DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION V
233 NORTH MICHIGAN, SUITE 1360
CHICAGO, IL 60601

April 13, 2012

Report Number: A-05-11-00044

Ms. Julie Hamos
Director
Illinois Department of Healthcare and Family Services
Prescott E. Bloom Building
201 South Grand Avenue East, 3rd Floor
Springfield, IL 62763

Dear Ms. Hamos:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Illinois Did Not Report All Medicaid Overpayments In Accordance With Federal Requirements*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Lynn Barker, Audit Manager, at (317) 226-7833, extension 21, or through email at Lynn.Barker@oig.hhs.gov. Please refer to report number A-05-11-00044 in all correspondence.

Sincerely,

/Sheri L. Fulcher/
Regional Inspector General
for Audit Services

Enclosure

cc:
Jamie Nardulli, Audit Liaison, IDHFS
Peggy Edwards, Audit Liaison, IDHFS

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ILLINOIS DID NOT REPORT ALL MEDICAID OVERPAYMENTS IN ACCORDANCE WITH FEDERAL REQUIREMENTS

Daniel R. Levinson
Inspector General

April 2012
A-05-11-00044

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to certain 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.

In Illinois, the Department of Healthcare and Family Services (State agency) administers the Medicaid program. The State agency, through the Illinois Department of Healthcare and Family Services, Office of Inspector General (HFS-OIG), conducts audits of Medicaid providers. In addition, HFS-OIG contracts annually with third parties to conduct audits of Medicaid providers. When State Medicaid audits identify overpayments, HFS-OIG sends letters to the providers identifying the overpayment amounts and providing information on arranging payments, sending additional documentation, or appealing the decision.

Section 1903(d)(2) of the Act requires the State to refund the Federal share of a Medicaid overpayment. Implementing regulations (42 CFR § 433.312) require the State to refund the Federal share of an overpayment to the provider at the end of the 60-day period following the date of discovery, whether or not the State agency has recovered the overpayment. The date of discovery for situations other than fraud or abuse is the date that a provider is first notified in writing of an overpayment and of the dollar amount subject to recovery (42 CFR § 433.316(c)). Federal regulations (42 CFR § 433.304) define an overpayment as "… the amount paid by a Medicaid agency to a provider in excess of the amount that is allowable for the services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." Because the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64), is due on a quarterly basis, the CMS *State Medicaid Manual* requires that the Federal share of overpayments be reported no later than the quarter in which the 60-day period ends.

OBJECTIVE

Our objective was to determine whether the State agency reported Medicaid overpayments on the CMS-64 in accordance with Federal requirements.

SUMMARY OF FINDINGS

The State agency did not report all Medicaid overpayments in accordance with Federal requirements. Based on our results, the State agency did not report Medicaid overpayments totaling $324,100 ($164,867 Federal share) in accordance with Federal requirements.

The State agency did not completely report 2 of the 137 overpayments reviewed on the CMS-64. The State agency reported the remaining 135 overpayments.

The State agency also did not report all Medicaid overpayments to providers within the 60-day requirement (116 of the 137 overpayments were reported late). Because the State agency did not properly report all overpayments within the 60-day requirement, the Federal Government may have incurred increased interest expense of $560,835.

The State agency did not properly report these overpayments because it had not developed and implemented internal controls to ensure that overpayments were reported on the CMS-64 in accordance with Federal requirements.

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayments of $324,100 on the CMS-64 and refund $164,867 to the Federal Government and

- ensure that future Medicaid overpayments are reported on the CMS-64 in accordance with Federal requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and recommendations. The State agency's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Medicaid Program

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

The Federal Government pays its share of State Medicaid expenditures according to a defined formula. To receive Federal reimbursement, State Medicaid agencies are required to report expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64).

In Illinois, the Department of Healthcare and Family Services (State agency) administers the Medicaid program. The State agency, through the Illinois Department of Healthcare and Family Services, Office of Inspector General (HFS-OIG), conducts audits of Medicaid providers. In addition, HFS-OIG contracts annually with third parties to conduct audits of Medicaid providers. When State Medicaid audits identify overpayments, HFS-OIG sends letters to the providers identifying the overpayment amounts and providing information on arranging payments, sending additional documentation, or appealing the decision.

Federal Requirements for Medicaid Overpayments

The Federal Government does not participate financially in Medicaid payments for excessive or erroneous expenditures. Section 1903(d)(2)(A) of the Act requires the Secretary of Health and Human Services to recover the amount of a Medicaid overpayment. Federal regulations (42 CFR § 433.304) define an overpayment as "… the amount paid by a Medicaid agency to a provider in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." A State has 60 days from the discovery of a Medicaid overpayment to the provider to recover, or attempt to recover, the overpayment before the Federal share of the overpayment must be refunded to CMS.[1] Section 1903(d)(2)(C) of the Act and Federal regulations (42 CFR part 433, subpart F) require a State to refund the Federal share of overpayments at the end of the 60-day period

[1] 42 CFR § 433.312(a). Effective March 23, 2010, section 6506 of the Patient Protection and Affordable Care Act, P.L. No. 111-148, provides an extension for the collection of overpayments. Except in the case of overpayments involving fraud, States have up to 1 year from the date of discovery of a Medicaid overpayment to recover, or to attempt to recover, the overpayment before making an adjustment to refund the Federal share of the overpayment. For overpayments identified before the effective date, the previous rules on discovery of overpayments remain in effect.

following discovery whether or not the State has recovered the overpayment from the provider.[2] Pursuant to 42 CFR § 433.316(c), an overpayment that is not a result of fraud or abuse is discovered on the earliest date:

> (1) … on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery; (2) … on which a provider initially acknowledges a specific overpaid amount in writing to the medicaid agency; or (3) … on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

In addition, Federal regulations (42 CFR § 433.320) require that the State refund the Federal share of an overpayment on its quarterly Form CMS-64. Provider overpayments must be credited on the CMS-64 submitted for the quarter in which the 60-day period following discovery ends (60-day rule). If the amount of an overpayment is adjusted downward (e.g. based on the provider's appeal) after the State has credited CMS with the Federal share, the State may reclaim the amount of the downward adjustment on a subsequent CMS-64 (42 CFR § 433.320(c)).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency reported Medicaid overpayments on the CMS-64 in accordance with Federal requirements.

Scope

Our review covered Medicaid provider overpayments of $1,000 or more that HFS-OIG identified in overpayment letters issued to providers that should have been reported on the CMS-64 during the period August 1, 2007, through July 31, 2009. We reviewed 137 of the 537 identified overpayments totaling $47,303,717.

We did not review the overall internal control structure of the State agency. We limited our internal control review to obtaining an understanding of the State agency's policies and procedures for identifying, collecting, and reporting Medicaid overpayments.

We performed fieldwork at the State agency offices in Springfield, Illinois, from January to October 2011.

[2] Sections 1903(d)(2)(C) and (D) of the Act and Federal regulations (42 CFR § 433.312) do not require the State to refund the Federal share of uncollectable amounts paid to bankrupt or out-of-business providers.

Methodology

To accomplish our audit objective, we:

- reviewed Federal laws, regulations, and CMS *State Medicaid Manual* provisions governing Medicaid overpayments;

- interviewed State agency officials on their policies and procedures for Medicaid overpayments subject to the 60-day rule and reporting those overpayments on the CMS-64;

- identified 537 overpayments for Medicaid services subject to the 60-day rule and identified by the HFS-OIG, totaling $47,303,717;

- selected a stratified random sample of 137 overpayments: all 37 overpayments of more than $250,000 and 100 from 500 overpayments of $1,000 to $249,999;

- established the dates of discovery using the dates that HFS-OIG notified Medicaid providers in writing of the overpayments and the dollar amount subject to recovery;

- determined the quarter in which the 60-day period following discovery of the overpayment ended;

- reviewed the CMS-64 to determine whether the Medicaid overpayments were reported within the quarter in which the 60-day period following discovery ended;

- determined whether providers selected as part of our sample were bankrupt or out of business; and

- computed the potentially higher interest expense to the Federal Government resulting from overpayments and income not reported within the required timeframe using the number of days between required reporting dates and the State fiscal year ended June 30, 2011.[3]

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

[3] We calculated the interest expense using the applicable interest rates pursuant to the Cash Management Improvement Act of 1990, P.L. No. 101-453.

FINDINGS AND RECOMMENDATIONS

The State agency did not report all Medicaid overpayments in accordance with Federal requirements. Based on our results, the State agency did not report Medicaid overpayments totaling $324,100 ($164,867 Federal share) in accordance with Federal requirements.

The State agency did not completely report 2 of the 137 overpayments reviewed on the CMS-64. The State agency reported the remaining 135 overpayments.

The State agency also did not report all Medicaid overpayments to providers within the 60-day requirement (116 of the 137 overpayments were reported late). Because the State agency did not properly report all overpayments within the 60-day requirement, the Federal Government may have incurred increased interest expense of $560,835.

The State agency did not properly report these overpayments because it had not developed and implemented internal controls to ensure that overpayments were reported on the CMS-64 in accordance with Federal requirements.

OVERPAYMENTS NOT REPORTED

Pursuant to 42 CFR § 433.312(a)(2), the State agency "… must refund the Federal share of overpayments at the end of the 60-day period following discovery … whether or not the State has recovered the overpayment from the provider." The regulation provides an exception only when the State is unable to recover the overpayment because the provider is bankrupt or out of business (42 CFR § 433.318).

Pursuant to 42 CFR § 433.320(c)(1) a downward adjustment is: "... allowed only if it is properly based on the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution processes specified in State administrative policies and procedures." In addition, the Departmental Appeals Board (DAB) has determined that the burden is on the State to provide evidence that its audit findings were incorrect or unreliable (e.g. California Department of Health Services, DAB No. 1240 (1991)).

For the period July 1, 2005, through September 30, 2009, the State agency did not fully report 2 of 137 Medicaid overpayments totaling $324,100 ($164,867 Federal share) on the CMS-64, in accordance with Federal requirements.

POTENTIALLY HIGHER INTEREST EXPENSE

Because the State agency did not report some overpayments, the Federal Government did not have the use of these funds. As a result, the Federal Government potentially incurred an increased interest expense of $560,835. However, we did not include this expense in the overpayments that we recommend the State agency refund.

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayments of $324,100 on the CMS-64 and refund $164,867 to the Federal Government and

- ensure that future Medicaid overpayments are reported on the CMS-64 in accordance with Federal requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and recommendations. The State agency's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

April 3, 2012

Department of Health and Human Services
Office of Audit Services, Region V
Attn: Sheri L. Fulcher, Regional Inspector General for Audit Services
233 North Michigan Avenue, Suite 1360
Chicago, Illinois 60601

Re: Draft Audit Report Number A-05-11-00044

Dear Ms. Fulcher:

Thank you for providing the opportunity to comment on your draft audit report entitled "*Illinois Did Not Report All Medicaid Overpayments In Accordance With Federal Requirements*".

The Department concurs with the finding. The Department will refund $164,867 via the CMS-64 Quarter Ending March 31, 2012. We will also report all future overpayments consistent with the statutory time frame in accordance with Federal requirements.

We appreciate the work completed by your audit team. If you have any questions or comments about our response to the audit, please contact Jamie Nardulli, External Audit Liaison, at (217) 558-2527 or through email at jamie.nardulli@illinois.gov.

Sincerely,

Julie Hamos

Julie Hamos
Director

E-mail: hfs.webmaster@illinois.gov

Internet: http://www.hfs.illinois.gov/