

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

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

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# *Office of Inspector General*

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## EXECUTIVE SUMMARY

***California claimed at least \$4 million for fiscal year 2011 in unallowable enhanced Federal reimbursement for Medicaid family planning services provided in east 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 east 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 east Los Angeles County. (We are reviewing central and southeast Los Angeles County in separate audits.) From October 1, 2010, through September 30, 2011, the State agency claimed approximately \$37.3 million (\$28.8 million Federal share) for family planning services provided in east 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 \$1.4 million for services considered to be at low risk of being unallowable and for reimbursements determined to be immaterial. From the remaining \$35.9 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 east Los Angeles County. Of the 120 sampled services, 92 complied and 28 did not comply with requirements. Of the 28 services, 20 were ineligible for reimbursement because they were not clearly provided for family planning purposes, and 8 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 \$4,049,335 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 \$4,049,335 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 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 AND OUR RESPONSE**

In written comments on our draft report, the State agency agreed that 7 of the 28 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 \$956,063 to the Federal Government. However, the State agency disagreed that the remaining 21 services were unallowable. The 21 services consisted of 15 services for the testing or treatment of sexually transmitted infections that were not provided as part of a family planning visit and 6 services involving annual visits for men. 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 28 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 21 services as testing or treatment of sexually transmitted infections or annual visits for men. 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.<sup>1</sup> (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 east 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

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<sup>1</sup> *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 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.<sup>2</sup>

### **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.

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<sup>2</sup> 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 east Los Angeles County.<sup>3</sup> (We are reviewing central and southeast Los Angeles County in separate audits.) From October 1, 2010, through September 30, 2011, the State agency claimed \$37,250,958 (\$28,849,005 Federal share) for family planning services provided in east Los Angeles County.<sup>4</sup> 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 \$1,384,300 for services considered to be at low risk of being unallowable and for reimbursements determined to be immaterial. From the remaining \$35,866,658, 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 east Los Angeles County. Of the 120 sampled services, 92 complied and 28 did not comply with requirements. Of the 28 services, 20 were ineligible for reimbursement because they were not clearly provided for family planning purposes, and 8 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 \$4,049,335 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.

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<sup>3</sup> 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. Thirty-seven of these ZIP Codes were located in the eastern area of Los Angeles County, which we refer to as “east Los Angeles County.”

<sup>4</sup> 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**

Providers must keep records as necessary to disclose the extent of the services provided to individuals receiving assistance under the State plan (the Act, § 1902(a)(27)(A)). Providers must provide these records to the State agency or the Secretary of Health and Human Services upon request (the Act, § 1902(a)(27)(B)).

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 28 family planning services, consisting of 20 services that were not clearly provided for family planning purposes and 8 family-planning-related services that were eligible for reimbursement only at the regular FMAP.<sup>5</sup> Using our sample results, we estimated that the State agency claimed at least \$4,049,335 in unallowable Federal reimbursement.

### **Services Were Not Clearly Provided for Family Planning Purposes**

Of the 20 services not clearly provided for family planning purposes, 15 were for the testing or treatment of sexually transmitted infections (which were not provided as part of a family planning visit), 4 were for services provided for other non-family-planning purposes (such as treatment of a urinary tract infection), and 1 was undocumented. For one service, the provider billed for a laboratory test, but there was no documentation to show that such a test was ordered or performed.

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

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<sup>5</sup> During our audit, State medical professionals performed a medical review of the 28 services that we determined did not comply with Federal requirements. The medical professionals concurred with our findings.

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**

Eight services were family-planning-related but were improperly claimed at the 90-percent rate. Of these services, six were annual visits for male patients, and two 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 \$4,049,335 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**

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 7 of the 28 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 \$956,063 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 20 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 15 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 eight services were eligible for reimbursement only at the regular FMAP, the State agency partially agreed with our finding and the related (third) recommendation. The State agency disagreed that six 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 two 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 28 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 21 services as testing or treatment of sexually transmitted infections or annual visits for men.

- Regarding the 15 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.
- Regarding the six 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.

CMS issued State Medicaid Directors Letter 14-003, effective April 16, 2014, which provides guidance on services related to sexually transmitted infections and annual visits for men. 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.

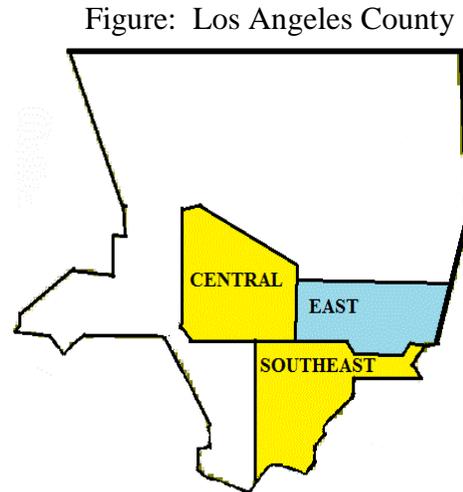
**APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Missouri Did Not Always Correctly Claim Costs for Medicaid Family Planning Drugs for Calendar Years 2009 and 2010</i>	<a href="#"><u>A-07-12-01118</u></a>	1/28/2014
<i>California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Drugs and Supplies Provided in San Diego County</i>	<a href="#"><u>A-09-12-02077</u></a>	6/25/2013
<i>Missouri Did Not Always Correctly Claim Costs for Medicaid Family Planning Sterilization Procedures for Calendar Years 2009 and 2010</i>	<a href="#"><u>A-07-12-01117</u></a>	6/12/2013
<i>Missouri Incorrectly Claimed Federal Reimbursement for Inpatient Claims With Sterilization and Delivery Procedures for Calendar Years 2009 and 2010</i>	<a href="#"><u>A-07-12-01121</u></a>	3/13/2013
<i>Arkansas Inappropriately Received Medicaid Family Planning Funding for Federal Fiscal Years 2006 Through 2010</i>	<a href="#"><u>A-06-11-00022</u></a>	1/18/2013
<i>California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in San Diego County</i>	<a href="#"><u>A-09-11-02040</u></a>	12/20/2012
<i>Wyoming Incorrectly Claimed Enhanced Reimbursement for Medicaid Family Planning Sterilization Costs</i>	<a href="#"><u>A-07-11-01100</u></a>	8/17/2012
<i>North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Waiver Services That Were Not Family Planning</i>	<a href="#"><u>A-04-10-01091</u></a>	6/15/2012
<i>North Carolina Incorrectly Claimed Enhanced Federal Reimbursement for Some Medicaid Services That Were Not Family Planning</i>	<a href="#"><u>A-04-10-01089</u></a>	6/15/2012
<i>Oregon Improperly Claimed Federal Reimbursement for Medicaid Family Planning Services Provided Under the Family Planning Expansion Project</i>	<a href="#"><u>A-09-11-02010</u></a>	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>	<a href="#"><u>A-09-10-02043</u></a>	6/29/2011

## APPENDIX B: AUDIT SCOPE AND METHODOLOGY

### SCOPE

We limited our review to FPACT program claims with provider billing ZIP Codes in east 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 central and southeast Los Angeles County in separate audits. We are not reviewing the rest of the county.)



From October 1, 2010, through September 30, 2011, the State agency claimed \$37,250,958 (\$28,849,005 Federal share) for family planning services provided in east Los Angeles County, representing 1,386,314 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 1,384,089 unique services. We did not review 310,029 services, totaling \$1,384,300, 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 1,074,060 services, totaling \$35,866,658.

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 February to July 2013 and performed our fieldwork at the State agency's office in Sacramento, California, and at provider locations in east 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 1,386,314 claim lines for family planning services provided in east Los Angeles County, totaling \$37,250,958 (\$28,849,005 Federal share);<sup>6</sup>
- grouped the 1,386,314 claim lines by claim control number, beneficiary identification number, date of service, and procedure code, which resulted in 1,384,089 unique services;
- removed 310,029 services, totaling \$1,384,300, consisting of 255,372 services with reimbursements that we determined to be immaterial and 54,657 services we considered to be at low risk of being unallowable; and
- developed a stratified random sample from the remaining 1,074,060 services, totaling \$35,866,658, 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.

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<sup>6</sup> 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 east 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 FFACT program.

### **SAMPLING FRAME**

The State agency provided us with a database of FFACT claims, from which we identified 1,386,314 claim lines for family planning services provided in east Los Angeles County, totaling \$37,250,958 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 1,384,089 unique services. From the resulting 1,384,089 services, we removed 54,657 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 255,372 services that had a reimbursement of less than this amount. After we removed these services, the sampling frame consisted of 1,074,060 services totaling \$35,866,658 (\$27,776,933 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 261,682 services.
- Stratum 2: services with a Medicaid-reimbursed amount from \$20.00 to \$39.99, consisting of 703,755 services.
- Stratum 3: services with a Medicaid-reimbursed amount of \$40.00 or more, consisting of 108,623 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 261,682, the stratum 2 frame was numbered 1 through 703,755, and the stratum 3 frame was numbered 1 through 108,623. 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)**

<b>Stratum</b>	<b>Number of Services in Stratum</b>	<b>Value of Stratum</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Number of Unallowable Services</b>	<b>Value of Unallowable Services</b>
1	261,682	\$3,177,923	40	\$486	7	\$78
2	703,755	25,094,596	40	1,501	12	466
3	108,623	7,594,139	40	2,865	9	680
<b>Total</b>	<b>1,074,060</b>	<b>\$35,866,658</b>	<b>120</b>	<b>\$4,852</b>	<b>28</b>	<b>\$1,224</b>

**Table 2: Sample Results (Federal Share Amounts)**

<b>Stratum</b>	<b>Number of Services in Stratum</b>	<b>Value of Stratum (Federal Share)</b>	<b>Sample Size</b>	<b>Value of Sample (Federal Share)</b>	<b>Number of Unallowable Services</b>	<b>Value of Unallowable Services (Federal Share)</b>
1	261,682	\$2,461,142	40	\$377	7	\$50
2	703,755	19,434,510	40	1,163	12	269
3	108,623	5,881,281	40	2,219	9	448
<b>Total</b>	<b>1,074,060</b>	<b>\$27,776,933</b>	<b>120</b>	<b>\$3,759</b>	<b>28</b>	<b>\$767</b>

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

	<b>Total Amount</b>	<b>Federal Share</b>
Point estimate	\$10,546,604	\$6,267,575
Lower limit	7,087,467	4,049,335
Upper limit	14,005,741	8,485,816



**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, whose primary purpose is family planning and 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. The audit period included claims processed during the period October 1, 2010 through September 30, 2011 in East Los Angeles County.

**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 East Los Angeles County. Of the 120 sampled services, 92 complied and 28 did not comply with requirements. Of the 28 services, 20 were ineligible for reimbursement because they were not clearly provided for family planning purposes, and 8 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). The OIG estimated that the State agency claimed at least \$4,049,335 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.

**DHCS Response:** Please see attached

**EFFECTS ON EXISTING LAW:** N/A

**ESTIMATED COST:** Between \$956,000 and \$4 million

**TIME FACTOR:** Due to Agency by March 14, 2014  
Due to OIG by March 20, 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 East Los Angeles 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 120 sampled services, the OIG found that the State agency did not comply with Federal requirements for 28 family planning services, consisting of 20 services that were not clearly provided for family planning purposes and 8 family-planning-related services that were eligible for reimbursement only at the regular FMAP. Using our sample results, we estimated that the State agency claimed at least \$4,049,335 in unallowable Federal reimbursement.

**Recommendation:** The OIG recommends DHCS refund \$4,049,335 to the Federal Government.

**Response:** 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 seven (7) of the 28 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 \$956,063 to the Federal Government.

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

Of the 20 services not clearly provided for a family planning purpose, 15 were for the testing or treatment of sexually transmitted infections (which were not provided as part of a family planning visit), 4 were for services provided for other non-family-planning purposes (such as treatment of an urinary tract infection), and 1 was undocumented. For one service, the provider billed for a laboratory test, but there was no documentation to show that such a test was ordered or performed. 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.

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DHCS disagrees with part of Finding #2 regarding the 15 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 four (4) services “provided for other non-family-planning purposes” and one (1) service claimed that lacked documentation. 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 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

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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

OPF 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 OPF 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 OPF 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:

- o Provider Profiles: Biannual Provider Profiles provides data on OPF 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.
- o 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.
- o 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, OPF will be initiating the following activities:

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

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- DHCS disagrees with the finding regarding the 15 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.

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

Eight services were family-planning-related but were improperly claimed at the 90-percent rate. Of these services, six were annual visits for male patients, and two 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.

**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 two (2) "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 identified few 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

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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 six (6) 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.