes or procedure codes that were not approved by CMS for reimbursement at the 90-percent rate. We did not review approximately 1 million claim lines, totaling $41.3 million, for drugs and supplies (to be reviewed in a future audit), pregnancy tests (a low risk of being unallowable), and reimbursements determined to be immaterial. We reviewed a stratified random sample from the remaining 1.5 million claim lines, totaling $55.5 million, for family planning services.

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.

Appendix A contains the details of our audit scope and methodology, Appendix B contains the details of our statistical sampling methodology, and Appendix C contains our sample results and estimates. Appendix D contains a list of related OIG reports on States' claims for family planning services.

FINDINGS

The State agency did not always comply with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning services provided under the FPACT program in San Diego County. As a result, the State agency claimed $5,671,216 in unallowable Federal reimbursement.

- Of the 110 sampled claim lines, 81 complied and 29 did not comply with requirements. Of the 29 claim lines, 23 were ineligible for reimbursement because the primary purpose of the visit was not family planning, 4 were eligible for reimbursement only at the regular FMAP because they were for followup visits, and 2 were ineligible for reimbursement because of insufficient documentation. Based on our sample results, we estimated that the State agency claimed $5,605,504 in unallowable Federal reimbursement.

- Of the $88,748 we reviewed separately, the State agency claimed $65,712 in unallowable Federal reimbursement for claim lines that contained either no procedure code or a procedure code that was not approved by CMS for reimbursement at the 90-percent rate.

The overpayment occurred because the State agency did not have billing procedures to ensure that it claimed reimbursement at the 90-percent rate only for services whose primary purpose was family planning. Also, the State agency's MMIS lacked edits to prevent followup services

from being claimed at the 90-percent rate and to ensure that claims contained a CMS-approved procedure code.

FEDERAL AND STATE REQUIREMENTS

According to section 1902(a)(27) of the Act, providers must keep records as necessary to disclose the extent of the service provided to individuals receiving assistance. Providers must provide these records to the State agency or the Secretary of Health and Human Services upon request.

The Manual, section 4270.B, states that only services clearly furnished for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate.

According to section 6.b of the Special Terms and Conditions, Federal reimbursement is available at the regular FMAP for services that are provided ancillary to a family planning service, such as followup visits, and that carry a diagnosis code indicating that they are related to a family planning service. In accordance with the section 6.e of the Special Terms and Conditions, CMS approved a list of procedure codes under the FPACT program and their applicable Federal reimbursement rates.

SERVICES WERE IMPROPERLY CLAIMED BECAUSE THEIR PRIMARY PURPOSE WAS NOT FAMILY PLANNING

On the basis of our review of client medical records for 110 sampled claim lines, we found that the State agency did not comply with Federal and State requirements for family planning services for 29 claim lines:

- For 23 claim lines, the primary purpose of the visit was not family planning, consisting of 13 visits for testing for sexually transmitted infections, 5 visits for treatment of a medical condition, and 5 visits for other non-family-planning purposes. These claim lines were not eligible for Federal reimbursement because no family planning service was provided. The State agency did not have billing procedures to ensure that it claimed reimbursement at the 90-percent rate only for services whose primary purpose was family planning. Specifically, the State agency required providers to use S-codes, which allowed services whose primary purpose was not family planning to be incorrectly claimed as family planning. The S-code is based on the family planning method selected by the FPACT client, not the purpose of the visit.

- For four claim lines, the primary purpose of the visit was followup to a family planning visit. Because these services were provided ancillary to a family planning service, these claim lines were eligible for Federal reimbursement only at the regular FMAP. We disallowed the difference in reimbursement between the 90-percent rate and the regular FMAP. The State agency's MMIS lacked edits to prevent these services from being claimed at the 90-percent rate.

- For two claim lines, there was insufficient documentation, including one claim line for which the provider was unable to locate the medical record. These claim lines were not eligible for Federal reimbursement.

During our audit, State medical professionals performed a medical review of the 29 claim lines that we determined did not comply with Federal and State requirements. The medical professionals did not provide evidence to support that the primary purpose of each visit was family planning.

On the basis of our sample results, we estimated that the State agency claimed $5,605,504 in unallowable Federal reimbursement.

PROCEDURE CODES WERE INELIGIBLE FOR REIMBURSEMENT AT THE 90-PERCENT RATE

Of the 2,688 claim lines totaling $88,748 that we reviewed separately, 35 complied with Federal and State requirements. However, 2,653 claim lines, totaling $65,712 in Federal reimbursement, did not comply with requirements. Of these claim lines, 2,610 contained a procedure code not eligible for Federal reimbursement, and 4 did not contain a procedure code. These claim lines were not eligible for Federal reimbursement. The remaining 39 claim lines contained a procedure code eligible for Federal reimbursement only at the regular FMAP. For these claim lines, we disallowed the difference in reimbursement between the 90-percent rate and the regular FMAP.

The State agency claimed unallowable Federal reimbursement because the MMIS lacked edits to ensure that claims contained procedure codes and that the procedure codes were approved by CMS for reimbursement at the 90-percent rate.

RECOMMENDATIONS

We recommend that the State agency:

- refund $5,671,216 to the Federal Government,

- establish billing procedures to ensure that only services whose primary purpose is family planning are claimed for reimbursement at the 90-percent rate, and

- establish MMIS edits to ensure that family planning claims meet Federal and State requirements for reimbursement at the 90-percent rate and at the regular FMAP for followup visits.

STATE AGENCY COMMENTS

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From October 1, 2008, through September 30, 2010, the State agency claimed $96,824,781 ($71,531,492 Federal share) for family planning services, drugs, and supplies provided to FPACT clients in San Diego County, representing 2,485,218 claim lines. Of these claim lines, we judgmentally selected for review 2,688 claim lines, totaling $88,748 ($66,232 Federal share), that had no procedure codes or procedure codes that were not approved by CMS for reimbursement at the 90-percent rate. We did not review approximately 1 million claim lines, totaling $41.3 million, for drugs and supplies (to be reviewed in a future audit), pregnancy tests (a low risk of being unallowable), and reimbursements determined to be immaterial. We reviewed a stratified random sample from the remaining 1.5 million claim lines, totaling $55.5 million ($40.9 million Federal share), for family planning services.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether the services provided to FPACT clients were eligible for Federal reimbursement at the 90-percent rate. We did not determine whether the clients met the eligibility requirements of the FPACT program.

We conducted our audit from April 2011 to January 2012 and performed our fieldwork at the State agency's office in Sacramento, California, and at provider locations in San Diego County.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance and the State plan;
- reviewed the Special Terms and Conditions of the section 1115 waiver for the FPACT program;
- 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 controls for claiming Federal reimbursement for family planning services;
- obtained family planning claim data from the State agency's MMIS for the audit period, representing 2,485,218 claim lines totaling $96,824,781 ($71,531,492 Federal share);
- judgmentally selected for review 2,688 claim lines, totaling $88,748, that had no procedure codes or procedure codes that were not approved by CMS for reimbursement at the 90-percent rate;

- did not review 999,873 claim lines totaling $41,259,030, consisting of 633,663 claim lines for drugs and supplies (to be reviewed in a future audit), 188,216 claim lines for pregnancy tests (a low risk of being unallowable), and 177,994 claim lines for reimbursements that we determined to be immaterial; and

- developed a stratified random sample from the remaining 1,482,657 claim lines for family planning services, totaling $55,477,003, by doing the following:

    - created three strata, representing claim lines with Medicaid-reimbursed amounts from $5.00 to $19.99, $20.00 to $39.99, and $40.00 or more;

    - selected from the sampling frame a stratified sample of 110 claim lines to determine whether family planning services complied with certain Federal and State requirements by (1) contacting providers to obtain medical record information for each sampled item, (2) reviewing the written physician notes to confirm the purpose of the client's visit, and (3) discussing with State medical professionals those sample items that we determined were unallowable for enhanced Federal reimbursement; and

    - estimated the unallowable Federal reimbursement paid in the sampling frame.

See Appendix B for the details of our statistical sampling methodology and Appendix C for our sample results and estimates.

To determine the State agency's Federal share, we reduced the total amount claimed by the CMS-approved deduction percentages (for clients who receive family planning services but are not eligible for public benefits under Federal law) and then applied the 90-percent rate.

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.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population of claims consisted of 2,485,218 claim lines totaling $96,824,781 for Medicaid family planning services, drugs, and supplies provided under the FPACT program in San Diego County from October 1, 2008, through September 30, 2010, for which the State agency claimed Federal reimbursement at the 90-percent rate.

SAMPLING FRAME

From the population of claims, we removed claim lines with no procedure codes or procedure codes that were not approved by CMS for reimbursement at the 90-percent rate. We reviewed these claim lines separately.

We removed claim lines related to drugs and supplies, which we plan to review in a future audit. We also removed claim lines for pregnancy tests, Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), and Indian Health Clinics (IHC) to yield a sampling frame with a greater possibility of potentially unallowable claim lines. We established a materiality level of $5.00 or more per claim line and removed claim lines that had a reimbursement of less than this amount. Finally, we removed claim lines that appeared to be duplicates. The table summarizes the number of claim lines excluded from the sampling frame and their total amounts.

Claim Lines Excluded From the Sampling Frame

Excluded Claim Lines	No. of Claim Lines	Claimed Amount
No procedure code or procedure code not approved by CMS for reimbursement at the 90-percent rate (reviewed separately)	**2,688**	**$88,748**
Other claim lines (not reviewed)		
Drugs and supplies	*633,663*	*39,688,564*
Pregnancy tests	*188,216*	*814,250*
RHC, FQHC, and IHC claim lines	*45*	*195*
Reimbursement less than $5.00	*177,925*	*754,695*
Potential duplicate claim lines	*24*	*1,326*
Subtotal	**999,873**	**$41,259,030**
Total	**1,002,561**	**$41,347,778**

After removing these claim lines, the sampling frame consisted of 1,482,657 claim lines totaling $55,477,003 for Medicaid family planning services.

SAMPLE UNIT

The sample unit was an individual Medicaid claim line for a family planning service provided to an FPACT client.

SAMPLE DESIGN

We used a stratified random sample to test the claim lines for allowability. To accomplish this, we separated the sampling frame into three strata:

- Stratum 1: claim lines with a Medicaid-reimbursed amount from $5.00 to $19.99, consisting of 274,142 claim lines.
- Stratum 2: claim lines with a Medicaid-reimbursed amount from $20.00 to $39.99, consisting of 844,105 claim lines.
- Stratum 3: claim lines with a Medicaid-reimbursed amount of $40.00 or more, consisting of 364,410 claim lines.

SAMPLE SIZE

We selected a total sample of 110 claim lines for family planning services as follows:

- 30 claim lines from stratum 1,
- 40 claim lines from stratum 2, and
- 40 claim lines from stratum 3.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units in each stratum, starting with the value of 1. After generating 30 random numbers for stratum 1, 40 random numbers for stratum 2, and 40 random numbers for stratum 3, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the unallowable Federal reimbursement paid.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results: Total Amounts

Stratum	Number of Claim Lines in Stratum	Value of Stratum	Sample Size	Value of Sample	Number of Unallowable Items	Value of Unallowable Items
1	274,142	$3,408,283	30	$378	10	$117
2	844,105	29,559,225	40	1,342	7	228
3	364,410	22,509,495	40	2,414	12	768
Total	**1,482,657**	**$55,477,003**	**110**	**$4,134**	**29**	**$1,113**

Sample Results: Federal Share Amounts

Stratum	Number of Claim Lines in Stratum	Value of Stratum (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Items	Value of Unallowable Items (Federal Share)
1	274,142	$2,518,044	30	$282	10	$89
2	844,105	21,816,270	40	982	7	134
3	364,410	16,610,522	40	1,769	12	531
Total	**1,482,657**	**$40,944,836**	**110**	**$3,033**	**29**	**$754**

Estimated Value of Unallowable Claims
(Limits Calculated for a 90-Percent Confidence Interval)

	Total Amount	Federal Share
Point estimate	$12,873,817	$8,478,471
Lower limit	8,717,378	5,605,504
Upper limit	17,030,256	11,351,438

APPENDIX D: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Waiver Services That Were Not Family Planning	A-04-10-01091	06/15/12
North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Services That Were Not Family Planning	A-04-10-01089	06/13/12
Oregon Improperly Claimed Federal Reimbursement for Medicaid Family Planning Services Provided Under the Family Planning Expansion Project	A-09-11-02010	01/26/12
Review of Costs for Inpatient Services in the Colorado Medicaid Family Planning Program	A-07-11-01097	10/05/11
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	06/29/11
Review of Louisiana Medicaid Inpatient Hospital Family Planning Services	A-06-10-00076	05/20/11
Family Planning Services Claimed by Illinois From October 1, 2007, Through September 30, 2009	A-05-10-00053	03/18/11
Family Planning Services Claimed by Ohio from October 1, 2007, through September 30, 2009	A-05-10-00035	03/11/11
Review of Family Planning Services Claimed by Washington State During the Period October 1, 2005, Through September 30, 2008	A-09-09-00049	02/28/11
Review of Family Planning Claims Submitted by Selected Providers Under the New York State Medicaid Program	A-02-09-01015	09/23/09
Family Planning Services Claimed by Michigan During October 1, 2005, Through September 30, 2007	A-05-09-00050	09/22/09
Family Planning Services Claimed Twice in Michigan for October 1, 2005, Through September 30, 2007	A-05-08-00064	06/12/09

APPENDIX E: STATE AGENCY COMMENTS

State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

OCT 2 9 2012

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
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San Francisco, CA 94103

Dear Ms. Ahlstrand:

The California Department of Health Care Services has prepared its response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled "California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in San Diego County," report number A-09-11-02040. DHCS appreciates the work performed by OIG and the opportunity to respond to the draft report.

Please contact Ms. Raj Khela, Audit Coordinator, at (916) 650-0298 if you have any questions.

Sincerely,

Toby Douglas
Director

Enclosure

cc: See next page

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Department of Health Care Services' Response to the Office of Inspector General's Draft Report Entitled:

California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in San Diego County

Report #A-09-11-02040

Finding: The State agency did not always comply with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning services provided under the FPACT program in San Diego County. As a result, the State agency claimed $5,671,216 in unallowable Federal reimbursement.

Recommendation: The State agency refund $5,671,216 to the Federal Government.

Response: Department of Health Care Services (DHCS) agrees with the recommendation.

DHCS has reviewed the sampling methodology, sampling results, and estimates. DHCS agrees with the recommendation. An Operational Instruction Letter will be sent to the Fiscal Intermediary (FI) with the instructions to update the system and discontinue the inappropriate claiming of 90 percent FFP for the identified procedure codes. Additionally, a memo to the Department's Accounting Office will also be generated with the instructions to make the appropriate accounting adjustments for the return of the unallowable Federal Reimbursement.

Finding: The State agency did not have billing procedures to ensure that it claimed reimbursement at the 90-percent rate only for services whose primary purpose was family planning.

Recommendation: The State agency establish billing procedures to ensure that only services whose primary purpose is family planning are claimed for reimbursement at the 90-percent rate.

Response: DHCS agrees with the recommendation.

The Family PACT program provides reproductive health services designed to support family planning methods for women and men, as gender appropriate by assisting individuals who have a medical necessity for family planning services. Family planning method management is the main purpose of each visit. Secondarily, Family PACT services include assistance with related reproductive health conditions to achieve and maintain optimal reproductive health. Primary benefits are services relevant to the use of family planning methods and include specified reproductive health care screening tests. Secondary benefits provided by Family PACT are family

planning-related services such as medical diagnosis and treatment services that are provided pursuant to a family planning visit.

As a result of this audit, it has been discovered that Family PACT providers have not provided sufficient staff training to ensure that only services whose primary purpose was family planning is claimed for reimbursement. The Office of Family Planning (OFP) intends to launch a continuing educational program for Family PACT providers with the goal to educate providers on the purpose of the Family PACT program and what constitutes a family planning visit. The Family PACT program's Policies, Procedures and Billing instructions (PPBI) manual will be revised to add language and examples regarding how providers should apply the standards and rules in their practices with Family PACT clients. This on-going educational training will be disseminated via a variety of forums, which include, but are not limited to, website postings, webinars, podcasts, and face-to face seminars.

The OFP is currently working on a system conversion to convert from the current special diagnosis codes (S-Codes) to ICD-9 codes. This conversion to ICD-9 will implement a system fix with hard edits to ensure appropriate billing and claiming. Only codes associated with family planning visit will be paid at the appropriate Federal Financial Participation (FFP) rate.

Also, with the implementation of a new Fiscal Intermediary payment system, the new payment system will allow for the appropriate payment of claims at the correct FFP rate.

In addition to the proposed corrective plan, an internal audit piece will be implemented to ensure that once corrective measures are established, providers are complying and following suit with the new requirements and policies regarding FFP claiming. These State audit activities may entail, depending on resources available, annual or semi-annual audits of a sample of Family PACT providers claiming FFP rates on certain procedures. As such, the program can proactively detect and correct overpayment on an ongoing basis.

Finding:	The State agency's MMIS lacked edits to prevent follow-up services from being claimed at the 90-percent rate and to ensure that claims contained a CMS-approved procedure code.
Recommendation:	The State agency establish MMIS edits to ensure that family planning claims meet Federal and State requirements for reimbursement at the 90-percent rate and at the regular FMAP for follow-up visits.

Response: DHCS agrees with the recommendation.

A Problem Statement has been initiated that will correct a system defect that resulted in the claiming of enhanced FFP for a limited number of procedure codes that were not authorized for 90-percent FFP claiming.