



May 9, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Child Delivery Claims and Newborn Claims Included in the
Kansas Medicaid Family Planning Program (A-07-10-04156)

Attached, for your information, is an advance copy of our final report on child delivery claims and newborn claims included in the Kansas Medicaid family planning program. We will issue this report to the Kansas Health Policy Authority within 5 business days.

If you have any questions or comments about this report, please do not hesitate to contact me at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov, or your staff may contact Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591 or through email at Patrick.Cogley@oig.hhs.gov. Please refer to report number A-07-10-04156.

Attachment



Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

May 12, 2011

Report Number: A-07-10-04156

Andrew Allison, Ph.D.
Executive Director
Kansas Health Policy Authority
Room 900-N Landon State Office Building
Topeka, KS 66612

Dear Dr. Allison:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Child Delivery Claims and Newborn Claims Included in the Kansas Medicaid Family Planning Program*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Debra Keasling, Audit Manager, at (816) 426-3213 or through email at Debra.Keasling@oig.hhs.gov. Please refer to report number A-07-10-04156 in all correspondence.

Sincerely,

/Patrick J. Cogley/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
CHILD DELIVERY CLAIMS AND
NEWBORN CLAIMS
INCLUDED IN THE
KANSAS MEDICAID
FAMILY PLANNING PROGRAM**



Daniel R. Levinson
Inspector General

May 2011
A-07-10-04156

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Kansas, the Kansas Health Policy Authority (the State agency) is responsible for administering the Medicaid program.

The amount of funding that the Federal Government reimburses to State Medicaid agencies, known as either Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. The State agency's FMAP rate ranged from 59.43 percent to 68.31 percent for claims paid from July 1, 2005, through June 30, 2009.

Federal requirements also make provisions for various specified services to be reimbursed at higher rates of FFP. Section 1903(a)(5) of the Act and 42 CFR § 433.10(c)(1) authorize reimbursement at an enhanced 90-percent FFP rate (90-percent FFP rate) for family planning services. Section 4270 of the CMS *State Medicaid Manual* (the manual) describes family planning services as those that prevent or delay pregnancy or otherwise control family size and may also include infertility treatments. Pursuant to the provisions of the manual, only items and procedures clearly furnished or provided for family planning purposes may be claimed at the 90-percent FFP rate.

CMS issued *Financial Management Review Guide Number 20* (the guide) to the State agency via Medicaid State Operations Letter 91-9, dated January 30, 1991. The guide states that any procedure provided to a woman known to be pregnant may not be considered a family planning service reimbursable at the 90-percent FFP rate.

For State fiscal years 2006 through 2009, the State agency was reimbursed \$19,997,233 (\$17,997,509 Federal share) for a variety of family planning services at the 90-percent FFP rate. Of this amount, we separately reviewed certain family planning costs totaling \$9,600,196 (\$8,640,176 Federal share) for specifically identified family planning pharmacy claims (A-07-10-04157), family planning sterilization services (A-07-10-04162), and selected other family planning claims (A-07-09-04146). This review covers the remaining \$10,397,037 (\$9,357,333 Federal share) for 2,781 child delivery claims and newborn claims, for which the State agency claimed reimbursement at the family planning 90-percent FFP rate.

OBJECTIVE

Our objective was to determine whether the child delivery and newborn claims submitted by providers and claimed by the State agency at the 90-percent FFP rate from July 1, 2005, through June 30, 2009, qualified as family planning services pursuant to Federal requirements.

SUMMARY OF FINDINGS

None of the family planning child delivery and newborn claims submitted by providers and claimed by the State agency at the 90-percent FFP rate from July 1, 2005, through June 30, 2009, qualified as family planning services pursuant to Federal requirements. However, for some claims, a portion of the claim qualified as an allowable family planning service.

Based on our review of a discovery sample of 30 claims and our review of all of the procedure and diagnosis codes, we determined that all 2,781 child delivery claims and newborn claims were erroneously claimed for 90-percent FFP and that the State agency received \$2,447,414 in unallowable Federal reimbursement. The \$2,447,414 represents the difference between the amount that the State agency claimed at the 90-percent FFP rate and the amount that should have been claimed at the standard FMAP rate pursuant to Federal requirements.

These errors occurred because the Medicaid Management Information System's (MMIS) edits did not always correctly identify claims for reimbursement at the 90-percent FFP rate. Also, a lack of oversight by the State agency allowed these claims to be reimbursed as family planning services.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$2,447,414 to the Federal Government;
- determine the amount of Federal Medicaid funds that were improperly reimbursed at the 90-percent FFP rate for child delivery and newborn services because they did not qualify as family planning services, both before and after our audit period, and refund that amount to the Federal Government; and
- ensure that MMIS edits appropriately identify claims that are ineligible for reimbursement at the 90-percent FFP rate.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not agree with our finding related to the 2,781 child delivery and newborn claims or our recommendation to refund \$3,045,450. It also described an additional review that it conducted to determine the portion of claims reviewed and related to sterilization. It stated that using this method resulted in a Federal refund of \$2,009,826.

With respect to our findings, the State agency said that all of the 2,781 claims included "... valid, CMS defined, family planning procedure codes, reimbursable at the 90-percent FFP rate. The claims primarily include sterilizations performed after the delivery of a child" The State agency added that "[p]erforming a sterilization procedure directly following the birth is very

common and is much more efficient than scheduling a separate, return procedure to perform the sterilization.”

The State agency did not address our second recommendation. With respect to our third recommendation, the State agency described corrective action that it implemented to ensure that MMIS edits assist in correctly apportioning funding for family planning services.

The State agency’s comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree that portions of some child delivery and newborn claims contained sterilization procedures, which are allowable family planning services. After reviewing the State agency’s method of calculating child delivery and newborn claims, we revised our calculations and reduced the amount of our questioned costs, and the associated recommended refund amount, from \$3,045,450 to \$2,447,414.

The State agency’s comments suggested that we were recommending that the State agency require hospitals to schedule separate, return procedures to perform sterilizations. In fact, we are not recommending that the State agency require hospitals to perform sterilization procedures separate from child delivery services. Our finding states, more narrowly, that the State agency is not entitled to Federal reimbursement at the 90-percent FFP rate for child delivery and newborn services.

Our finding is consistent with U.S. Department of Health & Human Services Departmental Appeals Board (the Board) Decision No. 1284, dated December 17, 1991, which dealt with a similar set of circumstances. The Board upheld a disallowance based on an Office of Inspector General audit finding that the New York State Department of Social Services (New York) had claimed both childbirth and sterilization services provided during the same hospital stay at the 90-percent FFP rate. New York asserted that in cases in which family planning was the primary procedure, the entire claim should be claimed at the 90-percent FFP rate. The Board ruled that New York “... did not show any reasonable basis for allocating the hospital stays and ancillary costs entirely to family planning in the sterilization and delivery claims” and upheld the related disallowance.

Regarding our second recommendation, we continue to advise that the State agency review claims outside of our audit period for similar errors.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicaid Program.....	1
Kansas Medicaid Program	1
Medicaid Coverage of Family Planning Services.....	1
Office of Inspector General Audits of Kansas Medicaid Family Planning Services.....	2
Medicaid Management Information System.....	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective.....	2
Scope.....	2
Methodology.....	3
FINDINGS AND RECOMMENDATIONS	4
UNALLOWABLE FAMILY PLANNING SERVICES	5
CAUSES OF THE OVERPAYMENTS	6
RECOMMENDATIONS	6
STATE AGENCY COMMENTS	6
OFFICE OF INSPECTOR GENERAL RESPONSE.....	7
APPENDIXES	
A: UNALLOWABLE REIMBURSEMENT	
B: STATE AGENCY COMMENTS	

INTRODUCTION

BACKGROUND

Medicaid Program

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

Kansas Medicaid Program

In Kansas, the Kansas Health Policy Authority (the State agency) is responsible for administering the Medicaid program. The State agency contracts with a fiscal agent, HP Enterprise Services (formerly Electronic Data Systems), to maintain its Medicaid Management Information System (MMIS), a computerized payment and information reporting system that processes and pays Medicaid claims.

The amount of funding that the Federal Government reimburses to State Medicaid agencies, known as either Federal financial participation (FFP) or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. The State agency's FMAP rate ranged from 59.43 percent to 68.31 percent for claims paid from July 1, 2005, through June 30, 2009. Federal requirements also make provisions for various specified services to be reimbursed at higher rates of FFP.

Medicaid Coverage of Family Planning Services

Section 1905(a)(4)(C) of the Act requires States to furnish "... family planning services and supplies ... to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies" Section 1903(a)(5) of the Act and 42 CFR § 433.10(c)(1) authorize reimbursement at an enhanced 90-percent FFP rate (90-percent FFP rate) for family planning services.

Section 4270 of the CMS *State Medicaid Manual* (the manual) states that family planning services include those that prevent or delay pregnancy or otherwise control family size and may also include infertility treatments. This provision of the manual generally permits reimbursement at a 90-percent FFP rate for certain services and items, to include counseling services and patient education; examination and treatment by medical professionals pursuant to States' requirements; devices to prevent conception; and infertility services, including sterilization reversals. Pursuant to the provisions of the manual, only items and procedures clearly furnished or provided for family planning purposes may be claimed at the 90-percent FFP rate.

CMS issued *Financial Management Review Guide Number 20* (the guide) to the State agency via Medicaid State Operations Letter 91-9, dated January 30, 1991.¹ Section IV, E of the guide states that any procedure provided to a woman known to be pregnant may not be considered a family planning service reimbursable at the 90-percent FFP rate.

The State agency administers family planning services through the Kansas Medicaid Family Planning Program. The State *Professional Provider Manual* defines family planning services as any medically approved treatment, counseling, drugs, supplies, or devices that are prescribed or furnished by a provider to individuals of childbearing age so those individuals can freely determine the number and spacing of their children.

Office of Inspector General Audits of Kansas Medicaid Family Planning Services

For State fiscal years 2006 through 2009, the State agency was reimbursed \$19,997,233 (\$17,997,509 Federal share) for a variety of family planning services at the 90-percent FFP rate. Of this amount, we separately reviewed certain family planning costs totaling \$9,600,196 (\$8,640,176 Federal share) for specifically identified family planning pharmacy claims (A-07-10-04157), family planning sterilization services (A-07-10-04162), and selected other family planning claims (A-07-09-04146). This review covers the remaining \$10,397,037 (\$9,357,333 Federal share) for 2,781 child delivery claims and newborn claims, for which the State agency claimed reimbursement at the family planning 90-percent FFP rate.

Medicaid Management Information System

Providers enrolled in the Medicaid program submit claims for payment to the State agency's MMIS, which is maintained by the State agency's fiscal agent. The State agency furnishes to providers an MMIS provider manual that contains instructions for the proper completion and submission of claims. The provider must complete certain fields on the electronic claim form to indicate the type of service provided.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the child delivery and newborn claims submitted by providers and claimed by the State agency at the 90-percent FFP rate from July 1, 2005, through June 30, 2009, qualified as family planning services pursuant to Federal requirements.

Scope

We reviewed \$10,397,037 (\$9,357,333 Federal share) that the State agency claimed for family planning services associated with child delivery procedures and newborn procedures in Kansas from July 1, 2005, through June 30, 2009. We did not review the overall internal

¹ This same provision appeared in the 1993, 1997, and 2002 updates to this document.

control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at the State agency's offices in Topeka, Kansas, from July 2009 through February 2010.

Methodology

To accomplish our objective, we:

- reviewed Federal laws, regulations, and guidance and the State plan;
- held discussions with CMS officials and acquired an understanding of CMS requirements and guidance furnished to State agency officials concerning Medicaid family planning claims;
- held discussions with State agency officials to gain an understanding of State agency policies, procedures, and guidance for claiming Medicaid reimbursement for family planning services;
- reconciled current-period and prior-period family planning claims reported on the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report),² to the State agency's supporting documentation;
- obtained from the State agency's fiscal agent a database of paid claims for the Kansas Medicaid Family Planning Program that were submitted from July 1, 2005, through June 30, 2009, and that contained 211,496 claim lines totaling \$19,993,630;
- identified the procedure codes and diagnosis codes that related to child delivery and newborn services and reviewed the procedure codes to verify that these claims were for child delivery services and newborn services;
- extracted 3,633 inpatient services that specifically related to the provision of child delivery services and newborn services, grouped these inpatient services in a separate database, and eliminated 156 zero-paid claims and 218 voided claims, resulting in 3,259 inpatient services, which constituted 2,781³ inpatient claims totaling \$10,397,037 (\$9,357,333 Federal share);

² The State agency uses the CMS-64 report to report Medicaid expenditures for Federal reimbursement.

³ Each claim submitted for reimbursement included charge information for all services provided; thus, some individual claims had more than one inpatient service associated with them. The detailed charge information for each service provided was listed on a separate line within that particular claim. Accordingly, the number of services provided (3,259) relates to the number of lines associated with the 2,781 claims we reviewed.

- reviewed the procedure codes and diagnosis codes of the 2,781 claims to determine whether these claims were for child delivery and newborn services;
- reviewed the costs associated with the portion of the 2,781 claims that related to an allowable family planning service;
- used simple random sampling to select a discovery sample of 30 claims from the sample frame of 2,781 claims;
- obtained the medical records from the performing providers for the 30 sampled claims and compared the records to the procedure codes to verify that the documentation was consistent with the procedure codes; and
- shared a schedule of the 2,781 inpatient claims and the results of our discovery sample of 30 claims with the State agency and solicited its comments.

To calculate the unallowable amount of FFP, we computed the difference between the family planning 90-percent FFP rate and the FMAP rate for each claim.

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 objective.

FINDINGS AND RECOMMENDATIONS

None of the family planning child delivery and newborn claims submitted by providers and claimed by the State agency at the 90-percent FFP rate from July 1, 2005, through June 30, 2009, qualified as family planning services pursuant to Federal requirements. However, for some claims, a portion of the claim qualified as an allowable family planning service.

Based on our review of a discovery sample of 30 claims and our review of all of the procedure and diagnosis codes, we determined that all 2,781 child delivery claims and newborn claims were erroneously claimed for 90-percent FFP and that the State agency received \$2,447,414 in unallowable Federal reimbursement. The \$2,447,414 represents the difference between the amount that the State agency claimed at the 90-percent FFP rate and the amount that should have been claimed at the standard FMAP rate pursuant to Federal requirements.

These errors occurred because the MMIS's edits did not always correctly identify claims for reimbursement at the 90-percent FFP rate. Also, a lack of oversight by the State agency allowed these claims to be reimbursed as family planning services.

UNALLOWABLE FAMILY PLANNING SERVICES

Section 4270 of the manual states that family planning services include those that prevent or delay pregnancy or otherwise control family size and may include infertility treatments. The manual states that only items and procedures clearly furnished or provided for family planning purposes may be claimed at the 90-percent FFP rate.

In addition, the guide, part (IV)(E), states that “[b]y definition, any procedure provided to a woman who is known to be pregnant cannot be considered a family planning service reimbursable at 90-percent FFP.”

Further, the U.S. Department of Health & Human Services Departmental Appeals Board (the Board) has ruled that in cases involving claims that include both child delivery and newborn procedures and family planning procedures, it is unreasonable to assign “... hospital stays and ancillary costs entirely to family planning in the sterilization and delivery claims.”⁴

We determined that the 2,781 child delivery claims and newborn claims, totaling \$10,397,037 (\$9,357,333 Federal share) that were submitted by providers and claimed by the State agency at the family planning 90-percent FFP rate from July 1, 2005, through June 30, 2009, included procedures that did not qualify as family planning services pursuant to Federal requirements. Specifically, each of the 30 claims in our discovery sample included child delivery and newborn procedures. (For example, one of the claims had surgical and admit diagnosis codes for child delivery, and the medical record clearly showed that the individual had delivered a baby.) Although the individuals had undergone sterilization procedures following child delivery, the State agency claimed the sterilization procedures as well as the child delivery and newborn procedures at the 90-percent FFP rate. The child delivery and newborn procedures did not qualify as family planning services and were therefore not eligible for Federal reimbursement at the 90-percent FFP rate.

Of the \$10,397,037 (\$9,357,333 Federal share) in claims identified, \$3,759,457 (\$3,383,511 Federal share) included no allowable family planning procedures; this amount therefore did not qualify for reimbursement at the 90-percent FFP rate. However, the remaining \$6,637,580 (\$5,973,822 Federal share) related to claims that included both unallowable child delivery and newborn procedures and allowable family planning procedures. For these claims, we used an alternative methodology provided (after our fieldwork) by the State agency to calculate the portion of each claim that could be related to unallowable child delivery and newborn procedures and the portion that could be related to an allowable family planning procedure. A more detailed depiction of our methodology for calculating all of these questioned costs appears as Appendix A.

For both the claims that did not include any allowable family planning procedures and the claims that included both unallowable child delivery and newborn procedures and allowable family planning procedures, the portion of the claims with unallowable family planning procedures could, however, be claimed for reimbursement at the standard FMAP rate that was applicable at the time each claim was paid. We calculated the correct Federal reimbursement

⁴ New York State Department of Social Services, DAB No. 1284 (1991).

using the standard FMAP rates and determined that the State agency received \$2,447,414 in unallowable Federal reimbursement.

CAUSES OF THE OVERPAYMENTS

The MMIS used a variety of indicators on the electronic claim form to identify family planning services that were eligible for reimbursement at the 90-percent FFP rate. In addition, the State agency's MMIS included edits to verify that the provider correctly selected the appropriate indicator. If these edits revealed that the provider had selected a family planning indicator for services unrelated to family planning services, the claim was returned to the provider for correction and resubmission. If the MMIS edit verified that the provider had correctly selected the appropriate indicator, those services were reported to CMS for the appropriate amount of Federal reimbursement.

The MMIS's edits did not always correctly identify claims for reimbursement at the 90-percent FFP rate. Specifically, the MMIS's edits were not sufficient to correctly identify unallowable child delivery and newborn procedures that were associated with claims that included some allowable family planning services.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$2,447,414 to the Federal Government;
- determine the amount of Federal Medicaid funds that were improperly reimbursed at the 90-percent FFP rate for child delivery and newborn services because they did not qualify as family planning services, both before and after our audit period, and refund that amount to the Federal Government; and
- ensure that MMIS edits appropriately identify claims that are ineligible for reimbursement at the 90-percent FFP rate.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not agree with our finding related to the 2,781 child delivery and newborn claims or our recommendation to refund \$3,045,450. It also described an additional review that it conducted to determine the portion of claims reviewed and related to sterilization. It stated that using this method resulted in a Federal refund of \$2,009,826.

With respect to our findings, the State agency said that all of the 2,781 claims included "... valid, CMS defined, family planning procedure codes, reimbursable at the 90-percent FFP rate. The claims primarily include sterilizations performed after the delivery of a child ..."

The State agency added:

[p]erforming a sterilization procedure directly following the birth is very common and is much more efficient than scheduling a separate, return procedure to perform the sterilization. If the State must require hospitals to perform a separate, return procedure for sterilization in order for the Medicaid Program to receive the 90% match, this would drive costs higher for the healthcare providers and the Program.

The State agency did not address our second recommendation. With respect to our third recommendation, the State agency described corrective action that it implemented to ensure that MMIS edits assist in correctly apportioning funding for family planning services.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree that portions of some child delivery and newborn claims contained sterilization procedures, which are allowable family planning services. After reviewing the State agency's method of calculating child delivery and newborn claims, we revised our calculations and reduced the amount of our questioned costs from \$3,045,450 to \$2,447,414.

The State agency's alternative method assumed that all claims that we questioned included an allowable family planning procedure. However, we determined that of the \$10,397,037 (\$9,357,333 Federal share) in claims reviewed, \$3,759,457 (\$3,381,511 Federal share) included no allowable family planning procedures and that the remaining \$6,637,580 (\$5,973,822 Federal share) related to claims that included both unallowable child delivery and newborn procedures and allowable family planning procedures. We revised our calculations based on information that the State agency provided in its written comments and in subsequent discussions, determined that the recommended refund amount should be \$2,447,414, and modified our finding and associated recommendation accordingly.

The State agency's comments suggested that we were recommending that the State agency require hospitals to schedule separate, return procedures to perform sterilizations. In fact, we are not recommending that the State agency require hospitals to perform sterilization procedures separate from child delivery services. Our finding states, more narrowly, that the State agency is not entitled to Federal reimbursement at the 90-percent FFP rate for child delivery and newborn services, even when child delivery services and sterilization procedures are provided during the same hospital stay.

Our finding is consistent with the Board's Decision No. 1284, which dealt with a similar set of circumstances. The Board upheld a disallowance based on an Office of Inspector General audit finding that the New York State Department of Social Services (New York) had claimed both childbirth and sterilization services provided during the same hospital stay at the 90-percent FFP rate. New York asserted that in cases in which family planning was the primary procedure, the entire claim should be claimed at the 90-percent FFP rate. The Board

ruled that New York "... did not show any reasonable basis for allocating the hospital stays and ancillary costs entirely to family planning in the sterilization and delivery claims" and upheld the related disallowance.

Regarding our second recommendation, we continue to advise that the State agency review claims outside of our audit period for similar errors. In particular, the State agency should review claims that were submitted until the time that it implemented its revised policy to ensure that MMIS edits assist in correctly apportioning funding for family planning services.

APPENDIXES

APPENDIX A: UNALLOWABLE REIMBURSEMENT

**DELIVERY/NEWBORN CLAIMS CONTAINING STERILIZATION
PROCEDURE/DIAGNOSIS CODES**

CMS ¹ Report Period	FMAP ²	Total	Portion of Claim Not Assoc w/ Family Planning Services ³	(C × 90%) minus (C × A)
	A	B	C	D
9/30/05	61.01%	\$196,142	\$135,337	\$39,234
9/30/06	60.41%	3,044,708	2,100,849	621,641
9/30/07	60.25%	1,583,616	1,092,695	325,077
9/30/08	59.43%	1,097,062	756,973	231,407
QE ⁴ : 12/08 & 03/09	66.28%	458,466	316,342	75,036
QE: 6/30/2009	68.31%	257,586	177,734	38,551
Total		\$6,637,580	\$4,579,930	\$1,330,946

**DELIVERY/NEWBORN CLAIMS NOT CONTAINING STERILIZATIONS
PROCEDURE/DIAGNOSIS CODES**

CMS Report Period	FMAP	Total	(B × 90%) minus (B × A)
	A	B	C
9/30/05	61.01%	\$0	\$0
9/30/06	60.41%	1,510,416	446,932
9/30/07	60.25%	2,256,362	671,268
9/30/08	59.43%	(1,981)	(605)
QE: 12/08 & 3/09	66.28%	1,597	379
QE: 6/30/2009	68.31%	(6,937)	(1,505)
Total		\$3,759,457	\$1,116,468

Total Unallowable Claims **\$10,397,037** **\$2,447,414⁵**

¹ Centers for Medicare & Medicaid Services.

² Federal medical assistance percentage.

³ Based on procedure codes 6621, 6622, 6624, 6629, 6631, 6632, 6639, and 9924, and diagnosis code V252. Per the alternative methodology provided by the State agency (after our fieldwork), these procedure codes, on average, account for 31 percent of a claim that contains both family planning services and non-family-planning services. Therefore, to determine the portion of the claim that was not associated with family planning services, we took the total combined claim times 69 percent (100 percent less 31 percent).

⁴ Quarter ended.

⁵ Differences in totals in this column are due to rounding.

APPENDIX B: STATE AGENCY COMMENTS



October 1, 2010

Mr. Patrick Cogley
Regional Inspector General
601 East 12th Street
Room 0429
Kansas City, Missouri 64106

RE: Office of Inspector General (OIG) Draft Audit Report Number A-07-10-04156

Dear Mr. Cogley:

The Kansas Health Policy Authority (KHPA) has reviewed the draft report entitled Review of Child Delivery Claims and Newborn Claims Included in the Kansas Medicaid Family Planning Program. The OIG's review determined that 2,781 claims were erroneously claimed at the 90-percent FFP and the State of Kansas received \$3,045,450 in unallowable Federal reimbursement. The report included the following three recommendations:

- Refund \$3,045,450 to the federal Government;
- Determine the amount of Federal Medicaid funds that were improperly reimbursement at the enhanced 90-percent FFP rate for child delivery and newborn services because they did not qualify as family planning services, both before and after our audit period, and refund that amount to the Federal Government; and
- Ensure that MMIS edits appropriately identify claims that are ineligible for reimbursement at the 90-percent FFP rate.

The Kansas Health Policy Authority has performed a detailed review of the report and the related claims. We disagree with the report findings for the following reasons.

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220

www.khpa.ks.gov

Medicaid and HealthWave:

Insurance Fund:

Phone: 785-296-3981
785-296-2364
Fax: 785-296-4813
785-296-6995

State Employee Health Plan

Phone: 785-368-6361
Fax: 785-368-7180

State Self

Phone:
Fax:

Mr. Patrick Cogley
October 1, 2010

Sterilization procedures were not performed on pregnant women

The first finding indicates that \$3,045,450 is unallowable Federal reimbursement that must be refunded to the Federal government because the hospitals performed sterilization procedures on pregnant women and family planning services cannot be performed on pregnant women. There is no basis for this finding. The sterilization procedures were performed following the birth, when the women were no longer pregnant. More than 30% of the claim payments relate to sterilization procedures that were performed after the delivery of a child. Because the sterilization procedures were performed on non-pregnant women, the portion of the claims related to family planning services is reimbursable at the 90-percent FFP rate.

All of the 2,781 claims reviewed by the OIG include a Family Planning procedure

An examination of the list of the 2,781 claims retrieved by the OIG reveals that all of the claims in the list include valid, CMS defined, family planning procedure codes, reimbursable at the 90-percent FFP rate. The claims primarily include sterilizations performed after the delivery of a child, with the predominant codes present being 6632 or 6639. Both codes are for bilateral ligation and division of fallopian tubes. Sterilizations were performed to prevent future pregnancies and the services clearly meet the criteria for reimbursement at the 90% match.

Federal policy encourages liberal coverage of family planning services through an enhanced match rate. Sterilization services are an appropriate method that prevents pregnancy and controls family size which is allowed by, Section 4270 of the CMS "State Medicaid Manual".

ICD-9 Descriptions for sterilization codes in claims set:

6632-Other bilateral ligation and division of fallopian tubes

6639-Other bilateral destruction or occlusion of fallopian tubes

863-Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue

9924-Injection of other hormone

The KHPA reviewed a random sample of 30 of the 2,781 claims. One hundred percent of the claims reviewed in the sample include a family planning service. The review found that 27 of the 30 inpatient claims had either ICD-9 code 6632, other bilateral ligation and division of fallopian tubes, or code 6639, other bilateral destruction or occlusion of

Mr. Patrick Cogley
October 1, 2010

fallopian tubes. Both of these codes are reimbursable at the 90-percent rate. Three of the 30 claims include ICD-9 code, 9924, injection of other hormone, which is also for preventing future pregnancy.

A separately scheduled sterilization procedure would unnecessarily increase costs

Performing a sterilization procedure directly following the birth is very common and is much more efficient than scheduling a separate, return procedure to perform the sterilization. If the State must require hospitals to perform a separate, return procedure for sterilization in order for the Medicaid Program to receive the 90% match, this would drive costs higher for the healthcare providers and the Program. This would also result in the performance of fewer sterilizations, resulting in increased pregnancies, which is not the intent of 90% coverage for Family Planning services. The State and healthcare providers should not be penalized by disallowance because the method of service delivery was a cost effective approach for performing the sterilization procedure. Family Planning services are present within the claims retrieved by the OIG and should be reimbursed at the 90% match, consistent with the intent of Federal policy.

Method for determining family planning reimbursement

Through the Kansas Medicaid inpatient rate setting process, hospital costs related to sterilizations are "costed", or built into the Medicaid peer group rates. This is performed by multiplying each hospital's ancillary charge for the sterilization procedure times the hospital-specific cost-to-charge ratio for the Operating Room cost center (where the costs were and incurred and the services were provided). Medicaid billed charges are mapped to the appropriate cost centers through this cost-finding process. Other charges related to the performance of the sterilization procedure may include anesthesia, lab charges, and other incidental ancillary charges.

Cost-to-charge ratios, for each hospital, are obtained from the hospital Medicare cost reports. Calculated Medicaid ancillary and routine service costs are summed for all hospitals to determine the overall average cost-per-discharge for each specific DRG. The DRG-specific cost-per-discharge is then divided by the overall average cost per-discharge, for all hospitals, for determining the DRG relative weights. The calculated weights reflect utilization of resources related to the services provided. A higher DRG weight reflects higher case acuity.

For determining the Medicaid payment, the calculated DRG weight is multiplied by the per-discharge peer group rate. The ancillary service charges for sterilizations are a driver for a portion of the Medicaid payment that is calculated using the DRG weight. Sterilization costs are averaged into the Medicaid reimbursement amount, which is generated by referencing the DRG weight.

Mr. Patrick Cogley
October 1, 2010

Sterilization reimbursement is present for a claim when a sterilization procedure code is present. Because sterilization costs are included in the reimbursement for the claim, the agency determined the portion of the claim costs related to family planning using a method for carving out the costs for sterilizations based on the billed charges related to the sterilization procedures divided by the total ancillary billed charges for the claims in the sample. The percentage of services related to family planning within the birth DRGs is 32.13%. The portion of the claim cost of \$10,397,288 related to family planning is \$3,341,104 (all-funds). The portion of this amount at 90% is \$3,006,994.

In addition to a review of specific Family Planning costs using a random sample, we also performed a separate review, for comparative purposes, using an alternative method. The payment for MSDRG 775 (CMS DRG 373), Vaginal Delivery without a Complicating Diagnosis was compared to MSDRG 767 (CMS DRG 374), Vaginal Delivery with Sterilization. This method compared the relative DRG weight values for each DRG, the difference representing the portion of the DRG weight related to the cost of the sterilization. The DRG weight difference was then multiplied by the Peer Group rate for determination of the portion of the claim payment related to the Sterilization procedure.

Based on this alternative review, we found that the sterilization procedure makes up approximately 34.01% of the payment for a birth with a sterilization procedure. Multiplying 34.01% times the all funds claims amount of \$10,397,288 results in sterilization payment, relative to the claims, of \$3,535,706. This amount is about \$194,602 more than the method that calculates the reimbursement amount based on a random sample of 30 claims. In summary, both methods resulted in similar results.

The resulting Federal refund is \$2,009,826.

Corrections to System Edits

The agency is working to apportion Family Planning funding correctly. The agency implemented a policy for correcting the Family Planning claiming process within the system. This policy explicitly defines a finite set of diagnosis code and procedure code combinations that allow a (non-pharmacy) claim to be processed with the enhanced family planning FFP rate. The methodology ensures that claims that do not have the required diagnosis and procedure code combination will pay at the standard FFP rate. All claims are considered ineligible for the enhanced FFP rate by default unless the correct combination of diagnosis and procedure code is present on the claim. The agency believes that this change meets the intent of the recommendation to ensure that MMIS edits appropriately identify claims not eligible for enhanced FFP.

For inpatient claims, the MMIS the logic looks for specific birth related MSDRGs. Within

Mr. Patrick Cogley
October 1, 2010

these birth related MSDRGs, the system then looks for the family planning procedure codes 6632, 6639 and 4 other valid family planning procedure codes. The count of identified sterilizations is multiplied by the reimbursement per sterilization procedure for determining the appropriate reclassification to the 90% match.

Thank you for the opportunity to respond to this draft audit report.

Sincerely,

A handwritten signature in cursive script that reads "Andy Allison".

Andrew Allison, PhD
Executive Director