TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Review of State Claims for the Costs of Family Planning Services Provided Through Medicaid Managed Care Programs (A-03-06-00200)

The attached final report provides the results of our review of State claims for the costs of family planning services provided through Medicaid managed care programs. After identifying issues with family planning costs claimed under fee-for-service programs, the Centers for Medicare & Medicaid Services (CMS) requested that we conduct this review. We conducted reviews in seven States: Arizona, Colorado, Delaware, Maryland, Missouri, Pennsylvania, and Virginia.

CMS defines family planning services as those services that prevent or delay pregnancy or otherwise control family size. States may claim enhanced 90-percent Federal funding for the costs of these services.

Our objectives were to (1) consolidate the results of the audits of seven States' methodologies for claiming the costs of family planning services provided through Medicaid managed care programs and (2) assess the adequacy of CMS's guidance and practices relative to determining such costs.

Six of the seven States we reviewed inflated the factors or rates used to claim reimbursement for family planning costs at the enhanced 90-percent rate or did not provide documentation to support their calculations as required. As a result, for $302,902,257 in claims reviewed (Federal share), these States claimed unallowable costs totaling $21,749,383 (Federal share):

- Four States inflated their factors by including ineligible beneficiaries and non-family-planning costs, which resulted in improper claims of $18,275,002.

- Two States did not provide documentation to support the calculation of rates on which they based their claims for family planning costs, which resulted in improper claims of $3,474,381.

We found no errors in the seventh State's methodology for claiming family planning costs.

We believe that CMS's lack of specific guidance and lack of controls to ensure that data used by the States conformed to their proposed methodologies contributed to the States' claiming and receiving approximately $21.7 million for unallowable costs.

We recommend that CMS:

- issue specific guidance to State agencies, consistent with current Medicaid regulations, to quantify a reasonable portion of the capitation payments attributable to family planning services;

- establish controls in its review process to ensure that the data States use to quantify family planning costs conform to the proposed methodologies for claiming the enhanced family planning rate; and

- specify retention requirements for base-year data.

In its written comments, CMS agreed with the assumptions on which we based the report and supported collection of funds improperly claimed by four States in our review. CMS agreed to issue guidance as specified in our first recommendation. CMS also confirmed that States should be required to maintain base-year data as long as they are using those data to support their claims. To address CMS's concerns related to the costs of data validation, we have revised our second recommendation to ensure that States conform to their proposed methodologies for quantifying family planning costs when they claim the enhanced family planning rate. CMS's comments are included in their entirety as Appendix B.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. 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 through e-mail at George.Reeb@oig.hhs.gov. Please refer to report number A-03-06-00200 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF STATE CLAIMS FOR THE COSTS OF FAMILY PLANNING SERVICES PROVIDED THROUGH MEDICAID MANAGED CARE PROGRAMS

Daniel R. Levinson
Inspector General

May 2007
A-03-06-00200

Office of Inspector General

http://oig.hhs.gov

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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 services as those services that prevent or delay pregnancy or otherwise control family size. States may claim enhanced 90-percent Federal funding for the costs of these services. The Federal share for most other Medicaid services is based on the Federal medical assistance percentage, which ranges from 50 to 83 percent.

Although the Act does not specifically require enhanced Federal funding for family planning services provided through managed care delivery systems, rather than the fee-for-service standard, CMS has permitted States to claim these costs. At CMS's request, we initiated audits of State claims for family planning services provided through managed care delivery systems. Between January 2005 and January 2006, we issued reports on seven States' claims.

OBJECTIVES

Our objectives were to (1) consolidate the results of our audits of seven States' methodologies for claiming the costs of family planning services provided through Medicaid managed care programs and (2) assess the adequacy of CMS's guidance and practices relative to determining such costs.

SUMMARY OF FINDINGS

Six of the seven States we reviewed inflated the factors or rates used to claim reimbursement for family planning costs at the enhanced 90-percent rate or did not provide documentation to support their calculations as required. As a result, for $302,902,257 in claims reviewed (Federal share), these States claimed unallowable costs totaling $21,749,383 (Federal share):

- Four States inflated their factors by including ineligible beneficiaries and non-family-planning costs, which resulted in improper claims of $18,275,002.

- Two States did not provide documentation to support the calculation of rates on which they based their claims for family planning costs, which resulted in improper claims of $3,474,381.

We found no errors in the seventh State's methodology for claiming family planning costs.

We believe that CMS's lack of specific guidance and lack of controls to ensure that data used by the States conformed to their proposed methodologies contributed to the States' claiming and receiving approximately $21.7 million for unallowable costs.

RECOMMENDATIONS

We recommend that CMS:

- issue specific guidance to State agencies, consistent with current Medicaid regulations, to quantify a reasonable portion of the capitation payments attributable to family planning services;

- establish controls in its review process to ensure that the data States use to quantify family planning costs conform to the proposed methodologies for claiming the enhanced family planning rate; and

- specify retention requirements for base-year data.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

CMS agreed with the assumptions on which we based our report and supported collection of funds improperly claimed by four States in our review. In response to our first recommendation, CMS agreed to issue guidance for quantifying the family planning portion of capitation rates. CMS did not agree with our second recommendation to validate the data used to claim family planning costs. It stated that the cost to develop systems to identify family planning encounters would be prohibitive. In response to our third recommendation, CMS agreed that States should be required to maintain base-year data as long as they are using those data to support their claims.

CMS's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

In response to CMS's comments, we have modified our second recommendation to express our original intent more clearly. In our review, we found that States submitted, and CMS approved, methodologies that proposed to calculate family planning costs based on data that contained eligible services and beneficiary populations. However, four of the seven States did not use the data described in the methodology. As a result, the four States claimed and received incorrect payments totaling $18,275,002. Therefore, we recommend that CMS establish controls in the review process to ensure that States conform to their proposed methodologies when they quantify family planning costs.

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INTRODUCTION

BACKGROUND

After identifying issues with family planning costs claimed under fee-for-service programs, the Centers for Medicare & Medicaid Services (CMS) requested that we conduct a review of family planning service costs claimed under Medicaid managed care programs. We conducted reviews in seven States: Arizona, Colorado, Delaware, Maryland, Missouri, Pennsylvania, and Virginia.

Medicaid Overview

Title XIX of the Social Security Act (the Act) established Medicaid as a jointly funded State and Federal program that provides medical assistance to qualifying low-income people. States administer the Medicaid program with Federal oversight by CMS. To participate in the Medicaid program, each State must receive CMS's approval of a State plan. The State plan is a comprehensive document that defines how the State will operate its Medicaid program.

Pursuant to section 1915(b) or 1115 of the Act, States may seek waivers from the traditional fee-for-service delivery systems to establish managed care delivery systems. Managed care may be provided through health maintenance organizations, prepaid health plans, or comparable entities that agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee, known as a capitation payment. Effective August 13, 2003, 42 CFR § 438.6(c) requires States that provide managed care using risk-based contracts to develop actuarially sound capitation rates based on the costs and utilization of Medicaid State plan services.

The Federal Government pays its share of most types of medical assistance expenditures according to a formula defined in section 1905(b) of the Act. That share is based on the Federal medical assistance percentage, which ranges from 50 to 83 percent.

Family Planning Services

Section 1905(a)(4)(C) of the Act requires States to provide family planning services to Medicaid beneficiaries. Section 4270 of the "State Medicaid Manual" 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. Section 4270 also permits States to define the services to include infertility treatment.

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. CMS issued a summary of relevant law and policy, entitled "Title XIX Financial Management Review Guide (Number 20): Family Planning Services," to State agencies for their use in identifying family planning services under Title XIX.[1] Although section 1905(a)(4)(c) of the Act does not specifically require

[1]CMS issued this guide in 2002. It is an expanded version of the 1997 guide that identified family planning procedure codes and provided assistance to its regional offices for reviewing such claims.

enhanced Federal funding for family planning services provided through managed care delivery systems, CMS has permitted States to claim these costs.

Family Planning Factors and Rates

To claim enhanced Federal funding for family planning services under managed care, the seven States we reviewed developed either family planning factors or rates to estimate the portion of the capitation payment attributable to family planning costs.[2] These estimates were based on fee-for-service claims. CMS approved the seven States' methodologies used to develop the factors and rates.

Five States developed family planning factors by dividing total family planning costs for a targeted population of Medicaid beneficiaries (the numerator) by total health care costs for the targeted population (the denominator) during the targeted timeframe.[3] The States then multiplied the factors, expressed as percentages of the capitation rate, by total capitation payments to estimate family planning costs.

Two States developed family planning rates by dividing total family planning costs for a targeted population of Medicaid beneficiaries for a targeted timeframe (the numerator) by estimated total member enrollment months for the timeframe (the denominator). The result established the estimated dollar amount of the monthly capitation rate attributable to family planning services for each member. The States multiplied this estimated dollar amount by member months of utilization to estimate family planning costs.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to (1) consolidate the results of our audits of seven States' methodologies for claiming the costs of family planning services provided through Medicaid managed care programs and (2) assess the adequacy of CMS's guidance and practices relative to determining such costs.

Scope

This report includes the significant results of our individual reviews. See Appendix A for a summary of the scope of those audits. Between January 2005 and January 2006, we issued a report to each of the seven States and provided a copy to CMS. For each audit, we reviewed only those controls necessary to achieve our audit objective.

We conducted our review at the CMS regional office in Philadelphia, Pennsylvania, and the CMS central office in Baltimore, Maryland.

[2]Six of the seven States contracted with private consultants or actuaries to compute the factors and rates.

[3]Targeted populations and timeframes represented fee-for-service beneficiaries in counties recently converted to managed care programs.

Methodology

To accomplish our objectives, we:

- reviewed relevant Federal laws, regulations, and guidance and State managed care waivers;

- reviewed and summarized the significant results of our seven individual reviews;

- calculated each State's unallowable costs by multiplying the questioned family planning costs by a rate representing the difference between the enhanced family planning rate and the State's statutory Federal medical assistance percentage rate; and

- met with CMS staff to discuss CMS regulations, guidance, oversight of family planning costs claimed under Medicaid managed care, review processes with regard to family planning rates and factors, and record retention policy.

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

FINDINGS AND RECOMMENDATIONS

Six of the seven States we reviewed inflated the factors or rates used to claim reimbursement for family planning costs at the enhanced 90-percent rate or did not provide documentation to support their calculations as required. As a result, for $302,902,257 in claims reviewed (Federal share), these States claimed unallowable costs totaling $21,749,383 (Federal share):

- Four States inflated their factors by including ineligible beneficiaries and non-family-planning costs, which resulted in improper claims of $18,275,002.

- Two States did not provide documentation to support the calculation of rates on which they based their claims for family planning costs, which resulted in improper claims of $3,474,381.

We found no errors in the seventh State's methodology for claiming family planning costs.

We believe that CMS's lack of specific guidance and lack of controls to ensure that data used by the States conformed to their proposed methodologies contributed to the States' claiming and receiving approximately $21.7 million for unallowable costs.

FAMILY PLANNING CLAIMS

During the audit periods, six of the seven States that we reviewed claimed unallowable family planning costs of $21,749,383. See Appendix A for the improper Federal payments by State.

Inflated Factors

Section 1903(a)(5) of the Act and 42 CFR §§ 432.50 and 433.15 allow Federal funding at an enhanced 90-percent rate for family planning services as defined in section 4270 of the "State Medicaid Manual" and subsequent guidance. Section 4270 defines family planning services to include services that prevent or delay pregnancy or otherwise control family size.

Four of the seven States inflated the data elements used to develop their family planning factors by including ineligible beneficiaries and costs for non-family-planning services. These States then applied the incorrectly calculated factors to their total capitation payments, which resulted in incorrect payments of $18,275,002 (Federal share). Specifically, these States included in the numerator of their calculations costs for Medicaid beneficiaries who were not approved for managed care and costs for such services as childbirth delivery provided in conjunction with sterilization.

Undocumented Rates

The "State Medicaid Manual," section 2497.1, requires that States have supporting documentation for claims in readily reviewable form. However, two States did not provide documentation to support their rate calculations, which resulted in improper payments of $3,474,381 (Federal share).

For example, Delaware used fee-for-service claims from 1991 through 1994 as its base-year data to calculate its managed care rates. Delaware then used these rates to calculate its family planning claims from 2000 through 2004. During our fieldwork, we asked for the base-year data to verify the reasonableness of the rates. The State informed us that it was not able to provide the data in a reviewable format because retrieving the data required the use of outdated hardware and software.

CENTERS FOR MEDICARE & MEDICAID SERVICES GUIDANCE AND PRACTICES

Effective August 13, 2003, 42 CFR § 438.6(c) requires States to develop actuarially sound capitation rates for risk-based contracts based on the costs and utilization of Medicaid State plan services, which include family planning services. This requirement was not in effect during the majority of the audit periods for the seven States. Furthermore, CMS did not provide specific guidance for States to quantify a reasonable portion of the capitation payments attributable to family planning services. In the absence of specific CMS guidance, States developed various methodologies, using their historical fee-for-service claims data, to calculate family planning factors or rates.

Although CMS reviewed each State's methodology, it did not have controls in place to ensure that the various data elements that each State used in its factor or rate computation conformed to the State's methodology. In addition, CMS did not issue specific guidance on how long historical base-year data must be retained and available for Federal audit.

We believe that CMS's lack of specific guidance and lack of controls to ensure that data used by the States conformed to their proposed methodologies contributed to the States' claiming and receiving approximately $21.7 million for unallowable costs.

RECOMMENDATIONS

We recommend that CMS:

- issue specific guidance to State agencies, consistent with current Medicaid regulations, to quantify a reasonable portion of the capitation payments attributable to family planning services;

- establish controls in its review process to ensure that the data States use to quantify family planning costs conform to the proposed methodologies for claiming the enhanced family planning rate; and

- specify retention requirements for base-year data.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

CMS agreed with the assumptions on which we based our report and supported collection of funds improperly claimed by four States in our review. In response to our first recommendation, CMS agreed to issue guidance that will require States to use the most recent, complete historical data to quantify the family planning portion of their capitation rates. CMS did not agree with our second recommendation to validate the data used to claim family planning costs. It stated that the cost to develop systems to identify family planning encounters would be prohibitive compared to the savings to be achieved. In response to our third recommendation, CMS agreed that States should be required to maintain base-year data as long as they are using those data to support their claims.

CMS's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

In response to CMS's comments, we have modified our second recommendation to express our original intent more clearly. In our review, we found that States submitted, and CMS approved, methodologies that proposed to calculate family planning costs based on data that contained eligible services and beneficiary populations. However, four of the seven States did not use the data described in the methodology. Rather, the States included ineligible services and beneficiaries in the data they actually used to calculate their family planning costs. As a result, the four States claimed and received incorrect payments totaling $18,275,002. Therefore, we recommend that CMS establish controls in the review process to ensure that States conform to their proposed methodologies when they quantify family planning costs.

APPENDIXES

APPENDIX A

FAMILY PLANNING CLAIMS AND UNALLOWABLE COSTS FOR THE SEVEN STATES REVIEWED

Report Number[1]	State	Audit Period	Federal Share	
			Family Planning Claims Reviewed	Unallowable Costs
A-03-03-00214	Pennsylvania	10/2000 – 02/2004	$102,926,476	$15,070,548
A-07-04-01004	Missouri	10/2000 – 09/2003	67,418,574	0
A-03-03-00218	Maryland	07/2000 – 03/2004	59,681,707	228,643
A-03-04-00209	Virginia	04/2001 – 03/2004	32,168,144	1,388,506
A-09-04-00027	Arizona	10/1999 – 09/2002	20,779,332	558,093
A-07-04-01005	Colorado	10/1999 – 12/2003	12,439,617	1,587,305
A-03-03-00220	Delaware	10/2000 – 06/2004	7,488,407	2,916,288
Total			**$302,902,257**	**$21,749,383**

[1]These reports are available at http://oig.hhs.gov.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: MAR 2 9 2007

TO: Daniel R. Levinson
Acting Inspector General

FROM: Leslie V. Norwalk, Esq.
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of State Claims for the Costs of Family Planning Services Provided Through Medicaid Managed Care Programs" (A-03-06-00200)

Thank you for the opportunity to review and comment on the subject OIG draft report. We agree with the assumptions upon which the OIG study and reports were based (i.e. that States which claim the enhanced match rate of 90 percent for family planning services provided through prepaid managed care programs should be able to provide documentation on the methodology for determining the amount claimed). We support the collection of funds claimed by four States that included ineligible beneficiaries and non-family planning costs in their claims as family planning expenditures. Further, States should be able to provide the documentation on which their claims are based and we support OIG's findings on the two States that could not do so.

We have the following comments on OIG's specific recommendations contained in the draft report:

OIG Recommendation

Issue specific guidance to State agencies, consistent with current Medicaid regulations, to quantify a reasonable portion of the capitation payments attributable to family planning services.

CMS Response

The CMS agrees to issue such guidance and require States to use the most recent, complete historical data available, whether from prepaid managed care data or fee-for-service.

OIG Recommendation

Validate data when reviewing proposed State methodologies for claiming the costs of family planning services provided through managed care programs.

CMS Response

The CMS believes that the cost and administrative investment required for a validation of all data used when States claim family planning costs at the enhanced match rate would outweigh the savings that could be achieved. The time and cost of the design, implementation, and data validation of an encounter data system that specifically served the purpose of identifying only those encounters that represented family planning services would be prohibitive when compared to the savings to be achieved.

- Family planning services represent a small amount of the total capitation rates paid in Medicaid.
- Many States are in the midst of developing validated encounter data for use in setting rates and risk adjustment, but these systems would not likely be of any assistance in identifying family planning encounters, since they usually identify data by category of service (e.g., inpatient hospital or physician) or long term diagnosis rather than a specific category like family planning.

OIG Recommendation

Specify retention requirements for base-year data.

CMS Response

The CMS believes that States should be required to maintain the base-year data, as well as the methodology used by the State, as long as it is using that data and methodology to support its claim for family planning expenditures. CMS will remind States that they are required to have supporting documentation for claims in a readily reviewable form. Unlike overall Medicaid payment data, which actuaries believe loses its validity for rate setting purposes after approximately 5 years, family planning expenditures, as a percentage of total Medicaid costs for a given category of beneficiaries, is a relatively stable number. Thus for this purpose, the age of the base-year data is not as significant as the maintenance of the data and methodology applied.