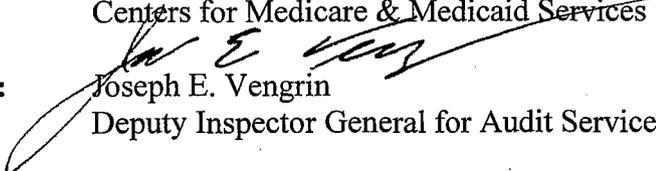




JAN - 5 2006

TO: Dennis G. Smith
Director, Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services

FROM: 
Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Family Planning Service Costs Claimed by Delaware's
Medicaid Managed Care Program (A-03-03-00220)

Attached is an advance copy of our final report on the Delaware Medicaid managed care program's claim for family planning service costs between October 2000 and June 2004. We will issue this report to Delaware within 5 business days. We conducted the audit at the request of the Centers for Medicare & Medicaid Services (CMS) as part of a multistate initiative.

Delaware contracts with managed care organizations to provide family planning services as required by the Social Security Act (the Act). States may claim 90-percent Federal funding for the costs of family planning services. The Federal share for most other Medicaid services in Delaware is about 50 percent. Although the Act does not specifically require enhanced Federal funding for family planning services provided through managed care delivery systems, CMS has permitted States to claim these costs. Delaware developed a methodology to calculate family planning costs by multiplying a per member per month rate by managed care member-months of utilization.

Our objective was to determine whether Delaware claimed family planning service costs under its Medicaid managed care program in accordance with its CMS-approved methodology and Federal statutes, regulations, and guidelines.

We could not validate Delaware's family planning service rates, which were based on fee-for-service claims incurred between July 1, 1991, and June 30, 1994, because Delaware did not provide documentation to support its calculations. Delaware contended that the Federal Government's right to review these data ended with the expiration of the record retention period in July 2000. We believe that Delaware is obligated to produce documentation demonstrating that the base-year data accurately reflect the current cost of providing family planning services. Because States must justify their claims for enhanced Federal payments, Delaware may not invoke the record retention limits as immunity against examination of its calculations.

Because Delaware could not justify its calculation of family planning service costs, it is not entitled to the \$2.9 million enhanced Federal share.

We recommend that Delaware:

- provide support for family planning service costs claimed between October 2000 and June 2004 or refund \$2,916,288 to the Federal Government and
- work with CMS to determine the amounts claimed for family planning service costs after June 2004, refund the enhanced portion to the Federal Government, and discontinue claiming family planning service costs at the enhanced rate until it provides adequate support for its family planning rates.

Delaware partially concurred and partially nonconcurred with our recommendations. Delaware did not agree that it had not provided supporting documentation. We continue to believe that unless Delaware provides adequate documentation, all claimed costs are unallowable and should be refunded.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470. Please refer to report number A-03-03-00220.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
SUITE 316
PHILADELPHIA, PENNSYLVANIA 19106-3499

JAN - 9 2006

Report Number: A-03-03-00220

Harry B. Hill
Director, Division of Social Services
Delaware Health and Social Services
State of Delaware
P.O. Box 906
New Castle, Delaware 19720

Dear Mr. Hill:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Family Planning Service Costs Claimed by Delaware's Medicaid Managed Care Program." A copy of this report will be forwarded to the HHS action official noted on the next page for review and any action deemed necessary.

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

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Page 2 – Harry B. Hill

If you have any questions or comments about this report, please do not hesitate to contact me at (215) 861-4470 or through e-mail at stephen.virbitsky@oig.hhs.gov or Robert Baiocco, Audit Manager, at (215) 861-4486 or through e-mail at robert.baiocco@oig.hhs.gov. Please refer to report number A-03-03-00220 in all correspondence.

Sincerely yours,



Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Nancy B. O'Connor, Regional Administrator
Centers for Medicare & Medicaid Services, Region III
Department of Health and Human Services
The Public Ledger Building, Suite 216
150 S. Independence Mall West
Philadelphia, Pennsylvania 19106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF FAMILY PLANNING
SERVICE COSTS CLAIMED BY
DELAWARE'S MEDICAID
MANAGED CARE PROGRAM**



**Daniel R. Levinson
Inspector General**

**JANUARY 2006
A-03-03-00220**

Office of Inspector General

<http://oig.hhs.gov>

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OAS FINDINGS AND OPINIONS

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



EXECUTIVE SUMMARY

BACKGROUND

Section 1905(a)(4)(c) of the Social Security Act (the Act) requires States to provide family planning services to Medicaid beneficiaries. The Centers for Medicare & Medicaid Services (CMS) defines family planning as those services that prevent or delay pregnancy or otherwise control family size. States may claim 90-percent Federal funding for the costs of family planning services. The Federal share for most other Medicaid services is computed using the Federal medical assistance percentage. In Delaware, this rate is about 50 percent. Although the Act does not specifically require enhanced Federal funding for family planning services provided through managed care delivery systems, CMS has permitted States to claim these costs.

Delaware Health and Social Services provides family planning services through its managed care program. Delaware calculated its initial family planning rates for each of its eight Medicaid beneficiary categories by dividing fee-for-service family planning expenditures paid between July 1, 1991, and June 30, 1994, by projected managed care enrollment months. The resultant base rates, periodically adjusted to correspond to increases in capitation payments, represented per member per month dollar amounts attributable to family planning costs. Between October 2000 and June 2004, Delaware claimed \$7.5 million in family planning service costs.

This audit is part of a CMS-requested multistate review of the rates used to claim family planning service costs at the 90-percent Federal funding rate.

OBJECTIVE

Our objective was to determine whether Delaware claimed family planning service costs under its Medicaid managed care program in accordance with its CMS-approved methodology and Federal statutes, regulations, and guidelines.

SUMMARY OF FINDINGS

We could not validate Delaware's family planning service rates, which were based on fee-for-service claims incurred between July 1, 1991, and June 30, 1994, because Delaware did not provide documentation to support its calculations. Delaware contended that the Federal Government's right to review these data ended with the expiration of the record retention period in July 2000.

We believe that Delaware is obligated to produce documentation demonstrating that the base-year data accurately reflect the current cost of providing family planning services. Because States must justify their claims for enhanced Federal payments, Delaware may not invoke the record retention limits as immunity against examination of its calculations. Our objective was to establish the validity of calculations used in current or recent claims for the enhanced Federal share, not to determine the allowability of costs claimed before the records retention period. Both Federal regulations and Departmental Appeals Board decisions make clear that if States

claim a 90-percent enhanced rate for family planning services, they must document these costs, regardless of the time elapsed since the base year for the cost calculations.

Because Delaware could not justify its calculation of family planning service costs, it is not entitled to the \$2.9 million enhanced Federal share.

RECOMMENDATIONS

We recommend that Delaware:

- provide support for family planning service costs claimed between October 2000 and June 2004 or refund \$2,916,288 to the Federal Government and
- work with CMS to determine the amounts claimed for family planning service costs after June 2004, refund the enhanced portion to the Federal Government, and discontinue claiming family planning service costs at the enhanced rate until it provides adequate support for its family planning rates.

DELAWARE'S COMMENTS

Delaware partially concurred and partially nonconcurred with our first recommendation by stating:

We do agree that Delaware should provide support for family planning services between October 2000 and June 2004 as well as all other times. We do not concur with the false suggestion that Delaware did not provide supporting documentation and we do not agree that we owe the Federal Government \$2.9 million because we cannot produce again 10 years later some piece of documentation that CMS already reviewed and approved several years ago.

Delaware also partially concurred and partially nonconcurred with our second recommendation by stating: "We agree that Delaware should work with CMS not only on family planning but on all things related to Medicaid. But this second recommendation is also misleading and false. It implies that Delaware has not/does not work with CMS to provide adequate support for managed care family planning claiming." Delaware's comments are included as Appendix B.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

The State Medicaid Manual, section 2497.1, stipulates that "Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation" Delaware failed to furnish source documentation supporting adjusted base rates used in claiming managed care family planning costs since October 2000. Unless Delaware provides adequate documentation, all claimed costs are unallowable and should be refunded.

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INTRODUCTION

BACKGROUND

Medicaid Overview

In 1965, Congress established Medicaid as a jointly funded State and Federal program that provides medical assistance to low-income people who qualify pursuant to Title XIX of the Social Security Act (the Act). In Delaware, Delaware Health and Social Services administers the Medicaid program with Federal oversight from the Centers for Medicare & Medicaid Services (CMS).

Medicaid Reporting Requirements

CMS requires States to report their Medicaid expenditures, both medical assistance and administrative, on Form CMS-64, Medicaid Program Expenditures Report (CMS-64). The Federal Government pays its share of medical assistance expenditures according to a formula defined in section 1905(b) of the Act. That share is known as the Federal medical assistance percentage (FMAP) and ranges from 50 percent to 83 percent depending upon each State's relative per capita income. The FMAP rate in Delaware is 50 percent for most services.

Family Planning Services

Section 1905(a)(4)(c) of the Act requires States to provide family planning services to Medicaid beneficiaries. The scope of family planning services is not further defined in the statute or by regulation. However, CMS provided general guidance in section 4270 of the State Medicaid Manual, which states that the purpose of the family planning benefit is "to aid those who voluntarily choose not to risk an initial pregnancy." Section 4270 further defines family planning services to include those services that prevent or delay pregnancy or otherwise control family size. It also permits States to define the services to include infertility treatment. CMS issued additional guidelines, "Title XIX Financial Management Review Guide (Number 20): Family Planning Services," to clarify the reporting of these services.¹

Pursuant to section 1903(a)(5) of the Act and 42 CFR §§ 432.50 and 433.15, States may claim 90-percent Federal funding for the costs of family planning services. Although section 1905(a)(4)(c) of the Act does not specifically require enhanced Federal funding for family planning services provided through managed care delivery systems, CMS has permitted States to claim these costs.

Delaware's Medicaid Managed Care Program

Enrollment in Delaware's Diamond State Health Plan program began in January 1996. CMS approved the program under a demonstration waiver granted pursuant to section 1115 of the Act.

¹CMS issued guidelines in 2002 to expand upon material issued in 1997 that identified procedure codes for family planning services and to provide assistance to its regional offices. The guidelines are also cited in section 2700.2 of the State Medicaid Manual.

Delaware contracts with managed care organizations to provide basic mental health and physical health services, including family planning. Most Medicaid beneficiaries are eligible for the program, with the exception of those receiving long term care in institutional or home- and community-based settings and those who are eligible for Medicare.

Delaware's Methodology for Claiming Family Planning Service Costs

Delaware calculated its initial family planning rates for each of its eight Medicaid beneficiary categories by dividing fee-for-service family planning costs paid between July 1, 1991, and June 30, 1994, by projected managed care enrollment months. (See Appendix A for rates.) The resulting base rates, periodically adjusted to correspond to increases in capitation payment rates, represented per member per month dollar amounts attributable to family planning costs.² Delaware calculated the costs of family planning services by multiplying family planning rates by member-months of utilization. The CMS regional office approved this methodology in July 1997, retroactive to January 1996.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Delaware claimed family planning service costs under its Medicaid managed care program in accordance with its CMS-approved methodology and Federal statutes, regulations, and guidelines.

Scope

This audit included Delaware's \$7.5 million claim for family planning service costs for the period October 2000 through June 2004. The Federal share of this claim totaled \$6.7 million. Included in the \$6.7 million was \$2.9 million representing the difference between the 90-percent enhanced family planning rate and Delaware's regular FMAP rate. We reviewed only those internal controls considered necessary to achieve our objective. We performed our fieldwork in New Castle, DE.

Methodology

To accomplish our objective:

- We reviewed relevant criteria, including the Act; the Inspector General Act of 1978; Federal Medicaid regulations; Federal record retention regulations; CMS's State Medicaid Manual, policy memorandums, and guidelines; Departmental Appeals Board (DAB) decisions; Delaware's State Medicaid plan; the Diamond State Health Plan waiver; and Delaware's methodology for computing the family planning rates.

²A capitation payment is a predetermined per member per month State payment to a managed care organization.

- We reconciled the total capitation payments made between October 2000 and June 2004 to those reported on the CMS-64 to determine the Federal share of the family planning service costs.
- We reconciled the Federal share claimed on the CMS-64 to the Federal share calculated using the family planning rates.

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

FINDINGS AND RECOMMENDATIONS

LACK OF DOCUMENTATION FOR DELAWARE’S FAMILY PLANNING SERVICE RATES

We could not validate Delaware’s family planning service rates for the audit period, which were based on fee-for-service claims incurred between July 1, 1991, and June 30, 1994, because Delaware did not provide the documentation to support its calculations. Delaware contended that the Federal Government’s right to review these data ended with the expiration of the record retention period in July 2000. The base-year claims were processed through a system that Delaware no longer uses. Delaware indicated that its claims processing contractor could retrieve the claims and provide them for review if the Federal Government were willing to bear the full cost, which Delaware contended would be significant.

Claims must have adequate supporting documentation to be eligible for Federal matching funds. Because States must justify their claims for enhanced Federal payments, Delaware may not invoke the record retention limits as immunity against examination of its calculations. Other States where we have performed similar reviews have cooperated in providing the relevant data, even if they were dated beyond the records retention requirements.

Thus, because Delaware could not justify its calculation of family planning costs, it is not entitled to the \$2.9 million enhanced Federal share.

States Are Required To Provide Evidence To Support Claims

States are required to produce documentation demonstrating that the use of base-year data accurately reflects the current cost of providing family planning services. Federal record retention regulations (45 CFR § 74.53(b)) do not limit the Federal Government’s right to unrestricted access, even beyond the 3-year retention period, to relevant documents that still exist.³ This principle was also established in the Inspector General Act of 1978, which states in section 6(a) that each Inspector General, in carrying out the provisions of this Act, is authorized “to have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material available to the applicable establishment which relate to programs and operations with respect to which that Inspector General has responsibilities under this Act.”

³Effective September 2003, the applicable regulation is 45 CFR § 92.42, which provides a substantially similar 3-year retention period.

The State Medicaid Manual, section 2497.1, states that:

Federal financial participation is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.

DAB has rejected grantees' arguments that record retention rules or the inaccessibility of records should limit an agency's ability to disallow otherwise unallowable costs. In Georgia Department of Medical Assistance, DAB No. 798 (1986), DAB concluded that even where the State alleged that recovery of documentation would be "difficult, if not impossible," the State was still obligated to justify its claims.

Delaware Did Not Provide Supporting Documentation

Delaware did not provide documentation to support the rates that it used to claim family planning service costs. To validate Delaware's methodology, we needed to review the family planning claims and beneficiary enrollment data for the State's fee-for-service delivery system between July 1, 1991, and June 30, 1994. Delaware contracted with an actuarial firm in 1995 to develop these rates. The firm compiled the claims data during the initial rate-setting process but did not retain the data. The base-year claims were processed through a system that Delaware no longer uses and were commingled with other Medicaid claims. Delaware stated that its claims processing contractor could retrieve the claims and provide them for review if the Federal Government were willing to bear the full cost, which Delaware contended would be significant.

Other States where we have performed similar reviews have cooperated in providing the relevant data even if they were dated beyond the records retention requirements. State and Federal Governments share Medicaid program costs. In this case, the cost to retrieve these claims could be reported as an administrative expense that the State and Federal Governments would share equally.

Delaware Contended That the Requirement To Produce Claims Data Ended in July 2000

Because its initial claim was filed in July 1997, Delaware contended that Federal regulations (45 CFR § 74.53(b)) did not require it to produce the claims data after July 2000. These regulations state that:

Financial records, supporting documents, statistical records, and all other records pertinent to an award shall be retained for a period of three years from the date of submission for the final expenditure report or, for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report.

Delaware stated that it was not required to retain and produce old records merely because they could be linked to some aspect of the program as it operates today. Delaware noted, and CMS confirmed, that CMS had reviewed and approved Delaware's methodology for claiming family

planning service costs for its managed care program. Delaware stated that CMS had not asked for the claims data since the State’s initial claim. Delaware contended that information that it provided for this review provided a “preponderance of evidence” that the rates were accurately established.

Because States must justify their claims for enhanced Federal payments, Delaware may not invoke the record retention limits as immunity against examination of its calculation. The objective of this audit was not to determine the allowability of costs claimed more than 3 years ago. Rather, we attempted to establish the validity of cost calculations used in current or recent claims for enhanced Federal payments. Both the regulations and DAB make clear that if States claim a 90-percent enhanced rate for family planning services, they must also document these costs, regardless of the time elapsed since the base year for the cost calculations. Otherwise, the record retention rules would establish a permanent bar against examination of States’ family planning rates.

The Federal Share of Delaware’s Unsupported Claim Was \$2.9 Million

Because of the lack of documentation, we were unable to determine the allowability of Delaware’s \$2.9 million enhanced Federal share. Between October 2000 and June 2004, Delaware claimed \$7.5 million in family planning service costs. (See the table below.) The Federal share of this claim totaled \$6.7 million and included \$2.9 million that represented the difference between the 90-percent enhanced family planning rate and the State’s regular FMAP.⁴

Composition of Family Planning Service Costs

Federal Fiscal Year	Family Planning Expenditures	Federal Share		
		Total	FMAP Rate	Enhanced Family Planning Rate
2001	\$1,894,973	\$1,705,475	\$947,486	\$757,989
2002	1,718,701	1,546,831	859,351	687,480
2003	2,319,237	2,087,313	1,192,805	894,508
2004	1,555,496	1,399,946	823,635	576,311
Total	\$7,488,407	\$6,739,565	\$3,823,277	\$2,916,288

RECOMMENDATIONS

We recommend that Delaware:

- provide support for family planning service costs claimed between October 2000 and June 2004 or refund \$2,916,288 to the Federal Government and
- work with CMS to determine the amounts claimed for family planning service costs after June 2004, refund the enhanced portion to the Federal Government, and discontinue

⁴Between October 2001 and March 2003, Delaware’s FMAP rate was 50 percent. Between April 2003 and June 2004, the rate was 52.95 percent.

claiming family planning service costs at the enhanced rate until it provides adequate support for its family planning rates.

DELAWARE’S COMMENTS

Delaware partially concurred and partially nonconcurred with our first recommendation by stating:

We do agree that Delaware should provide support for family planning services between October 2000 and June 2004 as well as all other times. We do not concur with the false suggestion that Delaware did not provide supporting documentation and we do not agree that we owe the Federal Government \$2.9 million because we cannot produce again 10 years later some piece of documentation that CMS already reviewed and approved several years ago.

Delaware also partially concurred and partially nonconcurred with our second recommendation by stating: “We agree that Delaware should work with CMS not only on family planning but on all things related to Medicaid. But this second recommendation is also misleading and false. It implies that Delaware has not/does not work with CMS to provide adequate support for managed care family planning claiming.”

The full text of Delaware’s comments is included as Appendix B.

OFFICE OF INSPECTOR GENERAL’S RESPONSE

The State Medicaid Manual, section 2497.1, stipulates that “Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation” Delaware did not comply with this requirement because it failed to furnish source documentation supporting adjusted base rates used in claiming managed care family planning costs since October 2000. Unless Delaware provides adequate documentation, all claimed costs are unallowable and should be refunded.

APPENDIXES

DELAWARE'S FAMILY PLANNING RATES CALCULATION

Delaware calculated its initial family planning rates by allocating \$3,545,033 in fee-for-service family planning costs paid between July 1, 1991, and June 30, 1994, among its eight Medicaid beneficiary categories. To derive per member per month (PMPM) rates, Delaware divided each category's family planning costs by the equivalent projected enrollment months. (See the table below.) For example, Delaware paid \$3,209,930 for family planning services for females between the ages of 18 and 44 who were eligible for Aid to Families with Dependent Children (AFDC).¹ Delaware divided the payments by 353,784 member-months for a rate of \$9.07 PMPM. Delaware slightly adjusted this and all other rates to reflect changes in the capitation payment rates. The adjusted family planning rate for these AFDC females was \$9.264 PMPM. For January 1996, Delaware estimated that these AFDC female beneficiaries incurred \$34,536.19 in family planning expenditures by multiplying the PMPM rate of \$9.264 by 3,728 member-months.

Initial Family Planning Rates

Category of Medical Assistance	Family Planning Costs	Member Enrollment Months	Unadjusted Rate	Adjustment	PMPM Rate
AFDC Female 11–17	\$119,164	126,855	\$0.94	\$0.024	\$0.965
AFDC Female 18–44	3,209,930	353,784	9.07	0.194	9.264
AFDC Male 18–44	599	21,799	0.03	(0.002)	0.028
AFDC Unisex 45+	693	12,931	0.05	(0.002)	0.048
SSI Unisex 0–17 ²	5,927	76,131	0.08	0.000	0.082
SSI Unisex 18+	76,357	171,842	0.44	0.000	0.449
General Assistance ³	17,467	66,728	0.26	(0.015)	0.245
SOBRA ⁴	114,896	5,883	19.53	2.210	21.737
Total	\$3,545,033				

¹Now known as Temporary Assistance for Needy Families, AFDC provided cash assistance to families with dependent children.

²This category includes individuals who are elderly, blind, or disabled and receive Supplemental Security Income (SSI) benefits under Title XVI of the Social Security Act.

³General Assistance is a State-funded program that provides cash assistance to low-income people who do not qualify for federally funded programs.

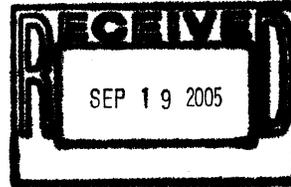
⁴This program covers pregnant and postpartum women and their children up to age 5 who are eligible under the provisions of the sixth Omnibus Budget Reconciliation Act (SOBRA) of 1986 (Public Law 99-509).

**DELAWARE HEALTH
AND SOCIAL SERVICES**DIVISION OF
SOCIAL SERVICES

TELEPHONE: (302)

September 15, 2005

Mr. Stephen Virbitsky
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
150 S. Independence Mall West
Suite 316
Philadelphia, Pennsylvania 19720



**Re: Report # A-03-03-00220
Review of Family Planning
Service Costs Claimed by
Delaware's Medicaid Managed
Care Program**

Dear Mr. Verbitsky:

We are writing in response to the draft "Review of Family Planning Service Costs Claimed by Delaware's Medicaid Managed Care Program."

As you might expect, Delaware disagrees with most of the statements in the Report and both recommendations in the Report. The Report almost completely ignores, obscures, misleads and misrepresents the history of Delaware's managed care family planning claims and methodology and our involvement with CMS and OIG staff on this issue. The draft Report states that the objective of the 2004 audit was "...to determine whether Delaware claimed family planning service costs under its Medicaid managed care program in accordance with CMS's approved methodology and Federal statutes, regulations, and guidelines." As Delaware explained to the OIG audit staff, this determination had already been made by the appropriate financial staff at the CMS (HCFA at that time) Regional Office at the time Delaware began to claim family planning for managed care in 1996.

One of the few things we agree with in this Report is the statement that "...CMS confirmed, that CMS reviewed and approved Delaware's methodology for claiming family planning service costs for its managed care program." CMS confirmed that they approved our managed care family planning methodology. CMS approved the methodology when it was initiated in 1996 and also at subsequent times when updates to the rates were implemented. Thus the stated objective of the audit had already been achieved by CMS for the Delaware Medicaid program.

Stephen Verbitsky Letter
Page 2

Since CMS reviewed and approved the documentation produced by the state, there was no reason for the state to anticipate that some federal oversight agency would show up eight years later and demand to recreate the same process all over again and require the state to produce all of the original documentation. And when the OIG made their request in 2003, at that point the original claims data was between 9-12 years old. We believe it was reasonable for Delaware to conclude in 1996 that since CMS approved our methodology, they must have determined that our family planning claims were fully in accord with CMS' Federal statutes, regulations and guidelines.

At this point, we believe that the original claims data from 1991 – 1994 might be available on computer tapes that are currently being held by our fiscal agent. However in July 2002, Delaware implemented a new MMIS computer system. We have been informed by our fiscal agent that we could determine if the old system's claims data is retrievable from the computer tapes only if we were able to acquire a mainframe computer and peripheral hardware that is substantially similar to the one that ran Delaware's previous MMIS. Then that mainframe computer would have to be loaded with all of the same (or very similar) systems software that existed on the old MMIS. Then the computer would have to be loaded with the old Delaware MMIS application software. After that was made to function, then the process of attempting to restore the old claims data could begin. The casual statement in the Report that Delaware could simply incur this administrative cost and get federal match completely ignores the enormity of such a project. Basically, this would approach the level of effort needed to develop an MMIS system with a cost that we believe would be many millions of dollars. This cost would be for a one-time ad hoc effort to retrieve some claims data and recreate a federal approval process that was timely completed by CMS in 1996.

The Report includes a section heading with the title "Delaware Did Not Provide Supporting Documentation". That statement, which is repeated in various forms throughout the Report is false. The fact is that Delaware's methodology for calculating the family planning portion of the managed care rates was specifically discussed with the Regional staff at the time it was developed in 1996. Delaware fully cooperated by providing any and all back-up supporting documentation requested by CMS staff at that time. We were fully prepared at that time to provide every single claim record from 1991 to 1994 if that was requested. After reviewing all of the information that CMS requested and we provided without exception, the Regional staff approved our methodology and our claiming.

Furthermore, when the OIG staff arrived in 2003, we provided to them extensive supporting documentation of everything we had available regarding our managed care family planning claims. They requested, but we do not have available the original base year claims data from 1991 to 1994. On November 3, 2003, [redacted] of the OIG staff called [redacted], Delaware Medicaid Chief of Administration, and stated that the OIG staff would not be pursuing the family planning audit. Other discussions with OIG staff at that time indicated that the report and recommendations would focus on

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ways to improve the family planning claiming process in the future. Our state indicated that we would support those recommendations and in fact we have implemented the recommendation we discussed with the OIG staff to have future family planning managed care rate adjustments actuarially re-determined.

Almost a year later, in October 2004, _____ called _____ to reverse field and say they decided to ask again for the 1991 to 1994 claims data that OIG already knew Delaware could not produce. And now that we have the draft Report, the entire focus is on the one supporting documentation that cannot be produced. There is nothing in the report about how to improve the process in the future. The Report does not acknowledge that Delaware produced extensive documentation for the OIG staff to review. Therefore, the OIG Report should be revised to state that Delaware produced all requested supporting documentation as requested by CMS in 1996 and produced it again in 2003 with the exception of claims data that was between 9 to 12 years old and which the state no longer has available. And the Report should be revised to state that the inability of the State to produce the old claims data prevents the OIG from recreating an approval process that CMA already completed in 1996.

We are not familiar with a 1986 Appeals Board ruling No. 798 referenced in the Report regarding some issue with the Georgia Medicaid program. Based on the description in the Draft OIG Audit Report, apparently the state was arguing that they should not have to justify its Medicaid claims because it would be difficult, if not impossible to recover documentation. We do not see how this decision applies to Delaware's situation. Delaware was willing to provide and did provide to CMS all documentation that was requested without any exception. And based on that documentation, CMS approved Delaware's methodology and claiming. That took place in 1996 and we provided extensive documentation again to OIG staff when they made their request in 2003. Our dispute is that we should not have to provide all the original documentation twice -- once when it is timely requested by the Federal government (and reviewed and approved by them) and then again a second time many many years later.

The Draft OIG Audit Report states that it is clear that the regulations and the DAB require that if State claims the 90% enhanced rate for family planning services, that they must also document these costs regardless of the time elapsed since the base year for the cost calculations. We believe it is equally clear that Delaware is fully in compliance with those requirements. Delaware produced all the documentation requested by CMS before any time elapsed, i.e., before any managed care family planning claims were submitted. We invited CMS staff to come and look at our documentation and our methodology and give us their approval which they did in 1996. In addition, as our managed care family planning claims continue to be submitted on quarterly reports, all of the managed care capitation claims upon which the family planning amounts are calculated each quarter are fully available for federal oversight agencies to review.

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We agree that Delaware Medicaid is required to produce documentation demonstrating that base year data accurately reflects the current cost of providing family planning services. That is why Delaware did produce all such data requested by CMS at the time the base year data was being analyzed and used to develop the family planning claiming methodology. Obviously, we knew and CMS staff knew that family planning claims for managed care payments would be a new element in Delaware's Medicaid program. We sought CMS' approval because the methodology adopted would be the basis of future claims. After reviewing the base year data to their satisfaction CMS approved the methodology. Obviously, once the underlying base period supporting documentation is reviewed and the methodology and calculations are approved by CMS, it seems logical that future claims relying on that same basis are also approved.

With regard to the two specific recommendations in the Report, as stated above, we disagree with the focus of the recommendations although we agree with some of the language as explained below:

Recommendation #1 – We partially concur and partially non-concur. The first recommendation is based on a false premise. We do agree that Delaware should provide support for family planning services between October 2000 and June 2004 as well as all other times. The Report gives the impression that Delaware refused to provide documentation to support our managed care family planning claims. The fact is that Delaware timely provided all requested supporting documentation to CMS staff when the managed care program was initiated. The supporting information was timely requested in 1996 by CMS prior to any claims being submitted by Delaware. And Delaware timely provided in 1996 every back-up and supporting document requested without exception, and we were fully prepared to provide any additional information at that time without exception. Delaware did not initiate any managed care family planning claiming until notified by CMS staff that they were satisfied with our methodology. Therefore, we concur that we should provide and in fact did provide all requested documentation. We do not concur with the false suggestion that Delaware did not provide supporting documentation and we do not agree that we owe the Federal Government \$2.9 million because we cannot produce again 10 years later some piece of documentation that CMS already reviewed and approved several years ago.

Recommendation #2 – We partially concur and partially non-concur. We agree that Delaware should work with CMS not only on family planning but on all things related to Medicaid. But this second recommendation is also misleading and false. It implies that Delaware has not/does not work with CMS to provide adequate support for managed care family planning claiming. That is not true.

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As we have stated over and over again, Delaware has worked with CMS and provided to CMS staff the supporting documentation that they themselves determined to be adequate. The state did not limit CMS' analysis in any way. The CMS staff determined when the supporting documentation provided was sufficient and authorized the state to move forward with the managed care family planning claiming. As stated previously, the OIG audit staff acknowledge in their report that "...CMS confirmed, that CMS reviewed and approved Delaware's methodology for claiming family planning service costs for its managed care program." And yet, throughout the entire remainder of the report, again and again the Report asserts that Delaware has not/does not cooperate with CMS and has not provided supporting documentation. At any point in time, Delaware has and will continue to work with and provide CMS staff with any requested documentation of our claims.

Also, Delaware already discontinued claiming family planning services at the enhanced rate until we provided adequate support for our rates to CMS. We did that in 1996 when managed care family planning claiming was first implemented in Delaware. After CMS reviewed and approved the documentation and the rates, then we resumed claiming family planning services. So we concur with the statement in the recommendations about discontinuing claiming until adequate support is provided and we have already complied with that recommendation nine years ago.

In conclusion, we believe that this draft OIG report is fundamentally flawed and almost completely misrepresents the documentation, review and approval process that has taken place between Delaware and the federal government with regard to Medicaid managed care family planning claiming. This entire area of Delaware's Medicaid FFP claiming was fully and fairly handled between Delaware and CMS at the appropriate time in 1996.

The OIG staff showed up eight years after the fact. Even though they refuse to acknowledge it in this Report, we give them all of the back up and supporting documentation that we have. Any reasonable person could look at all the information we provided and determine that our process for setting family planning managed care rates was a professionally done, most likely actuarially sound as well as CMS reviewed and approved at the time it was done. But the OIG staff continued to seek documentation until they regressed far enough in time that they found an informational request that the state could not respond to. Then they determined that nothing that had transpired between the State and CMS over the past eight years and none of the documentation that we have supplied to OIG staff could possibly justify Delaware's family planning claims. Only the documents that OIG was sure the state was no longer able to produce could provide the necessary justification. We completely reject this view.

In terms of corrective actions, we ask CMS to reject this unfair and misleading report. We ask CMS to correct the record on our behalf by acknowledging that this Report completely misrepresents the cooperative relationship we have had with CMS over many years of working with them regarding our family planning claims.

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We ask CMS to fully disclose and acknowledge that Delaware invited and requested CMS staff to review any and all supporting documentation and to approve our methodology before a single managed care family planning claim was submitted in 1996. And we ask CMS to further acknowledge that they approved our family planning managed care claims and stand behind their process in what had been a cooperative effort between our two agencies in 1996 and we think continues to this day.

Sincerely,



Harry B. Hill
Director

HBH/jh

Frank O'Connor - DMMA
Ted Gallagher - CMS

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This report was prepared under the direction of Stephen Virbitsky, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Robert Baiocco, *Audit Manager*
Carolyn Hoffman, *Senior Auditor*
David Besterman, *Senior Auditor*
Lisa Ferraro, *Auditor*
James Rhein, *Auditor*
Robert Adams, *Auditor*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.