Illinois Made Correct Medicaid Claim Adjustments

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General for Audit Services

April 2017
A-05-15-00031
The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

**Office of Audit Services**

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

**Office of Evaluation and Inspections**

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

**Office of Investigations**

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

**Office of Counsel to the Inspector General**

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG’s internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.
NOTICES

THIS REPORT IS AVAILABLE TO THE PUBLIC
at https://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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.
Illinois used the correct Federal medical assistance percentages when processing claim adjustments for public and private providers during the period October 2011 through September 2014.

INTRODUCTION

WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews\(^1\) found that States improperly adjusted Medicaid claims reported to the Centers for Medicare & Medicaid Services (CMS) on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64) at incorrect Federal medical assistance percentages (FMAPs). We therefore conducted a similar review of claim adjustments submitted by the Illinois Department of Healthcare and Family Services (State agency), which administers the Medicaid program in that State.

OBJECTIVE

Our objective was to determine whether the State agency used the correct FMAPs when it processed Medicaid claim adjustments reported on the CMS-64.

BACKGROUND

Medicaid Program

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, 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 State agency administers the Medicaid program and uses the Medicaid Management Information System (MMIS), a computerized payment and information report system, to process and pay Medicaid claims.

Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program

States use the standard CMS-64 to report actual Medicaid expenditures for each quarter and CMS uses it to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 and its attachments must be actual expenditures and be supported by documentation. States also use the CMS-64 to report claim adjustments and make adjustments for any identified overpayment or underpayment of the FMAP. The State agency makes adjustments for a variety of reasons, including correcting inaccurate provider billings and retroactive changes in provider payment rates.

\(^1\) See Appendix A for related OIG reports.
Federal Medical Assistance Percentages

The amount that the Federal Government reimburses to State Medicaid agencies, which is also referred to as the Federal share, is determined by the FMAP. The FMAP is a variable rate that is based on a State’s relative per capita income. With regard to claim adjustments, Federal reimbursement is available at the FMAP in effect at the time the State made the expenditure.

For October 2011 through September 2014, the period in which the claims we audited were adjusted, the FMAP for Illinois ranged from 50 percent to 90 percent.

Federal Requirements

Federal Medical Assistance Percentage Rates for Reimbursement

The Federal Government must reimburse the State at the FMAP rate in effect at the time the State made the expenditure (the Social Security Act, § 1903(a)(1)).

The CMS State Medicaid Manual, section 2500(D)(2), provides the following instructions to States: “When reporting expenditures for Federal reimbursement, apply the FMAP rate in effect at the time the expenditure was recorded in your accounting system. An expenditure occurs when a cash payment is made to a provider.…. To establish the FMAP rate applicable to a given expenditure, determine when the expenditure was made.”

Federal Medical Assistance Percentage Rate for Private Versus Public Providers

Section 2500.2(E)(4) states: “Increasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made and are matched at the FMAP rate for that quarter. Increasing adjustments related to public providers are considered adjustments to prior-period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency” (added emphasis).

HOW WE CONDUCTED THIS REVIEW

We reviewed Medicaid claim adjustments for public and private providers reported on the CMS-64 for the period October 2011 through September 2014. Specifically, we reviewed 3,659,608 Medicaid claim adjustments, composed of 611,615 private and 3,047,993 public provider claims, totaling $285 million. These claims totaled $85.1 million ($48.4 million Federal share) for public providers, and $200.2 million ($102.7 million Federal share) for private providers.

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 contains the details of our audit scope and methodology.
RESULTS OF AUDIT

The State agency used correct FMAPs when processing claim adjustments reported on the CMS-64 for both public and private providers. Accordingly, this report contains no recommendations.
# APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

<table>
<thead>
<tr>
<th>Report Title</th>
<th>Report Number</th>
<th>Date Issued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana Did Not Always Make Correct Medicaid Claim Adjustments</td>
<td>A-05-15-00022</td>
<td>10/31/2016</td>
</tr>
<tr>
<td>Ohio Did Not Always Make Correct Medicaid Claim Adjustments</td>
<td>A-05-14-00017</td>
<td>9/12/2016</td>
</tr>
<tr>
<td>Iowa Did Not Always Make Correct Medicaid Claim Adjustments</td>
<td>A-07-14-01135</td>
<td>3/26/2015</td>
</tr>
<tr>
<td>Massachusetts Did Not Always Make Correct Medicaid Claim Adjustments</td>
<td>A-01-13-00003</td>
<td>9/29/2014</td>
</tr>
<tr>
<td>Maine Did Not Always Make Correct Medicaid Claim Adjustments</td>
<td>A-01-12-00001</td>
<td>7/20/2012</td>
</tr>
</tbody>
</table>
APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed Medicaid claim adjustments for private and public providers reported on the CMS-64 for the period October 2011 through September 2014. Specifically, we reviewed 3,659,608 Medicaid claim adjustments, composed of 611,615 private and 3,047,993 public provider claims, totaling $285 million. These claims totaled $85.1 million ($48.4 million Federal share) for public providers, and $200.2 million ($102.7 million Federal share) for private providers.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we limited our review of internal controls to obtaining an understanding of the State agency’s procedures for processing and reporting claim adjustments on the CMS-64.

We conducted this audit from May 2015 through December 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed State agency officials and obtained an understanding of its procedures for processing claim adjustments for private and public providers and reporting those adjustments on the CMS-64;
- reconciled Medicaid claim adjustments to the quarterly CMS-64 report; and
- confirmed the State agency used the correct FMAPs when it processed Medicaid claim adjustments reported on the CMS-64.

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.