

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CALIFORNIA IMPROPERLY
CLAIMED ENHANCED FEDERAL
REIMBURSEMENT FOR MEDICAID
FAMILY PLANNING SERVICES
PROVIDED IN ORANGE COUNTY**

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**Gloria L. Jarmon
Deputy Inspector General
for Audit Services**

**July 2014
A-09-13-02044**

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

California claimed at least \$2.2 million for fiscal year 2012 in unallowable enhanced Federal reimbursement for Medicaid family planning services provided in Orange 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 Orange 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 was 50 percent during our audit period.

HOW WE CONDUCTED THIS REVIEW

From October 1, 2011, through September 30, 2012, the State agency claimed approximately \$22.9 million (\$17.7 million Federal share) for family planning services provided under the FPACT program in Orange 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 \$1.3 million for services considered to be

at low risk of being unallowable and for reimbursements determined to be immaterial. From the remaining \$21.6 million, we reviewed a random sample of 100 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 FFACT program in Orange County. Of the 100 sampled services, 74 complied and 26 did not comply with requirements. Of the 26 services, 22 were ineligible for reimbursement because they were not clearly provided for family planning purposes, and 4 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). On the basis of our sample results, we estimated that the State agency claimed at least \$2,280,044 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 services clearly provided for family planning purposes. Also, 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.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund \$2,280,044 to the Federal Government,
- establish billing procedures to ensure that only services clearly provided for family planning purposes are claimed for reimbursement at the 90-percent rate, and
- establish MMIS edits to ensure that FFACT claims meet Federal and State requirements for reimbursement at the 90-percent rate and at the regular FMAP for family-planning-related services.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency agreed that 9 of the 26 family planning services were not clearly provided for family planning purposes or were family-planning-related services eligible for reimbursement only at the regular FMAP and estimated that it would refund \$789,246 to the Federal Government. However, the State agency disagreed that the remaining 17 services for the testing or treatment of sexually transmitted infections that were not provided as part of a family planning visit were unallowable. 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 26 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 17 services as testing or treatment of sexually transmitted infections. For these reasons, we maintain that our findings and recommendations are valid.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	1
Background	1
Medicaid Program	1
Medicaid Coverage of Family Planning Services	1
California’s Medicaid Family Planning Program	2
State Requirements for the Family Planning Program	2
How We Conducted This Review	2
FINDINGS	3
Federal Requirements	3
State Agency Did Not Comply With Federal Requirements for Family Planning Services	4
Services Were Not Clearly Provided for Family Planning Purposes	4
Family-Planning-Related Services Were Eligible for Reimbursement Only at the Regular Federal Medical Assistance Percentage	4
RECOMMENDATIONS	4
STATE AGENCY COMMENTS	5
OFFICE OF INSPECTOR GENERAL RESPONSE	5
APPENDIXES	
A: Related Office of Inspector General Reports	6
B: Audit Scope and Methodology	7
C: Statistical Sampling Methodology	9
D: Sample Results and Estimates	11
E: State Agency Comments	12

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 Orange 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 FFACT 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 FFACT 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 50 percent.

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 FFACT 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 FFACT client, such as oral contraceptive, contraceptive injection, or barrier method.

HOW WE CONDUCTED THIS REVIEW

From October 1, 2011, through September 30, 2012, the State agency claimed \$22,872,207 (\$17,713,381 Federal share) for family planning services provided under the FFACT program in Orange County.² 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

² Our review did not include claims for family planning drugs and supplies, which will be covered in a future audit of Orange County.

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 \$1,277,831 for services considered to be at low risk of being unallowable and for reimbursements determined to be immaterial. From the remaining \$21,594,376, we reviewed a random sample of 100 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 Orange County. Of the 100 sampled services, 74 complied and 26 did not comply with requirements. Of the 26 services, 22 were ineligible for reimbursement because they were not clearly provided for family planning purposes, and 4 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). On the basis of our sample results, we estimated that the State agency claimed at least \$2,280,044 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 services clearly provided for family planning purposes. Also, the State agency’s MMIS lacked edits to prevent family-planning-related services from being claimed at the 90-percent rate.

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.”

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

On the basis of our review of client medical records for 100 sampled services, we found that the State agency did not comply with Federal requirements for 26 family planning services, consisting of 22 services that were not clearly provided for family planning purposes and 4 family-planning-related services that were eligible for reimbursement only at the regular FMAP.³ Using our sample results, we estimated that the State agency claimed at least \$2,280,044 in unallowable Federal reimbursement.

Services Were Not Clearly Provided for Family Planning Purposes

Twenty-two services were not clearly provided for family planning purposes. Of these services, 17 were for the testing or treatment of sexually transmitted infections that were not provided as part of a family planning visit, and 5 were for services provided for other non-family-planning purposes (such as testing for a urinary tract infection). 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 FFACT client, not the purpose of the service.

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

Four services were family-planning-related but were improperly claimed at the 90-percent rate. These services 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.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$2,280,044 to the Federal Government,
- establish billing procedures to ensure that only services clearly provided for family planning purposes are claimed for reimbursement at the 90-percent rate, and

³ During our audit, State medical professionals performed a medical review of the 26 services that we determined did not comply with Federal requirements. The medical professionals concurred with our findings.

- 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.

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 9 of the 26 family planning services were not clearly provided for family planning purposes or were family-planning-related services eligible for reimbursement only at the regular FMAP. Regarding our first recommendation, the State agency estimated that it would refund \$789,246 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 22 services were not clearly provided for family planning purposes, the State agency partially agreed with our finding and the related (second) recommendation. The State agency disagreed that 17 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.
- Regarding our finding that four services were eligible for reimbursement only at the regular FMAP, the State agency agreed with our finding and the related (third) recommendation.

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 26 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 17 services as 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.

CMS issued State Medicaid Directors Letter 14-003, effective April 16, 2014, which provides guidance on services related to 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
<i>Missouri Did Not Always Correctly Claim Costs for Medicaid Family Planning Drugs for Calendar Years 2009 and 2010</i>	<u>A-07-12-01118</u>	1/28/2014
<i>California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Drugs and Supplies Provided in San Diego County</i>	<u>A-09-12-02077</u>	6/25/2013
<i>Missouri Did Not Always Correctly Claim Costs for Medicaid Family Planning Sterilization Procedures for Calendar Years 2009 and 2010</i>	<u>A-07-12-01117</u>	6/12/2013
<i>Missouri Incorrectly Claimed Federal Reimbursement for Inpatient Claims With Sterilization and Delivery Procedures for Calendar Years 2009 and 2010</i>	<u>A-07-12-01121</u>	3/13/2013
<i>Arkansas Inappropriately Received Medicaid Family Planning Funding for Federal Fiscal Years 2006 Through 2010</i>	<u>A-06-11-00022</u>	1/18/2013
<i>California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in San Diego County</i>	<u>A-09-11-02040</u>	12/20/2012
<i>Wyoming Incorrectly Claimed Enhanced Reimbursement for Medicaid Family Planning Sterilization Costs</i>	<u>A-07-11-01100</u>	8/17/2012
<i>North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Waiver Services That Were Not Family Planning</i>	<u>A-04-10-01091</u>	6/15/2012
<i>North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Services That Were Not Family Planning</i>	<u>A-04-10-01089</u>	6/15/2012
<i>Oregon Improperly Claimed Federal Reimbursement for Medicaid Family Planning Services Provided Under the Family Planning Expansion Project</i>	<u>A-09-11-02010</u>	1/26/2012
<i>Review of Medicaid Family Planning Services Claimed Under the Oregon Health Plan During the Period October 1, 2006, Through September 30, 2009</i>	<u>A-09-10-02043</u>	6/29/2011

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

From October 1, 2011, through September 30, 2012, the State agency claimed \$22,872,207 (\$17,713,381 Federal share) for family planning services provided under the FPACT program in Orange County, representing 663,782 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 656,267 unique services. We did not review 150,624 services, totaling \$1,277,831, that were considered to be at low risk of being unallowable or that had reimbursements determined to be immaterial. We reviewed a random sample from the remaining 505,643 services, totaling \$21,594,376.

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 March to November 2013 and performed our fieldwork at the State agency's office in Sacramento, California, and at provider locations in Orange 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, 2011, through September 30, 2012, representing 663,782 claim lines for family planning services provided in Orange County, totaling \$22,872,207 (\$17,713,381 Federal share);
- grouped the 663,782 claim lines by claim control number, beneficiary identification number, date of service, and procedure code, which resulted in 656,267 unique services;
- removed 150,624 services, totaling \$1,277,831, consisting of 84,569 services with reimbursements that we determined to be immaterial and 66,055 services we considered to be at low risk of being unallowable;

- created a sample frame consisting of the remaining 505,643 services, totaling \$21,594,376;
- selected a simple random sample of 100 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 medical record information 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; and
- 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.

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 Orange County; paid by the State agency to providers from October 1, 2011, through September 30, 2012; 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 663,782 claim lines for family planning services provided in Orange County, totaling \$22,872,207 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 656,267 unique services. From the resulting 656,267 services, we removed 66,055 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 84,569 services that had a reimbursement of less than this amount. After we removed these services, the sampling frame consisted of 505,643 services totaling \$21,594,376 (\$16,723,765 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 simple random sample to test the services for allowability.

SAMPLE SIZE

We selected 100 sample units.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units from 1 through 505,643. 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 D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results (Total Amounts)

Number of Services in Sampling Frame	Value of Services in Sampling Frame	Sample Size	Value of Sample	Number of Unallowable Services	Value of Unallowable Services
505,643	\$21,594,376	100	\$3,736	26	\$1,021

Table 2: Sample Results (Federal Share Amounts)

Number of Services in Sampling Frame	Value of Services in Sampling Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Services	Value of Unallowable Services (Federal Share)
505,643	\$16,723,765	100	\$2,894	26	\$751

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

	Total Amount	Federal Share
Point estimate	\$5,163,272	\$3,796,329
Lower limit	3,189,093	2,280,044
Upper limit	7,137,452	5,312,613

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 Orange County*, Report Number A-09-13-02044.

- | | |
|--|---|
| <input checked="" type="checkbox"/> Request for Approval | <input type="checkbox"/> For Secretary's Information |
| <input type="checkbox"/> Request for Discussion | <input checked="" type="checkbox"/> For Secretary's Signature |
| | <input type="checkbox"/> For Governor's Information |
-

APPROVED:

Toby Douglas
Toby Douglas, Director
Department of Health Care Services

Date

Robert Ducay for
Diana S. Dooley, Secretary
Health and Human Services Agency

Date

DHCS 1053 (Revised 12/08)

SUMMARY/PRO-CON ARGUMENTS:

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 follow-up to a family planning service. The regular FMAP was 50 percent during OIG's audit period.

Summary of 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 Orange County. Of the 100 sampled services, 74 complied and 26 did not comply with requirements. Of the 26 services, 22 were ineligible for reimbursement because they were not clearly provided for family planning purposes, and 4 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). On the basis of the sample results, the OIG estimated that the State agency claimed at least \$2,280,044 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 services clearly provided for family planning purposes. In addition, 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.

- Refund \$2,280,044 to the Federal Government,
- Establish billing procedures to ensure that only services clearly provided for family planning purposes are claimed for reimbursement at the 90-percent rate
- 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.

DHCS Response

Please see attached

DHCS' Response to Draft Report
14-01 FPACT Orange County
Page 3

EFFECTS ON EXISTING LAW: N/A

ESTIMATED COST: Between \$789,246 and \$2,280,044

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 Orange County**

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

Based on OIG's review of client medical records for 100 sampled services, the OIG found that the State agency did not comply with Federal requirements for 26 family planning services, consisting of 22 services that were not clearly provided for family planning purposes and 4 family-planning-related services that were eligible for reimbursement only at the regular FMAP. Using their sample results, the OIG estimated that the State agency claimed at least \$2,280,044 in unallowable Federal reimbursement.

Recommendation: The OIG recommends DHCS refund \$2,280,044 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 nine (9) of the 26 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 \$789,246 to the Federal Government.

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

Twenty-two services were not clearly provided for a family planning purpose. Of these services, 17 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 testing for a urinary tract infection). 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 17 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 Family PACT PPBI manual, if warranted, and updates to the continuing educational training for Family PACT 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 reviews based on information collected from desk reviews and provider profiles.
- DHCS disagrees with the finding regarding the 17 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.

Four services were family-planning-related but were improperly claimed at the 90-percent rate.

These services 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 agrees with the finding and recommendation.

DHCS agrees with the finding regarding the four (4) "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.