DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

JAN - 9 2006

TO: Dennis G. Smith
Director, Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Family Planning Service Costs Claimed by Pennsylvania's Medicaid Managed Care Program (A-03-03-00214)

Attached is an advance copy of our final report on the Pennsylvania Medicaid managed care program's claim for family planning service costs between October 2000 and February 2004. We will issue this report to Pennsylvania within 5 business days. We conducted the audit at the request of the Centers for Medicare & Medicaid Services (CMS) as part of a multistate initiative.

Pennsylvania contracts with managed care organizations to provide family planning services as required by the Social Security Act (the Act). States may claim 90-percent Federal funding for the costs of family planning services. The Federal share for most other Medicaid services in Pennsylvania is about 54 percent. Although the Act does not specifically require enhanced Federal funding for family planning services provided through managed care delivery systems, CMS has permitted States to claim these costs. Pennsylvania developed a methodology to calculate family planning costs by multiplying a rate, known as a factor, by its managed care capitation payments.

Our objective was to determine whether Pennsylvania claimed family planning service costs under its Medicaid managed care program in accordance with its CMS-approved methodology and Federal statutes, regulations, and guidelines.

Pennsylvania did not claim family planning service costs in accordance with its CMS-approved methodology because it included the following ineligible costs in the numerator of its family planning factor calculation: (1) family planning service costs for beneficiaries not eligible to enroll in managed care and not represented in the denominator and (2) services that did not qualify as family planning.

As a result, between October 2000 and February 2004, Pennsylvania overstated its claim for family planning service costs by $44.4 million. By claiming these costs at the enhanced family planning rate of 90 percent, rather than its regular Federal share of about 54 percent, Pennsylvania received $15.1 million in unallowable Federal reimbursement.

We recommend that Pennsylvania:

- refund to the Federal Government $15,070,548 in family planning service costs incorrectly claimed between October 2000 and February 2004 and

- apply the audited family planning factors (Appendix A) for claims after February 2004 and refund the Federal share of any overpayments.

Pennsylvania did not concur with our recommended refund. However, Pennsylvania agreed to consider the prospective use of the audited factors. We continue to believe that our findings and recommendations are valid.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470. Please refer to report number A-03-03-00214.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
SUITE 316
PHILADELPHIA, PENNSYLVANIA 19106-3499

JAN 11 2006

Report Number: A-03-03-00214

Michael L. Stauffer
Deputy Secretary for Administration
Office of Administration
Department of Public Welfare
Commonwealth of Pennsylvania
Health and Welfare Building, Room 234
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

Dear Mr. Stauffer::

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Family Planning Service Costs Claimed by Pennsylvania's Medicaid Managed Care Program." A copy of this report will be forwarded to the HHS action official noted on the next page for review and any action deemed necessary.

The HHS action official will make the final determination as to actions taken on all matters reported. We request that you respond to the HHS 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

If you have any questions or comments about this report, please do not hesitate to contact me at (215) 861-4470 or through e-mail at stephen.virbitsky@oig.hhs.gov or Robert Baiocco, Audit Manager, at (215) 861-4486 or through e-mail at robert.baiocco@oig.hhs.gov. Please refer to report number A-03-03-00214 in all correspondence.

Sincerely yours,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Nancy B. O'Connor, Regional Administrator
Centers for Medicare & Medicaid Services, Region III
Department of Health and Human Services
The Public Ledger Building, Suite 216
150 S. Independence Mall West
Philadelphia, Pennsylvania 19106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF FAMILY PLANNING SERVICE COSTS CLAIMED BY PENNSYLVANIA'S MEDICAID MANAGED CARE PROGRAM

Daniel R. Levinson
Inspector General

JANUARY 2006
A-03-03-00214

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

Section 1905(a)(4)(c) of the Social Security Act (the Act) requires States to provide family planning services to Medicaid beneficiaries. The Centers for Medicare & Medicaid Services (CMS) defines family planning as those services that prevent or delay pregnancy or otherwise control family size. States may claim 90-percent Federal funding for the costs of family planning services. The Federal share for most other Medicaid services is computed using the Federal medical assistance percentage. In Pennsylvania, this rate is about 54 percent. Although the Act does not specifically require enhanced Federal funding for family planning services provided through managed care delivery systems, CMS has permitted States to claim these costs.

With the assistance of a private consultant, the Pennsylvania Department of Public Welfare developed a methodology to calculate its family planning service costs by multiplying a rate, known as the family planning factor, by its managed care capitation payments. The family planning factor represented the ratio of family planning expenditures to total health care expenditures and was computed using State fiscal year 1996 fee-for-service claims data. Between October 2000 and February 2004, Pennsylvania claimed $102.9 million in Federal funding for family planning service costs.

This audit is part of a CMS-requested multistate review of the rates used to claim family planning service costs at the 90-percent Federal funding rate.

OBJECTIVE

Our objective was to determine whether Pennsylvania claimed family planning service costs under its Medicaid managed care program in accordance with its CMS-approved methodology and Federal statutes, regulations, and guidelines.

SUMMARY OF FINDINGS

Pennsylvania did not claim family planning service costs in accordance with its CMS-approved methodology. Pennsylvania included the following ineligible costs in the numerator of its family planning factor:

- family planning service costs for beneficiaries not eligible to enroll in managed care and not represented in the denominator and

- services that did not qualify as family planning.

As a result, between October 2000 and February 2004, Pennsylvania overstated its claim for family planning service costs by $44.4 million. By claiming these costs at the enhanced family planning rate of 90 percent, rather than its regular Federal share of about 54 percent, Pennsylvania received about $15.1 million in unallowable Federal reimbursement.

RECOMMENDATIONS

We recommend that Pennsylvania:

- refund to the Federal Government $15,070,548 in family planning service costs incorrectly claimed between October 2000 and February 2004 and

- apply the audited family planning factors (Appendix A) for claims after February 2004 and refund the Federal share of any overpayments.

PENNSYLVANIA'S COMMENTS

Pennsylvania did not concur with our recommended refund. Pennsylvania acknowledged that the numerator of the family planning factor included statewide family planning claims. However, Pennsylvania argued that CMS had accepted the substitution of proxy data from Form CMS-64, Medicaid Program Expenditures Report. Pennsylvania did not agree that it had included non-family-planning costs in the numerator of the family planning factor because, it argued, we refused access to a complete set of the audit working papers on which we based the finding. However, Pennsylvania agreed to consider the prospective use of the audited factors.

The full text of Pennsylvania's comments is included as Appendix C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We provided Pennsylvania with those working papers directly related to our finding that Pennsylvania received more than $15 million in excess Federal reimbursement for family planning service costs. Because Pennsylvania provided no further documentation to support its contentions, we continue to believe that our findings and recommendations are valid.

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INTRODUCTION

BACKGROUND

Medicaid Overview

In 1965, Congress established Medicaid as a jointly funded State and Federal program that provides medical assistance to low-income people who qualify pursuant to Title XIX of the Social Security Act (the Act). In the Commonwealth of Pennsylvania, the Department of Public Welfare administers the Medicaid program with Federal oversight from the Centers for Medicare & Medicaid Services (CMS).

Medicaid Reporting Requirements

CMS requires States to report their Medicaid expenditures, both medical assistance and administrative, on Form CMS-64, Medicaid Program Expenditures Report (CMS-64). The Federal Government pays its share of medical assistance expenditures according to a formula defined in section 1905(b) of the Act. That share is known as the Federal medical assistance percentage (FMAP) and ranges from 50 percent to 83 percent depending upon each State's relative per capita income. The FMAP rate in Pennsylvania is approximately 54 percent.

Family Planning Services

Section 1905(a)(4)(c) of the Act requires States to provide family planning services to Medicaid beneficiaries. The scope of family planning services is not further defined in the statute or by regulation. However, CMS provided general guidance in section 4270 of the State Medicaid Manual, which states that the purpose of the family planning benefit is "to aid those who voluntarily choose not to risk an initial pregnancy." Section 4270 further defines family planning services to include those services that prevent or delay pregnancy or otherwise control family size. It also permits States to define the services to include infertility treatment. CMS issued additional guidelines, "Title XIX Financial Management Review Guide (Number 20): Family Planning Services," to clarify the reporting of these services.[1]

Pursuant to section 1903(a)(5) of the Act and 42 CFR §§ 432.50 and 433.15, States may claim 90-percent Federal funding for the costs of family planning services. Although section 1905(a)(4)(c) of the Act does not specifically require enhanced Federal funding for family planning services provided through managed care delivery systems, CMS has permitted States to claim these costs.

[1]CMS issued guidelines in 2002 to expand upon material issued in 1997 that identified procedure codes for family planning services and to provide assistance to its regional offices. The guidelines are also cited in section 2700.2 of the State Medicaid Manual.

Pennsylvania's Managed Care Program

In February 1997, Pennsylvania initiated the HealthChoices program, which required medical assistance beneficiaries in selected counties to enroll in managed care plans. CMS approved the program under a waiver granted pursuant to section 1915(b) of the Act. The program has two components: physical health and behavioral health. Pennsylvania contracts directly with managed care organizations for physical health services, including family planning.

Pennsylvania's Methodology for Claiming Family Planning Service Costs

Pennsylvania provided CMS with a letter in April 2001 that summarized its intended methodology for claiming family planning service costs in its Medicaid managed care program. For each claim submitted on the CMS-64, Pennsylvania proposed to multiply a rate, known as the family planning factor, by its total capitation payments made to managed care organizations. CMS requested that Pennsylvania calculate one family planning factor for each of its five Medicaid eligibility categories because its capitation payments varied according to eligibility category. Pennsylvania calculated the family planning factors with the assistance of a consulting firm using State fiscal year 1996 fee-for-service claims data.[2] The CMS regional office indicated that the methodology that Pennsylvania proposed was acceptable. However, CMS did not validate the fee-for-service expenditures used in calculating the family planning factors to ensure compliance with Pennsylvania's stated methodology.

According to Pennsylvania, the family planning factors represented "family planning costs associated with populations eligible to enroll in managed care and considers only those costs . . . which are included in the development of managed care premiums." Pennsylvania calculated these factors by dividing a:

- numerator that included "total fee-for-service family planning expenditures for recipients eligible to enroll in managed care" by a

- denominator of "total fee-for-service expenditures for recipients eligible for enrollment in managed care for services covered by managed care."

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Pennsylvania claimed family planning service costs under its Medicaid managed care program in accordance with its CMS-approved methodology and Federal statutes, regulations, and guidelines.

[2]Pennsylvania's State fiscal year 1996 ended June 30, 1996.

Scope

Our review covered Pennsylvania's $114.4 million claim for family planning service costs provided through its managed care program for the period October 2000 through February 2004.[3] The Federal share of this claim was $102.9 million, including $39.5 million representing the difference between the 90-percent enhanced family planning rate and Pennsylvania's FMAP rate.[4] We reviewed only those internal controls considered necessary to achieve our objective. We performed our fieldwork in Harrisburg, PA.

Methodology

To accomplish our objective:

- We reviewed relevant criteria, including the Act; Federal Medicaid regulations; CMS's State Medicaid Manual, policy memorandums, and guidelines; Departmental Appeals Board decisions; and Pennsylvania's State Medicaid plan, HealthChoices waiver, and methodology for computing the family planning factors.

- We reconciled the total capitation payments made between October 2000 and February 2004 to those reported on the CMS-64 to determine the Federal share of family planning service costs.

- We reconciled the Federal share claimed on the CMS-64 to the Federal share calculated using the family planning factors.

- We reviewed the numerator and denominator components of the family planning factors to determine whether Pennsylvania computed the factors according to its CMS-approved methodology.

    For the numerator (family planning expenditures):

    - We reconciled the total family planning service costs identified in Pennsylvania's correspondence to CMS to the fee-for-service expenditures reported on the CMS-64 for the year ended June 30, 1996.

    - We analyzed the services identified in a database to determine whether the claims represented family planning expenditures for beneficiaries eligible to enroll in managed care. Pennsylvania provided this database to support the numerator of its family planning factor calculations. This database, totaling $21.9 million, contained claims paid between July 1, 1995, and June 30, 1996. Each claim contained at least one family planning diagnosis code.

[3]Pennsylvania's claim for the quarter ended March 2004 included expenditures for January 2004 and February 2004, but not March 2004.

[4]Pennsylvania's FMAP rate for medical assistance payments during our review period ranged from 53.62 percent to 57.71 percent.

For the denominator (total health care expenditures), we reviewed documentation to support 1996 base-year costs of $973,762,876 to determine whether they represented total fee-for-service expenditures for beneficiaries eligible for enrollment in managed care for services covered by managed care.

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

FINDINGS AND RECOMMENDATIONS

Pennsylvania did not claim family planning service costs in accordance with its CMS-approved methodology. Pennsylvania included in its family planning factor calculations costs for certain services that were contrary to family planning guidelines in section 4270 of the State Medicaid Manual. As a result, between October 2000 and February 2004, Pennsylvania overstated its family planning factors and claimed $44.4 million in excess family planning service costs. By claiming these costs at the enhanced family planning rate of 90 percent, rather than at the FMAP rate of about 54 percent, Pennsylvania received $15.1 million in unallowable Federal reimbursement.

OVERSTATED NUMERATOR IN FAMILY PLANNING FACTOR CALCULATIONS

Pennsylvania overstated the numerator of its family planning factor calculations. The claims data supporting these expenditures included:

- $8.7 million in family planning services for beneficiaries not eligible to enroll in managed care and not represented in the denominator and

- $4.0 million in non-family-planning services.

Family Planning Services for Beneficiaries Not Eligible To Enroll in Managed Care and Not Represented in the Denominator

Pennsylvania included in the numerator of the family planning factor calculations claims for beneficiaries not eligible to enroll in its managed care program. This was contrary to its CMS-approved methodology, which defined the numerator as "total fee-for-service family planning expenditures for recipients eligible to enroll in managed care." Pennsylvania's managed care program operated in only 25 of its 67 counties.

To support these expenditures, Pennsylvania provided a database containing 313,180 fee-for-service claims, totaling $21,940,162, that contained at least 1 family planning diagnosis code.[5] The database covered services paid for the year ended June 30, 1996, for beneficiaries statewide.

[5]Pennsylvania computed its family planning factors using as its numerator $15.1 million in family planning expenditures reported on Form HCFA-64 (now the CMS-64) for the period July 1, 1995, through June 30, 1996. Pennsylvania did not maintain a claims database supporting the $15.1 million figure. At our request, Pennsylvania queried its paid claims file and generated a file containing $21.9 million in claims that contained at least one family planning service for the period July 1, 1995, through June 30, 1996. We used these claims in this review.

According to Pennsylvania's managed care waiver, only those beneficiaries in its 25 managed care counties were eligible to enroll. We removed 123,137 fee-for-service claims totaling $8,691,803 for Medicaid beneficiaries who did not reside in the 25 managed care counties and were not represented in the denominator. After we removed those ineligible costs, the database contained 190,043 claims totaling $13,248,359 for Medicaid beneficiaries who resided in the 25 managed care counties. The denominator of the family planning factor calculations correctly included total health care costs for residents of the 25 counties.

Non-Family-Planning Services

Pennsylvania improperly included non-family-planning services in the numerator of the family planning factor calculations. The 190,043 fee-for-service claims totaling $13,248,359 for Pennsylvania's 25 managed care counties included 1,674 multiple-service inpatient claims totaling $5,798,116 for family planning and non-family-planning services. Each of these multiple-service claims had at least one family planning diagnosis code. Most were coded as contraceptive management. Contraceptive management clearly represents a family planning service, usually sterilization. However, most of the claims (1,647 of 1,674) also included childbirth delivery services, clearly not family planning.

Pennsylvania should have included only the family planning service costs for these multiple-service claims in the numerator of its family planning factor calculations. Using an allocation methodology based on a longstanding agreement between Pennsylvania and CMS, we determined that $4,034,242 represented non-family-planning service costs in the 1,674 multiple-service inpatient claims and should not have been included in the numerator.

The following table illustrates this methodology using a claim for a cesarean section delivery and sterilization performed in April 1996. Pennsylvania paid $3,798.53 for this multiple-service claim and included the entire amount in the numerator of the family planning factor calculation as a family planning service. However, because the sterilization was the secondary diagnosis, Pennsylvania and CMS agreed that $1,018.39, or 26.81 percent, would be claimed as a family planning service. The remaining $2,780.14, or 73.19 percent, represented a non-family-planning service and should not have been included in the database.

Family Planning Allocation Methodology

Claim	Allocation Percentage	Allocation	Federal Share	Total	Component
$3,798.53	26.81%	$1,018.39	90.00%	$916.55	Family planning
3,798.53	73.19%	2,780.14	52.93%	1,471.53	Non-family-planning
				2,388.08	Total Federal share
				1,410.45	State share
				$3,798.53	**Total claim**

INADEQUATE OVERSIGHT OF FAMILY PLANNING FACTOR CALCULATIONS

Pennsylvania developed its family planning factors with the assistance of a consulting firm. The family planning factor calculations improperly included in the numerator (1) family planning service costs for beneficiaries not eligible to enroll in managed care and not represented in the denominator and (2) services that did not qualify as family planning.

Pennsylvania did not ensure that the claims data used to compute the family planning factors complied with its CMS-approved methodology or with CMS guidelines for claiming family planning services.

UNALLOWABLE FEDERAL REIMBURSEMENT

From the database of claims totaling $21,939,521 provided in support of the numerator of the family planning factor calculations, we first removed $8,691,803 that represented claims for Medicaid beneficiaries not eligible to enroll in the State's 25 managed care counties. Next, we removed $4,034,242 in non-family-planning services. We recalculated the family planning factors by dividing the family planning expenditures of $9,214,117 by total health care costs of $973,762,876. (See Appendix A.)

We applied the recomputed family planning factors to capitation payments of $8.3 billion paid between October 2000 and February 2004 and determined that Pennsylvania overstated its family planning service claims by $44,440,698. By claiming these ineligible family planning costs at the enhanced 90-percent rate rather than at its FMAP rate of about 54 percent, Pennsylvania received $15,070,548 in unallowable Federal reimbursement. (See Appendix B.)

RECOMMENDATIONS

We recommend that Pennsylvania:

- refund to the Federal Government $15,070,548 in family planning service costs incorrectly claimed between October 2000 and February 2004 and

- apply the audited family planning factors (Appendix A) for claims after February 2004 and refund the Federal share of any overpayments.

PENNSYLVANIA'S COMMENTS

Pennsylvania did not concur with our first recommendation. Pennsylvania acknowledged that the numerator of the family planning factor included statewide family planning claims. Pennsylvania noted that its CMS-approved methodological submission specifically stated that the numerator was developed by summarizing the total gross family planning service expenditures reported on the CMS-64 for State fiscal year 1996. According to Pennsylvania, CMS accepted the use of proxy data from the CMS-64 as a reasonable approach because the State planned to expand the managed care program statewide and no other method was available.

Pennsylvania did not concur that it had included non-family-planning costs in the numerator because, it argued, we refused access to a complete set of the audit working papers on which we based the finding. Pennsylvania also noted that its family planning factor could be understated because the factor might not have captured some family planning costs incurred in the base-year period but paid after that period. However, Pennsylvania agreed to consider the prospective use of our audited factors.

The full text of Pennsylvania's comments is included as Appendix C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We agree that Pennsylvania's methodological submission stated that the numerator summarized total gross family planning service expenditures. However, we believe that this statement must be viewed in context. In its letter and methodological submission to CMS, dated April 19, 2001, Pennsylvania repeatedly indicated that the numerator was limited to family planning expenditures for beneficiaries eligible for enrollment in managed care. For example, Pennsylvania's letter stated: "A key factor in developing the 'FP Factor' is assuring that the methodology represents family planning costs associated with populations eligible to enroll in managed care and considers only those costs (amounts and categories of services) which are included in the development of managed care premium rates." [Emphasis added.] The letter went on to define the numerator as "total fee-for-service family planning expenditures for recipients eligible to enroll in managed care for a target timeframe."

In its methodological submission, Pennsylvania repeated that the numerator included "total fee for service family planning expenditures for recipients eligible to enroll in managed care for a base year prior to implementation of managed care." [Emphasis added.] Pennsylvania specified 1996 as the base year because "Subsequent to 1996 both family planning fee for service costs and total fee for service expenditures are less precise, for the purpose of this calculation, since many costs are subsumed by the managed care process." Later in the same document, Pennsylvania stated that its consultant's data books detailed "total Medicaid expenditures by category of service for each of the geographic regions included in the managed care program." [Emphasis added.]

When viewed in its entirety, it seems clear, therefore, that Pennsylvania's approved methodology used a numerator consisting of total fee-for-service family planning expenditures for beneficiaries eligible to enroll in managed care in State fiscal year 1996. Pennsylvania had the data that it needed to act on the approved methodology.

We provided Pennsylvania with those working papers directly related to our finding that Pennsylvania received more than $15 million in excess Federal reimbursement for family planning service costs. Specifically, we provided Pennsylvania's original methodological submission and 12 electronic spreadsheet files. Eight of the twelve files represented claims that Pennsylvania provided to support its numerator expenditures. One file represented claims for beneficiaries in non-managed-care counties, as noted in our first finding. Another file represented inpatient claims that contained non-family-planning services, as identified in our second finding. The two remaining files contained our recalculation of the family planning

factors and our overpayment calculation. These papers fully supported our recommended disallowance of $15,070,548 and provided Pennsylvania with sufficient information on which to base its comments.

We disagree with Pennsylvania's comment that its factor could be understated because of family planning costs paid after the base year. Our audit reviewed State fiscal year 1996 base-year claims paid through September 2003 and found that Pennsylvania's family planning factors were overstated. It is unlikely that Pennsylvania would have received and paid claims related to State fiscal year 1996 subsequent to September 2003.

We are pleased that Pennsylvania agreed to consider adopting our audited family planning factors prospectively. However, because Pennsylvania provided no further documentation to support its contentions, we continue to believe that our findings and recommendations are valid.

APPENDIXES

FAMILY PLANNING FACTOR CALCULATIONS

Table 1 shows our recalculation of the numerator of the family planning factor calculations. From a database of claims totaling $21.9 million, we deducted (1) family planning service costs for beneficiaries not eligible to enroll in managed care and not represented in the denominator and (2) non-family-planning services. Our audited numerator totaled $9.2 million.

Table 1: Numerator–Family Planning Service Expenditures

Database of family planning claims	$21,940,162
Ineligible beneficiary expenditures	$(8,691,803)
Subtotal	**$13,248,359**
Non-family-planning expenditures	$(4,034,242)
Audited family planning expenditures	**$9,214,117**

Pennsylvania developed one family planning factor for each Medicaid eligibility category and allocated its numerator expenditures using actual managed care claims data. For example, Pennsylvania determined that 82.66 percent of its capitation payments went for Medicaid beneficiaries enrolled because they qualified as Temporary Assistance for Needy Families (TANF) beneficiaries. As shown in Table 2, Pennsylvania used these managed care percentages to allocate the numerator expenditures.

Table 2: Allocation of Numerator Expenditures

Category of Assistance	Managed Care Organization Expenditures	Allocation Percentage	Family Planning Costs
TANF[1]	$2,008,947	82.66%	$7,616,316
Health Beginnings[2]	39,676	1.63%	150,420
SSI with Medicare[3]	96,198	3.96%	364,706
SSI without Medicare[4]	212,118	8.73%	804,181
General Assistance[5]	73,458	3.02%	278,494
Total	**$2,430,397**	**100.00%**	**$9,214,117**

[1]TANF provides cash assistance to families with dependent children. The TANF factor is also used for capitation payments for maternity services, which Pennsylvania separates from all other capitation payments.

[2]Health Beginnings provides services to low-income families that include children and/or pregnant women.

[3]This category includes individuals who are elderly or disabled and receive Supplemental Security Income (SSI) with either Medicare Part A or Medicare Part A and Part B.

[4]This category includes individuals who are elderly or disabled and receive SSI with Medicare Part B only or no Medicare coverage.

[5]General Assistance provides cash and/or medical support to individuals and families who do not qualify for TANF but have income and resources below established standards.

The audited family planning factors are shown in Table 3. We multiplied the audited factors by the category-specific capitation payment to calculate what we believe Pennsylvania's claim for family planning service costs should have been. These category-specific capitation payments totaled $8.3 billion. (See Appendix B, Table 1.)

Table 3: Audited Family Planning Factor Computations

Category of Assistance	Family Planning Costs (A)	Total Costs (B)	Family Planning Factors (A/B)
TANF	$7,616,316	$315,077,889	2.42%
Health Beginnings	150,420	38,940,332	0.39%
SSI with Medicare	364,706	214,425,214	0.17%
SSI without Medicare	804,181	350,157,847	0.23%
General Assistance	278,494	55,161,594	0.50%
Total	**$9,214,117**	**$973,762,876**	

OVERPAYMENT CALCULATION

Using its family planning factors, Pennsylvania claimed that $114.4 million of its $8.3 billion in capitation payments for the Medicaid managed care program represented family planning service costs. As shown in Table 1, the Federal share of these expenditures totaled $102.9 million.

Table 1: Family Planning Costs Claimed

Federal Fiscal Year	Capitation Payment	Family Planning Service Costs	Federal Share
2001	$1,826,734,503	$26,358,305	$23,722,385
2002	2,299,555,514	30,771,975	27,694,778
2003	2,903,594,531	39,393,898	35,454,508
2004	1,300,205,617	17,838,672	16,054,805
Total	**$8,330,090,165**	**$114,362,850**	**$102,926,476**

Using our audited family planning factors, we believe that Pennsylvania should have claimed $69.9 million, not $114.4 million, in family planning service costs. The enhanced Federal share of the $69.9 million is $62.9 million. Pennsylvania is also entitled to its Federal medical assistance percentage share, $24.9 million, of the $44.4 million originally claimed at the enhanced rate. The total Federal share that Pennsylvania should have claimed was $87.9 million. (See Table 2.)

Table 2: Family Planning Costs Audited

Federal Fiscal Year	Expenditures			Federal Share		
	Family Planning	Non-Family-Planning	Total	Family Planning	Non-Family-Planning	Total
2001	$16,113,484	$10,244,821	$26,358,305	$14,502,136	$5,493,273	$19,995,409
2002	18,811,742	11,960,233	30,771,975	16,930,568	6,536,267	23,466,835
2003	24,091,661	15,302,237	39,393,898	21,682,495	8,895,181	30,577,677
2004	10,905,264	6,933,408	17,838,672	9,814,737	4,001,270	13,816,007
Total	**$69,922,152**	**$44,440,698**	**$114,362,850**	**$62,929,937**	**$24,925,991**	**$87,885,928**

Table 3 shows that the difference between the Federal share claimed and the audited Federal share is approximately $15.1 million.

Table 3: Federal Share of Overpayment

Federal Fiscal Year	Claimed	Audited	Overpayment
2001	$23,722,385	$19,995,409	$3,726,976
2002	27,694,778	23,466,835	4,227,943
2003	35,454,508	30,577,677	4,876,831
2004	16,054,805	13,816,007	2,238,798
Total	**$102,926,476**	**$87,885,928**	**$15,070,548**

COMMONWEALTH OF PENNSYLVANIA
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AUG 1 0 2005

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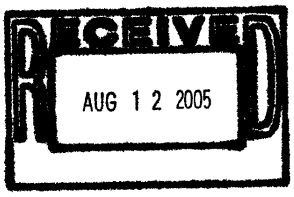

Dear Mr. Virbitsky:

Thank you for the June 13, 2005, letter which transmitted the draft report entitled "Review of Family Planning Service Costs Claimed by Pennsylvania's Medicaid Managed Care Program," Report Number: A-03-03-00214.

We appreciate the opportunity to review the draft report, as well as the extension you granted for submitting a response. We requested the extension in order to have an opportunity to review a complete set of your audit working papers, and thus be capable of fully evaluating the correctness of your findings and conclusions. Regrettably, you have declined to provide us with anything more than 12 Excel spreadsheets, and a copy of one of our own correspondence packages. Apparently, your new proprietary Teammate working paper system has made it difficult for you to provide the working papers and, therefore, you have decided to restrict our access to them. Our lack of access to your work papers is a serious problem, and it significantly impairs our ability to comment on your report.

Our response to the Findings and Recommendations in the draft report is based on the very limited documentation you have provided to us to support your findings and is set forth below:

SUMMARY OF FINDINGS

Pennsylvania Did Not Claim Family Planning Service Costs in Accordance With Its CMS-approved Methodology

The Department of Public Welfare (DPW) does not concur with this finding. We believe we followed the methodology that was approved by the Centers for Medicare and Medicaid Services (CMS) for claiming family planning costs.

The CMS Federal Audit Guide instructs states to develop a reasonable method for allocating costs between family planning and non-family planning activities. Our methodology of allocating these family planning costs was submitted to the CMS regional office by letter dated April 19, 2001, and this same methodology was approved by the CMS regional office on May 18, 2001. The allocation methodology we used is admittedly not perfect, and after extensive fieldwork you may have developed a better method, but our methodology meets the standard of being reasonable and was correctly applied.

Pennsylvania Included the Following Ineligible Costs in the Numerator of Its Family Planning Factor:

- Family Planning Service Costs for Beneficiaries Not Eligible to Enroll in Managed Care and Not Represented in the Denominator

  The DPW does not concur with this finding. It was made clear in our methodological submission to the CMS that the state would use proxy data to compute the numerator of the family planning factor. Your auditors have ignored this portion of our submission to the CMS.

  Your audit focuses on the fact the state said that the numerator of the family planning factor was to be total fee-for-service family planning expenditures for recipients eligible to enroll in managed care. However, the CMS knew that data was not available to compute the numerator directly and, therefore, page 5 of our methodological submission specifically stated that the numerator "was developed by summing the total gross family planning service expenditures reported on the HCFA-64 for the period 7/1/95-6/30/96."

  The CMS is intimately familiar with the HCFA-64 form and, therefore, the DPW could not have been more specific in disclosing our intention to use proxy data to compute the numerator. Our use of HCFA-64 proxy data in the numerator was accepted by the CMS as a reasonable approach. Given that the family planning factor was intended to be applied over a period of time when Pennsylvania's voluntary and mandatory Medicaid managed care program was to be expanded statewide and did, in fact, expand to all but a handful of counties, the use of statewide data from the HCFA-64 form was, in fact, a reasonable approach to computing the numerator.

- Services That Did Not Qualify As Family Planning

  The DPW does not concur with this finding. As stated in our approved methodological submission to the CMS, the numerator was developed by summarizing total gross family planning service expenditures reported on the HCFA-64 for the period July 1, 1995, to June 30, 1996. We believe an adjustment was then made to our family planning claim to account for multiple-service claims. However, because your office has declined to supply the working papers related to the family planning service costs audit, it has been impossible for us to evaluate this issue.

We also note that during the DPW meetings with the CMS regional office staff, there were discussions about the possibility that some allowable family planning costs may not have been captured in this methodology and, therefore, the factor may actually under-claim, rather than over-claim, our reimbursable family planning costs. Because this audit opens up the time period involved in the original claim, the DPW is entitled to claim these additional costs.

To the extent that your auditors have computed a better family planning factor than the one that the DPW used, we would like to consider adopting that factor prospectively. However, your refusal to supply us with your audit working papers makes such a consideration difficult. We reject your recommendation that we refund $15,070,548. The family planning factor we used was both reasonable and approved by the CMS, and you have not shown us that we applied it incorrectly. In closing, our position is that this is unfair to the Commonwealth who, in good faith, worked out this methodology with the CMS regional office; particularly in the amount of time that has passed since this process was implemented. If the Office of the Inspector General (OIG) thinks that a new methodology for claiming family planning costs should be implemented, and if CMS is in agreement, the DPW would be agreeable only on a prospective basis. If we are forced to comply with the OIG's recommendation to change the family planning factors of our methodology, we would certainly like to have additional service costs added that are allowable, but were not included in our original approved method.

Thank you for the opportunity to respond to this report. Please contact Andy Johnson, Bureau of Financial Operations, Audit Resolution Section, at (717) 783-6329 if you should need any further assistance.

Sincerely,

Michael Stauffer

Michael Stauffer

ACKNOWLEDGMENTS

This report was prepared under the direction of Stephen Virbitsky, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

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