REPORT DIGEST

PERFORMANCE AUDIT OF

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

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State of Illinois
Office of the 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.

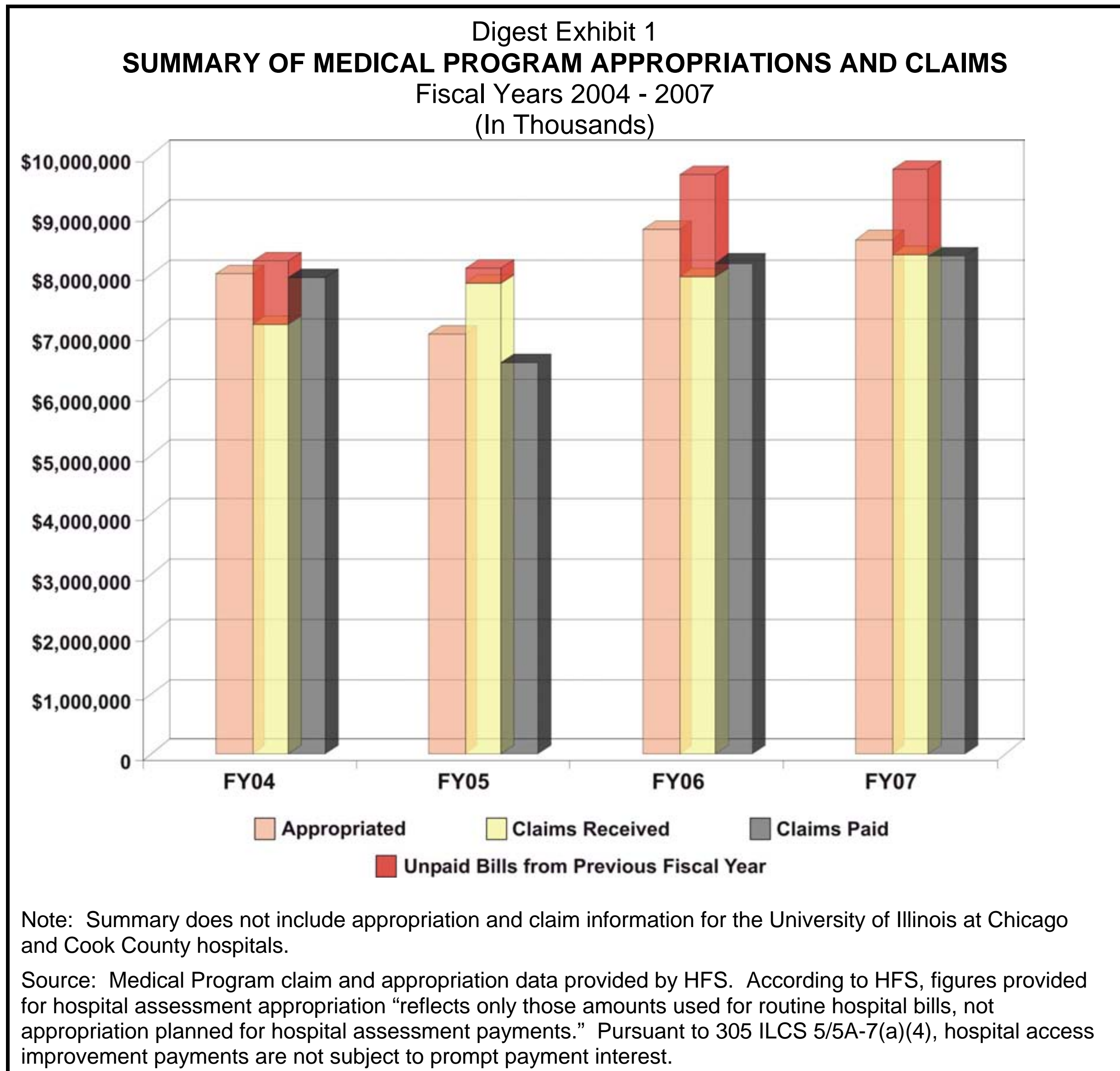
BACKGROUND

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)

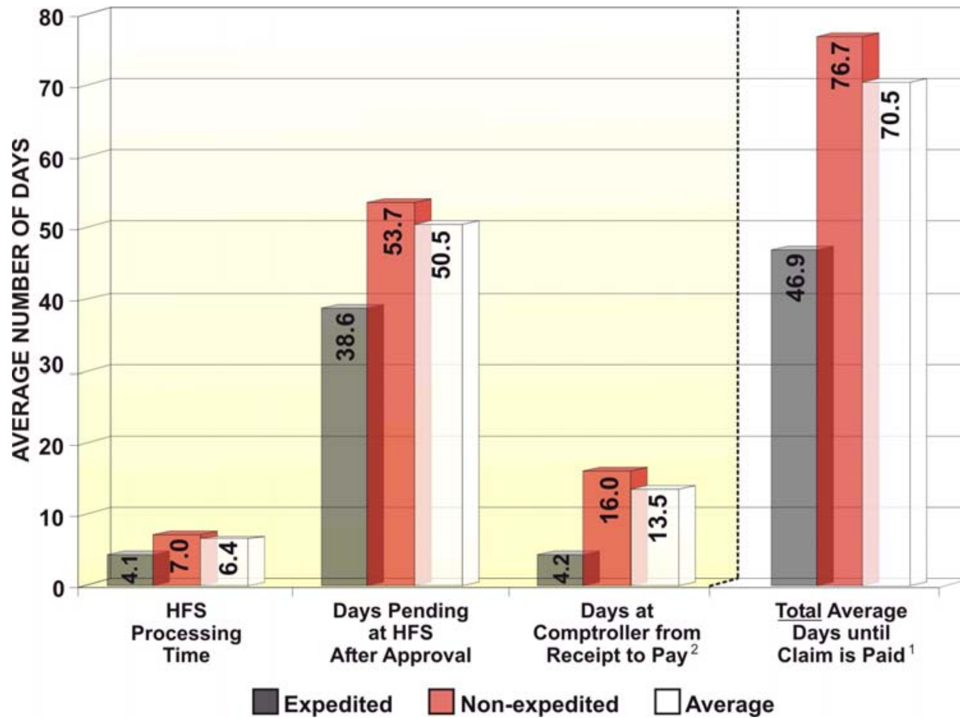
DELAYS IN MEDICAID PAYMENTS

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

	Before Exclusions			After Exclusions			
Fiscal Year	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

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May 2008