Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CALIFORNIA IMPROPERLY CLAIMED ENHANCED FEDERAL REIMBURSEMENT FOR MEDICAID FAMILY PLANNING DRUGS AND SUPPLIES PROVIDED IN SAN DIEGO COUNTY

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

Lori A. Ahlstrand
Regional Inspector General

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A-09-12-02077

Office of Inspector General

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EXECUTIVE SUMMARY

California claimed $627,000 in unallowable enhanced Federal reimbursement over 2 years for Medicaid family planning drugs and supplies 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. One of those reviews found that the California Department of Health Care Services (State agency) claimed approximately $5.7 million in unallowable Federal reimbursement for family planning services provided under the Family Planning, Access, Care, and Treatment (FPACT) program in San Diego County. That review did not include claims for family planning drugs and supplies.

The objective of this review was to determine whether the State agency complied with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning drugs and supplies provided under the 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, including drugs and supplies, 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, including drugs and supplies, 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 treatment services provided ancillary to a family planning service, such as treatment of a complication, and that carry a diagnosis code indicating that they are related to a family planning service. The Centers for Medicare & Medicaid Services 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 $38 million ($28.1 million Federal share) for family planning drugs and supplies provided to FPACT clients in San Diego County, representing 618,980 claim lines. (A claim line represented an individual drug or supply billed as part of a claim for an FPACT client.) We did

not review 293,259 claim lines, totaling $17.5 million, for drugs and supplies considered to be at low risk of being unallowable and for reimbursements determined to be immaterial. We reviewed a simple random sample from the remaining 325,721 claim lines, totaling $20.5 million.

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 drugs and supplies provided under the FPACT program in San Diego County. Of the 100 sampled claim lines, 83 complied and 17 did not comply with requirements. Of the 17 claim lines, 10 were ineligible for reimbursement because the primary purpose of the drugs or supplies was not family planning, 6 were ineligible for reimbursement because of insufficient documentation, and 1 was eligible for reimbursement only at the regular FMAP because the drug was provided for treatment of a complication. On the basis of our sample results, we estimated that the State agency claimed $627,053 in unallowable Federal reimbursement.

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 drugs and supplies whose primary purpose was family planning. Also, the State agency's Medicaid Management Information System (MMIS) lacked edits to ensure that family planning claims met Federal and State requirements for reimbursement at the 90-percent rate.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $627,053 to the Federal Government,
- establish billing procedures to ensure that only drugs and supplies 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.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency agreed with our overall finding that it did not always comply with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning drugs and supplies. The State agency also agreed with our first and second recommendations and provided information on actions that it had taken or planned to take to address our recommendations. However, the State agency disagreed with part of the draft report's third recommendation. We revised our finding to clarify that the State agency's lack of MMIS edits applied to all claim lines that did not comply with Federal and State requirements and revised our recommendation accordingly.

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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. One of those reviews found that the California Department of Health Care Services (State agency) claimed approximately $5.7 million in unallowable Federal reimbursement for family planning services provided under the Family Planning, Access, Care, and Treatment (FPACT) program in San Diego County.[1] That review did not include claims for family planning drugs and supplies.

OBJECTIVE

Our objective was to determine whether the State agency complied with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning drugs and supplies provided under the 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

[1] *California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in San Diego County,* A-09-11-02040, issued December 20, 2012.

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, including drugs and supplies, 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 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, including drugs and supplies, whose primary purpose is family planning and that are provided in a family planning setting. Federal reimbursement is available at the regular FMAP for treatment services that are provided ancillary to a family planning service, such as treatment of a complication, 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.[2] To account for clients who receive family planning services but are not

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

eligible for public benefits under Federal law,[3] 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 percent to 24 percent during our audit period.

HOW WE CONDUCTED THIS REVIEW

From October 1, 2008, through September 30, 2010, the State agency claimed approximately $38 million ($28.1 million Federal share) for family planning drugs and supplies provided to FPACT clients in San Diego County, representing 618,980 claim lines. (A claim line represented an individual drug or supply billed as part of a claim for an FPACT client.) We did not review 293,259 claim lines, totaling $17.5 million, for drugs and supplies considered to be at low risk of being unallowable and for reimbursements determined to be immaterial. We reviewed a simple random sample from the remaining 325,721 claim lines, totaling $20.5 million.

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 objectives.

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

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 drugs and supplies provided under the FPACT program in San Diego County. Of the 100 sampled claim lines, 83 complied and 17 did not comply with requirements. Of the 17 claim lines, 10 were ineligible for reimbursement because the primary purpose of the drugs or supplies was not family planning, 6 were ineligible for reimbursement because of insufficient documentation, and 1 was eligible for reimbursement only at the regular FMAP because the drug was provided for treatment of a complication. On the basis of our sample results, we estimated that the State agency claimed $627,053 in unallowable Federal reimbursement.

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 drugs and supplies whose primary

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

purpose was family planning. Also, the State agency's MMIS lacked edits to ensure that family planning claims met Federal and State requirements for reimbursement at the 90-percent rate.

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 and supplies 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 treatment services that are provided ancillary to a family planning service, such as treatment of a complication, 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.

DRUGS AND SUPPLIES WERE IMPROPERLY CLAIMED BECAUSE THEIR PRIMARY PURPOSE WAS NOT FAMILY PLANNING OR DOCUMENTATION WAS INSUFFICIENT

On the basis of our review of client medical records for 100 sampled claim lines, we found that the State agency did not comply with Federal and State requirements for family planning drugs and supplies for 17 claim lines:

- For 10 claim lines, the primary purpose of the drugs or supplies was not family planning. Of these claim lines, seven were for contraceptive supplies (for protection against sexually transmitted infections) provided during visits for testing or treatment of sexually transmitted infections. The remaining three claim lines were for oral contraceptive drugs provided to treat a medical condition, such as severe premenstrual symptoms and acne. Because no family planning services were provided during the visits, these claim lines were not eligible for Federal reimbursement. The State agency did not have billing procedures to ensure that it claimed reimbursement at the 90-percent rate only for drugs and supplies whose primary purpose was family planning. Specifically, the State agency required providers to use S-codes, which allowed drugs and supplies provided for purposes other than 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 six claim lines, there was insufficient documentation. For three of these claim lines, the providers billed for contraceptive supplies, but there was no documentation showing that contraceptive supplies had been dispensed. For two claim lines, there was nothing in the medical records to support prescriptions for oral contraceptive drugs. For one claim

line, the provider was unable to locate the medical record. These claim lines were not eligible for Federal reimbursement.

- For one claim line, the drug dispensed was provided to treat a complication caused by the client's birth control method. Because this drug was provided ancillary to a family planning service, this claim line was eligible for Federal reimbursement only at the regular FMAP. The amount that we disallowed was the difference between reimbursement at the 90-percent rate and reimbursement at the regular FMAP.

The State agency's MMIS lacked edits to ensure that family planning claims met Federal and State requirements for reimbursement at the 90-percent rate.

During our audit, State medical professionals performed a medical review of the 17 claim lines that we determined did not comply with Federal and State requirements. The medical professionals concurred with our findings.

On the basis of our sample results, we estimated that the State agency claimed $627,053 in unallowable Federal reimbursement.

RECOMMENDATIONS

We recommend that the State agency:

- refund $627,053 to the Federal Government,

- establish billing procedures to ensure that only drugs and supplies 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.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with our overall finding that it did not always comply with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning drugs and supplies. The State agency also agreed with our first and second recommendations and provided information on actions that it had taken or planned to take to address our recommendations.

However, the State agency disagreed with part of the draft report's third recommendation. The State agency commented that it had established MMIS edits to ensure that drugs related to treatments for complications are claimed at the regular FMAP, except for oral contraceptives. For the one claim line reviewed, an oral contraceptive was provided to treat a complication and was claimed at the 90-percent rate instead of the regular FMAP. The State agency commented that it "feel[s] this is more of a provider education issue than a system issue" and that it may be a

rare occurrence. The State agency also commented that it will revise its guidance to address the issue. The State agency's comments are included in their entirety as Appendix E.

We revised our finding to clarify that the State agency's lack of MMIS edits applied to all claim lines that did not comply with Federal and State requirements and revised our recommendation accordingly.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From October 1, 2008, through September 30, 2010, the State agency claimed $37,985,652 ($28,121,135 Federal share) for family planning drugs and supplies provided to FPACT clients in San Diego County, representing 618,980 claim lines. We did not review 293,259 claim lines, totaling $17,480,055, for drugs and supplies considered to be at low risk of being unallowable and for reimbursements determined to be immaterial. We reviewed a simple random sample from the remaining 325,721 claim lines, totaling $20,505,597 ($15,170,337 Federal share).

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 drugs and supplies 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 August 2012 to January 2013 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, including drugs and supplies;
- obtained family planning claim data from the State agency's MMIS for the audit period, representing 618,980 claim lines totaling $37,985,652 ($28,121,135 Federal share) for drugs and supplies;
- did not review 293,259 claim lines totaling $17,480,055, consisting of 234,420 claim lines for drugs and supplies considered to be at low risk of being unallowable and 58,839 claim lines for reimbursements that we determined to be immaterial; and
- reviewed a simple random sample selected from the remaining 325,721 claim lines, totaling $20,505,597.

We selected from the sampling frame a simple random sample of 100 claim lines to determine whether family planning drugs and supplies 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 determine the primary purpose of the drug or supply provided, and (3) discussing with State medical professionals those sample items that we determined were unallowable for enhanced Federal reimbursement. We then 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 objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population of claims consisted of 618,980 claim lines totaling $37,985,652 for Medicaid family planning 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 for drugs and supplies considered to be at low risk of being unallowable, such as contraceptive patches, rings, and injections. 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. 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
Low-risk drugs and supplies	234,420	$17,285,073
Reimbursement less than $5.00	58,839	194,982
Total	**293,259**	**$17,480,055**

After removing these claim lines, the sampling frame consisted of 325,721 claim lines totaling $20,505,597.

SAMPLE UNIT

The sample unit was an individual Medicaid claim line for an oral contraceptive drug or a contraceptive supply provided to an FPACT client.

SAMPLE DESIGN

We used a simple random sample to test the claim lines for allowability.

SAMPLE SIZE

We selected a sample of 100 claim lines for family planning drugs and supplies.

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 the frame from 1 to 325,721. After generating 100 random numbers, 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

No. of Claim Lines in Sampling Frame	Value of Sampling Frame	Sample Size	Value of Sample	No. of Unallowable Claim Lines	Value of Unallowable Claim Lines
325,721	$20,505,597	100	$5,928	17	$832

Sample Results: Federal Share Amounts

No. of Claim Lines in Sampling Frame	Value of Sampling Frame	Sample Size	Value of Sample	No. of Unallowable Claim Lines	Value of Unallowable Claim Lines
325,721	$15,170,337	100	$4,377	17	$613

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

	Total Amount	Federal Share
Point estimate	$2,710,943	$1,997,289
Lower limit	872,425	627,053
Upper limit	4,549,461	3,367,524

APPENDIX D: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in San Diego County	A-09-11-02040	12/20/12
Wyoming Incorrectly Claimed Enhanced Reimbursement for Medicaid Family Planning Sterilization Costs	A-07-11-01100	08/17/12
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	06/15/12
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 Prescribed Drug Costs in the Colorado Medicaid Family Planning Program	A-07-11-01095	10/17/11
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

APPENDIX E: STATE AGENCY COMMENTS

TOBY DOUGLAS
DIRECTOR

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

EDMUND G. BROWN JR.
GOVERNOR

APR 2 3 2013

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 (DHCS) has prepared its response to the U.S. Department of Health and Human Services, Office of Inspector General, draft report entitled, "California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Drugs and Supplies Provided in San Diego County," report number A-09-11-02077. DHCS appreciates the work performed by OIG and the opportunity to respond to the draft report.

Please contact Ms. Melanie Pascua, Audit Coordinator, at (916) 445-2410 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 Drugs and Supplies Provided in San Diego County

Report #A-09-12-02077

Finding #1: 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 drugs and supplies provided under the Family Planning, Access, Care, and Treatment (Family PACT) program in San Diego County. As a result, the State agency claimed $627,053 in unallowable Federal reimbursement.

Recommendation: The State agency refund $627,053 to the Federal Government.

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

DHCS has reviewed the sampling methodology, sampling results, and estimates. DHCS agrees with the recommendation. A memo to the Department's Accounting Office will be generated with instructions to make the appropriate accounting adjustments for the return of the unallowable federal reimbursement.

Finding #2: The State agency did not have billing procedures to ensure that it claimed reimbursement at the 90-percent rate only for drugs and supplies whose primary purpose was family planning.

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

Response: DHCS agrees with the finding and 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.

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. Efforts to date:

Continuing Educational Program for Family PACT Providers
Updates to the Family PACT Program Provider Orientation Training module emphasizes the primary purpose of the Family PACT program and what constitutes a family planning visit. The updated training module has been in use since May 2012 and will continue to be used in upcoming provider orientation sessions.

The OFP disseminated information and reinforced the primary purpose of the Family PACT program during the March 2012 Family PACT Stakeholders' Meeting.

Revisions to the Family PACT Program PPBI manual are being approved and projected to be in place by August 2013.

The workgroups recommended implementing on-going educational training for Family PACT providers via a variety of forums. Training will include updating the Fiscal Intermediary training modules. The trainings are projected to begin in August 2013

Also, DHCS has reached out to the Center for Medicare and Medicaid Services' (CMS) for guidance and clarification on the distinction between family planning and family planning related services and the sequencing of such services. DHCS asked CMS to clarify and confirm the allowable Federal Financial Participation rate for family planning and family planning related services. Finally, DHCS requested CMS guidance for the family planning policies to ensure a clear understanding of federal requirements as they relate to the Family PACT program.

System Conversion from S-diagnosis codes to ICD-9 codes
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 FFP rate. This system conversion is expected to be fully implemented by December 31, 2013.

Implementation of periodic audits
In addition to the proposed corrective plan, periodic audits will be implemented to ensure that once corrective measures are established, providers are complying and following suit with the new requirements and policies. These State audit activities may entail, depending on resources available, annual or semi-annual audits of a sample of Family PACT providers. As such, the program can proactively detect and correct overpayment on an ongoing basis. OFP is in communication with DHCS, Audits and Investigation Division to develop a plan of action to conduct annual or semi-annual audits of a sample of Family PACT providers to ensure compliance with program criteria.

Finding #3: The State agency's Medicaid Management Information System (MMIS) lacked edits to prevent drugs related to treatments for complications from being claimed at the 90-percent rate.

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 Federal medical assistance percentage (FMAP) for drugs related to treatments for complications.

Response: DHCS disagrees with the finding and recommendation.

DHCS established MMIS edits to ensure that drugs related to treatments for complications are claimed at the appropriate federal reimbursement rate. Drugs used to treat complications are at the regular FMAP with the exception of oral contraceptives, which are claimed at the 90-percent rate. There was one claim line reviewed in this audit where an oral contraceptive was provided to treat a complication of breakthrough bleeding caused by the client's birth control method. Family PACT's PPBI indicates that Estradiol should be used for breakthrough bleeding. Although the PPBI does not explicitly state that dispensing an oral contraceptive to treat this complication is not allowed, we feel this is more of a provider education issue than a system issue. This may be a rare occurrence hence our reluctance to agree to this finding. The Family PACT program's PPBI manual will be revised to add language regarding the use of Estradiol versus oral contraceptives for the treatment of the complication of breakthrough bleeding for Family PACT clients.