DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

July 5, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Lori S. Pilcher/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Oklahoma (A-06-09-00097)

Attached, for your information, is an advance copy of our final report on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Oklahoma. We will issue this report to the Oklahoma Health Care Authority within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Patricia Wheeler, Regional Inspector General for Audit Services, Region VI, at (214) 767-8414 or through email at Patricia.Wheeler@oig.hhs.gov. Please refer to report number A-06-09-00097.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

July 6, 2011

Report Number: A-06-09-00097

Ms. Carrie Evans
Chief Financial Officer
Oklahoma Health Care Authority
2401 NW 23rd Street, Suite A1
Oklahoma City, OK 73107

Dear Ms. Evans:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in Oklahoma*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414, or contact Warren Lundy, Audit Manager, at (405) 605-6183 or through email at Warren.Lundy@oig.hhs.gov. Please refer to report number A-06-09-00097 in all correspondence.

Sincerely,

/Anthony D. Wilkinson/ for
Patricia Wheeler
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE QUARTERLY MEDICAID STATEMENT OF EXPENDITURES FOR THE MEDICAL ASSISTANCE PROGRAM IN OKLAHOMA

Daniel R. Levinson
Inspector General

July 2011
A-06-09-00097

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly administer and fund 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. In Oklahoma, the Oklahoma Health Care Authority (State agency) administers the Medicaid program.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. Additionally, States receive a higher, or enhanced, Federal share for some Medicaid services, such as those related to family planning.

The American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provided an estimated $87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. With the Recovery Act funding, Oklahoma's FMAP for Medicaid expenditures increased from 65.90 percent to 74.94 percent for the quarter ended December 31, 2008.

The State agency claims Medicaid expenditures and the associated Federal share on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). This form shows the disposition of Medicaid funds used to pay for medical and administrative expenditures for the quarter being reported and any prior-period adjustments.

The State agency operates its Medicaid program primarily through a fee-for-service payment system and several waivers authorized by sections 1115 and 1915(c) of the Act. The State agency also offers the Program of Assertive Community Treatment (PACT), which includes comprehensive community-based behavioral health treatment and rehabilitation services for people with serious and persistent mental illnesses. Reimbursement for PACT services changed from an all-inclusive per diem rate to a per unit fee-schedule structure on July 1, 2008. To help compensate for lower payments, the State agency made three additional lump-sum payments for distribution to PACT providers during the period October 1, 2008, through December 31, 2009.

OBJECTIVES

Our objectives were to determine whether (1) the State agency claimed Federal reimbursement of Medicaid expenditures for the quarter ended December 31, 2008, in accordance with Federal requirements and (2) additional payments for PACT services made from October 1, 2008, through December 31, 2009, were allowable.

SUMMARY OF FINDINGS

For the quarter ended December 31, 2008, the State agency generally claimed Federal reimbursement of approximately $1 billion in Medicaid expenditures in accordance with Federal requirements. However, the State agency:

- applied incorrect FMAPs, resulting in an overstatement of the Federal share totaling $11,506;

- overlooked $6,140 ($4,602 Federal share) in expenditures on source documents when the CMS-64 report was compiled; and

- received an enhanced family planning Federal share totaling $126,613 for inpatient hospital expenditures, the appropriate amount of which we could not determine.

In addition, the State agency made $2,761,361 ($2,080,006 Federal share) in additional PACT-related payments that were not approved in the State plan and therefore were unallowable.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $2,091,512, consisting of:

    - $11,506 in enhanced Federal share that it improperly received and

    - $2,080,006 for additional PACT payments;

- claim a Federal credit of $4,602 for overlooked expenditures;

- work with CMS to determine what portion of the $126,613 in enhanced family planning Federal share that it received was allowable;

- ensure that the full range of diagnosis codes allowable at the enhanced family planning FMAP are entered into its computer system for family planning waiver services;

- establish review procedures to ensure that Medicaid expenditures are correctly compiled, assigned, and claimed in accordance with the approved State plan; and

- submit documentation to CMS supporting the reasonableness of the 35-percent rate for allocating inpatient hospital expenditures to the enhanced family planning FMAP.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, the State agency agreed with our finding related to incorrect FMAPs and said that it would correct the CMS-64 report for the quarter ended March 31, 2011. The State agency disagreed with or did not address our other findings. We removed one finding in response to the State agency's comments; however, we disagreed with the State agency's other positions.

The State agency's comments appear as the Appendix. We redacted a portion of the comments that dealt with the finding that we removed.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly administer and fund 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. In Oklahoma, the Oklahoma Health Care Authority (State agency) administers the Medicaid program. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time. Certain Medicaid services receive a higher FMAP, including family planning services (90 percent) and services provided through an Indian Health Service facility (100 percent).

As part of the implementation of their Medicaid programs, States may submit waiver requests to CMS; these waivers, when approved, allow exceptions to certain requirements or limitations of the Act. Two such waivers authorized by the Act are home and community-based waivers (section 1915(c)) and demonstration waivers (section 1115).

American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 (the Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provided fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provided an estimated $87 billion in additional Medicaid funding based on temporary increases in States' FMAPs.[1] Section 5000 of the Recovery Act provides for these increases to help avert cuts in health care payment rates, benefits, or services and to prevent changes to income eligibility requirements that would reduce the number of individuals eligible for Medicaid. Sections 5001(a), (b), and (c) of the Recovery Act provide that a State's increased FMAP during the recession adjustment period will be no less than its 2008 FMAP increased by 6.2 percentage points and that a State may receive an increase greater than 6.2 percentage points based on increases to its average unemployment rate. Oklahoma's FMAP for Medicaid expenditures increased 9.04 percent, from 65.90 percent to 74.94 percent, for the quarter ended December 31, 2008.

[1] The Education Jobs and Medicaid Assistance Act (P.L. No. 111-226, section 201) extended the recession adjustment period for the increased FMAP through June 30, 2011.

Oklahoma Medicaid Program

The State agency operates Oklahoma's Medicaid program primarily through a fee-for-service payment system and several primary care case management models organized under section 1115 waivers. Under the primary care case management models, the State agency contracts directly with physicians to provide primary care, coordination services, and specialty care referrals. The State agency also obtained a family planning waiver under section 1115 and various home and community-based waivers under section 1915(c). Through the family planning waiver, the State agency offers specific family planning services to individuals who otherwise would not have access to them.

The State agency also offers the Program of Assertive Community Treatment (PACT), which includes comprehensive community-based behavioral health treatment and rehabilitation services for people with serious and persistent mental illnesses. Providers of PACT services are teams within Medicaid-contracted outpatient behavioral health organizations and must be certified by the Oklahoma Department of Mental Health and Substance Abuse Services. Before July 1, 2008, PACT services were reimbursed under an all-inclusive per diem rate. After CMS expressed concern about the per diem rate, the State agency changed the payment to a per unit fee-schedule structure. The State agency made three additional lump-sum payments to the Oklahoma Department of Mental Health and Substance Abuse Services for distribution to PACT providers during the period October 1, 2008, through December 31, 2009.

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

The State agency claims Medicaid expenditures and the associated Federal share on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). The CMS-64 report is an accounting statement that the State agency, in accordance with 42 CFR § 430.30(c), must submit to CMS within 30 days after the end of each quarter. This form shows the disposition of Medicaid funds used to pay for medical and administrative expenditures for the reporting period and any prior-period adjustments. The CMS *State Medicaid Manual*, section 2500(A)(1), states that the amounts reported on the Form CMS-64 and its attachments must represent actual expenditures. In addition, all supporting documentation must be in readily reviewable form and available at the time the claim is filed.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether (1) the State agency claimed Federal reimbursement of Medicaid expenditures for the quarter ended December 31, 2008, in accordance with Federal requirements and (2) additional payments for PACT services made from October 1, 2008, through December 31, 2009, were allowable.

Scope

Our review covered more than $1 billion ($765 million Federal share) in Medicaid expenditures that the State agency claimed on the CMS-64 report for the quarter ended December 31, 2008. We did not include expenditures the State agency claimed on the sterilization line[2] because we reviewed them in more detail during our review of expenditures that the State agency claimed for hysterectomies.

Our review also covered $2,761,361 ($2,080,006 Federal share) in additional payments that the State agency claimed for PACT services during the period October 1, 2008, through December 31, 2009. This included $575,459 ($431,249 Federal share) claimed for the quarter ended December 31, 2008.

We limited our review of supporting documentation to records that the State agency maintained and did not evaluate claims submitted by providers to determine their validity. Our objectives did not require a review of the overall internal control structure of the State agency. Therefore, we limited our internal control review to the State agency's procedures for aggregating Medicaid expenditures on the CMS-64 report.

We conducted fieldwork at the State agency's offices in Oklahoma City, Oklahoma.

Methodology

To accomplish our objectives, we:

- reviewed applicable Federal laws and regulations and the State plan sections;
- interviewed CMS personnel responsible for monitoring the CMS-64 report;
- interviewed State agency officials to obtain an understanding of their policies and procedures for reporting Medicaid expenditures on the CMS-64 report;
- analyzed the State agency's procedures for aggregating Medicaid expenditures for the CMS-64 report to assess whether they would produce a reasonable and accurate claim for Federal reimbursement;
- acquired an understanding of the State agency's Medicaid waiver programs;
- assessed the overall accuracy of amounts claimed on the CMS-64 report by tracing them to supporting reports from the State agency's accounting system;
- selected seven CMS-64 report line item amounts totaling more than $789 million ($595 million Federal share), which was nearly 78 percent of the State agency's claimed

[2] The State agency claimed expenditures totaling $2,980,708 on the CMS-64 report's sterilization line and received $2,694,369 in Federal share for them. These expenditures will be addressed in a separate report (A-06-10-00047).

expenditures for the quarter: inpatient hospital services, nursing facility services, physician services, prescribed services, clinic services, home and community-based services, and other care services;

- traced expenditures included in the selected line items to detailed records and analyzed those records;

- selected and reviewed supporting documentation for a judgmental sample of expenditures that State agency officials manually entered into the State agency's accounting system;

- obtained and reviewed supporting documentation for additional payments for PACT services that the State agency claimed from October 1, 2008, through December 31, 2009; and

- discussed our results with the State agency.

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.

FINDINGS AND RECOMMENDATIONS

For the quarter ended December 31, 2008, the State agency generally claimed Federal reimbursement of approximately $1 billion in Medicaid expenditures in accordance with Federal requirements. However, the State agency:

- applied incorrect FMAPs, resulting in an overstatement of the Federal share totaling $11,506;

- overlooked $6,140 ($4,602 Federal share) in expenditures on source documents when the CMS-64 report was compiled; and

- received an enhanced family planning Federal share totaling $126,613 for inpatient hospital expenditures, the appropriate amount of which we could not determine.

In addition, the State agency made $2,761,361 ($2,080,006 Federal share) in additional PACT-related payments that were not approved in the State plan and therefore were unallowable.

EXPENDITURES FOR THE QUARTER ENDED DECEMBER 31, 2008

Incorrect Federal Medical Assistance Percentages

Section 1905(a)(4)(C) of the Act requires States to furnish "family planning services." Section 1903(a)(5) of the Act and 42 CFR § 433.10(c)(1) authorize reimbursement at a 90-percent FMAP rate for family planning services. Section 4270 of the CMS *State Medicaid Manual* (the manual) states that only items and procedures clearly furnished or provided for family planning purposes may be claimed at the 90-percent FFP rate.

Section 1905(b) of the Act and 42 CFR § 433.10(c)(2) authorize reimbursement for services provided through Indian Health Service facilities at 100 percent.

The State agency overstated the Federal share on the CMS-64 report by an additional $11,506. The State agency claimed $110,023 of expenditures at enhanced FMAPs. Although these expenditures were eligible for Federal reimbursement at the regular FMAP of 74.94 percent, they were not for family planning services or for services provided through Indian Health Services facilities. As a result, the State agency incorrectly received an enhanced Federal share of $19,137, which consisted of:

- $12,703 (Federal share) in enhanced family planning (i.e., the difference between 90 percent and 74.94 percent) and

- $6,434 (Federal share) in enhanced Indian Health Service funding (i.e., the difference between 100 percent and 74.94 percent).

This error occurred because a State agency official entered amounts from supporting documents in the wrong FMAP column on the CMS-64 report.

The State agency also claimed $50,668 in family planning waiver expenditures at the regular FMAP of 74.94 percent, even though these expenditures were eligible for the enhanced family planning FMAP of 90 percent. This occurred because the State agency had not programmed its computer system to assign the enhanced family planning FMAP to all diagnosis codes that were eligible to receive it. As a result, the State agency did not receive $7,631 in Federal share to which it was entitled.

Overlooked Expenditures

Pursuant to section 1903(a)(1) of the Act, the Federal Government pays its share of a State's Medicaid expenditures based on the FMAP.

The State agency did not claim $6,140 in expenditures for services offered under the Primary Case Management model. The amount was overlooked on source documents when the CMS-64 report was compiled. As a result, the State agency did not receive $4,602 in Federal reimbursement to which it was entitled.

Inpatient Hospital Services Allocated as Family Planning Services

CMS's *Financial Management Review Guide Number 20* (Review Guide) states that when multiple procedures are performed during a single hospital stay and one of them is related to family planning, a State claim for Federal reimbursement must distinguish between those costs attributable to family planning services and those costs attributable to other covered services. The Review Guide states that in the absence of regulations, CMS must accept any method of allocation a State adopts that reasonably allocates costs for the purpose of claiming the appropriate Federal reimbursement rate.

The State agency identified inpatient hospital claims with primary procedures that were not family planning procedures but had at least one family planning code, totaling a little more than $2.4 million. A State agency official manually reassigned 35 percent of this total, or $840,727, to the enhanced family planning FMAP of 90 percent. According to a State agency official, 35 percent was the allocation rate negotiated with CMS approximately 15 to 20 years ago.

The State agency could not show how it arrived at the 35-percent allocation rate or that CMS had accepted its allocation method. As a result, we could not determine the allowable portion of the enhanced family planning Federal share of $126,613 (i.e., the difference between 90 percent and 74.94 percent of $840,727) that the State agency received for the reassigned inpatient hospital expenditures.

PROGRAM OF ASSERTIVE COMMUNITY TREATMENT

Section 1903(a)(1) of the Act provides for Federal matching funds only for those costs made by a State under an approved State plan. Federal regulations (42 CFR § 430.10) require that the State plan describe "the nature and scope of its Medicaid program." In addition, the State plan should contain "all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation ...."

Following the July 1, 2008, change to the fee-schedule payment structure, PACT providers complained of decreased reimbursement. These complaints led the State agency to make three lump-sum payments to the Oklahoma Department of Mental Health and Substance Abuse Services between October 1, 2008, and December 31, 2009, for distribution to PACT providers. These payments were in addition to payments that the State agency made under the fee-schedule structure and were not approved in the State plan.

As a result, the State agency should not have claimed $2,761,361 in unallowable additional PACT payments on its CMS-64 report and should not have received the Federal share of $2,080,006.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $2,091,512, consisting of:

  - $11,506 in enhanced Federal share that it improperly received and

  - $2,080,006 for additional PACT payments;

- claim a Federal credit of $4,602 for overlooked expenditures;

- work with CMS to determine what portion of the $126,613 in enhanced family planning Federal share that it received was allowable;

- ensure that the full range of diagnosis codes allowable at the enhanced family planning FMAP are entered into its computer system for family planning waiver services;

- establish review procedures to ensure that Medicaid expenditures are correctly compiled, assigned, and claimed in accordance with the approved State plan; and

- submit documentation to CMS supporting the reasonableness of the 35-percent rate for allocating inpatient hospital expenditures to the enhanced family planning FMAP.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendation related to incorrect FMAPs and said that it would correct the CMS-64 report for the quarter ended March 31, 2011. However, the State agency disagreed with or did not address our other recommendations.

Regarding the inpatient hospital services allocated as family planning services, the State agency said that CMS had agreed that the 35-percent allocation rate was reasonable and that the methodology met the requirements of the Review Guide.

Finally, regarding the PACT payments, the State agency said that the payments were allowable under the State plan section related to supplemental payments for Behavioral Community Networks (BHCN). The State agency said that the section outlines the criteria for receiving supplemental payments. The State agency indicated that the criteria were met; thus, the payments were allowable under the State plan.

The State agency's comments appear as the Appendix. We redacted a portion of the comments that dealt with a finding that we removed.

OFFICE OF INSPECTOR GENERAL RESPONSE

We removed one finding in response to the State agency's comments; however, we disagreed with the State agency's other positions. Regarding the inpatient hospital services allocated as family planning services, the State agency could not provide support showing how it arrived at the 35-percent allocation rate or evidence that CMS had accepted its allocation method.

The documentation that the State agency provided to support the additional payments indicated that the payments were for direct PACT services, not supplemental payments to BHCNs. The section of the State plan that the State agency cited in its comments relates to clinic services. PACT services are not clinic services because they are provided in patients' homes, at work, and in community settings. Thus, the State plan section is not applicable to the additional PACT payments.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

April 7, 2011

Ms. Patricia Wheeler
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IV
1100 Commerce Street, Room 632
Dallas, TX 75242

Re: Report Number: A-06-09-00097

Dear Ms. Wheeler:

Please find our responses below to the above referenced Audit Report:

[redacted]

[redacted][1]

Finding: Applied incorrect FMAP's, resulting in an overstatement of the Federal Share totaling $11,506.

[1] **Office of Inspector General Note:** This section of the State agency's comments is not applicable because the finding or issue referred to by the auditee is not included in this report.

Response: OHCA concurs with the $11,506 overstatement due to inaccurately applied FMAP's and will correct on the CMS 64.9 report for the quarter ended March 31, 2011.

Finding: Received an enhanced Family Planning Federal share totaling $126,613 for inpatient hospital expenditures, the appropriate amount of which could not be determined.

Response: OHCA does not concur with the finding. Section 1903(a) (5) of the Social Security Act and 42 CPR §§ 433.10 and 433.15 provide enhanced 90% FFP for Family Planning services. Pursuant to section 4270 of the CMS "State Medicaid Manual," Family Planning services prevent or delay pregnancy or otherwise control family size. According to the manual, 90% Federal funding is available for these services. CMS "Financial Management Review Guide Number 20" states that inpatient hospital costs must be allocated when multiple procedures are performed and at least one of those procedures is related to family planning. To comply with these requirements, Oklahoma developed a blended rate methodology to determine the Federal share of inpatient hospital family planning for claims containing multiple procedures performed during the same inpatient hospital stay.

To comply with CMS requirements regarding family planning services provided along with non-family planning services, the State developed a blended rate methodology to determine the Federal share of inpatient hospital claims containing multiple procedures (e.g., delivery and sterilization) performed during the same inpatient hospital stay. The methodology which was agreed to by CMS and met the requirements of the Medicaid Operations Letter 91-9 issued on January 30, 1991 is a fairly benign approach to allocating the costs of these inpatient services. OHCA MMIS first takes all inpatient claims with a primary diagnosis of family planning and counts those at the enhanced 90% rate, then those are excluded, so the universe now considers only those claims with a diagnosis of family planning found somewhere in the 2nd to 5th diagnosis range, those claims are totaled and assigned a blended rate that basically says of that total, 35 % can be attributed to family planning services and claimed at the 90% enhanced rate. This is actually a fairly low rate considering that at the time the rate was developed we paid a per diem for these stays with minimal diagnosis information past the primary. Additionally, 2009 data shows that Medicaid paid for 33,669 births (64.29% of the total in Oklahoma) and in that process, family planning services are addressed as a routine matter. Also, Oklahoma Medicaid serves females at the rate of 2.5 times that of a male, in the adult population. Females are far more likely to seek family planning services than males and generally the cost for these services are much higher in the female population. The State's blended rate is 35% during our audit period and was agreed to be reasonable by CMS and to meet the requirement of the 1980 memorandum on the subject that was included with 1991 guidance.

Finding: Claimed unallowable additional Program of Assertive Community Treatment (PACT) payments on Form CMS-64 in the amount of $2,761,361 (Federal Share $2,080,006).

Response: OHCA does not concur that the additional payment was not an allowable expenditure and eligible for Federal matching funds. The total payment of $2,761,361 was an allowable expenditure under the State Plan; Attachment 4.19-B entitled “Supplemental Payments for Behavioral Community Networks (BHCN)”. This section of the State Plan outlines eligibility criteria for such supplemental payments. The Plan states “in order to maintain access and sustain improvement in clinical and non-clinical care, supplemental payments will be made to BHCNs that meet the following criteria:

(a) Must be a freestanding governmental or private provider organization that is certified by and operates under the guidelines of the Oklahoma Department of Mental Health and Substance Services (DMHSAS) as a Community Mental Health Center (CMHC) and;

(b) Participates in behavioral quality improvement initiatives based on measures determined by and in a reporting format specified by the Medicaid agency.

All required and necessary criteria were met resulting in an allowable Medicaid expenditure eligible for Federal matching participation.

If you have any questions, or need any additional information, please do not hesitate to call me at (405) 522-7359.

Sincerely,

Carrie Evans
Chief Financial Officer
Oklahoma Health Care Authority