Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WISCONSIN IMPROPERLY CLAIMED ENHANCED FEDERAL REIMBURSEMENT FOR SOME NON-FAMILY PLANNING SERVICES

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

Sheri L. Fulcher
Regional Inspector General
for Audit Services

October 2015
A-05-13-00034

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

Wisconsin improperly claimed at least $74,000 for enhanced Federal Medicaid reimbursement for non-family planning services.

WHY WE DID THIS REVIEW

Federal laws and regulations authorize Federal Medicaid reimbursement to States for family planning services at an enhanced Federal medical assistance percentage (FMAP) of 90 percent (90-percent rate). These services are funded through Medicaid or through demonstration projects, known as waivers, which allow States to expand Medicaid to grant eligibility to individuals who would not otherwise have been eligible or to provide services that are not typically covered. Previous Office of Inspector General reviews found that States improperly claimed reimbursement at the 90-percent rate for services that were eligible only for the regular FMAP or were ineligible for Federal reimbursement.

The objective of this review was to determine whether the Wisconsin Department of Health Services (the State agency) properly claimed Federal Medicaid reimbursement at the 90-percent rate for family planning services.

BACKGROUND

Section 4270(B) of the Centers for Medicare & Medicaid Services (CMS) *State Medicaid Manual* (the Manual) states that family planning services prevent or delay pregnancy or otherwise control family size and may also include infertility treatments. The Manual indicates that States are free to determine which services and supplies will be covered as long as those services are sufficient in amount, duration, and scope to reasonably achieve their purpose. However, only services and supplies clearly furnished for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate.

In Wisconsin, the State agency is responsible for administering the Medicaid program. Wisconsin covers family planning services and supplies for individuals eligible under Medicaid, the BadgerCare Plus Standard Plan, and the BadgerCare Plus Benchmark Plan. Wisconsin also provides family planning services to the optional categorically needy group of individuals described in Section 1902(ii) of the Social Security Act (the Act).

HOW WE CONDUCTED THIS REVIEW

Our review covered 1,541,228 family planning services and prescription drugs (collectively referred to as "family planning services") totaling $100,711,399 (Federal share), claimed from October 1, 2010, through September 30, 2012 (audit period). We selected a stratified random sample of 120 family planning services for detailed review and determined whether the State agency properly claimed Federal Medicaid reimbursement at the 90-percent rate. In computing the unallowable portion of the Federal share of payments, we calculated the difference between the 90-percent rate and the regular FMAP applicable for each quarter.

WHAT WE FOUND

The State agency did not always claim Federal Medicaid reimbursement for family planning services in accordance with Federal requirements. The State agency improperly claimed Federal Medicaid reimbursement at the 90-percent rate for 48 non-family planning services. Of the 120 sampled family planning services we reviewed totaling $103,443 (Federal share):

- 72 were claimed in accordance with Federal requirements;
- 25 were claimed for services unrelated to family planning; and
- 23 were claimed for child deliveries coupled with a subsequent sterilization.

The State agency did not always properly claim Medicaid reimbursement for family planning services because: (1) the State agency's edits to determine which claims should be processed for reimbursement at the 90-percent rate were not always effective and (2) the State agency did not have a process to allocate the family planning portion of delivery-related services when a patient was sterilized after childbirth. As a result of these errors, the State agency improperly claimed a total of $27,831 for Medicaid family planning services in excess of the FMAP rates for the sampled services. On the basis of our sample results, we estimated that the State agency improperly claimed at least $74,391 (Federal share) in Medicaid reimbursement for family planning services during our audit period.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $74,391 to the Federal Government for services that did not comply with Federal requirements for family planning services,
- improve system edits so that only allowable family planning services are claimed at the 90-percent rate, and
- implement a system edit to allocate family planning expenditures when sterilization is not the primary reason for the hospital or physician visit.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency generally concurred with our recommendations. Although the State agency noted that the amount reported in error, $74,391, resulted in an error rate of only 0.07 percent, it does concur with the amount and will refund the Federal share. Additionally, the State agency has approved corrective actions to remove the indicator that attests to whether a claim is family planning related and to cease enhanced Federal reimbursement for family planning claims linked to hospital related bundled payments. We maintain that our recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

Federal laws and regulations authorize Federal Medicaid reimbursement to States for family planning services at an enhanced Federal medical assistance percentage (FMAP) of 90 percent (90-percent rate). These services are funded through Medicaid or through demonstration projects, known as waivers, which allow States to expand Medicaid to grant eligibility to individuals who would not otherwise have been eligible or to provide services that are not typically covered. Previous Office of Inspector General reviews found that States improperly claimed reimbursement at the 90-percent rate for services that were eligible only for the regular FMAP or were ineligible for Federal reimbursement.

OBJECTIVE

The objective of this review was to determine whether the Wisconsin Department of Health Services (the State agency) properly claimed Federal Medicaid reimbursement at the 90-percent rate for family planning services.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). 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 States have considerable flexibility in designing and operating their Medicaid program, they must comply with applicable Federal requirements. In Wisconsin, the State agency is responsible for administering the Medicaid program.

The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the FMAP, which varies depending on the State's relative per capita income (section 1905(b) of the Act). For fiscal year (FY) 2011, the FMAP for Wisconsin ranged each quarter from 60.16 percent to 70.63 percent. For FY 2012, the FMAP for Wisconsin was 60.53 percent. The Act authorizes Federal reimbursement at the 90-percent rate for family planning medical assistance services (section 1903(a)(5) of the Act).

Medicaid Coverage of Family Planning Services

States furnish family planning services and supplies to individuals of childbearing age (including minors who can be considered sexually active) who are eligible under the State plan and desire such services and supplies (section 1905(a)(4)(C) of the Act).

Family planning services are those that prevent or delay pregnancy or otherwise control family size and may also include infertility treatments.[1] The Manual indicates that States are free to determine which services and supplies will be covered as long as those services are sufficient in amount, duration, and scope to reasonably achieve their purpose. However, only services and supplies clearly furnished for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate.

Family Planning Services in Wisconsin

Wisconsin covers family planning services and supplies for individuals eligible under Medicaid, the BadgerCare Plus Standard Plan, and the BadgerCare Plus Benchmark Plan. Wisconsin also provides family planning services to the optional categorically needy group of individuals described in Section 1902(ii) of the Social Security Act (the Act).

In Wisconsin, family planning services are available to individuals of childbearing age. Service providers determine "childbearing" age, except that sterilizations are limited to individuals who are 21 years and older. There is no gender restriction on family planning services and the State does not cover infertility testing and treatment.

Wisconsin's family planning benefit includes reproductive health care services aimed at contraceptive management and limited related services including:

- Services to prevent or delay pregnancy, including contraceptive pills, condoms, contraceptive implants, prescription drugs, and physician-administered injections;
- Voluntary sterilizations;
- Emergency contraception;
- Preventative medicine and patient education visits;
- Sexually transmitted disease/infection counseling, testing and treatment; and
- Related office visits.

HOW WE CONDUCTED THIS REVIEW

Our review covered 1,541,228 family planning services and prescription drugs (collectively referred to as "family planning services") totaling $100,711,399 (Federal share), claimed from October 1, 2010, through September 30, 2012 (audit period). We selected a stratified random sample of 120 family planning services for detailed review and determined whether the State agency properly claimed Federal Medicaid reimbursement at the 90-percent rate. In computing the unallowable portion of the Federal share of payments, we calculated the difference between the 90-percent rate and the regular FMAP applicable for each quarter.

[1] Section 4270(B) of the CMS *State Medicaid Manual* (the Manual).

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 A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The State agency did not always claim Federal Medicaid reimbursement for family planning services in accordance with Federal requirements. The State agency improperly claimed Federal reimbursement at the 90-percent rate for 48 non-family planning services. Of the 120 sampled family planning services we reviewed totaling $103,443 (Federal share):

- 72 were claimed in accordance with Federal requirements;
- 25 were claimed for services unrelated to family planning; and
- 23 were claimed for child deliveries coupled with a subsequent sterilization.

The State agency did not always properly claim Medicaid reimbursement for family planning services because: (1) the State agency's edits to determine which claims should be processed for reimbursement at the 90-percent rate were not always effective and (2) the State agency did not have a process to allocate the family planning portion of delivery-related services when a patient was sterilized after childbirth. As a result of these errors, the State agency improperly claimed a total of $27,831 for Medicaid family planning services in excess of the FMAP rates for the sampled services. On the basis of our sample results, we estimated that the State agency improperly claimed at least $74,391 (Federal share) in Medicaid reimbursement for family planning services during our audit period.

THE STATE AGENCY DID NOT ALWAYS ENSURE THAT SERVICES CLAIMED AT THE 90-PERCENT RATE WERE RELATED TO FAMILY PLANNING

Family planning services are provided to people who voluntarily choose not to risk an initial pregnancy or who desire to control family size (the Manual, § 4270(B)). States may determine specific services and supplies it will pay for as family planning; however, the services and supplies must reasonably achieve a family planning purpose. Only services and supplies provided for family planning purposes may be reimbursed at the 90-percent rate.

Of the 120 sample items we reviewed, 25 were for services improperly claimed as family planning:

- Nine were for individuals who received services related to mental health, such as schizophrenia, attention deficit disorder, psychosis, anxiety disorder, abnormal psychological development, or psychological testing. These types of services are not related to family planning.

- Three were for individuals who received services pursuant to high risk pregnancy supervision. These types of services are not considered family planning.

- Three were for individuals who received services pertaining to neuromuscular re-education. Neuromuscular re-education deals with retraining the brain, and spinal cord involuntary and reflex motor activities. These types of services are not related to family planning.

- Two were for individuals who received services pertaining to developmental delay treatment. These types of services are not considered family planning.

- The remaining eight were for individuals who received services pertaining to: wheelchair van mileage, gait therapy, cataracts, macular degeneration, colonoscopy, colposcopy, and gastritis. None of these types of services are considered family planning.

These types of services are not eligible as family planning services at the 90-percent rate; however, they would have been allowable for reimbursement as Medicaid services. To determine the amount of the overpayment caused by the State agency claiming at the 90-percent rate instead of the regular FMAP, we calculated the difference between the 90-percent rate and the regular FMAP.

Twenty-four of these errors occurred because the State agency's edits to determine which claims should be processed for reimbursement at the 90-percent rate were not always effective. Specifically, when a provider submits a claim, the provider marks "Y" or "N" on the claim to denote whether or not the claim is related to family planning. If the provider marks "Y," the State agency's system edits automatically process the claim for reimbursement at the 90-percent rate, even if the types of services in the claim are unrelated to family planning. The other error occurred because the State agency's edit permitted a colposcopy to be claimed at the 90-percent rate based on a family planning diagnosis code on the claim. CMS policy, however, does not consider colposcopies to be services performed primarily for family planning, but rather to identify and treat medical conditions.

As a result of these 25 errors, the State agency improperly claimed $371 (Federal share) for services in our sample that should not have been claimed as family planning services.

THE STATE AGENCY DID NOT PROPERLY ALLOCATE FAMILY PLANNING COSTS WHEN STERILIZATION WAS NOT THE PRIMARY PROCEDURE

CMS's *Financial Management Review Guide Number 20*, entitled *Family Planning Services* provides specific instructions for performing financial management reviews of claims for family planning services. The guide refers to a 1980 policy memorandum regarding CMS policy in allocating family planning inpatient hospital costs where multiple procedures are performed. That CMS policy states that when multiple procedures are performed during a single hospital stay and submitted as a single inpatient claim, a State claim for Federal reimbursement must distinguish between those costs attributable to family planning (eligible for 90-percent Federal reimbursement) and those costs attributable to other covered services (reimbursed at the regular Federal medical assistant percentages). CMS does not require a specific allocation method, but does require that the reasonableness of the methodology be determined on a State-by-State basis. Additionally, according to *New York State Department of Social Services*, DAB No. 1284 (1991), the allocation method adopted by a State must reasonably claim the appropriate rate of Federal reimbursement. The Decision further states that without a reasonable method to make this allocation properly, the State is not entitled to reimbursement at the enhanced rate.

Section 4270 of CMS's *State Medicaid Manual* generally permits a 90-percent rate of Federal reimbursement for medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception. Only items and procedures clearly furnished or rendered for family planning purposes may be claimed at the 90-percent rate.

For 23 of the 120 sample items we reviewed, the State agency did not properly allocate the family planning portion of a claim when family planning was not the primary reason for the hospital visit. In each of these cases, the patient's primary procedure related to child delivery.

As a result of these 23 errors, the State agency improperly claimed $27,460 (Federal share) for these claims at the 90-percent rate because it did not have a process to allocate the family planning portion of delivery-related services when a patient was sterilized after childbirth.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the State agency improperly claimed at least $74,391 in Medicaid reimbursement for family planning services that did not comply with Federal requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund $74,391 to the Federal Government for services that did not comply with Federal requirements for family planning services,

- improve system edits so that only allowable family planning services are claimed at the 90-percent rate, and

- implement a system edit to allocate family planning expenditures when sterilization is not the primary reason for the hospital or physician visit.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency generally concurred with our recommendations. Although the State agency noted that the amount reported in error, $74,391, resulted in an error rate of only 0.07 percent, it does concur with the amount and will refund the Federal share. Additionally, the State agency has approved corrective actions to remove the indicator that attests to whether a claim is family planning related and to cease enhanced Federal reimbursement for family planning claims linked to hospital related bundled payments.

We maintain that our recommendations are valid.

The State agency's comments are included in their entirety as Appendix D.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed family planning services reported in column D of the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report) from October 1, 2010, through September 30, 2012. Our review covered 1,541,228 family planning services totaling $100,711,399 (Federal share), claimed during the audit period.

We did not review the overall internal control structure of the State agency because our objective did not require us to do so. Rather, we limited our review to the State agency's procedures for processing claims for family planning services. We conducted our fieldwork from May 2013, through May 2015 at the State agency's office in Madison, Wisconsin.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, guidance, and the State plan;
- interviewed State agency officials to gain an understanding of policies and procedures for family planning services;
- obtained the claim data supporting the CMS-64 reports for Federal fiscal years 2011 and 2012 from the State agency;
- reconciled the claim data totals with the amounts claimed on the CMS-64 reports for Federal fiscal years 2011 and 2012;
- identified a sampling frame of 1,541,228 family planning services totaling $100,711,399 (Federal share);
- selected a stratified random sample of 120 family planning services;
- obtained the supporting claim documentation from the State agency;
- summarized the results of the review;
- estimated the overpayment in the total sampling frame of 1,541,228 family planning services; and
- discussed the results of our audit with the State agency.

See Appendix B for the statistical sampling methodology and Appendix C for the sample results and estimates.

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: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicaid family planning services and prescription drugs claimed by Wisconsin at the 90-percent rate from October 1, 2010, through September 30, 2012.

SAMPLING FRAME

The sampling frame consisted of 1,541,228 family planning services and prescription drugs totaling $100,711,399 (Federal share).

SAMPLE UNIT

The sample unit was a family planning service or prescription drug.

SAMPLE DESIGN

We selected a stratified random sample.

Stratum	Number of Claims	Amount of Claims (Federal Share)
1	3,688	$226,436
2	1,537,520	100,387,722
3	20	97,241
Total	**1,541,228**	**$100,711,399**

Stratum 1 contained family planning services, which we identified as having procedure or diagnosis codes unrelated to family planning.

Stratum 2 contained family planning services or prescription drug claims that were not otherwise included in stratum 1 or stratum 3.

Stratum 3 contained family planning services for sterilization services that did not have a procedure code or diagnosis code starting with V25.

SAMPLE SIZE

We selected a sample of 120 sample units, 30 from stratum 1, 70 from stratum 2, and 20 from stratum 3.

SOURCE OF RANDOM NUMBERS

We used the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software, RAT-STATS to generate the random numbers.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sampling frames for strata 1 and 2. After generating the random numbers, we selected the corresponding frame items. We reviewed all 20 frame items in stratum 3.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total Federal share of overpayments.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results (Federal Share)

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Sample Units With Errors	Value of Improperly Claimed Services
1	3,688	$226,436	30	$2,715	28	$783
2	1,537,520	100,387,722	70	3,487	0	0
3	20	97,241	20	97,241	20	27,048
Total	**1,541,228**	**$100,711,399**	**120**	**$103,443**	**48**	**$27,831**

Estimated Value of Improperly Claimed Services (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$123,389
Lower limit	74,391
Upper limit	172,387

APPENDIX D: STATE AGENCY COMMENTS

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

September 23, 2015

Ms. Sheri L. Fulcher
Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan Avenue, Suite 1360
Chicago, IL 60601

Re: Report No: A-05-13-00034

Dear Ms. Fulcher:

This letter sets forth the comments of the Wisconsin Department of Health Services (WIDHS) regarding the U.S. Department of Health and Human Services, Office of Inspector General's (OIG) draft report entitled *Wisconsin Inappropriately Claimed Enhanced Federal Reimbursement for Some Non-Family Planning Services*, Report No: A-05-13-00034, dated Aug 24, 2015 (hereinafter, "Draft").

The Draft report makes three recommendations:

DHHS OIG finding:

Refund $74,391 to the Federal Government for services that did not comply with Federal requirements for family planning services.

WI DHS Response:

The WIDHS has welcomed the OIG audit of our family planning claims. While we note that the OIG report is entitled *Wisconsin Inappropriately Claimed Enhanced Federal Reimbursement for Some Non-Family Planning Services*, it is important to recognize the results show an error rate of only 0.07%. As you indicate in your report, this audit included two years of claims data worth approximately $100,700,000, of which only $74,391 was determined errant. Several years ago WIDHS identified that the Wisconsin Medicaid program was significantly under-claiming the appropriate amount of federal reimbursement for family planning services. Given the results of the OIG audit, it appears the WIDHS is moving in the right direction. However, we are happy to continue our efforts to further improve our financial claiming process and we concur that $74,391 will appropriately be remitted back to our federal partners via the CMS-64 September 2015 quarterly report.

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DHHS OIG finding:

Improve system edits so that only allowable family planning services are claimed at the 90 percent rate.

WI DHS Response:

The OIG audit report correctly notes that claims submissions by providers may include use of an indicator by providers to attest whether a claim is family planning related. Provider attestation for certain service types, like family planning, is useful in order to exempt patients from cost sharing responsibility where appropriate. However, provider attestations are not always 100% accurate. To the extent that enhanced federal claiming has been linked to this attestation, we attribute the largest share of our claims error to inaccurate provider use of this indicator. With this in mind, the department has approved corrective action that disassociates the use of this indicator with enhanced federal reimbursement for family planning services. This will effectively address the finding that OIG generally describes as improving system edits.

DHHS OIG finding:

Implement a system edit to allocate family planning expenditure when sterilization is not the primary reason for the hospital or physician visit.

WI DHS Response:

The issue related to sterilization procedures that are coupled with inpatient childbirth is complicated by the fact that inpatient hospital payments follow a bundled payment method unlike professional claims. We concur with the underlying issue which is, in very few instances, bundled hospital payments qualify for more than one federal reimbursement percentage where a family planning diagnosis or procedure exists. However, the extremely low volume of such claim activity makes it more cost effective to forgo the federal revenue than commit to a major technical investment for little financial benefit. Therefore, the department has approved corrective action to cease enhanced federal reimbursement for the few family planning claims we experience that are linked to hospital related bundled payments.

Thank you for the opportunity to comment.

Sincerely,

Kitty Rhoades
Secretary
Wisconsin Department of Health Services