Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ILLINOIS MADE CORRECT MEDICAID CLAIM ADJUSTMENTS

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Office of Inspector General

https://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.

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

Report Title	Report Number	Date Issued
Indiana Did Not Always Make Correct Medicaid Claim Adjustments	A-05-15-00022	10/31/2016
Ohio Did Not Always Make Correct Medicaid Claim Adjustments	A-05-14-00017	9/12/2016
New York Made Correct Medicaid Claim Adjustments	A-02-14-01006	5/17/2016
North Carolina Did Not Always Make Correct Medicaid Claim Adjustments	A-04-14-00100	3/24/2016
Iowa Did Not Always Make Correct Medicaid Claim Adjustments	A-07-14-01135	3/26/2015
Massachusetts Did Not Always Make Correct Medicaid Claim Adjustments	A-01-13-00003	9/29/2014
Maine Did Not Always Make Correct Medicaid Claim Adjustments	A-01-12-00001	7/20/2012

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.