



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region V
233 North Michigan Avenue
Suite 1360
Chicago, IL 60601

September 3, 2010

Report Number: A-05-10-00013

Ms. Julie Hamos
Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763

Dear Ms. Hamos:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Overpayments Identified by the Illinois Division of Rehabilitation Services for Services Provided Between December 1, 1999, Through December 31, 2008*. 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 Stephen Slamar, Audit Manager, at (312) 353-7905 or through email at Stephen.Slamar@oig.hhs.gov. Please refer to report number A-05-10-00013 in all correspondence.

Sincerely,

/James C. Cox/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations (CMCHO)
Centers for Medicare & Medicaid Services
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Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICAID OVERPAYMENTS
IDENTIFIED BY THE ILLINOIS DIVISION
OF REHABILITATION SERVICES
FOR SERVICES PROVIDED FROM
DECEMBER 1, 1999, THROUGH
DECEMBER 31, 2008**



Daniel R. Levinson
Inspector General

September 2010
A-05-10-00013

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 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.

The Illinois Department of Healthcare and Family Services (the State agency) administers the State's Medicaid program in Illinois. It contracts with the Illinois Department of Human Services (DHS), Division of Rehabilitation Services (DRS) to operate three 1915(c) waiver programs on a day-to-day basis. DHS reimburses providers for claimed waiver services, and subsequently, submits claims for Medicaid reimbursement to the State agency. Among others, the DRS State Benefits Fraud Unit (Fraud Unit), on a post-payment basis, identifies overpayments made to these providers. The Fraud Unit documents the overpayments, contacts the provider that received the overpayment, verifies the overpayment amount with the provider, and sets up a system to track and recoup the identified overpayments.

Section 1903(d)(2) of the Act requires the State to refund the Federal share 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 the services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." Implementing regulations (42 CFR § 433.312) require the State Medicaid agency to refund the Federal share of an overpayment to a provider at the end of the 60-day period following the date of discovery, whether or not the State Medicaid 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 the specified dollar amount subject to recovery (42 CFR § 433.316(c)). For provider overpayments resulting from fraud or abuse, discovery occurs on the date of the State's final written notice of the overpayment determination (42 CFR § 433.316(d)).

Because the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64, is due on a quarterly basis, the CMS *State Medicaid Manual* requires 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 Medicaid overpayments were reported on the CMS-64 in accordance with Federal requirements.

SUMMARY OF FINDINGS

The State agency did not report all Medicaid overpayments on the CMS-64 in accordance with Federal requirements. Of the 100 overpayments reviewed, 75 were not reported or adjusted on the CMS-64. The remaining 25 were reported correctly or were not required to be reported.

Based on sample results, we estimate the State agency did not reimburse \$733,003 (\$368,094 Federal share) for overpayments claimed on behalf of beneficiaries who were institutionalized or otherwise not entitled to the services.

The State agency did not report these overpayments because it had not developed and implemented internal controls to ensure that overpayments identified by the Fraud Unit were reported on the CMS-64.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$368,094 to the Federal Government for identified overpayments and
- develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments.

STATE AGENCY COMMENTS

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

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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 applicable Federal requirements.

The Federal Government pays its share (Federal 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).

The Illinois Department of Healthcare and Family Services (the State agency) administers the State's Medicaid program in Illinois. The State agency contracts with the Illinois Department of Human Services (DHS), Division of Rehabilitation Services (DRS) to operate three 1915(c) waiver programs on a day-to-day basis. These waivers are generally provided to Medicaid-eligible beneficiaries in a community rather than an institutional setting. DHS reimburses providers for claimed waiver services, and subsequently, submits claims for Medicaid reimbursement to the State agency. Among others, the DRS State Benefits Fraud Unit (Fraud Unit), on a post-payment basis, identifies overpayments made to these providers. The Fraud Unit documents the overpayments, contacts the provider that received the overpayment, verifies the overpayment amount with the provider, and sets up a system to track and recoup the identified overpayments.

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 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 a provider to recover or attempt to recover the overpayment before the Federal share of the overpayment must be refunded to CMS. Section 1903(d)(2)(C) of the Act, as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985, and Federal regulations at 42 CFR part 433, subpart F, require a State to 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.¹ 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.

Pursuant to 42 CFR § 433.316(d), an overpayment resulting from fraud or abuse is discovered on the date of the final written notice of the State's overpayment determination that a Medicaid agency official or other State official sends to the provider.

In addition, Federal regulations (42 CFR § 433.320) require that the State refund the Federal share of an overpayment on its quarterly CMS-64. Provider overpayments must be credited on the CMS-64 submitted for the quarter in which the 60-day period following discovery ends.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our review covered overpayments identified by the Fraud Unit for services provided from December 1, 1999, through December 31, 2008. We reviewed 100 of the 3,581 identified overpayments totaling \$3,451,785. The scope of our audit did not include a medical review or an evaluation of the medical necessity of the overpayments identified by the Fraud Unit.

We did not assess the overall internal control structure of the State agency. We limited our review to gaining an understanding of the State agency's and DHS's controls related to Medicaid claims and payments for waiver services. We reviewed the Fraud Unit's internal controls and processes for identifying, documenting, and recouping the overpayments.

We performed fieldwork at the State agency and Fraud Unit offices located in Springfield, Illinois, from October 2009 through May 2010.

¹ Section 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 objective, we:

- reviewed Federal laws, regulations, and other requirements governing Medicaid overpayments;
- interviewed State agency, DHS, and Fraud Unit officials regarding policies and procedures relating to Medicaid overpayments subject to the 60-day rule, adjusting overpayments through the Medicaid Management Information Systems (MMIS), and reporting of overpayments on the CMS-64;
- identified 3,581 overpayments totaling \$3,451,785 subject to the 60-day rule that should have been reported on the CMS-64;
- selected a simple random sample of 100 overpayments identified by the Fraud Unit;
- established dates of discovery for the Fraud Unit's investigations of the overpayment subject to recovery;
- reviewed the supporting documentation prepared by the Fraud Unit including provider timesheets, long-term care reports, incarceration reports, and other supporting documentation;
- verified overpayments were originally claimed for Federal Financial Participation using data provided by the State's MMIS;
- determined whether overpayments were adjusted through MMIS;
- calculated the Federal share of the overpayments identified by the Fraud Unit using information from the MMIS; and
- estimated, based on the results of our simple random sample, the value of overpayments in the sample frame that were not reported during the audit period.

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.

FINDINGS AND RECOMMENDATIONS

The State agency did not report all Medicaid overpayments on the CMS-64 in accordance with Federal requirements. Of the 100 overpayments reviewed, 75 were not reported on the CMS-64. The remaining 25 were reported correctly or were not required to be reported.

Based on sample results, we estimate the State agency did not reimburse \$733,003 (\$368,094 Federal share) for overpayments claimed on behalf of beneficiaries who were institutionalized or otherwise not entitled to the services.

The State agency did not report these overpayments because it had not developed and implemented internal controls to ensure that overpayments identified by the Fraud Unit were reported on the CMS-64.

OVERPAYMENTS NOT REPORTED

Pursuant to 42 CFR § 433.312(a)(2), the State Medicaid 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 amount because the provider is bankrupt or out of business (42 CFR § 433.318).

For the period December 1, 1999, through December 31, 2008, we estimate that the State agency did not report Medicaid overpayments totaling \$733,003 (\$368,094 Federal share) received for waiver services deemed unallowable by the Fraud Unit. Of the 100 sampled overpayments, 75 totaling \$52,677 (\$26,383 Federal share) were not reimbursed to the Federal government. Specifically, the State agency did not report:

- 3 overpayments, totaling \$25,285, due to various acts of provider fraud.
- 68 overpayments, totaling \$16,299, for institutionalized beneficiaries. Fraud Unit supporting documentation shows institutional stays on the same dates as waiver services were claimed.
- 3 overpayments, totaling \$7,068, for waiver services not provided because either the beneficiary or their personal care assistant was incarcerated. Department of Corrections data obtained by the Fraud Unit shows incarceration dates which overlap with claimed waiver services.
- 1 overpayment, totaling \$4,025, for a deceased beneficiary. MMIS data confirms claims for reimbursement after the date of death of the beneficiary.

INTERNAL CONTROLS NOT IMPLEMENTED

The State agency did not implement internal controls to ensure that it correctly reported Medicaid overpayments identified by the Fraud Unit. Through discussions with the State agency and the Fraud Unit, we determined the two agencies did not communicate information concerning identified overpayments. Consequently, the State agency did not report on the CMS-64 overpayments identified by the Fraud Unit.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$368,094 to the Federal Government for identified overpayments and
- develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments.

STATE AGENCY COMMENTS

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

APPENDIXES

APPENDIX A: SAMPLING METHODOLOGY

POPULATION

The population consisted of overpayments identified by the State Benefits Fraud Unit for services provided from December 1, 1999, through December 31, 2008.

SAMPLE FRAME

The Illinois Department of Human Services, Division of Rehabilitation Services' State Benefits Fraud Unit provided a list of provider overpayments. The sampling frame was limited to overpayments for services provided to Medicaid eligible individuals with a finding amount greater than zero and not duplicated.

The sampling frame was an excel file containing 3,581 overpayments totaling \$3,451,785.

SAMPLE UNIT

The sample unit was an overpayment.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a random sample of 100 overpayments.

SOURCE OF RANDOM NUMBERS

Random numbers were generated by the Department of Health & Human Services, Office of Inspector General (OIG), Office of Audit Service's (OAS) RAT-STATS statistical software package.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of provider overpayments not properly reported.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Overpayments Not Reported in Sample	Value of Overpayments Not Reported in Sample
3,581	\$3,451,785	100	\$134,449	75	\$52,677

Estimated Medicaid Overpayments Not Reported on the CMS-64

(Limits Calculated for a 90-percent Confidence Interval)

	Total Unallowable	Federal Share
Lower Limit	\$733,003	\$368,094
Point Estimate	\$1,886,372	\$944,758
Upper Limit	\$3,039,740	\$1,521,422

APPENDIX C: STATE AGENCY COMMENTS



Pat Quinn, Governor
Julie Hamos, Director

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August 25, 2010

James C. Cox
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan Avenue
Suite 130
Chicago, Illinois 60601

Re: Report Number A-05-10-00013

Dear Mr. Cox:

Thank you providing the opportunity to comment on your draft audit report entitled "*Review of Medicaid Overpayments Identified by the Illinois Division of Rehabilitation Services for Services Provided From December 1, 1999, Through December 31, 2008*". The report recommended that we refund \$368,094 to the Federal Government for identified overpayments and that we develop and implement internal controls to correctly report and refund the Federal share of identified Medicaid overpayments. The following is our response:

The Department concurs and will refund the amount identified. The Department will work with the operating agency to assure that it is aware of the requirement to inform us when Medicaid overpayments are identified. Furthermore, the Department will perform routine follow up to verify that the operating agency complies with this requirement.

If you have any questions or comments about our response to the audit, please contact Peggy Edwards, Audit Liaison, at (217) 558-2495, or through email at peggy.edwards@illinois.gov.

Sincerely,

Julie Hamos
Director

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