Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MISSOURI DID NOT ALWAYS CORRECTLY CLAIM COSTS FOR MEDICAID FAMILY PLANNING DRUGS FOR CALENDAR YEARS 2009 AND 2010

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

Patrick J. Cogley
Regional Inspector General

January 2014
A-07-12-01118

Office of Inspector General

https://oig.hhs.gov/

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EXECUTIVE SUMMARY

Missouri claimed at least $487,000 in unallowable Federal reimbursement for Medicaid family planning prescribed drugs for CYs 2009 and 2010.

WHY WE DID THIS REVIEW

Family planning services prevent or delay pregnancy or otherwise control family size. Federal requirements authorize Federal Medicaid reimbursement to States for family planning services at an *enhanced* Federal medical assistance percentage (FMAP) of 90 percent (90-percent rate). 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 Department of Social Services, Missouri HealthNet Division (State agency), complied with Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning prescribed drug costs for calendar years (CYs) 2009 and 2010.

BACKGROUND

In Missouri, the State agency administers the Medicaid program. Federal reimbursement is available at the 90-percent rate for certain prescribed drugs associated with family planning services. Most of these prescribed drugs (family planning prescribed drugs) are used for birth control or for the stimulation of ovulation in infertile women. In Missouri, the State agency considered oral, topical, and implantable contraceptives as family planning prescribed drugs. Federal reimbursement is available at the regular FMAP (between 71.24 percent and 74.43 percent for our audit period) for non-family planning prescribed drugs.

We reviewed $21,912,488 ($19,721,239 Federal share) that the State agency claimed for family planning prescribed drugs, representing 358,779 claims, for CYs 2009 and 2010.

WHAT WE FOUND

The State agency did not always comply with Federal and State requirements when claiming Federal reimbursement for family planning prescribed drug costs for CYs 2009 and 2010. Of 107 sampled claims, 85 complied with requirements and 22 did not. Of the 22 claims, 21 were eligible for reimbursement only at the regular FMAP because the drugs were not prescribed for a family planning purpose (13 claims) or because the State agency could not support that the drugs were prescribed for a family planning purpose (8 claims). The other claim of the 22 was ineligible for reimbursement because the State agency lacked supporting documentation.

On the basis of our sample results, we estimated that the State agency received at least $487,351 in unallowable Federal reimbursement. The overpayment occurred primarily because the State agency lacked internal controls that would accurately identify which prescribed drug claims were allowable for Federal reimbursement at the 90-percent rate. Specifically, the State agency's

internal controls automatically classified contraceptive drugs as family planning services even in cases when the medication in question may have been prescribed for another (non-family planning) purpose.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $487,351 to the Federal Government,

- determine and refund the Federal share of any additional amounts related to family planning prescribed drugs that the State agency improperly claimed after our audit period, and

- strengthen internal controls to ensure that prescribed drug costs submitted for Federal reimbursement appropriately identify claims that are eligible for reimbursement at the 90-percent rate.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency disagreed with all of our recommendations. Specifically, the State agency said that its internal control procedure of classifying all contraceptive drugs as family planning services for reimbursement at the 90-percent rate was adequate. To this point, the State agency also stated that a contraceptive drug could still prevent a pregnancy despite the medical records not supporting the reasons for taking the drug. In addition, the State agency said that having pharmacies obtain diagnosis information from prescribing physicians is not consistent with current medical practice and added that there is no way for a pharmacy to transmit diagnosis information to the State agency on a drug claim transaction.

The State agency did not specifically comment on the claim that lacked supporting documentation.

Nothing in the State agency's comments caused us to change our findings or our recommendations.

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WHY WE DID THIS REVIEW

Family planning services prevent or delay pregnancy or otherwise control family size. Federal requirements authorize Federal Medicaid reimbursement to States for family planning services at an *enhanced* Federal medical assistance percentage (FMAP) of 90 percent (90-percent rate). Previous Office of Inspector General reviews (Appendix A) 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

Our objective was to determine whether the Department of Social Services, Missouri HealthNet Division (State agency), complied with Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for family planning prescribed drug costs for calendar years (CYs) 2009 and 2010.

BACKGROUND

Medicaid Program

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.

Missouri Medicaid Program

In Missouri, the State agency administers the Medicaid program. The amount that the Federal Government reimburses to State Medicaid agencies, known as Federal financial participation or Federal share, is determined by the Federal medical assistance percentage (FMAP), which varies based on a State's relative per capita income. Federal reimbursement is available at the regular FMAP (between 71.24 percent and 74.43 percent for our audit period) for non-family planning prescribed drugs.

Medicaid Coverage of Family Planning Prescribed Drugs

Section 1905(a)(4)(C) of the Social Security Act (the Act) requires States to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and who desire such services and supplies. The Act and Federal regulations authorize Federal reimbursement for family planning services at the 90-percent rate (section 1903(a)(5) of the Act; 42 CFR §§ 433.10(c)(1) and 433.15(b)(2)).

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 include infertility treatments. Federal reimbursement is available at the 90-percent rate for certain prescribed drugs associated with family planning services (family planning prescribed drugs).

CMS issued *Financial Management Review Guide Number 20* (the Guide) to the State agency via Medicaid State Operations Letter 91-9. The Guide allows State Medicaid agencies to use a variety of coding systems and codes for medications for which those agencies reimburse providers under Medicaid. Most of the medications covered as family planning prescribed drugs are used for birth control or for the stimulation of ovulation in infertile women. Other medications can be classified as family planning prescribed drugs if they are used incident to, or as part of, procedures performed for family planning purposes, such as pain medications following a sterilization procedure. However, the Guide does not specifically list, by pharmaceutical code, the medications that may be reimbursed at the 90-percent rate.

Family Planning Prescribed Drug Claims in Missouri

To classify claims that include family planning services, the State agency uses indicators such as procedure codes, diagnosis codes, surgical procedure codes, and modifiers. For family planning prescribed drugs, the State agency classified medications according to First Data Bank therapeutic class codes. Specifically, the State agency considered oral, topical, and implantable contraceptives as family planning prescribed drugs.

HOW WE CONDUCTED THIS REVIEW

For CYs 2009 and 2010, the State agency claimed $22,502,737 ($20,252,463 Federal share) for family planning prescribed drugs, representing 405,107 claims. (Each claim had one prescribed drug.) We did not review 46,328 claims, totaling $590,249, with reimbursements that either adjusted claims in quarters outside of our audit period or were determined to be immaterial. From the remaining 358,779 claims, totaling $21,912,488 ($19,721,239 Federal share), we reviewed a stratified random sample of 107 claims. Specifically, we reviewed 7 claims, in each of which the State agency had made payments of at least $2,000. We also reviewed a random sample of 100 claims from the remaining 358,772 claims.

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 describes our audit scope and methodology, Appendix C describes our statistical sampling methodology, and Appendix D describes our sample results and estimates.

FINDINGS

The State agency did not always comply with Federal and State requirements when claiming Federal reimbursement for family planning prescribed drug costs for CYs 2009 and 2010. Of 107 sampled claims, 85 complied with requirements and 22 did not. Of the 22 claims, 21 were eligible for reimbursement only at the regular FMAP because the drugs were not prescribed for a family planning purpose (13 claims) or because the State agency could not support that the drugs were prescribed for a family planning purpose (8 claims). The other claim of the 22 was ineligible for reimbursement because the State agency lacked supporting documentation.

On the basis of our sample results, we estimated that the State agency received at least $487,351 in unallowable Federal reimbursement. The overpayment occurred primarily because the State agency lacked internal controls that would accurately identify which prescribed drug claims were allowable for Federal reimbursement at the 90-percent rate. Specifically, the State agency's internal controls automatically classified contraceptive drugs as family planning services even in cases when the medication in question may have been prescribed for another (non-family planning) purpose.

DRUGS WERE IMPROPERLY CLAIMED BECAUSE THE STATE AGENCY COULD NOT SUPPORT THAT THE DRUGS WERE CLAIMED FOR A FAMILY PLANNING PURPOSE

Section 4270 of the Manual states that family planning services are those that prevent or delay pregnancy or otherwise control family size.

For family planning services, the U.S. Department of Health and Human Services Departmental Appeals Board (the DAB) has provided additional guidance regarding Federal reimbursement at the 90-percent rate. The DAB has ruled that "… the State [agency] bears the burden of justifying claims for enhanced rates…. It is not enough that the claims could possibly relate to family planning, or that the diagnoses do not preclude such a determination. Rather, the State [agency] must affirmatively document that the services were sought for family planning reasons."[1]

Contrary to the Federal requirement and administrative law ruling, the State agency improperly claimed Federal reimbursement for 21 claims at the 90-percent rate. Specifically, the State agency did not affirmatively document that the prescribed drugs were sought for family planning reasons.

- For 13 claims, providers informed us that the drugs associated with these claims were not prescribed for a family planning purpose as defined in the Manual. (For some of these claims, providers furnished information as to the actual, non-family-planning purpose of the prescription.)

- For 8 claims, we obtained the corresponding prescriptions from the relevant pharmacies. However, we were unable to obtain information from the providers or the State agency as

[1] New York State Department of Social Services, DAB No. 1364 (1992).

to the purposes of the prescriptions. Thus, we concluded that the State agency could not support a family planning purpose for these claims.

The prescribed drug costs related to these 21 claims were not allowable for reimbursement at the 90-percent rate, but were allowable for Federal reimbursement at the FMAP.

THE CLAIM FOR ONE DRUG WAS IMPROPERLY CLAIMED BECAUSE THE STATE AGENCY LACKED SUPPORTING DOCUMENTATION

Section 1902(a)(27) of the Act and 42 CFR §§ 431.17(c) and 433.32 require that services claimed for Medicaid reimbursement be documented. In addition, 13 Code of State Regulations 70-3.030 states that records must be maintained for 5 years. Contrary to these Federal and State requirements, the State agency improperly claimed Federal reimbursement for drug costs associated with one claim, with a June 30, 2009, date of service, that was not allowable for reimbursement. Specifically, neither the provider nor the pharmacy identified on the State agency's records had documentation to support the prescribed drug. Therefore, this claim was not allowable for Federal reimbursement.

INADEQUATE CONTROLS

The overpayment occurred primarily because the State agency lacked internal controls that would accurately identify which prescribed drug claims were allowable for Federal reimbursement at the 90-percent rate. Specifically, the State agency's internal controls automatically classified contraceptive drugs as family planning services even in cases when the medication in question may have been prescribed for another (non-family planning) purpose.

UNALLOWABLE FAMILY PLANNING CLAIMS

Of the 100 prescribed drug claims in our random sample, 22 claims totaling $1,185 ($1,067 Federal share) contained errors or lacked support. On the basis of our sample results, we estimated that the State agency received at least $487,351 in unallowable Federal reimbursement.

We did not identify any errors on the 7 claims in each of which the State agency had made payments of at least $2,000.

RECOMMENDATIONS

We recommend that the State agency:

- refund $487,351 to the Federal Government,

- determine and refund the Federal share of any additional amounts related to family planning prescribed drugs that the State agency improperly claimed after our audit period, and

- strengthen internal controls to ensure that prescribed drug costs submitted for Federal reimbursement appropriately identify claims that are eligible for reimbursement at the 90-percent rate.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with all of our recommendations. Specifically, the State agency said that its internal control procedure of classifying all contraceptive drugs as family planning services for reimbursement at the 90-percent rate was adequate. Regarding the claims that we questioned, the State agency stated that "… while a participant may request contraception for another reason, it could still prevent a pregnancy despite the medical records not supporting the reasons for taking a contraceptive drug."

In addition, the State agency said that having pharmacies obtain diagnosis information from prescribing physicians is not consistent with current medical practice because, according to the State agency, "[p]harmacy claims do not have diagnosis codes in the claims transaction." In this regard, the State agency said that there is no way for a pharmacy to transmit diagnosis information to the State agency on a drug claim transaction. The State agency added, "[o]btaining the information outside of the currently approved system causes a delay in dispensing the contraceptive which interferes with access."

The State agency did not specifically comment on the claim that lacked supporting documentation.

The State agency's comments appear in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

Nothing in the State agency's comments caused us to change our findings or our recommendations.

Regarding the 21 claims for which contraceptive drugs were not prescribed for family planning purposes, we either (1) received statements from the prescribing physicians' offices that confirmed that the contraceptive drugs were not prescribed for a family planning purpose or (2) were unable to obtain documentation from the State agency supporting the family planning purpose of the prescriptions. Therefore, we maintain that these claims were not allowable for Federal reimbursement at the 90-percent rate (but were allowable for Federal reimbursement at FMAP rates).

With respect to the State agency's comments that pharmacies are unable to obtain diagnosis information or transmit that information to the State agency, we note that our recommendations were directed at the State agency to comply with Federal requirements when claiming reimbursement at the 90-percent rate. To this point, we continue to follow the DAB ruling cited earlier, which states that "… the State [agency] bears the burden of justifying claims for enhanced rates…. It is not enough that the claims could possibly relate to family planning, or

that the diagnoses do not preclude such a determination. Rather, the State [agency] must affirmatively document that the services were sought for family planning reasons."

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS:

Report Title	Report Number	Date Issued
Missouri Did Not Always Correctly Claim Costs for Medicaid Family Planning Sterilization Procedures for Calendar Years 2009 and 2010	A-07-12-01117	6/12/13
Missouri Incorrectly Claimed Federal Reimbursement for Inpatient Claims With Sterilization and Delivery Procedures for Calendar Years 2009 and 2010	A-07-12-01121	3/13/13
Review of Prescribed Drug Costs in the Colorado Medicaid Family Planning Program	A-07-11-01095	10/17/11

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

For CYs 2009 and 2010, the State agency claimed $22,502,737 ($20,252,463 Federal share) for family planning prescribed drugs, representing 405,107 claims. (Each claim had one prescribed drug.) We did not review 46,328 claims, totaling $590,249, with reimbursements that either adjusted claims in quarters outside of our audit period or were determined to be immaterial. We reviewed a stratified random sample of 107 claims from the remaining 358,779 claims, totaling $21,912,488 ($19,721,239 Federal share). Specifically, we reviewed 7 claims, in each of which the State agency had made payments of at least $2,000. We also reviewed a random sample of 100 claims from the remaining 358,772 claims.

We did not review the overall internal control structure of the State agency or the Medicaid program. We reviewed only the internal controls that pertained directly to our objective.

We conducted this audit from October 2012 through August 2013.

METHODOLOGY

To accomplish our objective, we did the following:

- We reviewed applicable Federal laws, Federal and State regulations, CMS guidance, and the State plan.

- We held discussions with CMS officials to gain an understanding of CMS requirements and guidance furnished to State agency officials concerning Medicaid family planning claims.

- We held discussions with State agency officials to gain an understanding of how the State agency claimed Medicaid reimbursement for family planning services, including family planning prescribed drugs.

- We reconciled family planning claims reported on the CMS-64 reports[2] back to the State agency's supporting documentation for CY 2009 and 2010.

- We selected a stratified random sample of 107 family planning prescribed drug claims (each claim had one prescribed drug).

[2] States use the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter and CMS uses it to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must be actual expenditures and be supported by documentation.

- We requested that providers state whether the drug on the sampled claim was prescribed for a family planning purpose (as defined in the Manual).[3]

- For 8 of the 107 sampled claims, we did not receive sufficient information from the providers regarding the purposes of the prescriptions. For these claims, we asked the State agency to provide documentation regarding the purposes of the prescriptions.

- We provided one medical record to our Chief Medical Officer, who performed a medical review to determine whether the medical record affirmatively documented a family planning purpose.[4]

- We estimated the unallowable Federal reimbursement.

- We provided the results of our review to State agency officials on October 17, 2013.

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.

[3] We did not contact the providers for 2 of the 107 claims because the State agency cancelled their claims for Medicaid reimbursement after our audit period.

[4] This record was associated with one of the eight claims (in our first finding) for which we concluded that the State agency could not support a family planning purpose.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of 405,107 claims totaling $22,502,737 for Medicaid family planning prescribed drugs for which the State agency claimed Federal reimbursement at the 90-percent rate for CYs 2009 and 2010.

SAMPLING FRAME

From the population of claims, we removed claims that were negative adjustments to prior periods. We established a materiality level of $25.00 or more per claim and removed claims that had a reimbursement of less than this amount. Table 1 below summarizes the number of claims excluded from the sampling frame and their total amounts.

Table 1: Claims Excluded From the Sampling Frame

Excluded Claims	Number of Claims	Amount Claimed
Adjustments for other periods	3,396	$(139,071)
Reimbursement less than $25.00	42,932	$729,320
Total	**46,328**	**$590,249**

After removing these claims, the sampling frame consisted of 358,779 claims totaling $21,912,488.

SAMPLE UNIT

The sampling unit was a paid family planning prescribed drug claim.

SAMPLE DESIGN

We used a stratified random sample consisting of two strata, based on the Federal reimbursement amount for the claim, as shown in Table 2 below.

Table 2: Number of Claims Sampled per Stratum

Stratum	Claim Amount	Number of Claims	Total Amount Claimed Per Stratum
1	$25.00 – $1,999.99	358,772	$21,775,735
2	$2,000.00 and Greater	7	$136,753
Total		**358,779**	**$21,912,488**

SAMPLE SIZE

We selected a sample of 107 claims for family planning prescription drug claims.

Stratum 1 – 100 paid claims.
Stratum 2 – 7 paid claims.

We reviewed all claims in stratum 2.

SOURCE OF RANDOM NUMBERS FOR STRATUM 1

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE UNITS FOR STRATUM 1

We consecutively numbered the sample units in the frame from 1 to 358,772. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the unallowable Federal reimbursement.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Sample Results: Federal Share Amounts

Frame Size	Frame Value	Sample Size	Value of Sample	Number of Claims With Unallowable Federal Reimbursement	Amount of Unallowable Federal Reimbursement
358,772	$19,598,161	100	$ 4,590	22	$222
7	$ 123,078	7	$123,078	0	$ 0

Estimates of Unallowable Federal Reimbursement: Federal Share Amounts
(Limits Calculated for a 90-Percent Confidence Interval)

	Total Estimated Unallowable Federal Reimbursement
Point estimate	$ 796,761
Lower limit	$ 487,351
Upper limit	$ 1,106,171

APPENDIX E: STATE AGENCY COMMENTS

Missouri Department of
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December 26, 2013

Patrick J. Cogley
Regional Inspector General for Audit Services
HHS OIG-OAS, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

Dear Mr. Cogley:

This is in response to the Office of Inspector General's (OIG) draft report entitled "Missouri Did Not Always Correctly Claim Costs for Medicaid Family Planning Drugs for Calendar Years 2009 and 2010", Report Number A-07-12-01118. The Department of Social Services' (DSS) responses are below. The OIG recommendations are restated for ease of reference.

Recommendation 1: The OIG recommends that the State agency refund $487,351 to the Federal Government.

DSS Response: The DSS disagrees with the recommendation. Pharmacy claims use NDC (National Drug Codes) to identify the drug product being billed. Pharmacy claims are nationally standardized through the National Council for Prescription Drug Programs (NCPDP). The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires that a single standard be used for the electronic submission of retail pharmacy claims –NCPDP format. ICD-9 diagnosis codes are not part of the NCPDP standard. Pharmacy claims do not have diagnosis codes in the claims transaction. There is no way for the pharmacy to transmit diagnosis information to MO HealthNet on a drug claim transaction. MO HealthNet uses the First Data Band contraceptive therapeutic class codes to determine if a drug claim is for family planning purposes for the additional federal financial participation. For the pharmacy to obtain the information from the prescribing physician is not consistent with current medical practice. Obtaining the information outside of the currently approved system causes a delay in dispensing the contraceptive which interferes with access.

For the 22 claims in question, while a participant may request contraception for another reason, it still could prevent a pregnancy despite the medical records not supporting the reasons for taking a contraceptive drug. Therefore, DSS maintains that all pharmaceuticals in the contraceptive therapeutic class should be eligible for the enhanced federal financial participation.

Recommendation 2: The OIG recommends that the State agency determine and refund the Federal share of any additional amounts related to family planning prescribed drugs that the State agency improperly claims after our audit period.

DSS Response: The DSS disagrees with this recommendation as outlined in the response to Recommendation 1.

Recommendation 3: The OIG recommends that the State strengthen internal controls to ensure that prescribed drug costs submitted for Federal reimbursement appropriately identify claims that are eligible for reimbursement at the 90-percent rate.

DSS Response: The DSS disagrees with this recommendation. The DSS believes its internal controls for appropriate claiming of family planning services are adequate and are further supported by the response to Recommendation 1.

Please contact Jennifer Tidball, Director, Division of Finance and Administrative Services at 573/751-7533 if you have further questions.

Sincerely,

Brian D. Kinkade
Acting Director

BDK:JC:bsb