Department of Health and Human Services
Office of Inspector General
Office of Audit Services

December 2025 | A-05-24-00019

Illinois Made Unallowable Managed Care Capitation Payments on Behalf of Incarcerated Medicaid Enrollees

REPORT HIGHLIGHTS

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Illinois Made Unallowable Managed Care Capitation Payments on Behalf of Incarcerated Medicaid Enrollees

Why OIG Did This Audit

- Illinois pays managed care organizations to make services available to eligible Medicaid enrollees in return for a monthly fixed payment (capitation payment) for each enrollee.
- Previous audits found that State Medicaid agencies made unallowable capitation payments on behalf of incarcerated Medicaid enrollees.
- We performed this audit to determine whether Illinois made unallowable capitation payments on behalf of incarcerated Medicaid enrollees and to identify the dollar amount of any unallowable capitation payments that were not recovered.

What OIG Found

- Illinois made unallowable capitation payments totaling $263,186 ($229,423 Federal share) on behalf of 48 of the 100 incarcerated Medicaid managed care enrollees in our stratified random sample.
- On the basis of our sample results, we estimated that during our audit period Illinois made unallowable capitation payments on behalf of incarcerated Medicaid enrollees totaling at least $9.5 million ($8.3 million Federal share).

What OIG Recommends

We made two recommendations to Illinois: that it refund $8,366,521 (Federal share) for unallowable capitation payments made on behalf of incarcerated Medicaid enrollees and expand its automated process that terminates managed care enrollment to include inmates housed in a non-Illinois Department of Corrections facility.

Illinois accepted our recommendations and detailed steps it plans to take to address them.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Illinois Department of Healthcare and Family Services (State agency) pays managed care organizations (MCOs) a monthly fixed payment (capitation payment) for each eligible Medicaid enrollee to make Medicaid services available.[1] Previous audits found that State Medicaid agencies made unallowable managed care capitation payments on behalf of incarcerated Medicaid enrollees.[2] It was determined that these States did not always suspend managed care enrollment for Medicaid enrollees while they were incarcerated, permitting the unallowable capitation payments to occur. We are concerned that issues similar to those identified in previous audits could negatively impact Illinois' Medicaid program.

OBJECTIVE

Our objective was to determine whether the State agency made unallowable capitation payments to Medicaid MCOs on behalf of individuals incarcerated in State prisons and to identify the dollar amount of any unallowable capitation payments made on behalf of incarcerated enrollees that were not recovered.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act [the Act]). 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 each State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

States may offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care, or both.[3] Under the FFS model, the State pays providers directly for each covered service a Medicaid enrollee receives. Under managed care, the State pays a fee to an MCO for each

[1] A capitation payment is "a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract . . . for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment." (42 CFR § 438.2).

[2] Ohio Auditor of State, *Ohio Department of Medicaid Improper Capitation Payments*, Dec. 28, 2021. New York State Office of the Medicaid Inspector General, *Audit of Capitation Payments for Incarcerated Enrollees* (Final Audit Report Audit #: 19-7025), June 24, 2021. Accessed on May 5, 2025.

[3] We limited our audit to managed care capitation payments.

person enrolled in the managed care plan. State Medicaid managed care programs are intended to increase access to and improve the quality of health care for Medicaid enrollees.

States contract with MCOs to make services available to Medicaid enrollees, usually in return for a monthly capitation payment. In turn, the MCO pays providers for all the Medicaid services an enrollee may require that are included in the MCO's contract with the State. States make the capitation payments regardless of whether the enrollees receive services during the period covered by the payment. If an enrollee's enrollment is not suspended or terminated, capitation payments may continue automatically. States report these capitation payments on the States' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the rate of Federal financial participation (FFP), which is reflected in the Federal medical assistance percentage (FMAP) and varies depending on the State's relative per capita income as calculated by a defined formula (42 CFR § 433.10).

During our audit period, the average FMAP in Illinois was 56.88 percent, which includes the 6.2-percentage-point increase provided under the Families First Coronavirus Response Act (FFCRA). Because of the Patient Protection and Affordable Care Act's Medicaid expansion, payments for "newly eligible" adults were reimbursed at a 100-percent FMAP beginning 2014 through 2016, gradually declining to 90 percent by 2020 and continuing at 90 percent thereafter (Social Security Act § 1905(y)).

Federal Requirements

Federal regulations define an inmate of a public institution as "a person who is living in a public institution" and define a public institution as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control." A public institution includes a correctional institution. Medical institutions, along with several other settings, are excluded from the definition of a public institution.[4]

CMS considers an individual of any age to be an inmate if the individual is in custody and held involuntarily in a public institution through operation of law enforcement authorities. Correctional institutions include State and Federal prisons, local jails, detention facilities, and other penal settings (e.g., boot camps, wilderness camps). While correctional institutions may provide medical and related services, they are organized for the primary purpose of involuntary confinement and are not considered medical institutions. Inmates of a public institution who

[4] 42 CFR § 435.1010.

are held involuntarily may be enrolled in Medicaid, but States may generally not receive FFP for Medicaid covered services unless the inmate is an inpatient in a medical institution.[5, 6]

In guidance issued before our audit period, CMS noted that States should consider placing the eligibility of a Medicaid-enrolled inmate in a suspended status upon incarceration and/or setting up claim processing markers and edits to ensure that FFP for inmates is claimed only for Medicaid covered inpatient services delivered to inmates in a medical institution. Suspension of Medicaid benefits stops Medicaid coverage for enrollees who become incarcerated, in compliance with the inmate FFP exclusion.[7] The suspension is lifted once the individual is released from the correctional facility.

For States to receive the FFP increase during the COVID-19 Public Health Emergency (PHE), they were required by section 6008(b)(3) of the FFCRA, as amended by the Consolidated Appropriations Act, 2023, to provide continuous coverage to most Medicaid enrollees who were enrolled on or after March 18, 2020, through March 31, 2023. However, the FFCRA did not supersede the limitation on FFP for inmates of a public institution, and FFP for inmates continued to be limited to covered inpatient services.[8]

State Requirements

The State agency is generally not responsible for providing medical assistance for medical care, services, or supplies to a Medicaid enrollee while he or she is an inmate of a public institution. The Illinois Department of Corrections (IDOC), county, or other arresting authority is responsible for providing medical care. The State agency may seek FFP, to the extent allowable and with the cooperation of IDOC or the relevant county, for the costs of those services.

Illinois counties, the Illinois Department of Juvenile Justice, the Illinois Department of Human Services, and IDOC cooperate with the State agency in administering Medicaid enrollment

[5] Vikki Wachino, Director, Center for Medicaid & CHIP Services, CMS, (SHO) letter 16-007: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities, letter to state health officials (Apr. 28, 2016). Accessed on May 5, 2025.

[6] 42 CFR §§ 435.1009, 435.1010, and section 1905(a)(30)(A) of the Act. During our audit period, this provision was renumbered and is currently found at section 1905(a)(32)(A) of the Act. Further, effective Jan. 1, 2025 (which was after our audit period), the Consolidated Appropriations Act, 2023 removed the inmate FFP exclusion for certain services provided to eligible incarcerated juveniles who are within 30 days of their release and for the full range of Medicaid covered services provided to eligible incarcerated juveniles while pending disposition of charges.

[7] Effective Jan. 1, 2026, the Consolidated Appropriations Act, 2024 prohibits States from terminating an individual's Medicaid eligibility because the individual is an inmate of a public institution but allows States to suspend coverage during the period the individual is an inmate. This prohibition was in place before the audit period for eligible incarcerated juveniles under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act.

[8] CMS, *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies*, Jan. 6, 2021. Accessed on May 5, 2025.

during incarceration. That cooperation includes managing Medicaid eligibility processing and informing the State agency that a Medicaid enrollee has been detained or incarcerated. The State agency resumes responsibility for providing medical assistance upon release of the inmate to the community (305 ILCS 5/1-8.5).

Illinois Medicaid Managed Care Program

The State agency is the single State Medicaid agency responsible for administering Medicaid in Illinois. The State agency provides individuals in Illinois access to health care, including, but not limited to, medical, dental, mental health, and substance use treatment services. During our audit period, approximately 67 percent of Illinois' Medicaid population (3.2 million individuals) received benefits through MCOs under contract with the State agency.

According to Illinois' Medicaid managed care contracts, the State agency shall terminate enrollment in managed care when it is made aware that an enrollee is incarcerated in a county jail, IDOC facility, or Federal penal institution. Termination shall take effect on the last day of the month prior to the month in which the enrollee was incarcerated. Capitation payments to MCOs will be adjusted for retroactive disenrollment of enrollees. Adjustments shall be retroactive up to 24 months and can go beyond 24 months at the discretion of the State agency in instances including, but not limited to, incarceration.

Illinois Department of Corrections Prison Data Match and Medicaid Managed Care Enrollment Termination

IDOC provides the State agency a weekly list of incarcerated individuals (prison data). The prison data are then matched against Illinois' Medicaid enrollment data to identify any enrollees who become incarcerated. The State agency restricts Medicaid benefits to inpatient services and terminates managed care enrollment once the enrollees' incarceration status is identified.

The IDOC prison data identify inmates serving a State of Illinois prison sentence and contain five offender status categories. Only one offender status category, Adult Transition Center (ATC) Custody, allows FFP for inmates' Medicaid managed care because the ATC facilities meet the requirements of a "halfway house."[9] Inmates in an ATC facility are provided employment and educational opportunities, leisure time, and access to drug and alcohol counseling.

Inmates serving a sentence under the other four offender status categories are not eligible for FFP under Medicaid managed care:

- In Custody – Inmate is in an IDOC correctional facility.

[9] Vikki Wachino, Director, Center for Medicaid & CHIP Services, CMS, (SHO) letter 16-007: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities, letter to state health officials (Apr. 28, 2016). Accessed on May 5, 2025.

- Non-IDOC Custody – Inmate is serving an Illinois State prison sentence in a non-IDOC facility (e.g., county jail, Federal prison, non-Illinois State prison).
- Reception – Inmate is typically in a regional reception facility. Inmates remain in reception status until they are transferred to a permanent facility.
- Temporary Resident – Inmate is in an IDOC facility temporarily, typically while awaiting a court appearance.

Managed care enrollment is terminated using an automated process and a secondary process within the State agency's Medicaid Management Information System (MMIS). The automated process terminates managed care enrollment by updating the MMIS weekly using the IDOC prison data match. The inmate is disenrolled from Medicaid managed care retroactively to the last day of the month prior to incarceration, and capitation payments are prevented from continuing during the incarceration period. Any inpatient services already billed to an MCO for the month of incarceration would be rebilled to the State agency under the traditional FFS Medicaid program. The secondary process is initiated when a county caseworker receives an incarceration alert from the Data Exchange Activity Reporting System (DEARS).[10] The county caseworker is required to review the information provided in the DEARS alert to determine whether the incarceration status was previously known and the appropriate action was already taken for the enrollee. If the enrollee's Medicaid managed care enrollment was already terminated, no further action is necessary. If enrollment was not terminated, the caseworker is required to verify the enrollee's incarceration status on IDOC's website before processing the enrollee's termination.

Transformed Medicaid Statistical Information System

CMS maintains the Transformed Medicaid Statistical Information System (T-MSIS). Its primary purpose is to be an accurate, current, and comprehensive database of standardized enrollment, eligibility, and paid claim data about Medicaid enrollees that is used for administering Medicaid federally and helping to detect fraud, waste, and abuse in Medicaid.

T-MSIS contains enhanced information about enrollee eligibility, enrollee and provider enrollment data, service utilization data, claim and managed care data, and expenditure data. Timeliness issues prompted CMS to move toward a streamlined data submission process, along with an enhanced data repository. The T-MSIS data help to further CMS's goals with improved timeliness, reliability, and robustness, as well as an increase in the amount of data requested. States submit their T-MSIS data to CMS monthly. OIG has full access to T-MSIS data for all States.

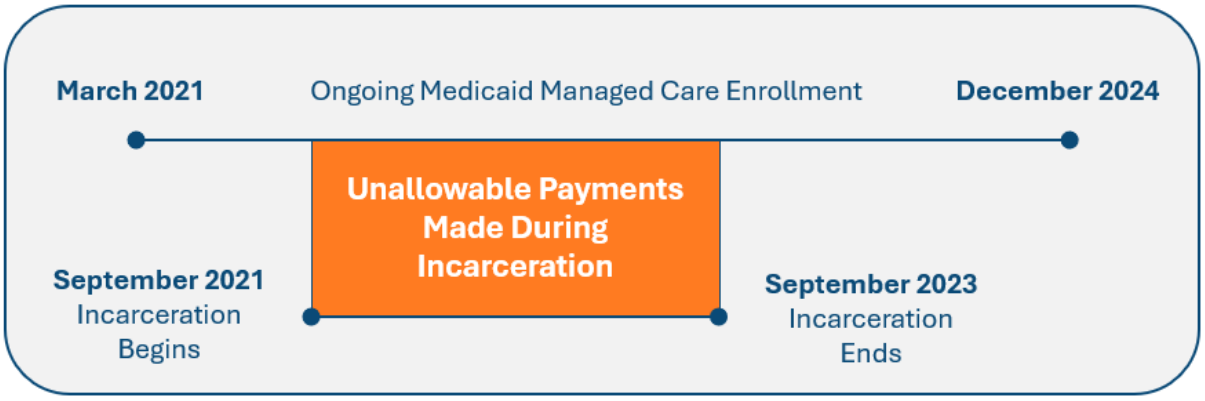
[10] DEARS is an interface that searches multiple data exchanges and compiles monthly reports that list individuals identified as having defined matches, including incarceration.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $22.5 million in Illinois Medicaid managed care capitation payments from October 1, 2020, through September 30, 2023 (audit period), that the State agency made on behalf of 11,722 incarcerated Medicaid enrollees.[11] To identify our population of capitation payments made by the State agency, we compared IDOC prison data to Illinois T-MSIS data by matching the enrollees' Social Security number (SSN), date of birth (DOB), and name. Our match compared the enrollees' Medicaid managed care capitation payment service dates to the enrollees' incarceration beginning and end dates in the IDOC prison data.

The figure below illustrates an example of a typical match we identified. In this example, the enrollee's managed care enrollment started in March 2021 and was still active as of December 2024. The enrollee's incarceration started in September 2021 and ended in September 2023. This match identified 23 consecutive months of unallowable managed care capitation payments that were made on behalf of an incarcerated Medicaid enrollee.[12]

Figure: Example of an Incarcerated Medicaid Managed Care Enrollment Match



To determine whether the State agency made unallowable managed care capitation payments on behalf of incarcerated Illinois Medicaid enrollees, we selected a stratified random sample of 100 incarcerated Medicaid enrollees with capitation payments totaling $412,224 ($358,622 Federal share). Using the results of our sample, we estimated the total value and Federal share of unallowable capitation payments that the State agency made during our audit period on behalf of enrollees who were incarcerated.

[11] The sampling frame includes Medicaid enrollees where the total capitation payment value for an enrollee's incarceration period is greater than $50.

[12] A Medicaid enrollee is generally eligible for managed care for an entire month at a time. To account for months with overlapping incarceration and allowable Medicaid managed care enrollment, our data match excluded the capitation payments for the months the enrollee was admitted and released from incarceration. In this example, only the capitation payments during October 2021 through August 2023 were included in our data match.

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 A contains the details of audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

FINDINGS

The State agency made unallowable managed care capitation payments on behalf of incarcerated Medicaid enrollees during our audit period. Of the 100 enrollees in our stratified random sample, we determined that capitation payments associated with 52 enrollees were either allowable or subsequently voided.[13] However, the State agency made unallowable capitation payments totaling $263,186 ($229,423 Federal share) on behalf of 48 incarcerated Medicaid enrollees.[14] On the basis of our sample results, we estimated that during our audit period the State agency made unallowable capitation payments on behalf of incarcerated Medicaid enrollees totaling at least $9.5 million ($8.3 million Federal share).[15]

We determined that the State agency did not always terminate managed care enrollment after receiving notification that an enrollee was incarcerated. The State agency indicated that the FFCRA's continuous enrollment requirement was not properly applied by the county caseworkers. Also, the State agency's automated process for terminating managed care enrollment did not include inmates serving an Illinois State prison sentence in a non-IDOC facility, so unallowable managed care capitation payments were made for those inmates.

[13] Capitation payments totaling $52,830 ($47,837 Federal share) were allowable because they were made on behalf of nine Medicaid enrollees who were inmates in an ATC facility.

[14] We confirmed the enrollees' Medicaid managed care enrollment and capitation payments using Illinois' MMIS and eligibility case files provided by the State agency. We also confirmed the incarceration admission and release dates with IDOC.

[15] Rounding to the nearest dollar, the amounts equaled $9,565,305 and $8,366,521, respectively.

THE STATE AGENCY MADE UNALLOWABLE PAYMENTS TO MANAGED CARE ORGANIZATIONS ON BEHALF OF INCARCERATED MEDICAID ENROLLEES

Inmates of a public institution who are held involuntarily may be enrolled in Medicaid.[16] However, according to Federal requirements, States generally may not receive FFP for Medicaid covered services unless the inmate is an inpatient in a medical institution.[17, 18]

From our stratified random sample of 100 Medicaid enrollees, we found that the State agency made unallowable managed care capitation payments on behalf of 48 incarcerated Medicaid enrollees, totaling $263,186 ($229,423 Federal share). On the basis of our sample results, we estimated that during our audit period the State agency made unallowable capitation payments on behalf of incarcerated Medicaid enrollees totaling at least $9.5 million ($8.3 million Federal share).

The State Agency Did Not Always Terminate Medicaid Managed Care Enrollment for Incarcerated Enrollees

The State agency did not terminate managed care enrollment for 48 Medicaid enrollees.[19] The State agency received notification of the enrollee's incarceration status for 29 of the 48 enrollees. However, the State agency and county caseworkers did not follow established policies and procedures to terminate managed care enrollment after receiving notification that the Medicaid enrollee was incarcerated. Our audit period occurred during the PHE, and the FFCRA's continuous enrollment requirement caused some confusion related to incarcerated Medicaid enrollees. The State agency published a policy memo in April 2020 that listed exceptions for the continuous enrollment requirement. The memo stated that no Medicaid disenrollments should occur during the PHE unless the enrollee was deceased, moved out of State, or voluntarily requested the cancellation. The memo did not list incarceration as a continuous enrollment exception, so the county caseworkers kept the incarcerated Medicaid enrollees' managed care enrollment active. For some of the 29 Medicaid enrollees, county caseworkers explicitly cited the FFCRA's continuous enrollment requirement as the reason for

[16] Vikki Wachino, Director, Center for Medicaid & CHIP Services, CMS, (SHO) letter 16-007: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities, letter to state health officials (Apr. 28, 2016). Accessed on May 5, 2025.

[17] 42 CFR §§ 435.1009, 435.1010, and section 1905(a)(30)(A) of the Act. During our audit period, this provision was renumbered and is currently found at section 1905(a)(32)(A) of the Act.

[18] In July 2024 (which was after our audit period), CMS granted the State agency waiver authority under section 1115(a) of the Act to conduct a demonstration project to facilitate incarcerated individuals' transition back to the community. Specifically, the State agency offers limited coverage for a targeted set of services furnished to certain incarcerated individuals for 90 days immediately prior to the individual's expected date of release. The waiver also addresses coverage of certain services for eligible juveniles under the Consolidated Appropriations Act, 2023.

[19] We limited our audit to managed care capitation payments. We did not determine whether any inpatient services were received by these 48 Medicaid enrollees because these services should have been paid only through the State agency's FFS program and not through managed care capitation payments.

using an eligibility override to continue Medicaid managed care enrollment. However, the FFCRA did not supersede the limitation on Medicaid FFP for inmates of a public institution, and the State agency should not have claimed FFP for the Medicaid managed care capitation payments.

For the remaining 19 enrollees, the State agency made unallowable managed care capitation payments because the Medicaid enrollees were not housed in an IDOC prison.[20] The State agency excluded inmates serving an Illinois State prison sentence in a non-IDOC facility from its automated process for terminating managed care enrollment.

Table 1 below summarizes the number of unallowable monthly capitation payments that were made on behalf of the 48 incarcerated Medicaid enrollees. Our analysis found that 19 of the 48 incarcerated Medicaid enrollees had 6 or fewer months of unallowable capitation payments. The remaining 29 sampled incarcerated Medicaid enrollees had more than 6 months of unallowable capitation payments. The unallowable capitation payments were not recovered from the MCOs.

Table 1: Number of Months With Unallowable Capitation Payments for 48 Incarcerated Enrollees

Number of Months With Unallowable Capitation Payments	Number of Incarcerated Medicaid Enrollees
3 or fewer months	12
4 to 6 months	7
7 to 12 months	14
13 to 18 months	9
More than 18 months	6
Total	**48**

RECOMMENDATIONS

We recommend that the Illinois Department of Healthcare and Family Services:

- refund $8,366,521 (Federal share) for unallowable capitation payments made on behalf of incarcerated Medicaid enrollees and

- expand the prisoner data match to Illinois Medicaid enrollment data so that it also includes inmates housed in a non-IDOC facility.

[20] Eighteen of the nineteen sampled Medicaid enrollees were in an Illinois county jail; the remaining enrollee was in a prison in another State.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency accepted our recommendations and detailed steps it plans to take to address them. The State agency said that it will implement programming changes to ensure individuals in non-IDOC custody status, who are ineligible for Medicaid, have their eligibility suspended during incarceration. Also, the State agency said it will refund the Federal share for the unallowable claims that were noted during our audit.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $22.5 million in Medicaid managed care capitation payments from October 1, 2020, through September 30, 2023 (audit period), that the State agency made on behalf of 11,722 incarcerated Illinois Medicaid enrollees. We selected a stratified random sample of 100 incarcerated Illinois Medicaid enrollees with managed care capitation payments totaling $412,224 ($358,622 Federal share), to determine whether the State agency made managed care capitation payments on behalf of incarcerated Illinois Medicaid enrollees during the audit period.

To identify our population of capitation payments made by the State agency on behalf of incarcerated Medicaid enrollees, we compared IDOC prison data to Illinois T-MSIS data and matched the enrollees' SSN, DOB, and name.

We assessed internal controls and compliance with laws and regulations necessary to satisfy the audit objective. In particular, we assessed the design, implementation, and operating effectiveness of the State agency's internal controls related to control activities and monitoring of capitation payments made on behalf of incarcerated Medicaid enrollees. As part of our internal control review, we reviewed the State agency's policies and procedures for identifying and terminating the managed care enrollment of Medicaid enrollees who were incarcerated. However, because our review was limited to these aspects of internal control, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit. Any internal control deficiencies we found are discussed in this report.

We conducted our audit work from July 2024 through September 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal laws, regulations, and guidance;
- obtained prison data from IDOC that contained a list of all incarcerated adults serving a State of Illinois prison sentence during calendar years 2020 through 2023;
- reviewed the State agency MCO contracts, laws, policies, and procedures that were in effect during the audit period to gain an understanding of the State agency's internal controls over preventing, identifying, and correcting capitation payments that were made on behalf of incarcerated Medicaid enrollees;
- identified sources that the State agency used to identify enrollees who were incarcerated;

- matched the IDOC prison data to Illinois T-MSIS data and identified 11,722 incarcerated Medicaid enrollees with managed care capitation payments, totaling $22,484,163, in the audit period;

- selected for review a stratified random sample of 100 Medicaid managed care enrollees with capitation payments, totaling $412,224 ($358,622 Federal share);

- validated the T-MSIS data for each sampled enrollee by:

    - comparing current enrollee data from the State agency to determine whether the enrollees' Medicaid managed care enrollment information was accurate and

    - comparing current capitation payment data from the State agency to determine whether a capitation payment occurred and whether any subsequent adjustments were made;

- reviewed sampled enrollees' MMIS information, eligibility case files, IDOC prison information, and other supporting documentation to determine whether the capitation payments were allowable;

- estimated, based on the sample results, the total value and Federal share of capitation payments that the State agency made during our audit period on behalf of incarcerated Medicaid enrollees by using the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software; and

- discussed the results of our audit with State agency officials.

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: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 11,722 incarcerated Medicaid enrollees with managed care capitation payments during the audit period of October 1, 2020, through September 30, 2023, totaling $22,484,163.[21]

SAMPLE UNIT

The sample unit was an incarcerated Medicaid enrollee.[22]

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample outlined in Table 2.

Table 2: Sample Design Summary

	Frame Information			
Stratum	**Stratum Dollar Boundaries**	**Number of Enrollees**	**Dollar Amount of Capitation Payments**	**Sample Size**
1	Incarcerated Medicaid enrollees with capitation payment amounts from $54.28 to $3,515.88	9,871	$8,673,248	50
2	Incarcerated Medicaid enrollees with capitation payment amounts from $3,519.17 to $43,165.53	1,851	13,810,915	50
	Totals	**11,722**	**$22,484,163**	**100**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG/OAS statistical software.

[21] The sampling frame includes Medicaid enrollees where the total capitation payment value for an enrollee's incarceration period is greater than $50.

[22] We identified more than one capitation payment for most incarcerated Medicaid enrollees. We grouped those payments into one payment record.

METHOD FOR SELECTING SAMPLE UNITS

We sorted each stratum using the enrollees' IDOC identification numbers and consecutively numbered the items in each stratum in the sampling frame. We generated random numbers for each stratum, and we selected the corresponding sampling frame items for review given the sample sizes defined in Table 2.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total value and Federal share of unallowable capitation payments in the sampling frame that the State agency made on behalf of incarcerated Medicaid enrollees during our audit period at the lower limit of the two-sided 90-percent confidence interval (Appendix C). Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

						Sampled Incarcerated Medicaid Enrollees With Unallowable Capitation Payments		
Stratum	**Frame Size**	**Total Value of Frame**	**Sample Size**	**Total Value of Sample**	**Federal Share of Sample**	**Number in Sample**	**Total Value of Unallowable Capitation Payments**	**Federal Share of Unallowable Capitation Payments**
1	9,871	$8,673,248	50	$40,454	$34,210	15	$14,503	$12,449
2	1,851	13,810,915	50	371,770	324,412	33	248,683	216,975
Total	**11,722**	**$22,484,163**	**100**	**$412,224**	**$358,622**	**48**	**$263,186**	**$229,423**[23]

Table 4: Estimated Unallowable Capitation Payments in the Sampling Frame That the State Agency Made on Behalf of Incarcerated Medicaid Enrollees
(Limits Calculated at the 90-Percent Confidence Level)

	Total Amount	**Federal Share**
Point estimate	$12,069,440	$10,490,001
Lower limit	9,565,305	8,366,521
Upper limit	14,573,574	12,613,482

[23] The stratum amounts do not sum to the total amount because of rounding.

APPENDIX D: STATE AGENCY COMMENTS

HFS
Illinois Department of
Healthcare and Family Services

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November 10, 2025

Department of Health and Human Services
Office of Audit Services, Region V
Attn: Sheri L. Fulcher, Regional Inspector General for Audit Services
223 North Michigan Avenue, Suite 802
Chicago, IL 60601

Re: Draft Audit Report A-05-24-00019

Dear Ms. Fulcher:

Thank you for providing the opportunity to comment on your draft audit report entitled "*Illinois Made Unallowable Managed Care Capitation Payments on Behalf of Incarcerated Medicaid Enrollees.*"

The Department of Healthcare and Family Services accepts the recommendation. The Department will implement programming changes to ensure individuals in Non-IDOC Custody status, who are ineligible for Medicaid, have eligibility suspended during incarceration. The Department will also refund the federal share noted by the auditors for the unallowable claims noted during the audit.

We appreciate the work completed by your audit team and the open lines of communication with HFS staff throughout this audit. If you have any questions or comments about our response to the audit, please contact Jamie Nardulli, Chief Internal Auditor at (217) 557-0576 or through email at Jamie.Nardulli@illinois.gov

Sincerely,

Elizabeth M. Whitehorn
Director

E-mail: hfs.webmaster@illinois.gov **Internet:** http://www.hfs.illinois.gov/

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Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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