LEGISLATIVE
AUDIT
COMMISSION

Review of
Department of Healthcare and Family Services
Two Years Ended June 30, 2015

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REVIEW: 4461
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
TWO YEARS ENDED JUNE 30, 2015

FINDINGS/RECOMMENDATIONS - 12

ACCEPTED - 7
IMPLEMENTED - 5

REPEATED RECOMMENDATIONS - 3
PRIOR AUDIT FINDINGS/RECOMMENDATIONS - 8

This review summarizes the auditors' reports of the Department of Healthcare and Family Services for two years (compliance) and one year (financial) ended June 30, 2015, filed with the Legislative Audit Commission May 12, 2016. The auditors performed a financial audit and compliance examination in accordance with State law and *Government Auditing Standards*. The auditors stated the financial statements presented fairly.

The Department of Healthcare and Family Services, formerly the Department of Public Aid, was officially renamed July 1, 2005. The Department is responsible for providing health care coverage for adults, children, seniors and the disabled; helping to ensure that Illinois children receive financial support from both parents by establishing and enforcing child support obligations; and effective management of healthcare purchasing.

The average monthly count of enrolled individuals for which the Department provided medical coverage was over 3.2 million in FY15. Enrolled individuals include pregnant women, infants, parents and caretaker relatives, adults with no minor children in the home, seniors, people with disabilities, and persons with breast and cervical cancer.

On the average, 3,227,361 individuals were enrolled in Medicaid in FY15 compared to 2,921,964 in FY14. While enrollment increased in FY15, average expenditures per enrollee also increased from $3,675 in FY14 to $3,784 in FY15, for total annual expenditures in FY15 of $12.2 billion compared to $10.7 billion in FY14. According to the FY17 budget book, in FY15, the Department's medical programs covered 1,541,203 children. The total number of adults with disabilities on Medicaid was 251,077, and the total number of seniors enrolled in Medical Assistance Programs was 192,524, which is a 3% increase over FY14. Of the 3.2 million people receiving Medicaid in FY15, the number of individuals enrolled in managed care was 2,090,179, or 65%, compared to 15.2% in FY14.

According to the Department in FY15, the Division of Child Support Enforcement served 479,450 families composed of TANF clients, mandatory Medical Assistance No Grant (MANG) clients and any other Illinois residents requesting child support enforcement services. More than $1.67 billion was collected and disbursed in child support and arrearages in FY15.

In FY15, the Department's Inspector General collected $105 million from providers for inappropriate actions and prevented payments of $99 million by catching recipients involved in inappropriate claiming.

The Director of the Department during most of the audit period was Julie Hamos who served from April 2010 until January 2015. The current Director, serving since January 2015 is Felicia Norwood. Director Norwood served Governor Edgar as a Policy Adviser for Health and Human Services from 1991-1994. She has more than twenty years of experience in public policy, business operations, and healthcare delivery systems. Before her appointment, Director Norwood was a senior executive in the health insurance industry.

The number of employees during the period under review is summarized as follows:

General Revenue Fund	**FY15**	**FY14**	**FY13**
Program Administration	225	220	214
Office of Inspector General	56	61	62
Attorney General	13	16	17
Medical	457	455	456
Managed Care	11	13	14
Kid Care – Look a Like	95	104	101
Prescribed Drugs	33	33	35
Medi Rev*	5	6	7
Total GRF	**895**	**908**	**906**
Other Funds			
Care Provider for Persons with DD	1	1	1
Long-Term Care Provider	7	6	6
Medical Special Purpose Trust	8	8	10
Child Support Administration	880	883	905
Public Assistance Recoveries Trust	293	301	269
Total Other Funds	**1,189**	**1,199**	**1,191**
GRAND TOTAL	**2,084**	**2,107**	**2,097**

* Medical electronic interchange recipient eligibility verification

Expenditures From Appropriations

The General Assembly appropriated $20.4 billion to the Department in FY15. About 31.9% or $6.5 billion of the Department's appropriated funds were from the General Revenue Fund. The Department also received appropriations totaling $11.8 billion from 20 other funds. Total expenditures from appropriated funds were almost $17.4 billion in FY15 compared to $16.3 billion in FY14 which represents an increase of about $1.1 billion, or 6.7%, over FY14. Some of the significant changes in expenditures were as follows:

- $767 million decrease in the General Revenue Fund expenditures was the result of expenditures in FY15 not including any transfers, and the result of a supplemental appropriation for transfer to the Healthcare Provider Relief Fund that was received in FY14 but not in FY15.

- $1.7 billion increase in the Healthcare Provider Relief Fund expenditures was the result of increased medical claims.
- $102 million decrease in the University of Illinois Hospital Services Fund was the result of less Medicaid services provided by the Hospital.
- $168 million increase in the County Provider Trust Fund was the result of lower personal services costs in FY15.
- $61 million decrease in the Electronic Health Record Incentive Fund was due to fewer medical professionals and hospitals being eligible for electronic health records incentive payments.
- $176 million increase in the Drug Rebate Fund was the result of an increase in Medicaid Part D Clawback expenditures and pharmacy expenditures.
- $23.4 million decrease in Medical Special Purpose Trust Fund was the result of higher costs incurred in the prior year for the Integrated Eligibility System implementation and also due to the Health Information Technology Initiative ARRA appropriation not being received in FY15.

Appendix A contains a summary of appropriations and expenditures for the period under review. During FY15, the Department spent an additional $578 million in non-appropriated funds. Lapse period expenditures were about $770 million, or about 4.2%.

Federal Assistance

Appendix B is a report of the Department's expenditures of federal grants and awards for FY15 and FY14. These expenditures totaled almost $11 billion in FY15. By far, the largest federal assistance program is the Medical Assistance Program which provides financial assistance to states for payments of medical assistance on behalf of cash assistance recipients, children, pregnant women, and the aged who meet income and resource requirements and other categorically eligible groups. Financial assistance is also provided to states to pay for Medicare premiums, co-payments and deductibles of qualified Medicare beneficiaries meeting certain income requirements.

Cash Receipts

Appendix C is a summary of cash receipts for FY15 and FY14. The Department's cash receipts were $15.1 billion in FY15 compared to $13.3 billion in FY14, an increase of $1.8 billion, or 13.5%. Some significant changes from FY14 to FY15 were as follows:

- $580 million decrease in the General Revenue Fund was due primarily to less funding from federal government resources.
- $163 million increase in the County Provider Trust Fund was due to an increase in the federal match rate during FY15 for the Cook County waiver program from 50% to 100% due to the ACA resulting in increased federal financial participation receipts.

- $140 million increase in the Public Aid Recoveries Trust Fund was due to an additional $39 million drawn into the fund for the medical assistance program, and also a result of the timing of the draws of federal financial participation.
- $95 million decrease in the Electronic Health Record Incentive Fund was the result of increased efficiencies in the program which led to less reimbursable costs.
- $33 million decrease in the Medical Interagency Program Fund was due to the Department not reimbursing the fund from the General Revenue Fund for the Children's Mental Health Initiative as a result of the cost being covered by the Department's share of federal financial participation money.
- $79 million increase in the Drug Rebate Fund was due to an increase in drug rebate collections in the Public Aid Recoveries Trust Fund attributable to the federal financial participation portion.
- $2.2 billion increase in the Healthcare Provider Relief Fund was the result of:
    - An increase in spending resulting in an increase in federal financial participation and an increase in federal financial participation received from other funds;
    - Reimbursement from the Department of Aging and the Department of Human Services for capitated coordinated care provided through contracts for clients for which the Departments were financially responsible; and
    - The transfer appropriation level and the timing of the transfers by the Illinois Office of the Comptroller.

Property and Equipment

Appendix D is a summary of property and equipment for FY15 and FY14. Property and equipment for which the Department was accountable was $14,371,000 at June 30, 2015, a decrease of $1.7 million over FY14. The Department's State property is composed of equipment items only.

Accounts Receivable

In FY15 net accounts receivable was about $597.7 million, and does not include $5.2 billion which is the allowance for uncollectible accounts. The accounts are subject to all manner of collection including internal offsets against future claims for providers with outstanding debt, Comptroller's Offset system, cyclical billings, letters and telephone contacts, private collection agencies, liens and judgments, and notification of credit reporting agencies. The Department has implemented other methods of collection such as: income withholding, unemployment insurance benefit intercept, federal income tax refund offset, professional license revocations, judicial remedies, driver's license revocation, new hire reporting, financial institution data match, agency collectors, Department of Revenue initiative, and referral to the Attorney General's office.

Accountants' Findings and Recommendations

Condensed below are the 12 findings and recommendations presented in the compliance examination report and financial audit. There were three repeated recommendations. The following recommendations are classified on the basis of updated information provided by Jamie Nardulli, Chief Internal Auditor, via electronic mail received September 23, 2016.

Accepted or Implemented

1. Establish controls over project management and due diligence, such as improving vendor relationships, monitoring, testing, etc. for major projects, such as the Integrated Eligibility System (IES).

Finding: The Department of Healthcare and Family Services and the Department of Human Services did not establish controls to conduct due diligence or ensure project management over the State of Illinois' Integrated Eligibility System (IES) development project.

IES was developed to consolidate and modernize eligibility functions for several human service programs by October 1, 2013. Three contracts totaling $167.8 million were executed for the development, oversight, and independent verification and validation of IES.

From August through November 2015, the auditors made several requests to the Departments for documentation related to project management, systems development, and contractual requirements for IES. The Departments had to rely on the vendors to provide the required documentation to respond to the auditors' requests. Additionally, during this timeframe, the vendors did not provide complete and accurate information responsive to the requests.

Given the severity of issues noted and the potential impact to the Departments' and the State's financial statements, the auditors met with the Departments' management in December 2015 to discuss the lack of due diligence, lack of complete documentation provided, and the delays associated with responding to requests. From December 2015 through February 2016, the Departments worked with the vendors to provide the auditors with information regarding identified risks and the associated corrective actions.

Based on the information provided by the Departments, Phase One of IES went live on October 1, 2013 even though it had known problems, required manual workarounds, and encountered data integrity and downtime issues. A review of documentation identified a significant number of critical deficiencies:

- The Departments did not conduct due diligence or assess the risks over the known problems at October 1, 2013.
- Over-reliance was placed on the vendors.
- System testing was inadequate and did not comply with development requirements.
- The Departments did not thoroughly review or assess testing completed by one of the vendors.

Accepted or Implemented – continued

- Project management was lacking. For example, during the auditor's testing of compliance with contractual requirements, the Departments were unable to provide the information and had to request deliverables from the vendors. In addition, it was noted the vendors routinely reviewed and approved the deliverables, rather than the Departments.

As a result of the lack of project management, IES did not accurately determine individuals' eligibility for various social service programs. (See Finding #2.) In addition, the Departments did not implement adequate security controls over IES. (See Finding #3.)

The Departments' management stated the weaknesses identified were the result of an inadequate process for collection and retrieval of supporting documentation of management's review and approval of contract deliverables and executive decision-making related to the planning, development, testing, assessment of risk, and implementation of the system.

Response: Accepted. Following are some of the steps taken since June 2015 to establish improved due diligence and controls over project management:

- Appointed a senior state employee who is a certified Project Manager as IES Phase 2 Project Director to refocus project management on industry standard project management principles. Two additional project managers added to maintain focus on these principles.
- Instituted joint management of comprehensive project schedule encompassing state and vendor efforts.
- Implemented observation sessions to validate results of System Test stage before moving into User Acceptance Test stage.
- Extended timeline for Phase 2 to increase User Acceptance Test stage from 12 to 43 weeks.
- Created detailed requirements traceability matrix to enable thorough due diligence of defects and workarounds.
- Refocusing on quality by requiring vendor quality reviews and joint quality review meetings with vendor.
- Redefining project deliverables jointly with vendor to focus on quality and acceptable defect levels for deployment.
- Revamping change management, decision management and documentation of deliverable approvals.
- Restructuring the SharePoint library to assure all documentation is filed in it appropriately and is accessible.

The Departments will continue to work proactively to implement sound project management principles in order to prevent project management weaknesses in the future.

Updated Response: Accepted. HFS implemented an Executive Project Steering Committee (EPSC) in 2014 to formalize project portfolio monitoring and management, which takes the form of a structured status reporting process. Project status, including key performance milestones and relevant financial data, is reviewed by the EPSC on a monthly basis and management identifies and follows up on any deviations in schedule, budget or decreases in performance.

A Department Project Management Office (PMO) was established and tasked with monitoring and assisting with project management according to prescribed industry best practices. When a project is initiated, the sponsor completes an intake form that aligns the project with an initiative from the HFS strategic plan. The project is then presented to the Project Review Board (PRB) and a Risk Assessment Form is completed to determine what level of risk the project presents if not completed. If the Risk Assessment determines the project to be medium or high risk it is then added to the EPSC agenda where it is tracked at an Agency level. Any low risk projects are considered operational and tracked by management of the unit responsible for the project's completion.

EPSC 2.0 was launched in January 2016 which added a PRB to the intake process to review projects upon their initiation to identify risk level and to determine the correct approach for tracking and monitoring.

The Requirements Traceability Matrix (RTM) was implemented for IES to: Ensure that all requirements defined for Phase 2 of IES have been validated by the State team, identify gaps in test coverage, and develop linkage between requirements to User Acceptance Testing scenarios and test cases.

2. **Implement controls over the review of the design and operations of the Integrated Eligibility System (IES) and future development projects. Take corrective actions over all defects. In addition, evaluate all eligibility criteria within IES to ensure cases are being properly approved.**

Finding: The Department of Healthcare and Family Services and the Department of Human Services lacked internal controls to review the design and operation of the State of Illinois' Integrated Eligibility System (IES) to sufficiently prevent or detect defects that could cause inaccurate determinations of eligibility. As a result, the auditors noted IES did not accurately determine eligibility for human service programs.

In order to meet the requirements of the Affordable Care Act of 2010, the Departments undertook a project to consolidate and modernize eligibility functions for over 100 human service programs funded by the federal government and the State of Illinois. On October 1, 2013, the Departments implemented IES and utilized it for the intake of applications and the determination of eligibility for human service programs.

Accepted or Implemented – continued

From October 1, 2013 through June 30, 2015, the Departments had:

	FY14	FY15
Applications submitted via IES	625,672	1,116,179
Applications approved via IES	514,499	894,680
Expenditures associated with applications approved via IES	$861,730,573	$3,307,145,211

In order to obtain social services, individuals are evaluated on hundreds of financial and non-financial criteria. To test the efficacy of IES' determination of eligibility for benefits, the auditors selected a sample of a subset of non-financial eligibility criteria including: residency, citizenship, and social security information.

The auditors tested all individuals which were approved within IES from October 1, 2013 to June 30, 2015, to ensure they were properly approved based on the eligibility criteria selected for testing. The testing identified multiple defects which resulted in individuals being improperly approved for certain programs. As a result of the defects identified, inappropriate expenditures were made to or on behalf of individuals as follows:

Fiscal Year	Individuals Inappropriately Approved	Department of Human Services Expenditures in Error	Department of Healthcare and Family Services Expenditures in Error
2014	751	$138,940	$1,294,177
2015	2,469	$338,931	$6,508,701

The more significant defects, which caused 3,220 individuals to be inappropriately approved, resulted in individuals being approved:

- Without meeting immigration requirements.
- Without verifications of citizenship.
- Without verification of residencies.
- Without valid SSNs or documentation of submitted SSN applications.
- For non-expedited Supplemental Nutrition Assistance Program (SNAP) benefits even though required citizenship information was not provided by a due date.
- For individuals who were not citizens and who did not provide other acceptable alternate information (i.e., legal permanent residents, refugees, etc.).

Based upon the non-financial eligibility criteria tested, the noted total expenditures made in error were not considered material by either Department with respect to their financial statements, and therefore, no adjustments were made.

Management of the Departments stated the exceptions noted can be attributed to the complexity of the federal laws governing each program's eligibility rules. Additionally, the eligibility rules for medical programs were changing while IES was being designed and built because the Federal Centers for Medicare and Medicaid Services continued issuing guidance and promulgating regulations.

<u>Response:</u> Accepted. The Departments will ensure that controls over the review of the design and operations of IES are complete and fully documented. A sophisticated system is already in place for documenting, tracking and prioritizing correction of all identified defects. Because of the size and complexity of the benefit programs IES controls, the Departments will review IES on an ongoing basis to assure accuracy of all eligibility determinations, both approvals and denials.

As stated in the finding above, the Departments did not view the erroneous expenditures as material and therefore did not make adjustments to their respective financial statements. The incorrect expenditures referenced for FY15 represent approximately two tenths of one percent of all expenditures associated with applications approved via IES. As was the case for the cost of the errors found in this audit, the Departments expect any additional errors that may be found will not affect more than a small percentage of enrollees or expenditures and that a substantial majority of eligibility decisions made by IES are correct.

The Departments will not attempt to recover payments deemed as incorrect because Medicaid providers performed services for clients in good faith under those eligibility determinations. A small percentage of DHS clients also received benefits based upon the determination of eligibility at the time.

<u>Updated Response:</u> Accepted. The Department corrected the production IES system to remedy all defects identified in the audit. HFS will review on-going eligibility and new approvals/denials on a regular basis to identify system issues and incorrect application of Agency policy. As a result of these reviews, the HFS Bureau of Eligibility Integrity will work with DHS Community Operations, IES testers, HFS and DHS Policy, HFS and DHS information systems to develop solutions to eliminate or reduce the errors. This process will be on-going.

3. **Establish controls that ensure Integrated Eligibility System (EIS) security is safeguarded, including monitoring the vendor's compliance with the security requirements outlined in the contract. Additionally, work with the vendors to promote the use of best practices and ensure:**
    - **IES security controls are adequately documented and comply with the required federal and State security standards.**
    - **Access rights are appropriate, based on job duties, approved and documented, and periodically reviewed.**
    - **All changes comply with approved change management procedures and are properly documented.**
    - **An adequately developed and tested disaster contingency plan exists.**
    - **State employees have access to the IES environment.**
    - **Device incompatibility issues are resolved.**
    -

Accepted or Implemented – continued

- **An acceptable means for users to recover their User Identifications is implemented.**

Finding: The Department of Healthcare and Family Services and the Department of Human Services had not implemented adequate security, change management, or recovery controls over the State of Illinois' Integrated Eligibility System (IES).

IES was developed to consolidate and modernize eligibility functions and to comply with the Affordable Care Act of 2010. As such, IES was required to comply with specific federal and State security standards.

The auditors requested from both of the Departments specific information related to the security, change management, and recovery controls over IES. During the review of information provided, the auditors identified a significant number of critical deficiencies:

- Neither of the Departments or vendor provided complete and detailed information necessary to support the implementation of security controls, including compliance with the federal and State security standards.
- The auditors identified three individuals with Global Security Administration rights; however, evidence to support the need for such powerful access rights was not provided.
- Contrary to accepted security practices, users were required to provide their dates of birth and social security numbers in order to recover their User Identifications.
- Changes were made by vendor to the infrastructure that did not comply with approved change management procedures.
- An adequately developed and tested disaster contingency plan had not been completed.

In addition, during the Departments' own review of security controls, they noted:

- IES and its servers could be accessed without authentication.
- The Departments had not ensured the vendor was able to provide a listing of users who had powerful privileges, accounts, or passwords.
- The Departments had not ensured the vendor maintained documentation to verify the approval of access rights.
- The Departments had not ensured the vendor maintained a complete listing of users on the infrastructure devices.
- Devices were not properly configured resulting in incompatibilities between devices.
- The Departments had not ensured the vendor implemented only approved changes to the infrastructure.
- The Departments had not ensured State personnel had access to the infrastructure.

The Departments acknowledge these matters are the Departments' responsibility and this responsibility cannot be outsourced.

Management of the Departments stated the primary focus was on gaining approval from federal CMS to connect IES to the Federal Data Services Hub by October 1, 2013.

Review: 4461

Response: Accepted. Many of the control weaknesses identified during this audit were identified by the IES Security Officer, HFS Security Manager (IES Security Team) and Technical Team since April of 2015 and the Vendor has been engaged to develop plans to resolve all currently identified weaknesses and vulnerabilities. The Departments will continue to work with the vendor to resolve the other deficiencies noted during this audit.

Updated Response: Accepted. The Department has established an ongoing analysis process to identify eligibility errors. The Phase I IES defects were documented, tracked and prioritized to address identity eligibility errors noted. The Department continues to ensure controls designed and operations of IES are complete and fully documented. The Department is continuing to work with its vendors to promote the use of best practices related to IES security controls, access rights, change control, disaster recovery and device compatibility estimating the completion to be March 2017.

4. Obtain or perform independent reviews of internal controls associated with third party service providers at least annually. The independent reviews should include an assessment of the following five key system attributes, as applicable:

- **Security - The system is protected against both physical and logical unauthorized access.**
- **Availability - The system is available for operation and use as committed or agreed.**
- **Processing integrity - System processing is complete, accurate, timely and authorized.**
- **Confidentiality - Information designated as confidential is protected as committed or agreed.**
- **Privacy - Personal information is collected, used, retained, disclosed, and disposed of in conformity with Department requirements.**

Perform a timely review of the report, assess the effect of any noted deficiencies, and identify and implement any compensating controls. Document and maintain reviews by the Department and corrective actions taken by the service provider.

Also, include a provision for an internal controls review in the agreements with the providers. In addition, assess and obtain applicable reports over the internal controls in place at the subservice organizations.

Finding: The Department of Healthcare and Family Services (Department) did not obtain or conduct timely independent internal control reviews over its external service providers used to process the Medicaid Incentive Payment Program (MIPP) payments and dental payments made on behalf of the State. Furthermore, the Department did not assess the need for independent internal control reviews at subservice organizations utilized by the external service provider of the State's Dental Program.

Accepted or Implemented – continued

In FY15, the Department utilized an application developed and hosted by an external service provider to process the MIPP payments, totaling $74.9 million. In addition, the Department utilized a third party service provider to process dental expenditures, totaling $198 million. During testing, the auditors noted the following:

- The Department did not obtain Service Organization Control (SOC) reports or conduct independent internal control reviews of the external service provider which processed the MIPP payments during the audit period.
- The agreement between the Department and the external service provider which processed the MIPP payments did not require an independent review to be completed.
- Although the Department received the required SOC report, dated December 10, 2014, from the service provider which processed the dental payments during the audit period, the Department had not reviewed and assessed the SOC report as of June 30, 2015.
- The SOC report obtained from the service provider which processed the dental payments indicated the service provider utilized subservice organizations to assist in the processing of the payments. As of June 30, 2015, the Department had not performed an analysis to determine the need to obtain information as to subservice organizations' internal controls over the processing of the State's dental payment transactions.

Department management stated that due to multiple staffing changes at multiple levels in the Agency, the requirement for an annual Service Organization Control report was inadvertently not included in the statement of work.

Updated Response: Accepted. The Department plans to conduct annual independent reviews with the providers and subservice organization and include assessments of the five key system attributes noted. Provisions included in provider agreements, within the assessment of internal controls, deficiencies will be documented and have compensating controls applied.

5. Recoup all advance payments to nursing facilities in compliance with the Illinois Public Aid Code, or seek statutory change.

Finding: The Department did not recoup advance payments to nursing facilities in accordance with the terms and timeframe established in the Illinois Public Aid Code.

The Department made advance payments totaling $45,398,230 to 210 nursing facilities. The payments were made to nursing facilities with significant outstanding Medicaid liabilities associated with services provided to residents with Medicaid applications pending and residents facing the greatest delays. The Department obtained written payment plan agreements from the facilities whereby the Department was to recoup the advance payments with three or six monthly installments from each facility. Both the three and the six month payment agreements provided for full recoupment by June 30, 2015. However, the Department and the nursing home representatives agreed that monthly recoupments would be postponed as a result of the long-term care application processing lagging behind the anticipated schedule. Consequently, auditors noted that at June 30, 2015, the Department recouped a total of only $11,568,770, representing two monthly installments recouped from each of the facilities that elected the six month installment plan and no installments were recouped from the facilities that elected the three month installment plan. The Department attempted to amend the statutory language to allow for the postponement of the recoupment of the advance payments, however the amendatory language did not become law as of the date of testing. At June 30, 2015, a total of $33,829,460 of the advance payments remained outstanding.

Department personnel stated there was an expectation the statutory requirement would be changed to allow an additional year for recoupment of the payments. The lack of a FY16 budget being passed impacted the passage of the amendatory language to delay recoupments.

Updated Response: Implemented. The Department established a recoupment plan including recoupment adjustments that applied credits against the future nursing home payments. As of September 2016, only $170, 650 of the recoupment is outstanding.

6. Submit past due accounts receivable to the Comptroller for placement in the Comptroller's Offset System in accordance with the Illinois State Collection Act of 1986 and the Statewide Accounting Management System. Further, where applicable, request the Attorney General to certify accounts receivable the Department has been unable to collect as uncollectible. (Repeated-2013)

Finding: The Department did not have adequate controls over the collections of accounts receivables. The Department failed to follow procedures regarding the referral of past due accounts to the Office of the State Comptroller's Offset System or, when deemed necessary, to the Office of the Attorney General to be written off.

During the prior compliance examination, auditors noted 12 accounts receivable accounts, totaling $1,873,070, outstanding for over one year. The Department submitted seven of these accounts, totaling $583,472, to the Comptroller's Offset System and one account was offset by the Department in the amount of $9,741 prior to or during FY15. During the current examination auditors noted one new account in the amount of $551,001, outstanding for over one year, had not been submitted to either the Comptroller's Offset System or sent to the Attorney General to be certified as uncollectible. Four accounts, totaling $1,279,857, remained outstanding from those identified in the previous examination. As of June 30, 2015, there were a total of five accounts receivable accounts totaling $1,830,858 outstanding over one year not submitted to either the Comptroller's Offset System or sent to the Attorney General to be certified as uncollectible. The Department's financial statements did not require an adjustment due to the accounts being considered uncollectible.

Accepted or Implemented – continued

Department management stated that due to overall complexity and a lack of staff resources, a review of all of the accounts noted above had not been completed to determine whether it was cost effective to place in the Comptroller's Offset System or whether such accounts receivable should be sent to the Attorney General for uncollectible certification.

Updated Response: Accepted. The Department is in the process of recouping the funds. As of September 2016, the Department has recouped monies from all five vendors with 100% from three, 50% from one vendor and 25% from another vendor.

7. Coordinate with the Department of Human Services and the Illinois Department on Aging and amend the interagency agreements to include procedures to permit long-term care providers access to eligibility scores for individuals, as required by the Illinois Public Aid Code.

Finding: The Department interagency agreements did not include all provisions required by the Illinois Public Aid Code relative to the nursing home prescreening project.

Auditors noted existing interagency agreements between the Department, the Department of Human Services (DHS) and the Illinois Department on Aging (IDoA) did not contain certain language required by the Code. Although an amendment to the original interagency agreements was drafted to address the requirements of the Code, the amendment had not been finalized or executed as of June 30, 2015.

Department personnel stated the interagency agreements have not been updated to address this particular responsibility because the IDoA (who receives this information from their contracted Case Coordination Units) had not yet developed a system to make this type of information available to long-term care providers.

Updated Response: Implemented. The Department circulated revised interagency agreements with both the Department of Human Services and the Department of Aging and they were signed in June 2016.

8. Coordinate with the Department of Children and Family Services, the Department of Human Services, the Illinois State Board of Education, the Department of Juvenile Justice and the Department of Public Health to establish and enter into an interagency agreement as required by the Custody Relinquishment Prevention Act.

Finding: The Department was not in compliance with the Custody Relinquishment Prevention Act which establishes a pathway for families on the verge of seeking services for their child's serious mental illness or serious emotional disturbance through the relinquishment of parental custody.

During testing, auditors noted the Department had not entered into an interagency agreement with the Department of Children and Family Services (DCFS), the Department of Human Services (DHS), the Illinois State Board of Education (ISBE), the Department of Juvenile Justice (DJJ) and the Department of Public Health (DPH) as of June 30, 2015 as required.

Department personnel stated they recognize the Department's responsibility to actively participate in the development and execution of an interagency agreement related to the Act, however, the Department does not believe it is the primary or lead agency to initiate the agreement. The Department believes the statute likely intends for DCFS or DHS to be the lead agency.

Response: Accepted. The Interagency Agreement required by the Custody Relinquishment Prevention Act was executed on April 19, 2016.

Updated Response: Implemented.

9. Timely calculate inpatient and outpatient rates that should take effect each year. (Repeated-2011)

Finding: The Department did not comply with certain provisions of its interagency agreement with Cook County Health and Hospitals System and Cook County Board of Commissioners (Cook County).

In the prior year compliance examination, it was noted the inpatient and outpatient rates were determined 2.5 months and 4.5 months after FY12 and FY13 began, respectively.

In FY14 inpatient and outpatient rates were determined 11 months after the fiscal year had begun. Adjustments were made after the rate determination to retroactively reimburse Cook County the correct inpatient and outpatient rates. In FY15, outpatient rates were determined timely, however, inpatient rates were not determined as of June 30, 2015. Instead, the Department used prior year inpatient rates the entire fiscal year.

Department management stated during FY14, negotiations with the providers caused unforeseen delays in rate implementation. In addition, the rates were not calculated during FY15 due to pending approval of a proposed inpatient rate amendment to the Illinois Medicaid State Plan.

Response: Accepted. The Department filed State Plan Amendment (SPA – 14-0012) in late January or early February of 2014. The SPA was to change our historical cost inflator from a hospital specific inflator to an inflator based on the Centers for Medicare & Government Services' Input Price Index (CIPI). This SPA will encompass both Cook and U of I hospital inpatient rates. Basically, the hospital specific cost inflator is a more volatile inflator that can vary drastically from year to year, up or down, and has been at the root of many of our problems with negotiating rates with these hospitals. The CIPI inflator is based on national industry standards, and generally is much more consistent over time. With the

Accepted or Implemented – continued

approval of SPA 14-0012, the implementation of CIPI cost inflators should almost completely alleviate the months-long negotiations. The SFY16 rate letters were sent July 2015 and the rates were in the system shortly thereafter.

Updated Response: Implemented. Effective January 1, 2016 with SPA 15-019, rates will be calculated on a DRG (diagnostic-related group) basis similar to most other hospitals in the State of Illinois. This change will remediate this finding.

10. Timely calculate inpatient and outpatient rates. Also, make equal monthly Disproportionate Share Hospital payments as required by the Illinois Medicaid State Plan.

Finding: The Department did not have adequate controls for hospital rates that were reimbursed to the University of Illinois Hospital and Clinics (Hospital) for services provided to individuals.

During review of the University of Illinois Fund, which included a review of the interagency agreement between the Board of Trustees of the University of Illinois and the Department, and testing of reimbursement rates determined by the Department, auditors noted the following:

- The Department did not calculate FY14 inpatient and outpatient rates in a timely manner. In FY14, inpatient rates were finalized nine months after the fiscal year had begun and outpatient rates were not finalized as of the fiscal year end.
- The Department did not calculate FY15 inpatient rates in a timely manner. In FY15, inpatient rates were finalized five months late. Adjustments were made after the rate determination to retroactively reimburse the Hospital the correct inpatient and outpatient rates.
- The Department did not make annual Disproportionate Share Hospital (DSH) payments in 12 equal monthly installments, as required by the Illinois Medicaid State Plan (State Plan). For FY14, the last 10 months' payments were made in August 2014 as a single payment. FY15 DSH payments were made in four installments.

Department management stated that lengthy rate negotiations with the Hospital in FY14 and awaiting a federal response to a State Plan Amendment request for FY15 contributed to the untimely rate calculations and adjustments. With respect to the untimely DSH payments, management stated payments were delayed until the Hospital and the Department were comfortable calculated amounts would not result in overpayments that would subsequently require repayment.

Response: Accepted. The Department filed State Plan Amendment (SPA – 14-0012) in late January or early February of 2014. The SPA was to change our historical cost inflator from a hospital specific inflator to an inflator based on the Centers for Medicare & Government Services' Input Price Index (CIPI). This SPA will encompass both Cook and U of I hospital inpatient rates. Basically, the hospital specific cost inflator is a more volatile inflator that can vary drastically from year to year, up or down, and has been at the root of many of our problems with negotiating rates with these hospitals. The CIPI inflator is based on national industry standards, and generally is much more consistent over time. With the approval of SPA 14-0012, the implementation of CIPI cost inflators should almost completely alleviate the months-long negotiations. The SFY16 rate letters were sent July 2015 and the rates were in the system shortly thereafter.

DSH payments were delayed until the Hospital and the Department were comfortable calculated amounts would not result in overpayments that would subsequently require repayment. This was a mutual decision between the Department and the Hospital. In 2016, the Department is now working without a budget, which causes cash flow concerns and continued delays in payments.

Updated Response: Implemented. Effective January 1, 2016 with SPA 15-019, rates will be calculated on a DRG basis similar to most other hospitals in the State of Illinois. This change will remediate this finding.

11. Follow current procedures and comply with the Illinois Administrative Code by conducting employee performance evaluations in a timely manner. Also, approve and date all timesheets as required by the form HFS 163. (Repeated-2005)

Finding: The Department did not have adequate controls over personal services. Auditors noted the following:

- The Department did not timely complete performance evaluations for 29 of 60 (48%) employees tested. The performance evaluations were performed between 31 and 252 business days after the last date in the period of performance. In addition, the Department did not perform one or more evaluations during FY14 and/or FY15 for 24 of 60 (40%) employees tested.
- Auditors selected a sample of 60 employees and examined their timesheets from three separate months. Auditors noted one of 60 employees had multiple timesheets not approved and/or dated by a supervisor.

Department management stated the exceptions noted for performance evaluations were due to human error. In addition, the Department stated the unapproved timesheets were due to an oversight.

Response: Accepted. The Department's Division of Personnel and Administrative Services will continue to send out notifications when evaluations are due and past due reminders. The Division of Personnel and Administrative Services will continue to track the evaluations as they are received and filed in the employee's personnel file in an effort to reduce the number that are not completed and signed in a timely manner. The Department will not process any merit compensation personnel transaction (i.e. promotions, separation, transfers etc.) with the exception of address change, if the employee's performance appraisal is past due.

Accepted or Implemented – concluded

12. Establish a Long-Term Services and Supports Disparities Task Force as required by the Illinois Public Aid Code, or seek a statutory change.

Finding: The Department did not establish a Long-Term Services and Supports Disparities Task Force as required by the Illinois Public Aid Code.

During the examination, auditors noted the Department had not established the Long-Term Services and Supports Disparities Task Force, so the duties of the Task Force had not been performed.

Department personnel stated the Task Force was not established due to previous Agency leadership electing not to pursue the creation of this task force, citing potential duplication with other coordination and transformation efforts underway in the Long-Term Services and Supports area.

Updated Response: Accepted. The Quality Subcommittee of the Medicaid Advisory Committee accepted the responsibilities of the Long Term Care Task Force as a workgroup/subgroup at the meeting held on May 6, 2016. The Department is in the process of identifying a new member to propose for appointment to chair the workgroup/subgroup, who has knowledge and expertise in providing long-term care services. A work plan will be developed once a chair has been identified.

Emergency Purchases

The Illinois Procurement Code (30 ILCS 500/) states, "It is declared to be the policy of the State that the principles of competitive bidding and economical procurement practices shall be applicable to all purchases and contracts...." The law also recognizes that there will be emergency situations when it will be impossible to conduct bidding. It provides a general exemption when there exists a threat to public health or public safety, or when immediate expenditure is necessary for repairs to State property in order to protect against further loss of or damage to State Property, to prevent or minimize serious disruption in critical State services that affect health, safety, or collection of substantial State revenues, or to ensure the integrity of State records; provided, however that the term of the emergency purchase shall not exceed 90 days. A contract may be extended beyond 90 days if the chief procurement officer determines additional time is necessary and that the contract scope and duration are limited to the emergency. Prior to the execution of the extension, the chief procurement officer must hold a public hearing and provide written justification for all emergency contracts. Members of the public may present testimony.

Notice of all emergency procurement shall be provided to the Procurement Policy Board and published in the online electronic Bulletin no later than three business days after the contract is awarded. Notice of intent to extend an emergency contract shall be provided to the

Procurement Policy Board and published in the online electronic Bulletin at least 14 days before the public hearing.

A chief procurement officer making such emergency purchases is required to file an affidavit with the Procurement Policy Board and the Auditor General. The affidavit is to set forth the circumstance requiring the emergency purchase. The Legislative Audit Commission receives quarterly reports of all emergency purchases from the Office of the Auditor General. The Legislative Audit Commission is directed to review the purchases and to comment on abuses of the exemption.

During FY14 the Department filed three affidavits for emergency purchases totaling $9,064,932 as follows:

- $8,169,152 for transportation for Medicaid participants; and
- $ 895,780 for two purchases regarding backup, recovery, and independent verification and validation of the Integrated Eligibility System.

During FY15 the Department filed no affidavits for emergency purchases.

Headquarters Designations

The State Finance Act requires all State agencies to make semiannual headquarters reports to the Legislative Audit Commission. Each State agency is required to file reports of all of its officers and employees for whom official headquarters have been designated at any location other than that at which their official duties require them to spend the largest part of their working time.

The Department of Healthcare and Family Services reported in July 2015 that 45 employees spent more than 50% of their working time away from their official headquarters.