January 13, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Review of Illinois' Reporting of Fund Recoveries in the Appeals Process on the Form CMS-64 (A-05-11-00052)

Attached, for your information, is an advance copy of our final report on Illinois' reporting of fund recoveries in the appeals process on the Form CMS-64. We will issue this report to the Illinois Department of Healthcare and Family Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Sheri L. Fulcher, Regional Inspector General for Audit Services, Region V, at (312) 353-2621 or through email at Sheri.Fulcher@oig.hhs.gov. Please refer to report number A-05-11-00052.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES **Office of Inspector General**

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

January 18, 2012

Report Number: A-05-11-00052

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 *Review of Illinois' Reporting of Fund Recoveries in the Appeals Process on the Form CMS-64*. 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-05-11-00052 in all correspondence.

Sincerely,

/Sheri L. Fulcher/
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
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF ILLINOIS' REPORTING OF FUND RECOVERIES IN THE APPEALS PROCESS ON THE FORM CMS-64

Daniel R. Levinson
Inspector General

January 2012
A-05-11-00052

Office of Inspector General

http://oig.hhs.gov

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.

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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.

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

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.

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), conducted audits of Medicaid providers. In addition, HFS-OIG contracted annually with third parties to conduct audits of Medicaid providers. When State Medicaid audits identified overpayments, HFS-OIG sent letters to the providers identifying the overpayment amounts and providing information on arranging payment, 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 the provider was first notified in writing of an overpayment and of the dollar amount subject to recovery (42 CFR § 433.316(c)). Appeal rights extended to a provider do not extend the date of discovery (42 CFR § 433.316(h)). 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 that were in the appeals process on the CMS-64 in accordance with Federal requirements.

SUMMARY OF FINDINGS

The State agency did not report all Medicaid overpayments in the appeals process in accordance with Federal requirements. For the period January 1, 2007, through September 30, 2009, the

State agency did not report Medicaid overpayments totaling $18,147,198 ($9,086,779 Federal share) in accordance with Federal requirements.

The State agency did not report 24 of the 27 overpayments reviewed on the CMS-64. The State agency correctly reported the remaining three overpayments. Because the State agency did not properly report overpayments on the CMS-64, the Federal Government may have incurred increased interest expense of $71,822.

The State agency did not properly report these overpayments because it had an unwritten policy of reporting overpayments not involving fraud or abuse when the provider appeals process was completed, rather than at the end of the 60-day period following discovery.

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayments of $18,147,198 on the CMS-64 and refund $9,086,779 to the Federal Government and

- ensure that future Medicaid overpayments that are in the appeals process 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), conducted audits of Medicaid providers. In addition, HFS-OIG contracted annually with third parties to conduct audits of Medicaid providers. When State Medicaid audits identified overpayments, HFS-OIG sent letters to the providers identifying the overpayment amounts and providing information on arranging payment, 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] Appeal rights extended to a provider do not extend the date of discovery (42 CFR § 433.316(h)). 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 that were in the appeals process 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 from January 1, 2007, through July 31, 2009, that should have been reported on the CMS-64 from January 1, 2007, through September 30, 2009. We reviewed 27 overpayments totaling $23,761,893 that were in the appeals process.[3]

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 March to May 2011.

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[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.

[3] State officials informed us during another OIG audit (A-05-11-00044) that the 27 overpayments were in the appeals process. That audit covered overpayments that were not in the appeals process.

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 27 overpayments for Medicaid services subject to the 60-day rule that were in the appeals process and identified by HFS-OIG between January 1, 2007, and July 31, 2009, totaling $23,761,893;

- 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, 2010.[4]

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.

[4] 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 that were in the appeals process in accordance with Federal requirements. For the period January 1, 2007, through September 30, 2009, the State agency did not report Medicaid overpayments totaling $18,147,198 ($9,086,779 Federal share) in accordance with Federal requirements.

The State agency did not report 24 of the 27 overpayments reviewed on the CMS-64. The State agency correctly reported the remaining three overpayments. Because the State agency did not properly report overpayments on the CMS-64, the Federal Government may have incurred increased interest expense of $71,822.

The State agency did not properly report these overpayments because it had an unwritten policy of reporting overpayments not involving fraud or abuse when the provider appeals process was completed, rather than at the end of the 60-day period following discovery.

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). Appeal rights extended to a provider do not extend the date of discovery (42 CFR § 433.316(h)).

For the period January 1, 2007, through September 30, 2009, the State agency did not report 24 of 27 Medicaid overpayments totaling $18,147,198 ($9,086,779 Federal share) on the CMS-64.

POTENTIALLY HIGHER INTEREST EXPENSE

Because the State agency did not report some overpayments that were in the appeals process, the Federal Government did not have the use of these funds. As a result, the Federal Government potentially incurred an increased interest expense of $71,822. 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 $18,147,198 on the CMS-64 and refund $9,086,779 to the Federal Government and

- ensure that future Medicaid overpayments that are in the appeals process 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

November 17, 2011

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-05-11-00052

Dear Ms. Fulcher:

Thank you for providing the opportunity to comment on your draft audit report entitled "*Review of Illinois' Reporting of Fund Recoveries in the Appeals Process on the Form CMS-64 for Fiscal Years 2008 and 2009*".

The Department concurs with the finding. The Department will refund $9,086,779 via the CMS-64 Quarter Ending December 31, 2011. We will also report all future overpayments consistent with the statutory time frame.

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
Director