Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MISSOURI INCORRECTLY CLAIMED FEDERAL REIMBURSEMENT FOR INPATIENT CLAIMS WITH STERILIZATION AND DELIVERY PROCEDURES FOR CALENDAR YEARS 2009 AND 2010

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Patrick J. Cogley
Regional Inspector General

March 2013
A-07-12-01121

Office of Inspector General

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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 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 Missouri, the Department of Social Services, Missouri HealthNet Division (the State agency), is responsible for administering the Medicaid program.

Consistent with this responsibility, the State agency submits to CMS, on a quarterly basis, its standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to report Medicaid expenditures for Federal reimbursement.

The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation or Federal share, is determined by the Federal medical assistance percentage (FMAP). The FMAP is a variable rate that is based on a State's relative per capita income. The State agency's FMAP ranged from 71.24 percent to 74.43 percent for claims paid during calendar years (CY) 2009 and 2010.

Federal requirements authorize Federal reimbursement at an enhanced 90-percent rate (90-percent rate) for family planning services, which include services that prevent or delay pregnancy or otherwise control family size and may also include sterilization procedures. When sterilization and delivery procedures are performed during a single hospital stay, CMS requires that the State agency's claim for Federal reimbursement distinguish between those costs attributable to family planning (eligible for Federal reimbursement at the 90-percent rate) and those costs attributable to other covered services (reimbursed at the FMAP).

During CYs 2009 and 2010, the State agency reported costs of $5,314,666 for 2,919 inpatient claims with sterilization and delivery procedures. These costs served as the State agency's basis for claiming Federal reimbursement.

OBJECTIVE

Our objective was to determine whether the inpatient claims with sterilization and delivery procedures that the State agency claimed as family planning services for CYs 2009 and 2010 qualified for Federal reimbursement at the 90-percent rate.

SUMMARY OF FINDING

None of the 2,919 inpatient claims with sterilization and delivery procedures that the State agency claimed as family planning services for CYs 2009 and 2010 qualified for Federal

reimbursement at the 90-percent rate. The State agency claimed costs for both procedures at the 90-percent rate on the CMS-64 reports. Because the State agency did not distinguish between the costs for family planning services (eligible for Federal reimbursement at the 90-percent rate) and those for non-family planning services (reimbursed at the FMAP), the State agency is not entitled to Federal reimbursement at the 90-percent rate for any of the claims.

The difference between the amounts associated with these two rates was $862,398, which represents excess Federal reimbursement for the 2,919 family planning inpatient claims.

This excess Federal reimbursement occurred because the State agency had not implemented policies and procedures to ensure that it claimed Medicaid costs for inpatient claims with sterilization and delivery procedures pursuant to Federal requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund $862,398 to the Federal Government,
- review costs for inpatient claims with sterilization and delivery procedures for quarterly reporting periods after our audit period and refund any overpayments to the Federal Government, and
- work with CMS to develop and implement policies and procedures that include a reasonable methodology to ensure that costs for inpatient claims with sterilization and delivery procedures are claimed pursuant to Federal requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our third recommendation but disagreed with our first and second recommendations. With respect to the claimed costs that we are questioning, the State agency said that its policy "…was to claim the entire inpatient claim at the ninety percent rate. Therefore, [the State agency] believes it is unreasonable to not allow any of the claims, or portion thereof, to be claimed at the ninety percent rate."

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in the State agency's comments caused us to change our findings or recommendations.

We acknowledge that the 2,919 inpatient claims that we reviewed contained sterilization procedures and that the associated costs were eligible for Federal reimbursement at the 90-percent rate—but only when claimed in accordance with Federal requirements. Specifically, in each instance when sterilization and delivery procedures were performed during a single hospital stay, a State Medicaid agency must distinguish between the cost for a sterilization procedure and the cost for a delivery. Moreover, the U.S. Department of Health and Human Services, Departmental Appeals Board, has ruled in a similar circumstance that without a reasonable

method to distinguish these costs, a State Medicaid agency is not entitled to Federal reimbursement at the 90-percent rate.

Because the State agency did not distinguish between these costs, we maintain that the State agency is not entitled to Federal reimbursement at the 90-percent rate for any portion of these claims.

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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.

States use the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter and CMS uses it to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must represent actual expenditures and be supported by documentation.

Missouri Medicaid Program

In Missouri, the Department of Social Services, Missouri HealthNet Division (the State agency), is responsible for administering the Medicaid program. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP). The FMAP is a variable rate that is based on a State's relative per capita income. The State agency's FMAP ranged from 71.24 percent to 74.43 percent for claims paid during calendar years (CY) 2009 and 2010.

The State agency uses its Medicaid Management Information System (MMIS) to process claims. MMIS is a computerized payment and information reporting system that States are required to use to process and pay Medicaid claims.

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 Federal reimbursement at an enhanced 90-percent rate (90-percent rate) for family planning services.

Section 4270 of the CMS *State Medicaid Manual* (the manual) describes family planning services as those that prevent or delay pregnancy or otherwise control family size. Family planning services include, but are not limited to, the following items and services: counseling services and patient education, examination and treatment by medical professionals in

accordance with States' requirements, devices to prevent conception, and sterilization procedures; and may include infertility services, including sterilization reversals.

The CMS *Financial Management Review Guide Number 20*: *Family Planning Services* (the guide) provides specific instructions for performing financial management reviews of claims for family planning services. The guide, published in 2002, incorporates by reference a 1980 memorandum on CMS's policy for allocating family planning inpatient hospital costs in cases when multiple procedures are performed. The guide also incorporates the 1991 U.S. Department of Health and Human Services, Departmental Appeals Board (DAB), Decision No. 1284 which addresses the methodology for allocating these costs in cases when multiple procedures are performed.

Family Planning Inpatient Sterilization Procedure Claims in Missouri

The State agency used computer programs to identify family planning inpatient claims according to diagnosis and procedure codes. The programs accessed the MMIS, which contains records of paid claims, and produced reports that listed claims with family planning services. Each month, the State agency generated a document called a sterilization report, which included inpatient claims that included sterilization procedures. This report listed, in summary format, the total costs for these claims and did not distinguish between the costs for family planning services and those for non-family planning services. The State agency used these reports for claiming family planning inpatient sterilization expenditures for Federal reimbursement on the CMS-64 reports.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the inpatient claims with sterilization and delivery procedures that the State agency claimed as family planning services for CYs 2009 and 2010 qualified for Federal reimbursement at the 90-percent rate.

Scope

We reviewed 2,919 inpatient claims with sterilization procedures for CYs 2009 and 2010 for which the State agency claimed costs totaling $5,314,666. We reviewed the FFP rates used to calculate the Federal reimbursement that the State agency received from its claimed expenditures, but we did not review the medical necessity of the claims. Further, we did not review the overall internal control structure of the State agency or the Medicaid program. We reviewed only the internal controls that pertained directly to our objectives.

We performed fieldwork at the State agency's offices in Jefferson City, Missouri, from January through May 2012.

Methodology

To accomplish our objective, we:

- reviewed Federal laws, regulations, and guidance and the State plan;

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

- held discussions with State agency officials to gain an understanding of how the State agency claimed Medicaid reimbursement for family planning inpatient sterilization procedures;

- reconciled a list of inpatient claims with sterilization and delivery procedures with the State agency's sterilization reports and with the amounts claimed on the CMS-64 reports, and for these claims:

    - identified the costs that the State agency claimed for reimbursement at the 90-percent rate and

    - calculated the amounts associated with the difference between the 90-percent rate and the FMAP; and

- discussed the results of our review with State agency officials and provided them with a list of questioned costs by quarter on August 30, 2012.

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 finding and conclusions based on our audit objectives.

FINDING AND RECOMMENDATIONS

None of the 2,919 inpatient claims with sterilization and delivery procedures that the State agency claimed as family planning services for CYs 2009 and 2010 qualified for Federal reimbursement at the 90-percent rate. The State agency claimed costs for both procedures at the 90-percent rate on the CMS-64 reports. Because the State agency did not distinguish between the costs for family planning services (eligible for Federal reimbursement at the 90-percent rate) and those for non-family planning services (reimbursed at the FMAP), the State agency is not entitled to Federal reimbursement at the 90-percent rate for any of the claims.

The difference between the amounts associated with these two rates was $862,398, which represents excess Federal reimbursement for the 2,919 family planning inpatient claims.

This excess Federal reimbursement occurred because the State agency had not implemented policies and procedures to ensure that it claimed Medicaid costs for inpatient claims with sterilization and delivery procedures pursuant to Federal requirements.

FEDERAL REQUIREMENTS

Federal regulations (42 CFR § 433.32(a)) require that the State agency "[m]aintain an accounting system and supporting fiscal records to assure that claims for Federal funds [reported on the CMS-64 report] are in accord with applicable Federal requirements …."

Pursuant to section 4270 of the manual, only items and procedures clearly furnished or provided for family planning purposes may be claimed at the 90-percent rate.

According to the guide, in order to be claimed at the 90-percent rate, the cost of a sterilization procedure must be distinguished from the delivery cost when sterilization and delivery procedures are performed during a single hospital stay. The 1980 CMS policy memorandum that is incorporated within the guide further states that when multiple procedures are performed during a single hospital stay and submitted as a single inpatient claim, a State's claim for Federal reimbursement must distinguish between those costs attributable to family planning (eligible for Federal reimbursement at the 90-percent rate) and those non-family planning costs attributable to other covered services (reimbursed at the FMAP). CMS does not require a specific allocation method, but requires that the reasonableness of the methodology be determined on a State-by-State basis.

Additionally, the DAB ruled that the method adopted by a State agency must reasonably serve to claim the appropriate rate of Federal reimbursement. The DAB added that without a reasonable method to make this allocation properly, the State is not entitled to Federal reimbursement at the 90-percent rate.[1]

INCORRECT FEDERAL REIMBURSEMENT FOR INPATIENT STERILIZATION AND DELIVERY PROCEDURES

None of the inpatient claims with sterilization and delivery procedures that the State agency claimed as family planning services for CYs 2009 and 2010 qualified for Federal requirement at the 90-percent rate. For all 2,919 inpatient claims in which sterilization procedures had been performed in addition to delivery procedures during single hospital stays, the State agency claimed costs for <u>both</u> procedures at the 90-percent rate on the CMS-64 reports.

The State agency used its sterilization reports, which included all costs for inpatient claims with sterilization and delivery procedures, to prepare the CMS-64 reports for each quarter in our audit period. However, the sterilization reports themselves did not distinguish between those costs attributable to family planning services and those costs attributable to non-family planning services.

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[1] <u>New York State Department of Social Services</u>, DAB No. 1284 (1991).

POLICIES AND PROCEDURES LACKING

These errors occurred because the State agency had not implemented policies and procedures to ensure that it claimed Medicaid costs for inpatient claims with sterilization and delivery procedures pursuant to Federal requirements. For these claims, the State agency did not have a methodology to distinguish between costs for family planning services and costs for non-family planning services, and thereby to claim sterilization procedures at the 90-percent rate and claim delivery procedures at the FMAP.

EXCESS FEDERAL REIMBURSEMENT

Because the State agency did not properly distinguish between the costs for family planning services and those for non-family planning services, the State agency is not entitled to Federal reimbursement at the 90-percent rate for any of the 2,919 claims. Accordingly, the State agency received $862,398 in excess Federal reimbursement, which represents the amount associated with the difference between the 90-percent rate and the FMAP.

The details of the excess Federal reimbursement are listed in Appendix A.

RECOMMENDATIONS

We recommend that the State agency:

- refund $862,398 to the Federal Government,

- review costs for inpatient claims with sterilization and delivery procedures for quarterly reporting periods after our audit period and refund any overpayments to the Federal Government, and

- work with CMS to develop and implement policies and procedures that include a reasonable methodology to ensure that costs for inpatient claims with sterilization and delivery procedures are claimed pursuant to Federal requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our first and second recommendations. The State agency said that "[t]he claims in question were clearly identified as claims for sterilization procedures" and added that its policy in effect during the audit period "… was to claim the entire inpatient claim at the ninety percent rate. Therefore, [the State agency] believes it is unreasonable to not allow any of the claims, or portion thereof, to be claimed at the ninety percent rate."

The State agency agreed with our third recommendation and said that it would work with CMS in the future to develop and implement an acceptable methodology.

The State agency's comments appear in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in the State agency's comments caused us to change our findings or recommendations.

We acknowledge that the 2,919 inpatient claims that we reviewed contained sterilization procedures and that the associated costs were eligible for Federal reimbursement at the 90-percent rate—but only when claimed in accordance with Federal requirements. However, each of these claims contained both sterilization and delivery procedures. For these instances, CMS provided clear guidance in 1980 on how to claim these costs, guidance which the DAB upheld in 1991.

The CMS *Financial Management Review Guide Number 20*: *Family Planning Services* states that in order to be claimed at the 90-percent rate, the cost of a sterilization procedure must be distinguished from the cost of delivery in each instance when sterilization and delivery procedures are performed during a single hospital stay. Moreover, the DAB has ruled in a similar circumstance that without a reasonable method to distinguish these costs, a State Medicaid agency is not entitled to Federal reimbursement at the 90-percent rate.

Because the State agency did not distinguish between these costs, we maintain that the State agency is not entitled to Federal reimbursement at the 90-percent rate for any portion of these claims.

APPENDIXES

APPENDIX A: CALCULATION OF QUESTIONED COSTS BY QUARTER

The Department of Social Services, Missouri HealthNet Division (the State agency) received $862,398 in excess Federal reimbursement. That amount consists of the difference between Federal reimbursement at the enhanced 90-percent rate (90-percent rate) ($4,783,200) and the amount associated with the lower Federal medical assistance percentage (FMAP) rates ($3,920,802). The following table presents details of the excess Federal reimbursement by quarter for Medicaid family planning inpatient sterilization and delivery procedures.

Table: Excess Federal Reimbursement

Quarter Ended	Amounts at 90-Percent Rate	Amounts at FMAP Rates	Net Difference Questioned Costs
03/31/2009	$568,580	($450,063)	$118,517
06/30/2009	564,276	(459,383)	104,893
09/30/2009	580,223	(472,366)	107,857
12/31/2009	657,677	(543,899)	113,778
03/31/2010	602,836	(498,545)	104,291
06/30/2010	631,961	(522,632)	109,329
09/30/2010	621,192	(513,726)	107,466
12/31/2010	556,455	(460,188)	96,267
Total	**$4,783,200**	**($3,920,802)**	**$862,398**

APPENDIX B: STATE AGENCY COMMENTS

JEREMIAH W. (JAY) NIXON, GOVERNOR • ALAN O. FREEMAN, DIRECTOR

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February 13, 2013

Patrick Cogley
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Region 0429
Kansas City, MO 64106

Re: OIG Report Number: A-07-12-01121

Dear Mr. Cogley:

This is in response to the Office of Inspector General's (OIG) draft report entitled "Missouri Incorrectly Claimed Federal Reimbursement for Inpatient Claims With Sterilization and Delivery Procedures for Calendar Years 2009 and 2010", Report Number A-07-12-01121. The Department of Social Services' (DSS) responses are below. The OIG recommendations are restated for ease of reference.

Recommendation 1: The OIG recommends that the State agency refund $862,398 to the Federal Government.

DSS Response: The DSS disagrees with this finding. The claims in question were clearly identified as claims for sterilization procedures. Missouri's policy in effect during the audit period was to claim the entire inpatient claim at the ninety percent rate. Therefore, DSS believes it is unreasonable to not allow any of the claims, or portion thereof, to be claimed at the ninety percent rate.

Recommendation 2: The OIG recommends that the State agency review costs for inpatient claims with sterilization and delivery procedures for quarterly reporting periods after our audit period and refund any overpayments to the Federal Government.

DSS Response: The DSS disagrees with this finding as explained in the response to Recommendation 1.

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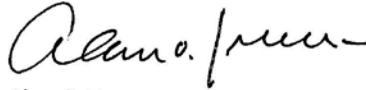
Recommendation 3: The OIG recommends that the State agency work with CMS to develop and implement policies and procedures that include a reasonable methodology to ensure that costs for inpatient claims with sterilization and delivery procedures are claims pursuant to Federal requirements.

DSS Response: The DSS agrees to work with CMS in the future to develop and implement an acceptable methodology to distinquish costs attributable to family planning from other covered services to ensure appropriate claiming pursuant to Federal requirements.

Please contact Jennifer Tidball, Director, Division of Finance and Administrative Services at (573)751-7533 if you have further questions.

Sincerely,



Alan O. Freeman
Director

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