January 20, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Oregon Improperly Claimed Federal Reimbursement for Medicaid Family Planning Services Provided Under the Family Planning Expansion Project (A-09-11-02010)

Attached, for your information, is an advance copy of our final report on Oregon's claims for Federal reimbursement for Medicaid family planning services provided under the Family Planning Expansion Project. We will issue this report to the Oregon Health Authority within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360 or through email at Lori.Ahlstrand@oig.hhs.gov. Please refer to report number A-09-11-02010.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

January 26, 2012

Report Number: A-09-11-02010

Bruce Goldberg, M.D.
Director
Oregon Health Authority
500 Summer Street NE, E-20
Salem, OR 97301

Dear Dr. Goldberg:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Oregon Improperly Claimed Federal Reimbursement for Medicaid Family Planning Services Provided Under the Family Planning Expansion Project*. 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, or contact Janet Tursich, Audit Manager, at (206) 615-2063 or through email at Janet.Tursich@oig.hhs.gov. Please refer to report number A-09-11-02010 in all correspondence.

Sincerely,

/Lori A. Ahlstrand/
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 and Human Services

OFFICE OF INSPECTOR GENERAL

OREGON IMPROPERLY CLAIMED FEDERAL REIMBURSEMENT FOR MEDICAID FAMILY PLANNING SERVICES PROVIDED UNDER THE FAMILY PLANNING EXPANSION PROJECT

Daniel R. Levinson
Inspector General

January 2012
A-09-11-02010

Office of Inspector General

http://oig.hhs.gov

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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.

Pursuant to section 1905(a)(4)(C) of the Act, States are required to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and desire such services and supplies. Section 1903(a)(5) of the Act and Federal regulations (42 CFR § 433.10(c)(1)) authorize Federal reimbursement for family planning services at an enhanced Federal medical assistance percentage of 90 percent (90-percent rate). Family planning services prevent or delay pregnancy or otherwise control family size.

In Oregon, the Oregon Health Authority (State agency) administers the Medicaid program. The State agency provides Medicaid family planning services under the Oregon Health Plan and the Family Planning Expansion Project (Expansion Project). This report focuses on family planning services provided under the Expansion Project. Another report (A-09-10-02043) focused on family planning services provided under the Oregon Health Plan.

The Expansion Project extends Medicaid coverage for family planning services to Oregon women and men who do not qualify for regular Medicaid and have family incomes at or below 185 percent of the Federal poverty level (Federal income limit). Because Expansion Project clients are not eligible for the regular Medicaid program, unallowable expenditures charged to the Expansion Project are unallowable in their entirety. Pursuant to the Oregon Administrative Rules (OAR), § 333-004-0020(1)(e), to be considered eligible for family planning services, the client must provide a valid Social Security number. Pursuant to OAR § 333-004-0120(1), the State agency is responsible for verifying the accuracy and appropriateness of payment under the Expansion Project.

During the period October 1, 2006, through September 30, 2009, the State agency claimed approximately $62.7 million ($56.4 million Federal share) for Medicaid family planning services provided to clients under the Expansion Project, representing 448,036 claims. Of these claims, we reviewed a random sample selected from 401,486 claims totaling $56,408,484, and we separately reviewed 46,550 claims totaling $6,273,285.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal reimbursement at the 90-percent rate for Medicaid family planning services provided under the Expansion Project in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

The State agency did not always claim Federal reimbursement at the 90-percent rate for Medicaid family planning services provided under the Expansion Project in accordance with Federal and State requirements:

- Of the 100 sampled claims, 89 claims complied with requirements. However, for 11 claims totaling $1,015, the State agency did not comply with Federal income eligibility requirements, or providers made billing errors. The erroneous claiming occurred because the State agency did not verify clients' family incomes, allowed up to $500 over the Federal income limit, or did not provide adequate oversight of providers' billing practices. Based on our sample results, we estimated that the State agency claimed $1,408,087 in unallowable Federal reimbursement.

- Of the $6.3 million that we reviewed separately, the State agency claimed $284,869 in unallowable Federal reimbursement for (1) clients who were not eligible to receive family planning services because they had family incomes that exceeded the Federal income limit or did not provide valid Social Security numbers or (2) claims that the State agency identified as duplicates. The erroneous claiming occurred because the State agency did not properly review clients' eligibility or have adequate controls to prevent and detect duplicate claims for family planning services.

In total, the State agency claimed $1,692,956 in unallowable Federal reimbursement.

In addition, of the $6.3 million that we reviewed separately, the State agency did not verify clients' family incomes or Social Security numbers for claims totaling $2,979,364 (Federal share). Because the supporting documentation was not readily available for these claims, we have set aside this amount for resolution by CMS and the State agency.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,692,956 to the Federal Government,

- work with CMS to resolve the $2,979,364 that we set aside,

- verify clients' family incomes and limit income eligibility in accordance with Federal requirements,

- verify that Social Security numbers provided by clients are valid, and

- strengthen controls to prevent and detect duplicate claims for family planning services.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and provided information on actions that it had taken or planned to take to address them. The State agency's comments are included in their entirety as Appendix C.

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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. Section 1115 of the Act authorizes demonstration projects (waivers) to assist in promoting the objectives of the Medicaid program.

Medicaid Coverage of Family Planning Services

Pursuant to section 1905(a)(4)(C) of the Act, States are required to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and desire such services and supplies. Section 1903(a)(5) of the Act and Federal regulations (42 CFR § 433.10(c)(1)) authorize Federal reimbursement for family planning services at an enhanced Federal medical assistance percentage of 90 percent (90-percent rate).

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. 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.

Oregon's Medicaid Family Planning Programs

In Oregon, the Oregon Health Authority (State agency) administers the Medicaid program. The State agency provides Medicaid family planning services under the Oregon Health Plan and the Family Planning Expansion Project (Expansion Project),[1] both of which are section 1115 waivers. This report focuses on family planning services provided under the Expansion Project. Another report (A-09-10-02043) focused on family planning services provided under the Oregon Health Plan.

CMS approved a section 1115 waiver for the Expansion Project beginning on January 1, 1999. The goal of the waiver was to extend Medicaid coverage for family planning services to Oregon women and men who did not qualify for regular Medicaid and had family incomes at or below 185 percent of the Federal poverty level (Federal income limit).

[1] The Expansion Project is now known as Oregon ContraceptiveCare or CCare.

The Expansion Project uses a State agency contractor's computerized payment and information system to process Medicaid claims for payment by the Statewide Financial Management Application. The expenditures related to the claims are reported on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, for Federal reimbursement. Because Expansion Project clients are not eligible for the regular Medicaid program, unallowable expenditures charged to the Expansion Project are unallowable in their entirety.

State Requirements for the Family Planning Expansion Project

The Oregon Administrative Rules (OAR), § 333-004-0010(12), define family planning services as those services provided to clients of childbearing age, including minors who are considered to be sexually active, that are intended to prevent pregnancy or otherwise limit family size. Pursuant to OAR § 333-004-0040: "[The Expansion Project] covers contraceptive management services that are a limited scope of family planning services directly related to initiating or obtaining a contraceptive method and maintaining effective use of that method." Contraceptive management services include, but are not limited to, annual exams; clinically indicated followup visits; management of side effects related to the contraceptive method; changing the method if medically necessary or requested by the client; family planning counseling and education; and laboratory tests, medical procedures (including vasectomy), and pharmaceutical supplies and devices related to contraceptive management.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency claimed Federal reimbursement at the 90-percent rate for Medicaid family planning services provided under the Expansion Project in accordance with Federal and State requirements.

Scope

During the period October 1, 2006, through September 30, 2009, the State agency claimed $62,681,769 ($56,413,592 Federal share) for Medicaid family planning services provided to clients under the Expansion Project, representing 448,036 claims. Of these claims, we reviewed a random sample selected from 401,486 claims totaling $56,408,484, and we separately reviewed 46,550 claims totaling $6,273,285.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective.

We conducted our audit from March 2010 to January 2011 and performed our fieldwork at the State agency's office in Portland, Oregon.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance;
- reviewed the waiver requirements for the Expansion Project;
- held discussions with CMS officials to gain an understanding of CMS guidance furnished to State agency officials concerning Medicaid family planning claims;
- held discussions with State agency officials to gain an understanding of State policies and controls for claiming Federal reimbursement for family planning services;
- obtained family planning claim data from the State agency contractor's computerized payment and information system;
- reconciled family planning claim data with Form CMS-64;
- created a sampling frame that contained 401,486 claims totaling $56,408,484 ($50,767,636 Federal share);
- selected from the sampling frame a simple random sample of 100 claims for which we reviewed client eligibility for services and client medical records; and
- estimated the unallowable Federal reimbursement paid in the sampling frame of 401,486 claims.

During our audit, the State agency identified 46,550 claims totaling $6,273,285 ($5,645,956 Federal share) that were (1) for clients whose eligibility for the Expansion Project was unknown and for whom supporting documentation was not readily available, (2) for a State-only program, (3) for clients who were not eligible for the Expansion Project, (4) potential duplicate claims, or (5) paid by private insurance companies. Therefore, we reviewed these claims separately:

- For 27,405 claims, the State agency said that it did not verify clients' family incomes. For 4,205 of these claims, the State agency also said that it did not verify Social Security numbers. We reported this issue as a finding and set aside these claims because the supporting documentation was not readily available.
- For 14,784 claims, the State agency said that these claims should have been funded only by the State agency. Before the beginning of our audit, the State agency had identified these claims and made an adjustment to Form CMS-64 to refund the amount owed to the Federal Government. We reviewed the State agency's adjustment and determined that it refunded the proper amount. We did not report this issue as a finding.

- For 2,109 claims, the State agency said that the claims were for clients who were not eligible to receive services because they had family incomes that exceeded the Federal income limit or did not provide valid Social Security numbers. We reviewed the State agency's process to identify claims for ineligible clients and judgmentally selected a sample of 30 claims to verify that these clients were not eligible for services. We reported the 2,109 erroneous claims as a finding.

- For 1,972 potential duplicate claims, the State agency verified that 883 claims were duplicates (2 claims for the same service and the same client on the same day). We reviewed the State agency's process to identify duplicate claims and its adjustment to Form CMS-64 to reduce the Federal reimbursement. We determined that the State agency did not refund the entire amount associated with claims identified as duplicates and reported this issue as a finding.

- For 280 claims, the State agency said that the claims were paid by private insurance companies and not included on Form CMS-64 for reimbursement by the Federal Government. We amended the sampling plan to reduce the sampling frame by 280 claims.

Appendix A contains the details of our sample design and methodology, and Appendix B contains our 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 objective.

FINDINGS AND RECOMMENDATIONS

The State agency did not always claim Federal reimbursement at the 90-percent rate for Medicaid family planning services provided under the Expansion Project in accordance with Federal and State requirements:

- Of the 100 sampled claims, 89 claims complied with requirements. However, for 11 claims totaling $1,015, the State agency did not comply with Federal income eligibility requirements, or providers made billing errors. The erroneous claiming occurred because the State agency did not verify clients' family incomes, allowed up to $500 over the Federal income limit, or did not provide adequate oversight of providers' billing practices. Based on our sample results, we estimated that the State agency claimed $1,408,087 in unallowable Federal reimbursement.

- Of the $6.3 million that we reviewed separately, the State agency claimed $284,869 in unallowable Federal reimbursement for (1) clients who were not eligible to receive family planning services because they had family incomes that exceeded the Federal income limit or did not provide valid Social Security numbers or (2) claims that the State

agency identified as duplicates. The erroneous claiming occurred because the State agency did not properly review clients' eligibility or have adequate controls to prevent and detect duplicate claims for family planning services.

In total, the State agency claimed $1,692,956 in unallowable Federal reimbursement.

In addition, of the $6.3 million that we reviewed separately, the State agency did not verify clients' family incomes or Social Security numbers for claims totaling $2,979,364 (Federal share). Because the supporting documentation was not readily available for these claims, we have set aside this amount for resolution by CMS and the State agency.

FEDERAL REQUIREMENTS

Pursuant to section 4270.B of the Manual, States are free to determine which family planning services and supplies will be covered as long as they are sufficient in amount, duration, and scope to reasonably achieve their purpose. However, the Manual states that only services and supplies clearly furnished for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate.

According to CMS's approval letter for the extension of the section 1115 waiver for the Expansion Project, dated December 21, 2006, the State agency will cover family planning services for uninsured clients who do not qualify for regular Medicaid and have family incomes at or below 185 percent of the Federal poverty level.

Pursuant to section 11325.A of the Manual, States' claims processing systems must ensure that all recipients were eligible when services were provided and check each claim before payment against all current and previously paid claims for which a duplicate payment could exist.

STATE REQUIREMENTS

Pursuant to OAR § 333-004-0020(1)(a), to be considered eligible for family planning services provided under the Expansion Project, the client's household income must be below 185 percent of the Federal level.[2] Pursuant to OAR § 333-004-0020(1)(e), the client is required to provide a valid Social Security number.

Pursuant to OAR § 333-004-0120(1), the State agency is responsible for verifying the accuracy and appropriateness of payment under the Expansion Project.

UNALLOWABLE CLAIMS IDENTIFIED IN THE SAMPLE

For 11 sampled claims totaling $1,015, the State agency did not comply with Federal income eligibility requirements, or providers made billing errors:

[2] This income threshold (below 185 percent of the Federal poverty level) is inconsistent with the one specified in the CMS approval letter (at or below 185 percent of the Federal poverty level). However, the State agency applied the threshold specified in the approval letter.

- For eight claims, clients' family incomes ranged from $186 to $2,462 over the Federal income limit. The State agency did not verify some clients' family incomes and provided services to other clients whose incomes exceeded the Federal income limit by as much as $500.

- For three claims, providers billed for (1) an order of supplies that was declined by the client or (2) orders of supplies that were not provided to the clients. The State agency did not provide adequate oversight of providers' billing practices.

Based on our sample results, we estimated that the State agency claimed $1,408,087 in unallowable Federal reimbursement.

UNALLOWABLE CLAIMS IDENTIFIED BY THE STATE AGENCY

Of the $6.3 million that we reviewed separately, the State agency claimed $284,869 in unallowable Federal reimbursement for ineligible clients and duplicate claims.

Ineligible Clients

The State agency claimed reimbursement for 2,109 claims, totaling $281,420 ($253,277 Federal share), for clients who were not eligible to receive services because they had family incomes that exceeded the Federal income limit or did not provide valid Social Security numbers. The erroneous claiming occurred because the State agency did not verify clients' family incomes or Social Security numbers.

Duplicate Claims

Of the 883 duplicate claims that the State agency identified, it did not refund the amount owed to the Federal Government for 241 claims totaling $35,102 ($31,592 Federal share).[3] Some of the duplicate claims were the result of a provider changing its billing system, and other duplicate claims were caused by provider billing errors. The erroneous claiming occurred because the State agency did not have adequate controls to prevent and detect duplicate claims for family planning services.

POTENTIALLY UNALLOWABLE CLAIMS

The State agency claimed reimbursement for 27,405 claims, totaling $3,310,404 ($2,979,364 Federal share), for clients who may not have been eligible to receive services. For these claims, the State agency did not verify clients' family incomes. In addition, for 4,205 of these claims, the State agency did not verify Social Security numbers. Because the supporting documentation was not readily available for the 27,405 claims, we have set aside $2,979,364 for resolution by CMS and the State agency.

[3] During our audit, the State agency refunded the amount owed to the Federal Government for 642 of these claims, totaling $72,788.

RECOMMENDATIONS

We recommend that the State agency:

- refund $1,692,956 to the Federal Government,
- work with CMS to resolve the $2,979,364 that we set aside,
- verify clients' family incomes and limit income eligibility in accordance with Federal requirements,
- verify that Social Security numbers provided by clients are valid, and
- strengthen controls to prevent and detect duplicate claims for family planning services.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and provided information on actions that it had taken or planned to take to address them. The State agency's comments are included in their entirety as Appendix C.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of Medicaid claims for family planning services and supplies submitted by providers under the Family Planning Expansion Project (Expansion Project) for which the Oregon Health Authority (State agency) claimed Federal reimbursement at an enhanced Federal medical assistance percentage of 90 percent during the period October 1, 2006, through September 30, 2009.

SAMPLING FRAME

The State agency provided us with a data file of claims for family planning services and supplies under the Expansion Project. This file excluded claims that were ineligible for reimbursement, duplicate claims, and claims where eligibility had yet to be determined. The result was a data file that contained 401,486 claims totaling $56,408,484 ($50,767,636 Federal share).

SAMPLE UNIT

The sample unit was an individual Medicaid claim for a family planning service or supply provided to an Expansion Project client.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected 100 claims for family planning services and supplies.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the frame from 1 to 401,486. 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 paid.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Sampling Frame Size	Value of Sampling Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Items	Value of Unallowable Items (Federal Share)
401,486	$50,767,636	100	$11,991	11	$1,015

ESTIMATED VALUE OF UNALLOWABLE CLAIMS
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$4,076,645
Lower limit	1,408,087
Upper limit	6,745,202

APPENDIX C: STATE AGENCY COMMENTS

Office of the Director
John A. Kitzhaber, MD, Governor

Oregon Health Authority
500 Summer Street NE, E-20
Salem, OR 97301
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October 25, 2011

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Re: Report Number A-09-11-02010

Dear Ms. Ahlstrand:

The Oregon Health Authority (OHA) appreciates the opportunity to respond to the draft report entitled *Review of Medicaid Family Planning Services Claims Under the Oregon Family Planning Expansion Project During the Period October 1, 2006, Through September 30, 2009,* from the U.S. Department of Health and Human Services, Office of Inspector General (OIG).

Please see below the OHA responses to the recommendations found within the draft report.

We recommend that the State agency refund $1,692,956 to the Federal Government.

OHA concurs with this recommendation.

OHA has made adjustments totaling $1,661,364 in September and October 2011. These adjustments will be reflected on the September and December 2011 CMS 64 reports. The remaining amount has been repaid by the CCare providers and the results of these repayments were reflected on the CMS 64 reports from December 2010 through June 2011.

We recommend that the State agency work with CMS to resolve the $2,979,364 that we set aside.

OHA concurs with this recommendation and will continue to work with the Centers for Medicare and Medicaid Services (CMS) to reach resolution.

We recommend that the State agency verify clients' family incomes and limit income eligibility in accordance with Federal requirements.

OHA concurs with this recommendation.

We have developed a plan of action to address income verification of program applicants. The plan has been submitted to CMS and progress is being made on implementing the plan.

We recommend that the State agency verify that Social Security numbers provided by clients are valid.

OHA concurs that the State agency should verify that Social Security numbers provided by clients are valid.

Prior to the OIG audit, the State developed a process to verify the Social Security numbers (SSN) of 100 percent of clients. As shared with auditors during the fieldwork period, the State implemented this process in February, 2010. Each month, State staff submit an electronic file of all enrollments and re-enrollments to the Social Security Administration (SSA) for SSN verification. For those records SSA is unable to verify, State staff perform manual verification checks and terminate eligibility of any client for whom SSN cannot be verified.

We recommend that the State agency strengthen controls to prevent and detect duplicate claims for family planning services.

OHA concurs with this recommendation.

State staff have enhanced its existing process to monitor and correct duplicate billing, i.e. payment of more than one claim for the same client on the same date of service. An initial, electronic edit had already been in place prior to the audit to prevent the processing of any claims with the same project number, clinic number, and date of service. An additional control was developed and implemented during the spring of 2010. After each month's claims processing, the claims file is checked for any duplicate

claims not identified through the edit (e.g., two different patient numbers used for the same client on the same date of service). When discovered, the billing agency is notified and asked to adjust the incorrect/duplicate claim. State staff then review subsequent claims files to assure that the duplicate claim has been corrected.

Additionally, we would like to offer corrections to two statements within the draft report regarding verification of eligibility for claims in the set aside amount. On page 3, in the first bullet of the section regarding the set aside claims, please change the first sentence to read "The State agency said that it did not verify clients' family incomes for 27,405 claims and did not verify clients' Social Security numbers for 4,205 claims." On page 6 of the draft report under the section entitled Potentially Unallowable Claims, please change the second sentence to read "For these claims, the State agency did not verify clients' family incomes for 27,405 claims and did not verify Social Security numbers for 4,205 claims."

Once again, thank you for the opportunity to respond to the recommendations found within Report Number A-09-11-02010. If you have any questions or concerns with the State's response, please feel free to contact Rian Frachele at 971-673-0364 or through e-mail at rian.frachele@state.or.us.

Sincerely,

Suzanne Hoffman,
Chief Operating Officer

cc: Bruce Goldberg, M.D., Director
Mel Kohn, M.D., M.P.H., Director for Public Health
Judy Mohr Peterson, Director for Medical Assistance Programs