REPORT DIGEST

ILLINOIS DEPARTMENT OF PUBLIC AID
FINANCIAL AUDIT
FOR THE YEAR ENDED JUNE 30, 1993
COMPLIANCE AUDIT
(In Accordance With The Single Audit Act of 1984 and OMB Circular A-128)
FOR THE TWO YEARS ENDED JUNE 30, 1993

{Expenditures and Activity Measures are summarized on the reverse page.}

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

NEED TO ESTABLISH A GENERAL LEDGER SYSTEM

The Department did not maintain a general ledger system needed to control, aggregate and summarize transactions affecting the accounts of the Department.

Department officials stated the resources needed to implement a general ledger system have not been available. At present, the Department relies on separate reports to compile internal and external financial reports. This is an inefficient method of financial reporting for an entity with over $6 billion in expenditures.

We recommended the Department establish a general ledger system to enhance controls and to facilitate preparation of the financial statements. (Finding 1, page 8 of Volume I)

Department officials agreed with our recommendation and stated, "The Department has requested additional funds to design a new automated accounting system which will include a general ledger system."

NEED TO MAINTAIN A CONSOLIDATED MEDICAID ASSESSMENT RECEIVABLE SYSTEM

The Department did not maintain an overall consolidated accounts receivable subsidiary ledger and a related aging report system for Medicaid assessments receivable.

The Medicaid assessment program generated approximately $409,000,000 and $688,000,000 in revenue in fiscal 1992 and 1993, respectively. The program also reported approximately $93,000,000 and $135,000,000 in receivables as of June 30, 1992 and 1993, respectively. Although the Department has individual reports of provider balances and an overall aging report, it does not maintain a consolidated aging and subsidiary ledger by provider.

We recommended the Department develop a consolidated accounts receivable subsidiary ledger and a related aging report for Medicaid assessment receivables. Further, this system should be reconciled to a control account on a monthly basis and any reconciling items should be resolved. (Finding 2, page 8 & 9 of Volume I)

Department officials agreed with our recommendation and stated, "The Department will develop a consolidated accounts receivable subsidiary ledger and aging for the three provider assessment funds. This ledger will be reconciled to the individual provider accounts on a monthly basis."

NEED TO CONSIDER ENHANCING PROGRAM TO AUDIT PROVIDERS

The process the Department uses to audit providers could be enhanced.

The Bureau of Medical Quality Assurance conducts audits of providers suspected of not complying with Department regulations. The Surveillance Utilization Review Subsystem (a

subsystem of the medicaid management information system) is utilized to identify providers whose statistics deviate from the average. A typical audit generates some instances of noncompliance which leads to a repayment of funds from the provider back to the Department. In fiscal year 1993, the Bureau's 32 auditors recouped over eight million by auditing approximately one-half of one percent of all providers. In fiscal year 1992, the auditors recouped over ten million dollars from providers. Two additional auditors were recently hired to audit down state nursing homes and hospitals which now brings the number of auditors to 34. Currently, each auditor generates approximately $250,000 per year. New auditors are paid approximately $36,000 per year including benefits.

We recommended the Department consider enhancing its program to audit providers. (Finding 4, pages 10 & 11 of Volume I)

Department officials agreed with our recommendation and stated, "The Department has reallocated staff and contracted with CPA firms to enhance audit coverage of providers. In addition, additional staff and computer equipment have been assigned to increase provider audit coverage."

PROCESSING PROVIDER PRIOR APPROVAL REQUESTS

The Department's Bureau of Comprehensive Health Services is not processing prior approval requests within the required regulatory time frame.

When a provider submits a request for a service or item requiring prior approval, the rules and regulations codified in the Illinois Administrative Code stipulate the request to be approved or denied within 21-30 days depending on the nature of the request. If the approval or denial from the Department is not given within the specified time frame, the request is approved automatically.

Of the 45 approved requests selected for our test work, 14 (31%) were not processed by the Bureau within the 21-30 day period and thus, were automatically approved. As a result, funds could be improperly expended since:

●Requests for prior approval which would normally be denied, are approved because the requests are not reviewed within 21-30 days.

●Requests for prior approval which would normally be approved for a lesser amount than requested are automatically approved as requested because they are not processed in a timely manner.

Management officials at the Department indicated that approximately 55,000 prior approval requests are manually processed annually, and they currently do not have the manpower to process all claims in a timely manner. The Department does not maintain statistics regarding the number of claims automatically approved due to an untimely review.

We recommended the Department examine the operational procedure for approving prior

approval requests. (Finding 5, page 11 of Volume I)

The Department agreed with our recommendation and stated, "The Department has taken several actions to address the staff shortages. Specifically, a budget request was made for software and computers to permit an automated simplified prior approval process."

NEED TO DEVELOP A FORMAL POLICY GOVERNING RATE SETTING FOR PRIVATELY HELD INTERMEDIARY CARE FACILITIES OF THE MENTALLY ILL

The Department does not have a formal written policy governing rate setting for privately held Intermediary Care Facilities for the Mentally Ill (ICR/MI). During fiscal 1992 and 1993, the Department paid out state funds totaling $99,000,000 for 6,910 recipients and $110,000,000 for 7,372 recipients, respectively.

The Department lacks a formal approved policy detailing the methodology utilized to set rates for ICR/MI facilities. The Department's Bureau of Program Reimbursement and Analysis uses an unsigned copy of a memorandum from a former Director of the Department to determine reimbursement rates. The undated memorandum discusses the implications of the Omnibus Budget Reconciliation Act (OBRA) of 1987. As a result, certain facilities previously identified as geriatric facilities were to be classified as ICF/MI facilities. According to OBRA, any facility with a mentally ill population which exceeds 50% is to be classified as an ICF/MI. The rate methodology used to set reimbursement rates for the geriatric facilities was not an appropriate tool to set rates for facilities servicing the mentally ill because services administered to the mentally ill tend to be more costly.

A Department official stated that the Bureau of Disability Services along with the Bureau of Program Reimbursement and Analysis are currently in the process of developing a methodology specifically for the ICF/MI facilities. This new methodology should be implemented in the second half of fiscal 1994.

We recommended that a formal written policy be developed which documents the authorized rate setting methodology. Further, this policy should be circulated to all affected parties. (Finding 6, pages 12 & 13 of Volume I)

Department officials agreed with our recommendation and stated, "The Department has been working on developing procedures and a work plan to perform Inspection of Care surveys and apply the Inspection of Care data to a rate methodology. Upon completion the procedure will be distributed to all affected parties."

INSPECTION OF CARE REVIEW PROCESS

The Department does not have a formal written policy addressing the procedures to follow when a facility wants to dispute their review score and the resulting reimbursement rates for serving the developmentally disabled and mentally ill.

Department officials within the Bureau of Program Reimbursement and Analysis indicate that of

the 225 facilities serving the developmentally disabled and the mentally ill, a number are questioning their review scores. The review score is one of the determinants of what reimbursement rates the facilities receive. Facility representatives frequently question their review scores in an attempt to increase reimbursement rates. Because the Department's Bureau of Program Reimbursement and Analysis sets rates, it must respond to these inquires although it does not perform the actual review. Further, no formal policy is in existence which explains the guidelines a facility must follow to mediate a dispute. This lack of formal policy results in additional time spent by the Department and providers to resolve disputes in review scores.

The Department also performs Inspection of Care reviews for long-term care facilities, however, a similar problem does not arise because a formal written policy exists detailing the procedures which must be followed to dispute a review score. This regulation (89 Illinois Administrative Code, Chapter I, Section 147.100) explains the process of reconsideration of assessments if a facility believes its assessment does not accurately reflect the level of services it provides to residents.

We recommended that specific written procedures for disputing review scores be established for those facilities serving the developmentally disabled and mentally ill populations. (Finding 8, pages 13 & 14 of Volume I)

Department officials agreed with our recommendation and stated, "The Department will notify facilities serving the developmentally disabled and mentally ill that the reconsideration process in Section 147.100 also applies to those facilities and should be immediately implemented."

NEED TO IMPROVE SECURITY OVER DISABILITY SERVICES' RATE SETTING PROGRAMS

The Department did not establish procedures to ensure that the Bureau of Disability Services' rate setting programs are protected from access by unauthorized personnel.

During the audit period, the Department created several new rate setting program libraries for each rate period. However, once the program libraries had been cleared for operation, the Department's security administrator was not notified in a timely manner that new program libraries existed. As a result, certain of these production program libraries were not being immediately protected under the Resource Access and Control Facility (RACF) security system.

We recommended the Department establish procedures to ensure the security administrator is notified in a timely manner of all new rate program libraries created. (Finding 10, page 15 of Volume I)

Department officials agreed with our recommendation and stated, "On September 17, 1993 the Department established a system which automatically places RACF protection on every rate setting program created."

NONCOMPLIANCE WITH STATE LAWS

The Department did not make timely reports to certain legislative leaders and the State Comptroller as required by law.

Pursuant to 30 ILCS 105/25, the Department is required to annually submit to the State Comptroller, Senate President, Senate Minority Leader, Speaker of the House, House Minority Leader and the respective Chairman and Minority Spokesman of the Appropriations Committee of the Senate and of the House, on or before December 31, a report of fiscal year funds used to pay for services provided in any prior fiscal year. The report is to document by program or service category those expenditures from the most recently completed fiscal year used to pay for services provided in prior fiscal years.

During our review, we noted the reports for 1991 and 1992 were not completed and filed until March 10, 1992 and January 7, 1993, respectively.

We recommended the Department allocate sufficient resources necessary to ensure compliance with all reporting requirements mandated by State law or seek legislative relief from the mandate. (Finding 12, pages 17 & 18 of Volume I)

Department officials agreed with our recommendation and stated, "The Department will make every effort to comply with all reporting requirements...."

NEED TO IMPROVE PAYMENT TIMELINESS

The Department's Bureau of Claims Processing is in violation of the federal regulations stipulating the time limitation for the payment of claims.

We tested 25 claims and found that 19 were not paid within the time limitations stipulated by the federal government. It was determined that payment for the claims was 12 to 99 days late. Thus, it took 42-129 days to pay these claims. The average number of days for payment was 78 days. The dollar value of these claims in our sample ranged from $18 to $24,248 with an average dollar value of $2,636.

As a result of noncompliance with federal regulations, the federal government is decreasing the percentage of federal financial participation available to the Department to fund the operations of the Medicaid Management Information System (MMIS). The percentage has been reduced from 75% to 65% throughout the calendar year 1993. This 10% reduction resulted in a loss of $3.4 million in federal funds for the Department in fiscal year 1993. We recommended the Department attempt to comply with this regulation to avoid losing more federal funding. (Finding 39, pages 75 & 76 of Volume II)

Department officials agreed with our recommendation, however, they state "... payment delays are the result of a continued shortfall of appropriated funds. During the current fiscal year the State has continued efforts to speed up payments. On December 6, 1993 the Department received notification from the federal government the MMIS was re-approved and federal financial participation for MMIS operations will be increased to 75% (from 65%) for calendar year 1994."

NEED TO IMPROVE RECORD KEEPING FOR THIRD PARTY LIABILITY CLAIMS

The Department does not maintain an adequate record keeping and reporting system for third party Medicaid claims, nor does it adequately pursue collection efforts in an efficient and effective manner.

The Social Security Act requires that State and local Medicaid agencies take all reasonable

measures to ascertain the legal liability of third parties to pay for services furnished to recipients. Medicaid is intended to be the payer of last resort; i.e., other available resources must be used before Medicaid pays the claim.

Although the Department has established procedures to identify liable third parties by matching computer files with insurance companies and with other State agency records, we noted the following deficiencies in record keeping and in collecting these receivables:

●For 8 of the 15 claims tested, totalling $3,020, the Department did not send the subsequent 2nd notice within the time frame specified in the Illinois Department of Public Aid, Accounts Receivable Policy Manual for Compliance with Terms of the 1986 State of Illinois Collections Act. Additionally, no third or fourth notice was sent during fiscal year 1992 or 1993. The Department's policy has been to send second notices after 90 days and not to send third or fourth notices. The Department's SCAAR (State Collection Act Accounts Receivable) manual requires second notices after 60 days of the first notice, third notices after 150 days of first notice, and fourth notices after 240 days of the first notice.

●The Department failed to devote sufficient resources to establish an overall consolidated accounts receivable subsidiary ledger and related aging report as required by good internal control practices. However, the Department has individual reports of third-party liability and an overall aging report. A consolidated system of record keeping would aid the Department in collecting and reporting the approximately $37.1 million in third-party receivables at June 30, 1993 and in processing the approximately 156,000 claims identified in 1993.

We recommended the Department: 1) implement procedures to ensure that it complies with the SCAAR's manual in sending out collection notices, and 2) develop a consolidated subsidiary ledger. (Finding 40, pages 76 & 77 in Volume II)

Department officials agreed with our recommendations and stated, "The Department will revise the SCAAR's manual to reflect the current practice for sending collection notices and will enhance the accounts receivable system by developing a consolidated subsidiary ledger from the individual account data."

OTHER FINDINGS

The remaining findings are of lesser significance and are being given attention by the Department. We will review the progress towards the implementation of our recommendations in our next compliance audit.

Mr. James R. Donkin, Chief Internal Auditor for the Department provided written responses to our findings and recommendations.

AUDITORS' OPINION

Our auditors state the Department's combined financial statements as of June 30, 1993 are fairly presented.

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WILLIAM G. HOLLAND, Auditor General

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SUMMARY OF AUDIT FINDINGS

Number of	This Audit	Prior Audit
Findings	25	39
Repeated Findings	1	11
Prior Recommendations Implemented or Not Repeated	38	22

SPECIAL ASSISTANT AUDITORS

KPMG Peat Marwick were our special assistant auditors for this audit.

DEPARTMENT OF PUBLIC AID
FINANCIAL AND COMPLIANCE AUDIT
For The Two Years Ended June 30, 1993

EXPENDITURE STATISTICS	**FY 1993**	**FY 1992**
●**Total Expenditures (All Funds)**	**$6,099,756,000**	**$5,607,127,000**
OPERATIONS TOTAL % of **Total** Expenditures	$531,887,916 9%	$512,021,126 9%
Personal Services % of Operations Expenditures Average No. of Employees	$250,058,617 47% 9,131	$256,391,384 50% 9,542
Other Payroll Costs (FICA, Retirement, Group Insurance) % of Operations Expenditures	$41,033,611 7%	$31,903,140 6%
Contractual Services % of Operations Expenditures	$93,557,417 18%	$90,214,247 18%
All Other Operations Items % of Operations Expenditures	$147,238,271 28%	$133,512,355 26%
AWARDS AND GRANTS % of **Total** Expenditures	$5,558,928,025 91%	$5,091,067,592 91%
REFUNDS % of **Total** Expenditures	$8,940,059 (Less than 1%)	$4,038,282 (Less than 1%)
●**Cost of Property and Equipment**	**$67,074,000**	**$63,842,000**

SELECTED ACTIVITY MEASURES	**FY 1993**	**FY 1992**
●Analysis of Adjudication and Payment Patterns (Payments from General Revenue Fund)		
- Overall Average Adjudication Time Elapsing In Calendar Days (Page 70, Volume I)	42.9 Days	51.8 Days
- Overall Average Time Elapsing In Calendar Days to Pay A Claim (Page 71, Volume I)	74.5 Days	103.6 Days
●Accrued Medical Costs Payable	$1,785,561,000	$1,398,091,000

AGENCY DIRECTOR(S)
During Audit Period: Mr. Phil Bradley Currently: Mr. Robert W. Wright