REPORT DIGEST

ILLINOIS DEPARTMENT OF PUBLIC AID
FINANCIAL AUDIT
FOR THE YEAR ENDED JUNE 30, 1995
COMPLIANCE AUDIT
(In Accordance With The Single Audit Act of 1984 and OMB Circular A-128)
FOR THE TWO YEARS ENDED JUNE 30, 1995

SYNOPSIS

●The Department of Public Aid's contract for the Healthy Moms/Healthy Kids Managed Care Program lacked sufficient controls to protect the State's interest.

●The Department failed to properly monitor a contract with a vendor hired to identify third party liability for medical expenses paid under the Medicaid Program. The Department also made payments to this vendor which were not specifically supported by the contract.

●The Department has not established adequate controls over its Local Area Networks (LANs). The Department has over 1,300 microcomputers connected to LANs and over $4,000,000 invested in microcomputer software.

●The Department failed to pay claims for medical services within a 30-day time limit as stipulated by federal regulations. The delays cost the Department $1.56 million in sanctions.

●The Department did not have adequate documentation for the determination of eligibility and assignment status of Job Opportunity and Basic Skills Training (JOBS) participants.

●The Department did not have adequate case documentation to substantiate the eligibility and level of support for the participants of the At Risk Program.

●The Department made AFDC payments to vendors without adequate supporting documentation and authorization.

●Timely annual reports were not filed communicating waiver of benefits for specific programs.

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

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

HEALTHY MOMS/HEALTHY KIDS CONTRACT

The Department of Public Aid's contract for the Healthy Moms/Healthy Kids Managed Care Program lacked sufficient controls to protect the State's interests. Controls that Public Aid officials should have considered including were: a requirement that actual expenditures by the contractor be reported to Public Aid, and a link between acceptable completion of contract deliverables and contract payments. In addition, Public Aid did not exercise some of the controls which were included in the contract.

Public Aid contracted with a firm to operate the Healthy Moms/Healthy Kids program in Chicago. The contract provided for maximum payments of $64 million dollars over 30 months from January of 1993 through June of 1995. The contract split payments into $25 million for an administrative component and $39 million for a service component.

The contract did not require the contractor to report actual expenditures to Public Aid. During the contract, federal and Public Aid officials determined that they needed a reporting of cost information. Based on cost information subsequently provided by the contractor for Fiscal Years 1993 and 1994, Public Aid calculated that the allowable profit was $1,369,212, compared to the actual $6,107,431 reported by the contractor. In addition, Public Aid calculated that $744,221 in excess indirect costs had been reported by the contractor.

In December 1994, Public Aid officials sent a letter to the contractor claiming an overpayment of approximately $5.48 million had been made for the administrative component of the Healthy Moms/Healthy Kids Managed Care Program contract. During negotiations in January of 1995, the contractor and Public Aid agreed that Public Aid would reduce the amount of overpayment to $500,000. The federal Health Care Financing Administration (HCFA) refused to approve this amendment noting that they believed the original overpayment claim was valid.

Starting in April 1995, Public Aid stopped paying the administrative component of the contract. According to Public Aid officials, they withheld approximately $2.2 million. In June of 1995, the contractor filed a lawsuit in the Court of Claims against Public Aid for $2.0 million. The lawsuit was pending at the close of our audit work. Public Aid did not renew the contract when it expired in June of 1995. (Finding 11, page 20, Volume I)

We recommended the Department of Public Aid assure that future contracts include controls to adequately protect the State's interests. Public Aid officials should then enforce those contractual provisions as needed.

Department officials agreed and stated that future contracts will be adequately controlled. The Department also described its efforts to monitor and control the contract in question.

THIRD PARTY LIABILITY CONTRACT COMPENSATION

The Department failed to properly monitor a contract with a vendor hired to identify third party liability for medical expenses paid under the Medicaid program. Additionally, the Department

made payments to the vendor for services that were not specifically supported by contract terms.

In fiscal year 1992, the Department made an administrative decision to enter into an agreement with the vendor to identify third party liability coverage for medical expenses paid, identify carriers with insurance coverage previously unknown to the Department, prepare claims for submittal to the carriers, and provide specific information to the Department for these matches.

Terms and conditions of the contract included:

●Effective dates of the contract were July 1, 1991 to June 30, 1994.

●The scope of the work relating to third party liability matches included providing access to insurance carriers' eligibility data through various databases, identifying carriers with insurance coverage which were previously unknown to the Department,preparing claims for submittal to the insurance carriers, and providing health insurance data to be incorporated into the Department's database.

●The fee for providing cross match services described above was a contingency fee of 19% of all cash collections.

However, effective December 16, 1993, the contract was amended to change the cost structure from the contingency fee (19% of cash collections) to a flat fee of $350 per valid referral. The term of the contract was also extended to June 30, 1996. Department management stated the amendment took place because the vendor agreed to perform additional steps to ensure insurance information was valid.

Below is an analysis of cash recoveries, cost avoidance and actual payments made to the vendor from 1992 - 1995 per data provided by the Department.

Fiscal Year	Cash Recoveries[1]	Cost Avoidance[2]	Cash Payments Made to Vendor[3]
1992	$1,160,000	$ 5,860,000	$ 220,000
1993	1,950,000	9,080,000	370,000
1994[4]	2,990,000	14,280,000	8,080,000
1995	4,850,000	20,510,000	7,540,000

[1]Cash recoveries - cash received from third parties due to the matches by the vendor.
[2]Cost avoidance - avoidance of payments for medical services through rejection of claims.
[3]Cash payments - expenditures made to the vendor for valid data matches.
[4]Formula modified for payments to vendor from contingency fee to flat fee effective December 16, 1993.

As illustrated in the table, the ratio of cash payments to cash recoveries and cost avoidance increased from 3.3% prior to the renegotiation to 36.6% after the renegotiation. Looking at changes in this ratio, one effect of the renegotiated billing terms appears to be an increase in the cost of the service relative to the value of the benefits of the service.

Department officials indicated that based upon an internal departmental investigation, the Department was attempting to recover approximately $5.1 million in payments made to the vendor that were not compensable under the contract. These fees included invalid data matches, matches for insurance coverage which was not effective, or coverage effective for a period outside the investigated period.

As required by the Department's Administrative Manual Section PR 1110.5, the Bureau Chief of the Department's originating unit is the monitor responsible for overseeing contracts and evaluating compliance. A department official has indicated that the Bureau of Collections failed to properly inform management of the impact of the renegotiation and failed to properly review the supporting documentation prior to approving the excessive payments to the vendor. A Department official explained that management accepted the recommendation of the Bureau of Collections and agreed to the terms of the renegotiated contract.

Good internal controls and sound business practices require that services acquired from outside vendors be monitored and reviewed for costs incurred and benefits derived. The Department should exercise due care when entering into and renegotiating all contracts with outside vendors and should follow the established monitoring procedures for these contracts. Tracking the performance measures and costs of significant contracts is a vital management tool and a necessary control. Good internal controls also dictate that invoices for payments be properly reviewed to provide assurance that the Department pays only actual costs incurred under terms of the contract.

The Department of State Police has advised us that the payments under this contract and circumstances surrounding amendments to this contract are the subject of a police investigation. (Finding 5, page 12, Volume I)

We recommended the Department continue in its efforts to recover funds paid to the vendor in error. We also recommended the Department more carefully review future contracts and contract amendments to provide assurance that the costs incurred under the contract are reasonable in comparison to the benefits derived.

The Department responded that it agreed with our recommendations and asserted that the Department's Director has asked the Office of General Counsel, Office of the Inspector General, and the Bureau of Internal Audits to review the Department's contract-monitoring procedures and recommend improvements by the end of January 1996.

INADEQUATE ACCESS CONTROLS OVER LOCAL AREA NETWORKS

The Department has not established adequate controls over its Local Area Networks (LANs). The Department has over 1,300 microcomputers connected to LANs and over $4,000,000

invested in microcomputer software. The Department relies on critical applications on the LAN, such as medical claims data. In addition, detailed LAN policies and procedures have not been developed to guide the Department's use of LANs. The Department has six LANs within the Bureau of Information Systems (BIS) and we reviewed the logical security on three LANs. We concluded that the Department did not have adequate procedures in place to ensure that control of the LANs was sufficient. We reviewed three of the Department's LANs and noted the following weaknesses:

- All users were allowed 24 hour access to the LAN.
- Several powerful LAN users were not required to change their passwords on a regular basis.
- There was no limit to the number of invalid access attempts prior to revoking a user ID. The lack of a limit greatly increases the potential for unauthorized access.
- Multiple common IDs with limited security controls were identified, and over 22% of the IDs on the LANs tested had not been used in over 30 days.
- LAN policies and procedures had not been developed to ensure standard security administration practices for each network.

Good internal controls require reasonable cost-effective procedures be implemented to ensure the integrity and security of information maintained on the Department's LANs.

Without the implementation of adequate controls and procedures for the LAN, there is a greater risk that unauthorized access to Department resources (including confidential information) may be gained or data destroyed. Once established, compliance with developed security procedures must be monitored to protect Department assets. (Finding 9, page 18, Volume I)

We recommended the Department develop security guidelines to ensure security controls are adequately addressed on the Department's LANs. We specified the following minimum standards and security parameters in our recommendations.

- Unless users require 24 hour access to the LAN, time restrictions should be set to limit when they can use the LAN.
- Unique passwords should be required for all users.
- Minimum password length should be at least four characters.
- Passwords should be changed at least every 35 days.
- The number of times a user can log into the LAN after their password expires should be limited to no more than three attempts.
- The number of times a user can attempt to log into the LAN before the ID is revoked should be limited to no more than five attempts.
- Generic IDs should be adequately controlled.
- Networks should be reviewed for compliance with security parameters and inactive IDs should be reviewed and removed as appropriate.
- Virus detection software should be installed.
- Computer equipment should be physically secured.

The Department responded that it agreed. The Department also described its efforts to implement our recommendation as follows. Specifically, the Department had previously

implemented 6 of the 10 recommended items. They are in the process of implementing Netware 4.1 to address security parameters; resetting the number of times a user can log onto the LAN after their password expires to no more than attempts (currently 5); and are surveying users to limit 24 hour access to only employees with specific needs. The only system with generic IDs is one that is in development. The generic ID's will be removed as soon as the new system goes into production.

PROMPT PAYMENT

The Department failed to pay claims for medical services within a 30-day time limit as stipulated by federal regulations.

Public Health Code of Federal Regulations (42 CFR Ch IV Section 447.45 (d)) states that the agency must pay 90 percent of all "clean" claims from practitioners within 30 days of the date of receipt. Clean claims are those that do not need to be sent back to the provider for reprocessing.

We tested 50 claims from July 1, 1993 through June 30, 1995, and found 39 claims paid between 1-209 days late. The Department failed to pay the claims due to the lack of available funds. The claims examined ranged from $6 to $15,789 with an average claim of $1,694. The average length of time to pay a claim was 95 days.

As a result of prior noncompliance with this federal regulation, the Federal Government has decreased the percentage of Federal Financial Participation (FFP) available to the Department to fund the administrative costs associated with the Medicaid Management Information System from 75% for fiscal year 1994 to 65% for fiscal year 1995. Continued non-compliance may result in more federal cut-backs. This 10% reduction in fiscal year 1995 translates into a loss of approximately $1.56 million in federal funds. **This finding has been repeated since 1987.** (Finding 25, page 53, Volume II)

We recommended the Department comply with the federal regulation. The Department said that it agreed, and the delay in payments is due to a lack of sufficient appropriation authority. (For previous agency responses, see Digest Footnote 1.)

JOBS PROGRAM - LACK OF ADEQUATE DOCUMENTATION

The Department did not have adequate case documentation for the determination of the eligibility and assignment status of Job Opportunity and Basic Skills Training (JOBS) participants.

Through the JOBS program, the federal government provides reimbursement to the State for programs intended to assure needy families with children obtain education, training, and employment to help them avoid long-term welfare dependency. Reimbursements can also be made for transportation costs and other work-related expenses. During the two years ended June 30, 1995, the Department disbursed approximately $69,513,000 relating to the JOBS Program which qualified for federal reimbursement.

Upon our examination of twenty JOBS program case files, thirteen case files were missing documentation required to validate eligibility of current JOBS recipients. In four of these cases, the Department could not locate the entire file.

Insufficient documentation existed due to a lack of an adequate supervisory review of the case files. Processing of aid payments was a priority, while documenting the approval process was secondary. Review and maintenance of case files was not determined to be a top priority of the JOBS caseworkers.

The Public Welfare Code of Federal Regulations (45 part 250.82) requires the Department to maintain an individual case record for each JOBS participant that documents significant case file requirements including eligibility/ineligibility requirements and assignment status (an evaluation of the participant's skills assigned during the initial assessment or reassessment of the participant).

Failure to maintain current and adequate case files could allow payments to be made to recipients who are ineligible under JOBS guidelines and could jeopardize future federal funding due to the apparent lack of administrative control over the JOBS records. (Finding 26, page 53, Volume II)

We recommended the Department strengthen its existing controls and procedures over the documentation of eligibility and assignment status of JOBS recipients.

The Department responded that it agreed and noted that, prior to the audit, the Department identified problems with inadequate documentation and developed a corrective action plan. Effective July 17, 1995, greater emphasis was placed on developing and implementing tools and procedures that provide for more case monitoring and accountability. The corrective action plan is scheduled for completion in February 1996.

AT RISK CHILD - INADEQUATE FILE DOCUMENTATION

The Department did not have adequate case documentation to substantiate the eligibility and level of support for the At Risk participants.

The At Risk Child Program provides child care to low-income working families who are at risk of becoming eligible for AFDC, thereby enabling such families to avoid welfare dependency. The program is also used for former AFDC families whose eligibility for transitional child care under the Family Support Act ends but who continue to need assistance with child care. Those eligible are required to fill out an initial application for eligibility. Upon acceptance, these cases are to be examined every six months. Eligible participants are also required to sign a legal certification which ultimately testifies to various pre-written statements. In addition, upon application and redetermination, participants are required to submit current payroll stubs to verify the participant meets the income criteria for eligibility. Form CFS 673 (Approval of Request for Transmittal Child Care Payments) and billing reports are also to be maintained in the file to document the participant is indeed approved and is being paid at the correct rate.

Upon examination of thirty case files, we noted the following:

Eligibility Determination
●Three files were missing payroll stubs for income verification.
●Two files were missing redetermination documentation and payroll stubs.
●One file was missing a legal care certification.
●One file was missing a legal care certification, an application, and a payroll stub.
●One file included none of the required documentation.

Expenditure Allowability
●Eight files were missing billing reports.
●Three files were missing from CFS 673.
●Two files were missing both the billing report and form CFS 673.
●One file included none of the required documentation.

Department personnel indicated they were unaware of formal guidelines or requirements for the inclusion of standard documents in every case file. Files are maintained by seventeen child care resource and referral agencies and eight DCFS regional offices throughout the state. The Department failed to assume accountability for the documentation as it was maintained by other agencies. The Department, in its role as lead agency, failed to adequately monitor and review the case files that support the At Risk determinations.

We recommended the Department strengthen its controls over the maintenance of case files.

The Department responded that it agreed, and also said it is taking the following actions. 1) The handbook used by the Child Care Resource and Referral (CCR&Rs) network in the administration of the program is being revised and clarified to assist staff in understanding and verifying eligibility and documentation requirements. 2) The Department will review and expand on-site monitoring. 3) The Department will develop a regular monitoring timetable for monitoring all CCR&Rs. The Department also stated that a pilot of the monitoring was initiated in the fall of this year (1995).

AFDC PROGRAM - LACK OF ADEQUATE DOCUMENTATION

The Department made AFDC payments to vendors without adequate supporting documentation and authorization.

Through the Aid to Families with Dependent Children Maintenance Assistance Program (AFDC) the State assists recipients in becoming self-sufficient. Child care is provided to enable individuals to participate in education and training activities, allowing them to accept and maintain employment. Temporary emergency assistance is also provided to families with children, and assistance is given to repatriated U.S. citizens and their dependents. During the two years ended June 30, 1995, the Department disbursed approximately $1 billion relating to AFDC which qualified for federal reimbursement.

We tested thirty AFDC program expenditures totalling $11,222.90 noting three instances of inadequate documentation.

●One reimbursement was made without proper authorization from a Department representative, as required by the AFDC Policies and Procedures Manual Section 625. The voucher disbursing order was not signed by the Director Office Supervisor. The voucher amount was $92.00.

●Two expenditures totalling $655.00 did not have Form 552 in the recipient's file. Form 552 is a required document as outlined in the AFDC Policies and Procedures Manual Section 1005. It authorizes a recipient to receive payments for goods and services rendered. The voucher amounts were $377.00 and $278.00, respectively.

The Public Welfare Code of Federal Regulations (45 CFR 205.60) requires that the Department maintain adequate supporting documentation to substantiate all AFDC payments. Failure to have adequate supporting documentation and perform an effective supervisory review of AFDC case files could cause reimbursements to be made to providers for goods or services that may not have been received by AFDC recipients or are unallowable. (Finding 28, page 56, Volume II)

We recommended that the Department ensure that its AFDC case files are complete and contain appropriate authorizations.

The Department agreed and said that it has established a pre-audit process to reject disbursing orders without a Supervisor's signature. The Department also said that its staff will be reminded to comply with the existing controls and procedures.

SUBMISSION OF WAIVER REPORTS

The Department failed to submit to the Health Care Financing Administration (HCFA) Annual 372 Reports within allowable time limitations.

The Medicaid program permits states to offer home- and community-based programs to individuals. The Social Security Act (Section 1902 (a) (1) - (10)) discusses the requirements for waiving institutionalization when cost effective care can be provided. HCFA 372 reports are annual reports providing information regarding the number of waiver recipients and related expenditures for each of the Department's waiver programs. The waiver programs allow individuals to "waive" institutionalization when cost-effective care can be provided at home.

There are six waiver programs administered by the Department that require annual HCFA 372 reports. The State Medicaid Manual Section 2700.6 page 2-232 requires the submission of the final HCFA 372 report for each waiver program within 18 months after the waiver program's fiscal year end. We reviewed twelve HCFA 372 reports that were required to be filed from July 1, 1993 - June 30, 1995 and noted five were submitted between 3 and 180 days late. Three waiver reports (Developmentally Disabled in 1995 and Developmentally Disabled/Nursing Home in 1994 and 1995) were submitted late due to changes in the report format. Two waiver reports (Elderly and Disabled in 1995) were not processed in a timely manner because the Department failed to adequately monitor the specific reporting requirements. These reports were also submitted after the allowable time period.

Failure to submit the reports in the required time period is a violation of the State Medicaid Manual section 2700.2. Violations may result in delays imposed by HCFA when attempting to renew a waiver program and may jeopardize the administration of future waiver programs. (Finding 30, page 59, Volume II)

We recommended HCFA reports be timely submitted as stipulated within the State Medicaid Manual. When unusual delays are encountered while preparing the report, HCFA should be informed of the circumstances, and an extension should be requested.

The Department responded that it agreed and described its plans to improve controls including a computerized monitoring of reports.

OTHER FINDINGS

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

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

AUDITORS' OPINION

Our auditors state the Department's combined financial statements as of June 30, 1995 are fairly presented.

_____

WILLIAM G. HOLLAND, Auditor General

WGH:JTD:pp

SUMMARY OF AUDIT FINDINGS

Number of	This Audit	Prior Audit
Findings	17	25
Repeated Findings	4	1
Prior Recommendations Implemented or Not Repeated	21	38

SPECIAL ASSISTANT AUDITORS

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

DIGEST FOOTNOTES

#25: PROMPT PAYMENT - Previous Agency Responses.

1987:The Department's claim processing system is operational and is capable of processing claims in conformance with federal regulations. The payment cycle is being used as a fiscal management tool in the allocation and regulation of state disbursements. The payment cycle will be normalized when funding levels can support a 30 day cycle.

1989:The Department's claim processing system is capable of processing claims in conformance with Federal regulations. Until May 1988 all bills were paid within the Federal guidelines. The system is currently paying 90% of all bills within 30 days.

1991:The Agency's failure to pay medical claims within the prescribed federal time limits resulted from a shortfall of appropriated funds.

1993:We agree. However, payment delays are the result of a continued shortfall of appropriated funds. During the current fiscal year the State has continued efforts to speed up payments. On December 6, 1993 the Department received notification from the federal government that MMIS was re-approved and federal financial participation for MMIS operations will be increased to 75% (from 65%) for calendar year 1994.

DEPARTMENT OF PUBLIC AID
FINANCIAL AND COMPLIANCE AUDIT
For The Two Years Ended June 30, 1995

EXPENDITURE STATISTICS	**FY 1995**	**FY 1994**
●**Total Expenditures (All Funds)**	**$7,712,403,000**	**$6,368,071,000**
OPERATIONS TOTAL % of **Total** Expenditures	$611,890,672 8%	$559,725,680 9%
Personal Services % of Operations Expenditures Average No. of Employees	$294,344,107 48% 9,284	$277,743,038 50% 9,156
Other Payroll Costs (FICA, Retirement, Group Insurance) % of Operations Expenditures	$50,098,947 8%	$46,077,030 8%
Contractual Services % of Operations Expenditures	$128,918,343 21%	$119,359,402 21%
All Other Operations Items % of Operations Expenditures	$138,529,275 23%	$116,546,210 21%
AWARDS AND GRANTS % of **Total** Expenditures	$7,088,841,816 92%	$5,796,050,453 91%
REFUNDS % of **Total** Expenditures	$11,670,512 (Less than 1%)	$12,294,867 (Less than 1%)
●**Cost of Property and Equipment**	**$81,908,000**	**$74,303,000**

SELECTED ACTIVITY MEASURES	**FY 1995**	**FY 1994**
●Analysis of Adjudication and Payment Patterns (Payments from General Revenue Fund)		
- Overall Average Adjudication Time Elapsing In Calendar Days (Page 78, Volume I)	65.1 Days	37.7 Days
- Overall Average Time Elapsing In Calendar Days to Pay A Claim (Page 78, Volume I)	81.3 Days	56.7 Days
●Accrued Medical Costs Payable at June 30	$1,576,511,000	$1,999,624,000

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