Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CALIFORNIA IMPROPERLY CLAIMED ENHANCED FEDERAL REIMBURSEMENT FOR MEDICAID FAMILY PLANNING SERVICES PROVIDED IN CENTRAL LOS ANGELES COUNTY

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EXECUTIVE SUMMARY

California claimed at least $2.9 million for fiscal year 2011 in unallowable enhanced Federal reimbursement for Medicaid family planning services provided in central Los Angeles 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 multiple 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. In California, we are conducting reviews of family planning services provided under the Family Planning, Access, Care, and Treatment (FPACT) program in several counties. 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 in San Diego County.

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 services provided under the FPACT program in central Los Angeles County.

BACKGROUND

In California, the State agency administers the Medicaid program. The State agency's FPACT program 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 Centers for Medicare & Medicaid Services' *State Medicaid Manual* states that Federal reimbursement is available at the 90-percent rate only for services clearly provided for family planning purposes. Under the California State plan, Federal reimbursement is available at the regular FMAP for family-planning-related services provided as part of or as followup to a family planning service. The regular FMAP decreased from 61.59 percent to 50 percent during our audit period.

HOW WE CONDUCTED THIS REVIEW

We limited our review to FPACT program claims with provider billing ZIP Codes in central Los Angeles County. (We are reviewing east and southeast Los Angeles County in separate audits.) From October 1, 2010, through September 30, 2011, the State agency claimed approximately $35.6 million ($27.6 million Federal share) for family planning services provided in central Los Angeles County. Some of the claim lines were for the same family planning service provided to a beneficiary on the same service date and billed on the same claim. We grouped claim lines that had the same claim control number, beneficiary identification number,

date of service, and procedure code. For this report, we refer to these grouped claim lines as unique "services." We did not review approximately $1.6 million for services considered to be at low risk of being unallowable and for reimbursements determined to be immaterial. From the remaining $34 million, we reviewed a stratified random sample of 120 services.

WHAT WE FOUND

The State agency did not always comply with certain Federal requirements when claiming Federal reimbursement at the 90-percent rate for family planning services provided under the FPACT program in central Los Angeles County. Of the 120 sampled services, 85 complied and 35 did not comply with requirements. Of the 35 services, 23 were eligible for reimbursement only at the regular FMAP because they were family-planning-related (provided as part of or as followup to family planning services), and 12 were ineligible for reimbursement because the services were not clearly provided for family planning purposes. On the basis of our sample results, we estimated that the State agency claimed at least $2,953,936 in unallowable Federal reimbursement.

The overpayment occurred because the State agency's Medicaid Management Information System (MMIS) lacked edits to prevent family-planning-related services from being claimed at the 90-percent rate. Also, the State agency did not have billing procedures to ensure that it claimed reimbursement at the 90-percent rate only for services clearly provided for family planning purposes.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $2,953,936 to the Federal Government,
- establish MMIS edits to ensure that FPACT claims meet Federal and State requirements for reimbursement at the 90-percent rate and at the regular FMAP for family-planning-related services, and
- establish billing procedures to ensure that only services clearly provided for family planning purposes are claimed for reimbursement at the 90-percent rate.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency agreed that 11 of the 35 family planning services were family-planning-related services eligible for reimbursement only at the regular FMAP or were not clearly provided for family planning purposes and estimated that it would refund $1,007,331 to the Federal Government. However, the State agency disagreed that the remaining 24 services were unallowable. The 24 services consisted of 17 services involving annual visits for men and 7 services for the testing or treatment of sexually transmitted infections that were not provided as part of a family planning visit. The State agency provided information on actions that it had taken or planned to take to address our second and third recommendations.

We based our findings on the Federal requirements effective during our audit period. State medical professionals reviewed the medical records for the 35 services that we determined did not comply with Federal requirements and concurred with our findings. In its comments, the State agency did not say that we incorrectly identified the 24 services as annual visits for men or testing or treatment of sexually transmitted infections. For these reasons, we maintain that our findings and recommendations are valid.

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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 multiple 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. In California, we are conducting reviews of family planning services provided under the Family Planning, Access, Care, and Treatment (FPACT) program in several counties. 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 in San Diego County.[1] (Appendix A lists related OIG reports on States' claims for family planning services.)

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 services provided under the FPACT program in central Los Angeles 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.

Medicaid Coverage of Family Planning Services

States must furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and desire such services and supplies (the Social Security Act (the Act), § 1905(a)(4)(C)). Federal law and regulations authorize Federal reimbursement for family planning services at the 90-percent rate (the Act, § 1903(a)(5), and 42 CFR § 433.10(c)(1)).

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 (§ 4270). The Manual indicates that States are free to determine which services and

[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.

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 provided for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate.

Section 2303 of the Patient Protection and Affordable Care Act (ACA) amended section 1902(a)(10) of the Act to give States the option to offer family planning services and supplies to individuals whose income does not exceed the eligibility level established by the State and allowed for additional family-planning-related services. CMS's State Medicaid Directors Letter 10-013, issued July 2, 2010, provides further guidance on the family-planning-related services mentioned in the ACA.

California's Medicaid Family Planning Program

In California, the State agency administers the Medicaid program. In accordance with the ACA, the State agency's FPACT program 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 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 at the start of Federal fiscal year (FFY) 2011 and decreased each quarter thereafter to 50 percent at the end of FFY 2011.[2]

State Requirements for the Family Planning Program

California's State Plan Amendment (SPA) 10-014, effective July 1, 2010, included coverage of family planning services and supplies and family-planning-related services. The SPA required that the State agency deduct 13.95 percent from its total expenditures when claiming Federal reimbursement to account for clients who receive family planning services but are not eligible for public benefits under Federal law, such as nonqualified aliens.

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.

[2] The FMAPs by quarter for FFY 2011 were 61.59 percent (first quarter), 58.77 percent (second quarter), 56.88 percent (third quarter), and 50 percent (fourth quarter). The American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5, provided for temporary increases in FMAP rates. P.L. No. 111-226 amended the Recovery Act to extend the increases through the third quarter of FFY 2011, with a phasedown over the second and third quarters of FFY 2011.

HOW WE CONDUCTED THIS REVIEW

We limited our review to FPACT program claims with provider billing ZIP Codes in central Los Angeles County.[3] (We are reviewing east and southeast Los Angeles County in separate audits.) From October 1, 2010, through September 30, 2011, the State agency claimed $35,578,298 ($27,553,613 Federal share) for family planning services provided in central Los Angeles County.[4] Some of the claim lines were for the same family planning service provided to a beneficiary on the same service date and billed on the same claim. We grouped claim lines that had the same claim control number, beneficiary identification number, date of service, and procedure code. For this report, we refer to these grouped claim lines as unique "services." We did not review $1,578,864 for services considered to be at low risk of being unallowable and for reimbursements determined to be immaterial. From the remaining $33,999,434, we reviewed a stratified random sample of 120 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 objectives.

Appendix B describes our audit scope and methodology, Appendix C describes our statistical sampling methodology, and Appendix D describes our sample results and estimates.

FINDINGS

The State agency did not always comply with certain Federal requirements when claiming Federal reimbursement at the 90-percent rate for family planning services provided under the FPACT program in central Los Angeles County. Of the 120 sampled services, 85 complied and 35 did not comply with requirements. Of the 35 services, 23 were eligible for reimbursement only at the regular FMAP because they were family-planning-related (provided as part of or as followup to family planning services), and 12 were ineligible for reimbursement because the services were not clearly provided for family planning purposes. On the basis of our sample results, we estimated that the State agency claimed at least $2,953,936 in unallowable Federal reimbursement.

The overpayment occurred because the State agency's MMIS lacked edits to prevent family-planning-related services from being claimed at the 90-percent rate. Also, the State agency did not have billing procedures to ensure that it claimed reimbursement at the 90-percent rate only for services clearly provided for family planning purposes.

[3] We divided Los Angeles County into six areas using natural divisions, such as major highways and geographical features. Our database of claim lines contained 193 provider billing ZIP Codes. Fifty-two of these ZIP Codes were located in the central area of Los Angeles County, which we refer to as "central Los Angeles County."

[4] Our review did not include claims for family planning drugs and supplies, which will be covered in a future audit combining providers from all of Los Angeles County.

FEDERAL REQUIREMENTS

The Manual states that only services and supplies clearly provided for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate (§ 4270.B).

CMS's State Medicaid Directors Letter 10-013 states that "family planning-related services are medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting" and are reimbursable at the State's regular FMAP. The letter further states: "Family planning-related services have historically been considered those services provided in a family planning setting as part of or as follow-up to a family planning visit. Such services are provided because they were identified, or diagnosed, during a family planning visit." Included in these family-planning-related services are annual visits for men at an office or a clinic. According to the letter, such a family planning visit may include a comprehensive patient history, physical, laboratory tests, and contraceptive counseling.

STATE AGENCY DID NOT COMPLY WITH FEDERAL REQUIREMENTS FOR FAMILY PLANNING SERVICES

On the basis of our review of client medical records for 120 sampled services, we found that the State agency did not comply with Federal requirements for 35 family planning services, consisting of 23 family-planning-related services that were eligible for reimbursement only at the regular FMAP and 12 services that were not clearly provided for family planning purposes.[5] Using our sample results, we estimated that the State agency claimed at least $2,953,936 in unallowable Federal reimbursement.

Family-Planning-Related Services Were Eligible for Reimbursement Only at the Regular Federal Medical Assistance Percentage

Twenty-three services were family-planning-related but were improperly claimed at the 90-percent rate. Of these services, 17 were annual visits for male patients, and 6 were followup visits to a previous family planning visit. Because the services were family-planning-related services, they were 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 prevent family-planning-related services from being claimed at the 90-percent rate.

Services Were Not Clearly Provided for Family Planning Purposes

Of the 12 services not clearly provided for family planning purposes, 7 were for the testing or treatment of sexually transmitted infections (which were not provided as part of a family planning visit), and 5 were for services provided for other non-family-planning purposes (such as a breast exam). Because the services were not clearly for family planning, they 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 services provided for family planning

[5] During our audit, State medical professionals performed a medical review of the 35 services that we determined did not comply with Federal requirements. The medical professionals concurred with our findings.

purposes. Specifically, the State agency required providers to use S-codes as primary diagnosis codes, which allowed services 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 service.

RECOMMENDATIONS

We recommend that the State agency:

- refund $2,953,936 to the Federal Government,

- establish MMIS edits to ensure that FPACT claims meet Federal and State requirements for reimbursement at the 90-percent rate and at the regular FMAP for family-planning-related services, and

- establish billing procedures to ensure that only services clearly provided for family planning purposes are claimed for reimbursement at the 90-percent rate.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our overall finding that it did not comply with Federal requirements for family planning services. However, the State agency agreed that 11 of the 35 family planning services were family-planning-related services eligible for reimbursement only at the regular FMAP or were not clearly provided for family planning purposes. Regarding our first recommendation, the State agency estimated that it would refund $1,007,331 to the Federal Government. The State agency also provided information on actions that it had taken or planned to take to address our second and third recommendations.

The State agency had the following comments on our specific findings:

- Regarding our finding that 23 services were eligible for reimbursement only at the regular FMAP, the State agency partially agreed with our finding and the related (second) recommendation. The State agency disagreed that 17 services involving annual visits for men were unallowable and stated that it had requested CMS guidance and clarification on the distinction between family planning and family-planning-related services and the sequencing of such services. However, the State agency agreed that the remaining six services were unallowable.

- Regarding our finding that 12 services were not clearly provided for family planning purposes, the State agency partially agreed with our finding and the related (third) recommendation. The State agency disagreed that seven services for the testing or treatment of sexually transmitted infections that were not provided as part of a family planning visit were unallowable and stated that it had requested CMS guidance and clarification on the criteria for family-planning-related services. However, the State agency agreed that the remaining five services were unallowable.

The State agency's comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

We based our findings on the Federal requirements effective during our audit period. State medical professionals reviewed the medical records for the 35 services that we determined did not comply with Federal requirements and concurred with our findings. In its comments, the State agency did not say that we incorrectly identified the 24 services as annual visits for men or testing or treatment of sexually transmitted infections.

- Regarding the 17 services involving annual visits for men, we based our finding on CMS's State Medicaid Directors Letter 10-013, which provides examples of family-planning-related services, such as annual visits for men that may include a comprehensive patient history, physical, laboratory tests, and contraceptive counseling. The letter states that such visits are included as family-planning-related services reimbursable at the State's regular FMAP, and the State medical professionals concurred that these services were family-planning-related.

- Regarding the seven services for the testing or treatment of sexually transmitted infections, we based our finding on the Manual, which states that only services and supplies clearly provided for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate. Nothing in the medical records indicated that the services were related to family planning, and the State agency provided no additional documentation. In addition, the State medical professionals concurred that these services were not clearly provided for family planning purposes.

CMS issued State Medicaid Directors Letter 14-003, effective April 16, 2014, which provides guidance on services related to annual visits for men and sexually transmitted infections. This guidance differs from State Medicaid Directors Letter 10-013, issued July 2, 2010. Because we based our findings on the CMS family planning guidance effective during our audit period, we maintain that our findings and recommendations are valid.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

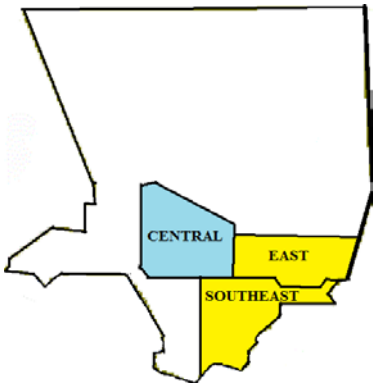
Report Title	Report Number	Date Issued
Missouri Did Not Always Correctly Claim Costs for Medicaid Family Planning Drugs for Calendar Years 2009 and 2010	A-07-12-01118	1/28/2014
California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Drugs and Supplies Provided in San Diego County	A-09-12-02077	6/25/2013
Missouri Did Not Always Correctly Claim Costs for Medicaid Family Planning Sterilization Procedures for Calendar Years 2009 and 2010	A-07-12-01117	6/12/2013
Missouri Incorrectly Claimed Federal Reimbursement for Inpatient Claims With Sterilization and Delivery Procedures for Calendar Years 2009 and 2010	A-07-12-01121	3/13/2013
Arkansas Inappropriately Received Medicaid Family Planning Funding for Federal Fiscal Years 2006 Through 2010	A-06-11-00022	1/18/2013
California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in San Diego County	A-09-11-02040	12/20/2012
Wyoming Incorrectly Claimed Enhanced Reimbursement for Medicaid Family Planning Sterilization Costs	A-07-11-01100	8/17/2012
North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Waiver Services That Were Not Family Planning	A-04-10-01091	6/15/2012
North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Services That Were Not Family Planning	A-04-10-01089	6/15/2012
Oregon Improperly Claimed Federal Reimbursement for Medicaid Family Planning Services Provided Under the Family Planning Expansion Project	A-09-11-02010	1/26/2012
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	6/29/2011

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We limited our review to FPACT program claims with provider billing ZIP Codes in central Los Angeles County. Because of the large size of Los Angeles County, we divided the county into areas using natural divisions, such as major highways and geographical features. The three areas identified in the figure represented 73 percent of the total amount that the State agency claimed in FFY 2011 for family planning services provided in Los Angeles County. (We are reviewing east and southeast Los Angeles County in separate audits. We are not reviewing the rest of the county.)

Figure: Los Angeles County



From October 1, 2010, through September 30, 2011, the State agency claimed $35,578,298 ($27,553,613 Federal share) for family planning services provided in central Los Angeles County, representing 1,269,640 claim lines. Some of the claim lines were for the same family planning service provided to a beneficiary on the same service date and billed on the same claim. We grouped claim lines that had the same claim control number, beneficiary identification number, date of service, and procedure code, resulting in a total of 1,264,875 unique services. We did not review 312,469 services, totaling $1,578,864, that were considered to be at low risk of being unallowable or that had reimbursements determined to be immaterial. We reviewed a stratified random sample from the remaining 952,406 services, totaling $33,999,434.

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 January to July 2013 and performed our fieldwork at the State agency's office in Sacramento, California, and at provider locations in central Los Angeles County.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance and the State 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 controls for claiming Federal reimbursement for family planning services;

- obtained family planning claim data from the State agency's MMIS for the period October 1, 2010, through September 30, 2011, representing 1,269,640 claim lines for family planning services provided in central Los Angeles County, totaling $35,578,298 ($27,553,613 Federal share);[6]

- grouped the 1,269,640 claim lines by claim control number, beneficiary identification number, date of service, and procedure code, which resulted in 1,264,875 unique services;

- removed 312,469 services, totaling $1,578,864, consisting of 205,300 services with reimbursements that we determined to be immaterial and 107,169 services we considered to be at low risk of being unallowable; and

- developed a stratified random sample from the remaining 952,406 services, totaling $33,999,434, by doing the following:

    - We created three strata, representing services with Medicaid-reimbursed amounts from $5.00 to $19.99, $20.00 to $39.99, and $40.00 or more.

    - We selected a total of 120 sample units, consisting of 40 sample units for each of the 3 strata.

    - We reviewed the stratified random sample of 120 services 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 service, (2) reviewing the written physician notes to confirm the purpose of the client's visit, and (3) discussing with State medical professionals those sampled services that we determined were unallowable for enhanced Federal reimbursement.

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

See Appendix C for the details of our statistical sampling methodology and Appendix D 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 percentage of 13.95 percent (for clients who receive family planning services but are not eligible for public benefits under Federal law) and then applied the 90-percent rate.

[6] The claim data consisted of services paid from October 1, 2010, through September 30, 2011, and provided on or after July 1, 2010.

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 C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of claim lines for Medicaid family planning services provided in central Los Angeles County on or after July 1, 2010; paid by the State agency to providers from October 1, 2010, through September 30, 2011; and claimed at the 90-percent rate under the FPACT program.

SAMPLING FRAME

The State agency provided us with a database of FPACT claims, from which we identified 1,269,640 claim lines for family planning services provided in central Los Angeles County, totaling $35,578,298 for our audit period. Some of these claim lines were for the same family planning service provided to a beneficiary on the same service date and billed on the same claim. We grouped the claim lines by claim control number, beneficiary identification number, date of service, and procedure code, which resulted in 1,264,875 unique services. From the resulting 1,264,875 services, we removed 107,169 services considered to be at low risk of being unallowable, such as urine pregnancy tests. We established a materiality level of $5.00 or more and removed 205,300 services that had a reimbursement of less than this amount. After we removed these services, the sampling frame consisted of 952,406 services totaling $33,999,434 ($26,330,861 Federal share).

SAMPLE UNIT

The sample unit was a unique service, defined as one or more of the same family planning procedure code billed on the same claim and for the same service date for a single beneficiary.

SAMPLE DESIGN

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

- Stratum 1: services with a Medicaid-reimbursed amount from $5.00 to $19.99, consisting of 284,603 services.

- Stratum 2: services with a Medicaid-reimbursed amount from $20.00 to $39.99, consisting of 438,246 services.

- Stratum 3: services with a Medicaid-reimbursed amount of $40.00 or more, consisting of 229,557 services.

SAMPLE SIZE

We selected a total of 120 sample units, consisting of 40 sample units for each of the 3 strata.

SOURCE OF RANDOM NUMBERS

We generated the random numbers for each stratum using the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE UNITS

The stratum 1 frame was numbered 1 through 284,603, the stratum 2 frame was numbered 1 through 438,246, and the stratum 3 frame was numbered 1 through 229,557. Using the random numbers generated for each stratum, we selected the corresponding frame items in each of the strata.

ESTIMATION METHODOLOGY

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

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results (Total Amounts)

Stratum	Number of Services in Stratum	Value of Stratum	Sample Size	Value of Sample	Number of Unallowable Services	Value of Unallowable Services
1	284,603	$3,576,458	40	$524	11	$142
2	438,246	14,411,370	40	1,373	11	402
3	229,557	16,011,606	40	2,799	13	824
Total	**952,406**	**$33,999,434**	**120**	**$4,696**	**35**	**$1,368**

Table 2: Sample Results (Federal Share Amounts)

Stratum	Number of Services in Stratum	Value of Stratum (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Services	Value of Unallowable Services (Federal Share)
1	284,603	$2,769,788	40	$406	11	$63
2	438,246	11,160,885	40	1,063	11	127
3	229,557	12,400,188	40	2,168	13	431
Total	**952,406**	**$26,330,861**	**120**	**$3,637**	**35**	**$621**

Table 3: Estimated Value of Unallowable Services
(Limits Calculated for a 90-Percent Confidence Interval)

	Total Amount	Federal Share
Point estimate	$10,145,688	$4,322,315
Lower limit	7,391,141	2,953,936
Upper limit	12,900,234	5,690,694

APPENDIX E: STATE AGENCY COMMENTS

State of California-Health and Human Services Agency | Department of Health Care Services

SECRETARY'S ACTION REQUESTED

TO: Diana S. Dooley, Secretary
Health and Human Services Agency

FROM: Toby Douglas, Director
Department of Health Care Services

PREPARED BY: Sarah Hollister, Audit Coordinator
Internal Audits

DATE: March 25, 2014

SUBJECT: 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 in Central Los Angeles County*, Report Number A-09-13-02012.

☒ Request for Approval
☐ Request for Discussion
☐ For Secretary's Information
☒ For Secretary's Signature
☐ For Governor's Information

APPROVED:

____/Toby Douglas/_____ _____3/27/14_____
Toby Douglas, Director Date
Department of Health Care Services

____/Robert Ducay for/_____ _____4/2/14 _____
Diana S. Dooley, Secretary Date
Health and Human Services Agency

DHCS 1053 (Revised 12/08)

SUMMARY/PRO-CON ARGUMENTS:

Background
The section 1115 waiver for the Family Planning, Access, Care, and Treatment (Family PACT) program states that Federal Medicaid reimbursement is available to States for family planning 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 an enhanced Federal medical assistance percentage (FMAP) of 90 percent (90-percent rate).

The Office of Inspector General (OIG) conducted an audit of family planning services claimed under the Family PACT program to determine whether the Department of Health Care Services (DHCS) complied with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning drugs and supplies. The audit period included claims processed during the period October 1, 2010 through September 30, 2011 in Central Los Angeles County.

Summary of Findings
OIG identified that DHCS did not always comply with certain Federal requirements when claiming Federal reimbursement at the 90-percent rate for family planning services provided under the FPACT program in central Los Angeles County. Of the 120 sampled services, 85 complied and 35 did not comply with requirements. Of the 35 services, 23 were eligible for reimbursement only at the regular FMAP because they were family-planning-related (provided as part of or as follow-up to family planning services), and 12 were ineligible for reimbursement because the services were not clearly provided for family planning purposes. Based on the OIG sample results, the OIG estimated that the State agency claimed at least $2,953,936 in unallowable Federal reimbursement.

The overpayment occurred because the State agency's Medicaid Management Information System (MMIS) lacked edits to prevent family-planning-related services from being claimed at the 90-percent rate. Also, the State agency did not have billing procedures to ensure that it claimed reimbursement at the 90-percent rate only for services clearly provided for family planning purposes.
OIG recommends DHCS:

- Refund $2,953,936 to the Federal Government,
- Establish billing procedures ensuring claims reimbursed at the 90-percent rate are only drugs and supplies whose primary purpose is family planning,

- Establish MMIS edits to ensure family planning claims meet Federal and State requirements for reimbursement at the 90-percent rate and at the regular FMAP for drugs related to treatments for complications.

DHCS Response

Please see attached

EFFECTS ON EXISTING LAW: N/A

ESTIMATED COST: Between $1,007,331 and $2,953,936

TIME FACTOR: Due to Agency by April 2, 2014
Due to OIG by April 7, 2014.

RECOMMENDATION: Approval

Department of Health Care Services Response to Office of the Inspector General's Report titled:
California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in Central Los Angeles County

Finding #1: The State agency did not comply with Federal requirements for family planning services.

On the basis of OIG's review of client medical records for 120 sampled services, the OIG found that the State agency did not comply with Federal requirements for 35 family planning services, consisting of 23 family-planning-related services that were eligible for reimbursement only at the regular FMAP and 12 services that were not clearly provided for family planning purposes. Using OIG's sample results, it was estimated that the State agency claimed at least $2,953,936 in unallowable Federal reimbursement

Recommendation: The OIG recommends DHCS refund $2,953,936 to the Federal Government.

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

DHCS has reviewed the sampling methodology, sampling results, findings, and estimates. DHCS agrees that 11 of the 35 services were either not clearly provided for family planning purposes, or were family planning-related services eligible only at the regular FMAP. DHCS estimates a refund of $1,007,331 to the Federal Government.

Finding #2: Services were not clearly provided for Family Planning purposes.

Of the 12 services not clearly provided for a family planning purpose, 7 were for the testing or treatment of sexually transmitted infections (which were not provided as part of a family planning visit), and 5 were for services provided for other non-family-planning purposes (such as a breast exam). Because the services were not clearly for family planning, they 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 services provided for family planning purposes. Specifically, the State agency required providers to use S-codes as primary diagnosis codes, which allowed services 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 service.

Recommendation: The OIG recommends DHCS establish billing procedures to ensure that only services clearly provided for family planning purposes are claimed for reimbursement at the 90-percent rate.

Response: DHCS partially agrees with the finding and recommendation.

DHCS disagrees with part of Finding #2 regarding the seven (7) services that "were for the testing or treatment of sexually transmitted infections (STI), which were not provided as part of a family planning visit," pending further clarification from CMS on the criteria for family planning-related services (such as STI services) provided pursuant to a family planning visit.

In April 2013, DHCS reached out to 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 (FFP) 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. DHCS has been recently informed by CMS that official clarifying guidance is being drafted and is expected to be released in early 2014.

- DHCS agrees with the finding regarding the five (5) services "provided for other non-family-planning purposes". DHCS has implemented the following corrective action plans.

System Conversion from S-diagnosis Codes to ICD-9 Codes
The DHCS, Office of Family Planning (OFP) has completed the system updates converting the local Family PACT S-diagnosis codes (S-Codes) to ICD-9-CM codes, effective December 30, 2013. This conversion to ICD-9-CM codes implement system edits to ensure appropriate billing by providers and FFP claiming by DHCS.
Encounters primarily for family planning will carry the family planning ICD-9-CM codes, and will be appropriately claimed at the enhanced FFP rate.
Encounters primarily for family planning-related services (such as treatment of complications from the use of contraceptive methods and treatment of an STI that was identified during a family planning visit) will be appropriately claimed at the regular FMAP rate.

The *Family PACT Policies, Procedures and Billing Instructions (PPBI) Manual*
The PPBI manual was revised to reflect the conversion from the local Family PACT S-Codes to ICD-9-CM codes. With the code conversion, current program policies were retained. Additionally, language in some of the PPBI sections was updated to clarify family planning and family planning-related policies. The revised PPBI manual was published on December 17, 2013.

In April 2013, DHCS reached out to CMS for guidance and clarification on the distinction between family planning and family planning related services and the sequencing of such services. This guidance will inform further revisions to the Family PACT PPBI manual, if warranted. DHCS has been recently informed by CMS that official clarifying guidance is being drafted and is expected to be released in early 2014.

Continuing Educational Program for FPACT Providers

OFP has launched a continuing educational program for Family FPACT providers to educate providers on the focus of the Family PACT program, what constitutes a family planning visit, and distinction between family planning and family planning-related services. The training module has been in use since May 2012. The module was recently revised for the 2014 Provider Orientation and Update seminars, which started in February 2014. As indicated above, CMS guidance will inform further revisions to the FPACT PPBI Manual, if warranted, and updates to the continuing education training for providers, as indicated.

Program Integrity Activities

The OFP has implemented several program integrity activities which assist in the processes for identification, collection, reporting, analysis and disposition of performance data and information on Family PACT Providers and the provision of services. These activities allow OFP staff to regularly measure and monitor provider activities against the purpose of the Family PACT program and identify when an opportunity exists to improve the quality of program services. Such activities include, but are not limited to:

- Provider Profiles: Biannual Provider Profiles provides data on OFP identified indicators of utilization management and quality improvements measures that are directly attributable to the Family PACT provider. The intent is to encourage the delivery of high-quality clinical services while promoting responsible use of funding resources.
- Medical Record Review Report: A report of qualitative findings, conducted every three or four years to assess the quality of clinical care in the Family PACT Program.
- Audits by DHCS, Audits and Investigations (A&I): Routine audits are conducted by A&I of Family PACT providers to ensure compliance with program criteria and to recover overpayments, if indicated.

In addition, OFP will be initiating the following activities:

- Desk Review: Review and analysis of individual provider claims and billing behavior based on current policy.
- Onsite Provider Review: Onsite provider review based on information collected on desk review and provider profiles.

- DHCS disagrees with the finding regarding the seven (7) services that "were for the testing or treatment of sexually transmitted infections which were not provided as part of a family planning visit."

In April 2013, DHCS requested CMS guidance and clarification on the criteria for family planning-related services (such as STI services) provided pursuant to a family planning visit. DHCS has been recently informed by CMS that official clarifying guidance is being drafted and is expected to be released in early 2014.

Finding #3: Family Planning Related Services were eligible for reimbursement only at the regular Federal Medical Assistance Percentage.

Twenty-three services were family-planning-related but were improperly claimed at the 90-percent rate. Of these services, 17 were annual visits for male patients, and six were follow-up visits to a previous family planning visit. Because the services were family-planning-related services, they were eligible for Federal reimbursement only at the regular FMAP. The amount that OIG 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 prevent family-planning-related services from being claimed at the 90-percent rate.

Recommendation: The OIG recommends DHCS establish MMIS edits to ensure that FPACT claims meet Federal and State requirements for reimbursement at the 90-percent rate and at the regular FMAP for family-planning-related services.

Response: DHCS partially agrees with the finding and recommendation.

- DHCS agrees with the finding regarding the six (6) "follow-up visits to a previous family planning visit. Because the services were family planning-related services, they were eligible for Federal reimbursement only at the regular FMAP."

OFP has MMIS edits in place, such as the MMIS 1703 Table (Family PACT FFP Table for Procedure Codes) which is used to determine the FFP rate for the services covered under the Family PACT program. However, there are a few services that may be claimed at the 90-percent rate or at the regular FMAP rate, depending on the type of encounter.

DHCS was in the process of developing an Operational Instruction Letter (OIL) to the Fiscal Intermediary (FI) with the instructions to update the system and discontinue the inappropriate claiming of 90-percent FFP for the few identified services. However, the development of the OIL was placed on hold pending the completion of the ICD-9 code

conversion project. With the completion of the ICD-9 code conversion project, DHCS will proceed with moving forward with the development of the OIL. The State anticipates that a System Development Notice (SDN) will need to be initiated to update the CA-MMIS system. The projected implementation of this SDN may take up to a year or longer, contingent upon the complexity of the changes required by the current system. The conversion to ICD-10, currently in progress and is effective October 1, 2014, may also impact the timeline for this project.

- DHCS disagrees with the part of Finding #3 regarding the seventeen (17) services that involved annual male visits, pending further clarification from CMS on the criteria pertaining to male family planning visits.

- In April 2013, DHCS requested CMS guidance and clarification on the distinction between family planning and family planning-related services and the sequencing of such services. DHCS has been recently informed by CMS that official clarifying guidance is being drafted and is expected to be released in early 2014.