

Attachment

The Honorable Michael Burgess

- 1. Under the Affordable Care Act, the federal government is paying 100 percent of the costs for Medicaid expansion populations. In addition, due to the ACA's 23 percent bump in the enhanced FMAP, the federal government is currently paying all of the costs for CHIP in 12 states. Does OIG have any concerns that the lack of state contribution will affect state incentives to ensure that Medicaid payments are appropriate and accurate?**

States share accountability for the integrity of the Medicaid program with the Federal Government. In situations in which the Federal Government is financing 100 percent of costs for Medicaid services, States could have less incentive to devote scarce oversight resources to ensuring the accuracy of Medicaid payments. We would consider areas in which the Federal Government pays 100 percent of costs to be higher risk than areas in which States share in costs.

The Honorable Frank Pallone, Jr.

Mr. Hagg, during the Energy and Commerce Health Subcommittee Hearing on "Examining Medicaid and CHIPS's Federal Medical Assistance Percentage" on February 10, 2016, you were asked a question by Mr. Cardenas which we request clarification on your response. During the hearing, Mr. Cardenas asked you, "One report that OIG has highlighted is a review of Federal reimbursement for family planning services in California, specifically in the San Diego area... ..In this report, over half of the improper claims were noted to be for visits that included testing for sexually transmitted infections. Is it true that after this report, CMS released guidance clarifying that STI testing is classified as family planning services for the purpose of calculating the FMAP?"

In April 2014, CMS issued a State Medicaid Director's letter clarifying policy regarding the coverage of family planning related services. The letter states "[f]amily planning services receive Federal financial participation at an enhanced rate of 90 percent, while family planning *related* services are matched at the [S]tates' regular Federal medical assistance percentage." CMS further states it has determined that services such as the "diagnosis and treatment of an STI are always provided 'pursuant to' a family planning service. These services will be eligible for Medicaid coverage as family planning related services, regardless of the initial purpose of the visit."

In your response, you acknowledged that CMS released a letter on the topic to State Medicaid directors in 2014, but with the caveat that you would be able to more accurately answer the question if you were able to review the letter. Subsequently, you stated that you believed that testing for "sexually transmitted infections would have been classified as family planning related, which would be billed at the regular FMAP rate and not the enhanced family planning FMAP rate."

- 1. Mr. Hagg, can you please verify the accuracy of your previous response? Is it true that in 2014, CMS released a letter that clarified STI testing should be classified as family planning services for the purposes of calculating the FMAP?**

In its April 2014 State Medicaid Director letter regarding Family Planning and Family Planning Related Services Clarification, CMS provided clarification regarding the coverage of family planning related services provided to individuals eligible under the optional categorically needy state plan group created by section 2303 of the Affordable Care Act. The letter states “[f]amily planning services receive Federal financial participation at an enhanced rate of 90 percent, while family planning *related* services are matched at the [S]tates’ regular Federal medical assistance percentage.” CMS further states it has determined that services such as the “diagnosis and treatment of an STI are always provided ‘pursuant to’ a family planning service. These services will be eligible for Medicaid coverage as family planning related services, regardless of the initial purpose of the visit.” Therefore, it is my understanding that under this policy clarification, STI testing services would be matched at the State’s regular FMAP.

- 2. In the San Diego report, OIG claimed that 23 out of the 29 claims surveyed were not eligible for *any* federal reimbursement (not even the regular federal match) because the "primary purpose of the visit was not family planning," even though the vast majority of these claims were related to testing and treatment for sexually transmitted infections. The Centers for Medicare and Medicaid Services released a Dear State Medicaid Director Letter on April 16, 2014 clarifying that STI services are always related to family planning. This makes sense, particularly since some STIs, if left untreated, could result in infertility. Given the recent Dear State Medicaid Director Letter, wouldn't you agree that OIG's earlier determination that STI services do not qualify for federal reimbursement because they are unrelated to family planning was incorrect?**

When OIG conducts audits, it performs those audits to determine compliance with the rules and regulations that are in place at the time of the audit. At the time OIG conducted the audit in question, the rules in place governing family planning services did not allow for Federal reimbursement for testing for STIs. When CMS issued its April 2014 letter, the agency changed policy and “determined that services such as the diagnosis and treatment of an STI are always provided ‘pursuant to’ a family planning service. These services will be eligible for Medicaid coverage as family planning related services, regardless of the initial purpose of the visit.” From April 2014 moving forward, OIG would use the CMS guidance in all audits of family planning claims.

- 3. I am concerned that OIG may be misinterpreting federal statute and implementing federal guidance regarding family planning when it conducts audits. For example, in addition to the reports you cite to today, OIG also conducted an audit of family planning claims in North Carolina. In that audit report, OIG determined that a majority of pharmacy claims for birth control did not qualify for the 90 percent match because they were prescribed for purposes other than contraception, such as to help regulate menstruation. Isn't it true, though, that regardless of a patient's reasons for using birth control that birth control still works to prevent pregnancy? Why would a**

patient's reasons for using a contraceptive negate the 90 percent match provided by federal statute when birth control is clearly a family planning service?

Yes, it is true that regardless of a patient's reasons for using birth control it works to prevent pregnancy. However, pursuant to section 4270(B)(2) of the CMS *State Medicaid Manual*, "only items and procedures clearly provided or performed for family planning purposes may be claimed at the 90 percent rate." Section 4270(B) also states Congress' "intent of placing emphasis on the provision of services to 'aid those who voluntarily choose not to risk an initial pregnancy,' as well as those families with children who desire to control family size." It is our understanding that birth control medication can be provided to treat numerous medical conditions such as, but not limited to, acne, endometriosis, and polycystic ovarian syndrome.

- 4. It is my understanding that Medicaid reimbursement works in two stages. At the first stage, the provider submits a claim to the state (or managed care plan). The state (or managed care plan) reviews the claims and reimburses the provider accordingly. At the second stage, the state seeks the federal match for its expenditures. Is it correct that providers do not directly receive reimbursement from the federal government, and that it is a state's responsibility – not a provider's responsibility – to ensure that only eligible claims receive the enhanced federal match?**

It is correct that the providers are paid by the States and not directly by the Federal Government. States withdraw Federal funds from the Department of the Treasury Payment Management System to pay the Federal share of Medicaid expenditures. Additionally, States report expenditures and the associated Federal share to CMS on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report). The State is responsible for claiming FMAP at the correct rate.

- 5. OIG conducts audits on other services, and has found, for example, that Texas was overpaid more than \$30 million in federal funds for non-emergency transportation services and New York was overpaid nearly \$77 million for disability services. While these services are valuable, family planning care has proven to have tremendous cost-savings, with every \$1 spent on publicly-funded contraceptive care saving more than \$7 in other costs. Is it fair to say that OIG routinely conducts audits for a variety of Medicaid services, that claims for unallowable costs for family planning services are relatively low when compared to other Medicaid services, and that the federal and state governments still benefit from the cost-savings generated from the provision of family planning services?**

It is fair to say that OIG routinely conducts audits of a variety of Medicaid services. These services can include family planning services, dental services, transportation services and many other services.

OIG has identified large amounts of unallowable claims for service areas other than family planning. Based on our recent work involving family planning services, we have identified unallowable payments totaling over \$82 million, or about 9.3 percent of all family planning costs that we have reviewed. While the \$82 million in unallowable

payments may be low compared to some other service areas, we consider the error rate of 9.3 percent to be high.

OIG does not have information about, and is not in a position to opine on, the cost-savings generated from the provision of family planning services.