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OFFICE OF THE AUDITOR GENERAL
WILLIAM G. HOLLAND

To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our report of the Department of Healthcare and Family Services' compliance with the mandates of the Prompt Payment Act for the Medicaid and Group Health Insurance programs, and the Department's process for receipt, approval, denial, and payment of vendor bills for services provided in the Medicaid program.

The audit was conducted pursuant to Legislative Audit Commission Resolution Numbers 136 and 137. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
May 2008

REPORT DIGEST

PERFORMANCE AUDIT OF

THE DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' PROMPT PAYMENT ACT COMPLIANCE AND MEDICAID PAYMENT PROCESS

Released: May 2008

State of Illinois
Office of the Auditor General

WILLIAM G. HOLLAND
AUDITOR GENERAL

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SYNOPSIS

Legislative Audit Commission Resolution Numbers 136 and 137 directed the Office of the Auditor General to conduct performance audits of the Department of Healthcare and Family Services' (HFS) Medicaid and Group Health Insurance Program activities relating to the Prompt Payment Act (Act) and its processing of Medicaid claims.

Regarding HFS' Medicaid claims receipt, approval, denial, and payment process, the audit concluded the following:

- Medicaid claims received in each of the past four fiscal years, when added to unpaid bills carried over from the prior year, have exceeded the funds available to timely pay providers. **On average, from FY05 – FY07, $1.5 billion of unpaid medical claims have been carried over into the next fiscal year.**
- HFS could **not** document how payment schedules and payment parameters used to make Medicaid payments were established.
- In FY06, it took HFS an average of **6 days to process** claims; however, it took HFS an average of **57 days to submit claims to the Comptroller** for payment.
- HFS used a **poorly defined and documented** process to expedite $5.7 million in "one-time drop" payments to providers in FY07.
- In CY06, it took HFS an average of **87 days** to **notify** non-expedited providers of a rejected service when the rejected service was submitted on a claim along with a service that was paid.
- In 2006, HFS used 123 error codes to notify providers of rejected services that were **not** listed in HFS' provider handbook.

Regarding HFS' compliance with the Prompt Payment Act, the audit concluded the following:

- Due to the delays in payment, **claims submitted to HFS have accrued a potential liability of almost $81 million in Prompt Payment Act interest since FY00.** Actual interest expected to be paid to providers is estimated by HFS to be less due to not all providers requesting eligible interest, as well as exclusions that may be applied to potential interest payments by HFS.
- HFS did not have a system in place to pay automatically owed interest (interest greater than $50) to providers until May 2007 – **almost eight years** after the inclusion of Medicaid claims in the Prompt Payment Act. Additionally, in FY06, it took HFS an average of **452 days** to pay requested interest to providers (interest between $5 and $50).
- HFS requires providers to follow a cumbersome process to request interest. Also, HFS is excluding certain claims from interest payments, some of which are not supported by Administrative Rule.
- The Court of Claims has ruled that the Administrative Rule's methodology for calculating prompt payment interest is **inconsistent** with the methodology prescribed by the Act.

REPORT CONCLUSIONS

Over the last several fiscal years, the Department of Healthcare and Family Services (HFS) has not paid Medicaid claims timely as required by the Prompt Payment Act due to the lack of State funds to pay Medicaid claims. The Illinois State Finance Act (30 ILCS 105/25(b)) allows HFS to make medical payments from appropriations for any fiscal year, without regard to the fact that the medical or child care services may have been provided in a prior fiscal year. This provision of the State Finance Act has allowed HFS to carry unpaid bills averaging $1.5 billion from FY05, FY06, and FY07 into the next fiscal year. **Claims received in each of the past four fiscal years, when added to the unpaid bills carried over from the prior year, have exceeded the funds available to timely pay medical providers.**

Due to the delays in payment, 3.3 million claims submitted to HFS accrued a potential liability of almost **$81 million** in Prompt Payment Act interest since FY00. Actual interest expected to be paid to providers is estimated by HFS to be less due to not all providers requesting eligible interest, as well as exclusions that may be applied to potential interest payments by HFS. As a result of its payment schedule used to regulate payments, in most instances HFS does not submit approved claims immediately to the Comptroller for payment. In FY06, it took HFS an average of **6 days to process claims**; however, it took HFS an average of **57 days to submit claims** to the Comptroller for payment. Payments are added to the payment schedule by HFS based on payment parameters for each provider type. The payment parameter is the number of days a Medicaid claim will be held by HFS before it is put on a payment schedule and submitted to the Comptroller for payment. According to HFS officials, HFS uses the payment schedule to regulate payments throughout the year to ensure there is enough appropriation at the end of the fiscal year to continue to make weekly payments to the "expedited" providers, physicians, All Kids, and monthly Medicare premium payments. Expedited providers are those providers that are paid on an accelerated payment schedule as discussed below.

HFS could not provide any documentation to support how the payment schedule and payment parameters are established. However, according to HFS officials, payment parameters are established based on the appropriation amount available for that provider type when compared to the predicted liability for that provider type. As an example, based on payment parameters provided by HFS, from September 1, 2006 until April 20, 2007, claims submitted by home health care providers were held at HFS for 118 days from receipt date (DCN date) before being eligible for payment.

Providers are generally paid pursuant to one of two payment schedules. The first is the regular payment schedule used to pay "non-expedited" providers (providers not paid on an accelerated payment schedule). The second is an accelerated schedule used to pay "expedited" providers. Pursuant to the Administrative Rule (89 Ill. Adm. Code 140.71(b)), expedited payments may be issued only under extraordinary circumstances, in which withholding of the expedited payment would impose severe and irreparable harm to the clients served. The difference between the two designations is expedited providers are given a higher priority and are paid weekly, while non-expedited providers are put on the regular payment schedule and, as a result, are not paid as timely.

HFS does not have any written policies, procedures, or guidelines that delineate what documentation a provider must submit to HFS to receive expedited payments. Additionally, HFS has no policies or procedures that delineate the review process used to determine whether a provider initially meets, and continues to meet, the eligibility requirements of the Administrative Rule. HFS also lacks a comprehensive policy as to whether a provider needs to enter into an agreement with HFS to receive expedited payments.

From the 2,058 providers that were expedited as of October 18, 2007, we randomly sampled 66 providers. HFS had current signed agreements with 24 of the 66 providers sampled. The following issues were identified:

- **Lack of documentation to substantiate the emergency nature of the request.** For the 24 providers sampled that had current signed agreements, 19 did not have documentation from the providers for HFS to verify that the providers met the Administrative Rule's requirements to substantiate the emergency nature of the request. The only documentation was a letter from the providers attesting that they met the eligibility requirements;

- **Lack of documentation of the number of Medicaid clients served.** For 22 of the 24 providers sampled that had current signed agreements, there was no documentation to support that the provider met the significance requirements related to the number of Medicaid clients served as required by the Administrative Rule; and

- **Outdated agreements and provider lists.** HFS does not have an annual application process to be an expedited provider for long term care and maternal and child health providers to ensure that the providers continue to meet the eligibility requirements. Additionally, expedited provider lists from Mt. Sinai and the University of Illinois at Chicago hospitals were not updated regularly by HFS.

HFS uses another poorly defined process to expedite payments to certain providers. These payments, referred to as "one-time drop" payments, are made to providers who, according to HFS officials, need a one-time infusion of cash (such as having difficulty in making payroll or making quarterly tax payments). If a provider's request is granted, HFS authorizes the payment of any outstanding claims.

Management controls over the one-time drop payment process are deficient. **There are no criteria and/or basis for these one-time drop payments included in the expedited payment section of the Administrative Rule (89 Ill. Adm. Code 140.71(b)) or in HFS' policies or procedures.** No policies or procedures exist to delineate the process for providers requesting or HFS' review and approval of the need for a one-time drop payment. **HFS does not require providers to submit a written request documenting their need or keep a log of one-time drop payment requests.** According to HFS officials, these providers usually contact HFS by phone and declare their emergency need to be paid.

During testing, auditors found that generally the only documentation to support one-time drop payments were the e-mails between HFS employees changing the payment parameters for these providers and an internal HFS spreadsheet which tracked the one-time drop payment requests. **There was no log or consistent documentation showing who outside HFS requested the payment or whether HFS determined that an emergency need existed.**

Auditors compared the one-time drop spreadsheet and e-mails and found neither was complete. HFS subsequently provided e-mails for all the one-time drops on the spreadsheet. However, the HFS official noted that the spreadsheet was not an "official" or all-inclusive list because other HFS staff may make requests for one-time drop payments for providers that may not be reflected on the spreadsheet. There were 178 one-time drop payments listed on the FY07 spreadsheet, totaling **$5.7 million**. These payments were made to 135 providers. Thirty-seven of the providers had 2 or 3 one-time drop payments in FY07. Also, there were e-mails with the names for at least 40 one-time drop providers that did not appear on the spreadsheet.

During FY06, expedited providers were paid an average of 47 days from the date the claim was received. Non-expedited providers were paid an average of 77 days from the date their claims were received. The majority (54 days) of the delay occurred after the claim was approved for payment and was being held by HFS before being sent to the Comptroller for payment.

However, if a provider's claim was **rejected** by HFS and then was subsequently paid, the provider experienced additional delays in getting paid. HFS is not notifying providers "as soon as possible" of its decision to deny claims as required by Administrative Rule (74 Ill. Adm. Code 900.70(c)). From our sample of 384 rejected services in calendar year 2006, we found that for non-expedited providers it took HFS an average of **87 days to notify providers** of a rejected service when the rejected service was submitted on a claim along with a service that was paid. Additionally, we found that in FY06, it took an average of **77 days** for non-expedited claims to be approved and paid. In this scenario, on average it would have taken **164 days** for a claim to be rejected by HFS and to be processed and paid once corrected by the provider. The 164 days does not include days taken by the provider to originally submit the claim or days needed by the provider to resubmit the rejected services. HFS was generally timely in notifying providers if the entire claim was rejected (an average of 12 days in calendar year 2006).

Additionally, when HFS notified providers of their rejected claims during calendar year 2006, providers may have experienced difficulty correcting the rejected services because some error codes reported to the providers were not on HFS' list of error codes found in the provider handbook. **We identified 123 error codes HFS used for rejected services that were reported to providers in 2006 that were not on the list of error codes found in HFS' provider handbook.** These error codes are used by providers to determine why a service was rejected so they can make the appropriate corrections in order to resubmit the rejected services within the required 12 month period.

Even though HFS did not pay all claims or notify all providers of rejected claims within 60 days, HFS instructs providers to resubmit a claim if the claim has not appeared on a remittance advice after 60 days from mailing the claim to HFS. As a result, providers may unnecessarily resubmit duplicate claims to HFS. During FY06, HFS paid 46.1 million claims after 60 days.

As directed by Legislative Audit Commission Resolution 137, we surveyed Medicaid providers asking them to identify problems they may have encountered with the claims rejection process. The survey specifically asked providers how often they understood the reason(s) why

the bill was rejected and whether or not they agreed with the decision to reject the claim. The majority of the providers (71%) responded that they usually or always understood the reason the claim was rejected. Fifteen percent responded that they rarely or never understood the reason.

Additionally, the majority of the providers (78%) responded that they sometimes, usually, or always agreed with the reason the claim was rejected. Twenty-two percent of the providers responded that they rarely or never agreed.

Sixty-seven percent of the providers responded that they had experienced a problem with the claims rejection process. Specific problems identified by providers included: HFS taking too long to deny claims; confusion why a claim was rejected; denial of clients after they had been approved; and denial for refilling a prescription too soon.

Since July 1999, HFS' handling of prompt payment interest has not been in compliance with the Prompt Payment Act or the Administrative Rule that governs the payment of prompt payment interest. Prompt payment compliance issues identified were:

- **HFS is not paying interest to providers in a "reasonable time" as required by 74 Ill. Adm. Code 900.90.** Since July 23, 1999, the Prompt Payment Act required HFS to **automatically** pay interest to Medicaid providers when interest penalties amount to $50 or greater. However, HFS did not have a system in place to pay automatically owed interest to providers until May 2007 – almost **eight years** after the inclusion of Medicaid claims in the Prompt Payment Act. Additionally, for interest amounts owed of at least $5 but less than $50 (which the Prompt Payment Act requires must be **requested** by the provider), it took HFS an average of **452 days** to pay providers requested interest in FY06.

- **HFS is excluding certain claims from interest payments, some of which are not supported by Administrative Rule.** In May 2007, after our audit began, HFS established an Exclusion Policy which lists several reasons why HFS will not pay accrued prompt payment interest to a provider. Some of the exclusions are supported by Administrative Rule; others, however, are not. Furthermore, HFS **retroactively** applied this Exclusion Policy to interest owed dating back to FY00.

- **HFS is not notifying providers within 60 days that an interest request has been denied, as required by**

Administrative Rule. If HFS approves part, but not all of the interest request, the provider is not notified of the denied part until the payment for the approved portion of the interest request is received. As noted above, in FY06 HFS took an average of 452 days to pay providers interest after it was initially requested.

HFS has no written policies, procedures, or guidelines that document how decisions are made that determine which providers are paid and when the payments are made. HFS does not have an adequate process in place to verify and calculate prompt payment interest. The process used by HFS to verify and calculate requested interest owed to Medicaid providers is not automated; it consists of a set of undocumented procedures applied by two individuals at HFS.

Between July 1999 and November 2007, approximately 3.3 million claims accrued a potential liability of almost **$81 million** in interest pursuant to the Prompt Payment Act. Claims with interest totaling at least $5 but less than $50 accrued a potential liability of $44.5 million while claims with interest totaling $50 or greater accrued a potential liability of $36.1 million. As of November 2007, HFS had paid a total of **$21.8 million** in prompt payment interest to providers for late payment of claims. The **$21.8 million** in payments fell into the following categories:

- **Interest totaling at least $5 but less than $50.** The Prompt Payment Act requires that providers must request this interest before it is paid (requested interest). Approximately 3.1 million claims had accrued a potential liability of **$44.5 million** in requested interest; however, **$35.7 million** has not been requested by providers. As of November 2007, providers had requested interest penalty payments totaling $8.8 million, of which HFS had paid only $3.6 million.

- **Interest totaling $50 or greater.** The Prompt Payment Act requires that interest totaling $50 or greater be paid automatically to providers (automatic interest). Approximately 273,000 claims have accrued a potential liability of **$36.1 million** in automatic interest since fiscal year 2000. As of November 2007, HFS had paid providers $16.6 million in automatic interest. Through the use of its newly adopted Exclusion Policy, HFS excluded $11.5 million of the $36.1 million in accrued potential interest liability.

- **Court of Claims interest.** Through rulings by the Court of Claims, long term care providers have been paid $1.6 million

in prompt payment interest as a result of late payment of claims made by HFS.

HFS requires providers to follow a cumbersome process to request interest, including requiring them to submit information not required by Administrative Rule. For example, when requesting interest, HFS requires the providers to calculate how much interest is owed to them. This can be very time intensive for providers to complete and is not relied upon by HFS. HFS does its own calculation once an interest request is received. In addition, HFS requires providers to include the warrant date on their request. The warrant date is not readily available to the providers and is of questionable need to HFS. It is also not correctly defined in HFS' Medical Interest Payment Instructions used by providers to request interest.

The methodology used by HFS to calculate prompt payment interest has been challenged by a group of long term care facilities through the Court of Claims. The claimants' position is that the method of calculating interest in the Administrative Rule is inconsistent with the method of calculation prescribed by the Prompt Payment Act. The Administrative Rule states that, "Interest is calculated at the rate of 1% per month. This results in **a daily interest factor** of .00033 (01/30)" (emphasis added). The Act states that, "An interest penalty of 1.0% of any amount approved and unpaid shall be added for **each month or fraction thereof** after the end of this 60 day period, until final payment is made" (emphasis added).

In May 2007, the Court of Claims ruled in favor of the claimants that a per month calculation should be used. For example, for a claim that accrued interest for 6 days, the Administrative Rule would require 6 x .00033 or 0.198% interest be paid. The Court's interpretation of the Act is that a full 1 percent interest must be paid for the 6 days. As a result, HFS paid these long term care facilities interest totaling $1.6 million as opposed to $1.1 million it would have paid following the interest calculation method prescribed by the Administrative Rule.

We surveyed other Midwestern states to determine whether their prompt payment laws cover payments for Medicaid claims. We contacted Iowa, Ohio, Wisconsin, Indiana, Michigan, and Missouri. Of the six states contacted, only Indiana, Missouri, and Ohio have prompt payment laws that include Medicaid. Michigan, Iowa, and Wisconsin do not pay interest on Medicaid claims. Wisconsin has guidelines related to timeliness of Medicaid payments, but there are no penalties if the timelines are not met.

We found that Illinois law allows more days to process its Medicaid claims before interest accrues than other states that were

surveyed. Illinois also pays a higher annual interest rate for claims that are not paid timely. In FY06, Illinois paid $9.6 million in prompt payment penalty interest while Missouri paid $0. Indiana reported that during calendar year 2007, less than $5,000 in interest was paid. Ohio did not report its interest paid in FY06. Illinois requires providers to submit a written request for payment of interest if the interest is $5 but less than $50. The other states pay all interest penalties automatically.

BACKGROUND

Legislative Audit Commission (LAC) Resolution Number 136 directed the Office of the Auditor General (OAG) to conduct a performance audit on the Medicaid Program and the Group Health Insurance Program at the Department of Healthcare and Family Services (HFS) for compliance with the mandates of the Prompt Payment Act. LAC Resolution Number 137 directed the OAG to conduct a management audit of HFS' process for receipt, approval, denial, and payment of vendor bills for services provided in the Medicaid program. This audit report addresses both LAC Resolutions. (page 7)

MEDICAL PROGRAM FUNDING

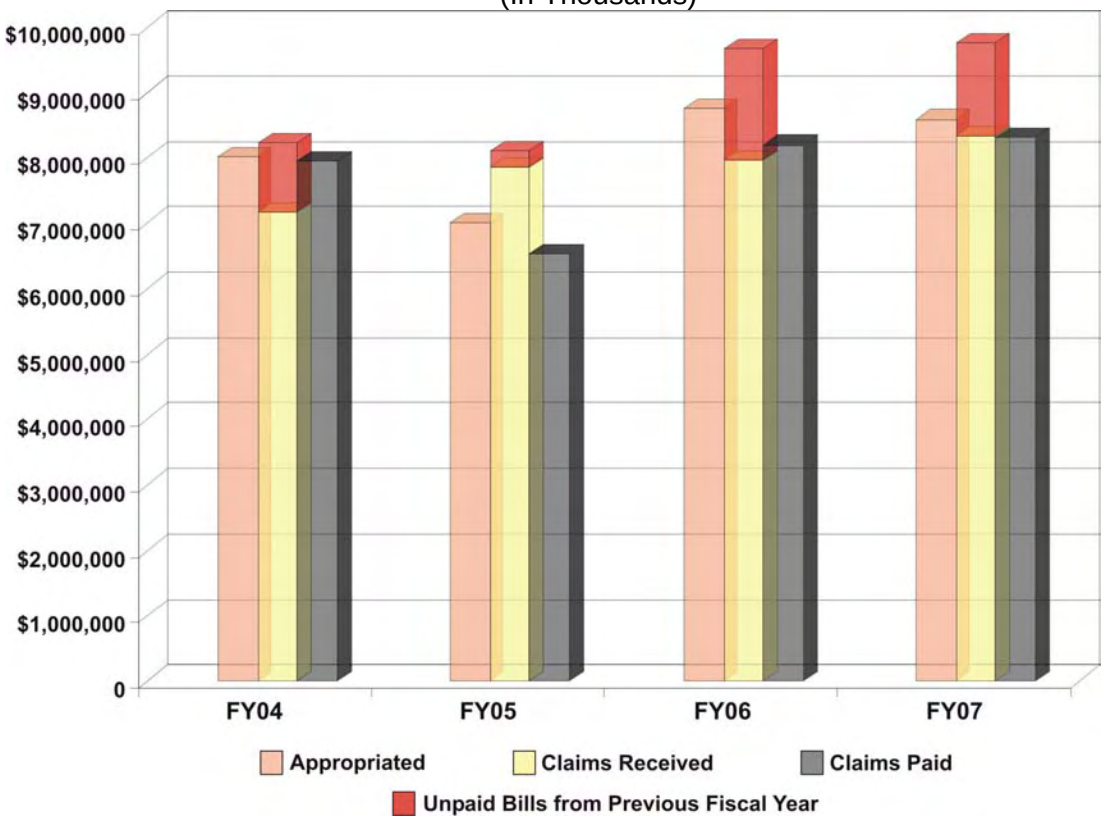
Over the last several fiscal years, HFS has not paid Medicaid claims timely as required by the Prompt Payment Act due to the lack of State funds to pay Medicaid claims. The Illinois State Finance Act (30 ILCS 105/25(b)) allows the Department of Healthcare and Family Services to make medical payments from appropriations for any fiscal year, without regard to the fact that the medical or child care services may have been provided in a prior fiscal year. This provision of the State Finance Act has allowed HFS to carry unpaid bills averaging $1.5 billion from FY05, FY06, and FY07 into the next fiscal year. Digest Exhibit 1 shows that the claims received in each of the past four fiscal years, when added to the unpaid bills carried over from the prior year have exceeded the funds available to timely pay medical providers. (pages 8-10)

Digest Exhibit 1

SUMMARY OF MEDICAL PROGRAM APPROPRIATIONS AND CLAIMS

Fiscal Years 2004 - 2007

(In Thousands)



Note: Summary does not include appropriation and claim information for the University of Illinois at Chicago and Cook County hospitals.

Source: Medical Program claim and appropriation data provided by HFS. According to HFS, figures provided for hospital assessment appropriation "reflects only those amounts used for routine hospital bills, not appropriation planned for hospital assessment payments." Pursuant to 305 ILCS 5/5A-7(a)(4), hospital access improvement payments are not subject to prompt payment interest.

PAYMENT SCHEDULE

As a result of its payment schedule used to regulate payments, in most instances HFS does not submit approved claims immediately to the Comptroller for payment. Claims submitted to HFS have accrued a potential liability of almost **$81 million** in Prompt Payment Act interest since FY00, due to the delays in payment.

Payments are added to the payment schedule by HFS based on payment parameters for each provider type. The payment parameter is the number of days a Medicaid claim will be held by HFS before it is put on a payment schedule and submitted to the Comptroller for payment. According to HFS officials, HFS uses the payment schedule to regulate

payments throughout the year to ensure there is enough appropriation at the end of the fiscal year to continue to make weekly payments to the "expedited" providers, physicians, All Kids, and monthly Medicare premium payments. Expedited providers are those providers that are paid on an accelerated payment schedule as discussed below.

HFS could not provide any documentation to support how the payment schedule and payment parameters are established. However, according to HFS officials, payment parameters are established based on the appropriation amount available for that provider type when compared to the predicted liability for that provider type. As an example, based on payment parameters provided by HFS, from September 1, 2006 until April 20, 2007, claims submitted by home health care providers were held at HFS for 118 days from receipt date (DCN date) before being eligible for payment.

Providers are generally paid pursuant to one of two payment schedules. The first is the regular payment schedule used to pay "non-expedited" providers (providers not paid on an accelerated payment schedule). The second is an accelerated schedule used to pay "expedited" providers. Pursuant to the Administrative Rule (89 Ill. Adm. Code 140.71(b)), expedited payments may be issued only under extraordinary circumstances, in which withholding of the expedited payment would impose severe and irreparable harm to the clients served. The difference between the two designations is expedited providers are given a higher priority and are paid weekly, while non-expedited providers are put on the regular payment schedule and, as a result, are not paid as timely. (pages 22-25)

EXPEDITED PROVIDERS

HFS does not have any written policies, procedures, or guidelines that delineate what a provider must submit to receive expedited payments.

HFS does not have any written policies, procedures, or guidelines that delineate what documentation a provider must submit to HFS to receive expedited payments. Additionally, HFS has no policies or procedures that delineate the review process used to determine whether a provider initially meets, and continues to meet, the eligibility requirements of the Administrative Rule. HFS also lacks a comprehensive policy as to whether a provider needs to enter into an agreement with HFS to receive expedited payments.

From the 2,058 providers that were expedited as of October 18, 2007, we randomly sampled 66 providers. HFS had current signed agreements with 24 of the 66 providers sampled. The following issues were identified:

- **Lack of documentation to substantiate the emergency nature of the request.** For the 24 providers sampled that had current signed agreements, 19 did not have documentation from the providers for HFS to verify that the providers met the Administrative Rule's requirements to substantiate the emergency nature of the request. The only documentation was a letter from the providers attesting that they met the eligibility requirements;

- **Lack of documentation of the number of Medicaid clients served.** For 22 of the 24 providers sampled that had current signed agreements, there was no documentation to support that the provider met the significance requirements related to the number of Medicaid clients served as required by the Administrative Rule; and

- **Outdated agreements and provider lists.** HFS does not have an annual application process to be an expedited provider for long term care and maternal and child health providers to ensure that the providers continue to meet the eligibility requirements. Additionally, expedited provider lists from Mt. Sinai and the University of Illinois at Chicago hospitals were not updated regularly by HFS. (pages 25-31)

ONE-TIME DROP PAYMENTS

HFS uses another poorly defined process to expedite payments to certain providers. These payments, referred to as "one-time drop" payments, are made to providers who, according to HFS officials, need a one-time infusion of cash (such as having difficulty in making payroll or making quarterly tax payments).

Management controls over the one-time drop payment process are deficient. There are no criteria and/or basis for these one-time drop payments included in the expedited payment section of the Administrative Rule (89 Ill. Adm. Code 140.71(b)) or in HFS' policies or procedures. No policies or procedures exist to delineate the process for providers requesting or HFS' review and approval of the need for a one-time drop payment. HFS does not require providers to submit a written request documenting their need or keep a log of one-time drop payment requests. According to HFS officials, these providers usually contact HFS by phone and declare their emergency need to be paid.

There are no criteria and/or basis for one-time drop payments in the Administrative Rule or in HFS' policies or procedures.

During testing, auditors found that generally the only documentation to support one-time drop payments were e-mails between HFS employees and an internal HFS spreadsheet. There was no log or

consistent documentation showing who outside HFS requested the payment or whether HFS determined that an emergency need existed.

Auditors compared the one-time drop spreadsheet and e-mails and found neither was complete. HFS subsequently provided e-mails for all the one-time drops on the spreadsheet. However, the HFS official noted that the spreadsheet was not an "official" or all-inclusive list because other HFS staff may make requests for one-time drop payments for providers that may not be reflected on the spreadsheet. There were 178 one-time drop payments listed on the FY07 spreadsheet, totaling **$5.7 million**. These payments were made to 135 providers. Thirty-seven of the providers had 2 or 3 one-time drop payments in FY07. Also, there were e-mails with the names for at least 40 one-time drop providers that did not appear on the spreadsheet. (pages 32-33)

DELAYS IN MEDICAID PAYMENTS

In FY06, it took HFS on average 6 days to process claims and 57 days to submit claims to the Comptroller for payment.

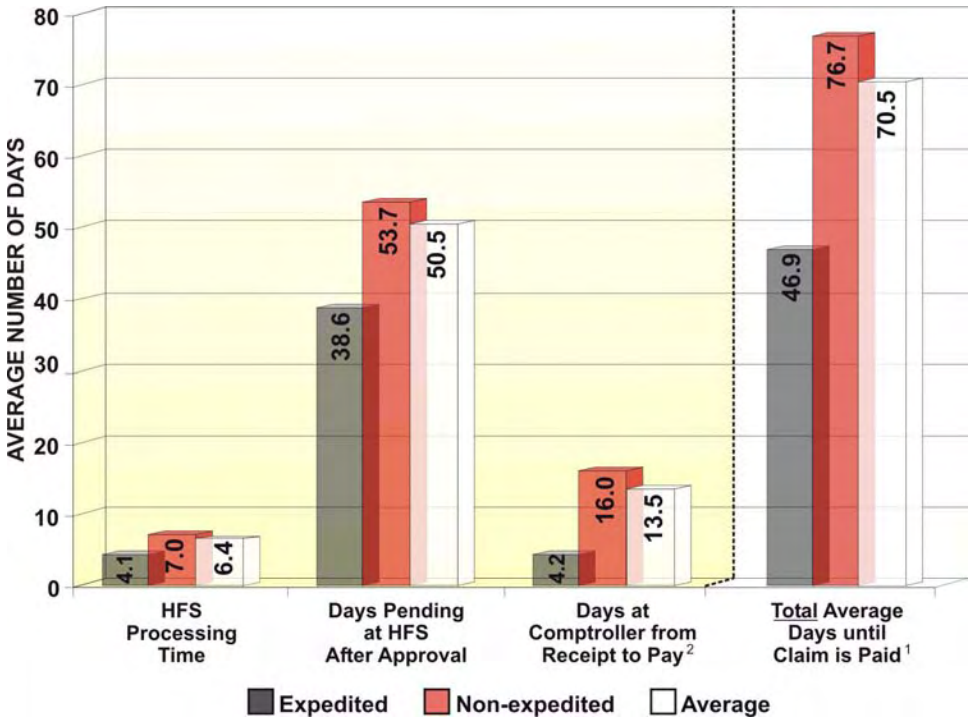
The primary delay in paying Medicaid claims occurs due to the payment schedules established by HFS. To determine exactly where delays in claim processing and payment occur, we looked at data for all claims paid during FY06. As seen in Digest Exhibit 2, it took HFS an average of **6 days** to process claims; however, it took HFS an average of **57 days** to submit claims to the Comptroller for payment. All together, it took a total of 71 days on average for claims to be processed by HFS and paid by the Comptroller.

During FY06, expedited providers were paid an average of 47 days from the date the claim was received. Non-expedited providers were paid an average of 77 days from the date their claims were received. The majority (54 days) of the delay occurred after the claim was approved for payment and was being held by HFS before being sent to the Comptroller for payment. (pages 34-37)

Digest Exhibit 2

AVERAGE DAYS FOR ALL FY06 CLAIMS TO BE PROCESSED AND PAID

By each stage in the life of the claim



Notes:

[1] Totals may not add due to rounding.

[2] Calculated from HFS voucher date to Comptroller warrant date. HFS officials stated that it could take one or two days from the date the claim was vouchered at HFS until it is received by the Comptroller.

Source: Illinois Department of Healthcare and Family Services all FY06 paid claims.

REJECTED CLAIM PROCESS

HFS is not notifying providers "as soon as possible" of its decision to reject claims as required by Administrative Rule (74 Ill. Adm. Code 900.70(c)). We found that HFS was not notifying providers timely in instances where a claim contained at least one rejected service and at least one paid service.

In CY06, it took HFS an average of 87 days to notify non-expedited providers of a rejected service when the rejected service was submitted on a claim along with a service that was paid.

From our sample of 384 rejected services from calendar year 2006, we found that for non-expedited providers it took HFS an average of **87 days** from the date of receipt to notify providers of a rejected service when the rejected service was submitted on a claim along with a service that was paid. Additionally, we found that in FY06, it took an average of **77 days** for non-expedited claims to be approved and paid. In this scenario, on average it would have taken **164 days** for a claim to be rejected by HFS and to be processed and paid once corrected by the provider. The 164 days does not include days taken by the provider to originally submit the claim or days needed by the provider to resubmit the rejected claim. HFS was generally timely in notifying providers if the entire claim was rejected (an average of 12 days in calendar year 2006).

Adequate Reporting of Rejected Claims to Providers

In 2006, HFS used 123 error codes to notify providers of rejected services that were not on the list of error codes found in HFS' provider handbook.

We determined that HFS rejected services for reasons that were **not** listed in the error codes found in the provider handbook. We compared the error codes that HFS used to notify providers during calendar year 2006 with the list of error codes published in the provider handbook found on HFS' website. We identified 123 error codes HFS used for rejected services that were not on the list of error codes found in HFS' provider handbook. These error codes are used by providers to determine why a service was rejected so they can make the appropriate corrections in order to resubmit the rejected services within the required 12 month period.

Resubmitting of Medicaid Claims

HFS' provider handbook instructs providers to resubmit a claim if the claim has not appeared on a remittance advice after 60 days from the date the provider mailed the claim to HFS. We determined that the average time it takes HFS to notify providers of rejected services when billed with a paid service was **87 days**, which is longer than the 60 days. Additionally, we determined that in FY06, 46.1 million of the 94.8 million paid claims (49%) were not paid by HFS within 60 days.

As a result, if the providers followed the instructions found in the handbook, the providers would unnecessarily be submitting numerous duplicate bills to HFS.

Survey of Providers

As directed by Legislative Audit Commission Resolution 137, we surveyed 315 Medicaid providers asking them to identify problems they may have encountered with the claims rejection process. The survey specifically asked providers how often they understood the reason(s) why the bill was rejected and whether or not they agreed with the decision to

reject the claim. The majority of the providers (71%) responded that they usually or always understood the reason the claim was rejected. Fifteen percent responded that they rarely or never understood the reason.

Additionally, the majority of the providers (78%) responded that they sometimes, usually, or always agreed with the reason the claim was rejected. Twenty-two percent of the providers responded that they rarely or never agreed.

Our survey also asked whether providers had encountered any problems with HFS' claims rejection process. Forty-five of 67 (67%) responded that they had experienced a problem with the claims rejection process. Specific problems identified by providers included: HFS taking too long to deny claims; confusion why a claim was rejected; denial of clients after they had been approved; and denial for refilling a prescription too soon. (pages 40-46)

Forty-five of 67 (67%) providers responded that they had experienced a problem with the claims rejection process.

HFS INTEREST CALCULATION PROCESS

Since July 1999, HFS' handling of prompt payment interest has not been in compliance with the Prompt Payment Act or the Administrative Rule that governs the payment of prompt payment interest. HFS does not have an adequate process in place to calculate and pay prompt payment interest. HFS uses a set of undocumented procedures to calculate and pay prompt payment interest owed to Medicaid providers. Additionally, the system used to calculate and pay prompt payment interest is not automated.

Interest Request Process

HFS requires providers to follow a cumbersome process to request interest. More specifically, HFS requires providers to submit requests for interest on a specified form that requires additional information not listed in the requirements found in the Administrative Rule. Based on meetings with HFS officials and analysis of HFS data, the **only** information needed by HFS to process interest penalties for providers is the document control number (DCN).

HFS requires providers to follow a cumbersome process to request interest, including requiring them to submit information not required by Administrative Rule.

One of the additional requirements placed on providers by HFS that is not required by the Administrative Rule is an estimation of the amount of interest owed. This can be very time intensive for providers to complete and is not relied upon by HFS. HFS does its own calculation once an interest request is received.

We tested 66 approved claims that were requested by providers for claims paid in FY06 and found that 34 of the 66 providers (52%) calculated the estimated amount of interest owed incorrectly.

Survey of Providers

We surveyed Medicaid providers and received 80 responses. Of the 77 that responded to this question, 51 (66%) answered that they did not know they could request interest penalty payments from HFS. Additionally, 48 of 79 (61%) responded they did not know if they were owed interest by HFS that they had not requested. Based on HFS interest data, we determined that claims for these 48 providers accrued $770,652 in requested interest for fiscal years 2000 through 2006. (pages 51-58)

REQUESTED INTEREST

The Prompt Payment Act requires that interest totaling at least $5 but less than $50 must be requested by the provider before it is paid. The process used by HFS to calculate and pay requested interest is not automated; it consists of a set of undocumented manual procedures applied by two individuals at HFS.

As seen in Digest Exhibit 3, approximately 3.1 million claims had accrued a potential liability of **$44.5 million** in requested interest; however, **$35.7 million** has not been requested by providers. As of November 2007, providers had requested interest penalty payments totaling $8.8 million, of which HFS had paid only $3.6 million.

Denied Interest Requests

HFS does not have a process in place to timely notify providers that their interest request will not be paid as required by Administrative Rule (74 Ill. Adm. Code 900.35). If HFS approves part, but not all of the interest request, the provider is not notified of the denied part until the payment for the approved portion of the interest request is received. In FY06, HFS took an average of **452 days** to pay providers interest after it was initially requested. On average, requests for interest were not paid within 60 days, and therefore, the providers were not being notified in 60 days of the denial as required by Administrative Rule. (pages 52, 53, 59, 60, 72)

Digest Exhibit 3
INTEREST ACCRUED, REQUESTED, AND PAID FOR CLAIMS WITH INTEREST ACCRUING TO $5 BUT LESS THAN $50
As of November 2007

Fiscal Year	Number of Eligible Claims	Potential Interest Amount [1]	Number of Interest Requests	Amount Requested	Number of Claims Paid	Total Interest Paid
2000	1,687	$24,367	0	0	0	$0
2001	4,025	$57,514	0	0	0	$0
2002	25,566	$314,340	240	$3,758	232	$3,592
As of July 2002, the number of days before interest accrues decreased from 90 to 60						
2003	643,888	$8,871,373	213,355 [2]	$2,758,992 [2]	209,697	$2,738,102
2004	315,783	$3,749,670	62,373 [2]	$599,879 [2]	62,302	$603,956
2005	279,864	$3,573,716	5,999	$139,844	4,225	$109,801
2006	1,039,550	$15,377,147	79,745	$2,764,104	3,614	$135,400
2007 [3]	762,237	$12,548,526	76,145	$2,548,176	0	$0
Totals	**3,072,600**	**$44,516,653**	**437,857**	**$8,814,753**	**280,070**	**$3,590,851**

Notes:

[1] The Potential Interest Amount is the potential interest liability before HFS applies its exclusions.

[2] In FY03 and FY04, a total of 242,261 interest requests were received from pharmacies totaling $2,344,818, which included some interest claims greater than $50.

[3] Since providers have one year from the date of service to submit claims, FY07 eligible claim and interest paid data is as of November 2007 and interest request data is as of September 2007.

Source: FY00 - FY07 interest data provided by HFS.

AUTOMATIC INTEREST

HFS is not paying interest to providers in a "reasonable time" as required by 74 Ill. Adm. Code 900.90. Since July 23, 1999, the Prompt Payment Act required HFS to automatically pay interest to Medicaid providers when interest penalties amount to $50 or greater. However, HFS did not have a system in place to pay automatically owed interest to providers until May 2007 – almost **eight years** after the inclusion of Medicaid claims in the Prompt Payment Act.

HFS did not have a system in place to pay automatically owed interest to providers until May 2007 – almost eight years after the inclusion of Medicaid claims in the Prompt Payment Act.

Digest Exhibit 4 shows approximately 273,000 claims have accrued a potential liability of **$36.1 million** in automatic interest since fiscal year 2000. As of November 2007, HFS had paid providers $16.6 million in automatic interest. Through the use of its newly adopted Exclusion Policy, HFS excluded $11.5 million of the $36.1 million in accrued potential interest liability.

Digest Exhibit 4

AUTOMATIC INTEREST ACCRUED, NOT PAID, AND PAID FOR CLAIMS WITH INTEREST ACCRUING TO $50 OR GREATER

As of November 2007

Fiscal Year	Before Exclusions			After Exclusions			
	Claims Received	Dollar Amount of Claims	Potential Interest Amount	Number Not Paid	Amount Not Paid	Claims Paid	Amount Paid [1]
2000	181	$1,499,422	$23,766	150	$21,232	31	$2,535
2001	520	$4,381,824	$71,380	439	$63,490	81	$7,891
2002	2,089	$53,476,435	$305,179	1,502	$221,089	587	$84,090
As of July 2002, the number of days before interest accrues decreased from 90 to 60							
2003	65,506	$406,714,913	$8,264,316	41,601	$5,027,178	23,905	$3,237,137
2004	22,181	$244,751,543	$3,087,243	11,099	$1,522,243	11,082	$1,565,000
2005	23,130	$231,621,984	$3,258,030	6,609	$1,023,889	16,521	$2,234,141
2006	101,355	$714,671,064	$13,103,646	28,457	$3,631,687	72,898	$9,471,960
2007 [2]	58,410	$639,325,990	$7,997,255	n/a	n/a	n/a	n/a
Totals [3]	**273,372**	**$2,296,443,175**	**$36,110,815**	**89,857**	**$11,510,808**	**125,105**	**$16,602,753**

Notes:

[1] All interest on these claims was paid in 2007.

[2] Since providers have one year from the date of service to submit claims, the FY07 data is not final. As of November 2007, HFS had not paid interest on FY07 claims.

[3] Totals may not add due to rounding.

Source: FY00 - FY07 interest data provided by HFS.

There are no internal controls or management reviews over the calculation of automatic interest owed to providers. The process used by HFS to verify and calculate automatic interest owed to Medicaid providers is not an automated system; it consists of a manual set of undocumented procedures applied by one individual at HFS. Consequently, if this individual were to make an error in approving or denying interest, it would likely go undetected. In addition, the interest database used by HFS is not password protected or encrypted to ensure the security of sensitive Medicaid claim information.

HFS is excluding certain claims from interest payments, some of which are not supported by Administrative Rule. In May 2007, after our audit began, HFS established an Exclusion Policy which lists 11 reasons why HFS will not pay accrued prompt payment interest to a provider. Some of the exclusions are supported by Administrative Rule; others, however, are not. Furthermore, HFS retroactively applied this Exclusion Policy to interest owed dating back to FY00. (pages 60-70)

TIMELY PAYMENT OF PROMPT PAYMENT INTEREST

The Department of Healthcare and Family Services is not paying interest to providers in a reasonable time as required by 74 Ill. Adm. Code 900.90. The only mandate found in statute or Administrative Rule relating to the timeframe for paying prompt payment interest is that agencies are to pay interest in a "reasonable time." The Administrative Rule does provide a specific time requirement for providers to submit a request for the interest. Providers should request interest within 90 days after the date of payment of the original claim.

Automatic Interest Payment Timeliness

HFS did not begin paying automatic interest penalties to providers until May 2007. As a result, after claims were excluded by HFS, $16,602,753 in automatic interest penalties accrued during fiscal years 2000 through 2006. This interest was not paid until May, August, September, and October 2007. Digest Exhibit 5 shows the month HFS paid the automatic interest for the original claim, by the year the original claim was paid.

Digest Exhibit 5
MONTH AND YEAR AUTOMATIC INTEREST WAS PAID SINCE MEDICAID CLAIMS WERE INCLUDED IN THE PROMPT PAYMENT ACT
By the fiscal year the original claim was paid by HFS

Fiscal Year Original Claim Paid	Month and Year Interest Paid by HFS					
	Between July 1999 and May 2007	May 2007	August 2007	September 2007	October 2007	Total Interest Paid
2000	$0	$65	$1,467	$1,003	$0	$2,535
2001	$0	$2,862	$2,868	$2,161	$0	$7,891
2002	$0	$758	$8,621	$74,711	$0	$84,090
2003	$0	$165,920	$878,604	$2,192,613	$0	$3,237,137
2004	$0	$23,280	$343,550	$1,198,170	$0	$1,565,000
2005	$0	$151,494	$493,077	$1,589,569	$0	$2,234,141
2006	$0	$0	$0	$0	$9,471,960	$9,471,960
2007 [1]	$0	$0	$0	$0	$0	$0
Totals [2]	**$0**	**$344,378**	**$1,728,188**	**$5,058,228**	**$9,471,960**	**$16,602,753**

Notes:
[1] Since providers have one year from the date of service to submit claims, the FY07 data is not final.
[2] Totals may not add due to rounding.

Source: FY00 - FY07 interest data provided by HFS, as of November 2007.

Requested Interest Payment Timeliness

HFS is not paying requests for interest payments by providers in a "reasonable time" as required by 74 Ill. Adm. Code 900.90. Although HFS has had a process in place to pay requested interest, it has not been paid in a reasonable time. In FY06, it took HFS an average of 452 days to pay providers their requested interest. The average number of days was calculated from the date the request was received by HFS to the date the warrant was issued by the Comptroller.

HFS has no written policies, procedures, or guidelines that document how decisions are made that determine which providers are paid and when the payments are made. The interest payment process is not automated. HFS staff noted that the manual process is very time-consuming. HFS does not have a process in place to systematically pay interest to providers. When auditors interviewed HFS staff on August 14, 2007, there was $472,000 in requested interest payments ready to be paid since May 2007, which had not yet been paid. (pages 71-72)

STATE PROMPT PAYMENT REQUIREMENTS

The State Prompt Payment Act (30 ILCS 540) (Act) and its related Administrative Rule (74 Ill. Adm. Code 900) require the payment of interest to vendors that provide goods or services to the State of Illinois in instances in which the State is late in the payment of a vendor's bill or invoice.

The Court of Claims has found that the Administrative Rule is inconsistent with the method of calculation prescribed by the Prompt Payment Act.

HFS uses the interest calculation methodology found in Administrative Rule. The calculation methodology prescribed in Administrative Rule has been challenged by a group of long term care facilities through the Court of Claims. The claimants' position is that the method of calculating interest in the Administrative Rule is inconsistent with the method of calculation prescribed by the Prompt Payment Act. The Administrative Rule states that, "Interest is calculated at the rate of 1% per month. This results in **a daily interest factor** of .00033 (01/30)" (emphasis added). The Act states that, "An interest penalty of 1.0% of any amount approved and unpaid shall be added for **each month or fraction thereof** after the end of this 60 day period, until final payment is made" (emphasis added).

In May 2007, the Court of Claims ruled in favor of the claimants that a per month calculation should be used. Digest Exhibit 6 compares the difference between the Act and the Administrative Rule. (pages 11-14)

Digest Exhibit 6
DIFFERENCE BETWEEN PROMPT PAYMENT ACT AND ITS ADMINISTRATIVE RULE RELATED TO THE CALCULATION OF INTEREST

Prompt Payment Act (30 ILCS 540/3-2)	**Administrative Rule (74 Ill. Adm. Code 900.100(a))**
An interest penalty of 1.0% of any amount approved and unpaid shall be added for **each month or fraction thereof** after the end of this 60 day period, until final payment is made (emphasis added).	Interest is calculated at the rate of 1% per month. This results in **a daily interest factor** of .00033 (01/30) (emphasis added).
Example Calculation: A $347,982.56 claim that accrued interest for 6 days.	
Calculation based on the Court of Claims interpretation of the Prompt Payment Act $347,982.56 x 1% = **$3,479.83** in owed interest	**Calculation based on Administrative Rule** $347,982.56 x 0.198% (6 days x .00033) = **$689.01** in owed interest
Source: 30 ILCS 540/3-2 and 74 Ill. Adm. Code 900.100(a).	

STATE EMPLOYEES GROUP HEALTH INSURANCE PROGRAM

The Group Health Insurance plans provide health insurance coverage to State employees. Depending on the plan, providers may be eligible for interest under the Prompt Payment Act or the Illinois Insurance Code. According to HFS officials, there has been no interest pursuant to the Prompt Payment Act accrued or paid to vendors by HFS for State Group Health Insurance. According to information provided by HFS officials, HFS paid $2.3 million in interest and $382,814 in interest to two vendors pursuant to the Illinois Insurance Code (215 ILCS 5/368a) in FY06.

HFS was not able to provide a complete list of providers that received the $2.3 million in interest paid. HFS officials provided a list of $3.0 million in interest paid by the vendor to providers (which included the $2.3 million paid by HFS to the vendor) but stated that the vendor was not able to break out the providers paid under the State's responsibility and the providers paid under the vendor's responsibility. As a result, HFS does not know who was paid the $2.3 million in State interest through the vendor and has no way to verify that the correct amount was paid. (pages 14-16)

RECOMMENDATIONS

The audit report contains 13 recommendations. Twelve recommendations were specifically for the Department of Healthcare and Family Services. One recommendation was directed to the Department of Healthcare and Family Services, the Office of the Comptroller, and the Department of Central Management Services. While the Department of Healthcare and Family Services' response noted that many of the recommendations will be implemented, the response did disagree in a few instances. The Office of the Comptroller and the Department of Central Management Services agreed with their recommendation. Appendix F to the audit report contains the agency responses.

WILLIAM G. HOLLAND
Auditor General

WGH\SAW

May 2008

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EXHIBITS	TITLE	PAGE

GLOSSARY OF TERMS

Adjustment – a change made by a provider or by the Department of Healthcare and Family Services (HFS) to a paid claim. Providers are allowed up to 12 months from the date of payment to submit changes to the previously billed services.

Automatic Interest – prompt payment interest amounting to $50 or more need not be requested by a provider, pursuant to the Prompt Payment Act. Agencies are responsible for calculating and paying such interest and are to do so within a reasonable time.

Bill – the vendor's standard bill or invoice for goods or services.

Court of Claims – has jurisdiction over claims against the State founded upon any State law or regulation other than Workmen's Compensation claims.

Data Warehouse – an electronic database of claims history documentation at HFS. The data warehouse is linked to the Medicaid Management Information System (MMIS) at HFS.

Document Control Number (DCN) – assigned to a bill that is received by HFS. The DCN provides the date a bill or invoice was presented to the agency.

Exclusion Policy – created by HFS in May 2007. The policy includes the general logic for 11 exclusions used by HFS to exclude certain claims from the payment of prompt payment interest.

Expedited Provider – a provider that receives accelerated claim payments per 89 Ill. Adm. Code 140.71(b). These payments are to be issued only under extraordinary circumstances to qualified providers of medical assistance.

Handbook for Providers of Medical Services – prepared for the information and guidance of providers who participate in the Illinois Medical Assistance Program. The handbook enables providers to know which services provided to eligible participants are covered, how to submit proper bills for services rendered, and where to make inquiries to the proper source when it is necessary to obtain clarification and interpretation of department policy and coverage.

HFS – The Illinois Department of Healthcare and Family Services; formerly known as the Illinois Department of Public Aid.

Interest Penalty – interest owed by a State agency as a result of the State not issuing a payment to a payee within 60 days of receipt of a proper bill or invoice as required by the State Prompt Payment Act (30 ILCS 540/3-2).

Interest Request Results Report – a form mailed by HFS to the vendor after the Comptroller mails out the interest payment. The form outlines those DCNs that have been paid prompt

payment interest requested by the provider and those DCNs that have been denied interest and for what reason.

Medicaid – the State-administered program that covers a broad range of health care services for children, low-income families, the elderly, and disabled people. This program is administered by the Illinois Department of Healthcare and Family Services.

Medicaid Management Information System (MMIS) – the automated data processing system at HFS. The system is maintained by the Bureau of Information Services within HFS and the Department of Central Management Services.

Non-Expedited Providers – the general population of providers that are paid by HFS on a regular payment schedule.

One-Time Drop Payment – one-time influx of cash to a provider that makes a request for payment to HFS even though the provider may fail to qualify for expedited status.

Payment Parameter – is the number of days a Medicaid claim will be held by HFS before it is put on a payment schedule and submitted to the Comptroller for payment. According to HFS, payment parameters are established based on the appropriation amount available for the provider type when compared to the predicted liability for that provider type.

Payment Schedule – used by HFS to determine when certain types of claims are paid. The payment schedule is set by appropriation code and provider type. Once a claim meets its payment parameter, it is then vouchered and scheduled to be sent to the Comptroller for payment.

Pending – time period beginning after HFS has finished processing a claim and ending with the vouchering of the claim to the Comptroller for payment.

Prompt Payment Act (30 ILCS 540 *et seq.*) – State law that governs instances where interest is payable to a provider because a State official or agency was late in the payment of a vendor's bill or invoice for goods or services furnished to the State.

Prompt Payment Administrative Rules (74 Ill. Adm. Code 900 *et seq.*) – rules promulgated jointly by the State Comptroller and the Department of Central Management Services to govern the uniform application of the State Prompt Payment Act.

Proper Bill – a bill or invoice containing sufficient and correct information necessary to process the payment for a liability of a State agency as provided in the Administrative Rule (74 Ill. Adm. Code 900.20), Comptroller's Statewide Accounting Management System manual, or as otherwise specified by the State agency responsible for payment.

Remittance Advice – a hard copy paper notification from HFS sent to providers notifying them of the payment, reduction in payment, or denial of claims submitted.

Requested Interest – prompt payment interest amounting to $5 but less than $50 which must be requested by the provider, pursuant to the Prompt Payment Act. The provider must submit a written statement to the appropriate State agency specifically requesting the State agency to pay an interest penalty.

Safety Net Hospital – an inner city hospital with a high volume of Medicaid patients. Safety net hospitals are expedited at zero days.

Service Lines – individual services found on a bill. The number of services that can be billed on one bill by providers varies depending on the provider type and whether the bill is submitted electronically or in hard copy.

Voucher Date – the date a voucher was created requesting authorization for payment to a payee from the Comptroller.

Warrant Date – the date the payment is issued by the Comptroller's Office.

Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

Over the last several fiscal years, the Department of Healthcare and Family Services (HFS) has not paid Medicaid claims timely as required by the Prompt Payment Act due to the lack of State funds to pay Medicaid claims. The Illinois State Finance Act (30 ILCS 105/25(b)) allows HFS to make medical payments from appropriations for any fiscal year, without regard to the fact that the medical or child care services may have been provided in a prior fiscal year. This provision of the State Finance Act has allowed HFS to carry unpaid bills averaging $1.5 billion from FY05, FY06, and FY07 into the next fiscal year. **Claims received in each of the past four fiscal years, when added to the unpaid bills carried over from the prior year, have exceeded the funds available to timely pay medical providers.**

Due to the delays in payment, 3.3 million claims submitted to HFS accrued a potential liability of almost **$81 million** in Prompt Payment Act interest since FY00. Actual interest expected to be paid to providers is estimated by HFS to be less due to not all providers requesting eligible interest, as well as exclusions that may be applied to potential interest payments by HFS. As a result of its payment schedule used to regulate payments, in most instances HFS does not submit approved claims immediately to the Comptroller for payment. In FY06, it took HFS an average of **6 days to process claims**; however, it took HFS an average of **57 days to submit claims** to the Comptroller for payment. Payments are added to the payment schedule by HFS based on payment parameters for each provider type. The payment parameter is the number of days a Medicaid claim will be held by HFS before it is put on a payment schedule and submitted to the Comptroller for payment. According to HFS officials, HFS uses the payment schedule to regulate payments throughout the year to ensure there is enough appropriation at the end of the fiscal year to continue to make weekly payments to the "expedited" providers, physicians, All Kids, and monthly Medicare premium payments. Expedited providers are those providers that are paid on an accelerated payment schedule as discussed below.

HFS could not provide any documentation to support how the payment schedule and payment parameters are established. However, according to HFS officials, payment parameters are established based on the appropriation amount available for that provider type when compared to the predicted liability for that provider type. As an example, based on payment parameters provided by HFS, from September 1, 2006 until April 20, 2007, claims submitted by home health care providers were held at HFS for 118 days from receipt date (DCN date) before being eligible for payment.

Providers are generally paid pursuant to one of two payment schedules. The first is the regular payment schedule used to pay "non-expedited" providers (providers not paid on an

accelerated payment schedule). The second is an accelerated schedule used to pay "expedited" providers. Pursuant to the Administrative Rule (89 Ill. Adm. Code 140.71(b)), expedited payments may be issued only under extraordinary circumstances, in which withholding of the expedited payment would impose severe and irreparable harm to the clients served. The difference between the two designations is expedited providers are given a higher priority and are paid weekly, while non-expedited providers are put on the regular payment schedule and, as a result, are not paid as timely.

HFS does not have any written policies, procedures, or guidelines that delineate what documentation a provider must submit to HFS to receive expedited payments. Additionally, HFS has no policies or procedures that delineate the review process used to determine whether a provider initially meets, and continues to meet, the eligibility requirements of the Administrative Rule. HFS also lacks a comprehensive policy as to whether a provider needs to enter into an agreement with HFS to receive expedited payments.

From the 2,058 providers that were expedited as of October 18, 2007, we randomly sampled 66 providers. HFS had current signed agreements with 24 of the 66 providers sampled. The following issues were identified:

- **Lack of documentation to substantiate the emergency nature of the request.** For the 24 providers sampled that had current signed agreements, 19 did not have documentation from the providers for HFS to verify that the providers met the Administrative Rule's requirements to substantiate the emergency nature of the request. The only documentation was a letter from the providers attesting that they met the eligibility requirements;

- **Lack of documentation of the number of Medicaid clients served.** For 22 of the 24 providers sampled that had current signed agreements, there was no documentation to support that the provider met the significance requirements related to the number of Medicaid clients served as required by the Administrative Rule; and

- **Outdated agreements and provider lists.** HFS does not have an annual application process to be an expedited provider for long term care and maternal and child health providers to ensure that the providers continue to meet the eligibility requirements. Additionally, expedited provider lists from Mt. Sinai and the University of Illinois at Chicago hospitals were not updated regularly by HFS.

HFS uses another poorly defined process to expedite payments to certain providers. These payments, referred to as "one-time drop" payments, are made to providers who, according to HFS officials, need a one-time infusion of cash (such as having difficulty in making payroll or making quarterly tax payments). If a provider's request is granted, HFS authorizes the payment of any outstanding claims.

Management controls over the one-time drop payment process are deficient. **There are no criteria and/or basis for these one-time drop payments included in the expedited**

payment section of the Administrative Rule (89 Ill. Adm. Code 140.71(b)) or in HFS' policies or procedures. No policies or procedures exist to delineate the process for providers requesting or HFS' review and approval of the need for a one-time drop payment. **HFS does not require providers to submit a written request documenting their need or keep a log of one-time drop payment requests.** According to HFS officials, these providers usually contact HFS by phone and declare their emergency need to be paid.

During testing, auditors found that generally the only documentation to support one-time drop payments were the e-mails between HFS employees changing the payment parameters for these providers and an internal HFS spreadsheet which tracked the one-time drop payment requests. **There was no log or consistent documentation showing who outside HFS requested the payment or whether HFS determined that an emergency need existed.**

Auditors compared the one-time drop spreadsheet and e-mails and found neither was complete. HFS subsequently provided e-mails for all the one-time drops on the spreadsheet. However, the HFS official noted that the spreadsheet was not an "official" or all-inclusive list because other HFS staff may make requests for one-time drop payments for providers that may not be reflected on the spreadsheet. There were 178 one-time drop payments listed on the FY07 spreadsheet, totaling **$5.7 million**. These payments were made to 135 providers. Thirty-seven of the providers had 2 or 3 one-time drop payments in FY07. Also, there were e-mails with the names for at least 40 one-time drop providers that did not appear on the spreadsheet.

During FY06, expedited providers were paid an average of 47 days from the date the claim was received. Non-expedited providers were paid an average of 77 days from the date their claims were received. The majority (54 days) of the delay occurred after the claim was approved for payment and was being held by HFS before being sent to the Comptroller for payment.

However, if a provider's claim was **rejected** by HFS and then was subsequently paid, the provider experienced additional delays in getting paid. HFS is not notifying providers "as soon as possible" of its decision to deny claims as required by Administrative Rule (74 Ill. Adm. Code 900.70(c)). From our sample of 384 rejected services in calendar year 2006, we found that for non-expedited providers it took HFS an average of **87 days to notify providers** of a rejected service when the rejected service was submitted on a claim along with a service that was paid. Additionally, we found that in FY06, it took an average of **77 days** for non-expedited claims to be approved and paid. In this scenario, on average it would have taken **164 days** for a claim to be rejected by HFS and to be processed and paid once corrected by the provider. The 164 days does not include days taken by the provider to originally submit the claim or days needed by the provider to resubmit the rejected services. HFS was generally timely in notifying providers if the entire claim was rejected (an average of 12 days in calendar year 2006).

Additionally, when HFS notified providers of their rejected claims during calendar year 2006, providers may have experienced difficulty correcting the rejected services because some error codes reported to the providers were not on HFS' list of error codes found in the provider handbook. **We identified 123 error codes HFS used for rejected services that were reported to providers in 2006 that were not on the list of error codes found in HFS' provider**

handbook. These error codes are used by providers to determine why a service was rejected so they can make the appropriate corrections in order to resubmit the rejected services within the required 12 month period.

Even though HFS did not pay all claims or notify all providers of rejected claims within 60 days, HFS instructs providers to resubmit a claim if the claim has not appeared on a remittance advice after 60 days from mailing the claim to HFS. As a result, providers may unnecessarily resubmit duplicate claims to HFS. During FY06, HFS paid 46.1 million claims after 60 days.

As directed by Legislative Audit Commission Resolution 137, we surveyed Medicaid providers asking them to identify problems they may have encountered with the claims rejection process. The survey specifically asked providers how often they understood the reason(s) why the bill was rejected and whether or not they agreed with the decision to reject the claim. The majority of the providers (71%) responded that they usually or always understood the reason the claim was rejected. Fifteen percent responded that they rarely or never understood the reason.

Additionally, the majority of the providers (78%) responded that they sometimes, usually, or always agreed with the reason the claim was rejected. Twenty-two percent of the providers responded that they rarely or never agreed.

Sixty-seven percent of the providers responded that they had experienced a problem with the claims rejection process. Specific problems identified by providers included: HFS taking too long to deny claims; confusion why a claim was rejected; denial of clients after they had been approved; and denial for refilling a prescription too soon.

Since July 1999, HFS' handling of prompt payment interest has not been in compliance with the Prompt Payment Act or the Administrative Rule that governs the payment of prompt payment interest. Prompt payment compliance issues identified were:

- **HFS is not paying interest to providers in a "reasonable time" as required by 74 Ill. Adm. Code 900.90.** Since July 23, 1999, the Prompt Payment Act required HFS to **automatically** pay interest to Medicaid providers when interest penalties amount to $50 or greater. However, HFS did not have a system in place to pay automatically owed interest to providers until May 2007 – almost **eight years** after the inclusion of Medicaid claims in the Prompt Payment Act. Additionally, for interest amounts owed of at least $5 but less than $50 (which the Prompt Payment Act requires must be **requested** by the provider), it took HFS an average of **452 days** to pay providers requested interest in FY06.

- **HFS is excluding certain claims from interest payments, some of which are not supported by Administrative Rule.** In May 2007, after our audit began, HFS established an Exclusion Policy which lists several reasons why HFS will not pay accrued prompt payment interest to a provider. Some of the exclusions are supported by Administrative Rule; others, however, are not. Furthermore, HFS **retroactively** applied this Exclusion Policy to interest owed dating back to FY00.

- **HFS is not notifying providers within 60 days that an interest request has been denied, as required by Administrative Rule.** If HFS approves part, but not all of the interest request, the provider is not notified of the denied part until the payment for the approved portion of the interest request is received. As noted above, in FY06 HFS took an average of 452 days to pay providers interest after it was initially requested.

HFS has no written policies, procedures, or guidelines that document how decisions are made that determine which providers are paid and when the payments are made. HFS does not have an adequate process in place to verify and calculate prompt payment interest. The process used by HFS to verify and calculate requested interest owed to Medicaid providers is not automated; it consists of a set of undocumented procedures applied by two individuals at HFS.

Between July 1999 and November 2007, approximately 3.3 million claims accrued a potential liability of almost **$81 million** in interest pursuant to the Prompt Payment Act. Claims with interest totaling at least $5 but less than $50 accrued a potential liability of $44.5 million while claims with interest totaling $50 or greater accrued a potential liability of $36.1 million. As of November 2007, HFS had paid a total of **$21.8 million** in prompt payment interest to providers for late payment of claims. The **$21.8 million** in payments fell into the following categories:

- **Interest totaling at least $5 but less than $50.** The Prompt Payment Act requires that providers must request this interest before it is paid (requested interest). Approximately 3.1 million claims had accrued a potential liability of **$44.5 million** in requested interest; however, **$35.7 million** has not been requested by providers. As of November 2007, providers had requested interest penalty payments totaling $8.8 million, of which HFS had paid only $3.6 million.

- **Interest totaling $50 or greater.** The Prompt Payment Act requires that interest totaling $50 or greater be paid automatically to providers (automatic interest). Approximately 273,000 claims have accrued a potential liability of **$36.1 million** in automatic interest since fiscal year 2000. As of November 2007, HFS had paid providers $16.6 million in automatic interest. Through the use of its newly adopted Exclusion Policy, HFS excluded $11.5 million of the $36.1 million in accrued potential interest liability.

- **Court of Claims interest.** Through rulings by the Court of Claims, long term care providers have been paid $1.6 million in prompt payment interest as a result of late payment of claims made by HFS.

HFS requires providers to follow a cumbersome process to request interest, including requiring them to submit information not required by Administrative Rule. For example, when requesting interest, HFS requires the providers to calculate how much interest is owed to them. This can be very time intensive for providers to complete and is not relied upon by HFS. HFS does its own calculation once an interest request is received. In addition, HFS requires providers to include the warrant date on their request. The warrant date is not readily

available to the providers and is of questionable need to HFS. It is also not correctly defined in HFS' Medical Interest Payment Instructions used by providers to request interest.

The methodology used by HFS to calculate prompt payment interest has been challenged by a group of long term care facilities through the Court of Claims. The claimants' position is that the method of calculating interest in the Administrative Rule is inconsistent with the method of calculation prescribed by the Prompt Payment Act. The Administrative Rule states that, "Interest is calculated at the rate of 1% per month. This results in **a daily interest factor** of .00033 (01/30)" (emphasis added). The Act states that, "An interest penalty of 1.0% of any amount approved and unpaid shall be added for **each month or fraction thereof** after the end of this 60 day period, until final payment is made" (emphasis added).

In May 2007, the Court of Claims ruled in favor of the claimants that a per month calculation should be used. For example, for a claim that accrued interest for 6 days, the Administrative Rule would require 6 x .00033 or 0.198% interest be paid. The Court's interpretation of the Act is that a full 1 percent interest must be paid for the 6 days. As a result, HFS paid these long term care facilities interest totaling $1.6 million as opposed to $1.1 million it would have paid following the interest calculation method prescribed by the Administrative Rule.

We surveyed other Midwestern states to determine whether their prompt payment laws cover payments for Medicaid claims. We contacted Iowa, Ohio, Wisconsin, Indiana, Michigan, and Missouri. Of the six states contacted, only Indiana, Missouri, and Ohio have prompt payment laws that include Medicaid. Michigan, Iowa, and Wisconsin do not pay interest on Medicaid claims. Wisconsin has guidelines related to timeliness of Medicaid payments, but there are no penalties if the timelines are not met.

We found that Illinois law allows more days to process its Medicaid claims before interest accrues than other states that were surveyed. Illinois also pays a higher annual interest rate for claims that are not paid timely. In FY06, Illinois paid $9.6 million in prompt payment penalty interest while Missouri paid $0. Indiana reported that during calendar year 2007, less than $5,000 in interest was paid. Ohio did not report its interest paid in FY06. Illinois requires providers to submit a written request for payment of interest if the interest is $5 but less than $50. The other states pay all interest penalties automatically.

BACKGROUND

Two Legislative Audit Commission (LAC) resolutions directed the Office of the Auditor General to examine various aspects of the Department of Healthcare and Family Services' processing of Medicaid claims and its compliance with the provisions of the Prompt Payment Act (see Appendix A). This audit report addresses the determinations of both Legislative Audit Commission resolutions.

LAC Resolution Number 136, adopted on March 6, 2007, directed the Office of the Auditor General to conduct a performance audit on the Medicaid Program and the Group Health Insurance Program at the Department of Healthcare and Family Services for compliance with the mandates of the Prompt Payment Act from July 1, 2003 through December 31, 2006. Exhibit 1-1 lists the six determinations specified by LAC Resolution Number 136.

Exhibit 1-1
AUDIT DETERMINATIONS FOR LAC RESOLUTION NUMBER 136

For Medicaid and Group Health Insurance Program bills with an excess of $50 in interest generated, determine the:	For Medicaid and Group Health Insurance Program bills with an excess of $5 but less than $50 in interest generated, determine the:
• number of bills by fiscal year	• number of bills by fiscal year
• amount of unpaid interest on bills by fiscal year	• amount of unpaid interest on bills by fiscal year
• amount of paid interest on bills by fiscal year	• amount of paid interest on bills by fiscal year

Legislative Audit Commission Resolution Number 137 directed the Office of the Auditor General to conduct a management audit of the Department of Healthcare and Family Services' process for receipt, approval, denial, and payment of vendor bills for services provided in the Medicaid program. Exhibit 1-2 lists the four determinations specified by LAC Resolution Number 137.

Exhibit 1-2
AUDIT DETERMINATIONS FOR LAC RESOLUTION NUMBER 137

For the Department of Healthcare and Family Services' process for receipt, approval, denial, and payment of Medicaid bills, determine:

- Whether and at what point there are delays in reviewing and processing vendor bills and payments;
- Whether decisions to reject bills as not being in proper form are adequately documented and communicated in a timely manner to vendors, including a sampling of vendors to identify problems they may have encountered with the process;
- Whether dates of receipt of proper bills are adequately documented; and
- Whether the regular, systematic process used by the Department of Healthcare and Family Services for reporting claim liability information to the Office of the Comptroller pertaining to claims received and approved, but not yet submitted to the Office of the Comptroller, is adequate.

MEDICAID PROGRAM

In Illinois, the Medical Assistance Program, or Medicaid, is the State administered program that covers a broad range of health care services for children, low-income families, the elderly, and disabled people. Medicaid is a joint program with costs shared by both the federal and state governments. Federal guidelines on eligibility, benefits, and provider payment rates are broad, thus allowing each state to establish its own guidelines as long as the guidelines meet certain minimum standards. In Illinois, the Medicaid program is administered by the Department of Healthcare and Family Services (HFS). Exhibit 1-3 displays a list of mandatory and optional Medicaid services paid for by HFS.

Medical Program Funding

Over the last four fiscal years, the total appropriation for medical claims has varied by as much as $1.76 billion. In FY04, the appropriation was $7.92 billion. In FY05, the appropriation decreased to $6.89 billion. In FY06, the appropriation increased to approximately $8.65 billion, but decreased by almost $150 million to $8.5 billion in FY07. According to HFS officials, in fiscal years 2006 and 2007, the appropriation consisted of five funds. The five funds were the General Revenue Fund, the Long Term Care Provider Fund, the Drug Rebate Fund, the Tobacco Settlement Fund, and the Hospital Provider Fund. According to HFS officials, the Drug Rebate and Tobacco Settlement Recovery funds were a cash resource, and the amount of actual cash received during these fiscal years did not reach the total amount that was appropriated. Therefore, the total appropriation could not be spent. Exhibit 1-4 shows the funds appropriated, amount of claims received, amount of claims paid, and the amount of unpaid bills from the previous fiscal year.

Unpaid Bills from Previous Fiscal Year

The Illinois State Finance Act (30 ILCS 105/25(b)) allows the Department of Healthcare and Family Services to make medical payments from appropriations for any fiscal year, without regard to the fact that the medical or child care services may have been provided in a prior fiscal year. This provision of the State Finance Act has allowed HFS to carry unpaid bills averaging $1.5 billion from FY05, FY06, and FY07 into the next fiscal year. Claims received in each of the past four fiscal years, when added to the unpaid bills carried over from the prior year, have exceeded the funds available to timely pay medical providers.

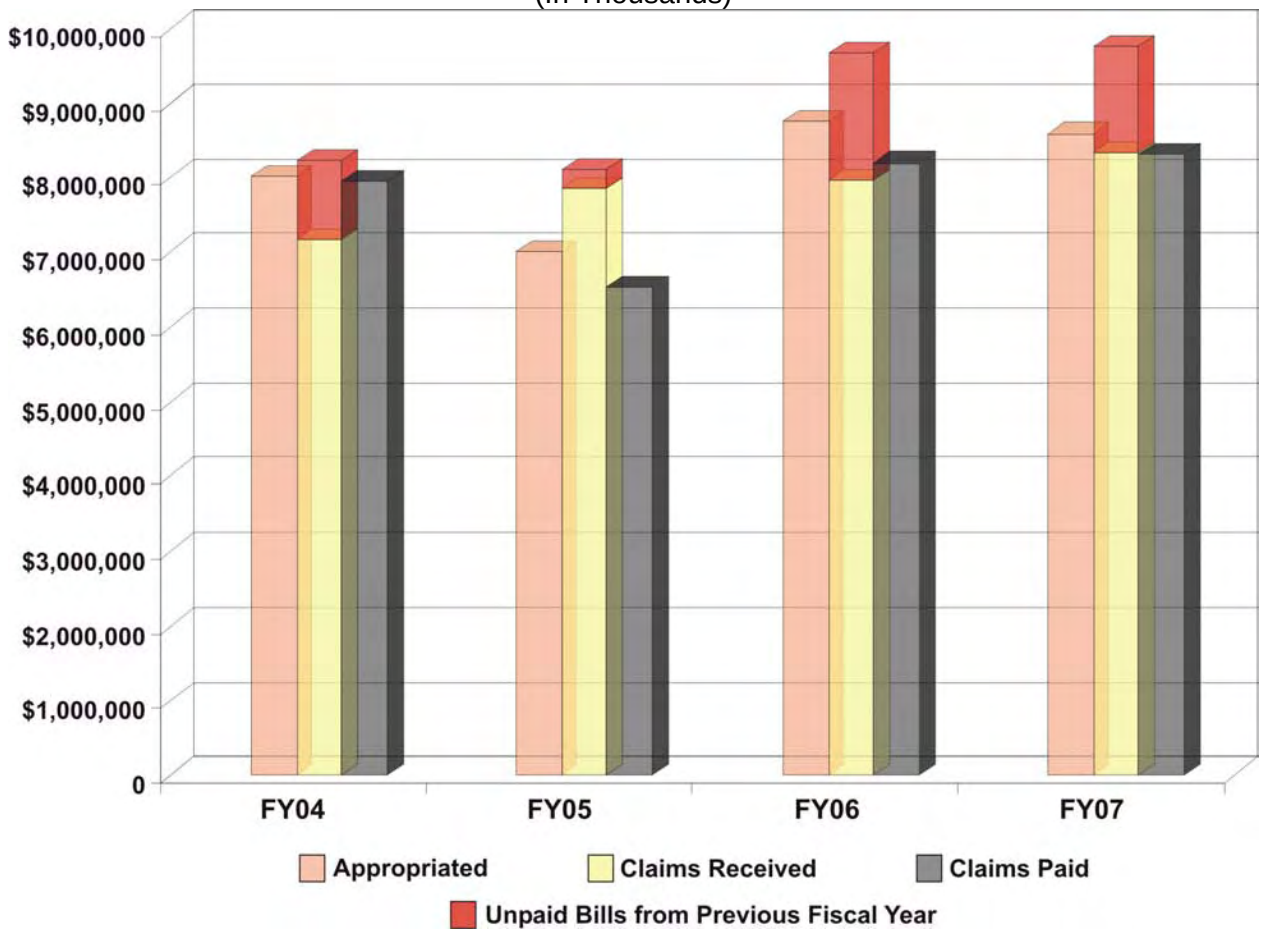
Claims from one year are being paid out of the next year's appropriation resulting in sizable delays in payments to providers. HFS and Comptroller officials have noted that the under funding of Medicaid has caused HFS to create a complex payment schedule to manage the payments to providers in order to ensure that there is cash available. The payment schedule is discussed in Chapter 2 of this report.

Exhibit 1-3
MANDATORY VERSUS OPTIONAL MEDICAL ASSISTANCE SERVICES IN ILLINOIS PAID BY THE DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

Federally Required Services	
Inpatient hospital care (other than those provided in an institution for mental diseases)	
Outpatient hospital care	
Ambulatory services provided by rural health clinics and federally qualified health centers	
Other laboratory and x-ray Services	
Nursing facility and home health services for individuals 21 years of age and older	
Early and periodic screening, diagnosis and treatment for individuals under 21 years of age	
Family planning services and supplies	
Physician services	
Nurse-midwife services	
Nurse practitioner (pediatric and family only)	
Home health -Nursing services -Home health aide -Medical supplies, equipment and appliances -Physical, occupational and speech therapies; audiology services	
Ambulatory services to presumptively-eligible pregnant women	
Pregnancy-related services and services for other conditions that might complicate pregnancy	
Emergency hospital services to aliens	
Medical and surgical services performed by a dentist	
Optional Services Provided	
Podiatric services	Care of individuals 65 years of age or older in institutions of mental disease -Inpatient hospital services -Nursing facility services
Optometric services	
Chiropractic services	
Other practitioner services	
Speech, hearing, and language therapy services	Home and community based services through federal waivers
Eyeglasses	
Screening services	Emergency hospital services
Dental services -Dentures -Emergency services	Transplants
	Transportation
	Special tuberculosis-related services
Clinic services (Medicaid clinic option)	Nurse anesthesia services
Physical therapy services	Hospice care services
Occupational therapy services	Prescribed drugs
Inpatient psychiatric services for individuals under 21 years of age	Religious non-medical health care institution services
Intermediate care facility services for mentally retarded (ICF/MR) including State-operated facilities	Rehabilitative services (Medicaid rehabilitation option)
Prosthetic devices including durable medical equipment and supplies	Services provided through a health maintenance organization or a prepaid health plan
Diagnostic services including durable medical equipment and supplies	Case management services (targeted case management)
Preventive services including durable medical equipment and supplies	Nursing facility services for individuals under 21 years of age
Program of All-Inclusive Care of the Elderly (PACE)	

Source: HFS Annual Report for the Medical Assistance Program (fiscal years 2004, 2005, 2006).

Exhibit 1-4
SUMMARY OF MEDICAL PROGRAM APPROPRIATIONS AND CLAIMS
Fiscal Years 2004 - 2007
(In Thousands)



Note: Summary does not include appropriation and claim information for the University of Illinois at Chicago and Cook County hospitals.

Source: Medical Program claim and appropriation data provided by HFS. According to HFS, figures provided for hospital assessment appropriation "reflects only those amounts used for routine hospital bills, not appropriation planned for hospital assessment payments." Pursuant to 305 ILCS 5/5A-7(a)(4), hospital access improvement payments are not subject to prompt payment interest.

STATE PROMPT PAYMENT REQUIREMENTS

The State Prompt Payment Act (30 ILCS 540) (Act) and its related Administrative Rule (74 Ill. Adm. Code 900) requires the payment of interest to vendors that provide goods or services to the State of Illinois in any instance in which the State is late in the payment of a vendor's bill or invoice. Medical assistance reimbursements for public aid recipients were excluded from the provisions of the Prompt Payment Act until July 23, 1999.

Prompt Payment Act

The Act states that a payment is considered "late" after 60 days of receipt of a "proper bill" or invoice. If payment is not issued within the 60 day period, an interest penalty of 1 percent of any amount approved and unpaid shall be added for each month or fraction thereof after the end of the 60 day period, until the final payment is made. The Act also states that the State Comptroller and the Department of Central Management Services (CMS) shall jointly promulgate rules and policies to govern the Act. According to the Act, these rules and policies shall be binding on all officials and agencies under the Act's jurisdiction.

Administrative Rule

The Administrative Rule defines a "proper bill" as a bill or invoice containing sufficient and correct information necessary for processing the payment. According to the Administrative Rule, a payment is late if the date of the payment is not within 60 days after the receipt of a proper bill. While the Act requires an interest penalty of 1 percent of any amount approved and unpaid shall be added for each month or fraction thereof after the end of 60 days, the Administrative Rule provides for a daily calculation of .00033 for each day the payment is late.

The Administrative Rule also provides guidance in several other areas relating to the payment of interest. These include:

- interest penalties must be processed on a voucher separate from the voucher the State agency submits for payment of the bill;
- interest penalties are simple interest and are not compounded;
- interest does not accrue on the date of payment;
- interest penalties must be charged to the same expenditure authority account to which the related goods or services were charged;
- interest is to be calculated for each individual vendor bill and may not be calculated based upon summing two or more bills together;
- interest penalties are required to be calculated and paid in a reasonable time; and
- any agency shall approve proper bills or deny bills with defects in whole or in part within 30 days of receipt.

In accordance with the Administrative Rule, HFS calculates interest payments based on a daily interest factor of .00033. The amount of the claim is multiplied by the daily interest factor

and the number of days past 60 to determine the interest due. Additionally, the Administrative Rule states that agencies are required to calculate and pay interest in a **reasonable time**. The Administrative Rule does not provide any further definition of reasonable time.

According to the Administrative Rule, if the interest accrued amounts to $50 or more, it is to be paid automatically and does not have to be requested by the vendor – referred to as *automatic interest* in this audit report. The Administrative Rule also states that interest accruing to $5 but less than $50 must be requested by the vendor – referred to as *requested interest* in this audit report. Accrued interest of less than $5 will not be paid, except for prescription services submitted to HFS by a pharmacy for All KIDS and the Children's Health Insurance Program. This exception for pharmacies was added to the Administrative Rule as of March 29, 2007.

In order to receive interest amounting to $5 but less than $50, the Administrative Rule (74 Ill. Adm. Code 900.90) requires the vendor to submit a written statement requesting the State agency to pay an interest penalty. The request process is discussed in greater detail in Chapter 4 of this report.

Calculation of Interest

The methodology used by HFS to calculate prompt payment interest has been challenged by a group of long term care facilities through the Court of Claims. The claimants' position is that the method of calculating interest in the Administrative Rule is inconsistent with the method of calculation prescribed by the Prompt Payment Act. Specifically, the position of these long term care facilities is that the Act requires payment of 1 percent for each full month, as well as payment of 1 percent for each fraction of a month until the original claim is paid. For example, if a claim accrued interest for 65 days (2 months and five days), the percentage of interest owed would be 3 percent. Exhibit 1-5 compares the difference between the Act and the Administrative Rule.

Exhibit 1-5
DIFFERENCE BETWEEN PROMPT PAYMENT ACT AND ITS ADMINISTRATIVE RULE RELATED TO THE CALCULATION OF INTEREST

Prompt Payment Act (30 ILCS 540/3-2)	**Administrative Rule (74 Ill. Adm. Code 900.100(a))**
An interest penalty of 1.0% of any amount approved and unpaid shall be added for **each month or fraction thereof** after the end of this 60 day period, until final payment is made (emphasis added).	Interest is calculated at the rate of 1% per month. This results in **a daily interest factor** of .00033 (01/30) (emphasis added).
Example Calculation: A $347,982.56 claim that accrued interest for 6 days.	
Calculation based on the Court of Claims interpretation of the Prompt Payment Act $347,982.56 x 1% = **$3,479.84** in owed interest	**Calculation based on Administrative Rule** $347,982.56 x 0.198% (6 days x .00033) = **$689.01** in owed interest
Source: 30 ILCS 540/3-2 and 74 Ill. Adm. Code 900.100(a).	

In May 2007, the Court of Claims ruled in favor of the claimants that a per month calculation should be used. The Court's opinion reads as follows:

> *Upon a careful review of the case law as well as the oral and written arguments submitted by both sides, this Court is of the opinion that the plain reading of the language of the Act clearly dictates a per month interest penalty calculation as it relates to this type of case.* ***The Joint Rules are in drastic conflict to this plain language and cannot be applied to change the meaning and application of the statutory intent of the Act*** (emphasis added).

An official from the Office of the General Counsel at HFS noted that HFS agrees with the opinion of the Court. Additionally, an HFS official from the Bureau of Claims Processing stated that HFS is bound by the Administrative Rule and is only applying the per month calculation on a case by case basis for those seeking interest payments through the Court of Claims. For these cases, HFS calculated a net interest of $1,620,411 to be paid to long term care providers prior to HFS Office of Inspector General (OIG) adjustments. To date, according to documentation provided by HFS, a net interest of $1,598,964 was paid to providers after deducting $21,447 in applicable OIG adjustments.

In order to understand the dollar significance between calculating interest on a monthly basis versus calculating interest on a daily basis, we requested the HFS data used to calculate the interest paid to long term care providers as a result of the May 2007 Court of Claims ruling. After receiving this information, we computed the daily calculated interest rate under the Administrative Rule and compared it to the $1.6 million calculated based on the monthly rate prescribed by the Prompt Payment Act. We determined that HFS would have paid $1,055,074 using the Administrative Rule's daily calculation method versus $1,620,411 using the monthly calculation method as a result of the ruling.

The State Prompt Payment Act (30 ILCS 540/3-3) requires the Comptroller's Office and the Department of Central Management Services to jointly promulgate rules and policies to govern this Act. We contacted both CMS and the Comptroller's Office to discuss the ruling by the Court of Claims. A CMS official said he was not aware of the ruling, and said that the Act was not specific. He added that the Act left it up to CMS and the Comptroller to promulgate the rules. Additionally, the CMS official noted that the per day calculation was used because it was the industry standard. He added that he was not aware of any other lawsuits regarding this issue. A Comptroller's Office official stated that legislative clarification is in order.

PROMPT PAYMENT ACT INTEREST CALCULATION	
RECOMMENDATION NUMBER 1	***The Office of the Comptroller, the Department of Central Management Services, and the Department of Healthcare and Family Services should immediately resolve the differences in interpretations between the Administrative Rule (74 Ill. Adm. Code 900.100) and the Prompt Payment Act (30 ILCS 540/3-2) regarding the method used to calculate prompt payment interest.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department partially agrees in that differences in interpretations of this rule should be resolved by the Comptroller and the Department of Central Management Services. However, as 74 Ill. Adm. Code 900.100 refers to joint rules of the Comptroller and the Department of Central Management Services, the Department of Healthcare and Family Services would have no action with regard to such resolution. The Department is required to calculate interest according to the rules published by the agencies with rulemaking authority on the issue and will follow any changes to those rules that those agencies make.
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES' RESPONSE	The Department agrees that there is an issue of interpretation that needs to be addressed. The Department will work with the Illinois Office of the Comptroller to address this issue.
OFFICE OF THE COMPTROLLER RESPONSE	We agree. Our office will seek legislative clarification and work with Central Management Services to adapt rules consistent with relevant language.

STATE EMPLOYEES GROUP HEALTH INSURANCE PROGRAM

In Illinois, there are indemnity (quality care), open access, and managed care plans for the State Employees Group Health Insurance Program. The Group Health Insurance plans provide health insurance coverage to State employees. Depending on the plan, providers may be eligible for interest under the Prompt Payment Act or the Illinois Insurance Code. The Illinois Insurance Code has different requirements for interest accrual than the Prompt Payment Act. This audit focused on interest paid pursuant to the Prompt Payment Act as directed by Legislative Audit Commission Resolution Number 136.

Group Health Insurance Plans under Prompt Payment Interest Requirements

According to HFS officials, there has been no interest pursuant to the Prompt Payment Act accrued or paid to vendors by HFS for State Group Health Insurance. There are five fully-insured managed care vendors that receive payment from the State on a capitated basis. The claims are submitted by the provider to the vendors and are paid by the vendors. The vendors assume any risk in excess of the capitation amounts. The five fully-insured managed care vendors are Health Alliance, Personal Care, HMO Illinois, OSF Health Plan, and Unicare.

There are four other programs that fall under the interest penalty provisions of the Prompt Payment Act, according to HFS officials: CIMRO (peer review vendor), Magellan (behavioral health vendor), Eyemed (vision service provider), and consultants and other contractual arrangements. CIMRO provides peer review services to all self-insured programs and payments are made on a per review basis. Magellan and Eyemed are paid on a capitated basis with the vendor assuming the risk similar to the fully-insured managed care vendors.

Additionally, there are vendors that operate as third party administrators for the self-insured components of the indemnity, open access, and managed care programs. These administrators are paid an administrative service charge for the services provided to the State. The administrative service charge payments are made directly to the vendor and fall under the Prompt Payment Act. The indemnity third party administrators are: CIGNA (medical claims administrator); Medco (prescription benefit manager); and CompBenefits (dental claims administrator). Intracorp is the utilization review vendor for CIGNA. The managed care and open access third party administrators are Health Alliance Illinois, OSF Winnebago, and HealthLink OAP. Medco is the prescription benefit manager for all three of these administrators.

Group Health Insurance Plans under Insurance Code Interest Requirements

In addition to the Prompt Payment Act, vendors may also fall under the interest penalty provisions of the Illinois Insurance Code. Applicable vendors include third-party administrators for the indemnity program. These administrators are CIGNA (medical claims administrator), Medco (prescription benefit manager), and CompBenefits (dental claims administrator). The State reimburses third-party administrators for payments to providers of claims incurred by members and dependents enrolled in these programs.

According to HFS officials, applicable vendors also include the managed care and open access vendors on contract with the State of Illinois. These vendors include Health Alliance Illinois, OSF Winnebago, and HealthLink OAP. The State reimburses these vendors for payments to providers of claims incurred by members and dependents enrolled in these programs. In addition, the State reimburses payments to Medco (the prescription benefit manager) for all three of these vendors for claims incurred by members and dependents enrolled in these programs.

We requested a list of providers that were paid interest by HFS under the Group Health Insurance program. According to information provided by HFS officials, HFS paid $2.3 million in interest to CIGNA and $382,814 in interest to CompBenefits pursuant to the Illinois Insurance Code (215 ILCS 5/368a) in FY06. This interest accrues after 30 days at a rate of 9 percent annually. Officials stated that interest accrued under the Illinois Insurance Code is automatically paid to the provider.

HFS provided a list of providers that were paid interest owed by CompBenefits totaling $382,814. HFS was not able to provide a complete list of providers that received the $2.3 million in interest paid to CIGNA. HFS officials provided a list of $3.0 million in interest paid by CIGNA to providers (which included the $2.3 million paid by HFS to CIGNA) but stated that CIGNA was not able to break out the providers paid under the State's responsibility and the

providers paid under CIGNA's responsibility. As a result, HFS does not know who was paid the $2.3 million in State interest through CIGNA and has no way to verify that the correct amount was paid.

ILLINOIS INSURANCE CODE INTEREST	
RECOMMENDATION NUMBER 2	***The Department of Healthcare and Family Services should obtain appropriate documentation from contractors to show the amounts and purposes of funds being disbursed.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department agrees with the recommendation. Subsequent to the management audit, the department has requested and will be receiving on a periodic basis, a report detailed by provider from CIGNA providing the amounts and purposes of funds being disbursed under the Illinois Insurance Code. The Department notes that it has been receiving reports from CIGNA on a periodic basis, which allow the Department to reconcile all payments to the activities listed in each of the Department's bank accounts.

OTHER STATES

We surveyed other Midwestern states to determine whether their prompt payment laws cover payments for Medicaid claims. We contacted Iowa, Ohio, Wisconsin, Indiana, Michigan, and Missouri. Of the six states contacted, only Indiana, Missouri, and Ohio have prompt payment laws that include Medicaid. Michigan, Iowa, and Wisconsin do not pay interest on Medicaid claims. Wisconsin has guidelines related to timeliness of Medicaid payments, but there are no penalties if the timelines are not met. Exhibit 1-6 is a comparison based on survey responses from Indiana, Missouri, and Ohio for the number of days before interest accrues, the FY06 annual interest rate, and the total amount of interest paid for FY06.

Exhibit 1-6
OTHER STATE PROMPT PAYMENT REQUIREMENTS FOR MEDICAID PAYMENTS
Based on Survey Responses from Other States

State	Days Before Interest Accrues	FY06 Annual Interest Rate	FY06 Interest Paid
Illinois	60	12%	$9.6 million
Indiana	21/30 [1]	3%	< $5,000 [2]
Missouri	45	7.25%	$0
Ohio	31	5%-6% [3]	- [4]

Notes:

[1] 21 days for electronic claims and 30 days for paper claims.

[2] Interest paid information provided by Indiana was for calendar year 2007.

[3] 5% was for the first half of the fiscal year and 6% was for the second half.

[4] Ohio did not report the interest paid during FY06.

Source: Survey of other states and OAG analysis of HFS data and Illinois prompt payment laws.

Time Periods for Late Payments

In Illinois, Medicaid claims begin to accrue interest 60 days after receipt of a proper bill. All three of the other states surveyed, that

had prompt payment laws that include Medicaid, had shorter time periods before interest began to accrue. In Indiana, Medicaid claims not paid within 21 days for electronic claims and 30 days for paper claims accrue interest. Medicaid claims in Missouri that are not processed within 45 days are subject to interest penalties retroactive to the 30th day on any unpaid balance. In Ohio, payment of interest applies to "clean claims" after the 31st day for any Medicaid claim that is unpaid.

Interest Paid

Illinois paid $9.6 million in prompt payment penalty interest during FY06. Two of the other states surveyed, Indiana and Missouri, which had prompt payment laws that include Medicaid, paid little if any interest. Missouri reported that in FY06 no interest was paid on Medicaid claims. Indiana reported that during calendar year 2007, less than $5,000 in interest was paid. Ohio did not report its interest paid in FY06.

Illinois requires providers to submit a written request for payment of interest if the interest is $5 but less than $50. All three of the states surveyed pay interest penalties automatically without a request of payment from providers. Indiana calculates interest payments automatically and pays interest through the system with the original claim. Missouri calculates interest automatically, but vouchers the interest payment separately from the original claim. Ohio calculates and pays interest claims greater than or equal to $10 automatically with the original claim.

Interest Penalty Rates

The interest penalty rate paid by Illinois is calculated at 1 percent per month or 12 percent annually, which is higher than the other states surveyed that paid interest. Indiana's Medicaid claims not adjudicated within 21/30 days are subject to a 3 percent annual interest rate (FY06). Missouri's annual interest rate is 3 percent above the average predominant prime rate quoted by commercial banks to large businesses, as determined by the Board of Governors of the Federal Reserve System. Missouri's annual rate for FY06 was 7.25 percent. Ohio's Tax Commissioner sets the short-term rate each October for the following calendar year. Therefore, for FY06, Ohio's rate was 5 percent from July 1, 2005 to December 31, 2005 and 6 percent from January 1, 2006 to June 30, 2006.

AUDIT SCOPE AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310. The audit's objectives were delineated in Legislative Audit Commission Resolutions 136 and 137 (see Appendix A), which directed the Office of the Auditor General to conduct performance audits on the Department of Healthcare and Family Services' (HFS) Medicaid and Group Health Insurance Program activities relating to the Prompt Payment Act and the processing of Medicaid claims.

Fieldwork for this audit was conducted between August 2007 and January 2008. We interviewed representatives from the Department of Healthcare and Family Services, the Office of the Comptroller, and the Department of Central Management Services. We reviewed the processes used by HFS for the approval and payment of Medicaid claims, and for the calculation, approval, and payment of prompt pay interest. We also analyzed electronic data from HFS to identify the interest owed, requested, approved, and paid for fiscal years 2000 through 2006. For a more detailed sampling and analytical methodology, see Appendix B.

In conducting this audit, we reviewed applicable State statutes and Administrative Rules. In addition, we reviewed applicable federal regulations and requirements. Compliance requirements were tested and reviewed to the extent necessary to meet the audit objectives. Any instances of non-compliance are included in this report.

We met with various officials from HFS to discuss the validity of the data used for processing Medicaid claims and interest associated with those claims. We reviewed and verified any methodologies or queries used by HFS to configure our various data requests. Although the process for calculating and approving interest is poorly documented by HFS, auditors were reasonably assured that the data was complete and accurate through various meetings, walk-throughs, independent calculations, and review of the queries used by HFS to produce the data.

We surveyed other states as well as a sample of Medicaid providers. The other states survey was designed to capture comparative information and included Iowa, Ohio, Wisconsin, Indiana, Michigan, and Missouri. The survey of Medicaid providers allowed providers to identify problems encountered with rejected claims and the payment of interest. The results of the provider survey can be found throughout this report.

We reviewed risk and internal controls at HFS related to the audit's objectives. The audit identified weaknesses in internal controls, which are included as findings in this report.

REPORT ORGANIZATION

The remainder of this report is organized into the following chapters:

- **Chapter Two** discusses Medicaid payment processing.
- **Chapter Three** discusses rejected Medicaid claims.
- **Chapter Four** discusses prompt payment interest owed and paid by HFS.

Chapter Two

MEDICAID PAYMENT PROCESSING

CHAPTER CONCLUSIONS

Claims submitted to HFS have accrued a potential liability of almost **$81 million** in Prompt Payment Act interest since FY00, due to the delays in payment. Actual interest expected to be paid to providers is estimated by HFS to be less due to not all providers requesting eligible interest, as well as exclusions that may be applied to potential interest payments by HFS. As a result of its payment schedule used to regulate payments, in most instances HFS does not submit approved claims immediately to the Comptroller for payment. In FY06, it took HFS an average of **6 days to process claims**; however, it took HFS an average of **57 days to submit claims** to the Comptroller for payment. Payments are added to the payment schedule by HFS based on payment parameters for each provider type. The payment parameter is the number of days a Medicaid claim will be held by HFS before it is put on a payment schedule and submitted to the Comptroller for payment. According to HFS officials, HFS uses the schedule to regulate payments throughout the year to ensure there is enough appropriation at the end of the fiscal year to continue to make weekly payments to the "expedited" providers, physicians, All Kids, and monthly Medicare premium payments.

HFS could not provide any documentation to support how the payment schedule and payment parameters are established. However, according to HFS officials, payment parameters are established based on the appropriation amount available for that provider type when compared to the predicted liability for that provider type. As an example, based on payment parameters provided by HFS, from September 1, 2006 until April 20, 2007, claims submitted by home health care providers were held at HFS for 118 days from receipt date (DCN date) before being eligible for payment.

Providers are generally paid pursuant to one of two payment schedules. The first is the regular payment schedule used to pay "non-expedited" providers (providers not paid on an accelerated payment schedule). The second is an accelerated schedule used to pay "expedited" providers. Pursuant to the Administrative Rule (89 Ill. Adm. Code 140.71 (b)), expedited payments may be issued only under extraordinary circumstances, in which withholding of the expedited payment would impose severe and irreparable harm to the clients served. The difference between the two designations is expedited providers are given a higher priority and are paid weekly, while non-expedited providers are put on the regular payment schedule and, as a result, are not paid as timely as expedited providers.

HFS does not have any written policies, procedures, or guidelines that delineate what documentation a provider must submit to HFS to receive expedited payments. Additionally, HFS has no policies or procedures that delineate the review process used to

determine whether a provider initially meets, and continues to meet, the eligibility requirements of the Administrative Rule. HFS also lacks a comprehensive policy as to whether a provider needs to enter into an agreement with HFS to receive expedited payments.

From the 2,058 providers that were expedited as of October 18, 2007, we randomly sampled 66 providers. HFS had current signed agreements with 24 of the 66 providers sampled. The following issues were identified:

- **Lack of documentation to substantiate the emergency nature of the request.** For the 24 providers sampled that had current signed agreements, 19 did not have documentation from the providers for HFS to verify that the providers met the Administrative Rule's requirements to substantiate the emergency nature of the request. The only documentation was a letter from the providers attesting that they met the eligibility requirements;

- **Lack of documentation of the number of Medicaid clients served.** For 22 of the 24 providers sampled that had current signed agreements, there was no documentation to support that the provider met the significance requirements related to the number of Medicaid clients served as required by the Administrative Rule; and

- **Outdated agreements and provider lists.** HFS does not have an annual application process to be an expedited provider for long term care and maternal and child health providers to ensure that the providers continue to meet the eligibility requirements. Additionally, expedited provider lists from Mt. Sinai and the University of Illinois at Chicago hospitals were not updated regularly by HFS.

HFS uses another poorly defined process to expedite payments to certain providers. These payments, referred to as "one-time drop" payments, are made to providers who, according to HFS officials, need a one-time infusion of cash (such as having difficulty in making payroll or making quarterly tax payments). If a provider's request is granted, HFS authorizes the payment of any outstanding claims.

Management controls over the one-time drop payment process are deficient. **There are no criteria and/or basis for these one-time drop payments included in the expedited payment section of the Administrative Rule (89 Ill. Adm. Code 140.71 (b)) or in HFS' policies or procedures.** No policies or procedures exist to delineate the process for providers requesting or HFS' review and approval of the need for a one-time drop payment. **HFS does not require providers to submit a written request documenting their need or keep a log of one-time drop payment requests.** According to HFS officials, these providers usually contact HFS by phone and declare their emergency need to be paid.

During testing, auditors found that generally the only documentation to support one-time drop payments were the e-mails between HFS employees changing the payment parameters for these providers and an internal HFS spreadsheet which tracked the one-time drop payment

requests. **There was no log or consistent documentation showing who outside HFS requested the payment or whether HFS determined that an emergency need existed.**

Auditors compared the one-time drop spreadsheet and e-mails and found neither was complete. HFS subsequently provided e-mails for all the one-time drops on the spreadsheet. However, the HFS official noted that the spreadsheet was not an "official" or all-inclusive list because other HFS staff may make requests for one-time drop payments for providers that may not be reflected on the spreadsheet. There were 178 one-time drop payments listed on the FY07 spreadsheet, totaling **$5.7 million**. These payments were made to 135 providers. Thirty-seven of the providers had 2 or 3 one-time drop payments in FY07. Also, there were e-mails with the names for at least 40 one-time drop providers that did not appear on the spreadsheet.

During FY06, expedited providers were paid an average of 47 days from the date the claim was received. Non-expedited providers were paid an average of 77 days from the date their claims were received. The majority (54 days) of the delay occurred after the claim was approved for payment and was being held by HFS before being sent to the Comptroller for payment.

MEDICAID CLAIM PAYMENT PROCESS

Providers submit Medicaid claims for payment either electronically or in hard copy by mail. HFS officials noted that approximately 94 percent of claims are received electronically. Electronic claims automatically receive a document control number (DCN) once received. The DCN includes the date the claim was received.

Hard copy claims are opened and scanned into a database. As part of the scanning process, hard copy claims are also assigned a document control number. To verify the process used for the assignment of the DCN, auditors observed the mail opening and scanning process. Mail is opened and scanned into the database daily. Reviews of the electronic assignment of document control numbers have also been conducted by the Auditor General's Information System auditors. No problems were noted with assignment of the DCN.

Once scanned, hard copy claims go through a series of validations. Any piece of information that is not recognized by the software is flagged. HFS staff manually review the questionable information and make the necessary corrections. This process is used to assure that the scanner read and interpreted the claim information properly before it is sent on for processing.

After validations on hard copy claims are complete, all claims in the database (including those received electronically) are run against a series of edit checks. HFS officials noted that about 50,000 claims per week are corrected as a result of the edit checks. Some of the problems can be fixed by HFS staff. These include inconsistencies between recipient names and numbers and between provider name and number. However, if the claim cannot be fixed by HFS, it is rejected and a remittance notice is sent notifying the provider of the problem.

After the edits have been run, some of the claims which contain multiple procedures are reviewed by nurses to determine if the pricing needs to be adjusted due to duplicate or overlapping procedures. According to HFS officials, 20,000 services are reviewed per day. However, about 47 percent of the 20,000 services are approved automatically based on known combinations of billing codes.

Once all reviews are complete, the claims are placed in a pending state where they wait to be sent to the Comptroller for payment. According to HFS officials, claims are sent to the Comptroller based on a payment schedule.

PAYMENT SCHEDULE

Claims submitted to HFS have accrued a potential liability of almost **$81 million** in Prompt Payment Act interest since FY00, due to the delays in payment. Actual interest expected to be paid to providers is estimated by HFS to be less due to not all providers requesting eligible interest, as well as exclusions that may be applied to potential interest payments by HFS. In most instances, HFS does not submit approved claims immediately to the Comptroller for payment. After claims are approved by HFS, the claims are held in a pending state at HFS. Subsequently, the claims are sent to the Comptroller's Office based on a payment schedule established by HFS.

HFS officials stated a payment schedule is necessary due to the underfunding of Medicaid and due to the State's lack of cash on hand. According to HFS officials, the payment schedule is used to ensure that HFS does not run out of its Medicaid appropriation before the end of each fiscal year. In the last three fiscal years, HFS has had medical bills on hand at the end of the fiscal year averaging $1.5 billion. According to HFS officials, HFS uses the schedule to regulate payments throughout the year to ensure there is enough appropriation at the end of the fiscal year to continue to make weekly payments to the "expedited" providers, physicians, All Kids, and monthly Medicare premium payments.

Providers are generally paid pursuant to one of two payment schedules. The first is the regular payment schedule (non-expedited provider). The second is an accelerated or expedited payment schedule (expedited provider). According to HFS officials, the average weekly expedited payment schedule is $35 million. Pursuant to the Administrative Rule, expedited payments may be issued only under extraordinary circumstances (89 Ill. Adm. Code 140.71(b)). The difference between the two designations is expedited providers are given a higher priority and are paid weekly, while non-expedited providers are put on the regular payment schedule and, as a result, are not paid as timely.

HFS could not provide any documentation to support how the payment schedule and payment parameters are established. We inquired about how the payment parameters for non-expedited providers are established. According to HFS officials, the payment parameters are established based on the appropriation amount available for that provider type when compared to the predicted liability for that provider type. Exhibit 2-1 lists the payment parameters for non-expedited providers established by HFS for FY07.

Payments are added to the payment schedule by HFS based on payment parameters for each provider type. The payment parameters found in Exhibit 2-1 are the number of days a Medicaid claim will be held by HFS before it is put on a payment schedule and submitted to the Comptroller for payment. As an example, based on payment parameters provided by HFS, from September 1, 2006 until April 20, 2007, claims submitted by home health care providers were held at HFS for 118 days from receipt date (DCN date) before being eligible for payment. When a schedule for home health care providers was ready for payment, all claims by home health care providers that met the payment parameter in effect were sent to the Comptroller for payment. The claims on that schedule were then paid by the Comptroller when funds became available. As will be discussed later in this chapter, HFS holds on to these approved claims for an extended period of time before they are submitted for payment. As a result, a large number of Medicaid claims accrue prompt payment interest.

According to HFS officials, the Bureau of Claims Processing maintains daily communication with the Comptroller's Office regarding fund balance, schedule size, and other pertinent matters. In addition, officials said the Bureau provides a daily Medical Schedule Release document to the Comptroller so the Cash Management Office is aware of the daily schedules. A report is also prepared and sent weekly to the Comptroller that identifies the State's Medicaid liability. Payments by the Comptroller are made by schedule type via the tape number.

Exhibit 2-1
EXAMPLES OF NON-EXPEDITED PAYMENT PARAMETERS DURING FY07
September 1, 2006 through April 20, 2007

Appropriation Type	Days[1]
Home Health Care	118
Appliances	118
Transportation	111
Other Related Medical Services	105
Independent Labs	93
LTC SLFs (Supported Living Facilities)	83
LTC IMDs (Institution for Mental Disease)	83
LTC IMDs Assessment Fund	83
Hospice	83
Hospital Ambulatory Care	70
Inpatient Hospital	65
Outpatient	65
Renal	60
Inpatient Hospital Disproportionate Share	59
Physicians	50
Pharmacy Services	50
Drug Rebate Fund	50
Pharmacy Services (Tobacco Settlement Fund)	50
Optometrists	50
Podiatrists	50
Chiropractors	50
Community Health Centers	50
LTC Geri Residential GRF	30
LTC Geriatrics Residential Assessment	30

Note:
[1] The number of days a Medicaid claim will be held by HFS before it is put on a schedule for submission to the Comptroller for payment.
Source: Department of Healthcare and Family Services.

Pursuant to Legislative Audit Commission Resolution Number 137, we asked officials at the Office of the Comptroller if the process used by HFS to report claim liability information pertaining to claims received and approved, but not yet submitted to the Comptroller was adequate. A Comptroller official stated that the communications that take place between HFS and the Comptroller's Office related to daily processing issues are adequate for most operational purposes. The Comptroller official noted that HFS has always maintained independent discretion

over the timing of submissions and the actual amounts submitted to the Comptroller within any given timeframe, thus HFS has complete autonomy over when the "clock" starts in regard to the aging of bills. Finally, the Comptroller's Office noted that the weekly report provides useful information as to the volume of bills pending, but does not provide an indication of HFS' plan for adjudication.

HFS officials indicated they do not have control over when the "clock" starts on the aging of bills as it begins at the time the provider submits the claim to HFS for processing. However, HFS does maintain control over when claims are sent to the Comptroller.

HFS officials further indicated that they have provided the Comptroller's Cash Management Office with daily spending reports and medical schedules in addition to the weekly report. HFS also has daily communications with Cash Management personnel on a variety of issues including changes in spending, forecasts of spending for the months to come, coordination on medical schedules and any other questions or concerns from the Comptroller's office.

MEDICAID PAYMENT SCHEDULE	
RECOMMENDATION NUMBER **3**	***The Department of Healthcare and Family Services should document how it determines when providers are paid and document its rationale and methodologies used to calculate provider payment parameters.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department partially agrees in that the Department should maintain adequate documentation regarding the determination of payment parameters that currently occurs through daily consultation with the Office of the Comptroller. The Department maintains that the existing documentation as to rationale and methodologies used to calculate provider payments is adequate, in that the Department utilizes available appropriations as passed by the General Assembly in the state budget. However, the Department will develop additional documentation regarding the process of setting payment parameters.
	AUDITOR COMMENT: *HFS responds that the existing documentation is adequate; however, no documentation was provided to auditors during the course of the audit. Also, on January 22, 2008, HFS' Administrator of the Division of Finance noted that there was no documentation related to how HFS determines payment parameters.*

EXPEDITED PROVIDERS

HFS does not have any written policies, procedures, or guidelines that delineate what documentation a provider must submit to HFS to receive expedited payments. Additionally, HFS has no policies or procedures that delineate the review process used to determine whether a

provider initially meets, and continues to meet, the eligibility requirements of the Administrative Rule. As of October 2007, there were 2,058 expedited providers on the list provided by HFS. The list includes providers that had been expedited since July 1996. Exhibit 2-2 shows the number of expedited providers by type.

Administrative Rule for Expedited Payments

According to 89 Ill. Adm. Code 140.71 (b), expedited claim payments to providers represent an acceleration of the regular payment schedule. These payments may only be issued under extraordinary circumstances to qualified providers of medical assistance services. Payments to expedited providers are made weekly by HFS and therefore, may further delay payments to non-expedited providers when the State is experiencing cash flow problems. Expedited payments are to be made only to a hospital organized under the University of Illinois Hospital Act or to qualified providers who meet the following requirements: 1) are enrolled with the Department of Healthcare and Family Services; 2) have experienced an emergency which necessitates expedited payments; and 3) serve a significant number of clients under the Medical Assistance Program.

Exhibit 2-2
COUNT OF EXPEDITED PROVIDERS BY PROVIDER TYPE

Provider Type	Count
Physicians	635
Other Transportation Providers	302
Pharmacies	220
Rural Health Clinics	214
Nursing Facilities	156
Medicar Providers	154
Federally Qualified Health Centers	121
Other Providers of Medical Equipment/Supplies	61
General Hospitals	47
Maternal and Child Health Providers	41
Taxicabs and Livery Companies	34
Home Health Agencies (in home)	11
Ambulance Service Providers	11
Independent Laboratories	10
Optometrists	9
Supportive Living Facilities	8
Nurse Practitioners	4
Podiatrists	3
Dentists	2
Registered Nurses	2
Psychiatric Hospitals	2
Rehabilitation Hospitals	2
Occupational Therapists	1
Speech Therapists	1
Mentally Retarded Facilities	1
Mental Health Service Providers	1
ICF/MI Facilities	1
Hospices	1
Encounter Rate Clinics	1
Certified Health Departments	1
Opticians/Optical Companies	1
Total	2,058

Source: Summary of HFS expedited provider list as of October 18, 2007.

Emergency Requirements

Emergency is defined as a circumstance under which withholding of the expedited payment would impose severe and irreparable harm to the clients served. The Administrative Rule includes two circumstances that may create such emergencies:

- Agency system errors which have precluded payments, or which have caused erroneous payments such that would severely impair the provider's ability to provide further services; and
- Cash flow problems encountered by the provider which are exclusively those of the provider or problems related to State cash flow that result in delayed payments which adversely impact the ability to serve clients.

Number of Client Requirements

The Administrative Rule defines several instances in which providers qualify as serving a significant number of clients. These include:

- 80 percent or more of residents must be eligible for public assistance for long term care facilities;
- four or more residents receiving exceptional care at long term care facilities;
- disproportionate share hospitals;
- 50 percent or more of patient revenue must be generated through Medicaid reimbursement for practitioners and other medical providers;
- sole source pharmacies not within a 25-mile radius of another pharmacy;
- government-owned facilities that meet cash flow criteria; and
- providers who have filed for Chapter 11 bankruptcy that meet the cash flow criteria.

Submission Requirements

The Administrative Rule lists submission requirements for providers to follow when applying for expedited status. In order to qualify for expedited payments, providers must submit the request in writing to HFS. The request must include:

- an explanation of the need for expedited payments; and
- supportive documentation to substantiate the emergency nature of the request.

Lack of Policies, Procedures, or Guidelines for Expedited Providers

Other than the Administrative Rule, the Bureau of Comprehensive Health Services, which approves the majority of expedited provider agreements, does not have any written policies, procedures, or guidelines related to expedited providers. Auditors met with HFS officials, reviewed the Administrative Rules, and tested a random sample of 66 providers from the list of 2,058 providers that were expedited as of October 18, 2007.

Within HFS, there is no consistency in the way HFS approves different provider types to be expedited. According to an HFS official, the Bureau of Comprehensive Health Services oversees the expedited process for all provider types except for long term care facilities. The Bureau of Long Term Care approves expedited long term care (LTC) facilities.

The Bureau of Long Term Care has policies and procedures only related to expediting LTC facilities, while the Bureau of Comprehensive Health Services does not have any policies or procedures. There are variations within the two bureaus because there is no consistent overall guidance.

According to HFS officials, the Bureau of Comprehensive Health Services requires expedited providers to re-apply to become expedited annually and requires pharmacies to re-

apply to become expedited every two years. HFS also uses a process of designating certain physicians and other provider groups as expedited without agreements with the providers such as private auto and rural health clinics. All rural health clinics and private auto payments are designated as expedited.

HFS lacks a comprehensive policy as to whether a provider needs to enter into an agreement with HFS to receive expedited payments. Neither the Administrative Rules nor HFS policy requires HFS to execute signed agreements with expedited providers. However, HFS had current signed agreements with 24 of the 66 of the providers in our random sample. There were several reasons provided by HFS as to why the other 42 providers did not have current signed agreements with HFS which include:

- 10 were private auto providers which are family members that provide transportation for Medicaid clients. According to HFS no agreement is necessary since these trips are 100% Medicaid and are all expedited;
- 9 were for Mt. Sinai physicians that were expedited per a list that included signatures from multiple physicians or individual attestation letters from physicians attesting that they had over 50% in billings from Medicaid;
- 6 were for rural health clinics. According to HFS officials, all rural health clinics are expedited per a decision by HFS administration and therefore there is no need for an agreement;
- 6 were for long term care providers that are handled by the Bureau of Long Term Care which have older Review of Cash Position Statements on file with HFS and do not have a routine review process for eligibility;
- 4 were for maternal and child health providers which have older agreements and do not have a routine review process for eligibility;
- 3 did not have agreements because the providers were "grandfathered in" after Medicare Part D went into effect, per the HFS Director;
- 2 were for University of Illinois at Chicago physicians that were expedited per an attestation letter from the hospital that included signatures from multiple physicians attesting that they had over 50% in billings from Medicaid. However, no signed agreement was on file with HFS;
- 1 was not an expedited provider, but the provider received a one-time drop payment; and
- 1 was expedited without an agreement per the Bureau Chief of Comprehensive Health Services.

Auditors raised the following additional issues related to the lack of policies, procedures, and guidelines.

Expedited Payment Parameters

HFS does not have any policies or guidelines to document the criteria used to determine the expedited payment parameters. In addition, 89 Ill. Adm. Code 140.71(b) does not have criteria related to setting payment parameters. As a result, there was no documentation for auditors to review documenting how payment parameters are set for expedited providers. For example, as seen in Exhibit 2-3, many provider types such as hospices are expedited at 50 days while rural health clinics are expedited at 23 days.

Lack of Supporting Documentation

HFS officials stated that these providers requesting expedited payments (except for hospitals and LTC providers) are not required to submit any financial documentation, such as financial statements, to support the emergency nature of the request. Without documentation, it is unclear how HFS assures that the emergency requirements found in the Administrative Rule are met. According to HFS officials, the provider must submit a signed letter to HFS, which states that it is meeting the guidelines in 89 Ill. Adm. Code 140.71(b). If approved, all payments are expedited by HFS and the provider is paid on a weekly basis for any claim that ages over a certain number of days referred to by HFS as the provider's payment parameter. Exhibit 2-3 lists examples of the parameters for payments for expedited providers for FY07. According to HFS officials, once providers are approved for expedited payments, their status is rarely changed.

Additionally, HFS does not have documentation to support the steps it takes to determine whether a provider meets the

Exhibit 2-3
FY07 EXPEDITED PAYMENT PARAMETERS

Provider Type	Days[1]
Physicians	50
Dentists	50
Optometrists	50
Podiatrists	50
Nurse Practitioners	50
Registered Nurses	50
Occupational Therapists	50
Speech Therapists	50
General Hospitals	50
Psychiatric Hospitals	50
Rehabilitation Hospitals	50
Mental Health Service Providers	50
Hospices	50
Federally Qualified Health Centers	50
Encounter Rate Clinics	50
Home Health Agencies (in home)	50
Certified Health Departments	50
Independent Laboratories	50
Opticians/Optical Companies	50
Other Providers of Medical Equipment/Supplies	50
Ambulance Service Providers	50
Medicar Providers	50
Taxicabs and Livery Companies	50
Other Transportation Providers	50
Private Auto	50
Pharmacies	40
Supportive Living Facilities	35
Mentally Retarded Facilities	35
Nursing Facilities	35
ICF/MI Facilities	35
Rural Health Clinics	23
Safety Net Hospitals	0

Note:

[1] The maximum number of days a Medicaid claim will be held by HFS before it is put on a schedule for submission to the Comptroller for payment. Expedited schedules are paid on a weekly basis.

Source: Department of Healthcare and Family Services.

criteria to be expedited found in 89 Ill. Adm. Code 140.71(b). We reviewed the files for a random sample of 66 expedited providers. For the 24 providers that had current signed agreements, 19 files (79%) did not have documentation from the providers for HFS to verify that the providers met the Administrative Rule's requirements to substantiate the emergency nature of the request. The only documentation available for review was a letter from the providers attesting that they met the eligibility requirements. The five files where providers submitted documentation contained items such as bankruptcy papers, a one page credit statement, and a 2005 tax return.

The Administrative Rule also requires providers to serve a significant number of clients under the Medical Assistance Program (Medicaid). The Administrative Rule then provides various definitions for "significant" depending on the provider type. For 22 of the 24 providers sampled that had current signed agreements, there was no documentation to support that the provider met the significance requirements related to the number of Medicaid clients served as required by the Administrative Rule.

Outdated Agreements with Expedited Providers

HFS does not have an annual application process to be an expedited provider for long term care and maternal and child health providers to ensure that the providers continue to meet the eligibility requirements. As a result, HFS is not updating long term care and maternal and child health providers' expedited agreements in a reasonable timeframe.

The Administrative Rule (89 Ill. Adm. Code 140.71(b)) requires providers to "…serve a significant number of clients under the Medical Assistance Program" in order to be expedited. For LTC providers, significance is defined as: 1) 80 percent or more of the residents must be eligible for public assistance; or 2) four or more residents must be receiving exceptional care at LTC facilities enrolled in the Exceptional Care Program.

We requested the six agreements for LTC facilities in our sample. One agreement could not be located by HFS. For the five agreements reviewed, we found the information was completed using cost reports that dated as far back as December 31, 2001. In addition, one agreement was approved for housing a total of four Exceptional Care patients according to a resident roster as of March 31, 2003. Without a routine process to continually review eligibility requirements, providers could continue to be expedited even if their significance levels fall below eligibility requirements.

In addition to long term care facility agreements, HFS is not updating maternal and child health provider agreements in a reasonable timeframe. None of the four maternal and child health provider agreements from our expedited sample were updated annually. The documentation provided by HFS shows that the current agreements on file for the four providers were from January 2001, April 2003, January 2006, and one dating back to 1993.

There were also instances identified where HFS made decisions to expedite providers that did not meet the criteria outlined by Administrative Rule. For example, HFS officials stated they allowed 3 of 66 providers from our sample to be "grandfathered in" to expedited status.

According to HFS officials, these providers were expedited prior to Medicare Part D. The officials noted that as a result of Medicare Part D, these providers lost a significant percentage of their revenue from Medicaid which took them below the significance limits required by the Administrative Rule.

Outdated Provider Lists for Mt. Sinai and U of I Hospitals

There were 11 providers from our sample of 66 that are physicians at either Mt. Sinai or the University of Illinois at Chicago hospitals. According to HFS officials, Mt. Sinai Hospital and the University of Illinois at Chicago Hospital are two of several safety net hospitals and are expedited at 0 days because they are considered cash flow sensitive. We found that provider lists from these hospitals were not updated regularly by HFS. A list of eligible physicians from Mt. Sinai Hospital is dated March 2001. Additionally, letters requesting expedited status from Mt. Sinai physicians were provided by HFS dated back to January 2003.

The list of eligible physicians from the University of Illinois at Chicago Hospital includes provider signatures dating back to June 2002. HFS officials stated that the providers on these lists continue to receive expedited payments unless a call is made by the hospital to notify HFS that a provider should be removed from expedited status. HFS should have policies and procedures that require the submission of eligible physician lists on a more routine basis.

EXPEDITED PAYMENT PROCESS	
RECOMMENDATION NUMBER **4**	***The Department of Healthcare and Family Services should:*** • ***develop written policies and procedures for reviewing, documenting, and approving all expedited providers to ensure that only providers that are eligible by the Administrative Rule receive expedited payments; and*** • ***ensure provider agreements and provider lists are updated regularly for all expedited payments.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department agrees with the recommendation and will further document in writing its existing procedures not already set forth in rule for verifying qualification for expedited status. While these policies and procedures are adequate, the Department acknowledges that they are not set down in a comprehensive document. The Department will continue its current policy of reviewing continued qualification of expedited status semi-annually for all non-LTC expedited providers. The Department will begin to periodically review the status of LTC providers.

	AUDITOR COMMENT: *During the course of the audit, HFS officials noted that expedited status is reviewed **annually** for providers and every other year for pharmacies, not semi-annually as noted in the Department's response. In their review of expedited agreements, auditors found no evidence that HFS' current review is completed on a semi-annual basis.*

ONE-TIME DROP PAYMENTS

HFS uses another poorly defined process to expedite payments to certain providers. These payments, referred to as "one-time drop" payments, are made to providers who, according to HFS officials, need a one-time infusion of cash (such as having difficulty in making payroll or making quarterly tax payments). If a provider's request is granted, HFS authorizes the payment of any outstanding claims. In FY07, HFS made **$5.7 million** in claim payments as a result of one-time drop requests.

Management controls over the one-time drop payment process are deficient. There are no criteria and/or basis for these one-time drop payments included in the expedited payment section of the Administrative Rule (89 Ill. Adm. Code 140.71(b)) or in HFS' policies or procedures. HFS does not require the provider to submit documentation of an emergency need. Additionally, no policies or procedures exist to delineate the process for providers requesting or HFS' review and approval of the need for a one-time drop payment. According to HFS officials, providers hear about the one-time drop process through word of mouth.

One-Time Drop Case Example

On June 29, 2006, an employee in the HFS Bureau of Comprehensive Health Services sent an e-mail to the Bureau of Technical Support requesting that a medical equipment provider's payment parameter be reduced in order to initiate a one-time drop. There was no documentation provided showing who had requested HFS to make the one-time drop payment or why it was necessary. Over the next month, the provider was paid $490,737 for outstanding unpaid claims. Prior to being designated as a one-time drop, no payments were made to the provider in June 2006, and only $83,291 had been paid to the provider since February 2006.

HFS does not require providers to submit a written request documenting their need or keep a log of one-time drop payment requests. According to HFS officials, these providers usually contact HFS by phone and declare their emergency need to be paid. Once HFS receives a one-time drop payment request, HFS officials stated they check to see whether HFS is behind on payments to the provider. If the provider has unpaid claims, an HFS official will authorize the payment of any outstanding claims (see inset for case example). An HFS official noted that providers are usually allowed to request a one-time drop once annually. However, the official noted that if the situation warrants it, he may approve more than one drop annually.

HFS does not keep a formal log or adequately track all one-time drop payments made in a year. We asked HFS how many one-time drop providers there were annually. An HFS official estimated that there would be between 100 and 1,000 – likely closer to 100. HFS provided a spreadsheet that tracked FY07 one-time drop payment requests as well as copies of internal HFS

e-mails authorizing the one-time drop payments. E-mail is used by HFS staff to request a change in the payment parameter which expedites the one-time drop payment and then a second e-mail is used to remove the one-time drop parameter at a later date.

Auditors compared the one-time drop spreadsheet and e-mails and found neither was complete. HFS subsequently provided e-mails for all the one-time drops on the spreadsheet. However, the HFS official noted that the spreadsheet was not an "official" or all-inclusive list because other HFS staff may make requests for one-time drop payments for providers that may not be reflected on the spreadsheet. There were 178 one-time drop payments listed on the spreadsheet. These payments were made to 135 providers. Thirty-seven of the providers had 2 or 3 one-time drop payments in FY07. Many of the providers receiving multiple one-time drop payments were therapists. Also, there were e-mails with the names for at least 40 one-time drop providers that did not appear on the spreadsheet.

During testing, auditors found that generally the only documentation to support one-time drop payments were the e-mails between HFS employees and the spreadsheet. There was no log or consistent documentation showing who outside HFS requested the payment or whether HFS determined that an emergency need existed.

<table>
<tr><th colspan="2">ONE-TIME DROP PAYMENTS</th></tr>
<tr><td>RECOMMENDATION NUMBER
5</td><td>The Department of Healthcare and Family Services should develop policies and procedures for authorizing one-time drop payments to providers. These policies should include criteria for eligibility and requirements for maintaining necessary documentation.</td></tr>
<tr><td rowspan="2">DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE</td><td>The Department agrees with the recommendation and will enhance its documentation of one-time payment drops, which represent less than seven 100ths of one percent (.0069) of claims paid.</td></tr>
<tr><td>AUDITOR COMMENT:

As noted in the audit report, the total dollar amount of one-time drop payments made by HFS in FY07 - $5.7 million - was not insignificant and should be documented.</td></tr>
</table>

DELAYS IN MEDICAID PAYMENTS

The primary delay in paying Medicaid claims occurs due to the payment schedules established by HFS. As will be discussed in this section, claims were processed and approved for payment an average of **6** days after receipt by HFS in FY06. However, on average, **57** days passed before they were vouchered and sent to the Comptroller's Office for payment. Providers that are paid on an expedited basis by HFS do not experience delays like those experienced by non-expedited providers.

To determine exactly where delays in claim processing and payment occur, we looked at data for all claims paid during FY06. The data contained only claims paid in FY06 and therefore does not include any information for claims that were denied and not paid during FY06. During FY06, 94.8 million claims were paid by HFS, and 46.1 million claims (49%) were paid by HFS after the required 60 days. The majority of those claims, 45 million, did not accrue at least $5 in prompt payment interest. We looked at the payments received by expedited providers versus non-expedited providers. There were 19.8 million claim payments made to expedited providers totaling over $2.7 billion. There were almost 75 million claim payments to non-expedited providers totaling almost $5.2 billion. On average, payments to expedited providers were made within the 60 day time period required by the Prompt Payment Act. However, on average, payments to non-expedited providers were not made within the 60 day time period required by the Prompt Payment Act.

Delayed Claim Payments to Non-Expedited Providers

As seen in Exhibit 2-4, during FY06, non-expedited providers experienced significantly longer payment delays than did expedited providers. The delays would have been greater during FY06 had the State not taken a $1 billion short term loan on November 22, 2005 to help pay Medicaid claims. Exhibit 2-4 shows that even with the $1 billion loan, there were six months during FY06 where non-expedited claims averaged 60 days or more at HFS before being vouchered and sent to the Comptroller for payment. The exhibit also shows that claims vouchered by HFS in July 2005, on average, had been sitting at HFS for more than three months. As a result, non-expedited providers were not paid at the end of FY05, but instead, were paid in the following fiscal year after HFS received its FY06 appropriation.

Where Delays Occur

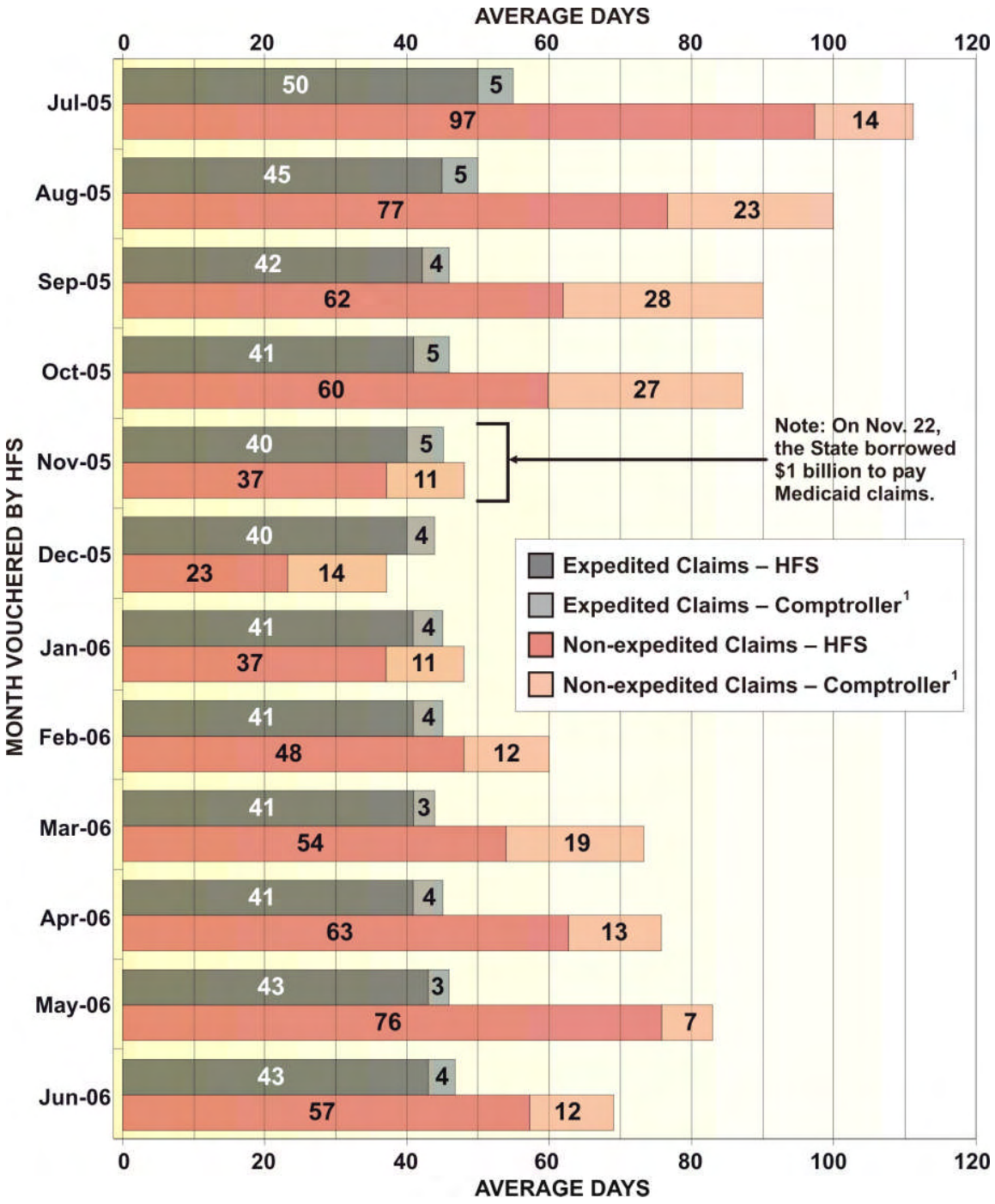
In FY06, delays in claim payments occurred as a result of the payment schedule while the claims were pending at HFS. In FY06, it took HFS an average of **6 days to process** claims; however, it took HFS **57 days to submit** claims to the Comptroller for payment. All together, it took a total of 71 days on average for claims to be processed by HFS and paid by the Comptroller. The average number of days it took to pay claims to expedited providers was 47 while the average number of days to pay non-expedited providers was 77. To determine exactly where the delays occurred, we looked at three different stages of the approval and payment process: 1) HFS processing time; 2) days pending at HFS; and 3) days at the Comptroller. Exhibit 2-5 shows the average time it took FY06 medical claims to be paid by each stage in the life of the claim.

Claims, once approved for payment, go into a pending state while they wait for the next available payment schedule. Since claims for expedited providers were all scheduled for less than 60 days and were paid weekly, their payments sat in pending for an average of 39 days. Claim payments to non-expedited providers sat pending payment for 54 days on average. This is a result of non-expedited providers having a payment parameter ranging from 30 to 118 days.

Additionally, because expedited providers are paid weekly by the Comptroller, the average number of days from the voucher date to when the claim was paid by the Comptroller was 4.2 days. Non-expedited providers are not paid on a weekly basis, and are paid when there is available cash on hand. The average number of days from the voucher date to the date paid by the Comptroller for non-expedited providers was 16 days.

Exhibit 2-4

AVERAGE DAYS FOR HFS AND THE COMPTROLLER TO PROCESS ALL FY06 EXPEDITED AND NON-EXPEDITED MEDICAL CLAIMS

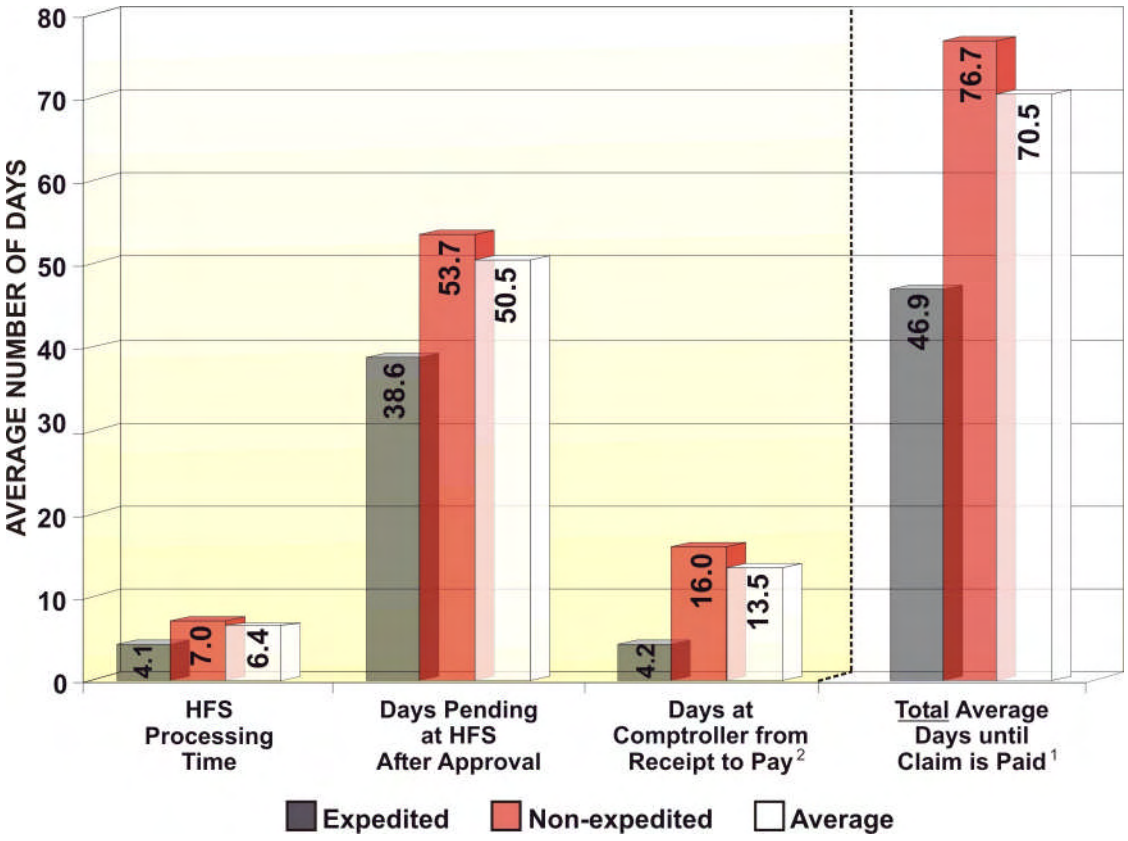


Note:

[1] Calculated from HFS voucher date to Comptroller warrant date. HFS officials stated that it could take one or two days from the date the claim was vouchered at HFS until it is received by the Comptroller.

Source: Illinois Department of Healthcare and Family Services all FY06 paid claims.

Exhibit 2-5
AVERAGE DAYS FOR ALL FY06 CLAIMS TO BE PROCESSED AND PAID
By each stage in the life of the claim



Notes:

[1] Totals may not add due to rounding.

[2] Calculated from HFS voucher date to Comptroller warrant date. HFS officials stated that it could take one or two days from the date the claim was vouchered at HFS until it is received by the Comptroller.

Source: Illinois Department of Healthcare and Family Services all FY06 paid claims.

SUBMISSION OF MEDICAID CLAIMS BY PROVIDERS

There is no State law or Administrative Rule that sets the number of claim forms or service lines per bill that HFS is required to follow. Additionally, an HFS official noted that spacing on each of the forms is the reason for the varying numbers of service lines by types of forms. HFS has eight different types of forms for Medicaid claim reimbursement. According to HFS officials, the number of services associated with a bill is dependent on the type of claim. In addition, the number of services associated with a bill also depends on whether the claim is submitted in hard copy or electronically.

As seen in Exhibit 2-6, for many of the invoice types, providers are allowed to submit more services per bill if the bills are submitted electronically. With the exception of drug invoices, providers can submit more service lines per electronic submission than they can per hard copy submission. The majority of electronic claim forms allow providers to submit up to 50 service lines. The majority of hard copy claim forms allow providers to submit up to seven service lines on a bill.

Hospitals are the only type of provider that can submit multiple pages of a hard copy claim for one bill. In all other cases, providers are limited to one page per hard copy bill. As a result, hard copy hospital claims can accrue prompt payment penalty interest for up to 55 services per bill. Additionally, hospitals can submit and accrue prompt payment penalty interest on 999 service lines per electronic form.

Exhibit 2-6
DIFFERENT TYPES OF INVOICES SUBMITTED TO HFS BY PROVIDERS FOR MEDICAID REIMBURSEMENT

Type of Invoice	Service Lines Allowed per Hard Copy Form	Services Lines Allowed per Electronic Form
Medical Equipment/Supplies	5	50
Physician	7	50
Transportation	8	50
Hospital	55	999
Drug (Pharmacies)	7	1[1]
Lab/Portable X-Ray	7	50
Health Agency	7	50
Provider/Optical Prescription	7	50

Note:

[1] According to HFS officials, there are actually four services per transmission; however, as a practical matter, there is almost always one service per transmission.

Source: HFS information summarized by the OAG.

Pharmacies can submit up to seven service lines per hard copy claim form, but according to HFS, there is almost always one service line per electronic claim form. Thus, each individual prescription becomes its own individual bill. As a result, electronically submitted pharmacy claims are not batched together for the calculation of interest. Eight pharmacies filed suit in the Court of Claims on September 26, 2006, arguing that HFS and the Comptroller are not following the Prompt Payment Act by calculating interest on each individual prescription. As of January 2008, the case was still pending.

Since interest is based off of the total dollar amount of a bill, the more service lines that a provider can include on a bill, the more interest a bill can accrue. As a result, hospital bills accrue more prompt payment interest than the other provider types. Additionally, pharmacies that submit claims electronically only have one prescription per bill, and therefore, rarely accrue any prompt payment interest.

Chapter Three

REJECTED MEDICAID CLAIMS

CHAPTER CONCLUSIONS

HFS is not notifying providers "as soon as possible" of its decision to reject claims as required by Administrative Rule (74 Ill. Adm. Code 900.70(c)). From our sample of 384 rejected services in calendar year 2006, we found that for non-expedited providers it took HFS an average of **87 days to notify providers** of a rejected service when the rejected service was submitted on a claim along with a service that was paid. Additionally, we found that in FY06, it took an average of **77 days** for non-expedited claims to be approved and paid. In this scenario, on average it would have taken **164 days** for a claim to be rejected by HFS and to be processed and paid once corrected by the provider. The 164 days does not include days taken by the provider to originally submit the claim or days needed by the provider to resubmit the rejected services. HFS was generally timely in notifying providers if the entire claim was rejected (an average of 12 days in calendar year 2006).

Additionally, when HFS notified providers of their rejected claims during calendar year 2006, providers may have experienced difficulty correcting the rejected services because some error codes reported to the providers were not on HFS' list of error codes found in the provider handbook. **We identified 123 error codes HFS used for rejected services that were reported to providers in 2006 that were not on the list of error codes found in HFS' provider handbook.** These error codes are used by providers to determine why a service was rejected so they can make the appropriate corrections in order to resubmit the rejected services within the required 12 month period.

Even though HFS did not pay all claims or notify all providers of rejected claims within 60 days, HFS instructs providers to resubmit a claim if the claim has not appeared on a remittance advice after 60 days from mailing the claim to HFS. As a result, providers may unnecessarily resubmit duplicate claims to HFS. During FY06, HFS paid 46.1 million claims after 60 days.

As directed by Legislative Audit Commission Resolution 137, we surveyed Medicaid providers asking them to identify problems they may have encountered with the claims rejection process. The survey specifically asked providers how often they understood the reason(s) why the bill was rejected and whether or not they agreed with the decision to reject the claim. The majority of the providers (71%) responded that they usually or always understood the reason the claim was rejected. Fifteen percent responded that they rarely or never understood the reason.

Additionally, the majority of the providers (78%) responded that they sometimes, usually, or always agreed with the reason the claim was rejected. Twenty-two percent of the providers responded that they rarely or never agreed.

Sixty-seven percent of the providers responded that they had experienced a problem with the claims rejection process. Specific problems identified by providers included: HFS taking too long to deny claims; confusion why a claim was rejected; denial of clients after they had been approved; and denial for refilling a prescription too soon.

REJECTED CLAIM PROCESS

During the processing of Medicaid claims by HFS, the claims are run against a series of edit checks to determine the validity of the claim. A list of edit check description codes are contained as an appendix to the Handbook for Providers of Medical Services, which can be found on the HFS website. The handbook states that providers will be held responsible for compliance with all policies and procedures found within the handbook. There are 98 pages of error codes that list 477 distinct error code numbers and explanations. The error codes in the handbook have not been updated since July 2005. We identified 123 error codes used by HFS during CY06 that were not listed in the handbook. Exhibit 3-1 shows examples of two common error codes with the explanations from the provider handbook found on the HFS website.

Exhibit 3-1
EXAMPLES OF ERROR CODE INFORMATION
From the Provider Handbook found on the HFS Website

Error Code	Message	Explanation
D05	SUBMITTED LATER THAN ONE YEAR AFTER SERVICE	A claim was submitted more than twelve (12) months after the date on which the service was provided. The Department will not process claims received more than twelve (12) months after the Date of Service. See Chapter 100, Topic 112.
R03	RECIPIENT NOT ELIGIBLE ON DATE OF SERVICE	A claim was received for a date of service which does not fall within the range of the patient's medical eligibility period. Review patient's records to ensure that the correct Recipient Identification Number was used for the dates of service being billed. If an error occurred, rebill with the correct date of service. If no error occurred, no payment can be made.

As of October 16, 2007, there were 23.1 million services with both first time rejections and all their subsequent rejections for calendar year 2006. Since there could be more than one reason for a service to be rejected, the total number of reasons rejected was more than the total number of services. The most common reason a service was rejected was for a duplicate payment voucher. This error code was used almost 3.9 million times during calendar year 2006. Exhibit 3-2 lists the top 20 reasons why services were rejected from the 23.1 million services rejected in calendar year 2006.

Once HFS' computer system determines that a service on a claim has an error, the service is rejected unless the error(s) can be corrected by HFS staff. The providers are notified of the rejection on a remittance advice. The remittance advices are in hard copy and are mailed to the

providers. Providers can contact HFS toll free at 1-877-782-5565 if they have questions as to why the services were rejected.

There are two ways providers receive a remittance advice for rejected services. The first is when an entire claim is rejected. The second way a provider receives a rejection is on a remittance advice when the entire claim is not rejected. As long as one or more of the services are approved for payment and one or more of the services are rejected, the provider will be notified of the rejection(s) on the remittance advice. The remittance advice is received with the payment for the approved services.

Exhibit 3-2
TOP 20 REASONS SERVICES WERE REJECTED
Calendar Year 2006

Error Code	Error Code Description	Number of Occurrences
D01	Duplicate Payment Voucher	3,856,452
B94	Part D Service - Bill Medicare	3,607,618
R03	Recipient Not Eligible on Date of Service	1,479,838
U25	Refill Too Soon	1,300,419
R17	Services Invalid for Recipient Age	1,068,198
A24	Not a Preferred Drug Call 1-800-252-8942	957,574
C16	Procedure Not Covered by IL Medical Assist	838,537
R09	Prior Approval Required	753,854
R41	Prior Approval Not on File	721,222
R36	Part B Service - Bill Medicare	602,610
A32	NDC Not Covered for Critical Care Provider	599,606
F72	Inval/Missing CLIA Cert for Date of Service	583,085
A12	Refill Too Soon Carry Over Days Supply	580,013
D05	Submitted Later Than One Year After Service	519,349
X09	Lab Procedure Previously Paid	495,763
B32	Other Payer ID Qualifier Not Equal 99	491,526
X73	Missing/Invalid Prior Approval Number	466,092
X06	Surgical Package Previously Paid	446,087
A50	Service Not Covered Without Modifier U1	435,175
C97	No Payable Service on Claim/Rebill	417,606

Source: Calendar Year 2006 rejected claim data provided by HFS.

Timeliness of Rejected Claim Notification

HFS is not notifying providers "as soon as possible" of its decision to reject claims as required by Administrative Rule (74 Ill. Adm. Code 900.70(c)). Legislative Audit Commission Resolution Number 137 asks whether decisions to reject bills (claims) as not being in proper form are adequately documented and communicated in a timely manner to vendors. We chose a random sample of 384 rejected services from more than 23 million rejected services in calendar year 2006 to determine whether HFS is notifying providers timely.

HFS was unable to provide auditors with the date the claims were rejected as required by Administrative Rule (74 Ill. Adm. Code 900.30(b)(4)). As a result, in order to determine how long it took HFS to notify providers of a rejected claim, auditors calculated the number of days between receipt of the claim and the date the provider was notified of the rejection.

As seen in Exhibit 3-3, we found that HFS was not notifying providers timely in instances where a claim contained at least one rejected service and at least one paid service. From our sample of rejected services, we found that for non-expedited providers it took HFS on

average **87 days** from the date of receipt to notify providers of a rejected service when the rejected service was submitted on a claim along with a service that was paid. Additionally, we found that in FY06, it took an average of **77 days** for non-expedited claims to be approved and paid. In this scenario, on average it would have taken **164 days** for a claim to be rejected by HFS and to be processed and paid once corrected by the provider. The 164 days does not include days taken by the provider to originally submit the claim or days needed by the provider to resubmit the rejected services.

HFS was generally timely in notifying providers if the entire claim was rejected. From our sample, for claims that were entirely rejected in calendar year 2006, HFS notified the providers of the rejection in an average of 12 days from the date of receipt.

The timely rejection of claims by HFS is necessary to ensure that providers have enough time to resubmit claims before the one year deadline expires. Several providers that responded to our survey noted that it takes so long for a claim to be rejected that when they resubmit the claim with the correct information, it is not paid because it was submitted after the one year time limit.

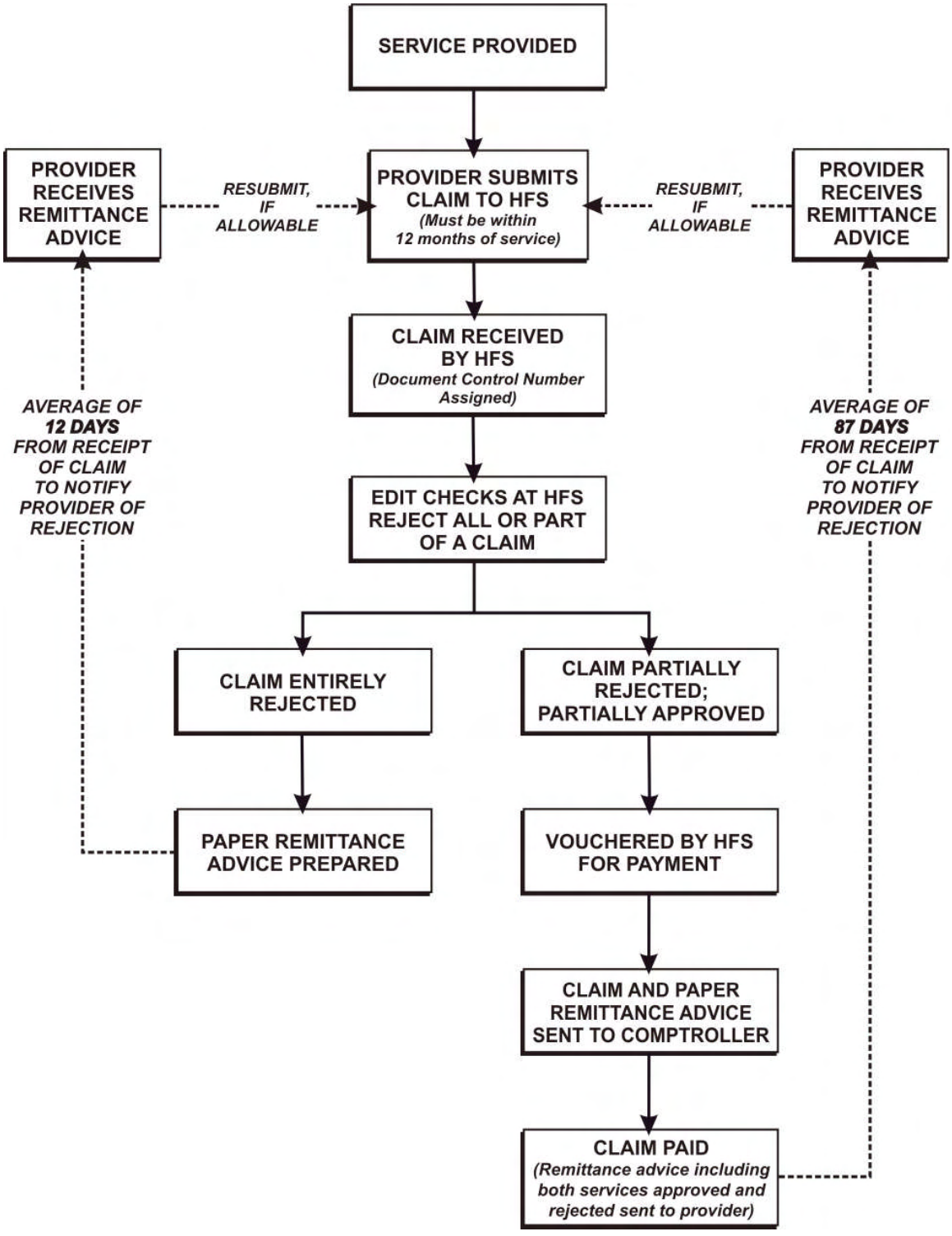
For providers to be eligible for medical payment consideration, Illinois Administrative Rule (89 Ill. Adm. Code 140.20) states that a claim or bill must be submitted or resubmitted following a prior rejection to HFS no later than 12 months after the date on which medical goods or services were provided or 24 months if Medicare is billed first. Therefore, since providers only have 12 months to resubmit rejected Medicaid claims, HFS should notify the providers of rejected claims as soon as possible after the discovery of the defect as required by 74 Ill. Adm. Code 900.70(c). This allows providers to have more time to resubmit rejected claims before the 12 month time period expires.

Adequate Reporting of Rejected Claims to Providers

During calendar year 2006, we determined that HFS rejected services for reasons that were **not** listed in the error codes found in the provider handbook. We compared the error codes that HFS used to notify providers during calendar year 2006 with the list of error codes published in the provider handbook found on HFS' website. We identified 123 error codes HFS used for rejected services that were reported to providers in 2006 that were not on the list of error codes found in HFS' provider handbook. These error codes are used by providers to determine why a service was rejected so they can make the appropriate corrections in order to resubmit the rejected service within the required 12 month period. Since the handbook's list of error codes contains a more detailed description than what is printed on the remittance advice, HFS should update the list of error codes that is available to providers to include all codes currently being used by HFS.

Remittance advices can be thousands of pages in length and the rejected claims are often mixed in with claims that are paid. From our sample of rejected claims, we found one remittance advice sent to a laboratory that was 10,650 pages. As a result, providers must look through thousands of pages in order to identify claims that were not paid. According to HFS officials, some providers have access to review claim status electronically through the MEDI system.

Exhibit 3-3
HFS PROCESS TO NOTIFY PROVIDERS OF REJECTED CLAIMS
From Sample of Calendar Year 2006 Rejected Claims



Source: HFS rejected process summarized by the OAG and sample of CY06 rejected claims.

REJECTED CLAIM NOTIFICATION	
RECOMMENDATION NUMBER **6**	***The Department of Healthcare and Family Services should:*** • ***maintain the date the claim was rejected as required by 74 Ill. Adm. Code 900.30(b)(4);*** • ***develop a process to notify providers as soon as possible of their rejected claims as required by 74 Ill. Adm. Code 900.70 to allow providers ample time to resubmit services that are rejected;*** • ***update the list of error codes that is available to providers to include all codes currently being used to reject claims by HFS; and*** • ***explore alternatives to notifying providers of rejected claims other than by sending hard copy remittance advices.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	• The Department respectfully disagrees with the recommendation and states the Department does maintain the dates of when claims are approved or rejected. The official date of action is the date of adjudication and is maintained in the Department's MMIS system for two years and in the Department's Medical Data Warehouse since 1996. Archived data is also available. • The Department respectfully disagrees with the recommendation. All rejected claims that have passed through the appropriate claims processing editing functions are already reported weekly to providers via the weekly rejected claim remittance advices. As is noted in the audit report, this notification occurs within an average of 12 calendar days from receipt of the claim. Notification of the dispensation of each service line on a paid claim is contained in the remittance advice, which can be delayed as a result of slow payment cycles. However, any provider may check the status of payment for every service on a claim processed for payment through the MEDI system. The status is available as soon as adjudication is complete, within approximately 6 days of receipt of the claim. This process is far superior and more efficient than any further mailing of paper status notification. • The Department agrees with the recommendation. Updated error code listings will be made available to providers in the most efficient and timely fashion. • The Department agrees with the recommendation and has already deployed one alternative and is currently piloting a second. Providers can currently check the status of any of their claims after seven days from submission via the Departments website's MEDI system. This system has been

	in place since 2004. Implementation of electronic remittance advices is being piloted with 119 Institutional providers and 828 Non-Institutional providers participating in the Pilot Project. The HIPAA 835 transactions will provide electronic claim results in lieu of the hard copy remittance. Electronic supplemental information will also be provided to fully explain reasons for rejects and other helpful information.
	AUDITOR COMMENTS: *On at least **6** different occasions during the course of the audit – January 7, 2008, January 16, 2008, January 23, 2008, January 25, 2008, January 30, 2008, and January 31, 2008 – auditors requested the rejected claim date for claims in our rejected claim sample. Five of the requests were in writing and one was verbal. HFS officials did not respond to the auditors' requests. Consequently, this recommendation was included in the audit report.* *As noted in the report, HFS is not notifying providers "as soon as possible" of its decision to reject claims as required by administrative rule. During testing, we found it took on average **87 days** for HFS to notify providers of rejected services when the rejected service was submitted on a claim along with a service that was paid.* *Furthermore, HFS responded that providers can check the MEDI system for the status of claims, but HFS officials acknowledged that not all providers use the MEDI system. Additionally, the administrative rule **requires HFS to "notify"** providers upon discovery of a claim with defects. The MEDI system does not notify providers; it is a system that some providers may use to check claim status.*

Resubmitting of Medicaid Claims

HFS' provider handbook gives guidance related to the resubmitting of Medicaid claims. The handbook instructs providers to resubmit a claim if the claim has not appeared on a remittance advice after 60 days from the date the provider mailed the claim to HFS. HFS did not pay all claims or notify all providers of rejected claims within 60 days in FY06. Because of the untimely way HFS notifies providers of rejected claims, if providers follow the instructions on resubmitting claims found in the handbook, providers will send in a large number of duplicate claims. The handbook states:

> *The action taken on each claim processed is reported to the provider on Form DPA 194-M-1, Remittance Advice. If more than 60 days has elapsed since the mailing of a claim and the action taken on that claim by the Department has not appeared on a Remittance Advice, the provider must assume that the claim was not received by the Department. The provider should prepare a new original claim for submittal to the Department. It is the responsibility of the provider to assure that a claim is submitted timely.*

We determined that the average time it takes HFS to notify providers of rejected services when billed with a paid service was 87 days, which is longer than the 60 days. Additionally, we determined that in FY06, 46.1 million of the 94.8 million paid claims (49%) were not paid by HFS within 60 days. As a result, if the providers followed the instructions found in the handbook, the providers would unnecessarily be submitting numerous duplicate bills to HFS. To eliminate duplication of work for both the providers and HFS, HFS should reexamine its policy that instructs providers to resubmit all claims that have not appeared on a remittance advice within 60 days.

REJECTED CLAIM RESUBMISSION POLICY	
RECOMMENDATION NUMBER 7	***The Department of Healthcare and Family Services should re-examine its policy that instructs providers to resubmit all claims that have not appeared on a remittance advice within 60 days.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department agrees and will instruct providers to resubmit only if their claims fail to appear in claims status on MEDI within 30 days of submission.

Survey of Providers

As directed by Legislative Audit Commission Resolution 137, we surveyed providers with rejected claims during calendar year 2006. The survey contained questions related to the Department of Healthcare and Family Services' claims rejection process. Of the 315 providers surveyed, 80 submitted a response.

Although all 315 surveys were sent to providers that had a claim denied during calendar year 2006, only 68 of the 80 responded that the Department of Healthcare and Family Services had rejected a Medicaid bill submitted for payment for that time period. The other 12 responded that they did not have any rejected claims. However, after our review, we confirmed that all providers in the sample had a rejected claim during calendar year 2006.

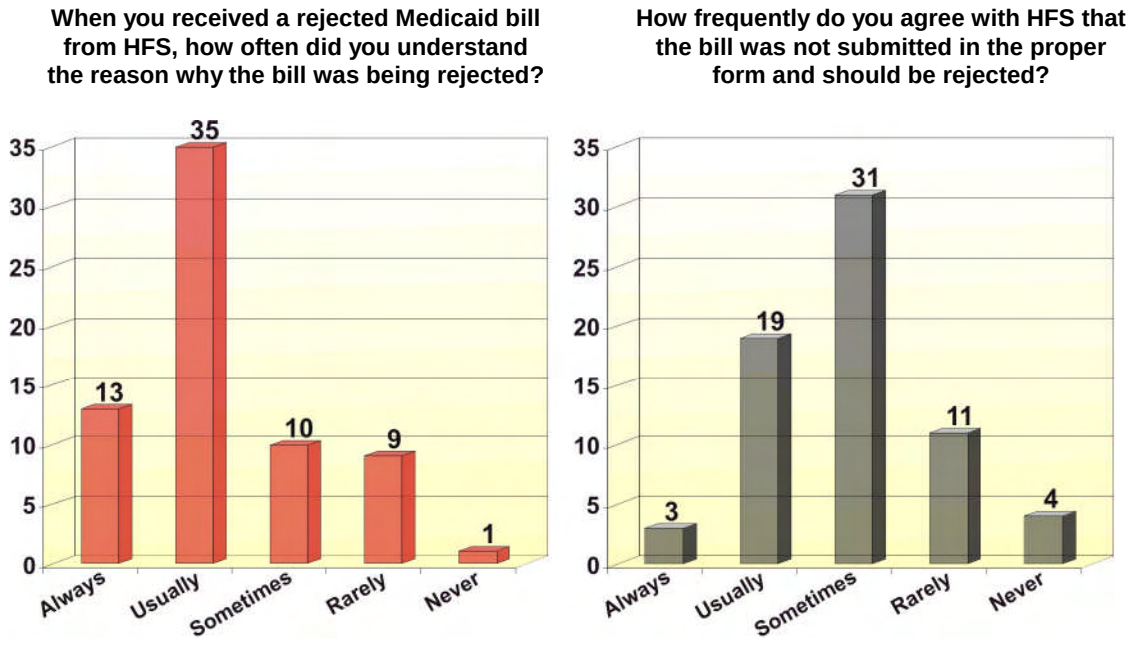
Understanding of Reason Rejected

The survey asked providers how often they understood the reason(s) why the bill was rejected and whether or not they agreed with the decision to reject the claim. The majority of the providers (71%) responded that they usually or always understood the reason the claim was rejected. Fifteen percent responded that they rarely or never understand the reason. The majority of the providers (78%) responded that they sometimes, usually, or always agreed with the reason the claim was rejected. Twenty-two percent of the providers responded that they rarely or never agreed. Exhibits 3-4 shows the results to the questions related to the understanding of the rejection by HFS.

The survey also asked providers to describe the most common reasons why bills were rejected by HFS. Common rejection reasons provided by respondents included: not primary

insurance/third party liability; ineligible at date of service; prior approval/quantity exceeded; duplicate charge or claim; spend down not met; refill too soon; and timeliness/more than 1 year.

Exhibit 3-4
SURVEY RESPONSES TO REJECTED CLAIM QUESTIONS
From the 68 providers that responded



Source: Survey responses of providers with rejected claims during calendar year 2006.

Problems and Provider Recommendations

Our survey asked whether providers had encountered any problems with HFS' claims rejection process. One of the 68 providers that responded to the survey did not answer the question on whether it had experienced problems with the claims rejection process. Forty-five of 67 (67%) responded that they had experienced a problem with the claims rejection process. Twenty-two of the 67 (33%) responded that they had not experienced any problems with the process. We followed up with HFS on several of the issues noted by providers. HFS noted that it has not conducted any recent surveys of providers. Examples of problems encountered by providers included:

- HFS taking too long to deny claims;
- confusion/unsure why a claim was rejected;
- denial of claims as duplicate when they were not a duplicate;
- reasons for suspending claims for review are not specifically stated;
- denial of clients after they had been approved; and
- denial for filling a prescription refill too soon.

If providers had problems, the survey asked them what they would recommend or suggest to improve the claims rejection process. Common recommendations providers would like to see implemented include:

- better explanation as to why claims are being rejected;
- extend hours of operation;
- give notice of guideline changes before bulk rejections occur;
- give specific reasons for suspending claims for review;
- process denials immediately instead of waiting for payments;
- respond more promptly to issues and inquiries;
- have reports online and electronic remittance advices;
- for the refill too soon rejection – display when the appropriate fill date will be; and
- have more HFS staff available to assist them.

REJECTED CLAIM PROBLEMS	
RECOMMENDATION NUMBER **8**	***The Department of Healthcare and Family Services should periodically survey providers to obtain their feedback on problems they are experiencing with the claims rejection process and ways it could be improved.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department respectfully disagrees with the recommendation. The Department's existing feedback mechanisms are more effective than conducting periodic surveys. These include having billing consultants assigned to different provider types who are in daily contact with providers to help them with billing issues. As problems are identified, Problem Resolution Requests (PRRs) or Project Initiation Requests (PIRs) are drafted to resolve the issues or change the system. The Department also regularly consults with provider associations on billing issues. Recent changes in processes have been made as a result of this constant interaction with providers. Finally, the Department's contracted Primary Care Case Management program administrator also has provider service representatives trained to help with billing issues.
	AUDITOR COMMENT: *Given the size and complexity of the Medicaid program and given the concerns raised by respondents to our provider survey, we continue to believe that a systematic, regular, and documented process for obtaining feedback from providers is important and advisable.*

Chapter Four

PROMPT PAYMENT INTEREST OWED AND PAID BY HFS

CHAPTER CONCLUSIONS

Since July 1999, the Department of Healthcare and Family Services' (HFS) handling of prompt payment interest has not been in compliance with the Prompt Payment Act or the Administrative Rule governing the payment of prompt pay interest. Prompt payment compliance issues identified were:

- **HFS is not paying interest to providers in a "reasonable time" as required by 74 Ill. Adm. Code 900.90.** Since July 23, 1999, the Prompt Payment Act required HFS to **automatically** pay interest to Medicaid providers when interest penalties amount to $50 or greater. However, HFS did not have a system in place to pay automatically owed interest to providers until May 2007 – almost **eight years** after the inclusion of Medicaid claims in the Prompt Payment Act. Additionally, for interest amounts owed of at least $5 but less than $50 (which the Prompt Payment Act requires must be **requested** by the provider), it took HFS an average of **452 days** to pay providers requested interest in FY06.

- **HFS is excluding certain claims from interest payments, some of which are not supported by Administrative Rule.** In May 2007, after our audit began, HFS established an Exclusion Policy which lists several reasons why HFS will not pay accrued prompt payment interest to a provider. Some of the exclusions are supported by Administrative Rule; others, however, are not. Furthermore, HFS **retroactively** applied this Exclusion Policy to interest owed dating back to FY00.

- **HFS is not notifying providers within 60 days that an interest request has been denied, as required by Administrative Rule.** If HFS approves part, but not all of the interest request, the provider is not notified of the denied part until the payment for the approved portion of the interest request is received. As noted above, in FY06 HFS took an average of 452 days to pay providers interest after it was initially requested.

HFS has no written policies, procedures, or guidelines that document how decisions are made that determine which providers are paid and when the payments are made. HFS does not have an adequate process in place to verify and calculate prompt payment interest. The process used by HFS to verify and calculate requested interest owed to Medicaid providers is not automated; it consists of a set of undocumented procedures applied by two individuals at HFS.

Between July 1999 and November 2007, approximately 3.3 million claims accrued a potential liability of almost **$81 million** in interest pursuant to the Prompt Payment Act. Actual interest expected to be paid to providers is estimated by HFS to be less due to not all providers requesting eligible interest, as well as exclusions that may be applied to potential interest payments by HFS. Claims with interest totaling at least $5 but less than $50 accrued a potential liability of $44.5 million while claims with interest totaling $50 or greater accrued a potential liability of $36.1 million. As of November 2007, HFS had paid a total of **$21.8 million** in prompt payment interest to providers for late payment of claims. The **$21.8 million** in payments fell into the following categories:

- **Interest totaling at least $5 but less than $50.** The Prompt Payment Act requires that providers must request this interest before it is paid (requested interest). Approximately 3.1 million claims had accrued a potential liability of **$44.5 million** in requested interest; however, **$35.7 million** has not been requested by providers. As of November 2007, providers had requested interest penalty payments totaling $8.8 million, of which HFS had paid only $3.6 million.

- **Interest totaling $50 or greater.** The Prompt Payment Act requires that interest totaling $50 or greater be paid automatically to providers (automatic interest). Approximately 273,000 claims have accrued a potential liability of **$36.1 million** in automatic interest since fiscal year 2000. As of November 2007, HFS had paid providers $16.6 million in automatic interest. Through the use of its newly adopted Exclusion Policy, HFS excluded $11.5 million of the $36.1 million in accrued potential interest liability.

- **Court of Claims ordered interest.** Through rulings by the Court of Claims, long term care providers have been paid $1.6 million in prompt payment interest as a result of late payment of Medicaid claims made by HFS.

HFS requires providers to follow a cumbersome process to request interest, including requiring them to submit information not required by Administrative Rule. For example, when requesting interest, HFS requires the providers to calculate how much interest is owed to them. This can be very time intensive for providers to complete and is not relied upon by HFS. HFS does its own calculation once an interest request is received. In addition, HFS requires providers to include the warrant date on their request. The warrant date is not readily available to the providers and is of questionable need to HFS. It is also not correctly defined in HFS' Medical Interest Payment Instructions used by providers to request interest.

HFS INTEREST CALCULATION PROCESS

The Department of Healthcare and Family Services does not have an adequate process in place to calculate and pay prompt payment interest as required by the Prompt Payment Act. HFS uses a set of undocumented procedures to calculate and pay prompt payment interest owed to Medicaid providers. Additionally, the system used to calculate and pay prompt payment interest is not automated.

If interest accrues to $50 or more on a bill, HFS is required to automatically pay the provider the interest owed - referred to in this report as "automatic interest." If interest accrues to at least $5 but less than $50, HFS is required to pay providers only if the providers request the interest - referred to in this report as "requested interest."

Exhibit 4-1 shows that since July 1999, approximately 3.3 million claims accrued a potential liability of almost **$81 million** in interest pursuant to the Prompt Payment Act. Actual interest expected to be paid to providers is estimated by HFS to be less due to not all providers requesting eligible interest, as well as exclusions that may be applied to potential interest payments by HFS. HFS has paid just under $21.8 million to providers for late claim payment penalties as required by the Prompt Payment Act as of November 2007.

Exhibit 4-1
INTEREST ACCRUED AND PAID ON CLAIMS
Between July 1999 and November 2007

Interest Type	Claims Accruing Interest [1]	Potential Interest Amount [1]	Total Paid
Requested (Interest at least $5 but less than $50)	3,072,660	$44,516,653	$3,590,851 [3]
Automatic (Interest $50 or greater)	273,372	$36,110,815	$16,602,753
Court of Claims Ordered Interest Payments	(2)	(2)	$1,598,964
Totals	**3,346,032**	**$80,627,468**	**$21,792,568**

Notes:

[1] Includes claims excluded from interest payments by HFS during the interest calculation process.

[2] Included within the number of claims accruing interest and the amount accrued categories for interest $50 or greater and interest at least $5 but less than $50.

[3] In FY04, requested interest totaling $2,344,818 was paid to pharmacies, which included some interest claims greater than $50.

Source: FY00 - FY07 interest data provided by HFS.

Several large pharmacies requested the payment of interest by HFS in FY03 and FY04. HFS paid 11 pharmacies $2.3 million for 242,261 claims that had accrued interest. Several providers have received prompt payment interest totaling almost $1.6 million as a result of rulings by the Court of Claims. These payments were reported separately by HFS.

HFS' handling of prompt payment interest payments has not been in compliance with the Prompt Payment Act and its related Administrative Rule. For example:

- HFS excluded some claims from interest payments. While some of the exclusions were appropriate, others resulted in providers not receiving interest for which they may have been entitled;
- HFS did not notify providers in a timely manner of denied requests for interest; and
- HFS did not pay interest to providers in a reasonable time.

We identified several other issues related to the payment of interest. These issues include the following:

- HFS did not have a system in place to pay, nor did it pay, automatic interest to providers until May 2007, almost eight years after the law became effective;
- Only two HFS employees were involved with calculating and approving interest payments to providers. One employee is responsible for calculating and approving automatic interest owed to providers, while the other employee is responsible for interest requested by providers;
- There were no guidelines or other written documentation to support the process used by HFS employees to calculate and approve interest owed to providers other than an Exclusion Policy created during the audit that is used by HFS to exclude claims from interest payments; and
- HFS required providers to utilize a cumbersome process to request interest.

REQUESTED INTEREST

The Prompt Payment Act requires that interest totaling at least $5 but less than $50 must be requested by the provider before it is paid. The process used by HFS to calculate and pay requested interest is not automated; it consists of a set of undocumented manual procedures applied by two individuals at HFS. Additionally, the process required by HFS for providers to request interest is cumbersome and is in excess of what is required by Administrative Rule. HFS also is not notifying providers within 60 days as required by Administrative Rule when interest requests are denied.

Interest Accrued, Requested, and Paid

Legislative Audit Commission Resolution Number 136 required the audit to include the following information for bills accruing interest in excess of $5 in interest but no more than $50 in interest:

- the number of bills that have generated in excess of $5 in interest but no more than $50 in interest, by fiscal year;

- the amount of unpaid interest on bills that have generated in excess of $5 in interest but no more than $50 in interest, by fiscal year; and
- the amount of paid interest on bills that have generated in excess of $5 in interest but no more than $50 in interest, by fiscal year.

Auditors obtained the requested interest database from HFS for fiscal years 2000 through 2007. HFS' interest database included interest requested on medical claims since the Prompt Payment Act was amended in July 1999 to include Medicaid claims. The requested interest figures reported in this report include all claims on the HFS database. Based on the database, there were no requests by providers for interest accrued on claims paid in fiscal years 2000 and 2001.

HFS does not pay interest to providers on Medicaid claims for at least one year after the issue date of the original payment. Since a full year had not passed, as of November 2007 no requested interest was paid for FY07 claims. Additionally, the Prompt Payment Act was amended effective July 2002 which changed the number of days before interest begins to accrue from 90 to 60.

Exhibit 4-2 shows that since FY00, claims submitted to HFS have accrued a potential liability of $44.5 million in interest penalties for claims with interest accruing to $5 but less than $50. Providers have only requested interest payments totaling $8.8 million or 20 percent of the total amount accrued. As of November 2007, HFS had paid requested interest to providers totaling only $3.6 million. Additionally, providers had not requested $35.7 million in accrued interest. HFS began to exclude some interest requests from payment beginning in December 2007. This was after the time period for our audit and, therefore, was not reviewed as part of this audit.

Exhibit 4-2
INTEREST ACCRUED, REQUESTED, AND PAID FOR CLAIMS WITH INTEREST ACCRUING TO $5 BUT LESS THAN $50
As of November 2007

Fiscal Year	Number of Eligible Claims	Potential Interest Amount [1]	Number of Interest Requests	Amount Requested	Number of Claims Paid	Total Interest Paid
2000	1,687	$24,367	0	0	0	$0
2001	4,025	$57,514	0	0	0	$0
2002	25,566	$314,340	240	$3,758	232	$3,592
As of July 2002, the number of days before interest accrues decreased from 90 to 60						
2003	643,888	$8,871,373	213,355 [2]	$2,758,992 [2]	209,697	$2,738,102
2004	315,783	$3,749,670	62,373 [2]	$599,879 [2]	62,302	$603,956
2005	279,864	$3,573,716	5,999	$139,844	4,225	$109,801
2006	1,039,550	$15,377,147	79,745	$2,764,104	3,614	$135,400
2007 [3]	762,237	$12,548,526	76,145	$2,548,176	0	$0
Totals	**3,072,600**	**$44,516,653**	**437,857**	**$8,814,753**	**280,070**	**$3,590,851**

Notes:

[1] The Potential Interest Amount is the potential interest liability before HFS applies its exclusions.

[2] In FY03 and FY04, a total of 242,261 interest requests were received from pharmacies totaling $2,344,818, which included some interest claims greater than $50.

[3] Since providers have one year from the date of service to submit claims, FY07 eligible claim and interest paid data is as of November 2007 and interest request data is as of September 2007.

Source: FY00 - FY07 interest data provided by HFS.

Interest Request Process

The Medical Interest Payment Instructions for providers are available for providers on HFS' website. The instructions give providers a list of what information is required and has a link to download the required form. See Appendix C for a copy of the instructions and required form.

HFS requires providers to follow a cumbersome process to request interest. More specifically, HFS requires providers to submit requests for interest on a specified form that requires additional information not listed in the requirements found in the Administrative Rule. Exhibit 4-3 shows what is required by Administrative Rule compared to what is required by HFS.

As shown on Exhibit 4-3, HFS requires providers to include significantly more information on its interest request form than required by Administrative Rule. Based on meetings with HFS officials and analysis of HFS data, the **only** information needed by HFS to process interest penalties for providers is the document control number (DCN). HFS maintains databases according to the DCN and calculates the interest accrued by the DCN.

Exhibit 4-3

COMPARISON OF REQUIREMENTS BETWEEN THE ADMINISTRATIVE RULE AND HFS POLICY FOR REQUESTING INTEREST PENALTY PAYMENTS BY PROVIDERS

Administrative Rule Requirements (74 Ill. Adm. Code 900.90)	**Required by HFS**
The provider must submit a written statement requesting payment of interest that includes:	**A separate request for each proper bill or invoice must be submitted and include:**
• a description of the original transaction	• the Document Control Number (DCN)
• the vendor's taxpayer identification number	• the payee number
• the invoice amount	• the total amount allowed for DCN
• the date the invoice was presented to the agency	• the DCN date
• the date of the vendor's invoice	
The statement should, if possible include:	
• the voucher number	• the voucher number
• the exact name of the vendor or payee as the name appeared on the payment warrant	• the payee name • the requestor name
• the vendor's invoice number	
• the appropriation account code	
• the obligation number	
• an estimate of the date upon which the interest penalty begins to accrue	
• any other information reasonably needed by the State agency to verify the interest penalty payment	• **the estimated interest owed** • **the warrant date** • the requestor address; city, state, zip & phone number • the payee address, city, state, & zip • the number of days interest owed • a contact signature & date

Source: 74 Ill. Adm. Code 900.90 and HFS website.

One of the additional requirements placed on providers by HFS that is not required by the Administrative Rule is an estimation of the amount of interest owed. Such an estimation process can be time intensive for providers, especially those which may have a large number of interest payments to claim. Also, although the providers are asked to calculate the interest, an interest calculation is performed by HFS to ensure that the calculation submitted by the provider is correct prior to payment. As a result, requiring the provider to calculate the interest owed is questionable. An HFS official noted that HFS uses this as a screening process, in that HFS does not want "millions" of requests for $2.00.

We tested 66 approved claims that were requested by providers for claims paid in FY06 and found that 34 of the 66 providers (52%) calculated the estimated amount of interest owed incorrectly. Given that the Administrative Rule does not require providers to estimate the amount of interest they are owed, that providers' estimates are frequently incorrect, and that HFS performs its own interest calculation, consideration should be given by HFS to eliminate this burdensome requirement for providers to estimate interest owed.

Medical Interest Payment Instructions also require providers to include the warrant date in their interest request, which is not required by Administrative Rule, may not be easily attainable by providers, and is of questionable need to HFS. The warrant date is not listed on the HFS remittance advice that providers receive with the payment of the original claim. Since the remittance advice is prepared by HFS prior to payment by the Comptroller, it does not contain the warrant date. As a result, it may be difficult for providers to calculate and request interest owed. HFS officials noted that they tell providers to go to the Comptroller's website to try to determine the warrant date.

Furthermore, the description of warrant date information found in the instructions is incorrect. The instructions note that the warrant date "provides estimate of the date upon which the interest penalty begins to accrue." The warrant date is actually the date the original claim is paid by the Comptroller and is the date upon which the interest penalty calculation ends.

Survey of Providers

We surveyed 315 Medicaid providers and received 80 responses. The survey asked several questions related to the requested interest process. Providers were asked if they were aware that they could initiate a written request for interest penalty payments of at least $5 but less than $50. Of the 77 that responded to this question, 51 (66%) answered that they did not know they could request interest penalty payments from HFS.

Additionally, 48 of 79 (61%) responded they did not know if they were owed interest by HFS that they had not requested. Based on HFS interest data, we determined that claims for these 48 providers accrued $770,652 in requested interest for fiscal years 2000 through 2006. Several of the providers also provided reasons as to why they did not request interest from HFS. Exhibit 4-4 lists a few of the reasons provided.

Exhibit 4-4
REASONS REPORTED BY PROVIDERS AS TO WHY THEY DO NOT REQUEST INTEREST ON MEDICAID CLAIMS FROM HFS

- At this point it seems like a waste of time to have a highly compensated employee chase money that most likely will not be recovered;
- Not Cost Effective - paperwork takes too long and is very confusing;
- The identification and request for interest payments is very manual. We do not dedicate our resources to this function, although we might begin to do so if it seems financially viable. If the process was more automatic, we would pursue; and
- Very time intensive to complete forms, track vouchers and supply all required information. They should just pay. We received our 1st and to date - only interest payment in August 07 dated back to claims from 7-23-99 to 6-30-05.

Source: OAG survey of Medicaid providers.

The survey also asked providers to give recommendations or suggestions to improve the process used by HFS to pay prompt payment interest. Their responses included:

- Set up a page on the HFS website for providers to request prompt payment interest;
- Pay bills on time and eliminate the interest problem;
- Put out an information notice to inform providers of the Prompt Payment Act;
- The State should pay without initiation from the provider; and
- Pay all interest automatically regardless of the amount.

REQUIREMENTS FOR REQUESTING INTEREST	
RECOMMENDATION NUMBER **9**	***Regarding the requirements for requesting interest, the Department of Healthcare and Family Services should:*** • ***make its requirements for requesting interest less cumbersome by only requiring providers to submit information that is necessary to process the request;*** • ***correctly define "warrant date" in its instructions; and*** • ***consider sending an informational notice to providers reminding them of the Prompt Payment Act and the requirements for requesting interest.***
Continued on following page	

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	• The Department agrees with the recommendation and with the implementation of the automated interest calculation process, will no longer require providers to calculate estimated interest. • The Department agrees with the recommendation and will clarify the meaning and purpose of "warrant date" in the instructions. • The Department agrees with this recommendation and has posted information and instructions on requesting interest on its website and has worked with provider associations that have publicized the Act, Rule and the request process to their members. The Department is moving away from costly paper mailings to notify providers of policies and does not agree to a paper mailing.
	AUDITOR COMMENT: *The auditors recommended sending an informational notice to providers, which could include paper mail, or other methods, such as e-mail. HFS does mail paper remittance advices to providers and an informational notice on prompt pay could be included in those mailings.*

Requested Interest Calculation

The system used to verify requested interest is a separate system than the one used to calculate automatic interest. HFS has no documentation to support the process used to verify and pay requested interest. Additionally, security over the interest database is lacking. We found that sensitive Medicaid claim information was not adequately protected to prevent disclosure. The process used by HFS to verify and calculate requested interest is not automated.

Once HFS receives a request for payment of interest, HFS visually verifies the request for accuracy. It is then checked by running a query through the Statewide Accounting Management System (SAMS) to verify when the claim was paid. Next, the request is entered into the Requested Interest Database and a query is run from the data warehouse to see if the request is eligible for interest. Once HFS makes the determination regarding payment of the interest, the action taken by HFS is manually entered into the Requested Interest Database. An Interest Request Results report is prepared and sent to the provider after the payment is made by the Comptroller. The report lists the interest paid and denied by the document control number.

Denied Interest Requests

HFS does not have a process in place to timely notify providers that their interest request will not be paid as required by Administrative Rule (74 Ill. Adm. Code 900.35). If HFS determines that a request for interest is denied, HFS is required by Administrative Rule to notify the provider **within 60 days** that the interest request is not payable under the Act. The notification **must include the reason** why the interest penalty is not going to be paid.

HFS reviews and approves interest requests by document control number. If the interest request for one bill or part of that bill is denied while other bills on the same voucher are approved, the provider is not notified of the denied request until the payment for the bills with approved interest are received. As discussed later in this chapter, on average, requests for interest are not paid within 60 days, and therefore, the providers are not being notified in 60 days of the denial as required by Administrative Rule.

Interest Request Results reports are sent to providers after the interest payment is made by the Comptroller. The Denied Interest Request Case Example illustrates how providers are not being notified of the denial within 60 days. These Interest Requests Results reports are not dated, and as a result, auditors could not determine when the reports were sent to providers.

Denied Interest Request Case Example

A provider requested interest on September 27, 2005. More than a year later, on November 30, 2006, HFS vouchered the interest payment and sent it to the Comptroller. A warrant was issued by the Comptroller for payment of this request on December 19, 2006.

The voucher listed on the request consisted of four bills. The interest request for one of the four bills was denied. The Rule requires that the provider be notified of the decision to deny the interest request within **60 days**. However, since the request was not paid for **448 days**, the notice of the denied interest was not received within the required 60 days.

Additionally, HFS does not date stamp the requests for interest payment upon receipt. We compared the date received from the HFS database with the date on the interest request from the provider. The date received in the database was on average 19 days after the date on the request forms from our approved request sample. The date received in the database was on average 15 days after the date on the request forms from our denied sample. Without an actual date of receipt, HFS does not have the ability to ensure it is complying with the 60 day notification mandate required by Administrative Rule.

NOTIFICATION FOR DENIED INTEREST REQUESTS	
RECOMMENDATION NUMBER **10**	***The Department of Healthcare and Family Services should:*** • ***notify providers within 60 days that their requests for interest penalty payments are denied as required by 74 Ill. Adm. Code 900.35;*** • ***date Interest Request Result reports that are sent to providers; and*** • ***date stamp interest requests upon receipt.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	• The Department agrees with this recommendation and will notify providers within 60 days that their interest requests are denied. • The Department agrees with this recommendation and will put a date on the report. • The Department agrees with the recommendation and, while dates were noted upon receipt of a request, an official Department date stamp is now being affixed to the request form.

AUTOMATIC INTEREST

Although the Prompt Payment Act (Act) required HFS to pay interest on Medicaid claims effective July 23, 1999, HFS did not pay automatically owed interest to providers until May 2007. The Act requires HFS to automatically pay interest to providers when interest penalties amount to $50 or greater. Like the process used to verify requested interest, the process used by HFS to verify and calculate automatic interest owed to Medicaid providers is not an automated system; it consists of a manual set of undocumented procedures applied by one individual at HFS.

Automatic Interest Owed, Paid, and Not Paid

Legislative Audit Committee Resolution Number 136 required the audit to include the following for bills accruing interest of $50 or greater:

- the number of bills that have generated in excess of $50 in interest, by fiscal year;
- the amount of unpaid interest on bills that have generated in excess of $50 in interest, by fiscal year; and
- the amount of paid interest on bills that have generated in excess of $50 in interest, by fiscal year.

We requested the automatic interest databases from HFS for fiscal years 2000 through 2007. The automatic interest figures in this report include all claims from the HFS databases. HFS did not have a process to pay automatic Prompt Payment Act interest in place until May

2007. Since HFS does not pay interest to providers on Medicaid claims for at least one year after the issue date of the original payment, as of November 2007 no automatic interest was paid for FY07 claims. Additionally, the Prompt Payment Act was amended effective July 2002 which changed the number of days before interest accrued from 90 to 60.

Exhibit 4-5 shows the automatic interest accrued, the interest not paid as a result of exclusions, and the interest paid by HFS since Medicaid claims were added to the Prompt Payment Act in July 1999. As of November 2007, HFS had paid more than $16.6 million in automatic interest. All $16.6 million was paid after April 2007 which was almost **eight years** after the inclusion of Medicaid claims to the Prompt Payment Act.

Exhibit 4-5
AUTOMATIC INTEREST ACCRUED, NOT PAID, AND PAID FOR CLAIMS WITH INTEREST ACCRUING TO $50 OR GREATER
As of November 2007

Fiscal Year	Before Exclusions			After Exclusions			
	Claims Received	Dollar Amount of Claims	Potential Interest Amount	Number Not Paid	Amount Not Paid	Claims Paid	Amount Paid [1]
2000	181	$1,499,422	$23,766	150	$21,232	31	$2,535
2001	520	$4,381,824	$71,380	439	$63,490	81	$7,891
2002	2,089	$53,476,435	$305,179	1,502	$221,089	587	$84,090
As of July 2002, the number of days before interest accrues decreased from 90 to 60							
2003	65,506	$406,714,913	$8,264,316	41,601	$5,027,178	23,905	$3,237,137
2004	22,181	$244,751,543	$3,087,243	11,099	$1,522,243	11,082	$1,565,000
2005	23,130	$231,621,984	$3,258,030	6,609	$1,023,889	16,521	$2,234,141
2006	101,355	$714,671,064	$13,103,646	28,457	$3,631,687	72,898	$9,471,960
2007 [2]	58,410	$639,325,990	$7,997,255	n/a	n/a	n/a	n/a
Totals [3]	**273,372**	**$2,296,443,175**	**$36,110,815**	**89,857**	**$11,510,808**	**125,105**	**$16,602,753**

Notes:

[1] All interest on these claims was paid in 2007.

[2] Since providers have one year from the date of service to submit claims, the FY07 data is not final. As of November 2007, HFS had not paid interest on FY07 claims.

[3] Totals may not add due to rounding.

Source: FY00 - FY07 interest data provided by HFS.

Automatic Interest Calculation Process

The process used to identify the universe of claims with interest owed is not documented in any policy or procedure manuals. The process used to calculate interest owed is performed by one individual at HFS. There are no internal controls or management reviews over the calculation of automatic interest owed to providers. The interest database used by HFS is not password protected or encrypted to ensure the security of sensitive Medicaid claim information.

To identify the potential universe of claims eligible for automatic interest, a query is run from the data warehouse. HFS does not pull data off of the warehouse for at least one year after claims are paid in order to ensure that all adjustments have been made to the claims. HFS

officials noted that this is done to make sure interest is being calculated on the correct amount and because HFS does not want to have to recoup any overpayments. After the data is extracted from the warehouse, a file is generated with the universe of claims in which interest accrued equal to or greater than $5.

One individual at HFS is responsible for running additional queries using Microsoft Access to further identify the universe of claims with interest accrued of $50 or greater, which are required to be paid automatically to the providers by HFS. Other steps to rename fields and exclude certain types of appropriation codes and providers are also completed by this individual. None of this process is documented by policies or procedures. Furthermore, there are no management controls over the calculation process; consequently, if this individual were to make an error in approving or denying interest, it would likely go undetected. These steps include excluding certain claims from interest payments. These exclusions are discussed in the following section.

INTEREST CALCULATION PROCESS	
RECOMMENDATION NUMBER **11**	***The Department of Healthcare and Family Services should:*** • ***develop policies and procedures to document the process used for calculating, processing, and paying interest owed to Medicaid providers;*** • ***automate the process used to calculate, process, review, and pay interest to Medicaid providers;*** • ***segregate duties performed to verify and calculate interest claims; and*** • ***ensure sensitive Medicaid claim information is adequately protected (password usage or encryption may be acceptable alternatives).***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE *Continued on following page*	• The Department agrees with the recommendation. The interest process has been automated and implemented. While documentation of procedures exists, this documentation will be further clarified. • The Department agrees with the recommendation. A fully automated interest payment process has been completed and will be utilized for future interest payments.

	• The Department agrees with the recommendation. The current process has been under the direct guidance of highly competent and experienced individuals who have taken great care to ensure integrity and accuracy in the process. The newly developed automated process will further include appropriate segregation of duties. • The Department respectfully disagrees with the recommendation and further disagrees with the characterization of data used to calculate interest payments as "sensitive Medicaid claim information" and is not aware of any legal definition for such term. Present security of and access to Department computer based information is tightly controlled through Office of Information Systems' policies and procedures. All employees must have an authorized log-on ID and password, which protects any confidential information, such as tax identification numbers, contained in the interest database. In addition, informational files related to interest payments in the Department can only be accessed via the particular staff currently responsible for interest processing.
	AUDITOR COMMENT: *On October 1, 2007, auditors copied numerous interest database files from an HFS employee's computer. Auditors observed that the interest databases were not password protected or encrypted. Since the interest databases contained sensitive information such as payee tax identification numbers, providers under investigation by the OIG, and providers with tax levies against them, auditors recommended that the data be protected either by password or by the use of encryption software.*

EXCLUDING CLAIMS FROM INTEREST PAYMENTS

Once the universe of claims that accrued interest is identified, a series of exclusions are applied to the claims to determine eligibility for payment. The policies for these exclusions were adopted by HFS in May and July of 2007. In May 2007, HFS adopted an Exclusion Policy related to prompt payment interest (see Appendix D). In July 2007, a second policy was adopted which justifies excluding claims with adjustments from interest payments (see Appendix E). Exhibit 4-6 shows the total claims and amounts by reason that were not paid on Medicaid claims received in FY06.

May 2007 Exclusion Policy

The Exclusion Policy, which was created during the course of this audit, lists 11 instances where HFS excludes claims from interest payments. Although some of these exclusions are

necessary and were being applied correctly, several of the exclusions were not supported by the law cited as the reason for the exclusion.

This policy was effective for automatic interest payments made by HFS in May 2007. This was the first time HFS made any automatic payments to providers since the Prompt Payment Act was amended in July 1999 to include Medicaid claims. In May 2007, 3,632 automatic interest payments totaling $344,378 were made on claims received between November 29, 1999 and April 5, 2005. HFS applied its Exclusion Policy to these claims that were received **prior** to the adoption of the policy. The same was true for interest paid in the following months. HFS did not apply this policy to requested interest payments until December 2007.

The following section discusses the exclusions used by HFS, and they are discussed in the order in which they appear in Exhibit 4-6.

Exhibit 4-6
SUMMARY OF EXCLUSIONS USED BY HFS TO NOT PAY INTEREST ON CLAIMS PAID DURING FY07

	Reason Not Paid	Number Not Paid	Amount Not Paid
Exclusions from the May 2007 Exclusion Policy	Claims Previously Adjusted	7,839	$1,393,325
	OIG Settlements	7,930	$1,069,246
	DCN to Pending Over 250 Days	1,967	$336,824
	Suit Filed in Court of Claims	4,280	$270,598
	Paid via Request Process	446	$87,114
	LTC Cost Report Holds	1,124	$84,244
	Government Entity	610	$63,694
	OIG Exceptions	2	$139
	Rejected Vouchers (FEIN)	0	$0
	DCN to Pending Minus 100 Days	0	$0
	Tax Levies	0	$0
	Contains Multiple Exclusions	4,027	$306,391
	Non-Certified Provider	222	$18,591
	SAMS Delete Date	10	$1,523
	Totals	**28,457**	**$3,631,687**

Note: Totals may not add due to rounding.

Source: FY06 interest data provided by HFS.

Claims Previously Adjusted

According to the Exclusion Policy, providers have up to 12 months from the date of payment to submit changes (adjustments) to previously billed services. The policy notes that for claims that are adjusted, accurate information to pay the bill did not exist until the provider's adjustment is processed by HFS. As a result, the policy states "the proper bill date for purposes of determining becomes the adjustment date and, coming after payment of the original service, no interest would be allowed."

Although this "claims previously adjusted" exclusion was included in the May 2007 Exclusion Policy, it was not used for the interest payments made in May. In other words, providers whose claims were adjusted **were paid** interest on those claims.

In July 2007, HFS developed a separate policy for adjusted claims. The July 2007 policy reiterates the rationale in the May 2007 Exclusion Policy. Based on the definition of "proper bill" in the Prompt Payment Act and the Administrative Rule, HFS excludes the payment of interest to providers for claims that were adjusted after payment by HFS. The Administrative Rule (74 Ill. Adm. Code 900.20) states:

> *"Proper Bill" shall be defined as: a bill or invoice containing sufficient and correct information necessary to process the payment for a liability of a State agency as provided in this Part . . . or as otherwise specified by the State agency responsible for payment.*

As a result, HFS determined that if a claim is adjusted after it was paid, the bill was not a "proper bill" and therefore is not eligible for interest payment. This policy became effective July 26, 2007. This exclusion is not explicitly provided for in statute or Administrative Rule. Additionally, there appears to be no reason why this exclusion went into effect on July 26, 2007. No changes were made to the Prompt Payment Act or its Administrative Rule that would support this new policy since HFS did pay interest on claims with adjustments in May 2007.

In August, September, and October 2007, HFS applied this exclusion to 43,264 automatic interest claims totaling $6,127,416. These 43,264 original claims that accrued automatic interest date as far back as 1999 and all were received by HFS prior to the effective date of the Exclusion Policy. Therefore, HFS applied these exclusions **retroactively** to almost eight years' worth of claims for these providers. These 43,264 claims were excluded from payment solely due to this policy or due to having an adjustment in addition to other exclusions.

Many times providers submit multiple service lines on a bill. The bill is assigned a number by HFS called the DCN. After the services from a bill are paid, if the provider adjusts **one** of the service lines at a later date, interest will not be paid on any of the service lines for that bill. As a result, several services are denied interest due to an adjustment on one service.

OIG Settlements

This exclusion is for providers that were audited by the OIG in which settlements are reached with the providers for repayment to the State for over-billings. According to HFS officials, claims with this exception fell in the time period when OIG had conducted a routine audit in which over-billings were determined. According to HFS, this leads to a settlement where the provider pays back the over-billed amount. The intent of this exclusion appears to ensure that interest is not paid on claims which were over-billed. However, this exclusion is applied to **all** claims submitted by the provider, and not just the claims that were over-billed. According to an HFS official, HFS does not go back and pay the owed interest to the provider after the audit is complete. As a result, if proper claims from these providers accrued interest, they were excluded from receiving payments. The Exclusion Policy notes this exclusion is supported by 74 Ill. Adm. Code 900.70(a).

DCN to Pending over 250 Days

HFS determined that any claim taking longer than 250 days to get to the pending file is an anomaly. The intent is to prevent any outliers from "slipping" through for payment. This exclusion uses 250 days which is not based on any requirement in statute or Administrative Rule. According to HFS, claims that exceed 250 in pre-payment review are automatically thrown out without being reviewed to determine whether interest should be paid. HFS should not deny interest to claims without determining the cause of the delay and whether interest is required to be paid by law.

Suit Filed in Court of Claims

Some providers have chosen to file suit in the Court of Claims to settle their interest claims. As a result, further interest payments by HFS are suspended. This is a logical exclusion to prevent duplicate payment of interest claims. However, HFS is not applying the exclusion properly. HFS is applying this exclusion to **all** of a provider's interest claims even though the claims with the Court of Claims are for a specific time period. Consequently, HFS would not be paying the provider interest for claims which are not covered by a Court of Claims ruling.

Paid via Request Process (Interest Previously Paid)

This exclusion identifies interest that has already been paid by HFS. This is a logical exclusion supported by 74 Ill. Adm. Code 900.90.

Long Term Care (LTC) Cost Report Holds

Failure by a long term care facility to file its annual cost report results in HFS holding further payments (both payments on claims and prompt payment interest) until the required report is filed. Once the required report is filed, HFS pays outstanding claims. However, HFS does not pay owed prompt payment interest once the report has been received. As illustrated by the case example, auditors asked if a provider was delinquent in filing its long term care cost

report during the time interest was payable, but submitted the cost report at a later date, would HFS go back and pay interest to the provider. An HFS official stated that HFS would not.

LTC Cost Report Hold Case Example

Between September 2001 and April 2004 a long term care provider submitted 143 claims to HFS totaling $265,658. The 143 claims accrued $9,528 in automatically owed prompt payment interest.

In FY07, when HFS decided to pay automatic interest to providers, this provider **was not paid any** of the accrued interest because the provider failed to submit its annual cost report timely in May 2004. The cost report was submitted 13 days late.

The Exclusion Policy states that the "department is not liable for interest on these providers as a result of the delay caused by the facilities' non-compliance." However, the exclusion used by HFS is not only excluding the interest incurred attributable to the delay in payment associated with the provider's late filing of the cost report. Rather it is excluding **all** interest owed to the provider that accrued prior to receipt of the late cost report. Excluding prompt pay interest payments in this manner is not supported by 89 Ill. Adm. Code 140.545.

Government Entity

Government entities are excluded in the Prompt Payment Act and are not entitled to interest payments. This is a logical exclusion supported by 74 Ill. Adm. Code 900.120.

OIG Exceptions

This exclusion stops interest payments to providers who are being investigated by the Department's Office of Inspector General (OIG) for possible fraud or abuse. This may be a reasonable exclusion while the investigation is on-going. HFS policy states that "Federal regulations exclude these situations from the timely payment criteria and it seems reasonable not to pay interest where possible fraud has occurred." While federal regulations do exclude claims from providers under investigation for fraud or abuse from the timely payment requirements, it does not support the policy of not paying prompt payment interest after such investigation is completed. Auditors inquired whether, after an investigation is completed, HFS goes back to check whether a provider who was not paid prompt payment interest because of an ongoing investigation, is entitled to receive interest that was not paid. An HFS official stated that the Department does not go back and make that determination, noting that once providers reach the point of being investigated by the OIG, their investigations are based on serious accusations and warrant an investigation. The Department's position to not pay prompt payment interest owed to a provider who was the subject of an investigation which finds no wrongdoing on the part of the provider is questionable.

Rejected Vouchers (FEIN)

This exclusion is for vouchers submitted to the Comptroller that do not meet the criteria to be accepted. The Comptroller returns the voucher to HFS and it is up to the provider to provide the correct information. The Exclusion Policy concludes that no interest is owed on

these vouchers as a result of action/inaction of the payee causing the payment delay and cites 74 Ill. Adm. Code 900.80(a).

DCN to Pending Minus 100 Days

This exclusion is used to exclude system-generated claims for long term care providers that are created and pended at mid-month and subsequently receive a document control number later in the month creating a negative value. This is due to the way long term care providers bill claims and does not apply to other types of providers.

Tax Levies

The Exclusion Policy notes that HFS is responsible for interacting directly with the IRS and intercepting payments to providers who are subject to a tax levy. Payments are to be redirected to the IRS to satisfy the levy. During interest calculations, interest accrued for providers with IRS tax levies are excluded and not paid to the provider. Additionally, according to an HFS official, HFS **does not** redirect the amount of the owed interest to the IRS to satisfy the levy. If prompt payment interest is owed to a provider, but the IRS has a tax levy against the provider, it would appear that HFS would be responsible for forwarding the prompt payment interest owed to the IRS (which would reduce the provider's tax liability).

Other Reasons Claims Were Excluded from Interest Payments

There are other exclusions used by HFS to withhold interest payments which are not covered in its Exclusion Policy. These exclusions are described below.

Contains Multiple Exclusions

These claims had more than one reason why they were excluded from interest payment.

Non-Certified Provider and SAMS Delete Date

These providers cannot be paid because the providers do not have the necessary information on file with the Comptroller to receive payment.

EXCLUSION OF INTEREST PAYMENTS	
RECOMMENDATION NUMBER **12**	***The Department of Healthcare and Family Services should:*** • ***examine its policies and procedures used to exclude claims from interest payment and include only those supported by law;*** • ***not apply exclusions retroactively unless expressly permitted by law; and*** • ***pay interest that has been withheld without legal support.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE *Continued on following page*	• The Department partially agrees with the recommendation. However, the assertion in the audit report that "Medicaid claims submitted to HFS have accrued almost $81 million in Prompt Payment Act interest since FY00" is not correct. Detailed information supplied to auditors clearly showed that the correct figure was $56.2 million. Of that amount, $34.4 million was interest in amounts between $5 and $50, and therefore, payable only if requested. The information provided to auditors, which at the time included estimates, also showed that of the $34.4 million in interest between $5 and $50, only $5.7 million was requested, bringing the estimated total interest due to $27.4 million ($5.7 million in requested interest, plus $21.8 million in automatic interest over $50). The actual total interest due, and paid now that final interest has been calculated for this time period, is $25.9 million. The Department will re-examine exclusions and make changes to improve their application, effectiveness and fairness, if necessary. The Department maintains that all so-called "exclusion policies" are steps taken to properly comply with the statutes and rules, pay interest when it is due and not pay interest when it is not due. Claims excluded under these policies were claims that were not payable during some or all of the time they were being processed. If a claim is not payable, it cannot accrue interest for not being paid. • The Department respectfully disagrees with the recommendation. The policies adopted by the Department relate to the process of calculation of any payment of penalties, and were applied to all automatic interest payments made after the policies were adopted. Exclusion policies are steps taken to determine whether an underlying claim is payable in order to determine if interest should be calculated. The Department has not retroactively changed a policy on whether a claim is payable. No previously paid interest to providers has been retroactively changed to reflect changes in current policies. • The Department partially agrees with the recommendation. The Department will re-examine the exclusions and make any

	changes to improve their application, effectiveness and fairness, if necessary. If it is found that an interest request previously denied should have been granted, the appropriate action will be taken.
	***AUDITOR COMMENTS**:* *The report has been clarified to note that HFS accrued a potential liability of almost $81 million in Prompt Payment Act interest since FY00, and that actual interest expected to be paid to providers is estimated by HFS to be less due to not all providers requesting eligible interest, as well as exclusions that may be applied to potential interest payments by HFS.* *Much of the "detailed information" referred to by HFS in its response was taken from a summary chart provided to auditors in August 2007. The summary chart noted that the FY06 and FY07 numbers were **estimates**, which may explain some of the differences between the numbers cited by HFS in its response and the numbers reported in Chapter 4. The accrued interest summary chart also appears to only include interest eligible for payment after exclusions were applied by HFS. To calculate the accrued interest, auditors used the **actual** databases used by HFS to calculate and pay interest prior to exclusions being applied, which shows potential interest accrued due to late payment of claims by HFS. These numbers were reviewed and approved by the Bureau Chief of Claims Processing, who is responsible for calculating and paying prompt payment interest to providers.* *HFS clearly **has** applied exclusions retroactively. The Department's Exclusion Policy was adopted in May 2007. This Policy was then applied to interest claims dating back to 1999. Applying policies adopted in 2007 to interest that accrued on claims from 1999 **is** a retroactive application of the policies.*

TIMELY PAYMENT OF PROMPT PAYMENT INTEREST

The Department of Healthcare and Family Services is not paying interest to providers in a reasonable time as required by 74 Ill. Adm. Code 900.90. The only mandate found in statute or Administrative Rule relating to the timeframe for paying prompt payment interest is that agencies are to pay interest in a "reasonable time." The Administrative Rule does provide a specific time requirement for providers to submit a request for the interest. Providers should request interest within 90 days after the date of payment of the original claim.

Automatic Interest Payment Timeliness

HFS did not pay automatic interest penalties to providers until May 2007. As a result, after claims were excluded by HFS, $16,602,753 in automatic interest penalties accrued during fiscal years 2000 through 2006. This interest was not paid until May, August, September, and October 2007. For example, between May and October 2007, HFS paid $3,237,137 in interest penalties that had accrued on claims originally paid in FY03. Exhibit 4-7 shows the month HFS paid the automatic interest for the original claim, by the year the original claim was paid.

Exhibit 4-7
MONTH AND YEAR AUTOMATIC INTEREST WAS PAID SINCE MEDICAID CLAIMS WERE INCLUDED IN THE PROMPT PAYMENT ACT
By the fiscal year the original claim was paid by HFS

Fiscal Year Original Claim Paid	Month and Year Interest Paid by HFS					Total Interest Paid
	Between July 1999 and May 2007	May 2007	August 2007	September 2007	October 2007	
2000	$0	$65	$1,467	$1,003	$0	$2,535
2001	$0	$2,862	$2,868	$2,161	$0	$7,891
2002	$0	$758	$8,621	$74,711	$0	$84,090
2003	$0	$165,920	$878,604	$2,192,613	$0	$3,237,137
2004	$0	$23,280	$343,550	$1,198,170	$0	$1,565,000
2005	$0	$151,494	$493,077	$1,589,569	$0	$2,234,141
2006	$0	$0	$0	$0	$9,471,960	$9,471,960
2007 [1]	$0	$0	$0	$0	$0	$0
Totals [2]	**$0**	**$344,378**	**$1,728,188**	**$5,058,228**	**$9,471,960**	**$16,602,753**

Notes:
[1] Since providers have one year from the date of service to submit claims, the FY07 data is not final.
[2] Totals may not add due to rounding.

Source: FY00 - FY07 interest data provided by HFS, as of November 2007.

Requested Interest Payment Timeliness

HFS is not paying requests for interest payments by providers in a "reasonable time" as required by 74 Ill. Adm. Code 900.90. Although HFS has had a process in place to pay requested interest, it has not been paid in a reasonable time. According to HFS officials, the delay in payment is due to the decision to not pay interest for at least one year after the claim is paid.

In FY06, it took HFS an average of 452 days to pay providers their requested interest. The average number of days was calculated from the date the request was received by HFS to the date the warrant was issued by the Comptroller.

Exhibit 4-8 shows the average number of days it took HFS to pay providers their requested interest by fiscal year requested. Requested interest payments to providers over the last several fiscal years ranged from an average of 124 days in FY05 to 452 days in FY06.

Exhibit 4-8
AVERAGE DAYS TO PAY PROVIDERS' INTEREST REQUESTS
As of November 2007

Fiscal Year Request Received	Number of Requests Paid	Average Days for HFS to Pay
2000 [1]	0	n/a
2001 [1]	0	n/a
2002 [1]	0	n/a
2003	12,890	217
2004	15,775	219
2005	4,540	124
2006 [2]	4,604	452
2007 [3]	0	n/a

Notes:

[1] According to HFS data, there were no requests for interest penalty payments submitted by providers in FY00, FY01, and FY02.

[2] Not included are 43,820 interest requests that had not been paid by HFS as of November 2007.

[3] Not included are 30,945 interest requests that had not been paid by HFS as of November 2007.

Source: Interest data provided by HFS.

HFS has no written policies, procedures, or guidelines that documents how decisions are made that determine which providers are paid and when the payments are made. The interest payment process is not automated. HFS staff noted that the manual process is very time-consuming. HFS does not have a process in place to systematically pay interest to providers. When auditors interviewed HFS staff on August 14, 2007, there was $472,000 in requested interest payments ready to be paid since May 2007, which had not yet been paid.

INTEREST PAYMENT TIMELINESS	
RECOMMENDATION NUMBER **13**	***The Department of Healthcare and Family Services should pay interest penalties owed to providers in a reasonable time as required by 74 Ill. Adm. Code 900.90.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department agrees and believes that its newly automated procedures for payment of interest will enable those payments to be made timely. The Department has paid all interest previously owed, which totals $25.9 million.

APPENDICES

APPENDIX A

Legislative Audit Commission Resolutions 136 and 137

RESOLUTION NO. 136
Presented by Senator Righter

WHEREAS, the Prompt Payment Act was adopted by the General Assembly to penalize the State for payment delays and thereby encourage timely payments to vendors; and

WHEREAS, the Prompt Payment Act, while a punitive measure against the State, provides fair compensation to vendors not receiving timely reimbursement for services rendered; and

WHEREAS, the Prompt Payment Act requires the State to automatically pay interest on any bill paid late that generates in excess of $50 in interest; and

WHEREAS, the Prompt Payment Act allows vendors to request interest on any bill paid late that generates in excess of $5 in interest, and

WHEREAS, the Department of Healthcare and Family Services has amassed millions of dollars in Prompt Payment interest over the past four years; and

WHEREAS, the vast amount of bills that have generated interest at the Department of Healthcare and Family Services are Medicaid and Group Health Insurance bills; and

WHEREAS, there is substantial evidence that the Department of Healthcare and Family Services is not paying interest on bills paid late as statutorily required by the Prompt Payment Act; therefore,

BE IT RESOLVED, BY THE LEGISLATIVE AUDIT COMMISSION that the Auditor General is directed to conduct a performance audit on the Medicaid Program and the Group Health Insurance Program at the Department of Healthcare and Family Services for compliance with the mandates of the Prompt Payment Act from July 1, 2003 through December 31, 2006; and be it further

RESOLVED, that the audit include but not be limited to, the following determinations:

- the number of bills that have generated in excess of $50 in interest, by fiscal year;
- the amount of unpaid interest on bills that have generated in excess of $50 in interest, by fiscal year;

- the amount of paid interest on bills that have generated in excess of $50 in interest, by fiscal year;
- the number of bills that have generated in excess of $5 in interest but no more than $50 in interest, by fiscal year;
- the amount of unpaid interest on bills that have generated in excess of $5 interest but no more than $50 in interest, by fiscal year;
- the amount of paid interest on bills that have generated in excess of $5 interest but no more that $50 in interest, by fiscal year; and be it further

RESOLVED, that the Department of Healthcare and Family Services and any other State agency, entity or person that may have information relevant to this audit cooperate fully and promptly with the Auditor General's Office in its conduct; and be it further

RESOLVED, that the Auditor General report his audit conclusions as soon as possible and make public his findings and recommendations upon completion in accordance with the provision of Section 3-14 of the Illinois State Auditing Act.

Adopted this 6th day of March, 2007.

Representative Frank J. Mautino
Co-chair

Senator Chris Lauzen
Co-Chair

RESOLUTION NO. 137
Presented by Representative Mautino

WHEREAS, State law requires the State Comptroller and the Department of Central Management Services to jointly promulgate rules and policies for the prompt payment of State obligations, including procedures and time frames for approving a bill or invoice from a vendor for goods or services furnished to the State; and

WHEREAS, the State Comptroller and the Department of Central Management Services have adopted such rules at Title 74 of the Illinois Administrative Code, Part 900; and

WHEREAS, those rules require State agencies to approve "proper bills" received from vendors or deny bills with defects, in whole or in part, within 30 days after receipt; and

WHEREAS, those rules also require State agencies to notify vendors as soon as possible when defects are discovered in a bill; the notification must indicate the nature of the defect and any additional information necessary to correct the defect, and

WHEREAS, State agencies are required to maintain adequate documentation of all such notifications and subsequent agency and vendor actions so as to determine when and from what date late payment interest is due and to resolve any related vendor disputes; and

WHEREAS, interest shall begin accruing on the 61st day after receipt of a proper bill and continues to accrue until the bill is paid by the Comptroller's Office; and

WHEREAS, the Department of Healthcare and Family Services acknowledges owing several million dollars in interest to vendors providing services in the Medicaid program whose bills were not paid in a timely manner; therefore

BE IT RESOLVED, BY THE LEGISLATIVE AUDIT COMMISSION that the Auditor General is directed to conduct a management audit of the Department of Healthcare and Family Services' process for receipt, approval, denial, and payment of vendor bills for services provided in the Medicaid program; and be it further

RESOLVED, that the audit include but not be limited to, the following determinations:

- whether and at what point there are delays in the reviewing and processing vendor bills and payments;
- whether decisions to reject bills as not being in proper form are adequately documented and communicated in a timely manner to vendors, including a sampling of vendors to identify problems they may have encountered with the process;
- whether dates of receipt of proper bills are adequately documented;
- whether the regular, systematic process used by the Department of Healthcare and Family Services for reporting claim liability information to the Office of the Comptroller pertaining to claims received and approved, but not yet submitted to the Office of the Comptroller, is adequate and

RESOLVED, that the Department of Healthcare and Family Services and the Office of the State Comptroller, and any other State agency, entity or person that may have information relevant to this audit cooperate fully and promptly with the Auditor General's Office in its conduct; and be it further

RESOLVED, that the Auditor General report his audit conclusions as soon as possible and make public his findings and recommendations upon completion in accordance with the provision of Section 3-14 of the Illinois State Auditing Act.

Adopted this 21st day of May, 2007.

Representative Frank J. Mautino
Co-chair

Senator Chris Lauzen
Co-Chair

APPENDIX B

Sampling & Analytical Methodology

Appendix B

SAMPLING & ANALYTICAL METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The objectives for this audit were delineated in Legislative Audit Commission Resolutions 136 and 137 (see Appendix A), which directed the Office of the Auditor General to conduct performance audits of the Department of Healthcare and Family Services' (HFS) Medicaid and Group Health Insurance Program activities relating to the Prompt Payment Act and the processing of Medicaid claims.

We interviewed representatives from several different Bureaus within the Department of Healthcare and Family Services. We also interviewed administrators at other State agencies including the Office of the Comptroller and the Department of Central Management Services. In addition, we contacted federal representatives from the U.S. Department of Health and Human Services.

In conducting this audit, we reviewed processes used by HFS for the approval and payment of Medicaid claims as well as the processes for the calculation, approval, and payment of prompt payment interest. We also analyzed electronic data from HFS to identify the interest owed, requested, approved, and paid for fiscal years 2000 through 2006. This electronic data from HFS was contained in numerous databases including the following:

- two databases for automatic interest covering fiscal years 2000 through 2006 and consisting of 214,962 records;

- one database for requested interest covering fiscal years 2000 through 2007 and consisting of 199,448 records;

- one database for both automatic and requested interest covering fiscal year 2007 and consisting of 826,067 records; and

- numerous additional databases for claims eligible for requested interest covering fiscal years 2000 through 2006 and consisting of 2,310,423 records.

We reviewed applicable State statutes and Administrative Rules. In addition, we reviewed applicable federal regulations and requirements. Compliance requirements were tested and reviewed to the extent necessary to meet the audit objectives. We also reviewed applicable interagency agreements and internal controls relating to the audit's objectives. A risk assessment was conducted to identify areas needing closer examination. The audit identified weaknesses in internal controls, which are included as findings in this report.

We met with various officials from HFS to verify the validity of the data used for processing Medicaid claims and interest associated with those claims. We reviewed and verified

any methodologies or queries used by HFS to configure our various data requests. Although the process for calculating and approving interest is poorly documented by HFS, auditors were reasonably assured the data was complete and accurate through various meetings, walk-throughs, independent calculations, and review of queries used by HFS to produce the data.

TESTING AND ANALYTICAL PROCEDURES

Fieldwork for this audit was conducted between August 2007 and January 2008. Auditors conducted the following testing during fieldwork to meet the audit's objectives.

- We compared a random sample of 25 paid interest claims from HFS with data from the Comptroller to validate HFS's interest database from FY06. More specifically, we compared the amount of the original claim, the amount of interest owed, and the dates the claim and interest were paid.

- We examined a statistically valid random sample to determine whether HFS was appropriately approving or denying interest requests in FY06. This resulted in a sample of 66 approved and 67 denied interest requests with a confidence level of 90 percent and an acceptable error rate of 10 percent.

- We tested a statistically valid random sample to review claims with filters or adjustments in FY06. This resulted in a sample of 67 claims with HFS-applied filters or adjustments and a confidence level of 90 percent and an acceptable error rate of 10 percent. The purpose of this sample was to determine whether the adjustment or filter was valid, whether the filtered or adjusted interest amount was paid, whether the filter or adjustment was applied appropriately, and whether the filter was applied consistently.

- We examined a statistically valid random sample to determine if HFS had the necessary documentation to establish expedited status per 89 Ill. Adm. Code 140 in FY07. This resulted in a sample of 66 expedited providers with a confidence level of 90 percent and an acceptable error rate of 10 percent.

- We tested a statistically valid random sample from 23 million claims with first time rejections and all subsequent rejections in calendar year 2006. This resulted in a sample of 384 rejected claims with a confidence level of 95 percent and an acceptable error rate of 5 percent. The purpose of this sample was to determine whether the reason for rejecting a claim was adequately documented, whether the reason was communicated timely, and whether a new document control number was assigned timely.

The sample of 384 rejected claims was also used to conduct a survey of providers as requested by Resolution Number 137. Some providers in our sample had duplicates (multiple claims rejected) while other surveys were returned to us. Therefore, 315 of the 384 Medicaid providers were surveyed in our sample. The survey allowed providers to identify problems encountered with rejected claims and the payment of interest. The results of the provider survey

can be found throughout this report. Results from the provider survey used in this audit are the views expressed by the providers that responded to the survey.

In addition, we contacted other states to compare prompt payment interest and adjustment processes with other states. We contacted representatives from the surrounding states including Iowa, Ohio, Wisconsin, Indiana, Michigan, and Missouri. Responses were received from all states surveyed.

APPENDIX C

HFS Medical Interest Payment Instructions

Note: The HFS Medical Interest Payment Instructions found in this Appendix were downloaded from the HFS website at http://www.hfs.illinois.gov/billing/interest.html.

Medical Interest Payment Request

- Medical Interest Penalties Request Form HFS 3805 (pdf)

INSTRUCTIONS for Requesting Interest under the Prompt Payment Act for interest alleged to be due from proper bills received by the Department of Healthcare and Family Services on or after July 1, 2002, for which the Department of Healthcare and Family Services is responsible for payment. "Proper bills received" include "Prepayment Reports" for Long Term Care Facilities which are generated by the Department. **These instructions are subject to change based on the final "Joint Rules of the Comptroller and the Department of Central Management Services: Prompt Payment" 74 Ill. Adm Code 900.10 et seq.**

1. Requests must be addressed as follows:
   Department of Healthcare and Family Services
   Interest Request
   Post Office Box 19127
   Springfield, IL 62763

2. Requests must be submitted by the provider who billed the Department or the payee who received the payment. Only requests from Provider or Payee stated on Remittance Advice will be accepted.

3. A request should be submitted within 90 days of the issue date of the warrant.

4. A separate request for each individual proper bill or invoice (Document Control Number or DCN) must be submitted to include the following information:

Requester's Name and Address For Providers, the name and address shall be the same as appears on the Provider's enrollment application with the Department. For Alternate Payees, the name and address shall be the same as appears on the Voucher for which the request is made.

Voucher Number (Pursuant to 74 Ill. Adm Code 900.90 (b)(3))

Warrant Date (Pursuant to 74 Ill. Adm Code 900.90 (b)(3)(provides estimate of the date upon which the interest penalty begins to accrue)) (By Julian or Calendar) (Convert both this date and the Date of DCN to the same format, either Julian or Calendar.)

Payee Number Named on the Warrant (Pursuant to 74 Ill. Adm Code 900.90 (b)(2)) Regardless of the identity of the requestor, payment of any interest due will only be paid to the payee who was listed on the original voucher.)

(The above four elements do not need to be repeated for multiple requests for interest for separate DCNs for the same Requestor from the same voucher if the request is submitted in one document (multiple request document). If a multiple request document is more than one page in length then each page beginning with page 2 should be identified as "Interest request for DCNs per Voucher No. _____, Page ___ of ___. Multiple page request documents should not be stapled, but should be paper clipped or rubber-banded.)

Document Control Number (DCN) (Pursuant to 74 Ill. Adm Code 900.90 (b)(2)(provides description of original transaction)) (10-digit number prior to 1/1/02, 12 digits after 1/1/02 - first column on voucher) Each DCN shall be stated separately, in the same order as they appear on the remittance advice, and individually numbered, 1, 2, 3 etc.

DCN Date (74 Ill. Adm Code 900.90 (b)(3) provides date a proper bill or invoice was presented to agency) (By Julian or Calendar) (The Calendar Date of DCN is determined by converting the first four digits of the DCN from its Julian representation to the regular calendar date. The first number indicates the last digit of the year and the next three numbers indicate the day of the year. (For example, DCN 2105123456 has the Julian date of 2105 which is April 15, 2002.)

Number of Days Interest Owed See CALCULATION OF ESTIMATED INTEREST DUE, below.

Total Amount Allowed for DCN (Pursuant to 74 Ill. Adm Code 900.90 (b)(2)(provides "Invoice amount") (dollar amount total for all paid services for the DCN - 7th column on voucher.)

Estimated Interest Owed (Pursuant to 74 Ill. Adm Code 900.90(b)(3), provides other information necessary to verify interest payment penalty, and 900.90(c) interest must be $5.00 or greater)) Include Estimated Amount of interest. (See CALCULATION OF ESTIMATED INTEREST DUE, below)

Certification

Each request or multiple request document shall contain a certification statement, meeting the requirements of the Department, signed and dated by an authorized representative of the requestor (contact signature).

If the certification is omitted from the request or unsigned, the request will not be processed and will be returned to the requestor.

Attach copy of page(s) from the remittance advice with the requested DCN(s) circled in black ink. For photocopying purposes, highlighted copies will not be accepted.

CALCULATION OF ESTIMATED INTEREST DUE

The interest request will be denied unless the **Number of Days between Issue Date of Warrant and the Date of DCN** is greater than 61 days. No interest accrues on date of payment (74 Ill. Adm. Code 900.100 (e)). Pursuant to 5 ILCS 70/1.11: The time within which any act provided by law is to be done shall be computed by excluding the first day and including the last, unless the last day is Saturday or Sunday or is a holiday as defined or fixed in any statute now or hereafter in force in this State, and then it shall also be excluded. If the day succeeding such Saturday, Sunday or holiday is also a holiday or a Saturday or Sunday then such succeeding day shall also be excluded.

Any interest determination made by the Department resulting in an amount less than $5.00 will be not be paid. (74 Ill. Adm. Code 900.90 (c))

Requestors should determine prior to submitting a request whether the request might result in an interest payment of $5.00 or more. To save administrative resources for both the requestor and the Department, requests estimated to result in less than $5.00 in interest for a DCN should not be submitted. To determine if the request computes to less than $5.00 for a DCN, the following formula may be used:

1. **Issue Date of Warrant** minus **Date of DCN** minus 61 equals interest payment days. (Example: 4/2/2003 minus 1/26/2003 equals 66 days minus 61 equals 5 interest payment days).

2. Multiply the interest payment days by 0.00033 (daily interest factor) to obtain the accrued interest factor. ((Example: 5 days times 0.00033 equals 0.00165 (accrued interest factor)).

3. Multiply the accrued interest factor by the **Total Amount Allowed for DCN** to obtain the amount of **Estimated Interest Due**. (Example: 0.00165 times $3,000 equals $4.95).

Medical Interest Penalties Request

(Type or legibly print information in black ink.)

Requestor Name: _____
Address: _____
City: _____
State: _____ Zip: _____
Phone #: _____

Voucher #: _____
Warrant Date: _____
Payee #: _____

Payee Name: _____
Address: _____
City: _____
State: _____ Zip: _____

I certify that all entries on this Medical Interest Penalties Request are true, accurate and complete and that I agree to keep and make available such records as are necessary to furnish such information regarding any payments requested as State officials may request. I understand that payment is made from State funds and that any false claims, statements, or documents, or concealment of material facts may be cause for prosecution or other appropriate legal action.

Contact Signature ***Date***

	Document Control Number (DCN)	DCN Date	Number of Days Interest Owed[1]	Total Amount Allowed for DCN[2]	Est. Interest Owed[3]
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					

[1]The difference between the DCN date and issue date of warrant minus 61 days. (Does not include the date of payment.)

[2]Seventh column on the voucher.

[3]Only log claims where the amount of interest owed is $5 or greater.

Interest penalty = .00033/day

If additional space is needed, continue on supplemental page. Copy supplemental as needed.

Page _____ **of** _____

DPA 3805 (R-4-03) IL478-2538

Medical Interest Penalties Request - Supplemental Page

(Type or legibly print information in black ink.)

Voucher #: _____

	Document Control Number (DCN)	DCN Date	Number of Days Interest Owed[1]	Total Amount Allowed for DCN[2]	Est. Interest Owed[3]
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
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21					
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25					
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27					
28					
29					
30					
31					
32					
33					
34					
35					

[1]The difference between the DCN date and issue date of warrant minus 61 days. (Does not include the date of payment.)

[2]Seventh column on the voucher.

[3]Only log claims where the amount of interest owed is $5 or greater.

Interest penalty = .00033/day

Page _____ **of** _____

Source: http://www.hfs.illinois.gov/billing/interest.html.

APPENDIX D

May 2007 Exclusion Policy

HFS PROMPT PAYMENT EXCLUSION POLICY

The following presents the general logic for the exclusions. **These 11 items match the filter columns previously provided in the informational tables given to the OAG along with the 04 – 06 interest files.**

1. **Claims previously adjusted** – Unique to billing practices of the state is the ability of the vendor to change the content of what was originally billed and paid by the state. Providers are allowed up to 12 months from the date of payment to submit changes (adjustments) to the previously billed services. Many reasons cause a provider to submit an adjustment ranging from simple mistakes in the procedure code billed to returning money to the department due to over-billings that were discovered by the provider through their own internal auditing processes. In these cases the proper bill definition of having the complete and accurate information to pay the bill does not exist until the provider's adjustment is processed by the department; hence, the proper bill date for purposes of determining becomes the adjustment date and, coming after the payment of the original service, no interest would be allowed. (See 42 CFR 447.45(d)(4))

2. **LTC Cost Report Holds** – Facilities are required to file cost reports with the department so proper rates can be computed. Failure to file timely cost reports results in the department placing a hold on further payments to the facility until the report is filed. Claims are then "delayed" until the facility complies with the department's requirements. Once the report is filed, the held claims are then released for payment which may be weeks or months following the initial delay. The department is not liable for interest on these providers as a result of the delay caused by the facilities' non-compliance. (89 Ill. Adm. Code 140.545)

3. **Rejected Vouchers (FEIN)** – Vouchers submitted to the Comptroller for payment must meet criteria of that office to be accepted and the warrant issued. An initial check comes from the matching of the payee's name and FEIN with the IRS. Any mismatch on the name or number results in the voucher being rejected back to the department. It is up to the payee to correct any conflicts with either the IRS, Comptroller, or department's payee information. This may take days or weeks for the payee to file appropriate notices with either the Comptroller or department. Once corrections have been made, the voucher is reprocessed to the Comptroller for payment. No interest is owed on these vouchers as a result of action/inaction of the payee causing the payment delay. (74 Ill. Adm. Code 900.80 (a))

4. **OIG Exceptions** – Providers who are being investigated by the OIG for possible fraud or abuse can have their claims suspended by the OIG while investigations are pursued. At any given point in time 80,000 to 90,000 claims are in suspended status for this reason. Any provider who is under investigation or in the process of being terminated from the Medicaid program is excluded from receiving interest payments. Federal regulations exclude these situations from the timely

payment criteria and it seems reasonable not to pay interest where possible fraud has occurred. (See 42 CFR 447.45(d) (4)(iii))

5. **OIG Settlements** – Hundreds of providers are audited by the OIG and settlements are reached with the provider for repayment to the state for overbillings by the provider. The settlements are in the millions of dollars and represent a significant recovery by the OIG. Claims that were billed during the audit period are excluded from interest because, if the correct billings were made originally, the actual interest owed may have been under the $50 automatic threshold or under the $5 limit for receiving any interest if requested. Additionally, it does not seem prudent to "reward" these providers by paying interest on top of the overbillings. Because the overbillings total such a large amount, correct billings initially may have allowed the state to pay those billings more timely. (See 74 Ill. Adm. Code 900.70(a))

6. **Court of Claims Cases** – Some providers have chosen to file suit in the Court of Claims with respect their receipt of interest. The substance of the suits has to do with the CMS/Comptroller rule and differing opinion of what the Act is suppose to mean. The Court is ruling in its interpretation of the Act that differs from the rule. Since each case stands on it own, any interest to be paid by the department's process is put on hold. Any interest previously paid will be deducted from any award made by the Court of claims. Since these providers have chosen the Court to settle their claim, any further interest payments by the department's process is suspended. (See 30 ILCS 540/3-1)

7. **Government Entities** – Exclusions in the Prompt Payment rule provide that government entities are not entitled to receive interest. The legal status code on file in the Comptroller vendor file is the determining status. A status of "08" indicates government entity. Consequently, the Comptroller's editing process will not allow an agency to process a payment for detail object code 1991 (interest under prompt pay) for a vendor with a legal status of "08". These situations will result in the voucher being rejected back to the submitting agency. (74 Ill. Adm. Code 900.120.120 (a), (h))

8. **Tax Levies** – The Comptroller has delegated the processing of all IRS tax levies to state agencies. The department is responsible for interacting directly with the IRS and intercepting payments to vendors who are subject to levy. These redirected payments are then sent to the IRS to satisfy the levy. Any interest payment made to a payee in levy status will result in the payment being redirected to the IRS.

9. **DCN to Pending over 250 days** – Any claim taking longer than 250 days to get to the pending file is an anomaly. The intent of this filter is to prevent any outliers that may have been missed in the above from "slipping" through for payment.

10. **DCN to Pending minus 100 days** –On rare occasions there are claims that are pended and then subsequently receive a DCN assignment later, producing an anomaly showing a negative value between the DCN to pending dates. The most frequent of these anomalies are the system-generated claims for LTC that are created and pended at mid month and then DCN'd and vouchered during the last half of the month. These are unique claims that should not to be considered in the calculation of interest, and are filtered out at this time.

11. **Interest Previously Paid** – Any interest previously paid through the request process or the auto process is excluded as a duplicative payment. (74 Ill. Adm. Code 900.90)

Source: Illinois Department of Healthcare and Family Services.

APPENDIX E

July 2007 Policy on Adjustments

HFS PROMPT PAYMENT

PROPER BILL DATE REGARDING ADJUSTMENTS

Based on the following, the Department treats a "proper bill date" of a claim, for the purposes of determining prompt payment interest, to be the date of the adjustment. Clearly the rule definition of "Proper Bill" requires that to be a proper bill, the information regarding the bill must be correct; therefore, until this information is correct, there can be no Proper Bill Date.

When the bill is not proper because it contains incorrect information that cannot be reasonably discovered by the Agency, then there is no proper bill and proper bill date until the adjusting information is received. Going one step further, there is nothing in the Act or rules that would obligate the Department to re-compute prompt payment interest based on what an original bill, if correct, would have generated. By the provider's own admission it was not correct, so it wasn't a proper bill.

Therefore, the agency waits for one year after initial payment of a bill – the time period during which adjustments may be made to paid bills (42 CFS 447.45(d)(4)) – to determine prompt payment interest. Effective with interest penalty payments to be made on an after 7/26/2007, DCN's found to have been adjusted will be excluded from interest computations.

The Prompt Pay Act states:

As used in this Act, "a proper bill or invoice" means a bill or invoice that includes the information necessary for processing the payment as may be specified by a State agency and in rules adopted in accordance with this Act.

and:

(1) Any bill approved for payment under this Section must be paid or the payment issued to the payee within 60 days of receipt of a proper bill or invoice.

The Rule provides this definition:

"Proper Bill" shall be defined as: a bill or invoice containing sufficient and correct information necessary to process the payment for a liability of a State agency as provided in this Part, the Comptroller's Statewide Accounting Management System (SAMS) manual, or as otherwise specified by the State agency responsible for payment.

The submission of the bill section in the rule states:

a) A bill submitted, lacking sufficient and/or correct information required by the State agency to process the bill, lacking taxpayer identification number, or to an address or person other than one designated in written instructions from the State shall not be considered a Proper Bill until it is completed, additional information provided, or it reaches the proper address or person.

The interest calc part of the rule states:

d) Interest shall begin accruing on the 61st day after receipt of a Proper Bill and shall continue to accrue until the bill is paid by the Comptroller's Office.

In section 140 of the Medical Payment Rule:

Section 140.25 Overpayment or Underpayment of Claims

a) When the Department, the provider, or the designated alternate payee has determined that an overpayment has been made, the provider or the alternate payee shall reimburse the Department for the overpayment. The Department shall recover overpayments made to or on behalf of a provider that result from improper billing practices. Such recovery may occur by setoff, crediting against future billings or requiring direct repayment to the Department.

In Chapter 100 of the provider handbook, the following references are made:

"132.3 ALL OTHER ADJUSTMENTS
Adjustments can only be made on paid claims. If a provider becomes aware that a claim has been submitted that will require an adjustment, no corrective action can be taken until the claim is adjudicated and appears on a Remittance Advice. As soon as the claim has been reported as a paid claim on a Remittance Advice, the provider should submit an Adjustment form to correct the payment. Copies of Adjustment forms and instructions for their completion are provided in General Appendix 6."

"133 REFUNDS
Although the Adjustment process in Topic 132 should generally be used whenever incorrect payment has occurred, there may be instances in which a provider considers it necessary to refund an overpayment to the Department."

"GENERAL APPENDIX 6
ADJUSTMENTS

An adjustment form is used to adjust an incorrect payment which has been reported on Form DPA 194-M-1, Remittance Advice."

Specific instructions ask for the adjustment type to be entered per the following:

"14. ADJ. (Adjustment) TYPE - On all provider-initiated adjustments, one of the following codes must be entered to identify the reason the adjustment is being requested:

01 Third Party Collection - This code is to be used when payment is received for a claim from another source after payment was made by the Department. Repayment must be made to the Department of any amount received from another source up to the amount received from the Department.

02 Billing or payment error on an individual Service Section detected by the provider or, for UB-92 billers, when a claim has been paid in error. This code is to be used when the provider determines:

Payment was made based on erroneous information entered in a Service Section of the claim such as an incorrect procedure code or charge; or

A Service Section was paid in error, e.g., a duplicate payment, a payment made on behalf of a patient unknown to the provider, etc.

03 Reconsideration - This code is to be used if the provider wants to ask that the Department review and determine whether special circumstances may permit a change in the amount paid for a specific service. This adjustment type does not apply to UB-92 billers."

Source: Illinois Department of Healthcare and Family Services.

APPENDIX F

Agency Responses

ILLINOIS DEPARTMENT OF
HFS Healthcare and Family Services

Rod R. Blagojevich, Governor
Barry S. Maram, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

March 31, 2008

Scott Wahlbrink
Audit Manager
Office of the Auditor General
740 East Ash
Springfield, Illinois 62703

Dear Mr. Wahlbrink:

Enclosed please find a copy of the Healthcare and Family Services responses to the Prompt Pay Audit. I have provided this on a diskette per your request.

Please contact me at (217) 785-9764 if you have any questions.

Sincerely,

Peggy Edwards

Peggy Edwards
HFS External Audit Liaison

E-mail: hfs.webmaster@illinois.gov

Internet: http://www.hfs.illlinois.gov

PROMPT PAYMENT ACT INTEREST CALCULATION	
RECOMMENDATION NUMBER **1**	***The Office of the Comptroller, the Department of Central Management Services, and the Department of Healthcare and Family Services should immediately resolve the differences in interpretations between the Administrative Rule (74 Ill. Adm. Code 900.100) and the Prompt Payment Act (30 ILCS 540/3-2) regarding the method used to calculate prompt payment interest.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department partially agrees in that differences in interpretations of this rule should be resolved by the Comptroller and the Department of Central Management Services. However, as 74 Ill. Adm. Code 900.100 refers to joint rules of the Comptroller and the Department of Central Management Services, the Department of Healthcare and Family Services would have no action with regard to such resolution. The Department is required to calculate interest according to the rules published by the agencies with rulemaking authority on the issue and will follow any changes to those rules that those agencies make.

ILLINOIS INSURANCE CODE INTEREST	
RECOMMENDATION NUMBER **2**	***The Department of Healthcare and Family Services should obtain appropriate documentation from contractors to show the amounts and purposes of funds being disbursed.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department agrees with the recommendation. Subsequent to the management audit, the department has requested and will be receiving on a periodic basis, a report detailed by provider from CIGNA providing the amounts and purposes of funds being disbursed under the Illinois Insurance Code. The Department notes that it has been receiving reports from CIGNA on a periodic basis, which allow the Department to reconcile all payments to the activities listed in each of the Department's bank accounts.

MEDICAID PAYMENT SCHEDULE	
RECOMMENDATION NUMBER **3**	***The Department of Healthcare and Family Services should document how it determines when providers are paid and document its rationale and methodologies used to calculate provider payment parameters.***

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department partially agrees in that the Department should maintain adequate documentation regarding the determination of payment parameters that currently occurs through daily consultation with the Office of the Comptroller. The Department maintains that the existing documentation as to rationale and methodologies used to calculate provider payments is adequate, in that the Department utilizes available appropriations as passed by the General Assembly in the state budget. However, the Department will develop additional documentation regarding the process of setting payment parameters.
	AUDITOR COMMENT: *HFS responds that the existing documentation is adequate; however, no documentation was provided to auditors during the course of the audit. Also, on January 22, 2008, HFS' Administrator of the Division of Finance noted that there was no documentation related to how HFS determines payment parameters.*

EXPEDITED PAYMENT PROCESS	
RECOMMENDATION NUMBER **4**	***The Department of Healthcare and Family Services should:*** • ***develop written policies and procedures for reviewing, documenting, and approving all expedited providers to ensure that only providers that are eligible by Administrative Rule receive expedited payments; and*** • ***ensure provider agreements and provider lists are updated regularly for all expedited payments.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department agrees with the recommendation and will further document in writing its existing procedures not already set forth in rule for verifying qualification for expedited status. While these policies and procedures are adequate, the Department acknowledges that they are not set down in a comprehensive document. The Department will continue its current policy of reviewing continued qualification of expedited status semi-annually for all non-LTC expedited providers. The Department will begin to periodically review the status of LTC providers.
	AUDITOR COMMENT: *During the course of the audit, HFS officials noted that expedited status is reviewed **annually** for providers and every other year for pharmacies, not semi-annually as noted in the Department's response. In their review of expedited agreements, auditors found no evidence that HFS' current review is completed on a semi-annual basis.*

ONE-TIME DROP PAYMENTS	
RECOMMENDATION NUMBER **5**	***The Department of Healthcare and Family Services should develop policies and procedures for authorizing one-time drop payments to providers. These policies should include criteria for eligibility and requirements for maintaining necessary documentation.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department agrees with the recommendation and will enhance its documentation of one-time payment drops, which represent less than seven 100ths of one percent (.0069) of claims paid.
	AUDITOR COMMENT: *As noted in the audit report, the total dollar amount of one-time drop payments made by HFS in FY07 -* ***$5.7 million*** *- was not insignificant and should be documented.*

REJECTED CLAIM NOTIFICATION	
RECOMMENDATION NUMBER **6**	***The Department of Healthcare and Family Services should:*** • ***maintain the date the claim was rejected as required by 74 Ill. Adm. Code 900.30 (b)(4);*** • ***develop a process to notify providers as soon as possible of their rejected claims as required by 74 Ill. Adm. Code 900.70 to allow providers ample time to resubmit services that are rejected;*** • ***update the list of error codes that is available to providers to include all codes currently being used to reject claims by HFS; and*** • ***explore alternatives to notifying providers of rejected claims other than by sending hard copy remittance advices.***

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	• The Department respectfully disagrees with the recommendation and states the Department does maintain the dates of when claims are approved or rejected. The official date of action is the date of adjudication and is maintained in the Department's MMIS system for two years and in the Department's Medical Data Warehouse since 1996. Archived data is also available. • The Department respectfully disagrees with the recommendation. All rejected claims that have passed through the appropriate claims processing editing functions are already reported weekly to providers via the weekly rejected claim remittance advices. As is noted in the audit report, this notification occurs within an average of 12 calendar days from receipt of the claim. Notification of the dispensation of each service line on a paid claim is contained in the remittance advice, which can be delayed as a result of slow payment cycles. However, any provider may check the status of payment for every service on a claim processed for payment through the MEDI system. The status is available as soon as adjudication is complete, within approximately 6 days of receipt of the claim. This process is far superior and more efficient than any further mailing of paper status notification. • The Department agrees with the recommendation. Updated error code listings will be made available to providers in the most efficient and timely fashion. • The Department agrees with the recommendation and has already deployed one alternative and is currently piloting a second. Providers can currently check the status of any of their claims after seven days from submission via the Departments website's MEDI system. This system has been in place since 2004. Implementation of electronic remittance advices is being piloted with 119 Institutional providers and 828 Non-Institutional providers participating in the Pilot Project. The HIPAA 835 transactions will provide electronic claim results in lieu of the hard copy remittance. Electronic supplemental information will also be provided to fully explain reasons for rejects and other helpful information.

	AUDITOR COMMENT: *On at least **6** different occasions during the course of the audit – January 7, 2008, January 16, 2008, January 23, 2008, January 25, 2008, January 30, 2008, and January 31, 2008 – auditors requested the rejected claim date for claims in our rejected claim sample. Five of the requests were in writing and one was verbal. HFS officials did not respond to the auditors' requests. Consequently, this recommendation was included in the audit report.* *As noted in the report, HFS is not notifying providers "as soon as possible" of its decision to reject claims as required by administrative rule. During testing, we found it took on average **87 days** for HFS to notify providers of rejected services when the rejected service was submitted on a claim along with a service that was paid.* *Furthermore, HFS responded that providers can check the MEDI system for the status of claims, but HFS officials acknowledged that not all providers use the MEDI system. Additionally, the administrative rule **requires HFS to "notify"** providers upon discovery of a claim with defects. The MEDI system does not notify providers; it is a system that some providers may use to check claim status.*

REJECTED CLAIM RESUBMISSION POLICY	
RECOMMENDATION NUMBER **7**	***The Department of Healthcare and Family Services should re-examine its policy that instructs providers to resubmit all claims that have not appeared on a remittance advice within 60 days.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department agrees and will instruct providers to resubmit only if their claims fail to appear in claims status on MEDI within 30 days of submission.

REJECTED CLAIM PROBLEMS	
RECOMMENDATION NUMBER **8**	***The Department of Healthcare and Family Services should periodically survey providers to obtain their feedback on problems they are experiencing with the claims rejection process and ways it could be improved.***

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department respectfully disagrees with the recommendation. The Department's existing feedback mechanisms are more effective than conducting periodic surveys. These include having billing consultants assigned to different provider types who are in daily contact with providers to help them with billing issues. As problems are identified, Problem Resolution Requests (PRRs) or Project Initiation Requests (PIRs) are drafted to resolve the issues or change the system. The Department also regularly consults with provider associations on billing issues. Recent changes in processes have been made as a result of this constant interaction with providers. Finally, the Department's contracted Primary Care Case Management program administrator also has provider service representatives trained to help with billing issues.
	AUDITOR COMMENT: *Given the size and complexity of the Medicaid program and given the concerns raised by respondents to our provider survey, we continue to believe that a systematic, regular, and documented process for obtaining feedback from providers is important and advisable.*

REQUIREMENTS FOR REQUESTING INTEREST	
RECOMMENDATION NUMBER **9**	***Regarding the requirements for requesting interest, the Department of Healthcare and Family Services should:*** • ***make its requirements for requesting interest less cumbersome by only requiring providers to submit information that is necessary to process the request;*** • ***correctly define "warrant date" in its instructions; and*** • ***consider sending an informational notice to providers reminding them of the Prompt Payment Act and the requirements for requesting interest.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	• The Department agrees with the recommendation and with the implementation of the automated interest calculation process, will no longer require providers to calculate estimated interest. • The Department agrees with the recommendation and will clarify the meaning and purpose of "warrant date" in the instructions. • The Department agrees with this recommendation and has posted information and instructions on requesting interest on its website and has worked with provider associations that have publicized the Act, Rule and the request process to their members. The Department is moving away from costly paper mailings to notify providers of policies and does not agree to a paper mailing.

	AUDITOR COMMENT: *The auditors recommended sending an informational notice to providers, which could include paper mail, or other methods, such as e-mail. HFS does mail paper remittance advices to providers and an informational notice on prompt pay could be included in those mailings.*

NOTIFICATION FOR DENIED INTEREST REQUESTS	
RECOMMENDATION NUMBER **10**	***The Department of Healthcare and Family Services should:*** • ***notify providers within 60 days that their requests for interest penalty payments are denied as required by 74 Ill. Adm. Code 900.35;*** • ***date Interest Request Result reports that are sent to providers; and*** • ***date stamp interest requests upon receipt.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	• The Department agrees with this recommendation and will notify providers within 60 days that their interest requests are denied. • The Department agrees with this recommendation and will put a date on the report. • The Department agrees with the recommendation and, while dates were noted upon receipt of a request, an official Department date stamp is now being affixed to the request form.

INTEREST CALCULATION PROCESS	
RECOMMENDATION NUMBER **11**	***The Department of Healthcare and Family Services should:*** • ***develop policies and procedures to document the process used for calculating, processing, and paying interest owed to Medicaid providers;*** • ***automate the process used to calculate, process, review, and pay interest to Medicaid providers;*** • ***segregate duties performed to verify and calculate interest claims; and*** • ***ensure sensitive Medicaid claim information is adequately protected (password usage or encryption may be acceptable alternatives).***

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	• The Department agrees with the recommendation. The interest process has been automated and implemented. While documentation of procedures exists, this documentation will be further clarified. • The Department agrees with the recommendation. A fully automated interest payment process has been completed and will be utilized for future interest payments. • The Department agrees with the recommendation. The current process has been under the direct guidance of highly competent and experienced individuals who have taken great care to ensure integrity and accuracy in the process. The newly developed automated process will further include appropriate segregation of duties. • The Department respectfully disagrees with the recommendation and further disagrees with the characterization of data used to calculate interest payments as "sensitive Medicaid claim information" and is not aware of any legal definition for such term. Present security of and access to Department computer based information is tightly controlled through Office of Information Systems' policies and procedures. All employees must have an authorized log-on ID and password, which protects any confidential information, such as tax identification numbers, contained in the interest database. In addition, informational files related to interest payments in the Department can only be accessed via the particular staff currently responsible for interest processing.
	AUDITOR COMMENT: *On October 1, 2007, auditors copied numerous interest database files from an HFS employee's computer. Auditors observed that the interest databases were not password protected or encrypted. Since the interest databases contained sensitive information such as payee tax identification numbers, providers under investigation by the OIG, and providers with tax levies against them, auditors recommended that the data be protected either by password or by the use of encryption software.*

EXCLUSION OF INTEREST PAYMENTS	
RECOMMENDATION NUMBER **12**	***The Department of Healthcare and Family Services should:*** • ***examine its policies and procedures used to exclude claims from interest payment and include only those supported by law;*** • ***not apply exclusions retroactively unless expressly permitted by law; and*** • ***pay interest that has been withheld without legal support.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	• The Department partially agrees with the recommendation. However, the assertion in the audit report that "Medicaid claims submitted to HFS have accrued almost $81 million in Prompt Payment Act interest since FY00" is not correct. Detailed information supplied to auditors clearly showed that the correct figure was $56.2 million. Of that amount, $34.4 million was interest in amounts between $5 and $50, and therefore, payable only if requested. The information provided to auditors, which at the time included estimates, also showed that of the $34.4 million in interest between $5 and $50, only $5.7 million was requested, bringing the estimated total interest due to $27.4 million ($5.7 million in requested interest, plus $21.8 million in automatic interest over $50). The actual total interest due, and paid now that final interest has been calculated for this time period, is $25.9 million. The Department will re-examine exclusions and make changes to improve their application, effectiveness and fairness, if necessary. The Department maintains that all so-called "exclusion policies" are steps taken to properly comply with the statutes and rules, pay interest when it is due and not pay interest when it is not due. Claims excluded under these policies were claims that were not payable during some or all of the time they were being processed. If a claim is not payable, it cannot accrue interest for not being paid. • The Department respectfully disagrees with the recommendation. The policies adopted by the Department relate to the process of calculation of any payment of penalties, and were applied to all automatic interest payments made after the policies were adopted. Exclusion policies are steps taken to determine whether an underlying claim is payable in order to determine if interest should be calculated. The Department has not retroactively changed a policy on whether a claim is payable. No previously paid interest to providers has been retroactively changed to reflect changes in current policies. • The Department partially agrees with the recommendation. The Department will re-examine the exclusions and make any changes to improve their application, effectiveness and

	fairness, if necessary. If it is found that an interest request previously denied should have been granted, the appropriate action will be taken.
	AUDITOR COMMENT: *The report has been clarified to note that HFS accrued a potential liability of almost $81 million in Prompt Payment Act interest since FY00, and that actual interest expected to be paid to providers is estimated by HFS to be less due to not all providers requesting eligible interest, as well as exclusions that may be applied to potential interest payments by HFS.* *Much of the "detailed information" referred to by HFS in its response was taken from a summary chart provided to auditors in August 2007. The summary chart noted that the FY06 and FY07 numbers were **estimates**, which may explain some of the differences between the numbers cited by HFS in its response and the numbers reported in Chapter 4. The accrued interest summary chart also appears to only include interest eligible for payment after exclusions were applied by HFS. To calculate the accrued interest, auditors used the **actual** databases used by HFS to calculate and pay interest prior to exclusions being applied, which shows potential interest accrued due to late payment of claims by HFS. These numbers were reviewed and approved by the Bureau Chief of Claims Processing, who is responsible for calculating and paying prompt payment interest to providers.* *HFS clearly **has** applied exclusions retroactively. The Department's Exclusion Policy was adopted in May 2007. This Policy was then applied to interest claims dating back to 1999. Applying policies adopted in 2007 to interest that accrued on claims from 1999 **is** a retroactive application of the policies.*

INTEREST PAYMENT TIMELINESS	
RECOMMENDATION NUMBER **13**	***The Department of Healthcare and Family Services should pay interest penalties owed to providers in a reasonable time as required by 74 Ill. Adm. Code 900.90.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department agrees and believes that its newly automated procedures for payment of interest will enable those payments to be made timely. The Department has paid all interest previously owed, which totals $25.9 million.

CMS
ILLINOIS Rod R. Blagojevich, Governor
DEPARTMENT OF CENTRAL MANAGEMENT SERVICES
Maureen T. O'Donnell, Acting Director

March 28, 2008

Scott Wahlbrink
Audit Manager
Office of the Auditor General
Iles Park Plaza
704 East Ash
Springfield, IL 62703-3154

Dear Mr. Wahlbrink:

The Department of Central Management Services (CMS) received your draft finding Prompt Payment Act Interest Calculation as addressed in an audit conducted of the Department of Healthcare and Family Services.

The recommendation (1) stated "The Office of the Comptroller, the Department of Central Management Services, and the Department of Healthcare and Family Services should immediately resolve the differences in interpretations between the Administrative Rule (74 Ill. Adm. Code 900.100) and the Prompt Payment Act (30 ILCS 540/3-2) regarding the method used to calculate prompt payment interest."

As discussed in the exit conference on March 18, 2008 and emailed to you on March 25, 2008:

Department of Central Management Services Response:
The Department agrees that there is an issue of interpretation that needs to be addressed. The Department will work with the Illinois Office of the Comptroller to address this issue.

Thank you for your consideration and attention to this issue.

Sincerely,

Maureen T. O'Donnell PR

Maureen T. O'Donnell
Acting Director
Department of Central Management Services

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March 27, 2008

Mr. Scott Wahlbrink
Audit Manager
Office of the Auditor General
740 East Ash
Iles Park Plaza
Springfield, Illinois 62703-3154

Re: Legislative Audit Commission Resolutions 136 and 137
- Administrative Rule that governs the Prompt Payment Act

Dear Mr. Wahlbrink:

Pursuant to Legislative Audit Commission Resolutions 136 and 137 regarding "an audit of the Department of Healthcare and Family Services' processing Medicaid claims and its compliance of the State Prompt Payment Act", we have completed our review of "the "confidential" draft report sections pertaining to our Office, which includes one recommendation relating to the Administrative Rule that governs the Prompt Payment Act." Our response to said audit is:

> We agree. Our office will seek legislative clarification and work with Central Management Services to adapt rules consistent with relevant language.

Sincerely,

Don Templeman

Don W. Templeman
Assistant Comptroller, Operations

cc: Rick Cornell, Assistant Comptroller, Policy, IOC
Rusti Cummings, Internal Auditor, IOC

DWT:LF:lf

Please respond to:

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