Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

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A-09-14-02028

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

California claimed at least $171,000 for fiscal year 2012 in unallowable enhanced Federal reimbursement for Medicaid family planning drugs provided in Orange County.

WHY WE DID THIS REVIEW

Family planning services prevent or delay pregnancy or otherwise control family size. Federal law and regulations authorize Federal Medicaid reimbursement to States for family planning services at an enhanced Federal medical assistance percentage of 90 percent (90-percent rate). Previous Office of Inspector General reviews found that the California Department of Health Care Services (State agency) claimed approximately $17.8 million in unallowable Federal reimbursement for certain family planning services, drugs, and supplies provided under the Family Planning, Access, Care, and Treatment (FPACT) program in three counties. One of these reviews found that the State agency claimed at least $2.2 million in unallowable Federal reimbursement for family planning services provided in Orange County. That review did not include claims for family planning drugs and supplies.

The objective of this review was to determine whether the State agency complied with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning drugs provided under the FPACT program in Orange County.

BACKGROUND

In California, the State agency administers the Medicaid program. The State agency, through its FPACT program, provides family planning services, drugs, and supplies to individuals of childbearing age who both reside in California and have incomes up to 200 percent of the Federal poverty level. Individuals eligible for the FPACT program are generally not otherwise eligible for Medicaid.

Federal law and regulations authorize Federal reimbursement for family planning services at the 90-percent rate. The Centers for Medicare & Medicaid Services' *State Medicaid Manual* states that Federal reimbursement at this rate is available only for services clearly provided for family planning purposes.

Under the FPACT program, only Medicaid providers are eligible to provide family planning services and prescribe drugs and supplies. Providers must keep records as necessary to disclose the extent of the services provided to beneficiaries and provide these records to the State agency or the Secretary of Health and Human Services upon request.

With limited exceptions, Medicaid is intended to be the payer of last resort when a beneficiary has other health insurance coverage. A State plan for medical assistance must provide that the State will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State plan. An FPACT provider must confirm whether a beneficiary has other health insurance coverage at each visit and remove the beneficiary from the FPACT program when such coverage is available for family planning.

HOW WE CONDUCTED THIS REVIEW

From October 1, 2011, through September 30, 2012, the State agency claimed $20,905,463 ($16,190,236 Federal share) for family planning drugs and supplies provided under the FPACT program in Orange County. We removed claim lines totaling $46,792 that appeared to be duplicate payments for a drug or supply, which we plan to review in a separate audit. (Each claim line was for a drug or supply provided to a beneficiary.) We also removed claim lines totaling $8,743,112 for drugs and supplies that were considered to be at low risk of being unallowable, that had immaterial reimbursements, or that were provided before July 1, 2010. (This removed all claim lines for supplies.) From the remaining claim lines for drugs, totaling $12,115,559, we reviewed a random sample of 120 claim lines.

WHAT WE FOUND

The State agency did not always comply with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning drugs provided under the FPACT program in Orange County. Of the 120 sampled claim lines, 111 complied and 9 did not comply with requirements. Of the nine claim lines, five were ineligible for reimbursement because of insufficient documentation, two were ineligible for reimbursement because the drugs were not prescribed by Medicaid providers, one was ineligible for reimbursement because the drug was not clearly provided for family planning purposes, and one was ineligible for reimbursement because the beneficiary had other health insurance coverage for family planning. On the basis of our sample results, we estimated that the State agency claimed at least $171,121 in unallowable Federal reimbursement.

The State agency claimed unallowable Federal reimbursement because it did not ensure that providers complied with the State agency's policies and procedures requiring providers to maintain supporting records, prescribe drugs only for family planning purposes, and remove beneficiaries from the FPACT program when other health insurance coverage is available for family planning. Additionally, the State agency did not have internal controls to prevent payment of claims for family planning drugs prescribed by non-Medicaid providers.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $171,121 to the Federal Government;

- ensure that providers comply with policies and procedures requiring them to maintain supporting records, prescribe drugs only for family planning purposes, and remove beneficiaries from the FPACT program when other health insurance coverage is available for family planning; and

- implement internal controls to prevent payment of claims for family planning drugs prescribed by non-Medicaid providers.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations and provided information on actions that it had taken or planned to take to address our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Family planning services prevent or delay pregnancy or otherwise control family size. Federal law and regulations authorize Federal Medicaid reimbursement to States for family planning services at an enhanced Federal medical assistance percentage of 90 percent (90-percent rate). Previous Office of Inspector General (OIG) reviews found that the California Department of Health Care Services (State agency) claimed approximately $17.8 million in unallowable Federal reimbursement for certain family planning services, drugs, and supplies provided under the Family Planning, Access, Care, and Treatment (FPACT) program in three counties. One of these reviews found that the State agency claimed at least $2.2 million in unallowable Federal reimbursement for family planning services provided in Orange County.[1] That review did not include claims for family planning drugs and supplies. (Appendix A lists related OIG reports on States' family planning claims.)

OBJECTIVE

Our objective was to determine whether the State agency complied with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning drugs provided under the FPACT program in Orange County.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Medicaid Coverage of Family Planning Services and Supplies

States must furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and desire such services and supplies (the Social Security Act (the Act) § 1905(a)(4)(C)). Federal law and regulations authorize Federal reimbursement for family planning services at the 90-percent rate (the Act § 1903(a)(5) and 42 CFR § 433.10(c)(1)).

The CMS *State Medicaid Manual* (the Manual) states that family planning services include those that prevent or delay pregnancy or otherwise control family size (§ 4270.B). The Manual indicates that States are free to determine which services and supplies will be covered as long as

[1] *California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in Orange County* (A-09-13-02044), issued July 25, 2014.

those services are sufficient in amount, duration, and scope to reasonably achieve their purpose. However, only services and supplies clearly provided for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate.

California's Medicaid Family Planning Program

In California, the State agency administers the Medicaid program. The State agency, through its FPACT program, provides family planning services, drugs, and supplies to individuals of childbearing age who both reside in California and have incomes up to 200 percent of the Federal poverty level. Individuals eligible for the FPACT program are generally not otherwise eligible for Medicaid. According to State regulations, family planning services include drugs and supplies (California Welfare and Institutions Code § 14132(aa)(8)).

The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims for payment. The expenditures related to the claims are reported on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, for Federal reimbursement. The State agency deducts 13.95 percent from its total expenditures when claiming Federal reimbursement to account for beneficiaries who receive family planning services but are not eligible for public benefits under Federal law, such as nonqualified aliens.[2]

HOW WE CONDUCTED THIS REVIEW

From October 1, 2011, through September 30, 2012 (audit period), the State agency claimed $20,905,463 ($16,190,236 Federal share) for family planning drugs and supplies provided under the FPACT program in Orange County, representing 248,367 claim lines. (Each claim line was for a drug or supply provided to a beneficiary.) We removed claim lines totaling $46,792 that appeared to be duplicate payments for a drug or supply, which we plan to review in a separate audit. We also removed claim lines totaling $8,743,112 for drugs and supplies that were considered to be at low risk of being unallowable, that had immaterial reimbursements, or that were provided before July 1, 2010. (This removed all claim lines for supplies.) From the remaining 83,380 claim lines for drugs, totaling $12,115,559, we reviewed a random sample of 120 claim lines.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B describes our audit scope and methodology, Appendix C describes our statistical sampling methodology, and Appendix D contains our sample results and estimates.

[2] California's State Plan Amendment (SPA) 10-014, effective July 1, 2010.

FINDINGS

The State agency did not always comply with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning drugs provided under the FPACT program in Orange County. Of the 120 sampled claim lines, 111 complied and 9 did not comply with requirements. Of the nine claim lines, five were ineligible for reimbursement because of insufficient documentation, two were ineligible for reimbursement because the drugs were not prescribed by Medicaid providers, one was ineligible for reimbursement because the drug was not clearly provided for family planning purposes, and one was ineligible for reimbursement because the beneficiary had other health insurance coverage for family planning. On the basis of our sample results, we estimated that the State agency claimed at least $171,121 in unallowable Federal reimbursement.

The State agency claimed unallowable Federal reimbursement because it did not ensure that providers complied with the State agency's policies and procedures requiring providers to maintain supporting records, prescribe drugs only for family planning purposes, and remove beneficiaries from the FPACT program when other health insurance coverage is available for family planning. Additionally, the State agency did not have internal controls to prevent payment of claims for family planning drugs prescribed by non-Medicaid providers.

FEDERAL AND STATE REQUIREMENTS

With limited exceptions, Medicaid is intended to be the payer of last resort when a beneficiary has other health insurance coverage. A State plan for medical assistance must provide that the State or local agency administering the plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the plan (the Act § 1902(a)(25)(A)). Third parties include health insurers, group health plans, managed-care organizations, pharmacy benefit managers, and other parties that are responsible for payment of a claim for a health care item or service. An FPACT provider must confirm whether a beneficiary has other health insurance coverage at each visit and remove the beneficiary from the FPACT program when such coverage is available for family planning (California *Family PACT Policies, Procedures and Billing Instructions Manual* (PPBI Manual)).

Providers must keep records as necessary to disclose the extent of the services provided to beneficiaries and provide these records to the State agency or the Secretary of Health and Human Services upon request (the Act § 1902(a)(27)).

Only services and supplies clearly provided for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate (the Manual § 4270.B). Under the FPACT program, only Medicaid providers are eligible to provide family planning services and prescribe drugs and supplies (California Welfare and Institutions Code § 24005(c) and PPBI Manual).

THE STATE AGENCY DID NOT COMPLY WITH FEDERAL AND STATE REQUIREMENTS WHEN CLAIMING FEDERAL REIMBURSEMENT FOR SOME FAMILY PLANNING DRUGS

Of the 120 sampled claim lines, 9 did not comply with Federal and State requirements:[3]

- Five claim lines were for drugs that were not sufficiently supported by documentation. We obtained the corresponding prescriptions from the pharmacies; however, we were unable to obtain beneficiary medical records from the providers or the State agency. Because the purpose of the drugs could not be confirmed through beneficiary medical records, the drugs were not eligible for Federal reimbursement.

- Two claim lines were for drugs that were not prescribed by Medicaid providers. Because the prescribing providers were not Medicaid providers, they were not eligible to provide family planning services under the FPACT program, and the drugs were not eligible for Federal reimbursement.

- One claim line was for a drug that was not clearly provided for family planning purposes. The provider prescribed an oral contraceptive drug to treat a medical condition only (irregular menses); therefore, the drug was not eligible for Federal reimbursement.

- One claim line was for a drug provided to a beneficiary who had other health insurance coverage for family planning. Because other health insurance coverage was available and Medicaid is the payer of last resort, the drug was not eligible for Federal reimbursement.

On the basis of our sample results, we estimated that the State agency claimed at least $171,121 in unallowable Federal reimbursement.

The State agency claimed unallowable Federal reimbursement because it did not ensure that providers complied with the State agency's policies and procedures requiring providers to maintain supporting records, prescribe drugs only for family planning purposes, and remove beneficiaries from the FPACT program when other health insurance coverage is available for family planning. Additionally, the State agency did not have internal controls to prevent payment of claims for family planning drugs prescribed by non-Medicaid providers.

[3] During our audit, State medical professionals performed a medical review of these nine claim lines and concurred with our findings.

RECOMMENDATIONS

We recommend that the State agency:

- refund $171,121 to the Federal Government;

- ensure that providers comply with policies and procedures requiring them to maintain supporting records, prescribe drugs only for family planning purposes, and remove beneficiaries from the FPACT program when other health insurance coverage is available for family planning; and

- implement internal controls to prevent payment of claims for family planning drugs prescribed by non-Medicaid providers.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendations and provided information on actions that it had taken or planned to take to address our recommendations. The State agency's comments are included in their entirety as Appendix E.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Texas Claimed Unallowable Federal Reimbursement for Some Family Planning Services	A-06-11-00016	3/17/2015
California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in Southeast Los Angeles County	A-09-13-02047	8/12/2014
California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in Orange County	A-09-13-02044	7/25/2014
California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in East Los Angeles County	A-09-13-02019	7/25/2014
California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in Central Los Angeles County	A-09-13-02012	7/25/2014
Missouri Did Not Always Correctly Claim Costs for Medicaid Family Planning Drugs for Calendar Years 2009 and 2010	A-07-12-01118	1/28/2014
California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Drugs and Supplies Provided in San Diego County	A-09-12-02077	6/25/2013
Arkansas Inappropriately Received Medicaid Family Planning Funding for Federal Fiscal Years 2006 Through 2010	A-06-11-00022	1/18/2013
California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in San Diego County	A-09-11-02040	12/20/2012

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

From October 1, 2011, through September 30, 2012, the State agency claimed $20,905,463 ($16,190,236 Federal share) for family planning drugs and supplies provided under the FPACT program in Orange County, representing 248,367 claim lines. (Each claim line was for a drug or supply provided to a beneficiary.) After we removed 164,987 claim lines for duplicate payments and other issues, our sampling frame consisted of 83,380 claim lines for drugs, totaling $12,115,559. We reviewed a random sample of 120 of these claim lines.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether the drugs provided to FPACT beneficiaries were eligible for Federal reimbursement at the 90-percent rate. We did not determine whether the beneficiaries met the eligibility requirements of the FPACT program.

We conducted our audit from May to December 2014 and performed our fieldwork at the State agency's office in Sacramento, California, and at provider locations in Orange County.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance and the State plan;
- held discussions with CMS officials to gain an understanding of CMS guidance furnished to State agency officials concerning Medicaid family planning claims;
- held discussions with State agency officials to gain an understanding of State policies and procedures for claiming Federal reimbursement for family planning services, drugs, and supplies;
- obtained FPACT claim data from the State agency's MMIS for the audit period, representing 248,367 claim lines for family planning drugs and supplies provided in Orange County, totaling $20,905,463 ($16,190,236 Federal share);
- removed 380 claim lines, totaling $46,792, that appeared to be duplicate payments for a drug or supply;
- removed 164,607 claim lines, totaling $8,743,112, consisting of 164,473 claim lines for drugs and supplies we considered to be at low risk of being unallowable, 129 claim lines that had immaterial reimbursements, and 5 claim lines with service dates before July 1, 2010;

- created a sampling frame consisting of the remaining 83,380 claim lines for family planning drugs, totaling $12,115,559;

- selected a simple random sample of 120 claim lines and:

    - contacted pharmacies and providers to obtain prescriptions and beneficiary medical records for the sampled claim lines and

    - reviewed the medical records we received to confirm the purpose of the drugs provided to the beneficiaries;

- discussed with State medical professionals those sampled claim lines that we determined were unallowable for Federal reimbursement; and

- estimated the unallowable Federal reimbursement paid in the sampling frame.

See Appendix C for the details of our statistical sampling methodology and Appendix D for our sample results and estimates.

To determine the Federal share, we reduced the total amount paid by the State agency by the CMS-approved deduction percentage of 13.95 percent (for beneficiaries who receive family planning services, including drugs, but who are not eligible for public benefits under Federal law) and then applied the 90-percent rate.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of claim lines for Medicaid family planning drugs provided in Orange County; paid by the State agency to pharmacies and providers during our audit period; and claimed at the 90-percent rate under the FPACT program.

SAMPLING FRAME

The State agency provided us with a database of FPACT claims, from which we identified 248,367 claim lines for family planning drugs and supplies provided in Orange County, totaling $20,905,463 for our audit period. We identified 380 claim lines, totaling $46,792, for 2 or more of the same drug or supply provided to a beneficiary by the same provider on the same service date. We removed these claim lines and plan to review them for potential duplicate payments in a future audit. We focused on claim lines for drugs and supplies provided on or after July 1, 2010, and removed five claim lines that had service dates before this date. We also removed 164,473 claim lines for drugs and supplies considered to be at low risk of being unallowable, such as condoms, emergency contraception, and contraceptive rings and injections. We established a materiality level of $5.00 or more and removed 129 claim lines that had a reimbursement of less than this amount. After we removed the 164,987 claim lines (which removed all claim lines for supplies), the sampling frame consisted of 83,380 claim lines for family planning drugs totaling $12,115,559 ($9,382,894 Federal share).

SAMPLE UNIT

The sample unit was a unique claim line for a drug provided to a beneficiary.

SAMPLE DESIGN

We used a simple random sample to test the claim lines for allowability.

SAMPLE SIZE

We selected 120 sample units.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units from 1 through 83,380. After generating 120 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the unallowable Federal reimbursement paid. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results (Total Amounts)

Number of Claim Lines in Sampling Frame	Value of Claim Lines in Sampling Frame	Sample Size	Value of Sample	Number of Unallowable Claim Lines	Value of Unallowable Claim Lines
83,380	$12,115,559	120	$17,405	9	$797

Table 2: Sample Results (Federal Share Amounts)

Number of Claim Lines in Sampling Frame	Value of Claim Lines in Sampling Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Claim Lines	Value of Unallowable Claim Lines (Federal Share)
83,380	$9,382,894	120	$13,480	9	$717

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

	Total Amount	Federal Share
Point estimate	$553,650	$498,286
Lower limit	190,136	171,121
Upper limit	917,164	825,450

APPENDIX E: STATE AGENCY COMMENTS

JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

June 29, 2015

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
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Dear Ms. Ahlstrand:

The California Department of Health Care Services (DHCS) has prepared its response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled *California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Drugs Provided in Orange County.*

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft report. Please contact Ms. Jacqueline Shepherd, Audit Coordinator, at (916) 650-0298 if you have any questions.

Sincerely,

[Jennifer Kent]

Jennifer Kent
Director

Enclosure

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Department of Health Care Services Response to the Office of Inspector General's Draft Report Entitled: California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Drugs Provided in Orange County

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Finding 1: The State agency did not always comply with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning drugs provided under the FPACT program in Orange County. Of the 120 sampled claim lines, 111 complied and 9 did not comply with requirements. Of the nine claim lines, five were ineligible for reimbursement because of insufficient documentation, two were ineligible for reimbursement because the drugs were not prescribed by Medicaid providers, one was ineligible for reimbursement because the drug was not clearly provided for family planning purposes, and one was ineligible for reimbursement because the beneficiary had other health insurance coverage for family planning. On the basis of our sample results, we estimated that the State agency claimed at least $171,121 in unallowable Federal reimbursement.

Recommendation 1: Refund $171,121 to the Federal Government.

Response: Department of Health Care Services (DHCS) agrees with the recommendation.

DHCS has reviewed the sampling methodology, sampling results, and estimates. DHCS agrees with the recommendation to refund $171,121 to the Federal Government. DHCS' Accounting Office will be instructed to initiate the appropriate accounting adjustments for the refund of unallowable federal reimbursement by the end of the 4th Quarter of this current federal fiscal year.

Finding 2: The State agency claimed unallowable Federal reimbursement because it did not ensure that providers complied with the State agency's policies and procedures requiring providers to maintain supporting records, prescribe drugs only for family planning purposes, and remove beneficiaries from the FPACT program when other health insurance coverage is available for family planning. Additionally, the State agency did not have internal controls to prevent payment of claims for family planning drugs prescribed by non-Medicaid providers.

Recommendation 2: Ensure that providers comply with policies and procedures requiring them to maintain supporting records, prescribe drugs only for family planning purposes, and remove beneficiaries from FPACT program when other health insurance coverage is available for family planning.

Response: DHCS agrees with the recommendation.

<u>The Family PACT Policies, Procedures and Billing Instructions (PPBI) Manual</u>
The PPBI manual is a reference document for providers which describes the Family PACT program policies and procedures, including *Family PACT Standards*. Family PACT providers are responsible to ensure that all practice members, associate practitioners, and ancillary staff are informed of the Family PACT policies and procedures; understand and follow current administrative practices; and deliver services consistent with the *Family PACT Standards*.

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As noted in the PPBI manual, and as part of requirements of being enrolled as a Family PACT provider, providers are responsible for maintaining records, consent forms, and required chart documentation in accordance with Medi-Cal regulations (as noted in the Provider Regulations section in Part 1 of the Medi-Cal manual). *The Family PACT Standards* require medical documentation to support services billed for reimbursement.

Each person seeking family planning services from Family PACT must report at each family planning visit any changes in the facts pertinent to their eligibility determination, such as any entitlement to other health coverage for family planning benefits to the provider at the time of application, recertification, or at any time the health coverage changes. The provider must affirm client eligibility at each visit. Health coverage status must be reaffirmed at each visit. If there are any changes, the provider must update the Health Access Programs (HAP) system. Whenever a client is determined no longer eligible for Family PACT, providers must deactivate the HAP card and advise the client of ineligibility and refrain from billing Family PACT for services.

Continuing Educational Program for Family PACT Providers
The Office of Family Planning (OFP) has a continuing educational program to educate Family PACT providers on the scope of the Family PACT program, including *Family PACT Program Standards*. This continuing educational program is done via quarterly Provider Orientations and Update trainings, as needed. In the Provider Orientation, we address medical documentation of services as part of the training. We will incorporate into the training, HAP card deactivation due to any changes affecting eligibility, such as other health coverage for family planning benefits.

Program Integrity Activities
The OFP has implemented several program integrity activities which assist in the processes for identification, collection, reporting, analysis and disposition of performance data and information on Family PACT providers and the provision of services. These activities allow OFP staff to regularly measure and monitor provider activities against the purpose of Family PACT and identify when an opportunity exists to improve the quality of program services. Such activities include, but are not limited to:

- Provider Profiles: Biannual Provider Profiles provides data on OFP identified indicators of utilization management and quality improvements measures that are directly attributable to the Family PACT provider. The intent is to encourage the delivery of high-quality clinical services while promoting responsible use of funding resources.
- Medical Record Review Report: A report of qualitative findings, conducted every three or four years to assess the quality of clinical care in Family PACT.
- Audits by DHCS, Audits and Investigations (A&I): Routine audits are conducted by A&I of Family PACT providers to ensure compliance with program criteria and to recover overpayments, if indicated.

In addition, OFP will conduct the following activities:

- Desk Review: Review and analysis of individual provider claims and billing patterns based on current policy.

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- Onsite Provider Review: Onsite provider reviews based on information collected from desk reviews and provider profiles.

Recommendation 3: Implement internal controls to prevent payment of claims for family planning drugs prescribed by non-Medicaid providers.

Response: DHCS agrees with the recommendation.

DHCS' Provider Enrollment Division (PED) began enrolling, ordering, referring, and prescribing (ORP) providers on January 1, 2013. Associated edits to the California Medicaid Management Information System (CA-MMIS) that added system files for the newly enrolling ORP providers, and claims edits to identify the ORP providers on claims and to deny claims when ORP providers are not enrolled, were completed on May 27, 2014. To reduce the impact to providers and beneficiaries, efforts were made to include as many eligible ORP providers in the fee-for-service claims system as possible by including active provider files from Medicare and Denti-Cal. In addition, California's managed care delivery system is available statewide, so efforts are also underway to incorporate Medi-Cal Managed Care Providers into the fee-for-service CA-MMIS for purposes of verifying that these providers are eligible for ordering, referring and prescribing goods and services paid through the fee-for-service system.

At this time, the claims processing edits are implemented with a "grace period", similar to the approach taken by Medicare. During this "grace period", claims are being reviewed but are not being denied when the ORP provider is not actively enrolled in the system. Instead, the billing providers are notified that the ORP provider listed on their claim is not enrolled and unless this is corrected, future claims will be denied. Reports are created on a monthly basis detailing the potentially impacted billing providers. These reports are reviewed by DHCS and are instrumental in determining provider types and the numbers of providers that need additional outreach, and to allow for an informed decision as to when the grace period will end.

An additional claims processing edit to allow only individual providers with an enrolled Type 1 National Provider Identifier (NPI) to be recognized as ORP providers on claims, was scheduled to be implemented on April 20, 2015. Once the additional Type 1 NPI limitation edit is implemented, DHCS will require a few months to review the reports from claims processing to determine when the numbers of potentially-denied claims have reduced enough to ensure that Medi-Cal beneficiaries would not be adversely affected by possible denial of medically-necessary goods and services. DHCS is currently assessing a revised implementation date.