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

**Office of Audit Services, Region VII**
**601 East 12th Street, Room 0429**
**Kansas City, MO 64106**

August 18, 2010

Report Number: A-07-09-04146

Andrew Allison, Ph.D.
Executive Director
Kansas Health Policy Authority
Room 900-N Landon State Office Building
Topeka, KS 66612

Dear Dr. Allison:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Selected Claims Included in the Kansas Medicaid Family Planning Program*. 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 (816) 426-3591, or contact Debra Keasling, Audit Manager, at (816) 426-3213 or through email at Debra.Keasling@oig.hhs.gov. Please refer to report number A-07-09-04146 in all correspondence.

Sincerely,

/Patrick J. Cogley/
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 SELECTED CLAIMS INCLUDED IN THE KANSAS MEDICAID FAMILY PLANNING PROGRAM

Daniel R. Levinson
Inspector General

August 2010
A-07-09-04146

# *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:

## *Office of Audit Services*

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## *Office of Evaluation and Inspections*

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## *Office of Investigations*

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

---

**THIS REPORT IS AVAILABLE TO THE PUBLIC**
at http://oig.hhs.gov

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.

**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

### 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 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. In Kansas, the Kansas Health Policy Authority (State agency) is responsible for administering the Medicaid program.

The amount of funding that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or alternatively as the Federal share, is determined by the Federal medical assistance percentage (FMAP). The State agency's FMAP ranged from 59.43 percent to 68.31 percent for claims paid from July 1, 2005, through June 30, 2009.

Federal requirements also make provisions for various specified services to be reimbursed at higher (that is, enhanced) rates of FFP. Section 1903(a)(5) of the Act and 42 CFR §§ 433.10(c)(1) and 433.15(b)(2) authorize reimbursement at an enhanced 90-percent FFP rate for family planning services. Section 4270 of the CMS *State Medicaid Manual* defines family planning services as those that prevent or delay pregnancy or otherwise control family size.

For State fiscal years 2006 through 2009, the State agency was reimbursed $19,997,484 ($17,997,736 Federal share) for a variety of family planning services at the enhanced 90-percent FFP rate. Of this amount, we separately reviewed certain family planning costs totaling $13,977,885 ($12,580,097 Federal share) for specifically identified child delivery and newborn claims (A-07-10-04156), family planning pharmacy claims (A-07-10-04157), and family planning sterilization services (A-07-10-04162). Thus, this review covers the remaining $6,019,599 ($5,417,639 Federal share) for selected family planning claims, for which the State agency claimed reimbursement at the family planning enhanced 90-percent FFP rate.

### OBJECTIVE

Our objective was to determine whether the $6,019,599 ($5,417,639 Federal share) in selected family planning claims submitted by providers and claimed by the State agency at the enhanced 90-percent FFP rate from July 1, 2005, through June 30, 2009, were allowable pursuant to Federal requirements.

### SUMMARY OF FINDINGS

Not all of the selected family planning claims submitted by providers and claimed by the State agency at the enhanced 90-percent FFP rate from July 1, 2005, through June 30, 2009, were allowable pursuant to Federal requirements. Of the 100 claims in our statistical sample, 51 qualified as family planning services and could be claimed for reimbursement at the enhanced

90-percent FFP rate. However, the remaining 49 claims in our sample totaling $42,274 (Federal share) were not allowable for reimbursement at the enhanced 90-percent FFP rate because the services in question could not be claimed as family planning services pursuant to Federal requirements (1 claim had two types of errors). Specifically, of the 49 remaining claims, the State agency received unallowable reimbursement for:

- 42 claims unrelated to family planning,

- 6 claims that did not have adequate informed consent for sterilization (these claims were unrelated to those made for the sterilization services that we are reviewing separately (A-07-10-04162)), and

- 2 claims that lacked sufficient supporting documentation.

Based on the results of our sample, we estimated that the State agency received $589,355 in unallowable Federal reimbursement. Of the 49 claims for which the State agency received unallowable reimbursement, 42 could have been claimed for reimbursement at the standard FMAP rate that was applicable at the time the claim was paid. For those 42 claims, we calculated the correct Federal reimbursement using the standard FMAP rates. The remaining 7 claims containing errors were unallowable for Federal reimbursement.

These errors occurred because the Medicaid Management Information System's (MMIS) edits did not always correctly identify claims for reimbursement at the enhanced 90-percent FFP rate and because Medicaid guidelines regarding informed consent for sterilization were not always followed.

## RECOMMENDATIONS

We recommend that the State agency:

- refund $589,355 to the Federal Government; and

- strengthen internal controls to ensure that family planning services submitted for Federal reimbursement are accurate by:

    - ensuring that MMIS edits appropriately identify claims that are ineligible for reimbursement at the enhanced 90-percent FFP rate and

    - adhering to the Medicaid guidelines regarding informed consent for sterilization.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred that a refund is due to the Federal Government and stated that it would work with CMS "… to determine the timing and amount of that refund." The State agency also concurred with our second recommendation and described corrective actions, in the form of strengthened internal controls, that it had implemented or planned to implement. In addition, the State agency said that the strengthened internal controls that it had implemented would more appropriately address a portion of our second recommendation that had appeared in our draft report.

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

## OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we modified our final report by removing the portion of our second recommendation that had appeared in the draft report and about which the State agency had expressed concerns. The corrective actions that the State agency described in its comments should, when fully implemented, adequately address our findings, but we did not verify those corrective actions.

## 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 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.

### State of Kansas Medicaid Program

In Kansas, the Kansas Health Policy Authority (State agency) is responsible for administering the Medicaid program. The State agency contracts with HP Enterprise Services (formerly Electronic Data Systems) to maintain its Medicaid Management Information System (MMIS), a computerized payment and information reporting system that processes and pays Medicaid claims.

The amount of funding that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or alternatively as the Federal share, is determined by the Federal medical assistance percentage (FMAP). The State agency's FMAP ranged from 59.43 percent to 68.31 percent for claims paid from July 1, 2005, through June 30, 2009. Federal requirements also make provisions for various specified services to be reimbursed at higher (that is, enhanced) rates of FFP.

### Medicaid Coverage of Family Planning Services

Section 1905(a)(4)(C) of the Act requires States to furnish family planning services and supplies to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies. Section 1903(a)(5) of the Act and 42 CFR §§ 433.10(c)(1) and 433.15(b)(2) authorize reimbursement at an enhanced 90-percent FFP rate for family planning services.

Section 4270 of the CMS *State Medicaid Manual* (the manual) defines family planning services as those that prevent or delay pregnancy or otherwise control family size. In addition, this provision of the manual generally permits an enhanced 90-percent FFP rate for the following items and services: counseling services and patient education; examination and treatment by medical professionals pursuant to States' requirements; devices to prevent conception; and infertility services, including sterilization reversals. The manual further specifies that an abortion may not be claimed as a family planning service. Pursuant to the provisions of the manual, only items and procedures clearly furnished or provided for family planning purposes may be claimed at the enhanced 90-percent FFP rate.

CMS issued *Financial Management Review Guide Number 20* (the guide) to the State agency via Medicaid State Operations Letter 91-9. The guide states that any procedure provided to a woman known to be pregnant may not be considered a family planning service reimbursable at the enhanced 90-percent FFP rate.

The State agency's requirements define family planning services as any medically approved treatment, counseling, drugs, supplies, or devices which are prescribed, or furnished by a provider, to individuals of child-bearing age for purposes of enabling such individuals to freely determine the number and spacing of their children.

For State fiscal years 2006 through 2009, the State agency was reimbursed $19,997,484 ($17,997,736 Federal share) for a variety of family planning services at the enhanced 90-percent FFP rate. Of this amount, we separately reviewed certain family planning costs totaling $13,977,885 ($12,580,097 Federal share) for specifically identified child delivery and newborn claims (A-07-10-04156), family planning pharmacy claims (A-07-10-04157), and family planning sterilization services (A-07-10-04162). Thus, this review covers the remaining $6,019,599 ($5,417,639 Federal share) for selected family planning claims, for which the State agency claimed reimbursement at the family planning enhanced 90-percent FFP rate.

### Medicaid Management Information System

Providers enrolled in the Medicaid program submit claims for payment to the State agency's MMIS, which is maintained by the State agency's fiscal agent. The State agency furnishes to providers an MMIS provider manual that contains instructions for the proper completion and submission of claims. The provider must complete certain fields on the electronic claim form to indicate the type of service provided.

The MMIS uses a variety of indicators on the electronic claim form to identify family planning services that are eligible for reimbursement at the enhanced 90-percent FFP rate. In addition, the State agency's MMIS uses edits and logic to verify that the provider correctly selected the appropriate indicator. If these edits revealed that the provider selected a family planning indicator for services unrelated to family planning services, the claim was returned to the provider for correction and resubmission. If the MMIS logic verified that the provider correctly selected the appropriate indicator, those services were reported to CMS for the appropriate amount of Federal reimbursement.

## OBJECTIVE, SCOPE, AND METHODOLOGY

### Objective

Our objective was to determine whether the $6,019,599 ($5,417,639 Federal share) in selected family planning claims submitted by providers and claimed by the State agency at the enhanced 90-percent FFP rate from July 1, 2005, through June 30, 2009, were allowable pursuant to Federal requirements.

## Scope

We reviewed $6,019,599 ($5,417,639 Federal share) of State agency claims related to family planning services in Kansas from July 1, 2005, through June 30, 2009. We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at the State agency's offices in Topeka, Kansas, from July 2009 through February 2010.

## Methodology

To accomplish our objective, we did the following:

- We reviewed Federal laws, regulations, guidance and the State plan.

- We held discussions with CMS officials and acquired an understanding of CMS requirements and guidance furnished to State agency officials concerning Medicaid family planning claims.

- We held discussions with State agency officials to ascertain State agency policies, procedures, and guidance for claiming Medicaid reimbursement for family planning services.

- We reconciled current period and prior period family planning claims reported on the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report),[1] back to the State agency's supporting documentation.

- We obtained a database of paid claims for the Family Planning program that were submitted by Medicaid providers in the State of Kansas for the period July 1, 2005, through June 30, 2009. The database contained 211,496 claim lines totaling $19,993,630. The Medicaid claim lines were extracted from the paid claims' database maintained by the State agency's fiscal agent. We then removed (1) claims for child delivery and newborn inpatient services, and for family planning prescription drugs because we reviewed these in separate reports, and (2) zero-paid claims which taken together left 48,264 claims lines totaling $6,019,599 remaining.

- We selected a stratified random sample of 100 claims from the 48,264 Family Planning Program claims (see Appendix A).

- We obtained and reviewed the supporting documentation for each sampled claim to determine the allowability of the claim.

[1] The CMS-64 report summarizes actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures.

- We provided the results of our review to State agency officials on March 17, 2010. In addition, we provided the State agency officials with the medical documents related to the 49 claims not eligible for the 90-percent FFP rate.

Appendixes A and B contain the details of our sampling and projection methodologies.

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 objective.

## FINDINGS AND RECOMMENDATIONS

Not all of the selected family planning claims submitted by providers and claimed by the State agency at the enhanced 90-percent FFP rate from July 1, 2005, through June 30, 2009, were allowable pursuant to Federal requirements. Of the 100 claims in our sample, 51 qualified as family planning services and could be claimed for reimbursement at the enhanced 90-percent FFP rate. However, the remaining 49 claims in our sample totaling $42,274 (Federal share) were not allowable for reimbursement at the enhanced 90-percent FFP rate because the services in question could not be claimed as family planning services pursuant to Federal requirements (1 claim had two types of errors). Specifically, of the 49 remaining claims, the State agency received unallowable reimbursement for:

- 42 claims unrelated to family planning,
- 6 claims that did not have adequate informed consent for sterilization,[2] and
- 2 claims that lacked sufficient supporting documentation.

Based on the results of our sample, we estimated that the State agency received $589,355 in unallowable Federal reimbursement. Of the 49 claims for which the State agency received unallowable reimbursement, 42 could have been claimed for reimbursement at the standard FMAP rate that was applicable at the time the claim was paid. For those 42 claims, we calculated the correct Federal reimbursement using the standard FMAP rates. The remaining 7 claims containing errors were unallowable for Federal reimbursement.

These errors occurred because the MMIS's edits did not always correctly identify claims for reimbursement at the enhanced 90-percent FFP rate and because Medicaid guidelines regarding informed consent for sterilization were not always followed.

[2] These claims were unrelated to those made for the sterilization services that we are reviewing separately (A-07-10-04162).

## UNALLOWABLE FAMILY PLANNING SERVICES

### Services Unrelated to Family Planning

Section 1903(a)(5) of the Act and 42 CFR §§ 433.10(c)(1) and 433.15(b)(2) authorize enhanced 90-percent Federal reimbursement for family planning services. Section 4270 of the manual defines family planning services as those that prevent or delay pregnancy or otherwise control family size. The manual states that only items and procedures clearly furnished or provided for family planning purposes may be claimed at the enhanced 90-percent FFP rate.

Contrary to these Federal requirements and guidelines, the State agency improperly claimed Federal reimbursement for costs associated with 42 services unrelated to family planning that were not allowable for reimbursement at the enhanced 90-percent FFP rate. The documentation contained in the medical files revealed that provider services unrelated to family planning had been rendered in these cases. For example, some of the unrelated services were for infection, obstetric care, echocardiogram, and appendectomy (refer to Appendixes C and D for the full list of unallowable services identified). Therefore, the costs related to the 42 claims were not allowable for reimbursement at the Family Planning Program's enhanced 90-percent FFP rate.

### Inadequate Informed Consent

42 CFR § 441.253(d) requires that at least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. These Federal regulations also state that an individual may consent to be sterilized at the time of a premature delivery if at least 72 hours have passed since she gave informed consent for the sterilization. In addition, the informed consent must have been given at least 30 days before the expected date of delivery. In addition, 42 CFR § 441.258(b) requires the consent form to be signed and dated by (1) the individual to be sterilized; (2) the interpreter, if one is provided; (3) the person who obtained the consent; and (4) the physician who performed the sterilization procedure. Section 8340 of the *Kansas Medicaid Hospital Manual* states that if the informed consent guidelines are not completely followed, the claim will be denied. These guidelines require that all data fields be completed and that the physician's statement on the sterilization consent form be signed and dated no more than two days prior to the surgery.

Contrary to these Federal requirements and guidelines, the State agency improperly claimed Federal reimbursement for six claims that were not allowable for reimbursement and should be denied.[3] Specifically,

- for two claims, informed consent was given on the same day as the sterilization procedure;

[3] Although these six claims were for sterilization procedures, our finding in this report focuses on the issue of informed consent. Accordingly, neither these six claims nor the costs associated with them bear upon the claims for the sterilization services that we are reviewing separately (A-07-10-04162).

- for one claim, the provider was not able to furnish us with a consent for sterilization;
- for one claim, the physician did not sign the consent form;
- for one claim, the physician did not date the consent form; and
- for one claim, the physician signed the consent form more than two days before the procedure.

Therefore, the costs related to the six claims were not allowable for reimbursement and should have been denied.

**Lack of Documentation**

Section 1902(a)(27) of the Act and 42 CFR §§ 431.17 and 433.32 require that services claimed for Federal Medicaid reimbursement be documented.

Contrary to these Federal requirements, the State agency improperly claimed Federal reimbursement for two claims that were not allowable for reimbursement and should have been denied because the providers could not provide documentation to support the services billed. Therefore, the costs related to the two claims were not allowable for reimbursement.

## CAUSES OF THE OVERPAYMENTS

The MMIS's edits did not always correctly identify claims for reimbursement at the enhanced 90-percent FFP rate. To classify family planning claims, the State agency's MMIS has edits and logic to identify family planning claims. However, the logic and edits used by the State agency's MMIS were not sufficient to correctly identify family planning claims.

## UNALLOWABLE FAMILY PLANNING CLAIMS

Our stratified random sample found 49 claims with errors totaling $42,274 (Federal share) of unallowable Federal reimbursement. Of these claims, 42 could, however, have been claimed for reimbursement at the standard FMAP rate that was applicable at the time the claim was paid. For those 42 claims, we calculated the correct Federal reimbursement using the standard FMAP rates. The remaining 7 claims containing errors were unallowable for Federal reimbursement.[4] Based on the results of our statistical sample, we estimated that the State agency received $589,355 in unallowable Federal reimbursement.

[4] One claim had two types of errors and thus could be included as an error in both categories of reimbursement allowability mentioned just above. The first error involved the fact that part of the claim was for a sterilization procedure; this part of the claim was unallowable for Federal reimbursement. The second error involved the fact that a service was claimed as a family planning service at the enhanced 90-percent FFP rate but was actually allowable for Federal reimbursement only at the standard FMAP rate. (See sample item 4 in Appendix C.) For purposes of determining the questioned costs, this claim was included with the 42 claims that could have received reimbursement at the standard FMAP rate and was not included with the 7 claims for which Federal reimbursement was entirely unallowable.

## RECOMMENDATIONS

We recommend that the State agency:

- refund $589,355 to the Federal Government; and

- strengthen internal controls to ensure that family planning services submitted for Federal reimbursement are accurate by:

    - ensuring that MMIS edits appropriately identify claims that are ineligible for reimbursement at the enhanced 90-percent FFP rate and

    - adhering to the Medicaid guidelines regarding informed consent for sterilization.

## STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred that a refund is due to the Federal Government and stated that it would work with CMS "… to determine the timing and amount of that refund." The State agency also concurred with our second recommendation and described corrective actions, in the form of strengthened internal controls, that it had implemented or planned to implement. Specifically, the State agency said that it had implemented policy changes to correct the family planning claims process within the MMIS and that it would update policy requirements regarding Medicaid informed consent guidelines for sterilization.

In addition, the State agency provided comments regarding a portion of the second recommendation as it appeared in our draft report. The State agency said that the strengthened internal controls that it had implemented would correct the MMIS edits and ensure that services unrelated to family planning are not claimed at the 90-percent FFP rate. The State agency expressed concern that that portion of our second recommendation could add "… undue burden on providers …" and create "… a potential source of error in the state funding process." The State agency added that the MMIS-based methodology that formed the basis of its corrective actions would more appropriately address that portion of our second recommendation and would offer "… the best mix of accuracy and efficiency in the family planning claims' process."

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

## OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we modified our final report by removing the portion of our second recommendation that had appeared in the draft report and about which the State agency had expressed concerns. The corrective actions that the State agency described in its comments should, when fully implemented, adequately address our findings, but we did not verify those corrective actions.

# APPENDIXES

# APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

## POPULATION

The population consists of paid family planning claims for which the Kansas Health Policy Authority (State agency) received reimbursement at the enhanced 90-percent Federal financial participation (FFP) rate for services furnished to Medicaid beneficiaries and claimed during the period July 1, 2005, through June 30, 2009.

## SAMPLING FRAME

We obtained a database of paid claims for the Kansas Medicaid Family Planning Program that were submitted by the Medicaid providers of the State of Kansas, for the period July 1, 2005, through June 30, 2009. The database contained 211,496 claim lines totaling $19,993,630. The Medicaid claim lines were extracted from the paid claims' database maintained by the State agency's fiscal agent.

We extracted 3,633 inpatient claim lines for child delivery and newborn inpatient services, and 133,810 prescription drug claim lines, and created a separate database. We reviewed claims associated with these services in separate audits. The remaining 74,053 claim lines were reduced by 4,237 zero-paid claim lines and 2,114 voided claim lines, leaving 67,675 claim lines, which we converted to 48,291 claims. We removed 27 claims that were less than zero, leaving 48,264 claims totaling $6,019,599, of which the Federal share is $5,417,639.

The claims were extracted by our advanced audit techniques staff from the State agency's Medicaid claim files provided to us by the State agency's fiscal agent from the Medicaid Management Information System.

## SAMPLE UNIT

Sampling unit was a paid claim for Medicaid Family Planning services.

## SAMPLE DESIGN

We used a stratified random sample with each stratum defined by paid amounts as shown below:

Stratum One: $1,000 and more – 230 paid claims
Stratum Two: $999.99 and less – 48,034 paid claims.

## SAMPLE SIZE

One hundred sample units (paid claims) were selected for review.

## SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services, statistical software (RAT-STATS).

## ESTIMATION METHODOLOGY

We used RAT-STATS to estimate the unallowable payments for Medicaid family planning services.

## APPENDIX B: SAMPLE RESULTS AND ESTIMATES

### Sample Results

| Stratum | Frame Size | Value of Frame (Federal Share) | Sample Size | Value of Sample (Federal Share) | Number of Incorrectly Paid Claims | Value of Incorrectly Paid Claims (Federal Share) |
|---|---|---|---|---|---|---|
| Paid claims of $1,000 and more | 230 | $928,711 | 30 | $116,211 | 30 | $40,797 |
| Paid claims of $999.99 and less | 48,034 | 4,488,928 | 70 | 6,510 | 19 | 1,477 |
| **Totals** | **48,264** | **$5,417,639** | **100** | **$122,721** | **49** | **$42,274** |

### Estimated Value of Incorrectly Paid Claims

(Limits Calculated for a 90 Percent Confidence Interval)

| | |
|---|---|
| **Point Estimate:** | $1,326,509 |
| **Lower Limit:** | **$589,355** |
| **Upper Limit:** | $2,063,663 |

## APPENDIX C: SUMMARY OF THE STATISTICAL SAMPLE – STRATA 1

| SAMPLE ITEM | CMS64[1] ICN[2] | QUALIFY AS FAMILY PLANNING? | PROCEDURE NOT RELATED TO FAMILY PLANNING | INADEQUATE INFORMED CONSENT | IDENTIFIED SERVICE BASED UPON ADMITTING DIAGNOSIS | AMOUNT OF CLAIM |
|---|---|---|---|---|---|---|
| 1 | 2006215011767 | No | X | | JOINT PAIN-PELVIS | $5,443.58 |
| 2 | 6006293006332 | No | X | | SUPERVIS OTH NORMAL PREG | $1,326.89 |
| 3 | 6006299003198 | No | X | | DELIVER-SINGLE LIVEBORN | $1,326.89 |
| 4[3] | 6006025005504 | No | X | | HYPERTENSION | $492.65 |
| 4 | 6006025005504 | No | | X | STERILIZATION | $594.63 |
| 5 | 6006333005781 | No | X | | DELIVER-SINGLE LIVEBORN | $1,326.89 |
| 6 | 2006361020396 | No | X | | CENTRAL NERVOUS SYSTEM COMPLICATOIN IN DELIVERY – ANTEPARTUM | $5,095.90 |
| 7 | 6006333005778 | No | X | | DELIVER-SINGLE LIVEBORN | $1,496.23 |
| 8 | 6006159006369 | No | X | | DELIVER-SINGLE LIVEBORN | $1,326.89 |
| 9 | 6006125007432 | No | X | | DELIVER-SINGLE LIVEBORN | $1,326.89 |
| 10 | 6007085000478 | No | X | | DELIVER-SINGLE LIVEBORN | $1,326.89 |
| 11 | 6006172000428 | No | X | | DELIVER-TWINS BOTH LIVE | $1,496.23 |
| 12 | 5207064006088 | No | X | | ABDMNAL PAIN UNSPCF SITE | $25,129.83 |
| 13 | 1106271002482 | No | | X | STERILIZATION | $2,854.87 |
| 14 | 6006125006875 | No | X | | DELIVER-SINGLE LIVEBORN | $1,326.89 |
| 15 | 2008330010208 | No | X | | OVARIAN CYST | $5,694.20 |
| 16 | 6006349006221 | No | X | | DELIVER-SINGLE LIVEBORN | $1,326.89 |
| 17 | 2006164000130 | No | X | | ABDMNAL PAIN UNSPCF SITE | $5,515.17 |

[1] The standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS64), summarizes actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures.

[2] Internal Control Number

[3] Sample item 4 contained two errors.

| SAMPLE ITEM | CMS64 ICN | QUALIFY AS FAMILY PLANNING? | PROCEDURE NOT RELATED TO FAMILY PLANNING | INADEQUATE INFORMED CONSENT | IDENTIFIED SERVICE BASED UPON ADMITTING DIAGNOSIS | AMOUNT OF CLAIM |
|---|---|---|---|---|---|---|
| **18** | 6006114002829 | No | X | | ABDMNAL PAIN UNSPCF SITE | $4,448.91 |
| **19** | 2006262019626 | No | X | | CELLULITIS OF FOOT | $5,095.90 |
| **20** | 6006099000333 | No | X | | DELIVER-SINGLE LIVEBORN | $1,326.89 |
| **21** | 6006195005676 | No | X | | DELIVER-SINGLE LIVEBORN | $1,496.23 |
| **22** | 6006293006370 | No | X | | SUPERVIS OTH NORMAL PREG | $1,326.89 |
| **23** | 2006156004628 | No | X | | OVARIAN CYST | $5,928.02 |
| **24** | 6006349006252 | No | X | | DELIVER-SINGLE LIVEBORN | $1,326.89 |
| **25** | 1106331005579 | No | | X | STERILIZATION | $2,843.55 |
| **26** | 2007142022014 | No | X | | PAIN IN LIMB | $815.39 |
| **27** | 2006354014749 | No | X | | NAUSEA WITH VOMITING | $20,681.41 |
| **28** | 6006099000332 | No | X | | DELIVER-SINGLE LIVEBORN | $1,496.23 |
| **29** | 2006342031617 | No | X | | ULCER OTHER PART OF FOOT | $1,040.80 |
| **30** | 2009083009714 | No | X | | SHORTNESS OF BREATH | $16,867.72 |

# APPENDIX D: SUMMARY OF THE STATISTICAL SAMPLE – STRATA 2

| SAMPLE ITEM | CMS64[1] ICN[2] | QUALIFY AS FAMILY PLANNING? | PROCEDURE NOT RELATED TO FAMILY PLANNING | INADEQUATE INFORMED CONSENT | UNABLE TO PROVIDE MEDICAL RECORDS | IDENTIFIED SERVICE BASED UPON ADMITTING DIAGNOSIS | AMOUNT OF CLAIM |
|---|---|---|---|---|---|---|---|
| 1 | 1005151002447 | No | X | | | NECROT ENTEROCOLITIS | $136.48 |
| 2 | 1005151003109 | No | | X | | ARTIFICIAL RUPTURE MEMBRANE - DELIVERY | $378.58 |
| 3 | 1005152001144 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $40.50 |
| 4 | 1005158003431 | No | | X | | STERILIZATION | $607.09 |
| 5 | 1005166002493 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $10.13 |
| 6 | 1005175001263 | No | | | X | CONTRACEPTIVE MANGMT | $7.43 |
| 7 | 1005175001665 | No | | | X | CERVICALGIA | $7.43 |
| 8 | 5205242000001 | No | X | | | ECTOPIC PREGNANCY | $170.60 |
| 9 | 1005175002274 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $46.68 |
| 10 | 1005175002453 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $46.68 |
| 11 | 1005175002529 | No | X | | | OVARIAN CYST | $52.30 |
| 12 | 1005175002767 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $54.13 |
| 13 | 1005175002771 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $17.00 |
| 14 | 1005175002773 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $24.43 |
| 15 | 1005178001407 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $54.00 |
| 16 | 1005178001408 | No | X | | | CONTRACEPT PILL SURVEILLANCE | $37.43 |
| 17 | 1005178001409 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $50.00 |

[1] The standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS64), summarizes actual Medicaid expenditures for each quarter and is used by CMS to reimburse States for the Federal share of Medicaid expenditures.

[2] Internal Control Number

| SAMPLE ITEM | CMS64[1] ICN[2] | QUALIFY AS FAMILY PLANNING? | PROCEDURE NOT RELATED TO FAMILY PLANNING | INADEQUATE INFORMED CONSENT | UNABLE TO PROVIDE MEDICAL RECORDS | IDENTIFIED SERVICE BASED UPON ADMITTING DIAGNOSIS | AMOUNT OF CLAIM |
|---|---|---|---|---|---|---|---|
| 18 | 1005178001430 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $52.80 |
| 19 | 1005178001463 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $82.44 |
| 20 | 1005178001791 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $52.30 |
| 21 | 1005178001797 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $40.00 |
| 22 | 5205242000002 | No | X | | | APPENDICITIS | $168.30 |
| 23 | 1005178003203 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $52.80 |
| 24 | 5205242000003 | No | X | | | OVARIAN CYST | $238.84 |
| 25 | 1005179001195 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $31.70 |
| 26 | 5205242000005 | No | X | | | MILD DYSPLASIA OF CERVIX | $119.42 |
| 27 | 1005179002166 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $23.34 |
| 28 | 1005179003759 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $59.44 |
| 29 | 1005179003805 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $431.09 |
| 30 | 1005179004043 | No | | X | | STERILIZATION | $17.00 |
| 31 | 1005179004049 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $59.44 |
| 32 | 5205242000006 | No | X | | | UTERINE PROLAPSE | $238.84 |
| 33 | 1005180001283 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $7.43 |
| 34[3] | 1005180001336 | No | X | | | PREGNATE STATE INCIDENTAL | $106.68 |
| 34 | 1005180001336 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $23.34 |
| 35 | 1005180001354 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $23.34 |
| 36 | 1005180001561 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $50.00 |

[3] Sample item 34 included two procedures.

| SAMPLE ITEM | CMS64[1] ICN[2] | QUALIFY AS FAMILY PLANNING? | PROCEDURE NOT RELATED TO FAMILY PLANNING | INADEQUATE INFORMED CONSENT | UNABLE TO PROVIDE MEDICAL RECORDS | IDENTIFIED SERVICE BASED UPON ADMITTING DIAGNOSIS | AMOUNT OF CLAIM |
|---|---|---|---|---|---|---|---|
| 37 | 1005180001576 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $36.35 |
| 38 | 1005180001582 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $50.00 |
| 39 | 1005180001589 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $50.00 |
| 40 | 1005180001590 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $24.04 |
| 41 | 1005180001592 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $465.54 |
| 42 | 1005180001594 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $24.04 |
| 43 | 1005180001595 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $465.54 |
| 44 | 5905228001091 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $31.47 |
| 45 | 1005180001712 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $46.68 |
| 46 | 5205242000007 | No | X | | | FEMALE GENITAL SYMPTOMS | $187.66 |
| 47 | 1005181000543 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $31.70 |
| 48 | 1005181000555 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $31.70 |
| 49 | 1005181000557 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $31.70 |
| 50 | 1005181001048 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $52.80 |
| 51 | 1005181002283 | No | X | | | ROUTINE GYNECOLOGICAL | $17.00 |
| 52 | 1005181002340 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $47.55 |
| 53 | 5205242000010 | No | X | | | HEMATURIA | $102.36 |
| 54 | 1005182001031 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $67.86 |
| 55 | 1005182001307 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $36.00 |

| SAMPLE ITEM | CMS64[1] ICN[2] | QUALIFY AS FAMILY PLANNING? | PROCEDURE NOT RELATED TO FAMILY PLANNING | INADEQUATE INFORMED CONSENT | UNABLE TO PROVIDE MEDICAL RECORDS | IDENTIFIED SERVICE BASED UPON ADMITTING DIAGNOSIS | AMOUNT OF CLAIM |
|---|---|---|---|---|---|---|---|
| 56 | 1005182001322 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $40.00 |
| 57 | 1005186001089 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $82.44 |
| 58 | 1005186001550 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $40.00 |
| 59 | 1005186001746 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $20.00 |
| 60 | 1005186001780 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $67.86 |
| 61 | 1005187001681 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $69.80 |
| 62 | 1005187001683 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $81.58 |
| 63 | 1005188000395 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $40.00 |
| 64 | 5205242000011 | No | X | | | ACUTE APPENDICITIS | $170.60 |
| 65 | 5205242000012 | No | X | | | ABSCESS OF APPENDIX | $187.66 |
| 66 | 1005188000545 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $52.80 |
| 67 | 1005188000848 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $431.09 |
| 68 | 1005188000938 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $74.47 |
| 69 | 1005188001457 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $378.58 |
| 70 | 1005188002011 | Yes | | | | ALLOWABLE FAMILY PLANNING SERVICE | $76.84 |

# APPENDIX E: STATE AGENCY COMMENTS

Coordinating health & health care for a thriving Kansas

KHPA™

KANSAS HEALTH POLICY AUTHORITY

July 13, 2010

Patrick Cogley
Regional Inspector General
601 East 12th Street
Room 0429
Kansas City, Missouri 64106

Dear Mr. Cogley:

The Kansas Health Policy Authority (KHPA) has received the draft report entitled Review of Family Planning Pharmacy Claims Submitted by Selected Providers under the State of Kansas Medicaid Program (Report A-07-09-04146).

The report recommends that KHPA:

- refund $589,355 to the Federal Government; and
- strengthen internal controls to ensure that family planning services submitted for Federal reimbursement are accurate by:
  - ensuring that MMIS edits appropriately identify claims that are ineligible for reimbursement at the enhanced 90-percent FFP rate,
  - adhering to the Medicaid guidelines regarding informed consent for sterilization, and
  - instructing the medical providers to submit family planning claims separately, and to mark the family planning indicator only for family planning services.

*KHPA Response:*

KHPA concurs that a refund is due to the Federal Government and will work with CMS to determine the timing and the amount of that refund.

KHPA also concurs with the OIG's second recommendation to strengthen controls within the MMIS, and on June 18, 2010 implemented a policy change to correct the Family Planning claim process within the MMIS. This policy explicitly defines a finite set of diagnosis code and procedure code

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
www.khpa.ks.gov

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health Plan:
Phone: 785-368-6361
Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

combinations that allow a (non-pharmacy) claim to be processed with the enhanced family planning FFP rate. Any claim that does not have the required diagnosis and procedure code combination will pay at the standard FFP rate. All claims are considered to be ineligible for the enhanced FFP rate by default unless the correct combination of diagnosis and procedure code is present on the claim. The family planning indicator was removed from the claim submission and replaced with the coding logic described above. KHPA believes that this change meets the intent of the second recommendation to ensure that MMIS edits appropriately identify claims not eligible for enhanced FFP.

KHPA will also update policy requirements regarding Medicaid informed consent guidelines for sterilization. Any claim submitted without meeting the consent requirements will be denied. KHPA will continue to work and offer training to providers regarding the informed consent guidelines for sterilization. KHPA will start recouping efforts of the monies from providers who are not adhering to the federal guidelines of consent forms.

The OIG's final recommendation is characterized as a strengthening of internal controls, but would require that providers determine which claims were eligible for federal family planning funds through Medicaid, and then mark those claims separately with a family planning indicator The indicator does not have an impact on the legitimacy of a claim, nor the amount of reimbursement for the claim, making it of questionable value to the provider and a potential source of error in the state funding process. A provider's check mark on the claim form is likely to be an unreliable and inconsistent indicator to determine which services should be funded with enhanced Federal matching dollars. It is the responsibility of states and the federal government, respectively, to determine their appropriate shares of funding for claims, and this process is best addressed through internal controls. As a result, the policy changes implemented on June 18, 2010 remove the family planning indicator on the claim form, and add new system logic to remove the provider from the process of identifying family planning services eligible for enhanced FFP. The identification of family planning services takes place in the coding and editing of the MMIS as claims process, which has the advantage of preventing claims of enhanced FFP for services the provider could have misidentified as being related to family planning. KHPA believes the MMIS-based methodology offers the best mix of accuracy and efficiency in the family planning claims process.
The OIG final recommends would also require providers to submit claims for family planning services separately. As a matter of policy, KHPA does not specify how providers should combine services or divide services for purposes of submitting a claim for payment. The MMIS allows providers to submit claims that represent a complete medical appointment or treatment episode. Requiring an artificial break in the claim to separate family planning services is inconsistent with common medical billing practice and adds undue burden on providers. KHPA believes the edits implemented in June appropriately identify services eligible for enhanced FFP, and prevent inadvertent claims of enhanced FFP for services that are inconsistent with Family Planning guidelines.

KHPA lacks the resources to audit every aspect of the Medicaid program at this level of detail, and recognizes the contribution that this and other external audits make to the integrity of the program. KHPA appreciates the efforts of the OIG staff in conducting this audit and their willingness to discuss issues during the audit process. Thank you for the opportunity to respond to this draft audit report.

Sincerely,

Andrew Allison, PhD
Executive Director