

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**CALIFORNIA IMPROPERLY  
CLAIMED ENHANCED FEDERAL  
REIMBURSEMENT FOR SELECTED  
CLAIM LINES FOR MEDICAID  
FAMILY PLANNING DRUGS AND  
SUPPLIES IN LOS ANGELES AND  
ORANGE COUNTIES**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



**Lori A. Ahlstrand  
Regional Inspector General  
for Audit Services**

**March 2016  
A-09-15-02014**

# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*California claimed approximately \$31,000 in unallowable enhanced Federal reimbursement over 1 year for Medicaid family planning drugs and supplies in Los Angeles and Orange Counties. Some of this amount represented duplicate payments, and the remainder was for drugs and supplies that were not provided to beneficiaries.*

### WHY WE DID THIS REVIEW

Family planning services prevent or delay pregnancy or otherwise control family size. Federal law and regulations authorize Federal Medicaid reimbursement to States for family planning services at an enhanced Federal medical assistance percentage of 90 percent (90-percent rate). Previous Office of Inspector General reviews found that the California Department of Health Care Services (State agency) claimed approximately \$18 million in unallowable Federal reimbursement for certain family planning services, drugs, and supplies provided under the Family Planning, Access, Care, and Treatment (FPACT) program in three counties. During our reviews of Los Angeles and Orange Counties, we identified potential duplicate claim lines for family planning drugs and supplies, which we excluded from those reviews. This review focuses on those claim lines.

Our objective was to determine whether the State agency complied with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for selected claim lines for family planning drugs and supplies provided in Los Angeles and Orange Counties.

### BACKGROUND

In California, the State agency administers the Medicaid program. The State agency, through its FPACT program, provides family planning services, drugs, and supplies to individuals of childbearing age who both reside in California and have incomes up to 200 percent of the Federal poverty level. Individuals eligible for the FPACT program are generally not otherwise eligible for Medicaid.

Federal law and regulations authorize Federal reimbursement for family planning services at the 90-percent rate. The Centers for Medicare & Medicaid Services' *State Medicaid Manual* states that Federal reimbursement at this rate is available only for services and supplies clearly provided for family planning purposes. Federal reimbursement is available only for allowable actual expenditures made on behalf of eligible beneficiaries for covered services provided by certified providers. In California, providers are responsible for verifying submitted claims with source documents and for verifying the accuracy of claims payment information upon receipt of payment.

### HOW WE CONDUCTED THIS REVIEW

From October 1, 2011, through September 30, 2012 (audit period), the State agency claimed approximately \$102.7 million (\$79.5 million Federal share) for family planning drugs and

supplies provided under the FPACT program in Los Angeles and Orange Counties, representing approximately 1.4 million claim lines. (Each claim line was for a drug or supply claimed for a beneficiary.) From these claim lines, we identified 584 claim lines as potential duplicates, totaling \$74,466. We considered potential duplicate claim lines as two or more claim lines submitted by a provider or pharmacy for the same drug or supply for a beneficiary on a single date of service. After we removed claim lines that had immaterial reimbursements or were submitted by pharmacies, we reviewed the remaining 426 claim lines totaling \$73,810.

## **WHAT WE FOUND**

The State agency did not always comply with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for selected claim lines for family planning drugs and supplies provided in Los Angeles and Orange Counties. Of the 426 claim lines we reviewed, 212 complied and 214 did not comply with requirements. Of the 214 claim lines, 171 were unallowable for reimbursement because they represented duplicate payments for drugs and supplies, and 43 were unallowable for reimbursement because they were for drugs and supplies that were not provided to the beneficiaries. As a result, the State agency claimed \$30,605 in unallowable Federal reimbursement.

The State agency claimed unallowable Federal reimbursement because its internal controls were not adequate to prevent duplicate payments for family planning drug and supply claims. Additionally, the State agency did not ensure that providers complied with its policies and procedures requiring providers to verify the accuracy of submitted claims for family planning drugs and supplies.

## **WHAT WE RECOMMEND**

We recommend that the State agency:

- refund to the Federal Government \$30,605 in unallowable reimbursement claimed for Los Angeles and Orange Counties,
- strengthen internal controls to prevent duplicate payments for family planning drug and supply claims,
- review its paid claims for family planning drugs and supplies from the other counties in California for our audit period and all counties for subsequent years to identify any duplicate payments and refund to the Federal Government its share of any unallowable amounts claimed, and
- ensure that providers comply with State agency policies and procedures requiring them to verify the accuracy of submitted claims for family planning drugs and supplies.

## **STATE AGENCY COMMENTS AND OUR RESPONSE**

In written comments on our draft report, the State agency agreed with our first and fourth recommendations and provided information on corrective actions that it had taken or planned to take to address those recommendations. The State agency disagreed with our second recommendation and partially agreed with our third recommendation.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid.

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## **INTRODUCTION**

### **WHY WE DID THIS REVIEW**

Family planning services prevent or delay pregnancy or otherwise control family size. Federal law and regulations authorize Federal Medicaid reimbursement to States for family planning services at an enhanced Federal medical assistance percentage of 90 percent (90-percent rate). Previous Office of Inspector General (OIG) reviews found that the California Department of Health Care Services (State agency) claimed approximately \$18 million in unallowable Federal reimbursement for certain family planning services, drugs, and supplies provided under the Family Planning, Access, Care, and Treatment (FPACT) program in three counties. During our reviews of Los Angeles and Orange Counties, we identified potential duplicate claim lines for family planning drugs and supplies, which we excluded from those reviews. This review focuses on those claim lines. (Appendix A lists related OIG reports on States' family planning claims.)

### **OBJECTIVE**

Our objective was to determine whether the State agency complied with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for selected claim lines for family planning drugs and supplies provided in Los Angeles and Orange Counties.

### **BACKGROUND**

#### **Medicaid Program**

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

Providers of Medicaid services submit claims to States to receive payment. The States process and pay the claims. The Federal Government pays its share (Federal share) of State medical assistance expenditures (42 CFR § 433.10). States are responsible for recovering from providers any amounts paid in excess of allowable Medicaid amounts and for refunding to CMS the Federal share (42 CFR § 433.312).

#### **Medicaid Coverage of Family Planning Services and Supplies**

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

The CMS *State Medicaid Manual* (the Manual) states that family planning services include those that prevent or delay pregnancy or otherwise control family size (§ 4270.B). 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 provided for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate.

### **California's Medicaid Family Planning Program**

In California, the State agency administers the Medicaid program. The State agency, through its FPACT program, provides family planning services, drugs, and supplies to individuals of childbearing age who both reside in California and have incomes up to 200 percent of the Federal poverty level. Individuals eligible for the FPACT program are generally not otherwise eligible for Medicaid. According to State regulations, family planning services include drugs and supplies (California Welfare and Institutions Code § 14132(aa)(8)).

The State agency uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims for payment. 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. The State agency deducts 13.95 percent from its total expenditures when claiming Federal reimbursement to account for beneficiaries who receive family planning services, including drugs and supplies, but who are not eligible for public benefits under Federal law, such as nonqualified aliens.<sup>1</sup>

### **HOW WE CONDUCTED THIS REVIEW**

From October 1, 2011, through September 30, 2012 (audit period), the State agency claimed \$102,680,562 (\$79,520,961 Federal share) for family planning drugs and supplies provided under the FPACT program in Los Angeles and Orange Counties, representing 1,421,982 claim lines. (Each claim line was for a drug or supply claimed for a beneficiary.) From these claim lines, we identified 584 claim lines as potential duplicates, totaling \$74,466. We considered potential duplicate claim lines as two or more claim lines submitted by a provider or pharmacy for the same drug or supply for a beneficiary on a single date of service. After we removed claim lines that had immaterial reimbursements or were submitted by pharmacies, we reviewed the remaining 426 claim lines totaling \$73,810.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B describes our audit scope and methodology.

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<sup>1</sup> California's State Plan Amendment 10-014, effective July 1, 2010.

## FINDINGS

The State agency did not always comply with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for selected claim lines for family planning drugs and supplies provided in Los Angeles and Orange Counties. Of the 426 claim lines we reviewed, 212 complied and 214 did not comply with requirements. Of the 214 claim lines, 171 were unallowable for reimbursement because they represented duplicate payments for drugs and supplies, and 43 were unallowable for reimbursement because they were for drugs and supplies that were not provided to the beneficiaries. As a result, the State agency claimed \$30,605 in unallowable Federal reimbursement.

The State agency claimed unallowable Federal reimbursement because its internal controls were not adequate to prevent duplicate payments for family planning drug and supply claims. Additionally, the State agency did not ensure that providers complied with its policies and procedures requiring providers to verify the accuracy of submitted claims for family planning drugs and supplies.

### FEDERAL AND STATE REQUIREMENTS

Federal reimbursement is available only for allowable actual expenditures made on behalf of eligible beneficiaries for covered services provided by certified providers (the Act § 1903(a)(1) and the Manual § 2497.1).

Only services and supplies clearly provided for family planning purposes may be claimed for Federal reimbursement at the 90-percent rate (the Manual § 4270.B).

Providers are responsible for all claims submitted regardless of who completed the claims. Providers are responsible for verifying submitted claims with source documents and for verifying the accuracy of claims payment information upon receipt of payment (*California Medi-Cal Provider Manual*, Part I, and Form DHCS 6153, *Medi-Cal Telecommunications Provider and Biller Application/Agreement*).

### THE STATE AGENCY CLAIMED UNALLOWABLE REIMBURSEMENT FOR SELECTED CLAIM LINES FOR FAMILY PLANNING DRUGS AND SUPPLIES

Of the 426 claim lines we reviewed, 214 did not comply with certain Federal and State requirements. The 214 claim lines consisted of 171 claim lines that represented duplicate payments for family planning drugs and supplies and 43 claim lines that were for family planning drugs and supplies not provided to the beneficiaries:

- For the 171 claim lines, providers generally rebilled a claim line to make a correction, such as changing the procedure code modifier or National Drug Code (NDC) for a drug or supply, and received payments for both the originally billed and corrected claim lines.<sup>2</sup>

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<sup>2</sup> A procedure code modifier further describes a procedure code without changing the definition of the code. The NDC is a unique number assigned to each drug or supply.

- For the 43 claim lines, drugs and supplies were dispensed to other individuals but billed with the wrong beneficiary identification numbers or not dispensed at all.

As a result, the State agency claimed \$30,605 in unallowable Federal reimbursement.

The State agency claimed unallowable Federal reimbursement because its internal controls were not adequate to prevent duplicate payments for family planning drug and supply claims. For example, the MMIS did not deny payments for claim lines that had a change to the procedure code modifier or NDC. Additionally, the State agency did not ensure that providers complied with its policies and procedures requiring providers to verify the accuracy of submitted claims for family planning drugs and supplies.

### **RECOMMENDATIONS**

We recommend that the State agency:

- refund to the Federal Government \$30,605 in unallowable reimbursement claimed for Los Angeles and Orange Counties,
- strengthen internal controls to prevent duplicate payments for family planning drug and supply claims,
- review its paid claims for family planning drugs and supplies from the other counties in California for our audit period and all counties for subsequent years to identify any duplicate payments and refund to the Federal Government its share of any unallowable amounts claimed, and
- ensure that providers comply with State agency policies and procedures requiring them to verify the accuracy of submitted claims for family planning drugs and supplies.

### **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the State agency agreed with our first and fourth recommendations and provided information on corrective actions that it had taken or planned to take to address those recommendations. The State agency disagreed with our second recommendation and partially agreed with our third recommendation:

- Regarding our second recommendation, the State agency commented that the duplicate payments were caused by provider billing errors. The State agency described corrective actions that it had taken to recover duplicate payments and stated that it would continue to conduct an evaluation of its system to determine how duplicate payments could be prevented in the future.
- Regarding our third recommendation, the State agency commented that it would review paid claims for family planning drugs and supplies from the other counties in California

for the audit period to identify potential duplicate payments but planned to determine whether further review of subsequent years was necessary.

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

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. Although the providers made billing errors, strong internal controls would have prevented duplicate payments for family planning drug and supply claims. We continue to recommend that the State agency review claims for years after our audit period to identify any duplicate payments.

**APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Wisconsin Improperly Claimed Enhanced Federal Reimbursement for Some Non-Family Planning Services</i>	<a href="#"><u>A-05-13-00034</u></a>	10/23/2015
<i>California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Drugs Provided in Orange County</i>	<a href="#"><u>A-09-14-02028</u></a>	7/28/2015
<i>Texas Claimed Unallowable Federal Reimbursement for Some Family Planning Services</i>	<a href="#"><u>A-06-11-00016</u></a>	3/17/2015
<i>California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in Southeast Los Angeles County</i>	<a href="#"><u>A-09-13-02047</u></a>	8/12/2014
<i>California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in Orange County</i>	<a href="#"><u>A-09-13-02044</u></a>	7/25/2014
<i>California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in East Los Angeles County</i>	<a href="#"><u>A-09-13-02019</u></a>	7/25/2014
<i>California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in Central Los Angeles County</i>	<a href="#"><u>A-09-13-02012</u></a>	7/25/2014
<i>California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Drugs and Supplies Provided in San Diego County</i>	<a href="#"><u>A-09-12-02077</u></a>	6/25/2013
<i>California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in San Diego County</i>	<a href="#"><u>A-09-11-02040</u></a>	12/20/2012

## **APPENDIX B: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

From October 1, 2011, through September 30, 2012, the State agency claimed \$102,680,562 (\$79,520,961 Federal share) for family planning drugs and supplies provided under the FPACT program in Los Angeles and Orange Counties, representing 1,421,982 claim lines. (Each claim line was for a drug or supply claimed for a beneficiary.) From these claim lines, we identified 584 claim lines as potential duplicates, totaling \$74,466. We considered potential duplicate claim lines as two or more claim lines submitted by a provider or pharmacy for the same drug or supply for a beneficiary on a single date of service. After we removed claim lines that had immaterial reimbursements or were submitted by pharmacies, we reviewed the remaining 426 claim lines totaling \$73,810.

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 limited our review to determining whether the State agency claimed unallowable Federal reimbursement for certain family planning drugs and supplies. We did not determine whether the beneficiaries met the eligibility requirements of the FPACT program.

We conducted our audit from January to August 2015 and performed our fieldwork at the State agency's office in Sacramento, California, and at provider locations in Los Angeles and Orange Counties.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed Federal and State laws, regulations, and guidance and the State plan;
- 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 procedures for claiming Federal reimbursement for family planning services, drugs, and supplies;
- obtained FPACT claims data from the State agency's MMIS for the audit period, representing 1,421,982 claim lines for family planning drugs and supplies provided in Los Angeles and Orange Counties, totaling \$102,680,562 (\$79,520,961 Federal share);
- removed 1,421,398 claim lines, totaling \$102,606,096, that were reviewed in previous audits or were removed from those audits for various reasons;
- identified 584 claim lines, totaling \$74,466, as potential duplicate claim lines;

- removed 158 claim lines, totaling \$656, that had immaterial reimbursements (less than \$10) or were submitted by pharmacies;
- reviewed the remaining 426 claim lines totaling \$73,810 and:
  - contacted providers to obtain beneficiary medical records and payment records for the claim lines and
  - reviewed the records to determine whether Federal reimbursement was allowable;
- discussed with the State agency those claim lines that we determined were unallowable for Federal reimbursement; and
- determined the unallowable Federal reimbursement paid.

To determine the Federal share, we reduced the total amount paid by the State agency by the CMS-approved deduction percentage of 13.95 percent (for beneficiaries who receive family planning services, including drugs and supplies, but who are not eligible for public benefits under Federal law) and then applied the 90-percent rate.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## APPENDIX C: STATE AGENCY COMMENTS



State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
GOVERNOR

February 23, 2016  
Ms. Lori Ahlstrand  
Regional Inspector General for Audit Services  
Office of Audit Services, Region IX  
90 – 7<sup>TH</sup> Street, Suite 3-650  
San Francisco, CA 94103

Dear Ms. Ahlstrand

The California Department of Health Care Services (DHCS) has prepared its response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled, *California Improperly Claimed Enhanced Federal Reimbursement for Selected Claim Lines for Medicaid Family Planning Drugs and Supplies in Los Angeles and Orange Counties*.

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft report. Please contact Ms. Sarah Hollister, Audit Coordinator, at (916) 650-0298 if you have any questions.

Sincerely,

[Jennifer Kent]

Jennifer Kent  
Director

Enclosure

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1501 Capitol Avenue, Suite 71.6001, MS 0000 • P.O. 997413 • Sacramento, CA 95899-7413  
(916) 440-7400 • (916) 440-7404 FAX  
Internet address: [www.dhcs.ca.gov](http://www.dhcs.ca.gov)

Ms. Lori Ahlstrand  
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cc: Mari Cantwell, Chief Deputy Director  
Department of Health Care Services  
1501 Capitol Avenue, MS 0000  
P.O. Box 997413  
Sacramento, CA 95899-7413

Rene Mollow, Deputy Director  
Health Care Benefits and Eligibility  
1501 Capitol Avenue, MS 4000  
P.O. Box 997413  
Sacramento, CA 95899-7413

Christina Moreno, Chief  
Office of Family Planning  
1500 Capitol Avenue, MS 8400  
P.O. Box 997413  
Sacramento, CA 95899-7413

Attachment

**Department of Health Care Services Response to: The Office of the  
Inspector General's report entitled, *California Improperly Claimed  
Enhanced Federal Reimbursement for Selected Claim Lines for Medicaid  
Family Planning Drugs and Supplies in Los Angeles and Orange Counties*  
(A-09-15-02014)**

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**Finding 1:** The State agency did not always comply with certain Federal and State requirements when claiming Federal reimbursement at the 90-percent rate for selected claim lines for family planning drugs and supplies provided in Los Angeles and Orange Counties. Of the 426 claim lines we reviewed, 212 complied and 214 did not comply with requirements. Of the 214 claim lines, 171 were unallowable for reimbursement because they represented duplicate payments for drugs and supplies, and 43 were unallowable for reimbursement because they were for drugs and supplies that were not provided to the beneficiaries. As a result, the State agency claimed \$30,605 in unallowable Federal reimbursement.

**Recommendation 1:** Refund to the Federal Government \$30,605 in unallowable reimbursement claimed for Los Angeles and Orange Counties.

**Response:** DHCS agrees with the recommendation

DHCS agrees to refund \$30,605 to the Federal Government. DHCS' Accounting Office will be instructed to initiate the appropriate adjustments for the refund of unallowable federal reimbursement by the end of the 4th Quarter of this current fiscal year.

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**Finding 2:** The State agency claimed unallowable Federal reimbursement because its internal controls were not adequate to prevent duplicate payments for family planning drug and supply claims.

**Recommendation 2:** Strengthen internal controls to prevent duplicate payments for family planning drug and supply claims.

**Response:** DHCS disagrees with the recommendation

The duplicate payments were caused by errors in provider billing. An Erroneous Payment Correction has been initiated to reconcile duplicate payments caused by errors in provider billing and recoup these payments. However, DHCS will continue to conduct evaluation of the system to determine how this can be prevented in the future. The estimated date of completion is June 2016.

Attachment

**Recommendation 3:** Review paid claims for family planning drugs and supplies from the other counties in California for the audit period and all counties for subsequent years to identify any duplicate payments and refund to the Federal Government its share of any unallowable amounts claimed.

**Response:** DHCS partially agrees to this recommendation.

DHCS will review paid claims for family planning drugs and supplies from the other counties in California for the audit period to determine if any potential duplicate payments are identified. This will help inform DHCS of next steps and if further review of subsequent years is necessary. The estimated date of completion is June 2016.

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**Finding #3:** The State agency did not ensure that providers complied with its policies and procedures requiring providers to verify the accuracy of submitted claims for family planning drugs and supplies.

**Recommendation 4:** Ensure that providers comply with State agency policies and procedures requiring them to verify the accuracy of submitted claims for family planning drugs and supplies.

**Response:** DHCS agrees with this recommendation.

Providers are responsible to follow the policies and procedures outlined in the Medi-Cal Provider Manual with respect to claim completion and submission. Providers are to use the Claims Inquiry Form process to request an adjustment for either an underpaid or overpaid claim, reconsideration of a denied claim, or as a tracer for a "lost claim" that does not appear on the provider's Remittance Advice Details.

The DHCS Office of Family Planning (OFP) has a continuing educational program to educate Family PACT providers on the scope of the Family PACT program, including policies and procedures. This continuing educational program is done via quarterly Provider Orientations, and Update trainings as needed. In the Provider Orientations, billing is addressed as part of the training. DHCS will incorporate into the training, additional education and information regarding claim submission policies and procedures as outlined in the Medi-Cal provider manual beginning in April 2016. In addition, DHCS-OFP will continue to conduct desk review and analysis of individual provider claims and billing patterns based on current policy. If warranted, referrals to DHCS' Audits and Investigations Division will be made to ensure compliance with policies and procedures and to recover overpayments, if indicated.