



December 20, 2010

**TO:** Donald M. Berwick, M.D.  
Administrator  
Centers for Medicare & Medicaid Services

**FROM:** /Joe Green/ for  
George M. Reeb  
Acting Deputy Inspector General for Audit Services

**SUBJECT:** Review of Illinois' Prompt Pay Compliance Under the American Recovery and Reinvestment Act of 2009 From January 1, 2009, Through September 30, 2009 (A-05-09-00083)

Attached, for your information, is an advance copy of our final report on Illinois' prompt pay compliance under the American Recovery and Reinvestment Act during the first 9 months of 2009. We will issue this report to the Illinois Department of Healthcare and Family Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at [Robert.Vito@oig.hhs.gov](mailto:Robert.Vito@oig.hhs.gov) or James C. Cox, Regional Inspector General for Audit Services, Region V, at (312) 353-2621 or through email at [James.Cox@oig.hhs.gov](mailto:James.Cox@oig.hhs.gov). Please refer to report number A-05-09-00083.

Attachment



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

December 22, 2010

Report Number: A-05-09-00083

Ms. Julie Hamos  
Director  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue East  
Springfield, IL 62763-0002

Dear Ms. Hamos:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Illinois' Prompt Pay Compliance Under the American Recovery and Reinvestment Act of 2009 From January 1, 2009, Through September 30, 2009*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Stephen Slamar, Audit Manager, at (312) 353-7905 or through email at [Stephen.Slamar@oig.hhs.gov](mailto:Stephen.Slamar@oig.hhs.gov). Please refer to report number A-05-09-00083 in all correspondence.

Sincerely,

/James C. Cox/  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Jackie Garner  
Consortium Administrator  
Consortium for Medicaid and Children's Health Operations  
Centers for Medicare & Medicaid Services  
233 North Michigan Avenue, Suite 600  
Chicago, IL 60601

Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF ILLINOIS' PROMPT PAY  
COMPLIANCE UNDER THE AMERICAN  
RECOVERY AND REINVESTMENT ACT  
OF 2009 FROM JANUARY 1, 2009,  
THROUGH SEPTEMBER 30, 2009**



Daniel R. Levinson  
Inspector General

December 2010  
A-05-09-00083

# *Office of Inspector General*

<http://oig.hhs.gov>

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## **EXECUTIVE SUMMARY**

### **Medicaid Program**

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income.

### **American Recovery and Reinvestment Act of 2009**

The American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provides, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act will provide an estimated \$87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. Pursuant to the Recovery Act, a State is not eligible for the increased FMAP for any clean claim received from a practitioner on days when the State did not comply with prompt pay requirements. Pursuant to 42 CFR § 447.45(d), a State Medicaid agency must pay 90 percent of all clean claims from practitioners within 30 days of the date of receipt and 99 percent of such claims within 90 days of the date of receipt.

### **Illinois Medicaid Program**

In Illinois, the Department of Healthcare and Family Services (the State agency) administers the State's Medicaid program. During the period January 1, 2009, through September 30, 2009, Illinois' Recovery Act FMAP increase ranged from 10.16 percent to 11.56 percent, resulting in additional Medicaid reimbursements totaling approximately \$1 billion. The State agency receives and processes Medicaid claims using Illinois' Medicaid Management Information System.

### **OBJECTIVE**

Our objective was to determine whether the State agency complied with the prompt pay requirements for receiving and reporting the increased FMAP.

### **SUMMARY OF FINDINGS**

The State agency did not always comply with the prompt pay requirements for receiving and reporting increased FMAP under the Recovery Act. As a result, it improperly received approximately \$2.5 million in increased FMAP for the period February 18, 2009, through September 30, 2009.

The State agency's initial prompt pay calculations included several inaccuracies related to the 30/90-day prompt pay requirements and the inclusion or exclusion of certain claims in the daily prompt pay compliance calculation.

In addition, the State agency failed to adjust the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) for the quarter ended June 30, 2009, for expenditures not eligible for increased FMAP.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund \$2,586,522 to the Federal Government for unallowable increased FMAP and
- ensure that calculations are performed in accordance with the prompt pay requirements.

## **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency agreed that it had applied an incorrect prompt pay standard and incorrectly excluded or included certain prompt pay claims. To cover all corrections, State agency officials said that they made an adjustment of \$2,586,522 and reported it on the December 2009 CMS-64. The State agency's comments are included in their entirety as the Appendix.

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## INTRODUCTION

### BACKGROUND

#### Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time.

#### American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provides, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act will provide an estimated \$87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. Section 5000 of the Recovery Act provides these increases to help avert cuts in health care provider payment rates, benefits, or services and to prevent changes in income eligibility requirements that would reduce the number of individuals eligible for Medicaid. For Federal fiscal year 2009, these temporary FMAP increases ranged from 6.2 to nearly 14 percentage points, depending on State unemployment rates.

Pursuant to section 5001(f)(2)(A) of the Recovery Act, effective February 18, 2009, and CMS guidance,<sup>1</sup> a State is not eligible for the increased FMAP for any claim received from a practitioner on days during any period in which the State did not comply with prompt pay requirements referenced at section 1902(a)(37)(A) of the Act. Pursuant to section 5001(f)(2)(B) of the Recovery Act, effective June 1, 2009, these requirements also apply to claims submitted by hospitals and nursing facilities. In this report, we refer to these requirements as the prompt pay requirements for receiving the increased FMAP under the Recovery Act.

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<sup>1</sup> State Medicaid Director Letter No. 09-004 (July 30, 2009) (CMS's guidance).

## **Prompt Pay Requirements**

Section 1902(a)(37)(A) of the Act and implementing regulations (42 CFR § 447.45) specify prompt pay requirements. Pursuant to 42 CFR § 447.45(d)(2), a State Medicaid agency “must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt.” Pursuant to 42 CFR § 447.45(d)(3), a State Medicaid agency must pay 99 percent of such claims within 90 days of the date of receipt.<sup>2,3</sup>

Federal regulations define a clean claim as a claim that can be processed without obtaining additional information from the provider or a third party. Clean claims do not include claims from a provider that is under investigation for fraud or abuse or claims under review for medical necessity (42 CFR § 447.45(b)).<sup>4</sup> CMS’s guidance to States defines the date of receipt as the actual date a State receives a claim from a provider. CMS further defines a claim’s payment date as either the payment check date, the date of an electronic funds transfer payment, the date that a payment is mailed, or the date on the Explanation of Benefits or denial notice for denied claims (CMS’s guidance, Appendix, section B).

## **Illinois State Medicaid Program**

Illinois’s Department of Healthcare and Family Services (the State agency) administers the State’s Medicaid program. The State agency receives and processes Medicaid claims using a computerized payment and information reporting system, the Illinois Medicaid Management Information System (MMIS). The State agency also tracks its daily compliance with the prompt pay requirements using the claims information recorded in MMIS.

During the period January 1, 2009, through September 30, 2009, Illinois’ Recovery Act FMAP increase ranged from 10.16 percent to 11.56 percent, resulting in additional Medicaid reimbursements totaling approximately \$1 billion.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the State agency complied with the prompt pay requirements for receiving and reporting the increased FMAP.

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<sup>2</sup> In general, a State Medicaid agency must pay all other claims within 12 months of the date of receipt.

<sup>3</sup> Because the Recovery Act was enacted on February 17, 2009, the first compliance date with respect to prompt pay requirements for receiving the increased FMAP under the Recovery Act for practitioner claims was February 18, 2009. Therefore, claims received 30 days before this date (on January 20, 2009) were the first claims subject to the 30-day requirement, and claims received 90 days before this date (on November 21, 2008) were the first claims subject to the 90-day requirement (CMS’s guidance).

<sup>4</sup> Throughout our report, “claims” refers to clean claims as defined pursuant to 42 CFR § 447.45(b).

## Scope

Our review covered all Medicaid claims received and adjudicated by Illinois for the period February 18 through September 30, 2009. We did not assess the State agency's overall internal control structure. We limited our review of internal controls to those applicable to our objective, which did not require an understanding of all internal controls over the Medicaid program. We reviewed the State agency's procedures for ensuring compliance with prompt pay requirements for receiving the increased FMAP under the Recovery Act.

We performed our fieldwork at the State agency's Medicaid offices in Springfield, Illinois, from May 2009 to May 2010.

## Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the State agency's policies and procedures for paying Medicaid providers and for complying with prompt pay requirements and met with State agency officials to gain an understanding of those policies and procedures;
- obtained from the State's MMIS the population of all claims received for each day during the period November 21, 2008, through September 30, 2009;
- validated the population of claims received by randomly selecting 8 sample days from the State's MMIS claim data file and testing them for completeness, accuracy, and validity;
- verified the State agency's methodology for identifying clean Medicaid claims and calculating prompt pay percentages;
- determined whether the State agency complied with the prompt pay requirements for receiving the increased FMAP for each date beginning February 18, 2009, through September 30, 2009, by:
  - determining the number of clean claims received,
  - computing for each claim the number of days between the date of receipt and the date of payment or denial,
  - determining the total number of claims paid or denied within 30 days and within 90 days, and

- calculating the percentage of claims paid or denied within 30 days and within 90 days;<sup>5</sup>
- validated the accuracy of the State agency's expenditures eligible for increased FMAP for the quarters ended March 31, 2009, June 30, 2009, and September 30, 2009;
- validated the revised prompt pay calculations that the State agency made during our audit period; and
- discussed the results of our audit with the State agency.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## **FINDINGS AND RECOMMENDATIONS**

The State agency did not always comply with the prompt pay requirements for receiving and reporting increased FMAP under the Recovery Act. As a result, it improperly received approximately \$2.5 million in increased FMAP for the period February 18, 2009, through September 30, 2009.

The State agency's initial prompt pay calculations included several inaccuracies related to the 30/90-day prompt pay requirements and the inclusion or exclusion of certain claims in the daily prompt pay compliance calculation.

In addition, the State agency failed to adjust the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) for the quarter ended June 30, 2009, for expenditures not eligible for increased FMAP.

## **FEDERAL GUIDANCE**

Section 5001(f)(2)(A) of the Recovery Act provides that the increased FMAP is not available "for any claim received by a State from a practitioner ... for such days during any period in which the State has failed to pay claims in accordance with" the timely processing of claims standards as referenced at section 1902(a)(37)(A) of the Act and in implementing Federal Medicaid regulations (42 CFR § 447.45(d)). Under the Recovery Act, the prompt pay provision with respect to practitioners applies only "to claims made for covered services after the date of enactment;" that is, because the Recovery Act was enacted on February 17, 2009, this provision applies for claims received on or after February 18, 2009. Section 5001(f)(2)(A) further provides

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<sup>5</sup> For each receipt date, we calculated these percentages by dividing the number of claims paid or denied within the specified period by the total claims received on that date.

that each State report, on a quarterly basis, compliance with the prompt pay requirements for claims made for covered services during each month of the preceding quarter.

Section 1902(a)(37)(A) of the Act and implementing regulations (42 CFR § 447.45) specify Federal prompt pay requirements. Pursuant to 42 CFR § 447.45(d)(2), a State Medicaid agency “must pay 90 percent of all clean claims from practitioners within 30 days of the date of receipt.” Pursuant to 42 CFR § 447.45(d)(3), a State Medicaid agency must pay 99 percent of such claims within 90 days of the date of receipt.

## **INACCURACIES IN THE STATE AGENCY’S INITIAL PROMPT PAY CALCULATIONS**

The State agency initially identified 46 days (\$16.3 million in increased FMAP) on which it did not comply with the prompt pay requirements during the period February 18, 2009, through September 30, 2009. For some but not all of these 46 days, the State agency improperly received increased FMAP.

### **Incorrect Standard Applied in Prompt Pay Calculations**

Because of a computer coding error, the State agency inadvertently calculated prompt pay compliance based on a 31/91 prompt pay requirement rather than the correct 30/90-day prompt pay requirement. Consequently, when the State agency conducted its daily compliance tests, it used claims that were received 31 days before the test day to determine whether at least 90 percent of those claims were paid as of the test day. It then identified claims received 91 days before the test day to determine whether at least 99 percent of those claims were paid as of the test day. As a result, the State agency incorrectly determined that some days were eligible for increased FMAP.

### **Claims Incorrectly Excluded From or Included In Prompt Pay Calculations**

Although CMS’s guidance provided proper information, the State agency incorrectly excluded three categories of claims from its initial prompt pay calculations. The three claim categories, the exclusion of which affected the accuracy of the prompt pay calculations, were:

- zero paid claims with no warrant (invoice for payment),
- denied clean claims, and
- dental claims previously excluded.

The State agency also incorrectly included Family Care Medicaid claims in its initial prompt pay calculations. The State agency subsequently determined that these claims were pending State plan approval by CMS and, therefore, were not eligible for traditional FMAP during the review period.

## **ADJUSTMENTS NOT MADE**

The State agency disclosed to us that it failed to adjust the CMS-64 for the quarter ended June 30, 2009, for expenditures not eligible for increased FMAP. Claims received at the end of the March 31, 2009, quarter and not paid until the following quarter were reported on the CMS-64 for the quarter ended June 30, 2009. To comply with section 5001(f)(2)(a)(ii), the State agency should have adjusted the total expenditures reported on the CMS-64 for the quarter ended June 30, 2009, to account for the claims from the prior period that were not eligible for increased FMAP. Consequently, the State agency inappropriately received increased FMAP related to the unreported not-eligible expenditures.

## **REVISED PROMPT PAY CALCULATIONS**

During the audit, the State agency revised its prompt pay calculations to correctly identify 37 days (\$18.8 million in increased FMAP) that did not comply with the prompt pay requirements. Claims received on these 37 days were not eligible for increased FMAP. The State agency also determined the adjustments needed to correct the CMS-64 for the quarters ended March, June, and September of 2009.

The effect of correcting prompt pay calculations and adjusting the CMS-64 resulted in the State agency not being eligible for \$2,586,522 of increased FMAP for \$22,262,056 in claims received on days when it did not comply with the prompt pay requirements.

At the close of the fieldwork, we validated that the State agency had accurately corrected its compliance miscalculations. However, we did not validate that the \$2,586,522 had been properly adjusted on the CMS-64.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund \$2,586,522 to the Federal Government for unallowable increased FMAP and
- ensure that calculations are performed in accordance with the prompt pay requirements.

## **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency agreed that it had applied an incorrect prompt pay standard and incorrectly excluded or included certain prompt pay claims. To cover all corrections, State agency officials said that they made an adjustment of \$2,586,522 and reported it on the December 2009 CMS-64. The State agency's comments are included in their entirety as the Appendix.

# **APPENDIX**



Pat Quinn, Governor  
Julie Hamos, Director

201 South Grand Avenue East  
Springfield, Illinois 62763-0002

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

October 29, 2010

Department of Health and Human Services  
Office of Audit Services, Region V  
Attn: James C. Cox, Regional Inspector General for Audit Services  
233 North Michigan Avenue, Suite 1360  
Chicago, Illinois 60601

Re: Draft Audit Report Number A-05-09-00083

Dear Mr. Cox:

Thank you for providing the opportunity to comment on your draft audit report entitled "*Review of Illinois' Prompt Pay Compliance Under the American Recovery And Reinvestment Act Between January 1, 2009, and September 30, 2009*".

Please find attached the Departments' response to the recommendations made in the audit report. We appreciate the work completed by your audit team.

If you have any questions or comments about our response to the audit, please contact Peggy Edwards, External Audit Liaison, at (217) 785-9764 or through email at [peggy.edwards@illinois.gov](mailto:peggy.edwards@illinois.gov).

Sincerely,

A handwritten signature in black ink that reads 'Julie Hamos'.

Julie Hamos  
Director

**Response:**

The State agrees that the incorrect standard was initially applied in the Prompt Pay calculation. The resulting \$257,748 FFP over claim was adjusted on the Quarter Ending December 2009 CMS 64 quarterly report.

As to the claims incorrectly excluded from or included in the Prompt Pay calculation, the State did not receive final prompt payment guidance until July 30, 2009, six months after ARRA was signed into legislation. The Prompt Pay Guidance SMD#09-004 issued July 30, 2009, Section O. Operational Issues stated:

“...We understand there may be a lag for States in operationalizing this provision, and that the amount of Federal funds for some expenditures may be inappropriately claimed by States at the increased FMAP while the States’ systems are being modified to correctly identify days that they are non-compliant with the prompt pay standard. When a State implements its tracking system after February 18, 2009, it will need to run the system retrospectively back to that date to document and verify prior period claims. We expect that States will make correcting prior period adjustments as appropriate to ensure that all expenditures are claimed correctly in accordance with all ARRA and other Federal requirements...”

The State would not have been able to make adjustments on the CMS 64 for quarter ending June 30, 2009, as the guidance was not issued until after that time. In addition, the adjustments could not have been made until after implementation of all of the programming changes. The guidance did not stipulate a timeframe as to when the adjustment should be made.

The State’s dental claims are processed by a third party vendor who also made system programming changes to provide information necessary to calculate prompt payment. Dental files were held by the vendor until those changes could be implemented. Based on the timing of the guidance and the State implemented changes, the earliest the State would have been able to make adjustments would have fallen during the quarterly report ending December 2009. To cover all corrections there was a prior period adjustment of \$2,586,522 reported on the CMS 64 for December 2009.

As appropriate action has been taken to correct these, no further action is warranted.