



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

May 22, 2008

Report Number: A-02-07-01001

Richard F. Daines, M.D.
Commissioner
New York State Department of Health
14th Floor, Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Dr. Daines:

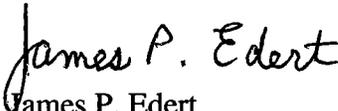
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Federal Medicaid Claims Made for Beneficiaries in the Family Planning Benefit Program in New York State." We will forward a copy of this report to the HHS action official 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact John Berbach, Audit Manager, at (518) 437-9390, extension 228 or through e-mail at John.Berbach@oig.hhs.gov. Please refer to report number A-02-07-01001 in all correspondence.

Sincerely,


James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF FEDERAL MEDICAID
CLAIMS MADE FOR
BENEFICIARIES IN THE FAMILY
PLANNING BENEFIT PROGRAM IN
NEW YORK STATE**



Daniel R. Levinson
Inspector General

May 2008
A-02-07-01001

Office of Inspector General

<http://oig.hhs.gov>

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

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 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 Medicaid 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.

The Federal share of the Medicaid program is referred to as Federal financial participation (FFP). Section 1903(a)(5) of the Social Security Act and 42 CFR §§ 433.10 and 433.15 provide enhanced 90-percent FFP for family planning services. According to section 4270 of the CMS "State Medicaid Manual," family planning services prevent or delay pregnancy or otherwise control family size.

The New York State Legislature enacted the Family Planning Benefit Program (FPBP) as part of Chapter 57 of the Laws of 2000. Chapter 57 added Section 366 (1)(a)(11) of the Social Services Law to expand eligibility for family planning services to individuals with incomes at or below 200 percent of the Federal poverty level, contingent upon approval of a Federal waiver. FPBP was approved by CMS as an amendment to New York's Section 1115 Partnership Plan Waiver on September 27, 2002, with an effective date of October 1, 2002. FPBP provides only Medicaid-reimbursed family planning services, exclusive of abortions, for eligible individuals. No other Medicaid services are eligible for Federal Medicaid reimbursement for beneficiaries in the FPBP.

OBJECTIVE

Our objective was to determine if New York State properly received Federal Medicaid reimbursement for claims submitted by providers for beneficiaries in the FPBP.

SUMMARY OF FINDINGS

New York State improperly received Federal Medicaid reimbursement for claims submitted by providers for beneficiaries in the FPBP. Of the 147 FPBP claims in our sample, 110 were eligible for Federal Medicaid reimbursement. However, 37 were not eligible for Federal Medicaid reimbursement. As a result, the State improperly received \$918,816 in Federal Medicaid funds.

This overpayment occurred because: (1) prior to May 2003, the State's Medicaid Management Information System edit routines did not adequately identify FPBP claims that were not related to family planning, (2) some providers incorrectly claimed services as family planning, and (3) some providers did not properly complete the Medicaid sterilization consent form.

RECOMMENDATIONS

We recommend that the State:

- refund \$918,816 to the Federal Government;
- re-emphasize to providers that only services directly related to family planning can be billed to Medicaid for beneficiaries in the FPBP;
- reinforce guidance to providers that a properly completed sterilization consent form must be prepared and maintained for all Medicaid sterilizations; and
- determine the amount of Federal Medicaid funds improperly reimbursed for FPBP claims unrelated to family planning subsequent to our audit period, and refund that amount to the Federal Government.

DEPARTMENT OF HEALTH COMMENTS

In its May 9, 2008, comments on our draft report, the State Department of Health (DOH) generally concurred with our first recommendation and fully concurred with our remaining recommendations. Regarding our first recommendation to refund \$918,816 to the Federal Government, DOH did not fully concur with the related audit findings and requested copies of working papers supporting the recommended refund. Specifically, DOH disagreed with our disallowance of certain claims related to HIV counseling and testing, and included a copy of Medicaid State Operations Letter 94-53, dated August 29, 1994. The letter stated that HIV counseling and screening are family planning services when they are provided in conjunction with a family planning encounter. Following a review of the working papers, DOH indicated that it will refund any excess Federal reimbursement associated with claims determined to have been inappropriately classified as family planning.

DOH's comments are included in their entirety as Appendix C to this report.

OFFICE OF INSPECTOR GENERAL RESPONSE

After considering DOH's comments, we continue to maintain that all disallowed services, including those related to HIV counseling and testing, were improperly claimed for Federal Medicaid reimbursement. We shared the medical records related to these services and our sample results with a CMS physician, who is a policy expert on family planning matters, for his determinations. The CMS physician determined that the HIV counseling and testing sample claims questioned in the report were not related to family planning. Nevertheless, we will provide DOH with copies of our working papers related to our error claims.

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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 Medicaid 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.

New York State's Medicaid Program

In New York State, the Department of Health (DOH) operates the Medicaid program. Within the DOH, the Office of Medicaid Management administers the program. DOH uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims.

The Federal share of the Medicaid program is referred to as Federal financial participation (FFP). The Federal share of a State's Medicaid program is determined by the Federal medical assistance percentage (FMAP). During our audit period (October 1, 2002, through June 30, 2006), the FMAP in New York State was 50 or 52.95 percent.¹

Medicaid Coverage of Family Planning Services

Section 1905(a)(4)(C) of the Act requires States to furnish family planning services and supplies to individuals of childbearing age who are eligible under the State plan and who desire such services and supplies. Section 1902(a)(10)(A) of the Act specifies that family planning services be available to "categorically needy" Medicaid beneficiaries, while section 1902(a)(10)(C) specifies that the services may be provided to "medically needy" Medicaid beneficiaries at the State's option. Section 1903(a)(5) of the Act and 42 CFR §§ 433.10(c)(1) and 433.15(b)(2) authorize 90-percent Federal funding for family planning services.

According to section 4270 of the CMS "State Medicaid Manual," family planning services prevent or delay pregnancy or otherwise control family size. In addition, this section generally permits an enhanced 90-percent rate of FFP for counseling services and patient education; examination and treatment by medical professionals pursuant to State requirements; laboratory examinations and tests; medically approved methods, procedures, pharmaceutical supplies, and devices to prevent conception; and infertility services, including sterilization reversals. The manual indicates that States are free to determine the specific services and supplies which will be

¹The FMAP was 50 percent from October 1, 2002, through March 31, 2003, 52.95 percent from April 1, 2003, through June 30, 2004, and 50 percent for claims paid from July 1, 2004, to June 30, 2006.

covered as Medicaid family planning services as long as those services are sufficient in amount, duration and scope to reasonably achieve their purpose. However, only items and procedures clearly furnished or provided for family planning purposes may be claimed at the 90-percent rate of FFP.

New York's Medicaid State plan states that family planning services and supplies for individuals of childbearing age are covered without limitations. State regulations (Official Compilation of Codes, Rules and Regulations of the State of New York, Title 18, section 505.13) define family planning services as the offering, arranging, and furnishing of those health services that enable individuals, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies. The regulations state that such services include professional medical counseling services, prescription drugs, nonprescription drugs and medical supplies prescribed by a qualified physician, nurse practitioner, or physicians' assistants, and sterilizations.

Family Planning Benefit Program

The New York State Legislature enacted the Family Planning Benefit Program (FPBP) as part of Chapter 57 of the Laws of 2000. Chapter 57 added Section 366 (1)(a)(11) of the Social Services Law to expand eligibility for family planning services to individuals with incomes at or below 200 percent of the Federal poverty level, contingent upon approval of a Federal waiver. Section 1115 of the Act authorizes CMS to waive compliance with certain requirements of the Act for experimental, pilot, or demonstration programs that are likely to assist in promoting the Act's objectives. A State plan waiver program must be approved by CMS and allows the State to claim Federal reimbursement for services not usually covered by Medicaid.

FPBP was approved by CMS as an amendment to New York's Section 1115 Partnership Plan Waiver on September 27, 2002, with an effective date of October 1, 2002. FPBP provides only Medicaid-reimbursed family planning services, exclusive of abortions, for eligible individuals. No other Medicaid services are eligible for Federal Medicaid reimbursement for beneficiaries in the FPBP.

Eligible recipients have access to services from all Medicaid-enrolled family planning providers, including hospital-based and free-standing clinics, obstetricians and gynecologists, physicians, nurse practitioners, pharmacies and laboratories. Recipients in the FPBP are assigned Recipient Aid Category (RAC) 56 and Recipient Medicaid Coverage Code (RMCC) 18 in the State's MMIS.

To assist providers with claim submissions, the State furnishes manuals and Medicaid guidance containing instructions for properly completing and submitting FPBP claims through the State's MMIS. On the Medicaid claim form are certain fields that the provider is required to complete. For example, the "family planning" field should be completed to indicate that a family planning service has been provided. In addition, a "family planning" diagnosis code in the V25 series (encounter for contraceptive management) must be used when such information is required on the claim form and a family planning service has been provided to a FPBP beneficiary.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine if New York State properly received Federal Medicaid reimbursement for claims submitted by providers for beneficiaries in the FPBP.

Scope

Our audit period covered October 1, 2002, through June 30, 2006. We did not review the overall internal control structure of the State or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We conducted fieldwork at the State Department of Health in Albany, New York; the State MMIS fiscal agent in Menands and Rensselaer, New York; and provider offices throughout New York State.

Methodology

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, guidance, and the State plan;
- held discussions with CMS officials and acquired an understanding of CMS's guidance to State officials on FPBP claims;
- held discussions with State officials to ascertain State policies, procedures, and guidance related to claiming Medicaid reimbursement for FPBP services;
- extracted all claims at the State MMIS fiscal agent with benefit codes RAC 56 and RMCC 18, which identified a sampling frame of 411,109 paid FPBP claims totaling \$34,561,583 (\$30,153,183 Federal share) for the period from October 1, 2002, through June 30, 2006;
- used stratified random sampling techniques to select a sample of 147 claims for review from the population of 411,109 claims;
- obtained and reviewed medical records from the 82 providers who submitted the 147 sample claims in order to make an initial determination as to whether the claimed services were related to family planning and eligible for Federal Medicaid funding under the FPBP;
- shared the medical records and our sample results with a CMS physician, who is a policy expert on family planning, for his opinions and determinations; and

- used a variable appraisal program to estimate the dollar impact of the improper Federal funding claimed in the total population of 411,109 claims.

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

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.

FINDINGS AND RECOMMENDATIONS

New York State improperly received Federal Medicaid reimbursement for claims submitted by providers for beneficiaries in the FPBP. Of the 147 FPBP claims in our sample, 110 were eligible for Federal Medicaid reimbursement. However, 37 were not eligible for Federal Medicaid reimbursement. As a result, the State improperly received \$918,816 in Federal Medicaid funds.

This overpayment occurred because: (1) prior to May 2003, the State's MMIS edit routines did not adequately identify FPBP claims that were not related to family planning, (2) some providers incorrectly claimed services as family planning, and (3) some providers did not properly complete the Medicaid sterilization consent form.

SERVICES UNRELATED TO FAMILY PLANNING

According to section 4270 of the CMS "State Medicaid Manual," family planning services prevent or delay pregnancy or otherwise control family size. The manual indicates that States are free to determine the specific services and supplies which will be covered as Medicaid family planning services as long as those services are sufficient in amount, duration and scope to reasonably achieve their purpose. However, only items and procedures clearly furnished or provided for family planning purposes may be claimed at the 90-percent rate of FFP.

New York's Medicaid State Plan states that family planning services and supplies for individuals of childbearing age are covered without limitations. State regulations (Official Compilation of Codes, Rules and Regulations of the State of New York, Title 18, section 505.13) define family planning services as the offering, arranging, and furnishing of those health services that enable individuals, including minors who may be sexually active, to prevent or reduce the incidence of unwanted pregnancies. The regulations state that such services include professional medical counseling services, prescription drugs, nonprescription drugs and medical supplies prescribed by a qualified physician, nurse practitioner, or physicians' assistants, and sterilizations. FPBP provides only Medicaid reimbursed family planning services, exclusive of abortions, for eligible individuals. No other Medicaid services are eligible for Federal Medicaid reimbursement for beneficiaries in the FPBP.

In 33 of the 147 sample claims, our review of the medical records and the expert opinion of a CMS physician indicated that services billed were not related to family planning. Therefore, these claims were not eligible for Federal Medicaid reimbursement. Of the 33 claims:

- 26 claims had service dates prior to May 2003, when the State implemented an edit in its MMIS that required a V25 diagnosis code for FPBP claims. None of the 26 claims contained a V25 diagnosis code and none were related to family planning. Examples of the improper claims included services for a fractured ankle, a heart catheterization, a vaginal hysterectomy, and pelvic inflammation.
- 5 claims were for clinic services determined by a CMS physician to be not directly related to family planning. These services included one claim for a Pap smear re-test, three claims for HIV counseling or testing, and one claim for vulval irritation.
- 1 claim related to an inpatient hospital stay for a delivery followed by a sterilization. This combination procedure is not eligible for Federal Medicaid reimbursement under the FPBP.
- 1 claim was a billing error related to a clinic visit that was rescheduled.

IMPROPER STERILIZATION CONSENT FORMS

Section 4270 of the CMS “State Medicaid Manual” states that 90-percent Federal funding is available for the cost of a sterilization if a properly completed sterilization consent form is submitted in accordance with the requirements of 42 CFR § 441, Subpart F. Regulations at 42 CFR § 441.256(a) state that Federal Medicaid reimbursement “... is not available in expenditures for any sterilization or hysterectomy unless the Medicaid agency, before making payment, obtained documentation showing that the requirements of this subpart were met.” In accordance with 42 CFR § 441.258(b)(4), the sterilization consent form must be signed and dated by the physician who performed the sterilization procedure.

Twenty-one of the 147 claims in our sample were for sterilization procedures requiring signed consent forms. For three of these cases, the physician did not sign or date the consent form as required.

LACK OF DOCUMENTATION

Section 1902(a)(27) of the Social Security Act and Federal regulations (42 CFR §§ 431.17 and 433.32) require that services claimed for Federal Medicaid funding be documented. For 1 of the 147 sampled claims, the provider could not locate any documentation to support the service billed.

CAUSES OF THE OVERPAYMENTS

As discussed below, we identified three main causes of the overpayment.

No Computer System Edit Prior to May 2003

In the seven months prior to the implementation of a MMIS edit in May 2003, which required a “family planning” diagnosis code (a V25 code) on the Medicaid claim form, the State improperly claimed Federal Medicaid reimbursement for claims without a V25 diagnosis code that were not related to family planning.²

Providers Improperly Claiming Services as Family Planning

During our visits to medical providers throughout the State, many provider officials (especially Planned Parenthoods) stated that they billed most of their claims to Medicaid as related to “family planning.” Based on the CMS physician’s review of the medical records related to the sample claims, we determined that providers improperly billed Medicaid for services that were unrelated to family planning.

Improperly Completed Sterilization Consent Forms

In some instances, a physician did not sign or date the Medicaid sterilization consent form as required. Therefore, the State improperly claimed Federal Medicaid reimbursement for these claims.

ESTIMATION OF THE UNALLOWABLE AMOUNT

Of the 147 claims in our statistical sample, 37 were not eligible for Medicaid reimbursement! Extrapolating the results of our sample, we estimate that the State improperly received \$918,816 in Federal Medicaid funds. The details of our sample results and estimates are shown in Appendix B.

RECOMMENDATIONS

We recommend that the State:

- refund \$918,816 to the Federal Government;
- re-emphasize to providers that only services directly related to family planning can be billed to Medicaid for beneficiaries in the FPBP;
- reinforce guidance to providers that a properly completed sterilization consent form must be prepared and maintained for all Medicaid sterilizations; and

²In addition to the 26 sample claims described on page 5, we found 2 other sample claims in error lacking a V25 diagnosis code on the claim form. These claims were made subsequent to May 2003. However, despite such errors, we believe that the State’s MMIS edit is correctly identifying family planning claims. Therefore, we make no recommendations related to the State’s MMIS edit routines.

- determine the amount of Federal Medicaid funds improperly reimbursed for FPBP claims unrelated to family planning subsequent to our audit period, and refund that amount to the Federal Government.

DEPARTMENT OF HEALTH COMMENTS

In its May 9, 2008, comments on our draft report, the State Department of Health (DOH) generally concurred with our first recommendation and fully concurred with our remaining recommendations. Regarding our first recommendation to refund \$918,816 to the Federal Government, DOH did not fully concur with the related audit findings and requested copies of working papers supporting the recommended refund. Specifically, DOH disagreed with our disallowance of certain claims related to HIV counseling and testing, and included a copy of Medicaid State Operations Letter 94-53, dated August 29, 1994. The letter stated that HIV counseling and screening are family planning services when they are provided in conjunction with a family planning encounter. Following a review of the working papers, DOH indicated that it will refund any excess Federal reimbursement associated with claims determined to have been inappropriately classified as family planning.

DOH's comments are included in their entirety as Appendix C to this report.

OFFICE OF INSPECTOR GENERAL RESPONSE

After considering DOH's comments, we continue to maintain that all disallowed services, including those related to HIV counseling and testing, were improperly claimed for Federal Medicaid reimbursement. We shared the medical records related to these services and our sample results with a CMS physician, who is a policy expert on family planning matters, for his determinations. The CMS physician determined that the HIV counseling and testing sample claims questioned in the report were not related to family planning. Nevertheless, we will provide DOH with copies of our working papers related to our error claims.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine if New York State properly received Federal Medicaid reimbursement for claims submitted by providers for beneficiaries in the FPBP.

POPULATION

The population consisted of Federal Medicaid claims for beneficiaries in the FPBP during our October 1, 2002, through June 30, 2006, audit period.

SAMPLING FRAME

The sampling frame was a Microsoft Access computer file containing 411,109 Federal Medicaid claims for beneficiaries in the FPBP. The total Medicaid reimbursement for the 411,109 claims was \$34,561,583, of which the Federal share was \$30,153,183. We extracted the Medicaid claims from the paid claims files maintained at the MMIS fiscal agent.

SAMPLE UNIT

The sampling unit was an individual Federal Medicaid claim for a beneficiary in the FPBP.

SAMPLE DESIGN

We used stratified random sampling techniques to evaluate the population of Federal Medicaid claims made for beneficiaries in the FPBP. To accomplish this, we separated the sampling frame into three strata as follows:

- Stratum 1: Claims with a Federal share payment amount from \$0.01 to \$700.00 --- 411,062 claims,
- Stratum 2: Claims with a Federal share payment amount greater than \$700.00 --- 20 claims, and
- Stratum 3: Claims for inpatient hospital services with invoice 12 --- 27 claims.

Note: All claims for inpatient hospital services with invoice 12, regardless of Federal share payment amount, are included in stratum 3.

SAMPLE SIZE

We selected a sample size of 147 claims as follows:

- 100 claims from the first stratum,
- 20 claims from the second stratum, and
- 27 claims from the third stratum.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services statistical sampling software, RAT-STATS 2005, version 6. We used the random number generator for our sample of 100 claims from stratum 1.

METHOD OF SELECTING SAMPLE ITEMS

We sequentially numbered the 411,062 claims in stratum 1. We selected 100 random numbers for stratum 1 and selected the corresponding frame items. We selected each of the claims in strata 2 and 3 and created a list of the 147 sample items.

CHARACTERISTICS TO BE MEASURED

We based our determination as to whether a sample claim was proper and allowable on applicable Federal laws and regulations, Federal guidance, a review of all information contained on the claim form, a review of documentation from the provider that submitted the claim, and, if applicable, a review of documentation from the provider who ordered the service. Specifically, if the following characteristic was met, the claim under review was considered improper and unallowable:

- The FPBP claim did not meet the criteria for reimbursement as a family planning service eligible for Federal Medicaid funding.

If a sample claim was determined to be in error and not related to a family planning service, we disallowed the entire Federal funding amount of the claim.

TREATMENT OF MISSING SAMPLE ITEMS

If supporting information was not found, we considered the sample item an error.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services variable appraisal program, RAT-STATS 2005, version 6, to appraise the sample results. We used the lower limit at the 90-percent confidence level to estimate the overpayment associated with the improper claiming.

SAMPLE RESULTS AND ESTIMATES

The results of our review of the 147 claims made for beneficiaries in the FPBP were as follows:

Sample Results

Stratum Number	Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Improper Claims	Value of Improper Claims (Federal Share)
1. <=\$700	411,062	\$30,067,312	100	\$6,837	7	\$613
2. >\$700	20	27,295	20	27,295	4	4,529
3. Inpatient hospital services	27	58,576	27	58,576	26	56,676
Totals	411,109	\$30,153,183	147	\$92,708	37	\$61,818

Estimates
(Limits Calculated for a 90-Percent Confidence Interval)

Midpoint: \$2,581,302
Lower Limit: \$918,816
Upper Limit: \$4,243,788

DOH STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

May 9, 2008

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No. A-02-07-01001

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the Department of Health and Human Services, Office of Inspector General's draft audit report A-02-07-01001 on "Review of Federal Medicaid Claims Made for Beneficiaries in the Family Planning Benefit Program in New York State."

Thank you for the opportunity to comment.

Sincerely,



Wendy E. Saunders
Chief of Staff

Enclosure

cc: Stephen Abbott
Deborah Bachrach
Homer Charbonneau
Ronald Farrell
Gail Kerker
Sandra Pettinato
Robert W. Reed
Philip Seward

**New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-07-01001 on
“Review of Federal Medicaid Claims Made for
Beneficiaries in the Family Planning Benefit Program
in New York State”**

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General's (OIG) draft audit report A-02-07-01001 on "Review of Federal Medicaid Claims Made for Beneficiaries in the Family Planning Benefit Program in New York State."

Recommendation #1:

We recommend that the State refund \$918,816 to the Federal Government.

Response #1:

The Department does not entirely agree with the audit findings, although it recognizes that prior to the implementation of system edits in May 2003, some of its Family Planning Benefit Program (FPBP) claims may not directly relate to family planning services. According to the second bullet on page 5 of the draft audit report, HIV counseling or testing is included amongst the services disallowed by the OIG, which is contrary to Department of Health and Human Services' policy addressed in Medicaid State Operations Letter #94-53, dated August 29, 1994 (copy attached). The Department requests to be furnished a copy of the audit workpapers supporting the recommended refund amount, including identification of the specific services and procedures disallowed. Following review of this data, the Department will refund any excess Federal reimbursement associated with claims determined to have been inappropriately classified as family planning.

Recommendation #2:

We recommend that the State re-emphasize to providers that only services directly related to family planning can be billed to Medicaid for beneficiaries in the FPBP.

Response #2:

The Department has included articles reinforcing the FPBP requirements in its Medicaid Update publications for May 2003, May 2007 and February 2008. Additionally, the Department has implemented enhanced system edits for all claims with a service date on or after July 1, 2007, utilizing the list of family planning services approved by CMS.

Recommendation #3:

We recommend that the State reinforce guidance to providers that a properly completed sterilization consent form must be prepared and maintained for all Medicaid sterilizations.

Response #3:

The Department will reinforce the requirement to properly complete and maintain sterilization consent forms in an upcoming edition of its Medicaid Update publication.

Recommendation #4:

We recommend that the State determine the amount of Federal Medicaid funds improperly reimbursed for FPBP claims unrelated to family planning subsequent to our audit period, and refund that amount to the Federal Government.

Response #4:

The refund explained in Response #1 above will encompass claims during and subsequent to the audit period.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to DMD:MOB-2

Region II
Federal Building
26 Federal Plaza
New York NY 10278-0045

AUG 29 1994

MEDICAID STATE OPERATIONS LETTER #94-53

FROM: Associate Regional Administrator
Division of Medicaid

TO: State Agencies Administering the Medicaid Program

SUBJECT: Inclusion of HIV Pre and Post-Test Counseling and
Screening in Family Planning Services

The purpose of this State Operations Letter is to inform you of HCFA's policy on HIV pre- and post-test counseling and screening in family planning services.

HIV blood testing and pre- and post -test counseling performed as part of a package of Sexually transmitted disease (STD) tests provided to women and men in conjunction with a family planning encounter is a family planning service.

If there any questions, please contact your State Representative at (212)-264-2775.

Stephen Staw for
Arthur J. O'Leary

