Office of Audit Services
Region I
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JAN 3 2006

Report Number: A-01-05-00002

Mr. Joshua Slen
Director
Office of Vermont Health Access
State of Vermont
103 South Main Street
Waterbury, Vermont 05671-1201

Dear Mr. Slen:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "Audit of Vermont's Medicaid Payments for Family Planning Services Reimbursed at Enhanced Rates for the Period October 1, 2003, through September 30, 2004." A copy of this report will be forwarded to the action official named below 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 the action 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.

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Please refer to Report Number A-01-05-00002 in all correspondence.

Sincerely yours,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Charlotte Yeh, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services – Region I
Department of Health and Human Services
Room 2325, JFK Federal Building
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF VERMONT'S MEDICAID PAYMENTS FOR FAMILY PLANNING SERVICES REIMBURSED AT ENHANCED RATES FOR THE PERIOD OCTOBER 1, 2003, THROUGH SEPTEMBER 30, 2004

Daniel R. Levinson
Inspector General

JANUARY 2006
A-01-05-00002

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Congress established the Medicaid program under Title XIX of the Social Security Act (the Act) to cover the medical care costs of persons with limited incomes and resources. Each State administers its Medicaid program in accordance with a State plan approved by the Centers for Medicare & Medicaid Services (CMS) to ensure compliance with Federal requirements.

Congress amended sections 1903(a)(5) and 1905(a)(4)(C) of the Act to promote family planning services. The CMS State Medicaid Manual defines family planning services as services that prevent or delay pregnancy or otherwise control family size. The enhanced Federal share of the costs of providing family planning services is 90 percent. For the period under review, most other Vermont Medicaid services claimed for Federal reimbursement were funded at the rates of 65.36 percent and 61.34 percent.

In Vermont, the Agency of Human Services, Office of Vermont Health Access (the State agency) administers the Medicaid program and is responsible for providing family planning services. The State agency claimed Federal reimbursement of $3,632,031 at the 90 percent enhanced rate for 61,988 family planning services for the Federal fiscal year that ended September 30, 2004.

OBJECTIVE

Our objective was to determine if the State agency properly claimed Federal financial participation (FFP) for claims related to family planning services in accordance with applicable Federal regulations and the Medicaid State Plan.

SUMMARY OF FINDINGS

From October 2003 through September 2004, the State agency improperly claimed excess Federal Medicaid reimbursement of $323,367 for family planning services. Specifically, these claims comprised:

- $197,582 for 4,003 duplicate claims reported on the State agency's CMS-64 submission for the quarter that ended December 31, 2003; and

- an estimated $125,785 for claims that were not eligible for the enhanced rate of 90 percent because they did not meet the definition of family planning services. These claims were allowable for Federal reimbursement as regular Medicaid services. Therefore, the amount in question represents the difference between the 90 percent reimbursement rate and reimbursement at the regular medical assistance payment rates that were in effect during the period under review.

The State agency claimed these costs because it did not reconcile the quarterly amounts claimed on the CMS-64 for enhanced family planning reimbursement with paid claim activity for such services. In addition, the State agency did not have adequate procedures in place to ensure that all claims for enhanced Federal reimbursement for family planning services were eligible in accordance with Federal regulations.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $197,582 for the Federal share of duplicate Medicaid claims and $125,785 for costs that were inappropriately claimed at the enhanced 90 percent rate of Federal reimbursement,

- reconcile claims for family planning reimbursement included on the CMS-64 quarterly report of expenditures with paid claim activity reports to ensure that the amounts claimed are accurate, and

- use the CMS Family Planning Services Guide for identifying those procedure and diagnosis codes that are eligible for 90 percent Federal reimbursement.

STATE AGENCY'S COMMENTS

In its response to the draft report dated December 20, 2005 (see APPENDIX B), the State agency agreed with our recommendations.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Under Title XIX of the Social Security Act (the Act), the Medicaid program pays for the health care costs of persons who meet certain medical and economic criteria. Medicaid costs are shared between the Federal Government and participating States. Within the Federal Government, the Medicaid program is administered by the Centers for Medicare & Medicaid Services (CMS).

To participate in the Medicaid program, a State must submit and receive CMS's approval of a State plan. The State plan is a comprehensive document describing the nature and scope of the State's Medicaid program. The Medicaid program pays for medically necessary services as specified in Medicaid law when these services are included in the State plan and provided to individuals eligible under the plan.

Medicaid Coverage of Family Planning Services

Section 1905(a)(4)(C) of the Act requires States to provide family planning services and supplies to individuals of childbearing age who are eligible under the State plan and who desire such services and supplies. Pursuant to section 1903(a)(5) of the Act and 42 CFR § 433.10 and § 433.15, the Federal Government funds 90 percent of the costs of family planning services covered by Medicaid. For the period under review, most other Vermont Medicaid services claimed for Federal reimbursement were funded at the rates of 65.36 percent and 61.34 percent.

Section 4270 of the CMS State Medicaid Manual states that family planning services are those provided to prevent or delay pregnancy or otherwise control family size. The Manual states that, in general, Federal funding at the 90 percent matching rate is available to pay for counseling services and patient education; examination and treatment by medical professionals in accordance with applicable State requirements; laboratory examinations and tests; medically approved methods, procedures, and pharmaceutical supplies and devices to prevent conception; and infertility services, including sterilization reversals.

Vermont's Medicaid Program

In Vermont, the Agency of Human Services, Office of Vermont Health Access (the State agency) administers the Medicaid program and is responsible for providing family planning services. The State agency defines family planning services as counseling and patient education, physician examinations and treatments, laboratory services, pharmaceutical supplies and devices to prevent conception, natural family planning methods, and sterilizations. Family planning services are identified based on specific procedure and diagnosis codes and are paid on a fee-for-service basis.

The State agency claimed Federal reimbursement of $3,632,031 at the 90 percent enhanced rate for family planning services for the Federal fiscal year that ended September 30, 2004.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine if the State agency properly claimed Federal financial participation for claims related to family planning services in accordance with applicable Federal regulations and the Medicaid State Plan.

Scope

Our review covered claims for family planning services provided from October 1, 2003, through September 30, 2004, that Vermont submitted for Federal reimbursement. We did not review the overall internal control structure of the State agency's Medicaid program. Rather, our internal control review was limited to the objective of our audit.

We performed fieldwork at the State agency in Williston, Vermont; at Electronic Data Systems (EDS), the State agency's fiscal agent, in Williston, Vermont; and at several providers' offices across the State from March 2005 through July 2005.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws and regulations related to family planning services;
- held discussions with CMS officials and obtained an understanding of CMS's guidance provided to State officials regarding Medicaid family planning claims;
- held discussions with State agency officials to ascertain State policies, procedures, and guidance for claiming Medicaid reimbursement for family planning services;
- visited several family planning providers and discussed the type and extent of services provided to Medicaid recipients; and
- reconciled the amounts claimed for Federal reimbursement at the enhanced rate for family planning services on the State agency's Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) with the State agency's supporting documentation.

We also selected and reviewed a statistical sample of 100 paid claims classified as family planning services provided from October 1, 2003, through September 30, 2004, from a universe of 61,988 such claims (see Appendix A). In reviewing the sample claims, we:

- compared paid family planning service claim data with provider billing documentation supporting the claim,
- determined whether the reviewed services were authorized by the Vermont Medicaid State plan and reimbursed at the appropriate rate,
- obtained and reviewed the medical records for the sample claims to confirm whether services provided were related to family planning, and
- used State agency medical personnel to assist in reviewing medical records.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

From October 2003 through September 2004, the State agency improperly claimed Federal Medicaid reimbursement of $323,367 for family planning services. Specifically, these claims comprised:

- $197,582 for 4,003 duplicate claims reported on the State agency's CMS-64 submission for the quarter that ended December 31, 2003, and
- an estimated $125,785 for claims that were not eligible for Federal reimbursement at the enhanced rate of 90 percent because they did not meet the definition of family planning services. These claims were allowable for Federal reimbursement as regular Medicaid services and, therefore, the amount in question represents the difference between the 90 percent reimbursement rate and the regular medical assistance payment rates that were in effect during the period under review.

The State agency claimed these costs because it did not reconcile the quarterly amounts claimed on the CMS-64 for enhanced family planning reimbursement with paid claim activity for such services. In addition, the State agency did not have adequate procedures in place to ensure that all claims for enhanced Federal reimbursement for family planning services were eligible in accordance with Federal regulations.

FEDERAL REQUIREMENTS

The CMS-64 is the quarterly financial report submitted by states that provides the basis for Federal reimbursement of Medicaid expenditures. Pursuant to 42 CFR § 430.30(c)(2), amounts reported on the CMS-64 must be actual expenditures for which the

states are entitled to Federal reimbursement. The report includes the State agency's claim for Federal reimbursement for family planning services.

The State Medicaid Manual, section 4270, states that:

> ". . . In general, FFP [federal financial participation] at the 90 percent matching rate is available for the costs of counseling services and patient education, examination and treatment by medical professionals in accordance with applicable State requirements, laboratory examinations and tests, medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception, and infertility services, including sterilization reversals . . . . Only items and procedures clearly provided or performed for family planning purposes may be matched at the 90 percent rate . . . . FFP at the 90 percent rate is <u>not</u> available for costs . . . related to other procedures performed for medical reasons . . . ."

CMS's Title XIX Financial Management Review Guide # 20: Family Planning Services (CMS Family Planning Services Guide) includes a coding matrix of specific procedure and diagnosis codes that are usually used to identify those ". . . services that are never or almost never family planning and should be disallowed, unless the State can provide evidence that the claim(s) represents services which were, in fact, clearly done for a family planning service . . . ." This guide states that any procedure provided to a woman known to be pregnant may not be considered a family planning service, reimbursable at 90 percent Federal funding. Likewise, tests and procedures performed during pregnancy, regardless of their purpose or intent, are not considered family planning services eligible for 90 percent Federal funding. Rather, these non-family-planning services are eligible for reimbursement at the State's normal Federal reimbursement rates for medical assistance payments. For the period of our review, Vermont's rates were 65.36 percent and 61.34 percent.

IMPROPER CLAIMS FOR FEDERAL REIMBURSEMENT

From October 2003 through September 2004, the State agency improperly claimed Federal Medicaid reimbursement of $323,367 for family planning services. Some of these claims were duplicates, and some were for services not eligible for Federal reimbursement.

Duplicate Claims

We reconciled the State agency's CMS-64 quarterly reports to supporting documentation and found that, for the quarter that ended December 31, 2003, the State agency's medical assistance payments included 4,003 duplicate family planning claims. The State agency received $197,582 in excess Federal reimbursements for these duplicate claims.

EDS, the State agency's claims processor, provided monthly statistical summary reports of paid claim activity for the State agency to use as the basis for the CMS-64. However, we found that the State agency did not routinely reconcile these reports with the actual

paid claims files to determine the accuracy of the amounts before it prepared and submitted the quarterly report. As a result, the State agency included the 4,003 duplicate claims in the December 2003 CMS-64 and received excess Federal reimbursement.

Discussions with EDS personnel indicated that technical programming problems had resulted in certain claims being included twice in the statistical report to the State agency. These problems were subsequently identified by EDS and reported to the State agency. However, the December 2003 CMS-64 report was never corrected. The State agency acknowledged that the Federal Government had paid for its share of the duplicate claims and that an adjustment to reduce the Federal reimbursement was necessary.

EDS indicated that it had corrected the technical problems in the reporting system. The duplicate claim problem was not evident in the remaining quarterly CMS-64 reports for the period of review.

Services Not Eligible for Enhanced Federal Reimbursement

We selected a random statistical sample of 100 claims totaling $4,947 in Federal payments from a universe of 61,988 family planning claims paid for the period October 1, 2003, through September 30, 2004. For 25 of these 100 claims, the State agency had improperly claimed Federal reimbursement at the 90 percent enhanced rate. These claims were related to services that were not intended to prevent or delay pregnancy or otherwise control family size. Thus the 25 claims were allowable for Medicaid reimbursement only at the regular Federal medical assistance payment rates that were in effect during this time. As a result, we estimate that the State agency received excess Federal reimbursement amounting to at least $125,785 (see Appendix A).

For the 25 claims in error, the procedure and/or diagnosis codes were for services that were not included in the CMS Family Planning Services Guide and involved medical services that were not related to family planning but instead were for other medical services of a non-family-planning nature. In fact, some of these services were for pregnant women. Our review of the providers' medical records for these claims confirmed these errors. State agency medical personnel also reviewed the claims and medical records and agreed that these claims were not for family planning services.

These errors occurred because the State agency did not have sufficient procedures in place to identify claims that were eligible for enhanced family planning reimbursement. Although the State agency used certain procedure and diagnosis codes for categorizing claims as family planning services, some of these codes were not in the CMS Family Planning Services Guide. States should use the codes in this guide for identifying claims eligible for the 90 percent enhanced reimbursement for family planning services.

By projecting from the results of the statistical sample, we estimate that the State agency inappropriately claimed at least $125,785 for enhanced Federal reimbursement from October 2003 through September 2004. This estimate represents the lower limit of the 90 percent confidence level. The unallowable amount of an inappropriate claim is the

difference between the 90 percent rate of reimbursement and the State agency's regular rates of Federal reimbursement for medical assistance payments, which were 65.36 percent and 61.34 percent during this period.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $197,582 for the Federal share of duplicate Medicaid claims and $125,785 for costs that were inappropriately claimed at the enhanced 90 percent rate of Federal reimbursement,

- reconcile claims for family planning reimbursement included on the CMS-64 quarterly report of expenditures with paid claim activity reports to ensure that the amounts claimed are accurate, and

- use the CMS Family Planning Services Guide for identifying those procedure and diagnosis codes that are eligible for 90 percent Federal reimbursement.

STATE AGENCY'S COMMENTS

In its response dated December 20, 2005, to our draft report, the State agency agreed with our recommendations (see Appendix B). The State agency indicated that it will reimburse the Federal Government $323,367 and will use the CMS Family Planning Services Guide to track family planning services.

APPENDIXES

APPENDIX A

SAMPLING METHODOLOGY

POPULATION

The sample population consisted of Medicaid claims classified as family planning services by the State agency and claimed for the enhanced Federal reimbursement rate of 90 percent during the period October 1, 2003 through September 30, 2004. This population included 61,988 claims for which the State agency received $3,632,031 in Federal funding.

SAMPLE DESIGN

We used a simple random sampling method to select 100 sample claims from the population for review to determine if the claims were allowable for reimbursement at 90 percent Federal funding. For those claims not eligible for 90 percent Federal funding we determined the difference between what was claimed and what should have been reimbursed to the State agency at the regular Federal medical assistance payment rates in effect at the time of the claim.

RESULTS OF SAMPLE

Sample Size	Value of Sample	Number of Errors	Value of Errors
100	$4,947*	25	$333**

* Federal share of sample claims reimbursed at 90 percent FFP.

** Represents difference between Federal reimbursement of 90 percent and the State agency's regular Federal medical assistance reimbursement at 65.36 percent or 61.34 percent.

PROJECTION OF RESULTS

The point estimate of the projection of the sample was $206,271, with a precision of plus or minus 39.02 percent at the 90-percent confidence level. The lower confidence limit of the projection was $125,785 and the upper confidence limit was $286,757. Accordingly, we are 95 percent confident that the dollar value of errors is at least $125,785.

VERMONT

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Agency of Human Services

December 20, 2005

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services
Region I
Office of Inspector General
Department of Health and Human Services
John F. Kennedy Federal Building
Boston, MA 02203

RE: A-01-05-00002

Dear Mr. Armstrong:

The State of Vermont has received and reviewed the draft report entitled "Audit of Vermont's Medicaid Payments for Family Planning Services Reimbursed at Enhanced Rates – October 2003 – September 2004."

Vermont agrees with the findings stated in this report and will reimburse $323,367.

Vermont will also use the CMS Family Planning Services Guide to track Family Planning Services under the Global Commitment to Health 1115 waiver.

Sincerely,

Joshua Slen
Director