LEGISLATIVE AUDIT COMMISSION

Review of
Department of Human Services
Two Years Ended June 30, 2021
622 Stratton Office Building
Springfield, Illinois 62706
217/782-7097

REVIEW: #4586
DEPARTMENT OF HUMAN SERVICES
TWO YEARS ENDED JUNE 30, 2021

RECOMMENDATIONS – 33

IMPLEMENTED/PARTIALLY IMPLEMENTED – 17
ACCEPTED – 16

REPEATED RECOMMENDATIONS – 27

PRIOR AUDIT FINDINGS/RECOMMENDATIONS – 38

This review summarizes the auditors' report of the Department of Human Services for the two years ended June 30, 2021, filed with the Legislative Audit Commission on September 29, 2022. The auditors conducted a compliance examination in accordance with state law and Government Auditing Standards.

This review summarizes the report on the Department of Human Services, which includes the facilities operated by DHS which includes:

- 6 Developmental Centers;
- 6 Mental Health Centers; and
- 1 combined Mental Health and Developmental Center;

DHS has 6 Divisions:

- Developmental Disabilities
- Mental Health
- Early Childhood
- Rehabilitation Services
- Family & Community Services
- Substance Use Prevention and Recover

The Illinois Department of Human Services (DHS) was created in 1997 by consolidating the Departments of Alcoholism and Substance Abuse, Mental Health, Developmental Disabilities and Rehabilitation Services, along with the client-centered services provided through the Departments of Children and Family Services, Healthcare and Family Services and Public Health. DHS established as its primary mission to provide our state's residents with streamlined access to integrated services, especially those who are striving for economic independence, and others who face multiple challenges to self-sufficiency.

The Secretary of DHS during the audit period was Grace Hou. The current Secretary is Dulce Quintero who was appointed in September 2023. Dulce Quintero served as Assistant Secretary at DHS from 2019 until 2023.

Appropriations and Expenditures

Appropriations ($ thousands)	FY20		FY21	
	Approp	Expend	Approp	Expend
GENERAL FUNDS				
Total Other Operations and Refunds	7.7	0.0	7.7	0.0
Designated Purposes				
GATA Technical Asst. and Navigation	1,500.0	499.8	750.0	121.9
Indirect Cost Principles	0.1	0.0	0.1	0.0
Office of the Inspector General	9,216.9	7,418.4	8,574.1	7,832.6
Operational Expenses	629,629.6	580,724.7	673,931.3	625,289.9
Sexually Violent Persons Program	2,269.4	2,269.4	5,269.4	5,269.4
State Operated Developmental Centers	269,698.9	261,087.3	293,274.1	285,929.0
State Operated Mental Health Facilities	214,925.6	203,724.0	221,569.5	218,433.7
Total Designated Purposes	1,127,240.5	1,055,723.6	1,203,368.5	1,142,876.5
Grants				
Access to Justice Grant Program	0.0	0.0	10,000.0	9,879.8
Access to Justice Grant Prog.-Resurrection	5,000.0	4,321.0	0.0	0.0
Access to Justice Grant Prog.-West Side Ctr	5,000.0	4,776.9	0.0	0.0
Addiction Prevention Related Services	1,102.1	1,031.0	1,102.1	903.5
Addiction Treatment - DCFS Clients	7,549.2	2,894.4	7,700.2	1,872.5
Addiction Treatment - Medicaid Eligible	27,838.1	15,094.4	16,154.9	8,913.7
Addiction Treatment - Special Population	5,949.7	4,499.1	6,049.7	2,146.3
Addiction Treatment Services	43,175.4	33,627.5	40,938.9	26,126.5
After School Youth Programs	14,237.3	12,896.8	14,522.0	13,657.4
Aid to Aged, Blind or Disabled	28,504.7	26,836.3	28,504.7	28,256.6
ARC of IL Life Span Project	471.4	471.4	471.4	471.4
Best Buddies	977.5	977.5	977.5	977.5
Books Over Balls	250.0	88.2	250.0	205.0
Boys and Girls Clubs of West Cook County	150.0	0.0	150.0	146.7
Ctr. For Changing Lives - Asst. for Families	150.0	0.0	150.0	150.0
Ctr. For Prevention of Abuse & Human Traff.	60.0	37.1	60.0	59.3
Chicago Fathers for Change	25.0	0.0	25.0	0.0
Chicago Westside Branch NAACP	250.0	0.0	250.0	198.7
Child Care Services	410,599.0	365,358.0	370,599.0	298,366.4
Children's Place	381.2	281.4	381.2	381.2
Community Services	7,222.0	5,337.9	7,366.4	6,108.1
Community Transitions and Syst. Rebalancing	47,320.2	37,768.0	51,609.6	47,512.4
Comm. Transitions and Syst. Rebal.-Colbert	29,319.5	21,969.4	50,253.9	45,844.7

Comprehensive Community Services	18,560.1	15,421.5	18,931.3	17,179.5
DCFS Comm. Integrated Living Arrangements	2,471.6	2,471.1	2,471.6	2,471.6
Dental Grants	986.0	681.0	986.0	373.2
Developmental Disabilities Grants	1,331,328.4	1,311,052.7	1,397,440.4	1,355,030.5
Developmental Disabilities Transitions	5,201.6	5,201.5	5,201.6	5,201.6
Domestic Violence Shelters	20,100.9	19,040.5	20,502.9	19,063.2
Early Intervention Program	108,691.9	108,691.9	115,891.9	104,691.9
Employability Development Services	9,145.7	3,737.8	9,145.7	7,092.3
Epilepsy Services	2,075.0	1,883.4	2,075.0	1,878.3
Evaluation, Determin., Disposit. And Assess.	1,200.0	1,033.3	1,200.0	988.9
Federal Decennial Census Funds	29,000.0	24,829.2	14,500.0	13,217.6
Food Stamp Employment & Training	3,651.0	764.0	3,651.0	2,003.6
Funeral & Burial Expense	4,000.0	2,891.4	6,000.0	2,443.9
Gateway Foundation	0.0	0.0	6,000.0	6,000.0
Grants to Promote Health & Safety-COVID	0.0	0.0	10,000.0	0.0
Healthy Families	10,040.0	8,923.4	10,040.0	9,301.8
Home & Community-Based Waiver	480.6	480.3	480.6	480.6
Home Services Program	520,259.6	506,504.5	597,259.6	583,222.9
Homeless Youth Services	6,154.4	5,723.3	6,277.5	5,863.6
Homelessness Prevention	5,000.0	4,985.6	5,000.0	5,000.0
Illinois Migrant Council	90.0	0.0	90.0	0.0
Immigrant Integration Services	6,500.0	6,049.9	30,000.0	29,339.1
Independent Living Centers	5,802.6	5,619.9	6,002.2	5,986.7
Independent Living Older Blind	134.1	134.1	146.1	146.1
Infant Mortality	31,665.0	27,417.4	31,665.0	24,786.2
Joseph Academy	360.0	360.0	360.0	360.0
Local Healthy Foods Incentive	0.0	0.0	500.0	0.0
Mental Health Grants, Child & Adolescent	134,082.2	113,629.8	124,263.7	102,828.4
Mental Health Psychotropic Medications	1,881.8	919.1	1,381.8	709.5
Mental Health Supportive Housing	21,968.3	11,382.6	22,247.7	12,159.5
National Alliance on Mental Illness - Services	180.0	180.0	180.0	180.0
O.U.R. Youth	100.0	0.0	100.0	58.2
Parents Too Soon	6,870.3	6,803.1	6,870.3	6,870.3
Phalanx Family Services	0.0	0.0	500.0	0.0
Pilot Program Opioid Dependents	500.0	182.8	500.0	273.9
Prevention Partnership, Inc.	350.0	350.0	350.0	350.0
Project for Autism	4,800.0	4,656.6	4,800.0	4,394.4
Project Success of Vermillion County	25.0	16.2	0.0	0.0
Rape Victims Prevention Act	7,659.7	7,659.7	7,659.7	7,590.0
Redeploy Illinois	6,373.6	2,881.6	6,373.6	3,780.1
Refugee Social Services	204.0	196.3	204.0	200.3

Refugees	1,126.7	451.8	1,126.7	316.9
Rehabilitation Serv. Federal Match	102.0	101.3	90.0	53.5
Respite Services	8,997.5	5,040.8	9,177.5	5,374.5
SIU Rural Health for Mental Health Supp. Serv.	100.0	41.3	250.0	90.7
Special Services	7,667.1	7,496.4	7,667.1	6,599.0
St. Mary's Hospital	500.0	327.5	500.0	408.1
State Match for Fed. Vocational Rehab. Prog.	8,950.9	8,829.7	8,950.9	8,942.0
Supportive Housing Services	15,849.7	15,831.3	16,166.7	16,156.4
TASC, Inc. for Supportive Release Center	175.0	175.0	175.0	154.5
Temporary Assistance to Needy Families	154,201.9	133,509.6	194,201.9	187,639.1
Thresholds	0.0	0.0	6,000.0	6,000.0
Tort Claims	475.0	55.4	475.0	410.0
Tort Claims Employees	10.9	0.8	10.9	0.4
Touched by an Angel Comm. Enrich. Center	250.0	250.0	250.0	250.0
Urban Autism Solutions - West Side Trans.	400.0	391.9	400.0	398.0
Welcoming Centers	3,600.0	3,558.9	5,000.0	4,078.5
West Austin Development Center	620.0	0.0	620.0	466.0
Westside Health Authority Crisis Intervention	1,000.0	1,000.0	1,000.0	1,000.0
Youth Employment Programs	19,000.0	16,512.6	19,000.0	12,060.1
Youth Guidance - Becoming a Man	1,000.0	840.1	1,000.0	990.4
Total Grants	3,167,452.4	2,945,436.2	3,356,827.4	3,085,083.5
TOTAL GENERAL FUNDS	**4,294,700.6**	**4,001,159.8**	**4,560,203.6**	**4,227,960.0**
OTHER STATE FUNDS				
Total Personal Services & Fringe Benefits	3,689.6	0.0	0.0	0.0
Total Contractual Services	300.0	299.6	300.0	299.1
Total Other Operations and Refunds	2,379.7	296.6	2,335.4	300.0
Designated Purposes				
Behavioral Health Special Projects	11,000.0	6,014.1	16,000.0	5,774.4
DHS GATA Unit	5,000.0	681.1	5,000.0	698.1
DHS Interagency Support Services	3,000.0	1,321.6	3,000.0	2,037.4
DHS Recoveries Trust	22,263.0	10,160.6	22,263.0	6,989.8
Drugs & Costs Associated w/Pharmacy Serv.	12,300.0	9,980.6	12,300.0	9,410.3
Energy Conservation & Efficiency Program	1,000.0	0.0	500.0	0.0
Framework Project Program	10,000.0	4,618.0	10,000.0	7,246.9
Implement Firearm Conceal & Carry	2,500.0	261.5	2,500.0	292.5
Mgmt. Info. Serv. Tech. Assist. & Support	6,636.6	0.0	4,636.6	0.0
Medicare Part D	1,507.9	695.2	1,507.9	639.6
Private Resources	10.0	0.0	10.0	0.0
Public Health Programs	368.0	0.0	368.0	0.0
Support Services	9,043.8	8,122.5	11,043.8	8,140.1
Total Designated Purposes	84,629.3	41,855.2	89,129.3	41,229.1

Grants				
Addiction Prevention Related Services	2,050.0	2,050.0	2,050.0	1,952.2
Addiction Treatment & Related Services	3,742.2	1,141.1	3,742.2	1,611.2
Addiction Treatment Services	5,105.8	2,144.2	5,105.8	2,382.9
Assistance for Homeless	300.0	170.1	500.0	484.6
Autism Awareness	50.0	19.9	50.0	23.0
Autism Cares	50.0	0.0	50.0	0.0
Autism Research Checkoff	25.0	0.0	25.0	0.0
Cannabis Regulation & Tax Act	11,000.0	959.1	28,000.0	10,914.9
Case Services to Individuals	2,413.7	2,377.1	0.0	0.0
Children's Health Programs	1,138.8	0.0	1,138.8	0.0
Children's Wellness Charities	50.0	0.0	50.0	0.0
Coalition for Tech. Asst. & Training	250.0	0.0	250.0	0.0
Compulsive Gamblers Treatment	6,800.0	3,225.8	6,800.0	5,657.8
COVID-19 Related Expenses	0.0	0.0	70,000.0	57,195.8
COVID-19 Related Mental Health Grants	0.0	0.0	30,000.0	29,931.7
Developmental Disabilities Grants	82,000.0	56,869.9	52,000.0	26,200.0
Developmental Disabilities Long Term Care	0.0	0.0	45,000.0	38,832.9
Developmental Disabilities Purchase of Care	9,965.6	0.0	9,965.6	0.0
DHS Community Services	15,000.0	0.0	15,000.0	30.4
Domestic Violence Programs	100.0	0.0	100.0	0.0
Domestic Violence Shelters	952.2	496.2	952.2	555.4
Early Intervention Program	185,000.0	170,596.8	195,000.0	138,648.5
Emergency and Transitional Housing	10,383.7	10,299.3	10,383.7	10,382.1
Grants Supportive Housing Services	3,382.5	3,348.9	3,382.5	3,309.6
Group Home Loans	200.0	24.0	200.0	26.0
Health and Human Services Medicaid Trust	32,400.0	20,907.8	42,400.0	37,309.0
Home Services Program	246,000.0	233,243.3	246,000.0	234,350.2
Homeless Youth Services	1,000.0	770.3	1,000.0	958.3
Homelessness Prevention	4,000.0	3,971.0	5,000.0	4,200.8
Housing for Families	50.0	0.0	50.0	0.0
Hunger Relief Checkoff	100.0	100.0	250.0	0.0
Medicaid-Mentally Ill/Kid Care	92,902.4	56,152.0	92,902.4	65,316.6
Mental Health Grants-Home-Based Program	1,300.0	1,185.3	1,300.0	1,117.3
Mental Health Treatment	3,000.0	0.0	3,000.0	1,846.3
Non-Medicaid Services for Comm. Youth Prog.	150.0	0.0	150.0	0.0
Open Door Project	315.5	0.0	0.0	0.0
Opioid Overdose Prevention Program	0.0	0.0	300.0	0.0
Sexual Assault Services	100.0	100.0	100.0	0.0
Sexual Assault Services & Prevention	600.0	171.5	600.0	600.0
Special Olympics IL & Children's Charities	1,000.0	1,000.0	1,000.0	1,000.0

Special Olympics IL Fund	50.0	14.8	50.0	16.3
Specialized Serv. For Human Traff. Survivors	100.0	0.0	100.0	0.0
State Match for Fed. Vocational Rehab. Prog.	0.0	0.0	6,147.6	5,863.7
Tobacco Enforcement Program	2,800.0	1,325.0	2,800.0	1,690.8
Welcoming Centers	0.0	0.0	30,000.0	29,978.3
Total Grants	725,827.4	572,663.4	912,895.8	712,386.6
TOTAL OTHER STATE FUNDS	**816,826.0**	**615,114.8**	**1,004,660.5**	**754,214.8**
FEDERAL FUNDS				
Total Personal Services & Fringe Benefits	164,766.6	113,202.4	172,972.7	115,996.2
Total Contractual Services	34,049.6	14,174.2	35,649.6	12,860.8
Total Other Operations and Refunds	14,268.8	2,753.8	13,668.8	1,801.9
Designated Purposes				
Alcohol & Substance Abuse Prevention	215.0	0.0	215.0	0.0
Federally Assisted Programs	7,388.3	1,623.7	7,388.3	1,320.3
COVID-19 Related Mental Health	0.0	0.0	30,000.0	30,000.0
Welcoming Centers	0.0	0.0	32,000.0	29,989.7
Maternal and Child Health Programs	458.1	0.0	458.1	0.0
Operation of Federal Employment	10,783.7	6,701.3	10,783.7	6,762.1
Support Services In-Service Training	366.7	0.0	0.0	0.0
Vocational Programming	152.9	112.6	152.9	29.8
Total Designated Purposes	19,364.7	8,437.6	80,998.0	68,101.9
Grants				
Addiction Prevention Related Services	18,500.0	13,712.5	21,500.0	15,053.0
Addiction Treatment & Related Services	19,000.0	8,255.1	19,000.0	13,556.0
Addiction Treatment Services	60,000.0	45,650.5	60,000.0	45,512.2
Business Enterprise Program for the Blind	3,527.3	2,469.8	3,527.3	2,764.7
Case Services to Migrant Workers	210.0	0.0	0.0	0.0
Child Care Assistance Program	0.0	0.0	1,300,000.0	0.0
Child Care Service Great Start	5,200.0	5,200.0	5,200.0	5,200.0
Child Care Services	408,800.0	350,808.9	778,800.0	228,654.4
Client Assistance Project	1,179.2	459.3	1,179.2	483.6
Community Grants	7,257.8	7,043.1	7,257.8	6,580.0
Developmental Disabilities Grants	90,000.0	84,871.4	122,500.0	66,059.3
DHS Federal Projects Fund	16,036.1	4,831.7	16,036.1	5,696.2
Donated Funds Initiative Program	22,729.4	17,785.8	22,729.4	17,378.5
Emergency Food Program	5,163.8	5,077.3	20,163.8	5,206.7
Emergency Solutions Grants Program	48,320.0	5,029.3	48,320.0	14,890.1
Employment & Training Program	485,000.0	305,275.8	485,000.0	413,128.0
Family Violence Programs	5,018.2	3,238.6	5,018.2	4,449.0
Farmer's Market Nutrition	500.0	116.1	500.0	56.8
Federal Assistive Tech. Act Services	1,050.0	464.4	1,050.0	764.4

Federal Vocational Rehabilitation Programs	55,000.0	44,393.3	65,000.0	50,793.0
Federal/State Employment Program	5,000.0	20.7	5,000.0	681.1
Free Distribution Food Supplies	230,000.0	159,504.0	230,000.0	128,430.4
Gear Up	3,516.8	0.0	3,516.8	3,087.7
Head Start State Collaboration	500.0	203.1	500.0	62.6
Independent Living Centers	4,177.2	3,154.7	4,507.2	3,417.1
Independent Living Older Blind	2,545.5	1,423.1	3,045.5	1,434.7
Juvenile Justice Planning & Action Grants	4,000.0	1,250.9	3,000.0	1,283.5
Maternal and Child Health Programs	9,401.2	0.0	2,000.0	0.0
Mental Health Block Grant	23,025.4	19,332.8	23,025.4	19,484.8
Mental Health Block Grant Children	4,341.8	3,222.9	4,341.8	3,237.2
MIEC Home Visiting Program	14,006.8	9,013.4	14,006.8	8,619.8
Migrant Day Care Services	3,422.4	3,006.2	3,422.4	3,304.7
Parents Too Soon	2,505.0	2,440.8	2,505.0	2,499.4
Partnership for Success Program	5,000.0	0.0	5,000.0	0.0
Prev. of Prescription Drug OD-Rel. Deaths	2,000.0	1,245.5	2,000.0	809.4
Public Health Programs	10,742.3	5,043.9	10,742.3	9,156.1
Race to the Top	16,000.0	0.0	5,000.0	0.0
Refugee Settlement Services	10,611.2	3,902.6	10,611.2	4,436.2
Services to Disabled Individuals	25,000.0	12,103.0	25,000.0	13,004.2
SNAP Education	18,000.0	13,444.1	30,000.0	15,032.5
SNAP Outreach	2,000.0	1,710.5	5,000.0	1,810.2
SNAP Pilot Employment & Training	21,857.6	69.3	5,000.0	0.0
SNAP to Success	1,500.0	504.7	2,500.0	1,344.6
SSI Advocacy Services	1,009.4	2.1	1,009.4	0.0
State Opioid Response	40,000.0	28,272.5	40,000.0	26,623.7
Supported Employment	1,900.0	629.4	1,900.0	568.6
Supportive Food Program - WIC	1,400.0	1,346.4	1,400.0	1,252.3
Tort Claims	10.0	0.0	10.0	0.0
WIC Program	60,049.0	55,663.3	75,049.0	53,722.2
Total Grants	1,776,013.4	1,231,192.8	3,501,874.6	1,199,528.9
TOTAL FEDERAL FUNDS	**2,008,463.1**	**1,369,760.8**	**3,805,163.7**	**1,398,289.7**
TOTAL	**7,119,989.7**	**5,986,035.4**	**9,370,027.8**	**6,380,464.5**

Accountants' Findings and Recommendations

Condensed below are the 33 findings and recommendations included in the audit report. Of these, 27 are repeated from the previous audit. The following recommendations are classified on the basis of information provided by the Department of, via electronic mail received September 29, 2022.

1. The auditors recommend the Department assume more responsibility for the transactions and balances reported in its financial statements that are initiated/estimated by other State agencies, including the following:

- **The Department should enter into an interagency agreement (IA) with HFS that details the responsibilities of each agency with regards to initiating, processing and recording transactions, and how the sufficiency of internal control over Department transactions will be monitored (i.e., annual internal audit, SOC 1 Type 2 audit, or other).**

- **Once an IA is executed, on a regular basis, the Department should determine if the control system and related monitoring agreed to through the IA is sufficient to prevent and detect significant financial statement errors. The sufficiency of internal control should be monitored each time there is a major change to MAP/CHIP programs or IT systems used for those programs.**

- **Expenditure and accrual amounts provided by HFS in connection with year-end reporting of Federal MAP receivables should be reconciled to CARS or agreed to reports and source data compiled by HFS.**

FINDING: *(Medical Assistance Program Financial Information) – First finding 2017, last finding 2021*

The Department of Human Services (Department) does not have an adequate understanding of the suitability of the design of internal control or the operating effectiveness of internal control in place over all data recorded in its financial statements for transactions initiated by other State agencies and recorded in the Department's financial statements.

During the testing of the financial statements and supporting documentation, auditors noted the following:

- The Department could not provide documentation of the preparation or the Department's review of expenditure reconciliations for Federal Medical Assistance Program (MAP) funds or the State Children's Health Insurance Program (CHIP) (Funds 0120, 0142, 0211, 0365, 0502, 0509, 0718) between amounts reported in the Department's Consolidated Accounting and Reporting System (CARS) and amounts reported in the Grant/Contract Analysis Forms (Form SCO-563s) provided to the Comptroller's Office (IOC) which support the receivable calculation for financial reporting. The amount per the Form SCO-563s (totaling approximately $374 million for total reimbursable costs "TRC" for Assistance Listing Numbers 93.767 and 93.778) is a computed amount (a formula), essentially the amount needed to achieve the reported receivable balance provided by the

Department of Healthcare and Family Services (HFS), a separate State agency. The Department does not retain a reconciliation between what is reported on the Form SCO-563s (claimable expenditures) and within CARS (all expenditures) for each fund. Additionally, there is no documentation maintained by the Department to support the calculation and methodology used by HFS in preparing the federal receivable amount (approximately $17.2 million for the two programs).

- During testing of expenditures and liabilities, auditors determined that the Department is not monitoring or reviewing the payments submitted by HFS, or the liabilities calculated by HFS, on behalf of the Department and reported in the Department's financial statements. When HFS submits a request for payment to the IOC, a summary file is also sent to the Department which goes through an interface and is recorded into CARS. An employee in the Department's Fiscal Services Bureau reconciles the payments between CARS and the IOC before accepting them into CARS. Although, the Department has documented their understanding of how transactions for DHS programs are processed within HFS, the Department was not able to provide auditors with documentation of their monitoring performed over the amounts reported in the Department's financial statements. Additionally, the Department is placing reliance on the internal control over the applicable HFS system without recent independent verification of the system. Currently, the Department receives summarized information from HFS and records the transactions into CARS and the GAAP packages without performing sufficient procedures to determine the accuracy of the information.

A good system of internal control requires that management review all significant accounts and balances recorded in the financial statements for accuracy, which includes transactions initiated by other State agencies.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

This finding was first noted during the Department's financial audit of the year ended June 30, 2017. In subsequent years, the Department has been unable to fully implement its corrective action plan.

Department management indicated they rely on the HFS Bureau of Claims Processing and the controls in the Medicaid Management Information System (MMIS). Although management has outlined a corrective action plan to address the findings, the plan was not executed prior to June 30, 2021.

Lack of sufficient internal controls over transactions and balances recorded in the Department's financial statements increases the likelihood of misstatements.

DEPARTMENT RESPONSE:
The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will pursue an interagency agreement with HFS and monitor audits and reviews performed on HFS data and internal controls.

UPDATED RESPONSE:
In Progress.

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will pursue an interagency agreement with HFS and monitor audits and reviews performed on HFS data and internal controls.

Corrective Action in Process:

1. New/augmented DHS/HFS IGA. (25% Complete)

2. Coordinate on annual basis with HFS regarding current year audits/reviews related to Federal Medical Assistance Program transactions (FMAP). (100% Complete)

3. Explore other alternatives and methodologies to improve internal controls over balances reported in financial statements that are initiated or estimated by HFS, based on current and ongoing audits and reviews. (100% Complete)

Estimated Date of Completion: 03/01/2023

2. The auditors recommend the Department obtain SOC 1 Type 2 reports or perform independent reviews of internal control associated with all SPs, at least annually. The independent reviews should include an assessment of the following 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.**

An independent review should also encompass the design and effectiveness of controls over the processing of Department transactions, where applicable. An independent review should also be performed to determine the adequacy of general IT controls over IES that are to be performed by DoIT. In addition, Auditors recommend the Department perform an analysis to determine the need to obtain information as to any subservice organization's internal controls and perform reviews as needed.

Auditors also recommend the Department prepare a register of contract performance requirements and use it to monitor contract compliance on a regular basis.

FINDING: *(Lack of Adequate Controls over the Review of Internal Controls over Service Providers) – First reported 2017, last reported 2021*

The Department of Human Services (Department) did not obtain independent internal control reviews over all service providers.

During the audit period, the Department identified seven service providers (SP) which provided various services. Additionally, the Department determined six of the SPs which provided services were material to their financial reporting process.

The services these six material SPs provided were:

1. Infrastructure Information Technology (IT) and IT related services for the State of Illinois' Integrated Eligibility System (IES) provided by the Department of Innovation and Technology (DoIT).
2. Processing of SNAP and cash assistance benefits for the Illinois LINK program– The SP processed approximately $5.8 billion of transactions during the audit period.
3. Electronic visit verification system for the Home Services program (HSP) personnel – The SP processed approximately $817 million of transactions during the audit period.
4. Processing of negotiable food instruments (Women, Infants and Children (WIC) program) – SP validated food instruments by performing data entry and system edits that either allowed payment or caused return of the food instrument to the bank of first deposit. The SP processed approximately $128 million in WIC vouchers during the audit period.
5. Home Based Services (developmental disabilities program) – SP processed timesheets for home based service workers, paid the workers, and filed the related payroll tax returns. The SP processed approximately $226 million of transactions during the audit period.
6. Provider claims processing for the Early Intervention (EI) program – SP received, reviewed and approved claims from Providers, and provided claims data to the Department for payment. Approximately $139 million in claims were approved for payment by the SP during the audit period. The SP also billed EI participants for their family participation fee and billed Medicaid for qualified services provided to EI participants.

During the testing, auditors noted:

- The Department did not obtain a System and Organization Control (SOC) examination, SOC 1 Type 2, report for 1 of the 6 (17%) SPs.
- Through the date the auditors ended fieldwork, on April 15, 2022, management had not performed monitoring procedures over three of the five SOC reports obtained (60%) covering items 2 through 4 listed above. That monitoring should

include evaluating required Department user controls and subservice entity controls the SOC reports did not provide assurance on.

Due to the conditions noted above, auditors were unable to determine if internal controls related to these four SPs were adequate, and auditors were required to perform alternative procedures.

Additionally, management did not retain a register of contract performance requirements with SPs to perform periodic performance monitoring.

Lack of SP SOC reports or reviews thereof increases the risk of unidentified internal control deficiencies over the affected program which could result in misstatements of the Department's financial statements, noncompliance with the provisions of laws, regulations, and the provisions of contracts and grant agreements, and could impact the Department's clients. Additionally, the lack of a register documenting contract performance requirements that is used to monitor contract performance, increases the risk that noncompliance with contractual performance requirements will occur and not be detected by the Department in a timely manner.

Alternative Audit Procedures Performed (DoIT):

The Statewide IES application and data reside on the DoIT environment. In this regard, DoIT is a SP to the Department. The Department did not obtain a SOC 1 Type 2 report for these services performed by DoIT and the Department did not perform alternative procedures to obtain evidence all services were provided in a sufficient manner.

The Department is responsible for the design, implementation, and maintenance of internal controls related to information systems and operations to assure its critical and confidential data are adequately safeguarded. The Department is also responsible for the design and maintenance of internal controls relevant to financial reporting. These responsibilities are not limited due to the processes being outsourced to an external party or another State agency.

In order to determine if the environment is secure in which IES resides, auditors performed general IT controls testing over 28 IES servers hosted by DoIT. As a result of the testing, auditors noted significant weaknesses in the controls over the environment.

Further, during the Department of Healthcare and Family Services' own internal security review, completed as part of its Plan of Actions and Milestones (2021) report to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (Federal CMS), other significant threats were identified over the DoIT's general IT environment which hosts IES.

The Code of Federal Regulations (Code) (45 C.F.R. § 95.621(f)(1)), *ADP System Security Requirement*, requires the Department to be responsible for the security of all automated data processing system (ADP) projects under development and operational systems involved in the administration of the U.S. Department of Health and Human Services

programs. The Department is required to determine the appropriate security requirements based on recognized industry standards or standards governing security of federal ADP systems and information processing.

Federal CMS' *MARS-E Document Suite* (minimum acceptable risk standards for exchanges), states protecting and ensuring the confidentiality, integrity, and availability of state Marketplace information, common enrollment information, and associated information systems is the responsibility of the states.

The industry standard for understanding business processes, internal controls, and the suitability and operating effectiveness of internal controls provided by a SP is through obtaining a SOC 1 Type 2 report. A SOC 1 Type 2 report provides:

a. SP management's description of the service organization's system;

b. A written assertion by SP management about whether in all material respects and, based on suitable criteria, including:
    i. SP management's description of the service organization's system fairly presents the service organization's system was designed and implemented throughout the specified period,
    ii. the controls related to the control objectives stated in SP management's description of the service organization's system were suitably designed throughout the specified period to achieve those control objectives, and, the controls related to the control objectives stated in SP management's description of the service organization's system operated effectively throughout the specified period to achieve those control objectives; and,

c. An Independent Service Auditor's report that:
    i. expresses an opinion on the matters in b (i–ii), and
    ii. includes a description of the service auditor's tests of controls and the results thereof.

Additionally, the Security and Privacy Controls for Information Systems and Organizations (Special Publication 800-53, fifth revision) published by the National Institute of Standards and Technology (NIST), System and Service Acquisition section, requires entities outsourcing their IT environment or operations to obtain assurance over the entities internal controls related to services provided. Such assurance may be obtained via System and Organization Control reports or independent reviews.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

This finding was first noted during the Department's financial audit of the year ended June 30, 2017. In subsequent years, the Department has been unable to fully implement its corrective action plan.

Department management indicated that due to timing issues and renewal of contracts with subcontractors assisting the Department in the review over the SOC reports, management was not able to complete monitoring checklists/ reviews over all reports, which included reviews over user controls and subservice controls. Department management further indicated, failure to obtain a SOC report from DoIT was due to oversight.

Without obtaining, reviewing, and monitoring a SOC 1 Type 2 report, or another form of independent internal controls review, the Department does not have assurance the SPs' or any subservice organizations' internal controls are adequate to ensure program activities that result in transactions recorded in the Department's financial statements are complete and accurate. Additionally, the Department is not able to ensure confidential and sensitive program data is adequately secured by the SP. The Department's failure to maintain adequate internal controls over the security of the IES environment increases the risk IES may be exposed to malicious attacks, security breaches, and unauthorized access to recipients' personal information. Lack of a register documenting contract performance requirements increases the risk of noncompliance with performance requirements occurring without timely detection.

DEPARTMENT RESPONSE:

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS has established a process to identify contracted third-party service providers by performing an analysis of the contractual third-party provider services and the contractual expenditures. The IDHS Office of Contract Administration is in the process of creating a department-wide policies and procedures protocol for all contracted third-party service providers that will ensure:

- adequate processes and procedures are established and monitored appropriately of third-party service provider internal controls and processes and subservice organization's internal controls as needed per analysis and review;
- all third-party service providers that are identified as required to complete an annual SOC Report are notified and monitored annually for timely submission of the SOC Reports;
- timely reviews and analysis of the third-party service provider submitted SOC Reports are performed annually;
- gaps in timing between the third-party service providers' SOC Reports and IDHS's financial data are adequately addressed by alternate control processes within the IDHS program areas or Divisions who utilize contracted third-party service providers;
- corrective action taken by the third-party service providers and the IDHS program areas or Divisions is documented and maintained.

Furthermore, the IDHS Office of Contract Administration will work with the Department of Innovation and Technology's contracting staff to obtain a SOC audit vendor to obtain a SOC 1 Type 2 audit.

UPDATED RESPONSE:
In Progress.

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS has established a process to identify contracted third-party service providers by performing an analysis of the contractual third-party provider services and the contractual expenditures. The IDHS Office of Contract Administration is in the process of creating a department-wide policies and procedures protocol for all contracted third-party service providers that will ensure:

- adequate processes and procedures are established and monitored appropriately of third-party service provider internal controls and processes and subservice organization's internal controls as needed per analysis and review;
- all third-party service providers that are identified as required to complete an annual SOC Report are notified and monitored annually for timely submission of the SOC Reports;
- timely reviews and analysis of the third-party service provider submitted SOC Reports are performed annually;
- gaps in timing between the third-party service providers' SOC Reports and IDHS's financial data are adequately addressed by alternate control processes within the IDHS program areas or Divisions who utilize contracted third-party service providers;
- corrective action taken by the third-party service providers and the IDHS program areas or Divisions is documented and maintained.

Furthermore, the IDHS Office of Contract Administration will work with the Department of Innovation and Technology's contracting staff to obtain a SOC audit vendor to obtain a SOC 1 Type 2 audit.

Corrective Action in Process:

A. The Office of Contract Administration (OCA) hired a Bureau Chief in June of 2022 who has been tasked with creating a beginning to end process and procedures protocol manual for all IDHS Programs and Divisions to utilize when contracting with a Third-Party Service Provider. (25% Complete)
B. OCA/Department of Innovation and Technology's contracting staff are in the process of executing a Statement of Work with a CPA vendor to conduct the initial SOC 1 Type 2 audit of the Integrated Eligibility System (IES). (25% Complete)

Estimated Date of Completion: 06/30/2023

3. The auditors recommend management increase the level and quality of supervisory review of year-end financial reporting including the following:

- **Complete a report checklist, such as the one available on the Government Finance Officers' Association (GFOA) website, to determine if all amounts and disclosures in the financial statements are complete and accurate, particularly complex areas like pensions and other post-employment benefits required disclosures.**
- **Carefully review audit entries from the prior period when determining the reversing entry to be recorded.**

FINDING: *(Weaknesses in Preparation of Year-End Department Financial Statements) - New*

The Department of Human Services' (Department's) year-end financial reporting in accordance with generally accepted accounting principles (GAAP) contained inaccurate information.

The Department does not have adequate controls over the completeness and accuracy of year-end financial reporting which resulted in errors in the GAAP basis financial statements and supporting schedules provided to the auditors. The Department does not perform a sufficient supervisory review of all amounts recorded in its financial statements and footnotes.

Auditors noted and the Department corrected the following disclosure errors related to Footnotes 9 and 10:

1. Most Department employees participate in the State Employees' Retirement System (SERS), which is a single-employer defined benefit pension trust fund. The pension expense amount reported in the draft financial statements for Footnote 9 for State Employees' Retirement System (SERS) was understated by $58.5 million. The Department netted the reversal of the contributions to the SERS Plan with pension expense to arrive at the pension expense amount disclosed in Footnote 9 - Defined Benefit Pension Plans.

2. Certain Department facility employees participate in the Teachers Retirement System of Illinois (TRS), which is a multiple employer cost sharing plan with a special funding situation. GASB Statement No. 68 *Accounting and Financial Reporting for Pensions*, requires that the Department, as an employer, record its portion of the non-employer contributing entity (NECE) pension expense pertaining to Department employees in the government wide financial statements (as a revenue and an expense). This amount for the year ended June 30, 2021 was approximately $6.8 million and the Department recorded approximately $3.2 million, the difference was deemed immaterial and not recorded.

3. The Department's employees are members of the State Employees Group Insurance Program sponsored by the State of Illinois, Department of Central Management Services for their other postemployment benefits (OPEB). The OPEB expense amount reported in the draft financial statements for Footnote 10 was understated by $12.8 million. The Department netted the reversal of the contributions to the OPEB Plan with OPEB expense to arrive at the OPEB expense amount disclosed in Footnote 10 – Postemployment Benefits.

Additionally, prior year audit entries for the General Revenue Fund (001) and the DHS Special Purposes Trust Fund (0408) were not correctly reversed during FY 2021 resulting in a misstatement in federal operating grant revenues. In FY 2020, audit adjustments were recorded to correct the accounting for federal operating grant revenues and receivables for the Child Care Assistance program. In the prior year, revenues earned by Fund 0001 were recorded as revenue in Fund 0408, resulting in a correcting entry and an interfund receivable and payable between the two funds. In FY 2021, the prior year entries were reversed solely to federal operating grant revenue as part of the year-end close process. A portion of the FY 2020 interfund balance was not liquidated and was forgiven. That portion ($24.7 million) should have been classified as a transfer between the two funds during FY 2021, instead of an adjustment to revenue. These errors were corrected by the Department.

GASB Statement 68, *Accounting and Financial Reporting for Pensions*, paragraph 45 requires the employer to disclose the amount of pension expense recognized by the employer in the reporting period financial statements. GASB Statement 68 paragraphs 94 and 95, require the employer to recognize pension expense and revenue for a non-employer contributing entity's total proportionate share of collective pension expense that is associated with the employer. GASB Statement 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*, paragraph 56 requires the employer to disclose the amount of OPEB expense recognized by the employer in the reporting period.

GASB Codification 1800 *Classification and Terminology* section notes the following guidance:

Interfund loans—amounts provided with a requirement for repayment. Interfund loans should be reported as interfund receivables in lender funds and interfund payables in borrower funds. This activity should not be reported as other financing sources or uses in the fund financial statements. If repayment is not expected within a reasonable time, the interfund balances should be reduced and the amount that is not expected to be repaid should be reported as a transfer from the fund that made the loan to the fund that received the loan.

A good system of internal control requires that management review all significant accounts and balances recorded and disclosed in the financial statements for completeness and accuracy.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that revenues applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.
Department management indicated of the issues noted, the inaccurate pension and OPEB disclosures were the result of the complexity of the accounting and disclosure requirements. Additionally, for the reversing entry error, the Department indicated the entirety of the activity for FY 2021 was not analyzed prior to reversing the prior year entry.

Under the current process, GAAP financial reporting errors occurred that materially misstated the Department's draft financial statements. In addition, the current process could have negatively impacted the Statewide financial statements. Accurate and timely financial statements of the Department's financial information for GAAP reporting purposes is important due to the complexity of the Department and the impact adjustments may have on the Statewide financial statements.

DEPARTMENT RESPONSE:
The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review the GFOA checklist regarding benefit plans and identify items that apply to IDHS pension and OPEB reporting.

UPDATED RESPONSE:
Implemented.

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review the GFOA checklist regarding benefit plans and identify items that apply to IDHS pension and OPEB reporting.

Corrective Action Completed:

1. The Department will obtain and review the GFOA checklist and will utilize it as appropriate to Departmental pension and post-employment benefit disclosures. (100% Complete)
2. The Department will review the audit entries from the prior period with the Crowe staff that prepares the Departmental financial statements. (100% Complete)

Date of Completion: 12/02/2022

4. The auditors recommend the Department work with SERS to annually reconcile its active members' census data from its underlying records to a report of census data submitted to SERS' actuary and CMS' actuary. After completing a full reconciliation, the Department may limit the annual reconciliations to focus on the incremental changes to the census data file from the prior actuarial valuation, provided no risks are identified that incomplete or inaccurate reporting of census data may have occurred during

prior periods. Any errors identified during this process should be promptly corrected by either the Department or SERS, with the impact of these errors communicated to both SERS' actuary and CMS' actuary.

Further, auditors recommend the Department implement controls to ensure census data events are timely and accurately reported to SERS.

FINDING: *(Weaknesses in Internal Controls over Census Data) – First reported 2020, last reported 2021*

The Department of Human Services (Department) had weaknesses in internal control over reporting its census data and did not have a reconciliation process to provide assurance census data submitted to its pension and other postemployment benefits (OPEB) plans was complete and accurate.

Census data is demographic data (date of birth, gender, years of service, etc.) of the active, inactive, or retired members of a pension or OPEB plan. The accumulation of inactive or retired members' census data occurs before the current accumulation period of census data used in the plan's actuarial valuation (which eventually flows into each employer's financial statements), meaning the plan is solely responsible for establishing internal controls over these records and transmitting this data to the plan's actuary. In contrast, responsibility for active members' census data during the current accumulation period is split among the plan and each member's current employer(s). Initially, employers must accurately transmit census data elements of their employees to the plan. Then, the plan must record and retain these records for active employees and then transmit this census data to the plan's actuary.

Auditors noted the Department's employees are members of both the State Employees' Retirement System of Illinois (SERS) for their pensions and the State Employees Group Insurance Program sponsored by the State of Illinois, Department of Central Management Services (CMS) for their OPEB. In addition, auditors noted these plans have characteristics of different types of pensions and OPEB plans, including single employer plans and cost-sharing multiple-employer plans. Finally, auditors noted CMS' actuaries use SERS' census data records to prepare the OPEB actuarial valuation.

During testing, auditors noted the following:

1) The Department had not performed a complete reconciliation of its census data recorded by SERS to its internal records to establish a base year of complete and accurate census data.

2) After establishing a base year, the Department had not developed a process to annually obtain from SERS the incremental changes recorded by SERS in their census data records and reconcile these changes back to the Department's internal supporting records.

The Department did perform a reconciliation after year end which was provided to auditors in March 2022.

Based on information auditors obtained while performing the audit, auditors learned these deficiencies are pervasive across the State's agencies participating in the SERS. These conditions significantly increase the risk there could be errors at one or more employers within the plans, and these errors could have a significant impact on SERS' and CMS' measurement of pension and OPEB liabilities, respectively.

In addition, auditors noted errors within CMS' allocation of OPEB-related balances across the State's funds, public universities, and the Illinois State Toll Highway Authority related to a failure by CMS to account for a separately financed specific OPEB liability for certain groups of employees at one component unit of the State. The impact of these errors resulted in the Department restating its beginning net position to decrease it by $1.1 billion as of July 1, 2020.

Based upon the significance of these issues alone, auditors concluded a material weakness exists within the Department's internal controls related to ensuring both SERS and CMS can provide their respective actuaries with complete and accurate census data related to the Department's active employees. Even given these exceptions, auditors performed detail testing of a sample of employees and certain data analysis tests of the total population of the Department's census data transactions reported to SERS. Based on this testing auditors did not note any exceptions.

For employers where their employees participate in plans with multiple-employer and cost-sharing features, the American Institute of Certified Public Accountants' Audit and Accounting Guide: State and Local Governments (AAG-SLG) (§ 13.177 for pensions and § 14.184 for OPEB) notes the determination of net pension/OPEB liability, pension/OPEB expense, and the associated deferred inflows and deferred outflows of resources depends on employer-provided census data reported to the plan being complete and accurate along with the accumulation and maintenance of this data by the plan being complete and accurate. To help mitigate against the risk of a plan's actuary using incomplete or inaccurate census data within similar agent multiple-employer plans, the AAG-SLG (§ 13.181 (A-27) for pensions and § 14.141 for OPEB) recommends an employer annually reconcile its active members' census data to a report from the plan of census data submitted to the plan's actuary, by comparing the current year's census data file to both the prior year's census data file and its underlying records for changes occurring during the current year.

Further, the State Records Act (5 ILCS 160/8) requires the Department make and preserve records containing adequate and proper documentation of its essential transactions to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Finally, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department establish and maintain a system, or systems, of internal fiscal and

administrative controls to provide assurance funds applicable to operations are properly recorded and accounted for to permit the preparation of reliable financial and statistical reports.

Department management indicated the Department was waiting for detailed instructions on performing the reconciliation and information from the Plan, prior to beginning the process.

Failure to ensure complete and accurate census data was reported to SERS could result in a material misstatement of the Department's financial statements and reduce the overall accuracy of pension/OPEB-related liabilities, deferred inflows and outflows of resources, and expense recorded by the State, the State's agencies, and other public universities and community colleges across the State. In addition, failure to reconcile active members' census data reported to and held by SERS to the Department's internal records could result in each plan's actuary relying on incomplete or inaccurate census data in the calculation of the pension and OPEB balances, which could result in a material misstatement of these amounts. Finally, the allocation error involving one component unit in the OPEB plan resulted in misstatements within each employer's allocation, which resulted in a restatement at the Department.

DEPARTMENT RESPONSE:

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS has performed a full initial reconciliation and IDHS will develop and implement a comprehensive (annual) reconciliation covering all new employees who have joined the agency since the last reconciliation.

UPDATED RESPONSE:

Implemented.

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS has performed a full initial reconciliation and IDHS will develop and implement a comprehensive (annual) reconciliation covering all new employees who have joined the agency since the last reconciliation.

Corrective Action Completed:

1. A full reconciliation was performed in the winter of 2021 and submitted to SERS in March of 2022. (100% complete)
2. A second reconciliation for FY22 was performed in the fall of 2022 and submitted to SERS on October 28, 2022 (100% complete)
3. The Agency is prepared and plans to perform (program is in place) the reconciliation process at the end of every fiscal year in cooperation with SERS.
4. The Agency has implemented several controls across the various payroll offices to ensure that detected errors are not repeated in order to provide accurate and timely information to SERS. This includes but is not limited to the following:
    a. Training on the Pension Code and its application to MH/DD Facilities.

b. DHS continues to work with SERS to acquire random data files throughout the fiscal year to do random checks.
c. DHS is applying reporting procedures to detect entries that could potentially be in error.
d. Ensuring the proper dissemination of SERS source documents (tier determination) from Personnel staff to Payroll staff as they apply to new employees.

Date of Completion: 11/01/2022

5. The auditors recommend management of both Departments work together to strengthen controls in the Change Management Plan by including:

- **Specific requirements for the prioritization or classification of changes,**
- **Definitions of the numerical grading for determining impact,**
- **Detailed documentation requirements for test scripts and results, impact analysis, design documentation, or other required documentation,**
- **Definitions of when changes are required to include a specific requirement, who should review the various steps, and when, and by whom approvals are required, and**
- **Requirements for backout plans to return the system to a previous functional version in the event a change moved into production causes undesired results, for individual infrastructure changes.**

FINDING: *(Insufficient Internal Controls over Changes to the Integrated Eligibility System (IES) and Recipient Data) – First reported 2017, last reported 2021*

The Department of Healthcare and Family Services and the Department of Human Services (collectively, the "Departments") had insufficient internal controls over changes to the Integrated Eligibility System (IES) and recipient data.

Management of the Departments have shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Departments' IES is the automated system used by the Departments which intakes, processes (with the assistance of caseworkers), and approves recipient applications, maintenance items, and redeterminations in order to determine eligibility and make payments for the State's human service programs.

Change control is the systematic approach to managing changes to an IT environment, application, or data. The purpose is to prevent unnecessary and/or unauthorized changes, ensure all changes are documented, and minimize any disruptions due to system changes.

IES Application Changes Policies and Procedures

The review of the April 20, 2020 IES Change Management Plan (Plan) noted the Plan did not:

- Define the requirements for the prioritization or classification of changes,
- Define the numerical grading for determining impact,
- Define the detailed documentation requirements for test scripts and results, impact analysis, design documentation, or other required documentation, and
- Define when changes were required to include a specific requirement, who was to review the various steps and when and by whom approvals were required.

Additionally, auditors noted backout plans to return the system to a previous functional version in the event a change moved into production caused undesired results had not been prepared for individual infrastructure changes.

Testing of IES Application Changes

Due to the Plan's limitations noted above, the scope of the audit procedures was limited to the Departments' testing and approval of IES changes prior to placing them into production. Specifically, auditors could not perform testing on other change management control procedures, which would otherwise be typically tested, as they were not included in the Plan.

The testing noted no exceptions during testing of IES application changes.

The internal control requirements of the *Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards* (Uniform Guidance) within the Code of Federal Regulations (Code) (2 C.F.R. § 200.303) requires the Departments to establish and maintain effective internal control over the Medicaid Program to provide reasonable assurance that the Departments are managing the Medicaid Program in compliance with federal statutes, regulations, and the terms and conditions and comply with federal statutes, regulations and terms and conditions of the Medicaid Program.

These internal controls should be in compliance with guidance in *Standards for Internal Control in the Federal Government* (otherwise commonly referred to as the Green Book) issued by the Comptroller General of the United States or the *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organization of the Treadway Commission (COSO).

The Code (45 C.F.R. § 95.621(f)(1)), *ADP System Security Requirement*, requires the Departments to be responsible for the security of all automated data processing (ADP) projects under development, and operational systems involved in the administration of the U.S. Department of Health and Human Services programs. The Departments are required to determine the appropriate security requirements based on recognized industry standards or standards governing security of federal ADP systems and information processing.

The National Institute of Standards and Technology (NIST), Special Publication 800-128, *Guide for Security-Focused Configuration Management of Information Systems*, states critical elements are to include:

- Developed and documented policies, plans, and procedures, and
- Properly authorized, tested, approved and tracking of all changes.

Furthermore, NIST, Special Publication 800-53, *Security and Privacy controls for Federal Information Systems and Organizations*, Configuration section, states policies and procedures should be in place detailing who can authorize modifications and how the authorizations are to be documented. Additionally, documentation of authorizations should be obtained prior to implementation.

The Departments' Change Management Policy and Procedure requires each change to IES have impact scores completed, Departments' approval of the requirements and design documents, Remedy ticket, release notes, and be approved by the IES Bureau Chief to move the change to the production environment.

This finding was first noted during the Departments' financial audits of the year ended June 30, 2017. In subsequent years, the Departments have been unable to fully implement its corrective action plan.

The Departments' management indicated the change management policies and procedures are in the process of being updated, however they are not yet complete due to other competing priorities.

Failure to establish and adhere to robust internal controls over changes to IES diminishes the Departments' ability to secure IES as well as the recipient data from unauthorized changes and accidental or intentional destruction or alteration.

DEPARTMENT OF HUMAN SERVICES' RESPONSE:

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review its Change Management policy and procedure to assure that it meets the auditor recommendations. IDHS will also review and modify, as needed, its documentation of the various steps and the responsible individuals, in the change approval process and work to develop a documented change backout plan.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:

The Department of Healthcare and Family Services (HFS) accepts the recommendation. HFS will work with the Department of Human Services to develop policy guidance that strengthens controls.

UPDATED RESPONSE:

In Progress.

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review its Change Management policy and procedure to assure that it meets the auditor recommendations. IDHS will also review and modify, as needed, its documentation of the various steps and the responsible individuals, in the change approval process and work to develop a documented change backout plan.

Corrective Action in Process:

1. DHS OIES will continue to review its Change Management policy and procedure to properly organize prioritization of changes, impact designation, test scripts and results, impact analysis, design, and documentation. (80% Complete)
2. DHS OIES will review and modify documentation of the various steps and responsible individuals in the Change Management approval process. (80% Complete)
3. DHS OIES will add formal backout procedures to the policy. (10% Complete) Due to the complexity of this process, the information on backout procedures as it pertains to the business decision steps will be included for DHS OIES. However, the technical procedures are with DoIT DHS and not included within the Change Management Plan.

Estimated Date of Completion: 03/01/2023

6. The auditors recommend management of the Departments enhance internal control over IES access by adopting a formal written policy or procedure requiring and/or including:

- **Documented approval from regional monitors that access changes were made as directed. The policy/procedure should address the form in which such approval will be documented, the number of days in which approvals (or corrections) should be communicated by the regional monitors, and the individual or division responsible for maintaining the documentation.**
- **The review of entitlements granted when conducting the review of access rights.**
- **A definition of "timely" for disabling an individual's access to the IES system, and a process for tracking whether access was revoked timely based on the definition.**

FINDING: *(Inadequate Access Review Procedures for the Integrated Eligibility System (IES)) – First reported 2020, last reported 2021*

The Department of Healthcare and Family Services and the Department of Human Services (collectively, the "Departments") failed to implement adequate procedures over the user access review process for the Integrated Eligibility System (IES).

Management of the Departments have shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes

relating to eligibility for these programs. The Departments' IES is the automated system used by the Departments which intakes, processes (with the assistance of caseworkers), and approves recipient applications, maintenance items, and redeterminations in order to determine eligibility and make payments for the State's human service programs.

During the audit, auditors noted the following deficiencies in the user access review procedures performed by the Departments:

- Evidence of timely, affirmative responses from the regional monitors, noting IES access has been corrected and validated, was not tracked or documented.
- There was insufficient evidence retained to conclude the access review included a review of entitlements (user access permissions and other rights) to ensure users' access was limited to only data they need to perform their job responsibilities.

Additionally, during the testing of the Departments' access provisioning policies, auditors noted the policies did not define the time period in which the Departments were required to disable a terminated individual's system access. Because there was no systemic record of the date access was removed nor a definition by management of timeliness thereof, auditors were unable to determine whether user access was removed timely when a user was transferred or terminated.

Departments' management indicated they are working to develop a solution to document the provisioning of employees in IES.

The Code of Federal Regulations (Code) (45 C.F.R. § 95.621 (f)(1)), *ADP System Security Requirement*, requires the Departments to be responsible for the security of all automated data processing (ADP) projects under development, and operational systems involved in the administration of the U.S. Department of Health and Human Services programs. State agencies are required to determine the appropriate security requirements based on recognized industry standards governing security of federal ADP systems and information processing.

The National Institute of Standards and Technology (NIST), Special Publication 800-53, *Security and Privacy Controls for Federal Information Systems and Organizations*, Access Control section, states an entity is to define within policies and procedures personal security transactions, establishment and termination of access, based on assessed risk of the entity's environment. Additionally, the U.S. Department of Health and Human Services' Security Rule adopted pursuant to the Health Information Portability and Accountability Act and published within the Code (45 C.F.R. § 164.308(a)(3)(ii)(C)), *Security and Privacy Controls for Federal Information Systems and Organizations – Administrative Safeguards*, requires the Departments to implement "procedures for terminating access to electronic protected health information when the employment of, or other arrangement with, a workforce member ends."

The Departments' management indicated that although IES tracks when access is revoked, the system is not programmed to track when the request for revoking access was initiated.

The Departments' failure to maintain adequate internal control over the review of user access rights increases the risk IES may be accessed by individuals who are not authorized to access recipients' personal and health information.

DEPARTMENT OF HUMAN SERVICES' RESPONSE:

The Illinois Department of Human Services (IDHS) accepts the recommendation. Late in Fiscal Year 2020, IDHS published on its OneNet additional details regarding the review and termination of IES access by the Regional Systems Monitors. Furthermore, IDHS will document procedures to include return notification from the Systems Monitors of the corrective actions taken from the access review and follow-up verification that the access granted to the individual agrees with the access requested.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:

The Department of Healthcare and Family Services (HFS) accepts the recommendation. HFS will work with the Department of Human Services to enhance internal control policy and procedures over IES.

UPDATED RESPONSE:

In Progress.

The Illinois Department of Human Services (IDHS) accepts the recommendation. Late in Fiscal Year 2020, IDHS published on its OneNet additional details regarding the review and termination of IES access by the Regional Systems Monitors. Furthermore, IDHS will document procedures to include return notification from the Systems Monitors of the corrective actions taken from the access review and follow-up verification that the access granted to the individual agrees with the access requested.

Corrective Action in Process:

1. DHS IES Regional Systems Monitor Coordinator will update its Access Termination Policy for IES on the DHS OneNet, to specify additional details listed in the finding. Termination policy has been updated to include a timeline instead of saying 'timely'. Timeline follows that of the DoIT DHS RACF policy to ensure continuity amongst systems. (100% Complete)
2. DHS IES Regional Systems Monitor Coordinator will work with DoIT-DHS to review changes to the current 'review session' frequency, to improve the users' access accuracy. DHS currently already had a monthly review; an Annual review was instituted as well in a similar structure as the DoIT DHS RACF security review to ensure continuity amongst systems. (100% Complete)
3. DHS IES Regional Systems Monitor will work with the DoIT-DHS CIO and DHS Business services to identify the best solution to track and document IES access actions taken and the individual who made the change action. Finalizing the new structure of the 4052; expect to provide to the DoIT DHS CIO by 12/17/22 so it can

be converted in a new solution the DoIT DHS CIO identified to better track, and document actions requested and taken. (80% Complete)

Estimated Date of Completion: 03/01/2023

7. The auditors recommend the Departments work with the Department of Innovation and Technology (DoIT) to allocate sufficient resources to enable a full recovery of IES in the event of a disaster. Additionally, in the interim, auditors recommend the Departments work with DoIT to develop a prioritization plan and emergency operating procedures to allow IES to operate under reduced capacity in the event of a disaster.

Auditors further recommend management of the Departments enhance the Disaster Recovery Plan to include:

- **Detailed recovery scripts,**
- **Detailed environment diagrams,**
- **IES support staff and vendor contact information,**
- **Responsibilities for recovery of IES,**
- **Documentation on the backup of IES, and**
- **The current environment for all areas.**

Finally, auditors recommend the Departments perform disaster recovery testing on a regular basis as defined in the Plan.

FINDING: *(Inadequate Disaster Recovery Controls over the Integrated Eligibility System (IES)) – First reported 2019, last reported 2021*

The Department of Healthcare and Family Services and the Department of Human Services (collectively, the "Departments") lacked the ability to perform a full disaster recovery, and lacked adequate disaster recovery controls over the Integrated Eligibility System (IES).

Management of the Departments have shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Departments' IES is the automated system used by the Departments which intakes, processes (with the assistance of caseworkers), and approves recipient applications, maintenance items, and redeterminations in order to determine eligibility and make payments for the State's human service programs.

The Departments did not have full disaster recovery functionality and consequently have not conducted disaster recovery testing over IES since 2019.

In addition, although the Department of Human Services' Disaster Recovery Plan (Plan) addresses the recovery and operation of IES, auditors noted the Plan did not include:

- Detailed recovery scripts,
- Detailed environment diagrams,
- IES support staff and vendor contact information,
- Responsibilities for recovery of IES,
- Documentation on the backup of IES, and
- Did not fully depict the current environments.

This finding was first noted during the Departments' financial audits of the year ended June 30, 2019. In subsequent years, the Departments have been unable to fully implement its corrective action plan.

The Code of Federal Regulations (Code) (45 C.F.R. § 95.621(f)(2)(ii)(F), *ADP System Security Requirements and Review Process*, requires the Departments' automated data processing (ADP) security plan, policies and procedures to include contingency plans to meet critical processing needs in the event of short or long-term interruption of service.

The National Institute of Standards and Technology (NIST), Special Publication 800-53, *Security and Privacy Controls for Federal Information Systems and Organizations*, Contingency Planning section, includes disaster recovery plans and the testing of disaster recovery plans as baseline security controls integral to ensuring appropriate security requirements and controls are applied to information systems.

The Departments' management indicated the project of implementing a fully functioning disaster recovery plan has been delayed due to staffing shortage issues since the Phase 2 database migration. Departments' management explained full disaster recovery functionality is not yet available in the current IES environment and it has outgrown the capacity of the legacy disaster recovery hardware. As such, Departments' management indicated the IES Disaster Recovery Plan cannot be accurately documented and a complete, end-to-end disaster recovery exercise cannot take place until the new disaster recovery environment at an alternate data center is completed and tested.

The lack of an adequate Disaster Recovery Plan and the lack of functionality with which to perform full disaster recovery could result in the Departments' inability to recover IES data in the event of a disaster, which could be detrimental to recipients of benefits, and the Departments', and State's operations.

DEPARTMENT OF HUMAN SERVICES' RESPONSE:

The Illinois Department of Human Services (IDHS) accepts the recommendation. An Information System Contingency Plan (ISCP) document for IES legacy is 90% completed. The DoIT-IDHS Bureau of Information Security and Audit Compliance will work on implementing an ISCP for the new IES Technical Refresh environment, using Alternate Data Center Architecture diagrams provided by its IT vendor. IDHS has tested continuation of operations plans in place for use in the event of a system outage.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:

The Department of Healthcare and Family Services (HFS) accepts the recommendation. HFS will support the lead, Department of Human Services, as they adopt and implement a disaster recovery plan.

UPDATED RESPONSE:
In Progress.

The Illinois Department of Human Services (IDHS) accepts the recommendation. An Information System Contingency Plan (ISCP) document for IES legacy is 90% completed. The DoIT-IDHS Bureau of Information Security and Audit Compliance will work on implementing an ISCP for the new IES Technical Refresh environment, using Alternate Data Center Architecture diagrams provided by its IT vendor. IDHS has tested continuation of operations plans in place for use in the event of a system outage.

Corrective Action in Progress:
Legacy IES:
Allocate sufficient resources to enable a full recovery of IES in the event of a disaster: (30% Complete)

Departments perform disaster recovery testing on a regular basis as defined in the Plan: With completion of Phase 2a of the IES Tech Refresh, the IES application database is now on new AIX servers, which synchronize with high availability disaster recovery (HADR) servers at the Alternate Data Center (ADC) in real time. DoIT is working to migrate other remaining IES application servers from old virtual centers to the new VMWare Cloud Foundation (VCF) platform, in logical groups and on Dell / Storage Resource Management (SRM) over the next 3 to 4 months. This effort will provide ADC replication for the application and the means for failover capability from the Central Computing Facility (CCF) to the ADC.

DoIT project management is currently working to document steps required for manual failover, which would include switching from the DoIT CCF database to the ADC HADR database, then reconfiguring all application software (COTS), batch processes, web application servers, etc. to utilize the ADC HADR database.

DoIT continues to work with IES consultants and project managers to finalize the IES Information System Contingency Plan (ISCP) with the new manual failover concept to provide detailed recover steps.

- Detailed recovery scripts, (25% Complete)
- Detailed environment diagrams, (100% Complete)
- IES support staff and vendor contact information, (100% Complete)
- Responsibilities for recovery of IES, (100% Complete)
- Documentation on the backup of IES, and (100% Complete)
- The current environment for all areas. (100% Complete)

Prioritization plan and emergency operating procedures to allow IES to operate under reduced capacity in the event of a disaster: A tabletop Datacap Business continuity plan

was completed in December 2022. Business continuity and continuation of operations plans for each DHS division and field location have been documented, which includes the IES application. (100% Complete)

Estimated Date of Completion: 11/30/2023

8. The auditors recommend management of the Departments either expand its existing agreement or execute a new detailed agreement with DoIT, and expand on the existing agreement between the Departments to ensure IES roles and responsibilities, required to be performed by each party, are formally documented.

FINDING: *(Detailed Agreement with the Department of Innovation and Technology (DoIT) not Sufficient and Inadequate Interagency Agreement for the IES)*

The Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) (collectively, the "Departments") each entered into an interagency agreement (IA) with the Department of Innovation and Technology (DoIT) which did not define each agency's roles and responsibilities with respect to the Integrated Eligibility System (IES). Additionally, HFS and DHS entered into an IA with each other which addressed IES access and data sharing, but the IA did not define each agency's roles and responsibilities with respect to the IES.

Management of the Departments have shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Departments' IES is the automated system used by the Departments which intakes, processes (with the assistance of caseworkers), and approves recipient applications, maintenance items, and redeterminations in order to determine eligibility and make payments for the State's human service programs.

The Departments' IES application and data resides on DoIT's environment. In addition, DoIT's staff is responsible for coordinating and making changes to the IES application and data after receiving approved instructions from the Departments. Furthermore, DoIT's staff assists the Departments with user access security.

Additionally, as set by the State of Illinois' State Plan under Title XIX of the Social Security Act (State Plan) (Section 1.1), the State has designated agency responsibility for administering and supervising the administration of the Medicaid Program to HFS. However, Section 1.1 of the State Plan allows HFS to delegate specific functions to other State agencies to assist with the administration of the Medicaid Program, pursuant to a written IA defining each agency's roles and responsibilities. As such, DHS administers several human service programs under the Medicaid Program, including developmental disabilities support services, rehabilitation services, and substance abuse (prevention and recovery).

Auditor Testing and Results

Interagency Agreements
During the audit, auditors noted the Departments had neither updated their existing agreement or, alternatively, entered into an additional IA with DoIT documenting roles and responsibilities for each function they perform on the Departments' behalf.

Additionally, auditors noted HFS and DHS had neither updated their existing agreement or, alternatively, entered into an additional IA to define the specific roles and responsibilities for each agency.

This finding was first noted during the Departments' financial audits of the year ended June 30, 2019. In subsequent years, the Departments have been unable to fully implement its corrective action plan.

The internal control requirements of the *Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards* (Uniform Guidance) within the Code of Federal Regulations (2 C.F.R. § 200.303), requires the Departments to: (1) establish and maintain effective internal control over the Medicaid Program to provide reasonable assurance the Departments are managing the Medicaid Program in compliance with federal statutes, regulations, and the terms and conditions; and (2) comply with federal statutes, regulations and terms and conditions of the Medicaid Program. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" (otherwise commonly referred to as the Green Book) issued by the Comptroller General of the Unites States or the "Integrated Framework" issued by the Committee of Sponsoring Organization of the Treadway Commission (COSO).

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires all State agencies to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and maintain accountability over State's resources.

The Departments' management indicated the IAs with DoIT and between each other had been delayed due to turnover in staff involved in the process.

The Departments' failure to execute the appropriate IAs increases the risk that IES functions will not be performed by each party in accordance with their assigned responsibility.

DEPARTMENT OF HUMAN SERVICES' RESPONSE:
The Illinois Department of Human Services (IDHS) accepts the recommendation. The Department will continue to finalize revisions of the draft intergovernmental agreement to identify the assigned roles of HFS, IDHS, and DoIT, and will complete the necessary intergovernmental agreement process.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:
The Department of Healthcare and Family Services accepts the recommendation. The Departments are currently working together to expand the agreement.

UPDATED RESPONSE:
In Progress.

Recommendation
Auditors recommend management of the Departments either expand its existing agreement or execute a new detailed agreement with DoIT and expand on the existing agreement between the Departments to ensure IES roles and responsibilities, required to be performed by each party, are formally documented.

Department of Human Services' Response
The Illinois Department of Human Services (IDHS) accepts the recommendation. The Department will continue to finalize revisions of the draft intergovernmental agreement to identify the assigned roles of HFS, IDHS, and DoIT, and will complete the necessary intergovernmental agreement process.

Corrective Action in Process:
A. Create draft IGA. Circulate to HFS and DoIT (100% Complete)
B. Review and incorporate any updates for HFS and DoIT. (100% Complete)
C. Submit Final IGA for approval at executive level of all 3 agencies. (IGA has been submitted for signatures at all 3 agencies) (75% Complete)

Estimated Date of Completion: 03/31/2023

9. The auditors recommend HFS management work with DHS to ensure all provider applications are properly reviewed, approved, and documented within IMPACT. In addition, auditors recommend HFS work with DHS to execute detailed interagency agreements which document specific roles and responsibilities as they relate to IMPACT. Finally, until the interagency agreement is finalized, auditors recommend DHS follow-up on issues identified pertaining to their providers, from the IMPACT monthly screenings.

FINDING: *(Insufficient Review and Documentation of Provider Enrollment Determinations and Failure to Execute Interagency Agreements) – First reported 2018, last reported 2021*

The Department of Healthcare and Family Services (HFS) failed to execute interagency agreements (IA) with the Department of Human Services (DHS) establishing adequate internal controls over operation of the State of Illinois' Illinois Medicaid Program Advanced Cloud Technology system (IMPACT). In addition, HFS failed to sufficiently review and document eligibility requirements either prior to the approval of eligibility, and/or during the required monthly screenings for enrolled providers.

Interagency Agreements
Auditors noted HFS did not enter into or have an existing IA with DHS defining each agency's roles and responsibilities as they related to IMPACT during fiscal year 2021.

HFS and DHS management indicated the IA has been drafted, however it has not yet been finalized.

Detail Sample Testing of IMPACT Providers at HFS
During fiscal year 2021, 24,209 provider enrollment applications were approved in IMPACT. In order to determine if the providers' applications were approved in accordance with Federal and State laws/rules/regulations, a sample of 60 approved applications were selected for testing. The testing noted seven (12%) approved provider applications did not contain documentation to substantiate a review of the provider's required professional license or board certification to confirm the licenses/certifications were valid at the time the application was approved.

HFS management indicated the failure to either document or confirm the applicants had a valid non-expired license with no current limitations on the providers license/certification was due to oversight.

Detail Sample Testing of IMPACT Providers at DHS
During testing, the auditors determined DHS did not solely utilize IMPACT as the official book of record or consistently rely on it to verify its providers met certain Medicaid requirements prior to approving them to provide services. Specifically, in fiscal year 2021, DHS performed procedures to determine if its providers met certain Medicaid requirements outside of IMPACT. Upon completion of those procedures, DHS personnel then entered the providers' information into IMPACT and approved the provider's file in order to grant approval for payment.

DHS management indicated it uses IMPACT for determining provider eligibility for Medicaid requirements, but each program is unique with various requirements that must be performed outside of IMPACT.

In order to determine if DHS provider applications were approved in accordance with federal and State laws/rules/regulations, prior to DHS entering their information into IMPACT, the auditors selected a sample of 60 approved applications for detailed testing and had no exceptions.

Additionally, on a monthly basis, IMPACT conducts monthly screenings of provider profiles against several databases to determine if the provider licenses are valid and current, and identifies suspected criminal activity. During testing, the auditors determined DHS personnel did not regularly follow-up on issues identified in IMPACT during the monthly screenings.

DHS indicated that follow-up reviews of issues have not been consistently performed due to the lack of an executed interagency agreement.

This finding was first noted during the Departments' financial audit reports for the year ended June 30, 2018. In subsequent years, the Departments have been unable to fully implement a corrective action plan.

The Code of Federal Regulations (Code) (42 C.F.R. § 455.412 (b)) requires the applicable Department to confirm that the provider's license has not expired and that there are no current limitations on the provider's license/certification.

The Code (42 C.F.R. § 455.412 (a)) requires the Departments to have a method for verifying that any provider claiming to be licensed in accordance with the laws of any State is licensed by such State. The Code (42 C.F.R. § 455.412 (b)) requires the confirmation that a provider's license has not expired and that there are no current limitations on the provider's license/certification. In addition, the Department's *Approval Process Document, applicable to Atypical Individuals and Individuals*, requires Department staff reviewing licenses to document their review of ensuring the licenses were valid and current in the comments section in IMPACT.

The Code (42 C.F.R. § 455.436 (c)(1)) requires the Departments to consult appropriate databases to confirm identity upon enrollment and reenrollment. In addition, the Code (42 C.F.R § 455.450 (a)(3)) requires the Departments to conduct database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type, in accordance with § 455.436.

The Code (2 C.F.R § 200.303), *Internal Controls*, requires the Departments to: (1) establish and maintain effective internal control over the Medicaid Program to provide reasonable assurance that the Departments are managing the Medicaid Program in compliance with federal statutes, regulations, and the terms and conditions; and (2) comply with federal statues, regulations and terms and conditions of the Medicaid Program. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" (otherwise commonly referred to as the Green Book) issued by the Comptroller General of the United States or the "Internal Control Integrated Framework" issued by the Committee of Sponsoring Organization of the Treadway Commission (COSO).

Additionally, the Code (42 C.F.R. § 431.17) requires the Departments to maintain records necessary for the proper and efficient operations of the State's Medicaid Plan.

Further, the Fiscal Control and Internal Auditing Act (FCIAA) (30 ILCS 10/3001) requires HFS and DHS to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that: (1) resources are utilized efficiently, effectively, and in compliance with applicable laws; (2) obligations and costs are in compliance with applicable laws; and (3) funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation and funds applicable to operations are properly recorded and accounted for to permit the preparation

of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

Inadequate controls over the operation of IMPACT, such as insufficient review, approval and monitoring of provider enrollment information, could result in providers being inaccurately determined eligible, the State expending federal and State funds for which providers eligibility have not been adequately demonstrated or documented, and could result in further expenditures to providers who are ineligible. Noncompliance with federal laws and regulations could result in denied claims, sanctions and/or loss of future federal funding, and ultimately inaccurate financial statements or financial information. Further, failure to execute interagency agreements increases the risk that IMPACT functions won't be performed by each party in accordance with their assigned responsibility.

DEPARTMENT OF HUMAN SERVICES' RESPONSE:

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work with the Department of Healthcare and Family Services (HFS) to ensure provider applications are properly reviewed, approved, and documented within IMPACT. An interagency agreement was drafted and submitted for final approval. IDHS will review the findings and follow up on deficiencies identified pertaining to our providers from the IMPACT monthly screenings.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:

The Department of Healthcare and Family Services accepts the recommendation. The interagency agreement is being finalized. Provider enrollment staff works with Department of Human Services (DHS) staff monthly, to conduct quality assurance reviews of provider applications approved during previous month. Any identified errors are communicated to DHS and corrected.

UPDATED RESPONSE:

Implemented.

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work with the Department of Healthcare and Family Services (HFS) to ensure provider applications are properly reviewed, approved, and documented within IMPACT. An interagency agreement was drafted and submitted for final approval. IDHS will review the findings and follow up on deficiencies identified pertaining to our providers from the IMPACT monthly screenings.

Corrective Action Completed:

A. The corrective action plan for this finding relative to the interagency agreement is completed because the interagency agreement between DHS DDD, DRS, and HFS Provider Enrollment and Office of Inspector General was fully executed on 6/10/2022; the agreement details the roles and responsibilities of each division involved.
B. For the sufficiency of review of applications, the Home Services Program is governed in large part by a collective bargaining agreement, which contains a procedure for conducting background screenings through the IMPACT system,

which are conducted as a condition of enrollment. Although full implementation of this process was delayed due to the exigency of COVID-19 response, the process was fully implemented beginning on February 16, 2022. Screening results connected to applications for enrollment are processed in accordance with the process laid out at pages 30-34 at: https://cms.illinois.gov/content/dam/soi/en/web/cms/personnel/employeeresources/documents/emp-seiupast.pdf . Respecting the monthly screenings, as has been the case since IMPACT's inception, when notified of monthly screening results, DRS takes appropriate action per applicable collective bargaining agreement procedures.

Date of Completion: 06/10/2022

10. The auditors recommend the Departments work with the service provider to obtain assurance the internal controls over IMPACT, data, and the infrastructure, including change control and user access, are adequate. Additionally, until the Departments execute an intergovernmental agreement which addresses all user access testing, auditors recommend DHS perform periodic user access reviews of all DHS employees with access to IMPACT.

FINDING: *(Inadequate General Information Technology Controls over IMPACT) – First reported 2018, last reported 2021*

The Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) (collectively, the "Departments") failed to establish and maintain adequate general information technology internal controls (general IT controls) over the operation of the State of Illinois' Illinois Medicaid Program Advanced Technology system (IMPACT).

In calendar year 2012, HFS and the State of Michigan's Department of Community Health entered into an intergovernmental agreement (IGA) for the State of Illinois (State) to utilize Michigan's existing Medicaid Management Information System (MMIS) and its related infrastructure with the goal of replacing the State's MMIS to accommodate the processing of the State's Medicaid provider enrollment determinations and all Medicaid claim payments to such providers. Since 2012, the State has implemented two phases of IMPACT: Electronic Health Record Medicaid Incentive Payment Program (eMIPP) and Provider Enrollment (PE).

An IGA was entered into in 2015 which formally established the Illinois-Michigan Program Alliance for Core Technology. Additionally, the parties agreed to pursue expansion of the Michigan MMIS environment to accommodate the processing of Illinois' Medicaid claims. The IGA required Michigan to extend its current system to utilize cloud architecture that would result in converged infrastructure, maximizing the effectiveness of shared resources, and allowing the shared services to be offered to HFS.

As a result of the Departments not having access to or control over IMPACT and its infrastructure, the auditors requested HFS provide a System and Organization Control (SOC) report which would provide the State and auditors information on the design and effectiveness of internal controls over IMPACT. In response, HFS provided a Security Assessment Report (Report), however, this report did not evaluate the design and implementation of Michigan's internal controls.

Specifically, the Report did not document:

- Timeframe/period in which the Security Assessment Report covered,
- Independent service auditor's report,
- Details of the testing conducted, and
- Details of Michigan's internal controls as they relate to:
  - Control environment,
  - Risk assessment processes,
  - Information and communication,
  - Control activities, and
  - Monitoring activities.

As a result, the auditors were unable to perform adequate procedures to satisfy themselves that certain general IT controls (change management) to IMPACT were operating effectively during the audit period.

Change Management

As a result of the Departments' failure to obtain a SOC report, as noted above, or conduct their own timely, independent internal control review over changes to IMPACT, data, or the infrastructure, the auditors were unable to determine if changes made during the audit period were proper and approved.

User Access Control

The auditors noted HFS included all users, including DHS users, in its annual IMPACT Provider Enrollment Access Review. However, due to no executed interagency agreement between HFS and DHS (see Finding 2021-009), there was no interim user access review completed for DHS.

Change Management

Departments' management indicated they believe the Security Assessment Report adequately assessed the internal controls over IMPACT, data, and infrastructure.

User Access Control

HFS management indicated IMPACT automatically locks accounts after 60 days of non-use. While the auditors do not disagree, the accounts lock after 60 days of inactivity, during the 60 days individuals will continue to have access. Further, the 60-day automatic lock is only for non-use. If the individual continues to utilize their account, it remains active. DHS management indicated they were relying on the user access review process performed by HFS.

This finding was first noted during the Departments' financial audit reports for the year ended June 30, 2018. In subsequent years, the Departments have been unable to fully implement a corrective action plan.

The Code of Federal Regulations (Code) (45 C.F.R §95.621(f)(1)), *ADP System Security Requirement*, requires the Departments to be responsible for the security of all automated data processing (ADP) projects under development, and operational systems involved in the administration of the U.S. Department of Health & Human Services programs. The Departments are required to determine the appropriate security requirements based on recognized industry standards or standards governing security of federal ADP systems and information processing.

The internal control requirements of the *Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards* (Uniform Guidance) within the Code (2 C.F.R. § 200.303) requires the Departments to: (1) establish and maintain effective internal control over the Medicaid Program to provide reasonable assurance the Departments are managing the Medicaid Program in compliance with federal statutes, regulations, and the terms and conditions; and (2) comply with federal statutes, regulations and terms and conditions of the Medicaid Program. These internal controls should be in compliance with guidance in *Standards for Internal Control in the Federal Government* (otherwise commonly referred to as the Green Book) issued by the Comptroller General of the United States or the *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organization of the Treadway Commission (COSO).

Additionally, the Security and Privacy Controls for Information Systems and Organizations (Special Publication 800-53, fifth revision) published by the National Institute of Standards and Technology (NIST), System and Service Acquisition and Configuration Management Sections, sanctions the development, implementation, and monitoring of internal controls over changes, access, and service providers.

Without having obtained and reviewed a SOC report, the Departments do not have assurance the service provider's internal controls over IMPACT, data and the infrastructure are adequate to protect from unauthorized changes and accidental and intentional destruction or alteration. Additionally, without performing periodic user access reviews of DHS users, unauthorized and/or inappropriate access to the IMPACT system could go undetected by the Departments for an extended period of time.

DEPARTMENT OF HUMAN SERVICES' RESPONSE:

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work with HFS and the service provider to ensure controls over IMPACT, data, and the infrastructure are adequate.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:

The Department of Healthcare and Family Services (HFS) accepts the recommendation. A SOC report will be generated and available for the next audit year which will provide HFS with the assurance needed regarding the internal controls over IMPACT.

UPDATED RESPONSE:
Implemented.

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work with HFS and the service provider to ensure controls over IMPACT, data, and the infrastructure are adequate.

Corrective Action Completed:
DHS will work with HFS to establish an annual review of DHS user's IMPACT system access.
(100% Complete) 12/9/2022 - DHS and HFS have completed an intergovernmental agreement for the IMPACT system (2023-128-IGA-FCS). This agreement, which describes roles and responsibilities for both DHS and HFS for IMPACT system / provider access compliance, expires 6/30/2025.

Date of Completion: 06/10/2022

11. The auditors recommend Department management and staff strengthen controls over records maintenance for each area in which a compliance requirement is present. To every extent possible, population records should be sequentially numbered. Further, auditors recommend the Department strengthen its internal controls to ensure it maintains complete and accurate populations.

FINDING: *(Complete Populations Not Provided) – First reported 2017, last reported 2021*

The Department of Human Services (Department) was unable to provide adequate records substantiating the completeness of populations for one or more laws, regulations, or other requirements selected for testing, as of the end of fieldwork. Due to these conditions, auditors concluded the Department's population records were not sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36) to test the Department's compliance with the following:

- While testing surplus property at the Elgin Mental Health Center and the Ludeman Developmental Center, auditors noted the Facility does not maintain a tracking mechanism for its surplus or transferable property. In addition, auditors noted the Elgin Mental Health Center does not include property and equipment purchased with federal grant tags on its property listing. Further, during testing of the Kiley Developmental Center's property and equipment items located in its designated Storage Homes, auditors identified several items that were either not tagged, tags

which were not visible, not inventoried, or deleted. As such, auditors concluded the Kiley Developmental Center does not properly maintain, or record property and equipment items located in its designated Storage Homes. Finally, during the testing of the Illinois Center for Rehabilitation and Education – Wood's property and equipment inventory, auditors noted the Facility failed to update its inventory records as required when performing annual inventory certification with the Department of Central Management Services, it does not maintain equipment listings that are complete and accurate representations of the equipment being held at the Facility or where the equipment is being held, and it does not have appropriate internal controls in place to safeguard against the accumulation of surplus or transferable property. Due to these conditions, auditors could not conclude the Department's State-Operated Facilities' population records were sufficiently precise and detailed to test the Department's property and equipment. Additional information on this matter can be found in Finding 2021-021.

- While testing the Illinois Public Aid Code (305 ILCS 5/12-4.7b), auditors noted the Department was not able to provide adequate records substantiating the population of benefit terminations for incarcerated individuals. Additional information on this matter can be found in Finding 2021-017.
- While testing locally held funds at the Illinois Center for Rehabilitation and Education – Roosevelt, auditors noted the Facility did not maintain a cash receipts journal to log cash received prior to entry into the Facility's general ledger. Further, while testing locally held funds at the Illinois Center for Rehabilitation and Education – Wood, auditors noted the Facility did not maintain an adequate general ledger for the Permanent Trust Fund. In addition, while testing petty cash funds at the Ludeman Developmental Center, auditors noted the Facility did not keep a cash receipts and disbursements journal for its petty cash box. Due to these conditions, auditors could not conclude the Department's State-Operated Facilities' population records were sufficiently precise and detailed to test the Department's locally held funds and petty cash funds. Additional information on these matters can be found in Finding 2021-018.

  While testing the Department's billing and payment of services rendered at its State-Operated Facilities during the examination period, auditors noted multiple inconsistencies between the Department's Program Directive and the performance of daily activities undertaken by the Developmental Disabilities and Mental Health Centers' Recipient Resource Unit staff, the Department's Central Office Revenue Cash Management Unit staff, and the Department's Central Office Collections Unit staff. Further, because the Department's State-Operated Facilities' main accounts receivable tracking system is a patient system, the auditors noted the system can lead to inaccuracies in the amounts due. Due to these conditions, auditors could not conclude the Department's State-Operated Facilities' population records were sufficiently precise and detailed to test the Department's process over the billing and payment for services rendered at the State-Operated Facilities during the examination period. Additional information on this matter can be found in Finding 2021-022.
- During the testing of non-pharmacy related commodities inventory, auditors noted the Department's year-end counts were conducted in early June 2021 due to a

decision made by Department management to perform counts prior to a system conversion from the Department's Central Office Warehouse Control System (WCS) and the Department's State-Operated Facilities' Commodity Control System (CCS) to the inventory module within the Enterprise Resource Planning (ERP) System, which was to become effective on July 1, 2022. Because each of the three State-Operated facilities selected for testing did not perform reconciliations from the time of the inventory count in early June 2021 to an inventory count as of June 30, 2021, auditors were unable to conclude non-pharmaceutical commodities inventory was properly entered into the ERP System, or whether non-pharmacy inventory assets and the Department's corresponding net position were properly recorded in the Department's FY 2021 financial statements. Due to these conditions, auditors could not conclude the Department's State-Operated Facilities' population records were sufficiently precise and detailed to test the Department's non-pharmacy related commodities inventory counts and processing during the examination period. Additional information on this matter can be found in Finding 2021-023.

- While testing compliance with user access to the Payroll Timekeeping System (PTS), auditors requested user listings from the Central office and individual State-Operated facilities in order to determine the accuracy and completeness of the populations. While the Elgin Mental Health Center, Ludeman Developmental Center and Illinois Center for Rehabilitation and Education - Roosevelt provided user listings, auditors were unable to verify the accuracy and completeness of the populations because PTS users were not consistent between the Central office and facility listings. Additional information on this matter can be found in Finding 2021-029.
- While testing compliance with various Mental Health and Developmental Disabilities Administrative Acts and other State laws governing the State-Operated Mental Health and Developmental Disabilities facilities, auditors noted the following:
    - For MH Code (405 ILCS 5/108(a-e)), the Ludeman Developmental Center was not able to provide adequate records substantiating the population of restraints issued during the examination period. Additional information on this matter can be found in Finding 2021-012.
    - For MH Code (405 ILCS 5/108(g-h)), the Ludeman Developmental Center was not able to provide adequate records substantiating the population of employees qualified to order the use of restraints at the Facility during the examination period. Additional information on this matter can be found in Finding 2021-012.
    - For MH Code (405 ILCS 5/2-108(a)) the Kiley Developmental Center did not have a complete and accurate population of restraints administered. Additional information on this matter can be found in Finding 2021-012.
    - For the Mental Health and Developmental Disabilities Administrative Act (MH Administrate Act) (20 ILCS 1705/47), the Kiley Developmental Center, the Ludeman Developmental Center, the Madden Mental Health Center, and the Murray Developmental Center were unable to provide adequate records substantiating the populations of visitor entry logs (for visitors who

visited the facilities' residents) during the examination period. Additional information on this matter can be found in Finding 2021-013.

- For the Statewide Accounting Management System (SAMS) Manual (Procedure 33.13.20), the Ludeman Developmental Center was unable to provide adequate records substantiating the population of interest receipts during the examination period. Additional information on this matter can be found in Finding 2021-018.
- For Mental Health (MH) Code (405 ILCS 5/2-113(b)-(f)), the Murray Developmental Center, the McFarland Mental Health Center, and the Ludeman Developmental Center, were not able to provide adequate records substantiating the population of incoming requests for information. Additionally, the Jack Mabley Developmental Center does not have a policy requiring the maintenance of documentation in residents' files regarding requests for information that have been rejected. Additional information on this matter can be found in Finding 2021-014.

Even given the population limitations noted above which hindered the ability to conclude whether the selected sample was representative of the population as a whole, auditors obtained the population provided by the Department for each of the areas above, selected a sample, and tested for compliance. For the samples tested, noncompliance was reported in the Findings referenced above.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

According to the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36), when using information produced by the entity, the practitioner should evaluate whether the information is sufficiently reliable for the practitioner's purposes, including, as necessary, obtaining evidence about the accuracy and completeness of the information, and evaluating whether the information is sufficiently precise and detailed for the practitioner's purposes.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the essential transactions of the Department to protect both the legal and financial rights of the State and of persons directly affected by the Department's activities.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable law.

Department management indicated that substantiating a complete population for the areas above was difficult based on the nature of the population.

Without the Department providing complete and adequate documentation to enable testing, auditors were impeded in completing the procedures and providing useful and relevant feedback to the General Assembly regarding the Department's compliance for the above areas. Further, the Department is unable to demonstrate it has met each compliance requirement it is subject to when sufficient records are not maintained.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. Each Division will work to strengthen controls to ensure adequate records are maintained and can be provided when requested.

UPDATED RESPONSE:

Partially Implemented.

The Department accepts the recommendation. Each Division will work to strengthen controls to ensure adequate records are maintained and can be provided when requested.

Corrective Action in Progress:

FCS

A. An Enhancement Request (ILIES 277765) has been entered in JIRA to request a standardized report showing all cases processed from the Illinois Department of Corrections/Cook County Corrections Cross Match. (100% Complete)
B. Enhancement Request will be reviewed, prioritized, and worked. (10% Complete)

Estimated Date of Completion: 12/31/2023

DDD

All of the issues noted in 2021-011 are also referenced in other findings and the corrective action plans can be found there for these areas.

DMH

The Department will strengthen controls over records maintenance.
Elgin: Implemented a process to monitor the tracking system for property. (100% complete)
Madden: Developed and implemented a process to track and audit visitor entry logs. Staff has been trained in the requirements and the process. Audits are in place. (100% complete)
McFarland: Implemented tracking tool to track incoming requests on the main phone line, educated staff answering main phone line. (100% complete)

Date of Completion: 06/30/2022

DRS

The Advanced Accountant position was filled as of 8/1/2022. The accountant will continue to ensure documents for the Permanent Trust Fund is completed on time and file for future access going forward. (100% Complete)

The facility timekeeper will ensure adequate record keeping will continue to be maintained at the facility and will be provided when requested. (100% Complete)

Date of Completion: 09/30/2022

Payroll

1) Internal PASC system contains SSN of all users. Periodically place the PASC file against the semi-monthly payroll file and look for individuals who are in PASC but not on payroll file. Individuals not on the payroll file are automatically deleted. (100% Complete)
2) Making direct contact with division timekeepers and provide listing of all users attached to their specific timekeeping group(s) and asking them to verify the validity of the user list. (100% Complete)
3) Timekeepers have been advised to contact central payroll when a timekeeper terminates/moves. (100% Complete)
4) Future plan will consist of direct contact and training of all timekeepers highlighting the importance of keeping central payroll apprised of any changes. Also providing a direct contact where they can go to relay this information as opposed to their individual payroll officer. (25% Complete)

Estimated Date of Completion: 03/31/2023

12. The auditors recommend Department management re-train staff on compliance with statutory requirements regarding the use of restraints. This training should include documentation requirements when restraints are ordered. Auditors also recommend Department management establish a process to monitor that annual training requirements are complied with.

FINDING: *(Noncompliance with Statutory Requirements Regarding the Use of Restraints and Seclusion) – First reported 2011, last reported 2021*

The Department of Human Services (Department) did not comply with statutory requirements regarding the use of restraints.

During fieldwork, auditors performed on-site testing regarding the use of restraints at eight of the Department's State-Operated facilities. As noted in Finding 2021-011, at the Ludeman Developmental Center and the Kiley Developmental Center auditors were unable to obtain a complete population of restraints issued and employees qualified to order the use of restraints on residents during the examination period.

Although auditors were unable to obtain the above complete populations, across all eight facilities auditors sampled and tested a total of 165 employees who administered restraints and 120 residents who were placed in restraints, which resulted in the following exceptions at five Department facilities:

Murray Developmental Center

- For 8 of 8 (100%) residents placed in restraints, the auditor was unable to determine whether the Facility Director was informed of the restraint in writing within 24 hours, as there was no supporting documentation maintained.
- For 2 of 8 (25%) residents placed in restraints, the Facility staff was unable to provide support for prior written authorization given by the Facility Director for the subsequent employment of restraints on a resident within 24 hours of a previously employed restraint as required.
- For 4 of 16 (25%) residents who used sign language as their primary means of communication, the Facility staff did not release the resident from restraints for a brief period each hour.
- For 3 of 38 (8%) employees tested, who were involved in the restraint process, the employee did not take the required training in a timely manner. Trainings were between 236 and 312 days overdue when the restraint was applied.

Chicago-Read Mental Health Center

- For 6 of 8 (75%) residents placed in restraints, the auditor was unable to determine whether the Facility Director was informed of the restraint in writing within 24 hours, as there was no supporting documentation maintained.
- For 2 of 9 (22%) residents placed in restraints, in which a secondary restraint was employed within a 48-hour period, Facility staff did not obtain prior written authorization from the Facility Director.
- For 8 of 8 (100%) residents placed in restraints, Facility staff could not provide documentation to show who applied the restraints. As a result, the auditor could not determine if the applicable employees were trained as required.
- For 1 of 16 (6%) sign language residents placed in restraints selected for testing, the auditor noted the Facility's listing contained inaccurate information. Specifically, the listing had a data entry error when inputting one resident's name.

Kiley Developmental Center

- As noted in finding 2021-011, the population of restraints administered was not complete and accurate. Specifically, the auditor noted within the sample of eight restraint packets, there were thirteen unlisted restraints and one restraint listed using the wrong date.
- For 2 of 8 (25%) residents placed in restraints, Facility staff could not provide support showing that the employee who applied the restraint had a current (non-expired) restraint training certification at the time that the restraint was administered. As such, the auditor was unable to determine if the employee was adequately trained when applying the restraint as required.
- For 3 of 8 (38%) residents placed in restraints, the auditor was unable to determine whether the Facility Director was informed of the restraint in writing within 24 hours,

as there was no supporting documentation maintained by the Facility.

McFarland Mental Health Center

- During testing, auditors noted the Facility did not have procedures in place for the Facility Director to approve, in writing, any seclusions ordered twice within 48 hours for the same resident, prior to administering the second seclusion.
- For 8 of 8 (100%) residents placed in restraints, Facility staff did not state in the resident's file the length of time the restraint was to be employed or the clinical justification for the length of time restraint was to be employed.
- For 3 of 8 (38%) residents placed in restraints, Facility staff did not maintain adequate documentation of the Facility Director, or her/his designee, being notified of the use of the restraint within 24 hours.
- For 2 of 8 (25%) residents placed in restraints, the Facility Director, or her/his designee, was not timely informed of the restraint in writing**.** The Facility Director was informed 48 to 72 hours after the restraint was applied.
- For 3 of 8 (38%) residents placed in restraints, in which a secondary restraint was employed within a 24-hour period, Facility staff did not obtain prior written authorization from the Facility Director.
- For 2 of 8 (25%) residents placed in restraints, the Facility had three employees whose last training completion was not completed within a year of the restraint being ordered.
- For 7 of 8 (88%) residents placed in restraints, Facility staff did not require the instructor to sign the Competency Skills Checklist for 24 associated employees.
- For 3 of 8 (38%) residents placed in restraints, Facility staff did not adequately review the patient's Personal Safety Plan to decide if the plan needed to be updated in accordance with the applicable Department Program Directive.

Ludeman Developmental Center

- As noted in Finding 2021-011, the Facility was unable to provide a complete population of restraints issued and employees qualified to order the use of restraints on residents during the examination period.
- For 2 of 6 (33%) residents placed in restraints, the resident was not examined by a physician or supervisory nurse within two hours after the initial employment of the emergency restraint.
- For 1 of 6 (17%) residents placed in restraints, Facility staff did not state in the resident's file the length of time restraint was to be employed.
- For 6 of 6 (100%) residents placed in restraints, Facility staff did not state in the resident's file the clinical justification for the length of time the restraint was to be employed.
- For 3 of 6 (50%) residents placed in restraints, the Facility Director or her/his designee was not timely informed of the restraint in writing within 24 hours. The notice was received in writing 1 day late for all instances tested.
- For 2 of 6 (33%) residents placed in restraints, Facility staff was unable to provide documentation of 2 employees' most recent training prior to the date of the restraint being applied. As such, the auditor was unable to determine if the employee was adequately trained when applying the restraint as required.

- For 5 of 6 (83%) residents placed in restraints, the Facility had 5 employees whose last training was not completed within a year of the restraint being ordered.
- For 2 of 6 (33%) residents placed in restraints, Facility staff did not require the instructor to sign the Competency Based Task Analysis (CBTA) Sign-off Sheet for 2 employees.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2011. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Mental Health and Developmental Disabilities Code (MH Code) (405 ILCS 5/2-108(a)) requires a written order of a physician, clinical psychologist, clinical social worker, clinical professional counselor, or registered nurse with supervisory responsibilities to employ the use of restraint. Section (405 ILCS 5/2-108(b)) requires in the event of a temporary emergency restraint order, a physician or supervisory nurse shall examine the recipient within two hours after the initial employment of the emergency restraint. Section (405 ILCS 5/2-108(c)) of the MH Code requires the person who ordered the restraint to inform the Facility Director or his designee in writing of the use of the restraint within 24 hours. Section (405 ILCS 5/2-108(d)) of the MH Code requires the Facility Director to review all restraint orders daily and inquire into reasons for the orders for restraint by any person who routinely orders them. Section (405 ILCS 5/2-108(e)) of the MH Code states that restraints may be employed during all or part of one 24-hour period, the period commencing with the initial application of the restraint. However, once a restraint has been employed during one 24-hour period, it shall not be used again on the same resident during the next 48 hours without the prior written authorization of the Facility director. Section (405 ILCS 5/2-108(g)) of the MH Code mandates all employees authorized to employ restraints on patients receive training in the safe and humane application of restraints and is required to maintain records detailing which employees have been trained and are authorized to apply restraint, the date of the training, and the type of restraint that the employee was trained to use. Finally, Section (405 ILCS 5/2-108(h)) of the MH Code mandates restraints imposed upon any recipient whose primary mode of communication is sign language, the recipient shall be permitted to have their hands free from restraint for brief periods each hour, except when freedom may result in physical harm to the recipient or others.

Additionally, the MH Code (405 ILCS 5/2-109(d)) states, once a seclusion has been employed during one 16-hour period, it shall not be used again on the same recipient during the next 48 hours without the prior written authorization of the Facility Director.

According to the Facility Procedural Guide # MD460 Use of Restraints & Seclusion (Containment) in Mental Health Facilities, all staff involved in the use of mechanical restraint and seclusion is to receive training and to demonstrate (ongoing and annual) competence. Only staff who demonstrated competency may implement, monitor, or supervise the use of restraint and seclusion in a Department of Mental Health Facility.

The Department's Mental Health Program Directive 02.02.06.030 requires that during a Physical Hold, Restraint, or Seclusion episode, the registered nurse, physician, and monitoring staff person are to encourage the individual to achieve the release criteria and may offer the individual the opportunity to use self-calming techniques, as appropriate, as identified in his/her Personal Safety Plan. After the Physical Hold, Restraint or Seclusion episode, as soon as clinically appropriate, but by the end of the next shift, the registered nurse will do a debriefing with the individual. The purpose of this debriefing is to review with the individual why previously identified early interventions were not employed or were not successful, if applicable; in order to identify with the individual any modifications or updates to the individual's Personal Safety Plan. Following the debriefing, staff will document modifications or updates to the individual's Personal Safety Plan.

Further, the Department's Mental Health Program Directive (02.03.03.010) requires authorized staff to write an order for restraint on the IL462-0044 RD after personally observing and examining the resident. In addition, the Directive requires the Supplemental Report of the Use of the Restraint and/or Emergency Behavior Intervention Procedures should be completed and reviewed by the authorized person or other individual designated in State Operated Development Centers (SODC) policy.

Additionally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department management indicated the conditions noted were due to a combination of human error, the practice of issuing verbal restraint orders and signing the written order after the restraint is applied, and policies and procedures not being followed.

Failure to have adequate internal controls over the use and application of restraints, and the training of persons administering restraints is noncompliance with the MH Code, could adversely affect the care and treatment of residents, and could subject the State to unnecessary legal risks. Furthermore, failure to re-train personnel within 12-month periods represents noncompliance with the Department's Mental Health Program Directive. Failure to retain complete and accurate records represents noncompliance with the State Records Act.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. The Department will re-train staff on compliance with statutory requirements regarding the use of restraints. This training will include documentation requirements when restraints are ordered. Furthermore, procedures to monitor compliance will be developed.

UPDATED RESPONSE:

Partially Implemented.

The Department accepts the recommendation. The Department will re-train staff on compliance with statutory requirements regarding the use of restraints. This training will include documentation requirements when restraints are ordered. Furthermore, procedures to monitor compliance will be developed.

Corrective Action in Progress:

DDD

A. SODC Operations will ensure corrective action plans at each of these Centers is implemented and includes re-training and compliance monitoring by the Center. (33% Complete)
B. SODC Operations has implemented a monthly monitoring report and is reviewing and testing restraint paperwork quarterly. (100% Complete)

Estimated Date of Completion: 01/31/2023

DMH

The Department will re-train staff on compliance with statutory requirements regarding the use of restraints. The training will include documentation requirements when restraints are ordered. The Department will also establish a process to monitor annual training.

Read and McFarland

The Department will revise the statewide restraint order form and directive to clearly identify notification of and approval by Facility Director. The facilities will train on the new form and Directive and implement the policy.

Read Only

The facility will ensure correct data entry when inputting patient information. The facility will implement a process to document who applies the restraints.

McFarland Only

The facility will implement the restraint order form and ensure timely notification of the Facility director in writing of restraint.

The facility will ensure employees are trained annually including signing off on competency skills checklist. The facility will ensure adequate review of patient's Personal Safety Plan to decide if needed to be updated

Status Update: 12/20/22 - 50% complete

Statewide – The Restraint Order Form was updated May 2022 to better document notification of and authorization by the facility Director. Revisions to the Statewide Program Directive on Restraints were finalized in December 2022. Facilities are currently updating policies, educating staff on the new Directive and Form, and implementing the new order form. An audit tool has been created to monitor implementation.

(50% Complete).

Estimated Date of Completion: 03/31/2023

13. The auditors recommend Department management enforce policies and procedures to ensure compliance with the MH Act regarding visitors to facilities and employees. The policies and procedures should include training personnel on compliance requirements and implement management oversight over compliance requirements. Auditors also recommend each Facility retain visitor entry logs as required. Further, auditors recommend the Department improve controls over building access and monitoring.

FINDING: *(Noncompliance with Statutory Requirements Regarding the Monitoring of Facility Visitors) – First reported 2017, last reported 2021*

The Department of Human Services (Department) did not comply with statutory requirements regarding the monitoring of Facility visitors.

The Mental Health and Developmental Disabilities Administrative Act (MH Act) (20 ILCS 1705/47) requires the Facility's director to develop and implement written policies and procedures to ensure that employees and visitors are properly identified at all times they are on the grounds of the Facility.

Although auditors were unable to obtain a complete population of visitor entry logs issued from four facilities during the examination period (Kiley Developmental Center, Ludeman Developmental Center, Madden Mental Health Center, and Murray Developmental Center), auditors performed on-site testing at nine of the Department's State-Operated facilities regarding monitoring of Facility visitors and employees (see Finding 2021-011). Auditors sampled and tested entry logs across the nine facilities. The testing of logs resulted in the following exceptions at nine of the Department's facilities:

Elgin Mental Health Center

- The Facility's visitor entry log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.

Madden Mental Health Center

- The Facility's visitor entry log appeared to be incomplete. Missing information included the date, time-in, time-out, signature of the individual, and purpose of visit.
- For 2 of 16 (13%) dates tested, Facility staff did not retain a copy of all visitor Pavilion entry logs created during the period. As a result, the auditor could not determine visitors to the Pavilion were adequately authorized.
- For 1 of 16 (6%) dates tested, the visitor was not located on the approved visitor list but was allowed to visit the resident. The Facility was also unable to provide documentation demonstrating the resident was contacted to obtain permission to allow the visitor to visit.
- For 1 of 16 (6%) dates tested, the visitor signed in on the Administration building/Security Desk entry log and appeared on the approved visitor list, but the visitor did not sign in on the Pavilion entry log as required.

- For 1 of 16 (6%) dates tested, the visitor signed in on the Pavilion entry log, but did not sign in on the Administration building/Security Desk entry log as required.

Murray Developmental Center

- The Facility's visitor entry log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- The Facility did not maintain adequate physical safeguards regarding building access and monitoring.
- For 4 of 8 (50%) dates tested, the visitor signed in on the Cottage entry log, but did not sign in on the Administration building/Security Desk entry log as required.
- For 2 of 8 (25%) dates tested, the visitor signed in on the Administration building/Security Desk's entry log but did not sign in on the Cottage entry log as required.

For 1 of 16 (6%) dates tested, Facility staff was unable to provide visitor Pavilion entry logs for testing. As a result, the auditor could not determine visitors to the Pavilion were adequately authorized.

Chicago-Read Mental Health Center

- The Facility's visitor entry log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.

McFarland Mental Health Center

- The Facility's visitor entry log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- The Facility's policies and procedures state that if a visitor is visiting a civil patient, the visitors are to only write the first name of the patient(s) they are visiting to ensure patient confidentiality. The auditor found numerous instances where patients' full names were written in the entry logs.
- For the Facility's monthly employee security verifications examined, 5 of 72 (7%) were found to be incomplete, as there were no indications of whether or not the employee selected for verification was in possession of their assigned keys and properly displaying their identification.

Jack Mabley Developmental Center

- During on-site testing, the auditors were not instructed to sign-in on the Business/Vendor entry log upon entry and exit of the Facility.

Kiley Developmental Center

- The Facility's visitor entry log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- The Facility's visitor policy does not address how the Facility ensures that visitor badges are to be returned.
- The Facility did not maintain adequate physical safeguards regarding building access

and monitoring.

- For 5 of 8 (63%) visitors tested, the visitor signed in on the Administration building/Security Desk entry log, but did not sign in on the House entry log as required.
- For 24 of 32 (75%) dates tested, Facility staff did not retain a copy of all Pavilion entry logs created during the period. As a result, the auditor could not determine visitors to the Pavilion were adequately authorized.

Illinois Center for Rehabilitation and Education – Wood

- The Facility's visitor entry log appeared to be incomplete. Missing information included the date, time-in, time-out, signature of the individual, purpose of visit.

Ludeman Developmental Center

- The Facility's visitor entry log appeared to be incomplete. Missing information included the date, time-in, time-out, organization or address of the individual, purpose, and area of visit.
- The Facility did not retain a copy of all housing unit visitor entry logs created during the examination period. Housing unit entry logs were maintained only for a period of 6 months.
- The Facility did not maintain adequate documentation of visitor entry logs throughout the examination period. Specifically, the Facility was unable to provide the entry logs for 12 of 24 (50%) months requested for Unit 1 Resident Houses, 18 of 24 (75%) months requested for Unit 2 Resident Houses, and 12 of 24 (50%) months requested for Unit 3 Resident Houses.
- During on-site testing, it was noted that two employees did not display proper identification while at the Facility as required.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Department's Records Retention Policy (Policy 95-85 #7), approved by the State Records Commission, requires the retention of all visitor logs for a period of five years.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities. Additionally, the State Records Act (5 ILCS 160/17a) states that regardless of other authorization to the contrary, no record shall be disposed of by the Facility, unless approval of the State Records Commission is first obtained.

The Illinois Administrative Code (59 Ill. Admin. Code 102.10(e)) states only persons on official business, such as employees, authorized visitors, and persons providing required goods and services shall have access to center/program campuses property.

The Madden Mental Health Center's Patient Visitation Policy requires all visitors to check in at the Security Desk and fill out the visitor's log. Afterwards, visitors are required to go directly to the pavilion where the patient resides and sign in on the Pavilion's visitor's log book.

Department management indicated the conditions noted were due to lack of training and resources, human error and failure to follow policy and procedures.
Failure to enforce policies and procedures to ensure compliance with the MH Act governing the identification of all visitors and employees to a Facility could result in unauthorized individuals' access to Facility grounds, posing an increased risk to the safety of the residents and Facility staff. Additionally, failure to provide adequate physical safeguards regarding building access and monitoring could result in unauthorized access to the Facility campus and residents.

DEPARTMENT RESPONSE:
The Department accepts the recommendation. The Department will work to ensure compliance with statutory requirements regarding monitoring of facility visitors and employees. Staff will be trained regarding the requirements when processing visitors signing in at the facilities and procedures will be developed to monitor compliance.

UPDATED RESPONSE:
Partially Implemented.

The Department accepts the Recommendation. The Department will work to ensure compliance with statutory requirements regarding monitoring of facility visitors and employees. Staff will be trained regarding the requirements when processing visitors signing in at the facilities and procedures will be developed to monitor compliance.

Corrective Action in Progress:

DRS
The Staff at the front desk has been informed on the procedures involved when logging in pertinent details of individuals visiting the ICRE-Wood Facility. (100% Complete)

The Department amended the visitor log to include a signature column to ensure accuracy and responsibility. (100% Complete)

The log is reviewed on a weekly basis by the Residential Care Worker Supervisor(s). (100% Complete)

Date of Completion: 11/30/2022

DDD
SODC Operations will ensure corrective action plans at each of these Centers is implemented that includes compliance with SODC Operations Visitor Protocol Guide and

DHS retention guidelines. Re-training and compliance monitoring by each Center as applicable. (75% Complete)

Estimated Date of Completion: 01/31/2023

DMH

The DMH Central Office will enforce policies and procedures to ensure compliance with the MH Act regarding visitors to facilities and employees. Education will be provided to each facility to ensure full understanding of the requirements along with monthly prompts to spot check visitor logs. Training will include management oversight over compliance requirements. Each Facility will retain visitor entry logs as required and improve controls over building access and monitoring.

Elgin, Madden, Read, McFarland

The facility will ensure complete documentation on visitor entry logs. (time in, time out, purpose of visit)

Madden only

The facility will ensure retention of all visitor entry logs as required. The facility will ensure visitor protocols are followed including approval list and signing in and out at entry and on unit.

McFarland Only

The facility will ensure visitor policies and protocols are followed including only writing only first not full name of patients on logs and completing monthly employee security verifications.

Status Update: 12/20/22 - 100% complete

Statewide – Education was provided to facilities regarding requirements involving visitor logs. Visitor logs are currently being audited by Central Office as part of the Senate Bill 472 Audit.

Madden – Madden completed training by 6/30/2022. Training highlighted proper completion of the logs, ensuring that pavilion and security log information matches, and logs will be retained for 5 years per standard. Process for auditing was implemented by 6/30/2022.

Chicago Read - retrained staff on the Program Directive 01.01.02.210 Physical Safeguards – Building Access Controls. Training completed 09/15/2022 Process for auditing is in place.

McFarland – Policy updated for visitors to only put patient's first name. Education provided to security officers, monthly security verifications are being audited by Security Chief. Education was completed and audits implemented by 11/15/22.

Date of Completion: 11/15/2022

14. The auditors recommend Department management review its systems of internal control over compliance to ensure:

1. **The Department's policies and procedures at each facility are up-to-date with current law and communicated to all staff;**

2. **Facility-level and Department-wide training on the Department's policies and procedures for areas with recurrent noncompliance or complexity are performed; and,**

3. **A monitoring process is functioning to timely identify areas of noncompliance with State laws and Department policies at the facilities and implement corrective action.**

FINDING: *(Noncompliance with Statutory Requirements Regarding Residents' Admissions, Discharges, and Requests for Information) – First reported 2017, last reported 2021*

The Department of Human Services (Department) did not comply with statutory requirements regarding residents' admissions, discharges, and requests for information.

Noncompliance with Resident Admission Rules and Regulations, and Requests for Information

The Mental Health and Developmental Disabilities Code (MH Code) (405 ILCS 5/2-113(a)) requires that upon admission, the Facility inquire of the resident if a spouse, family member, friend or an agency is to be notified of their admission. Good internal control requires employees to complete an admission form and maintain a copy of the admission form in the resident's file. The form should be signed by the employee making the inquiry of the resident.

Additionally, the MH Code (405 ILCS 5/2-113(b)-(f)) indicates that any person may request information from a developmental disability or mental health facility relating to whether an adult resident or minor resident admitted pursuant to Section 3-502 has been admitted to the facility. Any parties requesting information must submit proof of identification and list their name, address, phone number, relationship to the resident and reason for the request. The facility shall respond to the inquirer within 2 working days. If the resident is located at the facility, the facility director shall inform the resident of the request and shall advise the resident that disclosure of his presence at the facility will not obligate the resident to have contact with the inquirer. No information shall be disclosed unless the resident consents in writing to the disclosure. If the resident has consented to the release of information the facility shall inform the requesting party that the resident is located at the facility. The facility shall, with the resident's consent, tell the requesting party how to contact the resident. When the resident is not located at the facility or when the resident does not consent in writing to release such information, the facility shall inform the consenting party that no information is available regarding that person. Transactions pursuant to this section shall be noted in the resident's record.

Finally, Section (405 ILCS 5/4-201) of the MH Code indicates that a person with an intellectual disability shall not reside in a Department mental health facility unless the

person is evaluated and is determined to be a person with mental illness and the facility director determines that appropriate treatment and habilitation are available and will be provided to such person on the unit. In all such cases the Department mental health facility director shall certify in writing within 30 days of the completion of the evaluation and every 30 days thereafter, that the person has been appropriately evaluated, that services specified in the treatment and habilitation plan are being provided, that the setting in which services are being provided is appropriate to the person's needs, and that provision of such services fully complies with all applicable federal statutes and regulations concerning the provision of services to persons with a developmental disability. Additionally, any person admitted to a Department mental health facility who is reasonably suspected of having a mild or moderate intellectual disability, including those who also have a mental illness, shall be evaluated by a multidisciplinary team which includes a qualified intellectual disability professional designated by the Department facility director. Section (405 ILCS 5/4-203(b)) of the MH Code requires the Department to ensure that a monthly report is maintained for each Department mental health facility, and each unit of a Department developmental disability facility for dually diagnosed persons, which lists (1) initials of persons admitted to, residing at, or discharged from a Department mental health facility or unit for dually diagnosed persons of Department developmental disability facility during that month with a primary or secondary diagnosis of intellectual disability, (2) the date and facility and unit of admission or continuing, care, (3) the legal admission status, (4) the recipient's diagnosis, (5) the date and facility and unit of transfer or discharge, (6) whether or not there is a public or private guardian, (7) whether the facility director has certified that appropriate treatment and habilitation are available for and being provided to such person, and (8) whether the person or a guardian has requested review, and if so, the outcome of the review.

During fieldwork, auditors performed on-site testing at nine of the Department's State-Operated facilities regarding resident/student admissions. Although auditors were unable to obtain a complete population of individuals requesting information on residents' admissions from three facilities during the examination period (Murray Developmental Center, McFarland Mental Health Center, and Ludeman Developmental Center, see Finding 2021-011), auditors sampled and tested 60 residents/students and 21 requests for information across nine facilities which resulted in the following exceptions at eight of the Department's facilities:

Elgin Mental Health Center

- For 2 of 8 (25%) residents tested, Facility staff did not properly complete the resident's Application for Voluntary Admission form (IL462-2202M).
- For 1 of 11 (9%) residents tested, Facility staff did not maintain monthly certifications that the mental health evaluation was performed in the residents' records.
- For 6 of 8 (75%) residents tested, Facility staff did not document all of the required information from the individual requesting information about a resident. Specifically, the Facility did not document the requestor's address.
- For 7 of 8 (88%) residents tested, Facility staff did not respond to individuals who requested information about a resident.
- For 7 of 8 (88%) residents tested, Facility staff did not maintain documentation of the

request for information in the residents' files.

Madden Mental Health Center

- For dually diagnosed persons, Facility staff did not maintain monthly reports for those persons admitted to, residing at, or discharged from the Facility, as required per statute.
- For 5 of 21 (24%) residents identified by Facility staff as being diagnosed with an intellectual disability, the resident was not evaluated or certified by the Qualified Intellectual Disability Professional (QIDP).
- For 1 of 10 (10%) residents tested, Facility staff did not file the Facility Director's certification with the Office of the Secretary of the Department, as required.
- For 1 of 10 (10%) residents tested, the Facility Director's certification was not completed within 30 days of the evaluation as required.
- For 1 of 10 (10%) residents tested, the Facility Director's certification was not located in the resident's file as required.

Murray Developmental Center

- For 1 of 15 (7%) residents tested, Facility staff did not properly monitor or make changes to the resident's admission status.
- For dually diagnosed persons, Facility staff did not maintain monthly reports for those persons admitted to, residing at, or discharged from the Facility as required per statute.

Kiley Developmental Center

- For dually diagnosed persons, Facility staff did not maintain monthly reports for those persons admitted to, residing at, or discharged from the Facility, as required by statute.

For 1 of 15 (7%) residents tested, Facility staff did not make changes to the resident's admission status.

Ludeman Developmental Center

- For 1 of 4 (25%) residents tested, Facility staff could not provide the admission records for the resident.
- As noted in Finding 2021-011, the Facility disclosed that it has no controls or formal policy in place to document any requests for information were responded to within two working days.

Chicago-Read Mental Health Center

- For 11 of 11 (100%) residents tested, the *Request for Information* form did not include the requestor's address.
- For 1 of 11 (9%) residents tested, Facility staff was unable to locate the *Request for Information* form.

Illinois Center for Rehabilitation and Education - Roosevelt

- For 1 of 5 (20%) students selected for testing, the Student Admission Review Form was not complete, as it was missing the Admission Review Committee's decision to accept the student.

Jack Mabley Developmental Center

- During testing, the Facility indicated there were no external inquiries for information which were rejected during the examination period. However, as noted in Finding 2021-011, the Facility does not have a policy requiring the maintenance of documentation in residents' files regarding requests for information that have been rejected, when applicable.

Noncompliance with Resident Discharge Rules and Regulations

The Mental Health and Developmental Disabilities Code (MH Code) (405 ILCS 5/4-704(a)) requires the Facility Director to give written notice of the discharge to the resident, if he or she is 12 years of age or older, to the attorney and guardian, if any, to the person who executed the application for admission, and to the resident's school district when appropriate, at least 14 days prior to the discharge of a resident from a Department developmental disabilities facility under Section 4-701 or 4-702 of the MH Code. The notice, except that to the school district, should include the reason for the discharge and a statement of the right to object.

Additionally, Section (405 ILCS 5/3-903(a)) of the MH Code requires the Facility Director to give written notice of discharge from a Department mental health facility to the resident, his attorney, and guardian, if any, or in the case of a minor, to his attorney, to the parent, guardian, or person in loco parentis who executed the application for admission, to the resident's school district when appropriate, and to the minor if he is l2 years of age or older. The notice, except that to the school district, should include the reason for discharge and a statement of the right to object. Whenever possible, the notice should be given at least 7 days prior to the date of intended discharge.

During fieldwork, auditors performed on-site testing at eight of the Department's State-Operated facilities regarding discharge rules and regulations. Auditors sampled and tested 61 resident files across the four mental health facilities, and 45 resident files across the four developmental facilities which resulted in the following exceptions at six of the Department's facilities:

Chicago-Read Mental Health Center

- For 2 of 16 (13%) discharged residents tested, the discharge notice did not include the reason for the discharge.
- For 3 of 16 (19%) discharged residents tested, Facility staff did not maintain records of the residents' discharge. As a result, the auditor was unable to test compliance with the MH Code.

McFarland Mental Health Center

- For 1 of 5 (20%) discharged residents tested, the Facility discharged the patient after recommending to the court that the individual is fit to stand trial and should be discharged, but prior to receiving the judge's order to discharge the patient.

Murray Developmental Center

- For 5 of 6 (83%) discharged residents tested, Facility staff did not provide a written notice of discharge to the resident. As a result, the auditor was unable to test

compliance with the MH Code.

- For 5 of 6 (83%) discharged residents tested, Facility staff did not timely provide a written notice of discharge to the residents' guardian, or individual who executed the application for admission. The written notices were submitted between 3 and 15 days late.
- For 3 of 6 (50%) discharged residents tested, the discharge date reported in the Facility's database differed from the resident's actual discharge date on the Notice of Discharge form. The dates in the Facility's database ranged from 6 days prior to and 27 days following the actual discharge date.

Jack Mabley Developmental Center

- For 1 of 9 (11%) discharged residents tested, Facility staff did not provide the written notice of discharge to all applicable parties at least 14 days prior to the discharge. The written notice was submitted 45 days late.

Kiley Developmental Center

- For 6 of 15 (40%) discharged residents tested, Facility staff did not provide the written notice of discharge to all applicable parties at least 14 days prior to the discharge. The written notices were submitted between 12 and 14 days late.
- For 3 of 15 (20%) discharged residents tested, Facility staff was unable to provide support to substantiate a written notice of discharge was prepared and delivered to required individuals. As a result, the auditor was unable to test compliance with MH Code.
- For 3 of 15 (20%) discharged residents tested, Facility staff was unable to provide any supporting documentation related to the resident's discharge. As a result, the auditor was unable to test compliance with MH Code.

Ludeman Developmental Center

- For 10 of 15 (67%) discharged residents tested, Facility staff did not provide the written notice of discharge to all applicable parties at least 14 days prior to the discharge date. The written notices were submitted 3 to 16 days late.
- For 2 of 15 (13%) discharged residents tested, the date the notice of discharge was provided to the resident was not documented. As a result, the auditors were unable to determine whether the resident was provided notice of discharge at least 14 days prior to the discharge.
- For 1 of 15 (7%) discharged residents tested, the date the notice of discharge was provided to the resident's guardian was not documented. As a result, the auditors were unable to determine whether the guardian was provided notice of discharge at least 14 days prior to the discharge.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to

furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department management indicated the underlying cause was due to employee oversight and the need to retrain staff on policy and procedures.

Failure to ensure conformity with statutory requirements regarding each resident's admission to and discharge from Department facilities could adversely impact the care and treatment of each resident, could hinder a resident's interaction with parties external to the facility, may result in intellectually disabled persons not residing in a facility appropriate to their needs, and represents non-compliance with State Law.

DEPARTMENT RESPONSE:
The Department accepts the recommendation. The Department will review internal policies to ensure compliance with current law, to educate staff on department wide policies, and to establish ongoing monitoring processes.

UPDATED RESPONSE:
Partially Implemented.

The Department accepts the recommendation. The Department will review internal policies to ensure compliance with current law, to educate staff on department wide policies, and to establish ongoing monitoring processes.

Corrective Action in Process:

DDD

A. SODC Operations will ensure corrective action plans at each of these Centers is implemented that includes policy review/revision and retraining as applicable to address the noted issues with admissions and discharges. (50% Complete)
B. SODC Operations will develop a monthly reporting form to be implemented at all SODCs to meet statute guidelines related to a monthly report for dually diagnosed individuals. (50% Complete)
C. SODC Operations will ensure each SODC has a policy in place with appropriate staff trained for external inquiries. (50% Complete)

Estimated Date of Completion: 02/15/2023

DMH

Central Office Quality staff will review policies and procedure at the facilities to ensure: 1. policies and procedures at each facility are up-to-date with current law and communicated to all staff; 2. Facility-level and Department-wide training on the Department's policies and procedures for areas with recurrent noncompliance or complexity are performed; 3: a monitoring process is functioning to timely identify areas of noncompliance with State laws and Department policies at the facilities and implement corrective action.

Elgin
The facility will: ensure proper completion of the voluntary application; maintain monthly certifications that the mental health evaluation was preformed; document all required information from individual requesting information about a resident; ensure that staff respond to individuals who requested information about a resident; maintain documentation of the request for information in the resident's file

Madden
For dually diagnosed pts, the facility will: maintain monthly reports for MIID persons admitted to, residing at, or discharged from facility; ensure patients identified as ID, are evaluated or certified by a QIDP; ensure proper filing of the facility directors certification with the Office of the Secretary of the Department; ensure proper completion of the FD certification within 30 days of the evaluation; ensure filing FD certification in the patient resident's file.

Chicago Read
The facility will: ensure the Request for Information form includes the requestor's address; ensure staff is knowledgeable of where to locate the Request for Information form; ensure the discharge notice includes the reason for discharge; ensure staff did not maintain records of the resident's discharge.

McFarland
The facility will ensure that the patients are not discharged by court prior to receiving the judge's order.

Status Update: 12/20/22 - 50% complete
A system was developed to review the processes in place at all facilities. Central office has begun audits during site visits.
Elgin – Retrained staff on specific findings – completion of voluntary applications, ROIs - and have begun audits.
Madden- Revised MIID policies and trained staff. They continue to monitor, however, Madden has been unable to retrain adequate staffing levels in HIM to complete coding in a timely manner. They continue to search to fill medical records positions. They have obtained help from Central Office staff to assist with coding.
Chicago Read- Retrained staff on completion of the external communication logs and has begun audits.
McFarland – Education provided to Health Information Management Department and being reviewed by Administrator.

Estimated Date of Completion: 06/30/2023

DRS
Due to an oversight by the Medical Consultant, the electronic signature on one admissions file was not completed during the COVID pandemic. Addressed and completed in August 2021. (100% Completed)

Date of Completion: 08/30/2021

15. The auditors recommend the Department provide dental services, and physical and mental health examinations to residents as required. Auditors recommend the Department improve internal control over the completion and retention of information pertaining to facility residents such as examination records and medication records. Further, auditors recommend the Department properly maintain dental equipment to ensure that sufficient routine and preventative dental services can be provided to residents.

FINDING: *(Noncompliance with Statutory Requirements Regarding Residents' Dental, Mental, and Physical Examinations) – First reported 2017, last reported 2021*

The Department of Human Services (Department) did not comply with statutory requirements regarding resident's dental, mental, and physical examinations.

The Mental Health and Developmental Disabilities Administrative Act (MH Act) (20 ILCS 1705/7) requires all residents in a department facility be given a dental examination by a licensed dentist or registered dental hygienist at least once every 18 months and be assigned to a dentist for such dental care and treatment as is necessary.

In addition, the MH Act also states that all medications administered to recipients shall be administered only by those persons who are legally qualified to do so by the laws of the State of Illinois and that medication shall not be prescribed until a physical and mental examination of the recipient has been completed.

During fieldwork, auditors performed on-site testing at eight of the Department's State-Operated facilities regarding resident dental, mental and physical examinations, where auditors sampled and tested 57 residents for required dental examinations and 64 residents prescribed medication, across the eight facilities, which resulted in the following exceptions at seven of the facilities:

Madden Mental Health Center

- For 1 of 8 (13%) residents tested who were prescribed medication, the medication was prescribed and administered before a mental examination was completed. Facility staff was unable to provide supporting documentation of a report being submitted from the physician to the Facility Director to substantiate the reasons for prescribing the medication prior to completing the mental examination.
- For 7 of 32 (22%) residents tested who were prescribed medication, the Facility nurse did not initial the designated box on the Medication Administration Record (MAR) form. As such, the auditor was unable to determine which nurse attempted to administer the medication and whether or not they were properly licensed.
- For 4 of 32 (13%) residents tested who were prescribed medication, the Facility nurse who administered the medication did not sign the bottom of the MAR form as required.

Murray Developmental Center

- For 2 of 8 (25%) residents tested who were prescribed medication, the MAR forms

were not retained by the Facility. As such, the auditor was unable to determine the reasonableness of the medication administered.

- For 4 of 8 (50%) residents tested who were prescribed medication, the Facility nurse did not properly complete the MAR. In addition, for 7 out of the total 25 (28%) instances the 4 residents would have received medication, the Facility nurse administering the medication did not initial in the appropriate box at the time of administration. As such, the auditor was unable to determine the reasonableness of the medication administered.
- For 1 of 8 (13%) residents tested who were prescribed medication, Facility staff did not maintain a copy of the physician's order for the medication. As such, the auditor was unable to determine the reasonableness of the medication administered.

Jack Mabley Developmental Center

- For 2 of 8 (25%) residents tested who were prescribed medication, the Facility nurse who administered the medication did not sign the bottom of the MAR form as required.
- For 3 of 8 (38%) residents tested, the residents did not have a dental examination performed at least once every 18 months. The dental examinations were performed 25 to 118 days late.
- For 1 of 8 (13%) residents tested, the resident was not given an initial dental examination within 30 days of admission, or at any time prior to leaving the Facility (159 days, or approximately 5 months, after entering).

Kiley Developmental Center

- For 3 of 8 (38%) residents tested who were prescribed medication, Facility staff could not provide records of a physical or mental examination performed prior to prescribing medication.
- For 5 of 8 (63%) residents tested, the residents did not have a dental examination performed at least once every 18 months. As of June 30, 2021, the corresponding dental examinations were 576 to 758 days overdue.

Ludeman Developmental Center

- Through discussions with Facility personnel, the auditor noted the Facility did not maintain its dental equipment properly at the Facility during the examination period. Specifically, the auditor noted the dental equipment owned by the Facility became unusable and beyond repair prior to and throughout the examination period. In addition, during the examination period, the Facility staff received additional guidance from the federal government and the Department's Central Office of equipment needed to legally conduct dental procedures according to new federal regulations and COVID-19 pandemic rules. Therefore, the Facility had to cease in-house operations of routine dental examinations. At the time of the auditor's visit to the Facility, the Facility did not have a timeline as to when routine dental procedures at the Facility would re-start. Facility staff stated that all needed procedures (i.e., extractions, scaling, etc.) have been conducted on an as-needed-basis through the Facility's contracted oral surgeon, as it had even prior to the COVID-19 pandemic due to the client's need for general anesthesia. On the other

hand, due to a lack of usable, in-house dental equipment, Facility staff stated that routine and preventative dental services have been lacking.

- For 16 of 29 (55%) residents tested who were prescribed medication, the Facility nurse administering the medication did not sign the MAR.
- For 4 of 8 (50%) residents tested, the resident did not have a dental examination performed at least once every 18 months. The dental examinations were performed 21 to 223 days late.

Chicago-Read Mental Health Center

- For 2 of 8 (25%) residents tested, the resident did not have a dental examination performed at least once every 18 months. The dental examinations were performed 290 and 315 days late.

McFarland Mental Health Center

- For 6 of 8 (75%) residents tested, Facility staff was unable to provide supporting documentation to show the residents were provided dental examinations every 18 months. As such, the auditor was unable to determine if the Facility provided the required dental examinations.
- For 1 of 8 (13%) residents tested, the resident did not have a dental examination performed at least once every 18 months. The dental examination was performed 233 days late.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Facilities' Dental Procedures (Policy Number 12-02) state all individuals will be referred for a dental examination within 30 days of admission.

The State Property Control Act (30 ILCS 605/4) requires the Facility to be held accountable for the supervision, controls, and inventory of all property under its jurisdiction. Title 40, *Protection of Environment*, of the Federal Code of Regulations (40 C.F.R § 441.30) requires no later than July 14, 2020, that all dental practices must install and be able to operate and maintain at least one amalgam separator that meet the requirements of the American National Standards Institute (ANSI) American National Standard/American Dental Association (ADA) Specification 108 for Amalgam Separators. The Department's guidance dated May 21, 2020, requires initial dental procedures in the dental clinic will only involve those of low or lower risk for aerosol production and all dental clinic rooms as of the date of release only had adequate protections for low or lower risk procedures. Due to the condition of the clients housed at the Facility, all procedures are considered high risk for aerosol production.

Additionally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department

designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department management indicated the instances of noncompliance were attributable to human error and the need to retrain staff on policy and procedure. For dental examination not performed, the Department indicated the conditions noted were due to the COVID-19 pandemic complications and employee oversight.

Failure to provide residents timely dental, mental, or physical examinations could adversely affect the care and treatment of the resident as well as impact the operations of the facilities. Further, it represents noncompliance with State law. Failure to retain documentation supporting resident care impedes the ability to monitor the provision of necessary care to residents. Failure to properly maintain dental equipment can result in the Facility being unable to properly provide services to residents as required under the Act.

DEPARTMENT RESPONSE:
The Department accepts the recommendation. Compliance monitoring will be implemented to ensure Medication Administration Records are completed accurately and dental examinations meet statutory requirements.

UPDATED RESPONSE:
Partially Implemented.

The Department accepts the recommendation. Compliance monitoring will be implemented to ensure Medication Administration Records are completed accurately and dental examinations meet statutory requirements.

Corrective Action in Progress:

DDD
SODC Operations will ensure corrective action plans at each of these Centers is implemented and includes re-training and compliance monitoring by the Center. (30% Complete)

Estimated Date of Completion: 01/31/2023

DMH
Madden: retrain physicians proper dating and timing of the comprehensive psychiatric evaluation to show that an evaluation was completed prior to the prescribing of medication. Retrain Nursing Staff on completion of the MAR.
Read: Retrain staff on requirement to provide dental exams once every 18 months. Audit to ensure compliance.
McFarland: Educate staff on requirement to provide dental services and proper documentation.

Status Update: 12/20/22 – (50% complete)

Madden –Retrained physicians on timing of and proper documentation of completion of comprehensive psychiatric evaluations prior to ordering medications. Retrained nurses on completion of the MAR.
Chicago-Read – Retrained staff on 18-month requirement of Dental Exam but have had difficulty retaining a Dentist on staff to complete routine exams. Emergencies are sent out.
McFarland – Staff educated on requirement and need to document status. Difficulty securing dental services in the community.

Estimated Date of Completion: 12/31/2023

16. The auditors recommend the Department develop written policies and procedures for on-site prenatal care for residents who are not verbal or who otherwise cannot communicate with a provider of care because of a severe disability. Auditors also recommend the Department obtain and retain documentation of approval received for administering pregnancy tests to residents, prior to conducting the tests. The auditors also recommend the Department retain a record of all residents' menstrual cycles and pregnancy tests administered, as required. Further, auditors recommend the Department establish comprehensive Department-wide internal controls over compliance with the MH Act regarding pregnancy testing and residents' menstrual cycles, which should include training personnel on compliance requirements and outline management oversight over compliance requirements.

FINDING: *(Noncompliance with Statutory Requirements Regarding Pregnancy Policies, Administering Pregnancy Tests and Recording Residents' Menstrual Cycles) – First Reported 2017, last reported 2021*

The Department of Human Services (Department) did not comply with statutory requirements regarding policies for prenatal care of non-verbal residents, administering pregnancy tests, and recording resident's menstrual cycles.

The Mental Health and Developmental Disabilities Administrative Act (MH Act) (20 ILCS 1705/10.1) requires every woman of child-bearing age who is admitted to a facility under the jurisdiction of the Department, with her consent or the consent of her guardian, be tested for pregnancy upon admission and thereafter as indicated. Additionally, it requires for a resident who is admitted to and remains in a facility for more than 60 days, a record of each such resident's menstrual cycles to be maintained. In addition, the MH Act requires that on-site prenatal care shall be provided to recipients who are not verbal or who otherwise cannot communicate with a provider of care because of a severe disability, in which case the Facility administrator shall also seek the consent of the recipient's legal guardian for special care for the recipient or shall arrange for a temporary or limited guardianship of the person for the purpose of obtaining consent to diagnosis and treatment of the recipient.

During fieldwork, auditors performed on-site testing at eight of the Department's State-Operated facilities. Auditors sampled and tested 60 residents across the eight facilities, which resulted in the following exceptions regarding resident records at three of the Department's facilities:

Murray Developmental Center

- For 5 of 8 (63%) residents tested, Facility staff were unable to provide documentation that a pregnancy test was administered upon admission.
- For 1 of 8 (13%) residents tested, a pregnancy test was administered before the guardian signed a consent form. The form was signed 18 days after the pregnancy test was administered.
- For 3 of 8 (38%) residents tested, a pregnancy test was not administered on the date of admission. The tests were administered 2 to 16 days after admission.
- For 2 of 8 (25%) residents tested, Facility staff did not maintain monthly menstrual records (Form IL462-0034).
- For 2 of 8 (25%) residents tested, Facility staff did not obtain the proper pregnancy testing consent form.

McFarland Mental Health Center

- For 6 of 15 (40%) residents tested, the consent for pregnancy testing forms were not properly completed.
- For 2 of 15 (14%) residents tested, the pregnancy tests were consented to but were not performed.
- For 1 of 15 (7%) residents tested, Facility staff was unable to provide all of the resident's monthly menstrual records.

Ludeman Developmental Center

For 1 of 1 (100%) resident tested, Facility staff was unable to provide any of the resident's monthly menstrual records.

Additionally, during fieldwork, auditors noted 4 of 8 (50%) Facilities' policies and procedures do not address on-site prenatal care to residents who are not verbal or who otherwise cannot communicate with a provider of care because of severe disability. These Facilities include: Elgin Mental Health Center, Ludeman Developmental Center, Jack Mabley Developmental Center, and McFarland Mental Health Center.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department management indicated the conditions noted were due to human error. Department management also indicated there are informal policies and procedures over prenatal care for residents who are non-verbal but no written policies.

Failure to have formally developed policies and procedures can result in the improper treatment of residents who are not verbal or who otherwise cannot communicate when they are pregnant and under the care of the Department. Failure to obtain or retain a signed consent form prior to administering a pregnancy test to a resident could result in a resident receiving unauthorized medical care and/or subject the State to unnecessary legal risks. Failure to perform or retain a record of a resident's pregnancy testing and menstrual cycle could adversely affect the care and treatment of the resident as well as impact the operations of the facilities. Further, it represents noncompliance with State law.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. Generally, the Division of Mental Health does not offer on-site prenatal care to patients as such care is generally provided by external providers outside the facility. However, the Department will review and revise current policies to include written procedures for on-site prenatal care for instances when pregnant patients may briefly reside and receive on-site prenatal care for that brief time at IDHS facilities, including for residents who are nonverbal or who otherwise cannot communicate with a provider of care because of a severe disability. Furthermore, the Department will obtain and retain documentation of approval received for administering pregnancy tests to residents, prior to conducting the tests. In addition, the Department will retain a record of all residents' menstrual cycles and pregnancy tests administered, as required. Finally, the Department will establish comprehensive Department-wide internal controls regarding pregnancy testing and residents' menstrual cycles, including training personnel and management oversight to ensure compliance with the Mental Health Act.

UPDATED RESPONSE:

In Progress

The Department accepts the recommendation. Generally, the Division of Mental Health does not offer on-site prenatal care to patients as such care is generally provided by external providers outside the facility. However, the Department will review and revise current policies to include written procedures for on-site prenatal care for instances when pregnant patients may briefly reside and receive on-site prenatal care for that brief time at IDHS facilities, including for residents who are nonverbal or who otherwise cannot communicate with a provider of care because of a severe disability. Furthermore, the Department will obtain and retain documentation of approval received for administering pregnancy tests to residents, prior to conducting the tests. In addition, the Department will retain a record of all residents' menstrual cycles and pregnancy tests administered, as required. Finally, the Department will establish comprehensive Department-wide internal controls regarding pregnancy testing and residents' menstrual cycles, including

training personnel and management oversight to ensure compliance with the Mental Health Act.

Corrective Action in Progress:

DDD
SODC Operations will ensure corrective action plans at Murray and Ludeman Centers is implemented that includes retraining and compliance monitoring to address these issues. (33% Complete)

Estimated Date of Completion: 03/31/2023

DMH
McFarland will implement a new pregnancy consent form and retrain staff. Will conduct audits to ensure pregnancy tests are ordered and menses are tracked per policy.

Status Update: 12/20/22 – (75% complete)

McFarland – Implemented new pregnancy consent form and educated staff. Audit showed errors. Re-Educated staff and will audit again in January 2023.

Estimated Date of Completion: 01/31/2023

17. The auditors recommend Department management execute all interagency agreements as required by law. In addition, auditors recommend all parties to the interagency agreements sign the agreement prior to the effective dates. Further, they recommend Department management enter into interagency agreements with the IDOC and the sheriffs' offices of each Illinois County which do not have signed agreements.

FINDING: *(Inadequate Execution and Monitoring of Interagency Agreements) – First reported 2015, last reported 2021*

The Department of Human Services (Department) failed to adequately execute and monitor interagency agreements.

During the examination period, auditors noted the following:

- For 4 of 22 (18%) interagency agreements tested, the interagency agreements were not signed before the effective date. These agreements were signed between 10 and 238 days after the effective date.

  Good internal controls require the approval of agreements prior to the effective date. The Statewide Accounting Management System (SAMS) Manual (Procedure 15.20.30) indicates a contract is reduced to writing when the contract is signed by

the vendor and then by more than one authorized agency representative at the earliest dated signature.

Department management indicated the interagency agreements took some time to get reviewed and signed due to revisions and updates.

- The Department's Secretary did not execute their signature on the interagency agreement pertaining to preventative services to youth and young adults by January 22, 2020, as required. The Department's Secretary executed their signature on the interagency agreement on March 16, 2020, which is 54 days after the required execution date.

  The Children and Family Services Act (20 ILCS 505/43(a)), requires that in order to intercept and divert youth in care from experiencing homelessness, incarceration, unemployment, and other similar outcomes, within 180 days after July 26, 2019, the Department of Children and Family Services, the Department of Human Services, the Department of Healthcare and Family Services, the Illinois State Board of Education, the Department of Juvenile Justice, the Department of Corrections, the Illinois Urban Development Authority, and the Department of Public Health Shall enter into an interagency agreement for the purpose of providing preventive services to youth in care and young adults who are aging out of or have recently aged out of custody or guardianship of the Department of Children and Family Services.

  Department management indicated the final draft of the interagency agreement was completed after January 22, 2020. The additional time it took to finalize the review and obtain all required signatures was attributable to competing priorities of Department staff.

- During testing of the Illinois Public Aid Code (305 ILCS 5/12-4.7b), auditors noted the following:
  - For 73 of 102 (72%) counties in the State of Illinois, the Department had not established a data sharing interagency agreement with the respective sheriff offices.

    Department management indicated they sent out a limited number of data sharing agreements while they worked to create the technical process by which sheriff offices could submit their data.

  - The Department does not have data sharing interagency agreements with the Illinois Department of Corrections (IDOC) to formally allow the use of data provided by those entities.

    Department management indicated the data exchange with the IDOC has been in place for many years; however, the Department could not confirm

whether an interagency agreement was executed prior to the original implementation of the match.

- The data provided by the Department to be used by the auditors for the testing of benefit termination for incarcerated individuals was based on current Integrated Eligibility System data as of the date of testing (which was after June 30, 2021). Therefore, subsequent changes to the data (changes made to the data after June 30, 2021) are incorporated into the population that was provided for testing. As a result, the population provided as of the date of the request may not properly represent the population for the period under examination. Specifically, due to this limitation, auditors were unable to determine if there were additional individuals which should have been included in the population provided by the Department and subjected to the testing (see Finding 2021-011).

  Department management indicated an automated report within IES does not currently exist for the data requested, so the data extraction had to be manually performed at the time of the request.

The Illinois Public Aid Code (Code) (305 ILCS 5/12-4.7b) requires the Department to enter into intergovernmental agreements to conduct monthly exchanges of information with the Illinois Department of Corrections, the Cook County Department of Corrections, and the office of the sheriff of every other county to determine whether any individual included in an assistance unit receiving public aid under any Article of this Code is an inmate in a facility operated by the Illinois Department of Corrections, the Cook County Department of Corrections, or a county sheriff.

- During the performance of testing the Rehabilitation of Persons with Disabilities Act (20 ILCS 2405/3(f)), auditors noted the following:
  - The Department did not have an executed interagency agreement with the Department on Aging and the Department of Healthcare and Family Services regarding intake procedures and eligibility criteria for persons who may need long term care.
  - The Department could not document that it sufficiently monitored service providers who performed prescreening for Home Services Program eligibility on the Department's behalf, in order to determine if the services are being performed in accordance with Department policy.

The Rehabilitation of Persons with Disabilities Act (20 ILCS 2405/3(f)) requires the Department to execute, relative to nursing home prescreening, written inter-agency agreements with the Department on Aging and the Department of Healthcare and Family Services, to affect the intake procedures and eligibility criteria for those persons who may need long term care. On and after July 1, 1996, all nursing home prescreening for individuals 18 through 59 years of age shall be conducted by the Department, or a designee of the Department

Department management indicated an interagency agreement has been drafted and was provided to the other parties for review and approval; however, due to competing priorities the interagency agreement was unable to be finalized by all parties during the examination period. Since the interagency agreement was not executed, the Department has not performed the monitoring as drafted in the interagency agreement.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2015. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Department enters into multiple agreements with other State agencies and other units of government. The purpose of the agreements is to assist the Department in fulfilling its mandated mission. In order to assess whether the agreement is reasonable, appropriate, and sufficiently documents the responsibilities of the appropriate parties, the agreement needs to be approved prior to the effective date. Additionally, failure to execute final agreements that are mandated by law is noncompliance with the applicable law and noncompliance could negatively impact those affected by the law.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. The Department will work to ensure all future interagency agreements are signed prior to the effective date and any required statutory deadlines. To ensure compliance with requirements of the Illinois Public Aid Code (305 ILCS 5/12-4.7b), the IDHS Division of Family & Community Services continues to work with the Department of Innovation and Technology in the development of a reporting process for each sheriff's office. IDHS has sent data sharing agreements to all county sheriff offices. Sixty-two have signed agreements and clarifications were received noting two counties do not house inmates. The Department will continue to work with the Illinois Department of Corrections to create a new data sharing agreement covering the existing match process.

UPDATED RESPONSE:

In Process

The Department accepts the recommendation. The Department will work to ensure all future interagency agreements are signed prior to the effective date and any required statutory deadlines. To ensure compliance with requirements of the Illinois Public Aid Code (305 ILCS 5/12-4.7b), the IDHS Division of Family & Community Services continues to work with the Department of Innovation and Technology in the development of a reporting process for each sheriff's office. IDHS has sent data sharing agreements to all county sheriff offices. Sixty-two have signed agreements and clarifications were received noting two counties do not house inmates. The Department will continue to work with the Illinois Department of Corrections to create a new data sharing agreement covering the existing match process.

Corrective Action in Progress:

FCS

- FCS continues to work with DoIT in creating a reporting process that will work for all county sheriffs. A basic process has been developed and continues to be piloted and refined. (75% Complete)
    - 12/13/22 Update: IDHS DoIT was able to complete a successful run of data from those county sheriff's offices utilizing the electronic process. A meeting is being scheduled with statewide processing to discuss distribution of the report for the sheriff's matches. 75% complete, estimated date of completion 06/2023

- Data Sharing Agreements have been sent to all county sheriff offices. (Sixty-two sheriff offices have signed agreements and two have indicated they do not house inmates) (100% Complete - 08/2022)

- Follow up calls will be made to those sheriff offices that have not responded in returning data sharing agreements. (50% Complete)
    - 12/13/22 Update: Follow up calls have been made to all county offices and files have been updated to reflect current contact information. (100% complete - 10/2022)

- A meeting will be scheduled with IDOC, DoIT and DHS to review requirements of creating a data sharing agreement. (100% Complete – 08/2022)

- After draft IGA is completed, it will be routed for appropriate signatures. (5% Complete)
    - 12/13/22 Update: An MOU was drafted and sent to IDHS legal for input and review. Meeting scheduled to review with legal. 5% complete, estimated date of completion 06/2023

Estimated Date of Completion: 06/30/2023

DRS

The Interagency Agreement concerning prescreens was executed by DHS, DOA, and HFS in May of 2022. For future IGAs, DRS will include language saying the agreement is effective on a certain date or upon execution by all parties, whichever is later. (100% Complete)

18. The auditors recommend Department management and staff comply with current laws, regulations, and policies and procedures regarding locally held funds, petty cash, and postage. Auditors also recommend management segregate duties over the receipt, recording, and deposit of cash at the Illinois Center for Rehabilitation and Education - Roosevelt and the Kiley Developmental Center.

FINDING: *(Inadequate Administration of Locally Held Funds, Petty Cash, and Postage) – First reported 2009, last reported 2021*

The Department of Human Services (Department) inadequately administered locally held funds (bank accounts), petty cash, and postage during the examination period. Exceptions were noted regarding the administration, accounting, reconciliation, reporting, receipt, and disbursement of these funds.

During fieldwork, auditors tested quarterly reporting of receipts and disbursements of locally held funds at five of the Department's State-Operated facilities. The auditors sampled and tested a total of 120 Other Special Trust Fund (Fund 1139) transactions, 141 Resident's Trust Fund (Fund 1143) transactions, 120 Rehabilitation Fund (Fund 1144) transactions, 48 Special Revenue Trust Fund (Fund 1149) transactions, 28 Permanent Fund (Fund 1150) transactions, and 106 Burr Bequest Fund (Fund 1272) transactions. Auditors also performed on-site testing of the Department's petty cash funds and postage meters at five of the Department's State-Operated facilities. The auditors selected 75 petty cash transactions and tested the postage meter balances for the years-ended FY 2020 and FY 2021 across the five facilities. Based on the locally held fund, petty cash, and postage procedures, auditors noted the following exceptions at five of the Department's facilities:

Elgin Mental Health Center

Locally Held Funds

- During testing of the locally held funds' receipts and disbursements, auditors noted the following:
    - For 1 of 15 (7%) Rehabilitation Fund (Fund 1144) disbursements tested, totaling $86, the disbursement did not agree to the supporting documentation provided as the purchase was made in British pound currency and was not properly converted to U.S. dollars, resulting in an underpayment of $3.
    - For 1 of 15 (7%) Rehabilitation Fund (Fund 1144) disbursement tested, totaling $101, the disbursement did not agree to the Facility's general ledger.
- For 2 of 16 (13%) receipts and disbursements tested, amounts reported on the Report of Receipts and Disbursements (C-17) during the second quarter of FY 2021 for the Other Special Trust Fund (Fund 1139) did not agree to the Facility's general ledger. Total receipts for the quarter were reported on the C-17 as $2,645, while the Facility's general ledger reported it as $7,083, resulting in a variance of ($4,438). Total disbursements for the quarter were reported on the C-17 as $2,089, while the Facility's general ledger reported it as $17,731, resulting in a variance of ($15,642).

Illinois Center for Rehabilitation and Education - Roosevelt

Locally Held Funds

- The Facility had insufficient segregation of duties over cash receipts process for either of the locally held funds (Special Revenue Trust Fund (Fund 1149) and Permanent Fund (Fund 1150)) utilized at the Facility during the examination period.

One office employee has custody, authorization, and recordkeeping responsibilities.

- As noted in Finding 2021-011, the Facility did not maintain a cash receipts journal to log cash receipts received prior to entry into the Facility's general ledger software for either of the locally held funds utilized at the Facility during the examination period. Further, the Facility did not implement adequate compensating and/or mitigating controls to provide reasonable assurance that the Facility can appropriately account for all receipts from the beginning of the receipts process to the end of the receipts process without a cash receipts journal.
- During testing of Special Revenue Trust Fund (Fund 1149) quarterly C-17s, auditors noted the following:
    - For 3 of 8 (38%) C-17's tested, the Facility's receipts recorded in its general ledger did not reconcile to the C-17's. Variances ranged from $73 to $950.
    - For 3 of 8 (38%) C-17's tested, the Facility's disbursements recorded in its general ledger did not reconcile to the C-17's. Variances ranged from $270 to $1,051.

Petty Cash

- The Facility's General Revenue petty cash fund's turnover rates on its Petty Cash and Fund Usage Report (Form C-18) submitted in Calendar Years 2020 and 2021, were .486 and 0.0, respectively. Even with the reductions to petty cash after Calendar Year 2020 from $500 to $150, the Facility still did not have sufficient transactions to maintain proper turnover levels.
- During testing of Facility's petty cash fund receipts and disbursements, auditors noted the following:
    - For 4 of 4 (100%) disbursements tested, totaling $76, notation of payment was not made on the face of the petty cash voucher or the vendor's invoice after payment.
    - For 2 of 3 (67%) reimbursement vouchers tested, totaling $345, signatures on the reimbursement vouchers did not include one additional authorizing signature other than the Facilities' petty cash fund custodian.
    - For 3 of 3 (100%) reimbursement vouchers tested, totaling $376, documentation that reimbursements were verified by an employee other than the Facility's petty cash fund custodian was not present.

<u>Kiley Developmental Center</u>

Locally Held Funds

- The Facility had insufficient segregation of duties over its cash receipt processing for all of the locally held funds (Other Special Trust Fund (Fund 1139), Resident's Trust Fund (Fund 1143), Rehabilitation Fund (Fund 1144)) utilized at the Facility during the examination period.
- During testing of bank reconciliations, auditors noted the following:
    - Cash reported in the June 30, 2021, Other Special Trust Fund (1139) general ledger did not reconcile to the corresponding bank reconciliation.

As a result, the general ledger was understated compared to the bank reconciliation by $428 as of June 30, 2021.
    - Cash reported in the June 30, 2021, Rehabilitation Fund (1144) general ledger did not reconcile to the corresponding bank reconciliation. As a result, the general ledger was understated compared to the bank reconciliation by $944 as of June 30, 2021.
    - Cash reported in the June 30, 2021, Resident's Trust Fund (1143) general ledger did not reconcile to the corresponding bank reconciliation. As a result, the general ledger was understated compared to the bank reconciliation by $483 as of June 30, 2021.
- For 4 of 8 (50%) Other Special Trust Fund (1139) C-17's tested, the C-17 did not reconcile to the corresponding bank reconciliation. As a result, the C-17's was overstated compared to the general ledger by $5 in FY 2020 and understated by $12,429 in FY 2021.
- For 1 of 8 (13%) Rehabilitation Fund (1144) C-17's tested, the C-17 did not reconcile to the corresponding bank reconciliation. As a result, the C-17 was understated compared to the bank reconciliation by $944.
- For 1 of 8 (13%) Resident's Trust Fund (1143) C-17's tested, the C-17 did not reconcile to the corresponding bank reconciliation. As a result, the C-17 was understated compared to the bank reconciliation by $483.
- For 1 of 8 (13%) Other Special Trust Fund (1139) C-17's tested, disbursements did not reconcile to the disbursements journal. As a result, the C-17 was overstated compared to the disbursements journal by $12,000.

Petty Cash

- There was insufficient segregation of duties over preparing the Facility's General Revenue Petty Cash Internal Control Certification (C-86) which was prepared and signed by the Facility's petty cash fund custodian.

Illinois Center for Rehabilitation and Education – Wood

Locally Held Funds

- During testing of Special Revenue Trust Fund (Fund 1149), auditors noted the following:
    - The Facility did not perform bank reconciliations during the examination period for Fund 1149.
    - For 1 of 9 (11%) disbursements tested, totaling $100, the supporting documentation could not be located. As a result, the auditor was unable to determine whether the disbursement was properly approved and recorded in the Facility's general ledger or whether the disbursement met the purpose of Fund 1149.
    - While reviewing the FY 2021 2nd Quarter C-17, the auditor noted a comment indicating the beginning of year balance was overstated by $550 as a result of missing petty cash. In addition, upon review of documentation to close out the petty cash box, the auditor noted the Facility was only authorized by the Office of Comptroller to maintain a petty cash box in the amount of $100. As a result, it does not appear the Facility was maintaining a petty cash box in the amount authorized by the Office of Comptroller. Further, the auditor noted

the Facility recorded the $550 in missing petty cash as a commodities expense on the FY 2021 2nd through 4th Quarter C-17's for Fund 1149. This should have been recorded as "other" expense rather than a commodities expense.
    - For 1 of 8 (13%) C-17's tested, the disbursements recorded in the Facility's general ledger did not reconcile to the FY 2021 4th Quarter C-17 for Fund 1149. A variance of $552 was noted, with $550 of the variance being due to the missing petty cash noted above.
    - For 1 of 8 (13%) C-17's tested, the receipts recorded in the Facility's general ledger did not reconcile to the FY 2021 4th Quarter C-17 for Fund 1149. The amount of the variance was $1.15.
    - With the exception of months in which partial refunds of bank maintenance fees were received, the Facility lost money in the bank account associated with Fund 1149 each month. Even in months with no activity other than the monthly interest and monthly maintenance fees, the maintenance fees are higher than the interest earned, resulting in a net loss each month to the cash balance of Fund 1149.
- The Facility did not monitor or review the investments the Facility made with the money held within the Permanent Trust Fund (1150).
- As noted in Finding 2021-011, the Facility is not maintaining an adequate general ledger for the Permanent Trust Fund; as a result, the Facility is unable to adequately perform bank reconciliations.

<u>Ludeman Developmental Center</u>

Locally Held Funds

- As noted in Finding 2021-011, the general ledger provided by the Facility as a population of interest receipts recorded during the examination period, did not prove to be an accurate representation of all interest received by the Resident's Trust Fund (Fund 1143) during the examination period. Multiple issues were identified by the auditor during the testing of interest receipts, including inconsistencies with the use of batch processing of the interest receipts recorded in the general ledger and items appearing to have been recorded twice.
- During testing of the Other Special Trust Fund (Fund 1139) quarterly C-17s, auditors noted the following:
    - For 7 of 8 (88%) C-17's tested, the receipts recorded in the Facility's general ledger did not reconcile to the C-17's. Variances range from ($1,930) to $94.
    - For 8 of 8 (100%) C-17's tested, the disbursements recorded in the Facility's general ledger do not reconcile to the C-17's. Variances range from ($1,893) to $599.
    - For 2 of 2 (100%) C-17's tested, the ending balance per the reconciliation did not agree with the ending balance per the bank statements. For the two quarters tested, both balances per the bank statement was $499 less than the balance reported in the C-17's.
- During testing of the Resident's Trust Fund (Fund 1143) quarterly C-17s, auditors

noted the following:

- For 2 of 2 (100%) C-17's tested, the ending balance per the reconciliation did not agree with the ending balance per the bank statements by a difference of ($77,324) and $170,097 for FY 2020 and FY 2021, respectively.
- For 8 of 8 (100%) C-17's tested, disbursements recorded in the Facility's general ledger did not reconcile to the C-17's. Variances range from ($12,920) to $6,507.
- For 8 of 8 (100%) C-17's tested, receipts recorded in the Facility's general ledger did not reconcile to the C-17's. Variances range from ($234,188) to $50.

- During testing of the Other Special Trust Fund's (Fund 1139) receipts and disbursements, auditors noted the following:
  - For 1 of 20 (5%) disbursements tested, totaling $521, Facility staff was unable to provide adequate supporting documentation to substantiate whether the disbursement was properly recorded. Specifically, the documentation did not include support to verify whether the amount paid and recorded for payroll was accurate.
  - For 1 of 20 (5%) disbursements tested, totaling $690, the amount recorded in the Facility's general ledger and bank statement did not agree with supporting documentation for the expense, by an amount of $2.
- During testing of the Resident's Trust Fund's (Fund 1143) receipts and disbursements, auditors noted the following:
  - For 2 of 14 (14%) interest receipts tested, totaling $336, the amount recorded in the Facility's general ledger and bank statement did not agree with supporting documentation for the receipt by a difference of $148.
  - For 9 of 14 (64%) interest receipts tested, totaling $1,549, Facility staff did not record the interest in the Facility's general ledger timely. The interest receipts were recorded between 5 and 120 days after the 30-day reasonable timeframe as determined by the auditors.
  - For 1 of 9 (11%) interest receipts tested, the interest amount was recorded twice, overstating receipts by $171.

- During testing of the Resident's Trust Fund (Fund 1143) bank reconciliations, auditors noted the following:
  - The Facility's June 30, 2021, bank reconciliation for Fund 1143 showed no adjusted difference; however, the auditor found that after they recalculated the reconciliation there was a difference of $3,501.
  - As noted in the previous examination, the Facility uses a bank account for Fund 1143, which charges bank fees. Utilizing a bank account which charges fees is a breach of the Facility's fiduciary duty in overseeing residents' money. Bank fees reduce the bank balance, which reduces the interest earned on the account, and interest each resident is earning.
  - For 4 of 9 (44%) outstanding checks tested for the Fund 1143's in its June 30, 2021, bank reconciliation, totaling $4,333, the checks had been

outstanding for longer than 60 days at the time of the reconciliation. Checks were outstanding between 16 and 96 days beyond the 60-day maximum.

- For 4 of 4 (100%) deposits tested, totaling $8,097 for Fund 1143's June 30, 2021, bank reconciliation, the deposits were not timely added to the Facility's general ledger. The deposits were recorded in the Facility's general ledger between 61 and 859 days past the initial deposit date.
- For 2 of 5 (40%) service charges tested, totaling $12,313 for Fund 1143's June 30, 2021, bank reconciliation, the service charges were not timely submitted to the Department of Human Services' Central Office for payment within 30 days of being received by the Facility. These charges were 45 and 347 days late as of June 30, 2021.

Petty Cash

- Two of 29 (7%) disbursements tested from the Facility's General Revenue petty cash fund were issued out of sequence.
- The Facility's petty cash fund turnover rates on its Petty Cash Fund Usage Report (Form C-18) for Calendar Years 2019 and 2020 were under six, and the Facility did not initiate a reduction, as required.
- The Change of Custodianship form (Form C-85) was not completed by the Facility's previous petty cash fund custodian.
- For 7 of 15 (47%) disbursements tested, totaling $284, notations of payment were not made on the face of the petty cash vouchers or the vendor's invoices.
- For 2 of 12 (17%) reimbursements tested, the reimbursement vouchers do not have adequate support for $102 of their associated disbursements. Copies of the vendor invoices or the petty cash disbursement forms were not attached to the reimbursement voucher (Form C-13).
- For 12 of 12 (100%) reimbursements tested, totaling $1,682, Facility staff was unable to provide support for the reimbursement warrants having been verified with petty cash fund vouchers by the Facility's petty cash fund custodian and another employee.
- Signatures for 3 of 12 (25%) reimbursement vouchers, totaling $442, did not include the Facility's petty cash fund custodian as the receiving officer.
- The Facility issued an inappropriate $60 disbursement to an employee for the reimbursement of costs to renew a commercial driver's license. This license did not appear to have any connection to the employee's job description. The Facility was also unable to provide documentation that this inappropriate use of funds was approved by the Office of Comptroller.
- Three consecutively numbered checks were issued to the same employee to purchase similarly described items for the same residential house totaling $278. This appears to be an instance of stringing disbursements to purchase items in excess of $100.00.
- Three of 17 (18%) deposit amounts in the Facility's petty cash fund checking account registers do not agree with the amounts on the vouchers for which the deposits are attributed. The total variance between the voucher amount and recorded amount is ($84).
- As noted in Finding 2021-011, the Facility does not keep a cash receipts and

disbursements journal for its petty cash box. As a result, the auditor was unable to reconcile and determine the accuracy of the cash box.

- In the prior year examination (2018/2019), the auditors found the Facility's petty cash fund balance had been increased to $1,000.00; however, the Facility could not provide support authorizing/approving the increase from the Office of Comptroller or from the Department's Central Office. In the current examination, the auditor noted the Facility continued to operate the petty cash fund at the higher, unapproved level from July 1, 2019, to January 20, 2021. As a result, the Form C-18 filed by the Facility in January 2020 inaccurately reported the dollar level of the Fund as $1,000.00. Facility management told the auditor in the current examination that the error was identified by the Department's Central Office, and the fund balance was subsequently decreased back to the approved balance of $600, and Facility management further told the auditor the additional $400 was returned to the Department's Central Office. However, the Facility was unable to support the return of the $400 to the Department's Central Office.
- A disbursement appeared on the Facility's petty cash fund FY 2020 checking account register twice; once on August 19, 2019, and again on October 31, 2019. Comparison to the bank statement indicated the October 2019 check was actually a subsequent disbursement, recorded inaccurately. Also, the checking account register never included the subsequent disbursement. This demonstrates a lack of internal control over the recording of transactions in the checking account register and during the Facility's reconciliation process.
- On May 6, 2021, the checking account register of the Facility's petty cash fund had a negative balance of ($58). This demonstrates a lack of internal control over the use of the checking account.
- A warrant for $88, issued by the Office of Comptroller for a reimbursement voucher, was not deposited.

Postage

- The postage meter was not monitored to prevent unauthorized use during the examination period, and the auditor did not identify any compensating or mitigating internal controls which would prevent unauthorized use.
- The Facility did not have adequate controls over the amounts available in the postage meter during the examination period. Specifically, the auditor noted there was no communication between the Business Office and the switchboard operators regarding when and how much funds are available to upload to the meter. Employees bring the Facility mail to the switchboard office to run through the postage meter by the switchboard operator on duty at the time. Because no password is required and the door to the office is kept unlocked, occasionally, staff will enter the office and run the mail through the meter on their own, without supervision of the switchboard operators. Once mail is posted, the mail is placed in a mail container, which the postal service will pick up.
- The Facility failed to maintain all of its postage meter reports. Due to this condition, the auditor was unable to determine the reasonableness of postage usage for FY 2020 and FY 2021.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2009. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

The Department of Human Services' Program Directive (02.08.01.010) states that the Facility's Business Administrator is responsible for ensuring that adequate accounting controls exist over all locally held funds. This includes responsibility for: a) establishing and maintaining adequate and effective controls over cash; c) posting transactions onto the Locally Held Fund System (general ledger) timely and accurately to the proper accounts; d) reconciling bank accounts for locally held funds; f) ensuring that disbursements are properly authorized; h) providing Central Office with all information necessary to meet the Department's reporting requirements for locally held funds.

The Statewide Accounting Management System (SAMS) Manual (Procedure 33.13.20) requires the Facility to submit accurate C-17s reflecting the receipts and disbursements occurring in each locally held fund, each quarter.

The Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/22) requires the Facility to keep an itemized account of all receipts and expenditures of funds.

The SAMS Manual (Procedure 09.10.40) requires the petty cash fund to turn over approximately six times annually to ensure the proper dollar level of the fund. Additionally, the SAMS Manual (Procedure 09.10.40) requires the Facility to reduce dollar level of the fund if the C-18 report shows insufficient activity to support the present dollar level of the fund.

The SAMS Manual (Procedure 09.10.40) further requires notation of payment to be made on the face of the internal petty cash vouchers (or attached there-to) or vendor's invoices or statements after payment by the custodian to the individual. It also requires someone other than the custodian to examine the petty cash vouchers and approve reimbursement to the petty cash Fund. Additionally, it requires a Petty Cash Internal Control Certification (Form C-86) to be submitted to the Office of Comptroller for all petty cash funds over $100 on a biennial basis. The certification must be prepared by someone other than the custodian.

Lastly, the SAMS Manual (Procedure 09.10.40) requires both the former and successor custodian to complete a single Form C-85, showing the exact status of the fund at the date of change in custodians, and that copies should be provided to each signer. Furthermore, the DHS Administrative Directive (01.09.01.020) is consistent with this requirement stating the Form C-85 must be signed by the departing and the newly

designated petty cash fund custodians and each signer shall be entitled to retain one copy.

According to the Public Funds Deposit Act (30 ILCS 225/1), where public funds are defined in the Public Funds Investment Act (30 ILCS 235/1) as current operating funds, special funds, interest and sinking funds, and funds of any kind or character belonging to or in the custody of any public agency, any custodian of public funds may deposit such funds in a savings and loan association, savings bank, or State or national bank in this State, or deposit those funds into demand deposit accounts in accordance with Section 6.5 of the Public Funds Investment Act. Further, when such deposits become collected funds and are not needed for immediate disbursement, they shall be invested within 2 working days at prevailing rates or better.

The Illinois Procurement Code (30 ILCS 500/50-55) requires the facility to inventory or stock no more than a 12-month need of equipment, supplies, commodities, articles, and other items, except as otherwise authorized by the facility's regulations

Lastly, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable law; that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation; and revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

Department management indicated the errors noted were due to employee error and oversight.

It is important to properly administer locally held funds as they are not subject to appropriations, are often in a fiduciary capacity, and are held outside the State Treasury. In addition, failure to adequately administer locally held funds could lead to fraud, theft, or overdraft charges. Inadequate administration of petty cash, locally held funds, and postage meters represents noncompliance with State statutes. Inadequate controls over the locally held and petty cash funds results in noncompliance with the Department's Program Directive, SAMS Manual, and other requirements and could result in errors or irregularities not being detected in the normal course of business.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. The Department will work to strengthen controls over the administration of locally held funds, petty cash, and postage. The Department will re-train staff on proper procedures, ensure segregation of duties where feasible, and implement a process to monitor compliance.

UPDATED RESPONSE:

In Process.

The Department accepts the recommendation. The Department will work to strengthen controls over the administration of locally held funds, petty cash, and postage. The Department will re-train staff on proper procedures, ensure segregation of duties where feasible, and implement a process to monitor compliance.

Corrective Action in Progress:

DDD

A. SODC Operations will ensure corrective action plans at each of these Centers is implemented and includes re-training and compliance monitoring by the Center. (10% Complete)
B. SODC Operations will do periodic checks of bank reconciliations and C-17s for Kiley and Ludeman to ensure balances reconcile. (50% Complete)

Estimated Date of Completion: 03/01/2023

DRS

Effective 8/1/2022, the new Advanced accountant will perform bank reconciliations, maintain general ledgers for the two Locally Held Funds (Amusement and Bequest Funds). The Business Administrator will train the new accountant on proper procedures, ensure proper segregation of duties whenever possible as soon as the vacant position of Account Technician I is filled. The Business Administrator will implement a process to monitor. (50% Complete. waiting for the accountant position to be filled by BRS)

ICRE-Wood no longer maintains Petty Cash at the Facility. (100% Complete – Closed 8/27/2019)

The Facility no longer maintain investment accounts at the local bank for the LHF. Both accounts were changed to regular checking accounts; with no substantial bank fees associated with the accounts. (100% Complete)

Estimated Date of Completion: 06/30/2023

DMH

DMH will require oversight by the Business Administrator to ensure that disbursements from locally held funds match the supporting documentation and the Facility's General Ledger. Mandatory training will be done at all DMH facilities to certify this oversight is in place.

DMH Operations will randomly review facility C-17s to ensure that the total receipts and disbursements for the quarter match the C-17 as reported. This will confirm balances reconcile.

Estimated Date of Completion: 01/31/2023

19. The auditors recommend Department management and staff comply with current processes and procedures regarding employee performance evaluations and properly calculate employee fringe benefits. Further, they recommend Department management provide additional training to supervisors pertaining to its Directive and the Act and hold staff accountable for maintaining appropriate time records and I-9s.

FINDING: *(Inadequate Controls over Personal Services) – First reported 2017, last reported 2021*

The Department of Human Services (Department) did not maintain all necessary and required supporting documentation in employee payroll and personnel files. Also, the Department failed to timely administer employee performance evaluations and inaccurately calculated fringe benefits of employees. Finally, the Department did not maintain time records in compliance with the State Officials and Employees Ethics Act and the Department's Administrative Directive.

Employee File Testing

During testing of employee payroll and personnel files at the Department's Central Office, auditors noted the following:

- For 2 of 60 (3%) employees tested, attendance reports were not signed by the employee's supervisor.
- For 2 of 60 (3%) personnel files tested, a completed employment application form was missing from the employee's personnel folder and could not be located by the Department.
- For 9 of 60 (15%) personnel files tested, the U.S. Citizenship and Immigration Services (USCIS) 1-9 Employment Eligibility Verification Forms (I-9) were missing from the employee's personnel folder and could not be located by the Department.
- For 24 of 60 (40%) personnel files tested, performance evaluations were not completed in a timely manner. In total 77 possible employee evaluations were examined for the 60 employees selected for testing; some employees were not required to have an evaluation due to their status as a new hire, or due to their termination during the period. For FY 2020, 16 of 45 (36%) employee evaluations tested were not completed timely, ranging from 8 to 604 days late. For FY 2021, 12 of 32 (38%) employee evaluations tested were not completed timely, ranging from 10 to 266 days late.

The Department's Administrative Directive (01.02.02.170) requires timekeepers to be responsible for keeping the time and attendance of all staff in the assigned area. Each timekeeper is to complete the Daily Staff Attendance Report (IL444-4141) for every calendar day (including weekends and holidays), or is to ensure that another timekeeper completes it. Supervisors, or the supervisor's designee, are responsible for approving the IL444-4141.

USCIS instructions for I-9s require Section 1 to be completed no later than the first day of employment. After completing Section 1, the employee is to sign their name and document the date signed. Additionally, Section 1 of the I-9 Form requires the employee to indicate whether a preparer, translator, or other individual provided assistance in completing the I-9. The employer is to complete and sign Section 2 of the I-9 within 3 days of the employees' first day of employment.

In addition, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Further, personnel rules issued by the Department of Central Management Services (80 Ill. Admin. Code 302.270) require an evaluation of employee performance be prepared by the Department not less often than annually. Annual evaluations support administrative personnel decisions by documenting regular performance measures.

During testing of fringe benefits for employees with personally assigned vehicles, auditors noted the following exceptions:

- For 4 of 10 (40%) employees tested, the employees' Quarterly Report of Commuting form reported personal use of an assigned vehicle indicating a larger benefit than the amount deducted on the employees' paychecks, totaling $792.
- For 1 of 10 (10%) employees tested, the employee's Quarterly Report of Commuting form could not be provided for 2 of the 8 quarters tested.

The Department's Administrative Directive (01.05.05.070) states that employees operating a personally assigned, State-owned vehicle are required to report each quarter the number of days the State vehicle was used for commuting purposes and are to be charged a fringe benefit in the amount of $3.00 per day of use. Good internal controls require the amounts calculated be accurate. The Quarterly Report of Commuting form is the Department's mechanism for the employee's quarterly reporting.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Further, good internal controls require amounts calculated when issuing paychecks to be accurate.

Employee Time Records Testing

During fieldwork, auditors performed on-site testing over employee timesheet records at five of the Department's State-Operated facilities. The testing resulted in the following

exceptions at all five facilities:

Elgin Mental Health Center

- While testing Monthly Attendance Records (MARs), they noted the following:
  - For 5 of 60 (8%) MARs tested, the MARs were not signed and dated by the timekeeper within 10 working days of the employee's receipt of the MAR.
  - For 1 of 60 (2%) MARs tested, the MAR was signed by the timekeeper before the employee's receipt and review of the MAR.
  - For 4 of 60 (7%) MARs tested, the MARs were signed and dated by the timekeeper before the supervisor's approval.
  - For 1 of 60 (2%) MARs tested, the MAR was not properly dated by the employee.
  - For 1 of 60 (2%) MARs tested, the MAR did not contain any of the required signatures and/or dates from the employee, supervisor, and/or timekeeper.
- While testing Staff Request for Time Off (IL444-4140), they noted the following:
  - For 34 of 121 (28%) days tested, the employee did not properly complete the IL444-4140 as the type and amount of time did not agree to the employee's respective MAR, or the form was missing the employee's social security number.
  - For 11 of 15 (73%) employees tested, the IL444-4140s, IDHS Work Away Records (IL444-4604s), and/or Daily Staff Attendance Reports (IL444-4141s) could not be provided.
  - For 4 of 15 (27%) employees tested, the Facility allowed employees to use leave time for their regular shift and then work another shift at an overtime rate on the same day. Auditors noted 6 instances in which this occurred during the months tested.

Kiley Developmental Center

- While testing Monthly Attendance Records (MARs) they noted the following:
  - For 6 of 60 (10%) MARs tested, the MAR was not signed by the employee.
  - For 4 of 60 (7%) MARs tested, the employees did not sign the MAR timely. The MARs were signed between 5 and 53 days late.
  - For 1 of 60 (2%) MARs tested, a date was not included with the signature.
  - For 8 of 60 (13%) MARs tested, the MAR did not contain signatures of the supervisor and/or the timekeeper.
  - For 3 of 60 (5%) MARs tested, the MAR contained a stamped version of the approval from the supervisor and/or timekeeper.
  - For 5 of 60 (8%) MARs tested, the MAR was not signed by the timekeeper within 10 working days of receipt. The signatures were between 5 and 31 days late.
  - For 3 of 60 (5%) MARs tested, Facility staff was unable to provide the corresponding Staff Request for Time Off forms (IL444-4140), the Daily Staff Attendance Reports (IL444-4141), and the IDHS Daily Attendance Sheets (IL444-4605).
- While testing Daily Staff Attendance Reports (IL444-4141), they noted the following:

  - 59 of 249 (24%) IL444-4141s tested were not approved by the supervisor and/or the timekeeper.
  - 35 of 249 (14%) IL444-4141s tested contained a stamped version of the timekeeper's approval.
  - For 6 of 249 (2%) IL444-4141s tested, the leave time reported did not match the leave time reported on the employee's MAR.
  - For 1 of 249 (1%) IL444-4141s tested, the amount of leave time reported was incorrect.
  - For 1 of 249 (1%) IL444-4141s tested, the leave time reported was for another employee.
- While testing Staff Requests for Time Off (IL444-4140), they noted the following:
  - 8 of 249 (3%) IL444-4140s tested contained a stamped version of the supervisor's approval.
  - For 2 of 249 (1%) IL444-4140s tested, Facility staff was unable to provide the completed form.
- While testing IDHS Attendance Sheets (IL444-4605), they noted the following:
  - For 3 of 249 (1%) IL444-4605s tested, the employees were not paid for overtime worked.
  - For 1 of 249 (.4%) IL444-4605s tested, Facility staff was unable to provide the Attendance Sheet.

Illinois Center for Rehabilitation and Education - Roosevelt

- Through multiple inquiries with Facility staff, it was noted the Facility is currently suffering from severe understaffing, which has led to a substantial work backlog. Specifically, the Facility staff and the auditors noted a shortage of staff in the following areas: the business office and the education, transportation, residential, social services, and nursing departments.
- While testing Monthly Attendance Records (MARS) they noted the following:
  - The Facility maintains official timekeeping information by month and pay-code instead of within an employee's official timekeeping file as required.
- While testing Staff Request for Time Off (IL444-4140) they noted the following:
  - For 2 of 56 (4%) dates tested, the Work Away Records (IL444-4604) did not agree to the applicable Daily Staff Attendance Reports (IL444-4141).
  - For 1 of 56 (2%) dates tested, the IL444-4140 did not trace to the IL444-4141.
  - For 5 of 56 (9%) dates tested, the IL444-4141 was not properly completed.
  - For 1 of 56 (2%) dates tested, the MAR did not trace to the IL444-4141.

Illinois Center for Rehabilitation and Education – Wood

- Through multiple inquiries with Facility staff, it was noted the Facility is currently suffering from severe understaffing which has led to a substantial work backlog. More specifically, the staff and the auditors noted a shortage of staff in the following areas: IT, social workers, receptionist, accounting, nurses and teachers.

- While testing Monthly Attendance Record (MARs), they noted the following:
  - For 2 of 23 (9%) MARs tested, the MAR could not be located within the employee's personnel file.
  - For 4 of 23 (17%) MARs tested, the MARs were signed and completed between 5 and 35 days past the 10-day requirement.
  - For 4 of 23 (17%) MARs tested, the MARs did not include the date(s) reviewed by the employee, supervisor and/or timekeeper and/or all required signatures.
  - The Facility does not maintain an official timekeeping file for each employee.
- While testing Staff Request for Time Off (IL444-4140), they noted the following:
  - For 1 of 8 (13%) employees tested, Facility staff was able to provide documentation to support the employees leave of absence noted on IL444-4140.
  - For 10 of 66 (15%) dates tested, Facility staff could not provide the respective employee's IL444-4140.
  - For 2 of 66 (3%) dates tested, the IL444-4140s were not properly completed or approved.
  - For 4 of 66 (6%) dates tested, the IL444-4140s were approved 11 to 49 days after leave was taken. As such, the auditor was unable to determine if the supervisor verified the employee had available benefit time prior to the time taken.
  - For 5 of 66 (8%) dates tested, the IL444-4140s did not trace to the corresponding Daily Staff Attendance Records (IL444-4141).
  - For 11 of 66 (17%) dates tested, Facility staff could not provide the IL444-4140s corresponding IL444-4141.
  - For 32 of 66 (48%) dates tested, the IL444-4140s were not properly completed.
  - For 3 of 66 (5%) dates tested, the MARs did not agree to the IL444-4140s.
  - For 3 of 66 (5%) dates tested, the Work Away Record (IL444-4604) did not agree to the corresponding IL444-4141.
  - For 6 of 66 (9%) dates tested, the IL444-4604s were not properly completed.

<u>Ludeman Developmental Disabilities Center</u>

- Through multiple inquiries with Facility staff, it was noted the Facility is currently suffering from severe understaffing, which has led to a substantial work backlog. More specifically, the staff and the auditors noted a shortage of staff in the following areas: IT, social workers, receptionist, accounting, nurses and teachers.
- Through discussion with Facility staff, it was determined that payroll vouchers, specifically base pay, were inconsistent pay period to pay period. The auditor requested information to recalculate selected vouchers; however, the information provided was not sufficient to perform the recalculation. Nonetheless, the support provided was enough to conclude that the base pay on the payroll vouchers was inconsistent pay period to pay period without reasonable explanation.

- While testing Monthly Attendance Record (MARs), auditors noted the following:
  - For 7 of 53 (13%) months tested, Facility staff could not provide the MAR that should be located within an employee's personnel file.
  - For 13 of 46 (28%) months tested where the MAR could be provided, the MARs did not contain all required signatures from the employee, supervisor, and/or timekeeper.
  - For 3 of 46 (7%) months tested where the MAR could be provided, the MARs were not signed and completed within 10 working days of employee receipt.
  - For 1 of 46 (2%) months tested where the MAR could be provided, the MAR did not include the date reviewed by the timekeeper. As a result, the auditor was unable to verify whether the MAR was completely reviewed within 10 working days.
  - The Facility maintains each employee's timekeeping documents at multiple locations, including each timekeeper's office, the Facility's file room, and the Unit House in which the employee is assigned, instead of within one official timekeeping file, as required.
- While testing Staff Request for Time Off (IL444-4140), they noted the following:
  - For 97 of 348 (28%) dates tested, Facility staff was unable to provide the IL444-4140s.
  - For 7 of 348 (2%) dates tested, Facility staff was unable to provide the corresponding Daily Staff Attendance Report (IL444-4141).
  - For 172 of 348 (49%) dates tested, Facility staff was unable to provide both the IL444-4140s and IL444-4141s.
  - For 13 of 348 (4%) dates tested, the IL444-4140s did not agree to the corresponding IL444-4141s.
  - For 157 of 348 (45%) dates tested, the corresponding IL444-4141s were not properly completed. Specifically, the IL444-4141s did not contain information such as the entered by dates, who prepared the forms, initials of all required shift supervisors, were not signed by the house supervisors, etc.
  - For 39 of 348 (11%) dates tested, the MARs did not trace to the corresponding IL444-4141s.
  - For all employees tested with leave of absence time noted, Facility staff was unable to provide additional support required to approve leave time associated with a leave of absence.
  - For 20 of 348 (6%) dates tested, the IL444-4140s were not properly completed or approved.
  - For 1 of 348 (0.3%) dates tested, the IL444-4140 was approved 34 days after leave was taken. As such, the auditor was unable to determine if the supervisor verified the employee had available benefit time prior to the time taken.
  - For 2 of 348 (1%) dates tested, Facility staff allowed employees to use leave time (i.e., sick, vacation, personal, and accumulated holiday time) for their regular shifts and then work another shift paying overtime on the same day.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The State Officials and Employees Ethics Act (Act) (5 ILCS 430/5-5(c)) requires the Department's personnel policies to require its employees to periodically submit time sheets documenting the time spent each day on official State business to the nearest quarter hour. The Act further requires timesheets to be maintained by the fiscal office for at least two years.

Additionally, the Department's Administrative Directive (Directive) (01.02.02.170) requires employees to be responsible for completing the DHS Attendance Sheet (IL444-4605) on a daily basis, in ink, documenting the time of their arrival and departure from their designated headquarters on the days they are present. Supervisors are responsible for appointing a timekeeper to keep accurate and timely attendance records for each employee within the assigned area. After the employee has documented their time on the IL444-4605, the timekeepers are then responsible for keeping the time and attendance of all staff in their assigned area. To do so, each timekeeper is to complete the Daily Staff Attendance Report (IL444-4141) for every calendar day (including weekends and holidays) or ensure that another timekeeper completes it. The Directive goes on to state that employees are responsible for submitting the Staff Request for Time Off form (IL444-4140) to request time off. If working away, the Directive further states a supervisor may choose to utilize the Work Away Record (IL444-4604) as one method for tracking "work away" status which must be attached to the IL444-4141. "Work Away" is defined in the Directive as time spent on official state business away from the employee's designated business address. Then, each month, the employee will receive a Monthly Attendance Record report (MAR) for their review. Employees are to promptly review the MAR and determine whether it accurately reflects time spent on official state business and authorized leave. The MAR is then maintained in the employee's official timekeeping file. Timekeepers, employees, and immediate supervisors, or the immediate supervisor's designee, are responsible for ensuring all timesheets, time-off requests, and work away requests are properly completed, approved, and reviewed. Additionally, supervisors are responsible for ensuring that time and attendance records are retained for a 3-year period on-site and 2 years archived off-site for a total of 5 years.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the facility designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the facility's activities.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable law; and funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation.

Department personnel stated the errors identified above were due to employee error.

Annual performance evaluations are important to ensure all employees understand the duties and responsibilities assigned to them and that they are adequately performing the duties for which they are being compensated. Without performance evaluations there is no documented basis for promotion, demotion, discharge, layoff, recall, or reinstatement and current employment status. Further, failure to maintain complete I-9s is a violation of USCIS requirements and could expose the Department to penalties. Failure to properly calculate fringe benefits subject the State to unnecessary legal risks for underpayments and inaccurate expenditures for potential overpayments. Finally, by not maintaining appropriate time records, the Department is not in compliance with the Act and its Directive which could result in improper payments to employees and inaccurate accrual of benefit time.

DEPARTMENT RESPONSE:
The Department accepts the recommendation. IDHS will develop tools and training to address the retention requirements and timeliness to ensure adherence to various rules, regulations, and compliance requirements. IDHS will develop a plan that will incorporate a quality assurance review process.

UPDATED RESPONSE:
Partially Implemented.

The Department accepts the recommendation. IDHS will develop tools and training to address the retention requirements and timeliness to ensure adherence to various rules, regulations, and compliance requirements. IDHS will develop a plan that will incorporate a quality assurance review process.

Corrective Action in Progress:

DDD
SODC Operations will ensure corrective action plans at each of these Centers is implemented and includes re-training and compliance monitoring by the Center. (50% Complete)

Estimated Date of Completion: 01/31/2023

DRS
Mandatory all staff training to review Personnel Policy and Procedures to address MARS, 4140's, and 4141's was held August 16-18, 2022. (100% Complete)

Date of Completion: 08/18/2022

DMH
DMH will ensure that all staff are re-trained in the policies and procedures relating to MARS, 4140s, 4141s, and 4604s. A periodic check of these documents will occur by DMH Operations to confirm policies and procedures are being followed appropriately.

Date of Completion: 01/31/2023

20. The auditors recommend the Department retrain staff who are directly involved with executing and monitoring contractual agreements to ensure compliance with State law and internal policies. Auditors also recommend the Department file emergency purchases with the Auditor General within 10 days after the procurement.

FINDING: *(Inadequate Controls over Contractual Agreements and Emergency Purchases) – New*

The Department of Human Services (Department) did not maintain adequate internal control over contractual agreements and emergency purchases.

Emergency Purchases

During testing of emergency purchases, auditors noted the following:

- For 1 of 17 (6%) emergency purchased tested, the Department did not file the emergency purchase with the Auditor General within 10 days after the procurement. Specially, they noted the emergency purchase was not filed.

The Illinois Procurement Code (30 ILCS 500/20-30(c)) requires the Department's chief procurement officer making a procurement to file statements with the Procurement Policy Board, the Commission on Equity and Inclusion, and the Auditor General within 10 calendar days after the procurement setting forth the amount expended, the name of the contractor involved, and the conditions and circumstances requiring the emergency procurement.

Department management indicated it was not filed due to the volume of emergency purchases and insufficient staff resources at the height of the COVD-19 pandemic.

Contractual Agreements

During testing of contractual agreements, auditors noted the following:

- For 2 of 60 (3%) contracts tested, the Contract Obligation Document was inaccurately completed. For the two contracts, the wrong award code was used.

The Statewide Accounting Management Systems (SAMS) Manual (Procedure 15.10.50) requires the Contract Obligation Document (C-23) to contain data elements which include the award code. In addition, good business practices require the Contract Obligation Document to contain accurate information in all fields.

Department management indicated the errors noted above were due to human error.

- For 3 of 32 (9%) new contracts tested, contracts were filed with the Office of Comptroller between 3 and 43 days late.

The SAMS Manual (Procedure 15.10.40) requires the Department to file with the Office of Comptroller a copy of a contract, purchase order, grant, lease, cancellation or modification thereto within 30 days of execution. For filing purposes, "execution" occurs when all required elements of an agreement have been written and formally approved (in writing) by all parties as required by law for filing with the Office of Comptroller.

Department management indicated the errors noted above were due to human error.

Construction Contracts

During testing of construction contracts, auditors noted the following:

- For 1 of 2 (50%) construction contracts, totaling over $50,000, the Department was not able to provide documentation support that a surety bond was received from the vendors.

The Public Construction Bond Act (30 ILCS 550/1) states all officials, boards, commissions, or agents of this State, or of any political subdivision thereof, in making contracts for public work of any kind costing over $50,000 to be performed for the State, or of any political subdivision thereof, shall require every contractor for the work to furnish, supply and deliver a bond to the State, or to the political subdivision thereof entering into the contract, as the case may be, with good and sufficient sureties. The surety on the bond shall be a company that is licensed by the Department of Insurance authorizing it to execute surety bonds and the company shall have a financial strength rating of at least A- as rated by A.M. Best Company, Inc., Moody's Investors Service, Standard & Poor's Corporation, or a similar rating agency. The amount of the bond shall be fixed by the officials, boards, commissions, commissioners or agents, and the bond, among other conditions, shall be conditioned for the completion of the contract, for the payment of material, apparatus, fixtures, and machinery used in the work and for all labor performed in the work, whether by subcontractor or otherwise.

Department management indicated this was due to oversight.

Failure to timely file emergency purchases with the Auditor General is noncompliance with State law and could impact decisions made by State officials. Additionally, failure to accurately complete Contract Obligation Documents could result in misleading information in the Department's and the Office of Comptroller's records. Failure to file contracts in a timely manner is noncompliance with the SAMS Manual. Failure to maintain adequate documentation for construction contracts inhibits the Department's ability to determine if contractors performed as required under contract terms. Finally, failure to require the contractor to furnish, supply, and deliver a bond to the State is considered

noncompliance with State statute and can leave the State subject to unnecessary litigation risk.

DEPARTMENT RESPONSE:
The Department accepts the recommendation. The Department will implement additional protocols to address the errors for the processing of Emergency Purchases, Contractual Agreements, and Construction Contracts. Furthermore, the Department conducted a training on Emergency Purchases in October 2021 to reduce the risk of reoccurrence.

UPDATED RESPONSE:
Implemented.

The Department accepts the recommendation. The Department will implement additional protocols to address the errors for the processing of Emergency Purchases, Contractual Agreements, and Construction Contracts. Furthermore, the Department conducted a training on Emergency Purchases in October 2021 to reduce the risk of reoccurrence.

Corrective Action Completed:

- Training Held October 2021 on Emergency Purchases
- Intranet instruction on Emergency Procurements updated.
- Personal Service Contractor for Procurement assigned to permanently oversee Emergency Procurements and the reporting of Final Cost. Please note, in accordance with 30 ILCS 500/20-30(c) and with the Chief Procurement Officer's (CPO) procedure, it is the responsibility of the CPO to notify the Auditor General. The notice of the emergency procurement and the final cost is delivered to the CPO via the e-procurement system, BidBuy.

Date of Completion: 7/1/2022

21. The auditors recommend Department management and staff comply with current policies and procedures regarding property and equipment and follow the control system in place. Additionally, the Department should adequately maintain buildings and facilities to prevent further deterioration.

FINDING: *(Lack of Physical Control Over State Property) – First reported 2005, last reported 2021*

The Department of Human Services (Department) did not have adequate internal control over State property inventories and recordkeeping. State property control included responsibilities at the Department's State-Operated facilities and its Central Office locations.

As of June 30, 2021, the Department values its state property at $283.1 million.

Central Office Location Testing

During testing of lease and installment purchase agreements, auditors noted 4 of 5 (80%) new lease agreements did not have a properly completed Account for Leases-Lessee Form (SCO-560) as required by the Office of Comptroller's Statewide Accounting Management System (SAMS) Manual. Specifically, one sample did not include total economic life and remaining life, and all four samples did not include a response for lease option code.

The SAMS Manual (Procedure 27.20.60) requires information to be completed on the SCO-560 for the Office of Comptroller to determine if a leased asset should be considered a capital lease asset. The SCO-560 includes the preparer to enter the total economic life- in years, remaining life at lease date- in years, and the lease option code, among others.

Department management indicated they did not have adequate processes in place to verify the integrity and accuracy of data within the Department's Office of Contract Administration, which led to incomplete and insufficient data being reported on the SCO-560's.

State-Operated Facility Testing

Further, during fieldwork, auditors performed on-site property and equipment inventory tests at five of the Department's State-Operated facilities. Our testing results indicated significant concerns with regards to four of the five facilities' property and equipment records.

Particularly, auditors noted Elgin Mental Health Center and Ludeman Developmental Center do not track surplus or transferable property. Specifically, during the tour of the grounds at Ludeman Developmental Center, the auditor observed a warehouse with a large surplus of property that was either surplus or transferable. Items were randomly sampled from the floor to determine if they were being tracked by the Facility. The auditor determined that 5 of 8 (63%) items sampled were not being tracked on the property listing.

In addition, auditors also noted Elgin Mental Health Center does not include property and equipment purchased with federal grant tags on its property listing.

Further, during testing of Kiley Developmental Center's property and equipment items located in its designated Storage Homes, the auditor identified several items that were either not tagged, tags which were not visible, not inventoried, or deleted. As such, auditors concluded Kiley Developmental Center does not properly maintain, or record property and equipment items located in its designated Storage Homes.

Finally, during the testing of Illinois Center for Rehabilitation and Education – Wood's property and equipment inventory, auditors noted the Facility failed to update its inventory records as required when performing annual inventory certification with the Department of Central Management Services, it does not maintain equipment listings that are complete and accurate representations of the equipment being held at the Facility or

where the equipment is being held, and it does not have appropriate internal controls in place to safeguard against the accumulation of surplus or transferable property.

As noted in Finding 2021-011, due to the conditions noted above auditors concluded the four of five State-Operated facilities' records were not sufficiently precise and detailed. Even with the limitations noted above, they tested the five facilities' State property and equipment records and noted the following exceptions:

Elgin Mental Health Center

- For 2 of 5 (40%) surplus items tested, totaling $292, the items were no longer in use but have not been transferred or disposed of.
- For 1 of 5 (20%) surplus items tested, the item could not be traced to the Facility's property listing. As a result, the auditor could not determine the cost of the item.
- For 2 of 5 (40%) surplus items tested, totaling $1,500, the Facility prepared a Request for Deletion from Inventory and removed the items from the Facility's property records even though the Department of Central Management System's (CMS) Surplus had not picked the items up.
- For 2 of 15 (13%) items tested from the Facility's property inventory listing, totaling $940, the auditor could not physically locate the items.
- For 7 of 15 (47%) equipment transactions tested, Facility staff recorded the transaction in the wrong period. Due to this error, the Facility's assets were understated by $6,678 at June 30, 2021.
- The Facility did not adequately maintain its buildings and grounds. During a tour of the Facility, the auditors noted stagnant water or water that had leaked in through the roof in the Jonathan Burr Unit, Property Control (Wines), and the Pipe Shop.

Illinois Center for Rehabilitation and Education - Roosevelt

- During a walkthrough of the Facility, the auditor noted the grounds were not properly maintained. Specifically, the auditor observed several instances of property deterioration, including a deteriorated pool previously used for student rehabilitation, sidewalk damage, parking lot damage, and a damaged picnic table. During further testing, auditors noted budget requests were submitted to the Capital Development Board for prioritization and ranking in its capital budget request to the Governor's Office of Management and Budget. The budget request also included many other issues regarding property at the Facility, which include the following:
    - The Facility elevators are in need of refurbishing;
    - Wheelchair protectors are damaged beyond repair;
    - All dorm room walls are damaged;
    - Doors are damaged and pressures are not Americans with Disabilities Act Standards for Accessible Design (ADA) compliant;
    - Bathrooms lack privacy and are not ADA compliant;
    - The Facility does not have a knox box (which is used to allow firefighters and paramedics to enter the building immediately for the Facility, a life/safety issue);

  - The Facility does not have a shelter for the students from the inclement weather;
  - The Facility has a domestic hot water heater which is approximately 40 years old, antiquated, and inefficient;
  - The Facility's steam traps are failing and have been identified in the Department's Family and Community Services and the Illinois Department of Commerce and Economic Opportunity reports as needing replaced; and
  - The Facility's chiller is beyond its useful life and needs to be replaced.
- For 48 of 55 (87%) items selected for cutoff testing, the equipment was not recorded at the proper cost. Due to this error, the Facility's assets were understated by $3,516 at June 30, 2021.
- For 3 of 15 (20%) items tested from the Facility's property listing, totaling $7,454, the items were found in locations that did not match the locations listed on the property listing.
- For 1 of 15 (7%) items tested from the Facility's property listing, totaling $1,049, the auditor could not physically locate the item.
- For 2 of 15 (13%) items tested from the Facility floor totaling $1,406, the items were in different locations on the property listing than their physical location.
- For 1 of 15 (7%) items tested from the Facility floor, the item could not be located on the property listing. As a result, the auditor could not determine the cost of the item.

Kiley Developmental Center

- For 1 of 15 (7%) items tested from the Facility's property listing, totaling $1,172, the auditor could not physically locate the item.
- For 3 of 15 (20%) items tested from the Facility's property listing, totaling $3,738, the items were found in locations that did not match the locations listed on the property listing.
- For 4 of 15 (27%) items tested from the Facility's property listing, totaling $1,956, the items were not properly tagged.
- For 1 of 15 (7%) items tested from the Facility floor, the item could not be located on the property listing. As a result, the auditor could not determine the cost of the item.
- For 3 of 15 (20%) items tested from the Facility floor, totaling $1,676, the items were in different locations on the property listing than their physical location.
- For 7 of 15 (47%) large equipment transactions tested, totaling $13,596, the Facility did not maintain supporting documentation for the transactions. As a result, the auditor could not determine the sufficiency of the transactions.
- For 2 of 15 (13%) large equipment transactions tested, the supporting documentation for the transactions did not agree with the Facility's property listing. The auditor noted the equipment items were overvalued by $1,005 and undervalued by $8,886, respectively, on the Facility's property listing.
- The Facility did not accurately complete the Detailed Inventory Systems Report that is filed with CMS. Specifically, the auditor noted Facility staff did not accurately report housing information for 1 out of 55 (2%) building units reported.

Illinois Center for Rehabilitation and Education – Wood

- The Facility does not have appropriate segregation of duties for the process of acquiring equipment and the performance of annual inventory. The same person is responsible for making purchases, receiving the equipment, maintaining the inventory, and performing annual inventory.
- For 3 of 7 (43%) items tested from the Facility's property listing, totaling $3,895, the auditor could not physically locate the item.
- For 2 of 7 (29%) items tested from the Facility's property listing, totaling $1,467, the items were not assigned a location on the Facility's inventory listing.
- For 2 of 7 (29%) items tested from the Facility's property listing, totaling $816, the items were in different locations on the property listing than their physical location.
- For 3 of 14 (21%) items tested from the Facility's property listing, totaling $2,779, the items were found to be in non-working condition and were not listed as being surplus or transferable.
- For 2 of 9 (22%) items tested from the Facility's property listing, the item could not be located on the property listing. As a result, the auditor could not determine the cost of the item.
- For 6 of 11 (55%) items tested from the Facility's property listing, the items did not have appropriate inventory tags affixed to them.
- The Facility's grounds were not properly maintained. The auditor observed several instances of property deterioration while touring the Facility grounds, including an overgrown courtyard and a water leak in the main lobby.

Ludeman Developmental Center

- For 4 of 15 (27%) items tested from the Facility's property listing, totaling $2,055, the auditor could not physically locate the items.
- For 2 of 15 (13%) items tested from the Facility's property listing, totaling $2,811, the items were in different locations on the property listing than their physical location.
- For 3 of 15 (20%) items tested from the Facility floor, the items could not be located on the property listing. As a result, the auditor could not determine the cost of the items.
- For 2 of 30 (7%) items tested from the Facility's property listing and Facility floor, the items were either surplus or transferable property.
- The Facility's grounds were not properly maintained. The auditor observed several instances of property deterioration while touring the Facility grounds, including sidewalks that are broken up and cracked and roads with large potholes.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2005. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The State Property Control Act (Act) (30 ILCS 605/4) requires every responsible office of State government to be accountable for the supervisions, control, and inventory of all items under their jurisdiction.

Further, per the Act (30 ILCS 605/7.1), except as stated by law, all surplus real property held by the State of Illinois shall be disposed of by the administrator as provided in this Section. "Surplus real property" as used in this section, means any real property to which the State holds fee simple title or lesser interest, and is vacant and determined by the head of owning agency to no longer be required for the State agency's needs and responsibilities and has no foreseeable use by the owning agency.

The Illinois Administrative Code Section (44 Ill. Admin. Code 5010.400) requires agencies to adjust property records within 90 days after acquisition, change, or deletion of equipment items.

The Statewide Accounting Management System (SAMS) (Procedure 29.10.10) requires agencies to maintain detailed records of all property which includes the correct descriptions of the asset and correct information of its location. Additionally, agencies are required to identify assets that are obsolete, damaged, or no longer used in operations and, if necessary, remove them from asset records. The asset records should be reconciled with the results of inventory and updated accordingly.

In addition, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation; and revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

Finally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department management indicated there was a breakdown in the process for documenting the movement of equipment in or out of the locations that resulted in terms not being accurately reflected on inventory documentation.

Failure to properly control and record State property is statutory noncompliance and increases the potential for possible loss or theft of State property. Failure to transfer or find a use for excess property does not allow the State to manage State assets in the most economical manner and could lead to unnecessary purchases by other State agencies. Failure to properly record State property can lead to inaccurate financial information being reported. In addition, failure to properly maintain property could lead to further damage and/or unsafe conditions.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. IDHS Office of Business Services is working with various Department locations on property procedures and reiteration of the importance of strict adherence to documented policy. In addition, requests for maintenance and repair projects for buildings and facilities have been submitted, as required, to the Capital Development Board for review and funding.

UPDATED RESPONSE:
Implemented.

The Department accepts the recommendation. IDHS Office of Business Services is working with various Department locations on property procedures and reiteration of the importance of strict adherence to documented policy. In addition, requests for maintenance and repair projects for buildings and facilities have been submitted, as required, to the Capital Development Board for review and funding.

Corrective Action Completed:
DHS Property Control will reiterate present property procedures, as well as provide updated Property Control Manual (once finalized) which will include instructions on procurement, transfer, and deletion of state property from DHS inventory. In addition, maintenance and repair project requests will continue to be submitted to Capital Development Board for review and funding

Date of Completion: 02/28/2022

22. The auditors recommend Department management update its policies and procedures governing accounts receivable and ensure staff comply with the updated policies and procedures. Additionally, auditors recommend Department management and staff maintain detailed records of all billings and the corresponding collections to facilitate proper reporting of accounts receivable activity. Auditors also recommend Department management and staff consider writing off delinquent or uncollectible accounts to reflect only realizable amounts.

FINDING: *(Inadequate Controls over Accounts Receivable) – First reported 2007, last reported 2021*

The Department of Human Services (Department) is in violation of its policies and procedures, as well as, statutory requirements regarding the administration of accounts receivable at is State-Operated Developmental Disabilities (DD) and Mental Health (MH) Centers.

Specifically, during testing auditors noted the Department had outdated and incomplete written policies and procedures regarding the billing and payment of services rendered at its State-Operated DD and MH Centers during the examination period. Particularly, auditors noted multiple inconsistencies between the Department's Program Directive

governing DD and MH Centers accounts receivable collection procedures, and the performance of daily activities undertaken by the DD and MH Centers' Recipient Resource Unit staff, the Department's Central Office Revenue Cash Management Unit staff, and the Department's Central Office Collections Unit staff.

Also, during testing, auditors noted the RE-2 accounts receivable system (RE-2 System) section of the Revenue and Receivable Narrative (an internal control document provided annually to the auditors by the Department's Central Office staff) was inconsistent with the Department's Program Directive governing DD and MH Centers accounts receivable collection procedures and the daily activities undertaken by the Department staff noted above.

Finally, during the testing, auditors requested the Department provide them the population of outstanding accounts receivable at three State-Operated DD and MH Centers selected for testing as of June 30, 2021. In response to the request, each of the three State-Operated DD and MH Centers provided them a copy of their respective Center's GAAP Aging Report generated by the Department's RE-2 System. However, due to the limitations of the RE-2 System being an admission/discharge system (i.e., patient system), not a financial reporting system (i.e., payment system), auditors noted inaccuracies in the GAAP Aging Report when comparing them to residents' patient files. Specifically, because the RE-2 System is a patient system, as soon as a client is admitted a clock will start which begins billing of clients, whether billing should have started or not, and it cannot be paused or adjusted for any circumstances other than discharge. This can lead to inaccuracies in the amounts due.

As a result of the auditors being unable to accurately and completely determine the Department's process over the billing and payment for services rendered at the State-Operated MH and DD Centers, auditors were unable to determine if the Department materially complied with the billing and payment of services rendered during the examination period.

Further, due to the conditions noted above, auditors were unable to conclude the Department's population records were sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C §205.36) to fully test the Department's compliance with requirements governing accounts receivable collections procedures at the State-Operated DD and MH Centers. See Finding 2021-011.

Even given the population limitation noted above which hindered the ability of the accountants to conclude whether selected samples were representative of the population as a whole, auditors performed on-site testing of 60 residents' accounts receivable at three of the Department's State-Operated DD and MH Centers. The testing resulted in the following exceptions:

<u>Elgin Mental Health Center</u>

- For 2 of 45 (4%) residents tested who were Medicaid recipients, Center staff failed to bill the client after discharge.
- For 2 of 22 (9%) residents tested who had left the Facility, Center staff did not send a Notice of Determination (Notice) until years after discharge, instead of a month after discharge. The Notices were sent 118 and 132 months late.
- For 1 of 13 (8%) residents tested with a balance over 180 days old, Center staff failed to notify the Department's Central Office to write off the account after 180 days of it being outstanding. The account, as of June 30, 2021, was outstanding for 96 months.
- In the prior examination, auditors noted $2,107,173 in payments from Medicare, Medicaid, and the Social Security Administration which were not applied to individual client accounts or refunded to the applicable program. In the current examination, Center staff could not provide an update on the unapplied amounts.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2007. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Illinois Administrative Code (59 Ill. Admin. Code 106) and the Mental Health and Developmental Disabilities Code (405 ILCS 5/5-108) require the Department to bill, collect, and establish accounts receivable for services provided in its mental health and developmental disabilities facilities. To facilitate these processes at the facilities, the Department has developed State-Operated Mental Health/Developmental Disabilities AR Collection Procedures (Department's Program Directive 02.08.01.040).

The Department's Program Directive (02.08.01.040) requires the Center to complete the proper ILL-1 form upon an individual's admittance to the facility. The Directive states that between the ninth and eleventh month of an account receivable's generation, a Notice to Revenue Management Section of an Account Problem (IL462-0681) form is to be sent to the Bureau of Collections, Revenue Management Section (RMS) to request assistance in efforts to collect receivables with collection problems. Additionally, the Directive states facility resource staff generates the Notice of Determination (IL462-0612) form from the Reimbursements System II (RE-2), and mails the IL462-0612 form to the debtor in the first month that an individual enters a facility. The client's guardian should be receiving a Notice of Determination (NoD) detailing the rates being charged and/or changed during the period. The Directive offers further guidance stating that an individual account is not due until 90 days after the IL462-0612 form is mailed. Lastly, the Directive establishes that Center staff mail the Collection Activities Delinquent Notice (IL462-0642) form when the account becomes delinquent.

In addition, the Illinois State Collection Act of 1986 (Act) (30 ILCS 210/2) mandates the Department to capture receivable information and report receivables in accordance with rules established by the Office of the Comptroller. Further, the Act (30 ILCS 210/3) states it is the public policy of the State to aggressively pursue the collection of accounts or claims due and payable to the State through all reasonable means.

Further, the Social Security Act Section 1128J(d) states that overpayments are to be reported and returned within 60 days of the overpayment being identified.

Finally, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds, property, other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and maintain accountability over the State's resources; and that revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

Department management indicated the errors were due to employee error, lack of staff training, and understaffing.

Failure to regularly update policies and procedures creates inconsistencies in the billing and collection practices followed at each State-Operated DD and MH Center. Failure to make timely determinations of residents' ability to pay and follow-up on accounts receivable in a timely manner may result in the delay or loss of revenue. In addition, the lack of adherence to policies, procedures, and internal controls can lead to an understatement or overstatement of net collectible accounts receivable.

DEPARTMENT RESPONSE:
The Department accepts the recommendation. The IDHS Office of Fiscal Services has updated and implemented accounts receivable procedures. The IDHS Division of Mental Health will continue to review policies and procedures over accounts receivable and ensure staff are adequately trained.

UPDATED RESPONSE:
Implemented.

The Department accepts the recommendation. The IDHS Office of Fiscal Services has updated and implemented accounts receivable procedures. The IDHS Division of Mental Health will continue to review policies and procedures over accounts receivable and ensure staff are adequately trained.

Corrective Action Complete:
The Department will update the narrative document that outlines the policies and procedures relating to accounts receivable.

Date of Completion: 06/24/2022

23. The auditors recommend Department management allocate the necessary resources to fully convert inventories to the ERP System and reconcile opening balances as of July 1, 2021. Auditors also recommend staff comply

with current policies and procedures regarding commodities and follow internal control systems in place.

FINDING: *(Inadequate Controls over Commodities) – First reported 2013, last reported 2021*

The Department of Human Services (Department) did not maintain adequate internal control and oversight over its pharmaceutical and non-pharmaceutical commodities inventory. Inventory control included responsibilities at the Department's State-Operated facilities and Central Office locations.

Central Office Location Testing

During fieldwork, auditors observed the FY 2021 year-end commodity inventory counts for the Department's Central Office Pharmacy and the Department's Central Office Springfield non-pharmaceutical warehouse locations. For non-pharmacy related inventory, auditors noted the Department's year-end counts were conducted in early June 2021 due to a decision made by Department management to perform counts prior to a system conversion from the Department's Warehouse Control System (WCS) to the inventory module within the Enterprise Resource Planning (ERP) System, which was to become effective on July 1, 2022. Because traditional year-end inventory tests could not be performed by the auditors on the Department's year-end balances (as the Department did not conduct recounts at June 30, 2021), auditors inquired of the Department as to whether or not during the weeks after the early June 2021 inventory observation there were any additional inventory that had been physically received but was not entered into WCS as of June 30, 2021. This inquiry would allow auditors to determine whether or not the Department accurately recorded inventory assets at June 30, 2021. Department management stated there were such items and provided documentation to support 9,452 items (totaling $154,299) which were not accounted for during FY 2021's ending inventory balances. As a result, auditors noted those non-pharmacy inventory assets and the Department's corresponding net position were understated in the Department's FY 2021 financial statements. This amount was deemed immaterial to the financial statements as a whole, therefore an adjustment was not recorded by the Department.

State-Operated Facility Testing

Further, during fieldwork, auditors performed on-site pharmacy and non-pharmacy commodities inventory tests at three of the Department's State-Operated facilities.

At each of the three facilities tested, auditors noted (as auditors did at the Central Office locations indicated above) that for non-pharmacy related inventory the facilities' year-end counts were conducted in early June 2021 due to a decision made by Department management to perform counts prior to a system conversion from the Department's State-Operated Facilities' Commodity Control System (CCS) to the inventory module within the ERP System, which was to become effective on July 1, 2022. Further, because each of the three facilities did not perform reconciliations from the time of the inventory count in early June 2021 to an inventory count as of June 30, 2021, auditors were unable to conclude non-pharmaceutical commodities inventory was properly entered into the ERP

System, or whether non-pharmacy inventory assets and the Department's corresponding net position were properly recorded in the Department's FY 2021 financial statements. This amount was deemed immaterial to the financial statements as a whole, therefore an adjustment was not recorded by the Department.

As noted in Finding 2021-011, due to these conditions' auditors concluded the Department's records were not sufficiently precise and detailed. Even with the limitations noted above, auditors tested the three facilities' inventory counts and noted the following exceptions at three of the facilities:

Elgin Mental Health Center

- For 2 of 30 (7%) pharmacy inventory items counted during annual inventory, the Facility's counts did not agree with auditor test counts. The discrepancy between counts ranged from 2 to 13 units and totaled to $1.05.
- For 27 of 30 (90%) non-pharmacy inventory items counted during annual inventory, the Facility's counts did not agree with auditor test counts. The discrepancy between counts ranged from 2 to 1,600. The total of the discrepancy is unknown.
- For 4 of 256 (2%) pharmacy inventory adjustments, the adjustments were either not made, or were made for the improper amounts. The 4 inventory adjustments were made for (226) items in total, instead of (237) in total, resulting in an (11) unit error totaling $2.97.
- For 1 of 3 (33%) pharmacy items with high quantity tested, the quantity on hand was incorrectly entered as 100 bottles of 100 count instead of 1 bottle of 100 count. As a result, inventory was overstated by $48,114.
- For 1 of 1 (100%) item with a total inventory value over $15,000, the item had a turnover ratio of .94. The Illinois Procurement Code (30 ILCS 500/50-55) requires the facility to stock no more than a 12-month supply of inventory, 1 turn.
- There is a segregation of duties issue within the general stores inventory cycle, as the same employees are responsible for ordering, receiving, recording, maintaining custody, and counting the inventory items. Additionally, the same employees are responsible for reconciling, reviewing reconciliations, approving adjustments, and posting adjustments.

Kiley Developmental Center

- For 30 of 36 (83%) non-pharmacy inventory items counted during the annual inventory, the auditor counts did not agree to the Facility's ending inventory reports for June 30, 2021. The discrepancy between counts ranged from 240 to 311 items. The total of the discrepancy is unknown.
- The ending inventory balances were $211,448 and $314,327 for June 30, 2020 and June 30, 2021, respectively, representing a 49% increase from FY 2020 to FY 2021. As there was not a significant change in the Facility operations between fiscal years, this variance does not appear reasonable. The auditor also noted the significant change occurred primarily during the month of June of 2021, as the balance on June 1, 2021, was $206,556.

Ludeman Developmental Center

- The Facility did not physically count all of its inventory items during its year-end inventory counts in early June 2021. Specifically, the auditor noted there were four inventory types (total quantity of 51 items) listed in the Commodity Control System (CCS) that were not counted.
- Seven inventory types listed in the CCS did not agree with the Facility's count sheets, resulting in a net understatement of inventory of $910.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2013. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Statewide Accounting Management System (SAMS) Manual (Procedure 03.60.20) requires the Department to perform an annual physical count of inventory on hand and to reconcile the results to inventory records to ensure the completeness and accuracy of those records. In addition, inventory held by governmental funds should be valued at cost.

In addition, generally accepted accounting principles require the proper valuation of inventory for financial reporting purposes. This would require verifying detailed transactions agree to recorded inventory balances.

Finally, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable law; that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation; and that revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

Department management indicated they were aware of problems with the commodity inventory system and steps were being taken to convert the Department to the new ERP System. This contributed to the decision to count inventory earlier than usual. However, due to inability to fully convert to the new ERP System, the Department had to continue utilizing the present commodity system until full implementation at all locations could be accomplished as of July 1, 2021. Furthermore, Department management indicated reconciliations were performed however, there were errors identified due to employee oversight.

Failure to develop and maintain strong controls over commodities could lead to fraud, waste, and abuse of commodity items. Furthermore, failure to maintain accurate year-end inventory records resulted in the inventory balances being misstated and improperly presented in the Department's financial statements.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. Following the conversion to the Enterprise Resource Planning (ERP) system effective July 1, 2021 and attendant reconciliation and reporting issues, the Department continues to train and retrain staff on job functions to ensure compliance with current policies and procedures.

UPDATED RESPONSE:
Implemented.

The Department accepts the recommendation. Following the conversion to the Enterprise Resource Planning (ERP) system effective July 1, 2021, and attendant reconciliation and reporting issues, the Department continues to train and retrain staff on job functions to ensure compliance with current policies and procedures.

Corrective Action Completed:
Effective 07/01/2021, DHS converted to the Enterprise Resource Planning (ERP) system. Training and refresh training of staff on functions and procedures, as well as new system is to be done. (100% Complete)

Date of Completion: 11/30/2022

24. The auditors recommend Department management comply with State law by completing and adopting rules related to the assignment and operations of monitors and receiverships for CILAs provider agencies. Auditors also recommend the Department finalize and implement the CILA Rule, and its associated look-back reviews policies and procedures. Further, auditors recommend the Department perform the planned monitoring of CILA resident's personal funds.

FINDING: *(Failure to Implement Policies and Rules over Community-Integrated Living Arrangements and Community-Based Residential Settings and Adequately Monitor CILAs) – First reported 2017, last reported 2021*

The Department of Human Services (Department) failed to finalize and implement policies and rules for certain community-integrated living arrangements (CILA), and community-based residential settings.

Failure to Finalize and Implement Rules

During the previous examination period, auditors noted the Department had drafted but had not yet finalized and implemented rules related to the assignment and operations of monitors and receiverships for CILAs as required by the Act. During the current examination period, auditors noted the Department still had not finalized and implemented the rules, and as of June 30, 2021, the adoption of the rules was 9.5 years past the date required by statute.

The Community-Integrated Living Arrangements Licensure and Certification Act (210 ILCS 135/9) states that by December 31, 2011, the Department shall adopt rules under the Illinois Administrative Procedure Act that govern the assignments and operations of monitors and receiverships for community-integrated living arrangements wherein the Department has identified systemic risks to individuals served. The rules are required to specify the criteria for determining the need for independent monitors and receivers, their conduct once established, and their reporting requirements to the Department. These monitors and receivers shall be independent entities appointed by the Department and not staff from State agencies.

Department management indicated the continued delay in finalizing the rules were due to insufficient staffing resources and changes in the Federal Home Community Based Setting Rule. Department management indicated the draft rule was submitted to the Joint Committee on Administrative Rules (JCAR) for pre-review in February of 2022. The Department has received feedback, is making final changes to the draft, and will resubmit to JCAR for approval.

Further, during the examination period, auditors noted the Department had not implemented rules regarding community-based residential settings. As of June 30, 2021, the adoption of the rules was 9.5 years past the date required by statute.

The Mental Health & Developmental Disabilities Act (20 ILCS 1705/73(b)) requires the Department to draft and promulgate rules governing community-based residential settings. The rules for community-based residential settings are to include settings that offer to persons with serious mental illness (i) community-based residential recovery-oriented mental health care, treatment, and services; and (ii) community-based residential mental health and co-occurring substance use disorder care, treatment, and services. The Act requires the rule to have been drafted by January 1, 2012.

Department management indicated that for the first time in nearly 20 years, CILA rules have been undergoing a major rewrite and after having previously gone through First Notice with the JCAR, the CILA rules were re-published by the Secretary of State, for public comment, on June 10, 2022.

Failure to Finalize and Implement Policies, and Adequately Monitor the CILA Program

In July 2018, the Office of the Auditor General (OAG) released a Performance Audit of the Department's Oversight of the CILA Program (CILA Performance Audit) pursuant to Illinois House of Representatives Resolution Number 34. The OAG's original CILA Performance Audit contained 26 recommendations in which the Department was to take corrective actions necessary to ensure all areas responsible for the CILA Program have adequate management oversight to ensure material compliance with all relevant governing laws, regulations, contracts, and grants agreements. During the previous examination, auditors reported the Department had implemented 7 of 26

recommendations, partially implemented 17 of the 26 recommendations, and had not implemented 2 of the 26 recommendations.

As required by *Governmental Auditing Standards*, auditors followed up on the Department's implementation of corrective actions for the 19 partially implemented or not implemented recommendations during the examination period. Due to the impact of the COVID-19 pandemic the federal Centers for Medicare & Medicaid Services (CMS) approved Illinois' request to amend 1915(c) Home and Community-Based Services (HCBS) waivers with the Emergency Preparedness and Response (Appendix K). Appendix K extended deadlines for certification licensure, quality assessment, fiscal reporting and other requirements for service providers until after the COVID-19 pandemic emergency period. As a result, 7 of the remaining 19 recommendations associated with areas impacted by Appendix K are not repeated. Auditors will follow-up on these areas after the federal CMS waiver has expired. For the other 12 recommendations auditors could follow-up on during the examination period, auditors noted the following exceptions:

- The Bureau of Accreditation Licensure and Certification (BALC) did not perform planned monitoring of CILA providers regarding residents' personal funds. Department management indicated they planned to monitor providers' safeguarding of personal funds by adding questions to the BALC interview forms which are utilized during interviews with residents and their guardians during the survey process. However, the planned procedures were not performed. Auditors were provided the individual and guardian interview forms utilized during the examination period and did not identify questions pertaining to personal funds.
- As of June 30, 2021, the Department had drafted but not finalized rules and policies/procedures as follows:
    - Updates to Administrative Rule 115 (the CILA Rule, 59 Ill. Admin. Code 115), to comply with federal guidance. The CILA Rule is drafted and is undergoing the JCAR process as of the end of fieldwork.
    - The BALC Process and Procedure Manual was also being revised during the examination period and was not finalized until September 2021. The previous version of the Manual was last revised in August 2009.
    - The Division of Developmental Disabilities is in the process of developing and communicating a policy or procedure to formalize the look-back review process; however, the policy/procedure was not finalized until September 2021.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or system, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable law.
Further, the CILA Licensure and Certification Act (210 ILCS 135/9.1) addresses the protection of an individual's personal funds while in a CILA provider agency.

Finally, the CILA Rule defines the survey process to be used by the Department to determine the degree of compliance with the CILA Rule that a CILA provider agency has to maintain.

Department management indicated they are in the process of converting to fillable forms and BALC's previous questions regarding fiscal administrative review were inadvertently deleted due to human error. Department management also indicated the BALC Policy & Procedure Manual was undergoing revisions during the audit period, and the Division of Developmental Disabilities was in the process of developing procedures to formalize the look-back review process during the audit period, however these items were not completed timely due to competing priorities.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

Failure to adopt and implement rules that govern assignment and operations of monitors and receiverships for CILAs and community-based residential settings could adversely impact the care and treatment of individuals and represents noncompliance with the Act. Failure to perform planned monitoring procedures for residents' personal funds increases the risk of fraud and negligence in the handling of the funds. Failure to adopt and implement the CILA Rule, and look-back review policies and procedures, increases the risk that important activities regarding the CILA environment will not be performed correctly or at all.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. The requirements for Monitors and Receivership and Personal Funds Management have been incorporated into draft Rule 115. The IDHS Division of Developmental Disabilities has begun to review comment letters and will formulate responses as well as make necessary changes to the draft Rule based on the feedback received from the First Notice. It is anticipated that the Rule will be posted for second notice by December 2022. The IDHS Division of Developmental Disabilities developed a policy for look-back reviews with the policy being implemented in September 2021. Finally, the IDHS Bureau of Accreditation, Licensure, and Certification has added questions to the Individual, Staff, and Guardian interview forms that are used when conducting a full survey to ensure planned monitoring of resident's personal funds.

UPDATED RESPONSE:

In Process.

The Department accepts the recommendation. The requirements for Monitors and Receivership and Personal Funds Management have been incorporated into draft Rule 115. The IDHS Division of Developmental Disabilities has begun to review comment letters and will formulate responses as well as make necessary changes to the draft Rule based on the feedback received from the First Notice. It is anticipated that the Rule will be posted for second notice by December 2022. The IDHS Division of

Developmental Disabilities developed a policy for look-back reviews with the policy being implemented in September 2021. Finally, the IDHS Bureau of Accreditation, Licensure, and Certification has added questions to the Individual, Staff, and Guardian interview forms that are used when conducting a full survey to ensure planned monitoring of resident's personal funds.

Corrective Action in Progress:

DDD

Incorporate Monitors and Receivership language into Rule 115. (50% Complete)

Incorporate Personal Funds Management language into Rule 115. (50% Complete)

Implement look-back review policies and procedures. (100% Complete)

Estimated Date of Completion: 06/30/2023

BALC

- Revise Guardian Interview form to include a question about individual's access to personal funds. (100% Complete)
- Revise Individual Interview form to include a question about access to personal funds. (100% Complete)
- Revise Staff Interview form to include a question about individual's access to personal funds. (100% Complete)

Date of Completion: 08/08/2022

25. The auditors recommend Department management submit all reports on or before the due date as specified in the applicable State law.

FINDING: *(Late Submission of Required Reports) – First reported 2013, last reported 2021*

The Department of Human Services (Department) did not submit required reports to the Governor, the General Assembly, other officials, or the Department's website in a timely manner as required by State law.

During the examination period, the Department was required to submit various reports to the Governor, the General Assembly, and other officials. The topics of these reports include the Emancipation of Minors Act, the Rehabilitation of Persons with Disabilities Act, the Public Aid Code, the Accountability for the Investment of Public Funds Act, and the Statewide Accounting Management System (SAMS) Manual. These reports were not filed in a timely manner.

- The Emancipation of Minors Act (750 ILCS 30/2(g)) requires the Department to annually report to the General Assembly, beginning January 1, 2019, and annually thereafter through January 1, 2024, regarding homeless minors older than 16 years of age but less than 18 years of age referred to a youth transitional housing program, for whom parental consent to enter the program is not obtained.

  During testing, auditors noted the Department did not timely submit annual reports required to be filed during the examination period. Specifically, auditors noted the combined report for FY 2018/2019 which auditors noted as exceptions during the previous examination was submitted 611 days late. In addition, auditors noted the FY 2020 report was submitted 245 days late.

  Department management indicated the filing of this report is the responsibility of the Department but requires coordination and communication with the Department of Children and Family Services as they have the required information for the report. Due to inadequate time allowed by the statute between the reporting period end date and required submission date, and staff transitions in the Department's Office of Legislation the reports were not submitted timely.

- The Rehabilitation of Persons with Disabilities Act (20 ILCS 2405/3(d)) required the Department to report in writing, to the Governor, annually on or before the first day of December. The annual report was to first contain a statement of the existing conditions of comprehensive rehabilitation services, habilitation and rehabilitation in the State. Second, the report was to contain a statement of suggestions and recommendations with reference to the development of comprehensive rehabilitation services, habilitation and rehabilitation in the State. Third, the report was to contain an itemized statement of the amounts of money received from federal, State and other sources, and of the objects and purposes to which the respective items of these several amounts were devoted to.

  During testing, auditors noted the Department could not provide documentation the required annual reports for rehabilitation services, habilitation and rehabilitation in the State, were filed with the Governor's Office by December 1, 2019 or December 1, 2020.

  Department management indicated documentation to support the transmission of the reports to the Governor's Office was not retained due to oversight.

- The Rehabilitation of Persons with Disabilities Act (20 ILCS 2405/3(f)) required the Department to submit an annual report on programs of services it has established to prevent the unnecessary institutionalization of persons in need of long-term care and who meet the criteria for blindness or disability as defined by the Social Security Act, thereby enabling them to remain in their own home. The report was required to be filed with the Governor and General Assembly on or before March 30 each year.

During testing, auditors noted the Department could not provide documentation that the required FY 2019 and FY 2020 annual reports on programs and services were timely prepared or filed with the Governor by March 30, 2020, and March 30, 2021, respectively.

Department management indicated that due to staffing changes and a lack of internal controls governing the record keeping of mailings, the Department was unable to locate documentation regarding the timely transmission of these reports to the designated recipients as required by the statute.

- The Public Aid Code (Code) (305 ILCS 5/11-5.1(h)) requires the Department and the Department of Healthcare and Family Services to publish quarterly reports on their progress in implementing policies and practices pursuant to Section 11-5.1 of the Code, as modified by Public Act 101-0209. Per the Code (305 ILCS 5/11-5.1(h)(2)), initial reports were to be issued within 90 days after the effective date for Public Act 101-0209, which would have been for the quarter ended October 31, 2019. In addition, the Code (305 ILCS 5/11-5.1(h)(3)) required the reports to be published on the Department's website.

  During testing, auditors noted the following:
  - For 4 of 8 (50%) quarterly progress reports tested, the reports were not published timely. The quarterly progress reports were published between 106 and 381 days after quarter end.
  - For 2 of 8 (25%) quarterly progress reports tested, the reports were not published to the Department's website.

  Department management indicated the reports were not published in accordance with the Code due to the report filings being interpreted as non-essential work per the Governor's Executive Orders, during the early stages of the COVID-19 pandemic.

- The Accountability for the Investment of Public Funds Act (30 ILCS 237/10) requires the Department to make available on the Internet and update at least monthly by the 15th of the month, sufficient information concerning the investment of any public funds held by the Department.

  During testing, auditors noted the following:
  - For 4 of 24 (17%) months tested, reports related to invested funds were posted to the Department's website between 1 and 18 days late.

  Department management indicated three of the reports were posted late due to staff turnover as well as certain State-Operated facilities not submitting supporting bank statements on a timely basis. Furthermore, Department management indicated one of the monthly reports was filed late due to the system not allowing the report to be uploaded.

- The Illinois Public Aid Code (305 ILCS 5/12-5), requires the Department to report to the General Assembly at the end of each fiscal quarter the amount of all funds received and paid into the Social Services Block Grant Fund and the Local Initiative Fund and the expenditures and transfers of such funds for services, programs and other purposes authorized by law. The Illinois Public Aid Code does not identify a due date for the quarterly reports. Auditors inquired with Department management who communicated they considered reports to be timely if filed within the next fiscal quarter (90 days). Although 30 to 60 days is more typically used as a reasonable period for requirements such as this, auditors tested using the 90-day period defined by management.

  During testing, auditors noted the following:
  - For 8 of 10 (80%) quarterly reports tested, they noted the reports were not submitted in a timely manner. The reports were filed between 70 and 709 days after the end of the next fiscal quarter.

  Department personnel stated the delays were due to staff turnover and miscommunication on coordination of responsibility to notify cognizant groups to disseminate the data appropriately and timely.

- The SAMS Manual (Procedure 33.13.20) requires the Department to quarterly file the Report of Receipts and Disbursement for Locally Held Funds (C-17 report) to the Office of the Comptroller no later than the last day of the quarter for each locally held fund maintained by the Department.

  During testing, auditors noted the following:
  - For 1 of 32 (3%) quarterly reports tested for the WIC Redemption account (U.S.D.A. Women Infants and Children Fund 0700), the C-17 report was submitted to the Office of Comptroller 2 days late.

  Department management indicated the quarterly report was not filed timely due to staff turnover.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2013. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

Failure to prepare, submit, or publish required reports to the Governor, General Assembly, and other officials in a timely manner is noncompliance with State law and could impact decisions made by the Governor, General Assembly, and other officials.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. The Department is developing a centralized process to ensure mandated reports are filed timely.

UPDATED RESPONSE:
In Process.

To mitigate past issues and bolster best practices related to IDHS' many mandated reports, the Office of Legislative Affairs ("OOL") is pursuing a number of changes. DHS expects to implement them by April 1, 2023.

OOL is rewriting the Position Description for a vacant position on the team. In this CAP, the position is called the Legislative Analyst ("LA"). The revised LA Position Description will specify that the role includes, amongst other duties: (1) managing the tracking, distribution, and record-keeping of IDHS' mandated reports, (2) serving as IDHS' designee for uploading required materials to the State Library's Electronic Depository ("SLED"), and (3) ensuring that IDHS has a new SLED designee in place when the LA leaves OOL. Specifically, they must (A) meet with the Legislative Director to determine a new SLED Designee, and (2) email the State Library's Director to notify them of IDHS' new designee.

OOL is securing a central email address: IDHSReports@illinois.gov (or something similar depending on availability). Using a centralized email address, rather than employees' email addresses, will allow the LA and other OOL team members to distribute reports and access proofs of distribution even as the team roster changes over time.

After the Illinois General Assembly ("ILGA") adjourns from their Spring Session each year, the LA will lead OOL in compiling a list of new, IDHS-relevant Public Acts ("PA"). They will distribute the list to Subject Matter Experts ("SME") in the Divisions and to Executive Staff, asking them to provide feedback and analysis of any PAs that impact their work. OOL will compile the SME analysis and redistribute to the Divisions and Executive Staff.

If any of the PAs contain mandates related to Reporting, the LA and OOL will add the information to an Agency Reporting List. The list will contain information including which Division and which SME is responsible for timely completion of that particular report. When the Division completes a mandated report, the designated SME will email it to IDHSReports@illinois.gov. The LA, or another member of OOL, will (1) email the report to the entities required in the controlling statute, with a request for *send receipts* and *read receipts*, and (2) upload the report to the SLED. If required by statute, the LA will also (3) request paper copies from the IDHS Print Office, (4) personally deliver or mail copies to any required entities, with a request for proof of receipt, and (5) scan and email the proofs of receipt to IDHSReports@illinois.gov. (35% Complete)

Estimated Date of Completion: 04/01/2023

26. The auditors recommend Department management enhance its processes and internal controls so that accidents are reported within DCMS required time

frames, annual licenses and insurance verification certification are timely obtained from Department employees and retained within the employees' records, and vehicles are properly maintained and utilized within DCMS policies.

FINDING: *(Lack of Compliance with Policies for Vehicles) – First reported 2017, last reported 2021*

The Department of Human Services (Department) did not comply with governing State laws and regulations relating to its employees' use of State Vehicles. Specifically, auditors identified issues relating to the Department not obtaining and retaining annual licenses and insurance verification certifications, untimely filing of individually assigned vehicles, untimely reporting of vehicle accidents, and inadequate controls over vehicle maintenance and utilizations.

Insurance Verification Cards Not Filed

During testing of travel related vouchers, auditors noted the following:

- For 3 of 25 (12%) employees tested who used privately owned vehicles for State business, the Department did not have the employee complete their respective Form IL 444-4042 (Insurance Verification Card).

The Illinois Vehicle Code (625 ILCS 5/10-101(b)) requires every employee of the State, who operates for purposes of State business a vehicle not owned, leased, or controlled by the State, to procure insurance in the limit of the amounts not less that the amounts required in Section 7-203 of the Act.

Additionally, the Illinois Administrative Code (80 Ill. Admin. Code 3000.300(f)) requires employees using private vehicles on State business to have insurance coverage in an amount not less than that required by Section 10-101(b) of the Illinois Vehicle Code (625 5/10-101(b)). Prior to authorization, the Department's Secretary is required to have the applicable employees file a statement certifying that they are duly licensed and carry at least the minimum insurance coverage.

Department management indicated the error identified was due to staff oversight.

Reporting Requirements for Individually Assigned Vehicles

During testing, auditors noted the Individually Assigned Vehicle (IAV) Annual Reports for FY 2020 and FY 2021 were submitted 7 and 38 days late, respectively.

The Illinois Administrative Code (44 Ill. Admin. Code 5040.340) requires the Department to report to the Department of Central Management Services (DCMS) annually and when changes occur a listing of vehicle assigned specifically to individuals. The report is required to include the name of each employee assigned a vehicle, the equipment

number and license plate of the assigned vehicle, employee's headquarters and residence, and any additional information requested by DCMS. For FY 2020 and FY 2021, the Department was required to file the reports by October 23, 2020, and November 14, 2021, respectively.

Department management indicated they believed they were in compliance with the Illinois Administrative Code as both reports were submitted annually as the Illinois Administrative Code requires.

Reporting Requirements for Vehicle Accidents

During testing, auditors noted 2 out of 5 (40%) instances of accidents involving State owned vehicles used by Department employees during the examination period were not reported to DCMS within 7 calendar days. The reports were submitted 2 and 32 days late.

The Department's Administrative Directive (01.05.05.030), regarding reporting of motor vehicle accidents and insurance coverage requires that as a condition of coverage, employees involved in a motor vehicle accident are required to have a legible written report of the accident in the DCMS Division of Risk Management no later than seven (7) calendar days following the accident. Failure to comply with this important condition in the plan may result in forfeiture of insurance coverage to the employee.

Further, the Illinois Administrative Code (44 Ill. Admin. Code 5040.520(i)) requires the Department to submit a Motorist's Report of Illinois Motor Vehicle Accident form (Form SR-1) to DCMS within 7 calendar days following an accident.

The finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In the subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

Department management indicated the instances noted were the result of the respective employee not submitting documentation to the Department's Fleet Management Division timely.

Annual Certification of Licensure and Liability Insurance

During testing of individually assigned vehicles, auditors noted the following:

- For 3 of 10 (30%) individuals tested, the Department did not have the applicable employee submit an annual certification of licensure and liability insurance. Specifically, auditors noted one individual did not file the required certification for FY 2021, while the remaining two individuals did not file the required certification for FY 2021 and FY 2020.
- For 3 of 10 (30%) individuals tested, the applicable employee submitted the annual certification of licensure and liability insurance to the Department between 18 and 335 days late.

The Illinois Vehicle Code (625 ILCS 5/7-601(c)) requires every employee of the Department who is assigned a specific vehicle owned or leased by the State on an ongoing basis to provide the certification annually to the director or chief executive officer of his or her agency. The certification to be provided during the period July 1 through July 31 of each calendar year, or within 30 days of any new assignment of a vehicle on an ongoing basis, whichever is later.

Department management indicated the errors identified were due to staff oversight.

Maintenance and Utilization of State Vehicles

During testing of maintenance and utilization records for Department vehicles, auditors noted the following:

- For 8 of 25 (32%) vehicles tested, vehicle maintenance was not performed as required.
- For 3 of 25 (12%) vehicles tested, the Department could not provide documentation to support an annual inspection was performed.
- For 2 of 25 (8%) vehicles tested, vehicles were not utilized in accordance with DCMS vehicle use policy.

DCMS issued a Memorandum to agency vehicle coordinators on September 24, 2018, which outlines maintenance, lube, oil and filter change interval policies for passenger vehicles. Per this Memorandum, the standard lube, oil and filter change interval requirement for passenger fleet vehicles 10 years and older is 3,000 miles or 12 months, whichever comes first. For passenger vehicles 9 years and newer, the policy is 5,000 miles or 12 months, whichever comes first. Tire rotation on all passenger vehicles is required every other oil change.

Further, the Illinois Administrative Code (44 Ill. Admin. Code 5040.410(a)) requires the Department to have its vehicles inspected by DCMS or an authorized vendor at least once per year or as required by law and is to maintain vehicles in accordance with the schedules provided by DCMS or with other schedules acceptable to DCMS that provide for proper care and maintenance of special use vehicles.

Finally, DCMS' Vehicle Usage Policy requires underutilized vehicles that are not able to be redeployed due to age, mileage, and/or condition to be turned-in to DCMS' Surplus Property to be disposed through a sale on Ibid, the State's online auction site, or offered to another agency at DCMS's discretion.

The finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In the subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

Department management indicated vehicles were underutilized or maintenance of vehicles was not performed timely due to the COVID-19 pandemic. Specifically, Department management indicated facilities were short staffed, making it difficult to

perform routine maintenance. Further, some facilities were forced to rely on DCMS for oil changes and tire rotations as well as their annual inspections, which proved to be an issue, since DCMS garages were closed down or backlogged.

Failure to ensure employees driving their personal vehicles for State business are properly insured represents noncompliance with the Illinois Vehicle Code and could expose the State to unnecessary liability. Failure to submit individually assigned vehicle annual reports in a timely manner is considered noncompliance with the Illinois Administrative Code. Failure to report accidents to DCMS in a timely manner may impact the State's ability to investigate and defend itself against resulting claims. Failure to submit annual license and insurance certificates on time as required by the Illinois Vehicle Code is noncompliance with State statute and could leave the State open to avoidable risks. Failure to maintain and utilize vehicles in accordance with DCMS policy could result in the vehicle not being operable through its estimated useful life and could result in costly repairs.

DEPARTMENT RESPONSE:
The Department accepts the recommendation. The Office of Business Services will work with Executive Leadership and Division Directors to develop additional procedures to ensure vehicle maintenance and reporting is completed timely and that annual licenses and insurance verification certifications are timely obtained and retained within employees' records.

UPDATED RESPONSE:
In Process.

The Department accepts the recommendation. The Office of Business Services will work with Executive Leadership and Division Directors to develop additional procedures to ensure vehicle maintenance and reporting is completed timely and that annual licenses and insurance verification certifications are timely obtained and retained within employees' records.

Corrective Action in Progress:
The procedures for addressing and reporting of vehicle maintenance will be reiterated to all divisions as well as the requirements that certifications of license and insurance be completed and submitted timely.

Business Services will work with Executive Leadership and Division to update existing Administrative Directives and divisional mandate to adherence.

Estimated Date of Completion: 02/28/2023

27. The auditors recommend the Department ensure the Disaster Recovery Plan is updated to include adequate recovery procedures, including business continuity procedures, for the Department's facilities, or references to specific

recovery plans maintained by the facilities. Once updated, the Department should ensure the Disaster Recovery Plan is adequately tested and updated annually, including testing of the Department's systems.

FINDING: *(Weaknesses in Contingency Planning) – First reported 2005, last reported 2021*

The Department of Human Services (Department) did not ensure adequate disaster recovery planning and testing was conducted during the examination period.

The Department's Disaster Recovery Plan had not been updated since 2018. Based on the review, auditors noted the Disaster Recovery Plan did not include specific recovery or business continuity procedures, or reference to existing recovery plans for the Department's facilities.

Additionally, although a table top recovery exercise associated with mainframe operations was performed, a comprehensive test was not performed using the alternate data center or backups of the Department's systems and data during the examination period.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation.

The *Contingency Planning Guide for Federal Information Systems* (Special Publication 800-34) published by National Institute of Standards and Technology (NIST) promotes the formal development and testing of disaster recovery plans. Tests of disaster recovery plans (and any associated documentation) verify that the plan, procedures, resources (including personnel) provide the capability to recover critical systems within the required timeframes.

The finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2005. In the subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

Department management indicated although there had been staffing constraints, they believed the facilities had established recovery plans and were testing annually. Department management also indicated the COVID-19 pandemic was a contributing factor to the weaknesses identified.

Failure to have an updated, comprehensive Disaster Recovery Plan and ensuring the Disaster Recovery Plan is adequately tested increases the risk of extended recovery timeline and system unavailability.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. The Department will work with the Department of Innovation and Technology (DoIT) to update the agency Disaster Recovery Plan to include more comprehensive documentation and testing of facility-specific plans and procedures. Furthermore, the Department continues to work with DoIT to formulate and document a process to test the Alternate Data Center and backups of agency systems and data. These will be accomplished annually, while continuing the annual Tabletop Exercises for the legacy systems.

UPDATED RESPONSE:
In Process.

The Department accepts the recommendation. The Department will work with the Department of Innovation and Technology (DoIT) to update the agency Disaster Recovery Plan to include more comprehensive documentation and testing of facility-specific plans and procedures. Furthermore, the Department continues to work with DoIT to formulate and document a process to test the Alternate Data Center and backups of agency systems and data. These will be accomplished annually, while continuing the annual Tabletop Exercises for the legacy systems.

Corrective Action in Progress:
DHS will continue work to update its current Disaster Recovery plans to include specific business continuity procedures and facilities recovery procedures. (60% complete)

- An Information System Contingency Plan for the IWIC system was completed and approved in May of 2021. There is currently no DR documentation for Cornerstone; this system is being phased out at this time.

DHS will also work to complete a full Disaster Recovery exercise that encompasses failover to the alternate data center along with system and data recovery.

- IWIC application servers were successfully failed over to the ADC in May 2022 and failed back in October 2022. An approved Information System Contingency Plan (ISCP) is on file for IWIC. (100% Complete)
- The Cornerstone system (FoxPro) is reliant on DoIT Citrix cloud infrastructure and is currently Disaster Recovery (DR) capable. DoIT Resiliency is compiling and will publish the Citrix infrastructure DR plan in calendar 2023. At this point, a DR exercise for Cornerstone can take place (10% Complete)

DHS system owners worked with DoIT Resiliency to complete a failover test of the replicated mainframe at the Alternate Data Center in April 2022. Fourteen representative DHS mainframe applications were tested (ten of these were successful). (80% Complete)

- An issue was identified in that Clinical systems access via CICS with special scripts specific to DHS sessions, which resulted in Clinical systems testers not being able to access their applications to test. DoIT Resiliency is working with IBM to remediate the issue and a follow-up failover test is anticipated for Clinical in 2023.

  - Approved Information System Contingency Plans are on file for Clinical systems.
- DataCap servers were successfully failover / failback tested to the DoIT ADC, with the final report from DoIT-Resiliency provided in March 2022. (100% Complete)
- IWIC application servers were successfully failed over to the ADC in May 2022 and failed back in October 2022. An approved Information System Contingency Plan (ISCP) is on file for IWIC. (100% Complete)

Estimated Date of Completion: 12/31/2023

28. The auditors recommend the Department:

- **Create a formalized IT Strategic Plan to communicate long term goals and strategy to DoIT;**

- **Update the interagency agreement between the Department and DoIT to formally define performance criteria for both parties and established Key Performance Indicator metrics to measure that performance; and,**
- **Update the interagency agreement to define roles and responsibilities for security, processing integrity, availability, and confidentially controls.**

FINDING: *(Inadequate Agreement to Ensure Compliance with IT Security Requirements) – New*

The Department of Human Services (Department) had not entered into a sufficiently detailed, comprehensive Department-wide agreement with the Department of Innovation and Technology (DoIT) to ensure prescribed requirements and available security mechanisms were in place in order to protect the security, processing integrity, availability and confidentiality of its systems and data.

During the examination period, auditors noted the Department had entered into an interagency agreement with DoIT effective FY 2020 through FY 2022. However, the review of the interagency agreement noted it lacked the detail needed to adequately address the security, processing integrity, availability and confidentiality of the Department's systems and data, as well as identify each agency's responsibilities. Auditors also noted the inter-agency agreement did not establish formal performance criteria for each agency.

Additionally, auditors noted the Department had not created a formal Information Technology strategic plan to provide to DoIT.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by National Institute of Standards and Technology (NIST), System and Services Acquisition Section, requires the formal development of agreements outlining responsibilities between all parties, defining a strategic plan, and establishing a regular review of contract compliance with contractual terms.

Department management indicated they believed the interagency agreement was sufficiently detailed to satisfy requirements.

Failure to clearly define responsibilities could result in a failure for one party to properly identify and manage risks within their scope of responsibilities resulting a loss of confidentiality, integrity, or availability of Department's data.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. IDHS and the Department of Innovation and Technology (DoIT) are working to execute a new Client Agency Intergovernmental Agreement which contains language attesting to DoIT Enterprise policies, procedures, standards, and operational requirements which DoIT will adhere to in providing secure IT services and support to IDHS. In addition, the Department will work with DoIT-DHS leadership to formalize an IT Strategic Plan and communicate its long-term goals and strategies to DoIT-Central.

UPDATED RESPONSE:

Implemented.

The Department accepts the recommendation. IDHS and the Department of Innovation and Technology (DoIT) are working to execute a new Client Agency Intergovernmental Agreement which contains language attesting to DoIT Enterprise policies, procedures, standards, and operational requirements which DoIT will adhere to in providing secure IT services and support to IDHS. In addition, the Department will work with DoIT-DHS leadership to formalize an IT Strategic Plan and communicate its long-term goals and strategies to DoIT-Central.

Corrective Action Complete:

DHS will work to ensure its newest interagency agreement with DoIT include more specific language to provide formal performance criteria and metrics. (100% Complete)

- DoIT and DHS have completed new Intergovernmental Agreement 2023-025-IGA-PRS, effective to June 30, 2025. The new agreement contains language describing DoIT security policies and roles, security operations such as user access rights, classification of data, security events and breach handling, security auditing and investigation, etc. procedures DoIT will adhere to in supporting DHS applications.

DHS will also work to include specific agency responsibilities along with a formal IT strategic plan. (100% Complete)

- DoIT-DHS has compiled an IT strategy for DHS applications called DHS Application Rationalization.
    - ***App Modernization -*** Phase I has been completed - This included discovery and creation of application inventory document and application management processes
        - o Phase II dialogue has begun with DHS tech owners of production applications Phase II discussions and with business owners. Meeting to review Application Rationalization with Division Directors time and date TBD.
    - ***Application Management*** - The retirement of obsolete applications is ongoing, team working with business owners and DHS archivist on disposition of dormant data.
    - ***Access replacement -*** the team has completed discovery work with each business unit. An "Access" application inventory (documenting what each application is used for) has been completed. The next phase of the effort will include deeper dive discussions with business resources.

Date of Completion: 07/01/2022

29. The auditors recommend Department management ensure the Department's PTS and CARS administration staff work to ensure system access is removed timely.

FINDING: *(Access to Systems Not Controlled) -First reported 2019, last reported 2021*

The Department of Human Services (Department) did not adequately control access to its systems.

During the testing of systems access, auditors noted user access to the Payroll and Timekeeping System (PTS) and the Consolidated Accounting and Reporting System (CARS) was not timely deactivated after separation from the Department. During the testing, auditors compared user accounts as of June 30, 2021 generated from the respective systems, to a listing of all employees terminated during FY 2021, and auditors noted 63 of 1,394 (4.5%) users of PTS and 8 of 361 (2%) users of CARS retained access after their separation date. These 71 employees were terminated between 12 and 321 days prior to June 30, 2021.

Even given the population limitations which hindered the ability to conclude whether the sample selected of Facility PTS users was representative of the population as a whole at the Elgin Mental Health Center, Ludeman Developmental Center, and Illinois Center for Rehabilitation and Education - Roosevelt (See Finding 2021-011), auditors obtained the populations of the Department's users at the facilities to determine if access was appropriate.

During the testing of PTS access at the Department's State-Operated facilities, auditors noted the following:

- User access was not revoked after employee's separation,
- User access rights were given to individuals seemingly not employed by the respective facility during the examination period,
- User access was incorrectly assigned to the wrong facility location, and
- User access was not in alignment with job responsibilities.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by National Institute of Standards and Technology (NIST), Access Control Section, promotes controls for ensuring access to system resources are appropriately authorized. Furthermore, the Department's Administrative Directive (01.02.02.180) outlines provisions for system access in general and requires the Departments Security Coordinators to revoke a separated employee's computer system access at the end of the employee's final day.

Department management stated the primary access termination occurs at the network level, and then at the RACF layer used to restrict access to mainframe-based application systems, preventing employees from accessing state resources. Removal of a user's RACF access prevents access to PTS and CARS residing on the mainframe. However, this has led to the Department's incorrect reliance on network and RACF access removal for access management instead of removing application specific access.

Failure to deactivate access to computer systems is noncompliance with the Department's Administrative Directive and could result in unauthorized access to the Department's systems and data.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. The Department no longer requires Resource Access Control Facility (RACF) IDs for all employees, only for those with a specific need for mainframe access. The Department has begun the process of disabling RACF IDs for individuals with no need for access. DoIT-DHS Management Information Services (MIS) Security will continue to review its access provisioning policies and procedures to ensure proper onboarding and offboarding is emphasized to the agency RACF Coordinators. DoIT-DHS MIS Security will continue to work with the DoIT-DHS Customer Service Training Bureau to document the process of provisioning and de-provisioning "training only" accounts. The Office of Fiscal Services will continue to work with DHS-DoIT to modify user access to systems as staff move throughout and/or leave the Agency. IDHS Office of Fiscal Services will emphasize this requirement, which is included in the off-boarding packet for employees. Furthermore, the Department has replaced use of the Consolidated Accounting and Reporting system (CARS) system with

the Enterprise Resource Planning (ERP) system, which will eliminate many of the access control issues.

UPDATED RESPONSE:
In Process.

The Department accepts the recommendation. The Department no longer requires RACF IDs for all employees, only for those with a specific need for mainframe access. The Department has begun the process of disabling RACF IDs for individuals with no need for access. DoIT-DHS MIS Security will continue to review its access provisioning policies and procedures to ensure proper onboarding and offboarding is emphasized to the agency RACF Coordinators. DoIT-DHS MIS Security will continue to work with the DoIT-DHS Customer Service Training Bureau to document the process of provisioning and de-provisioning "training only" accounts. The Office of Fiscal Services will continue to work with DHS-DoIT to modify user access to systems as staff move throughout and/or leave the Agency. IDHS Office of Fiscal Services will emphasize this requirement, which is included in the off-boarding packet for employees. Furthermore, the Department has replaced use of the CARS system with ERP, which will eliminate many of the access control issues.

Corrective Action in Progress:

Internal PASC system contains SSN of all users. Periodically place the PASC file against the semi-monthly payroll file and look for individuals who are in PASC but not on payroll file. Individuals not on the payroll file are automatically deleted. (100% Completed)

Making direct contact with division timekeepers and provide listing of all users attached to their specific timekeeping group(s) and asking them to verify the validity of the user list. (100% Completed)

Timekeepers have been advised to contact central payroll when a timekeeper terminates/moves. (100% Completed)

Future plan will consist of direct contact and training of all timekeepers highlighting the importance of keeping central payroll apprised of any changes. Also providing a direct contact where they can go to relay this information as opposed to their individual payroll officer. (25% Completed)

Estimated Date of Completion: 03/31/2023

30. The auditors recommend Department management enhance its policies and procedures to ensure facilities and community agencies timely submit written responses to the OIG. Auditors further recommend that if responses are not received within the 30 calendar days outlined by statute, the Secretary determines the appropriate corrective action to be taken as required by law.

FINDING: *(Untimely Receipt of Facility and Community Agency Responses to the Department OIG) - New*

The Department of Human Services (Department) did not ensure mental health facilities, developmental disabilities facilities, and community agencies under its operational authority timely filed written responses with the Department's Office of the Inspector General (OIG).

The Department's OIG Services was created by the Department of Human Services Act (Act) (20 ILCS 1305/1-17) to investigate and report upon allegations of abuse, neglect, or financial exploitation of individuals receiving services within mental health facilities, developmental disabilities facilities, and community agencies operated, licensed, funded, or certified by the Department, but not licensed or certified by any other State Agency.

Further, the Act (20 ILCS 1305/1-17(n)(1)) requires within 30 calendar days from receipt of a substantiated investigative report or an investigative report which contains recommendations, absent a reconsideration request, the facility or community agency shall file a written response with the OIG that addresses, in a concise and reasoned manner, the actions taken to: (i) protect the individual; (ii) prevent recurrences; and (iii) eliminate the problems identified. The written response is required to include the implementation and completion dates of such actions. If the written response is not filed within the allotted 30 calendar day period, the Act then requires the Department's Secretary to determine the appropriate corrective action to be taken.

During the examination period, auditors tested 21 OIG investigate reports in order to determine if the respective facilities or community agency timely filed their written response. The results of the testing indicated 4 of the 21 (19%) investigative report responses from facilities and community agencies were not timely filed within 30 calendar days of receiving the report from the Department's OIG. Responses to the four reports were submitted between 10 and 47 days late by the applicable facility or community agency. During the 10-47 days, auditors further noted the Department's Secretary was not notified the written responses were not submitted within the required 30-day period for the four reports, and therefore, the Secretary did not determine corrective action to be taken.

Department management stated for various reasons the applicable facilities and community agencies were unable to complete the responses within the 30 calendar days. Department management further stated the unfiled responses were not brought to the Secretary's attention because Department management knew the responses were being worked on and would ultimately be completed and submitted by the facilities and community agencies.

Failure to properly file and respond to investigative reports could result in matters not being addressed or remedied in a timely manner, affecting those individuals utilizing the response facilities and community agencies.

DEPARTMENT RESPONSE:
The Department accepts the recommendation. The Department will review and revise policies and procedures to ensure facilities and community agencies submit timely written responses to the IDHS OIG. The Department will also develop a process to ensure that the IDHS Secretary or their designee is notified if responses are not received within 30 calendar days as required so that the Secretary or their designee may determine the appropriate corrective action to be taken.

UPDATED RESPONSE:
In Process.

The Department accepts the recommendation. The Department will review and revise policies and procedures to ensure facilities and community agencies submit timely written responses to the IDHS OIG. The Department will also develop a process to ensure that the IDHS Secretary or their designee is notified if responses are not received within 30 calendar days as required so that the Secretary or their designee may determine the appropriate corrective action to be taken.

Corrective Action in Progress:

Process established for OIG to notify IDHS Secretary or their designee, so that the Secretary or their designee may determine the appropriate corrective action to be taken. (50% Completed)

Policies and procedures reviewed and revised to ensure facilities and community agencies submit timely written response to IDHS OIG. (0% Completed)

Estimated Date of Completion: 6/30/2023

31. The auditors recommend the Department:

- **Develop a project management framework for new application development.**
- **Develop a risk management methodology, perform a comprehensive risk assessment, and implement risk reducing internal controls.**
- **Review the results of vulnerability scanning activity performed to ensure vulnerabilities are remediated timely and information assets are protected.**
- **Document evidence of their annual review of policies and procedures.**
- **Ensure all confidential information is safeguarded and adequately disposed when no longer needed.**

- **Ensure all confidential information is encrypted when sending via email.**

FINDING: *(Weaknesses in Cybersecurity Programs and Practices) – First reported 2019, last reported 2021*

The Department of Human Services (Department) had not implemented adequate internal controls related to cybersecurity programs and practices.

The Department is responsible for the protection of sensitive information collected including Social Security Numbers, personally identifiable information, protected health information, and financial information associated with fulfilling its overall mission.

The Illinois State Auditing Act (30 ILCS 5/3-2.4) requires the Auditor General to review State agencies and their cybersecurity programs and practices. During the examination of the Department's cybersecurity program, practices, and control of confidential information, auditors noted the Department had not:

- Developed a project management framework for new application development.
- Developed a risk management methodology, perform a comprehensive risk assessment, or implemented risk reducing internal controls.
- Reviewed the results of vulnerability scanning activity performed to ensure vulnerabilities were remediated timely and information assets were protected.
- Documented evidence of their annual review of policies and procedures.

Furthermore, during the performance of on-site walk-throughs for seven State-Operated facilities, auditors noted instances of confidential information containing Protected Health Information (PHI) that was not secured and could be viewed by the public. Additionally, for one State-Operated facility, the auditor noted confidential information was being emailed without proper encryption.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by National Institute of Standards and Technology (NIST), requires entities to consider risk management practices, threat environments, legal and regulatory requirements, mission objectives and constraints in order to ensure the security of their applications, data, and continued business mission.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and maintain accountability over the State's resources.

Department management indicated limited resources contributed to the weaknesses noted along with failure to adhere to policies pertaining to PHI at the facilities.

The lack of adequate cybersecurity programs and practices could result in unidentified risk and vulnerabilities, which could ultimately lead to the Department's volumes of personally identifiable information and protected health information being susceptible to cyber-attacks and unauthorized disclosure.

DEPARTMENT RESPONSE:

The Department accepts the recommendation. The Department will continue to work with the Department of Innovation and Technology (DoIT) to perform formal Agency Enterprise IT Risk Assessments on IDHS systems. IDHS will publish language which makes specific reference to its required compliance with DoIT standards. The Department will compile and document Agency systems data stored electronically, on paper, or both. The Department will continue to work to protect all confidential information and remind personnel that evidence provided for business-only purposes should be in electronic form when at all possible and in a password-protected, encrypted format and documentation which includes confidential information will undergo redactions before it is provided. Furthermore, the Department will ensure all employees and agency partners complete the required annual Security Awareness Training.

UPDATED RESPONSE:

In Progress.

The Department accepts the recommendation. The Department will continue to work with the Department of Innovation and Technology (DoIT) to perform formal Agency Enterprise IT Risk Assessments on IDHS systems. IDHS will publish language which makes specific reference to its required compliance with DoIT standards. The Department will compile, and document Agency systems data stored electronically, on paper, or both. The Department will continue to work to protect all confidential information and remind personnel that evidence provided for business-only purposes should be in electronic form when at all possible and in a password-protected, encrypted format and documentation which includes confidential information will undergo redactions before it is provided. Furthermore, the Department will ensure all employees and agency partners complete the required annual Security Awareness Training.

Corrective Action in Progress:

DHS will work to develop a formal project management framework for new application development and formal along with developing a formal risk management methodology. (75% Complete)

DoIT-DHS Security will document and record its review and remediation efforts of vulnerability scanning activity results. (100% Complete)

DHS will work to adopt a tracking method of documenting the annual review of policies and procedures. (50% Complete)

Through training and agency reminders DHS will reinforce the proper safeguarding, disposal of and email encryption process for confidential information. (100% Complete)

DoIT-DHS will complete a DoIT enterprise Agency-wide Risk Assessment exercise (hosted by DoIT Governance, Risk, and Compliance bureau), present findings / results to DHS and DoIT-DHS leadership, and work to remediate gaps identified in the assessment. (100% Complete)

Estimated Date of Completion: 06/30/2023

32. The auditors recommend Department management revise policies which are currently conflicting, maintain and develop internal controls that adequately provide transportation trainings to staff, and enhance management oversight to ensure trip information packets are filled completely.

FINDING: *(Inadequate Controls over Forensic Patient Transport)*

The Department of Human Services (Department) did not implement adequate corrective actions related to its Elgin Mental Health Center (Elgin MHC) Forensic Patient Transport Procedures.

In August 2016, the Office of the Auditor General (OAG) released a Performance Audit of the Department's Forensic Patient Transport Procedures pursuant to Illinois House of Representatives Resolution Number 199 and amended by Legislative Audit Commission Resolution Number 147. The OAG's Forensic Patient Transport Performance Audit contained 5 recommendations in which the Department was to take corrective actions necessary to ensure responsible parties at the Elgin MHC had adequate policies and procedures to ensure material compliance with all relevant governing laws, rules, and regulations. During the previous examination, auditors reported the Department had implemented 2 of the 5 recommendations, and partially implemented 3 of the 5 recommendations.
As required by *Governmental Auditing Standards*, auditors were required to follow-up on the Department's implementation of the corrective actions for the three partially implement recommendations during the examination period.

Based on the follow-up testing procedures, auditors noted the Department still had not yet fully implemented the three partially implemented recommendations. Specifically, auditors noted the following exceptions:

- Revising internal conflicting policies:
  The Department's Elgin MHC Program Directive 02.02.02.101 conflicts with the Department's Office of the Inspector General (OIG) Administrative Code regarding incident reporting.

The Department's OIG Administrative Code (59 Ill. Admin. Code 50.20) requires that the required reporter should report by phone the incident to the OIG hotline within four hours after the initial discovery of the incident. However, the Elgin MHC Program Directive (02.02.05.010) indicates an incident is to be reported in writing to the OIG by completing the OIG Incident Report Form.

Department management indicated that a revised Program Directive was drafted but was still under review during the examination period due to competing priorities of Department managerial staff.

- Ensuring Trip Information packets are filled out completely and appropriately for all trips:
-

During fieldwork, auditors selected 60 trips during the examination period and noted 53 of 60 (88%) trip packets were either not maintained by the Department or did not contain all required detail.

Elgin MHC Forensic Treatment Program Policy 730 (FTP 730), *Transportation Outside the Secure Setting for Court/ Medical/ Other - issued 4/29/2015 and revised 8/29/17*, requires pre-trip documentation to have a vehicle safety & security checklist, a trip information packet, among other documentation. The trip information packet includes details such as date, route, and staffing level. After the trip, the trip information packet is required to be reviewed by the Sallyport Officer to insure it is complete and noted on the Sallyport Officer checklist. If approved, the trip information packet is then to be signed by the senior security office assigned to the trip. The reviewing supervisor is then required to note any additional instructions for the transportation team.

Department management indicated staff responsible for the trip packets did not track them upon returning to the facility due to employee error.

- Ensuring Elgin MHC staff receive annual training on current transportation policy and application of security devices:
-

During fieldwork, auditors selected 21 security personnel at the Elgin MHC during the examination period and noted 9 of 21 (43%) did not attend their annual transportation training.

FTP 730 requires all transportation staff to complete training in current transportation procedure at least annually.

Department management indicated the security personnel did not attend training or maintain documentation of the training due to employee error.

Failure to complete and maintain accurate documentation over forensic transport procedures represents noncompliance with State regulations. Further, failure to follow

internal controls governing the transportation of patients increases the risk of potential harm to the patient, Elgin MHC staff, or unassuming third parties.

DEPARTMENT RESPONSE:
The Department accepts the recommendation. The Department will ensure all local facility policies do not conflict with Statewide Directives and policies will be revised as needed. The Department will train staff on policy changes and ensure that policies and procedures are followed, including correct completion of transportation packets. Furthermore, the Department will ensure facilities conduct training according to internal policies.

UPDATED RESPONSE:
Implemented.

The Department accepts the recommendation. The Department will ensure all local facility policies do not conflict with Statewide Directives and policies will be revised as needed. The Department will train staff on policy changes and ensure that policies and procedures are followed, including correct completion of transportation packets. Furthermore, the Department will ensure facilities conduct training according to internal policies.

Corrective Action in Progress:
All trip packets are collected in a central location and monthly audits are being conducted by the facility to determine compliance. Monthly audits will cease when 3 months of 100% compliance is achieved. (100% Complete)

Facility will complete training of all security personnel. (100% Complete)

Date of Completion: 12/01/2022

33. The auditors recommend Department management enhance its internal controls over the tracking of assigned cellular phones and retain documentation demonstrating the cancelation of cellular phones after the employee has separated from the Department's employment.

FINDING: *(Inadequate Controls over Cellular Phones) - New*

The Department of Human Services (Department) did not maintain adequate internal controls over the tracking of assigned cellular phones or documenting the cancelation of assigned cellular phones.

Specifically, during fieldwork auditors noted the following:

- For FY 2020 and FY 2021, there were 72 and 192 cellular phones, respectively, which were documented as being assigned to individuals who had previously separated from the Department.
- For 5 of 14 (36%) employees selected for testing who had been assigned cellular phones but then subsequently separated from the Department, the Department could not provide documentation in order for auditors to assess the device had been returned in a timely manner after the employees' departure.

The Illinois Department of Innovation and Technology's (DoIT), Wireless Communication Device Policy (Policy), states the Department's Telecommunications Coordinator is responsible for managing the Department's supply of wireless communication devices (WCD), including the following: determining whether a WCD is available for reuse from the Department's existing inventory; regularly reviewing WCD to ensure the WCD is assigned to the proper user(s) and is placed on the correct service plan based on usage; and, forwarding approved and complete services requests, including the name of the WCD user. Further, the Policy states the Department's Telecommunications Coordinator is responsible for securing the return of the WCD issues to an employee who no longer has a need for the WCD, and that the Department is responsible for maintaining an inventory of inactive WCD available for reassignment.

The Department's Administrative Directive (01.02.02.180) states all State-issued property (including cellular phones) must be returned to their separating employee's immediate supervisor before the effective date of separation. The supervisor is then required to contact the appropriate Property Control Coordinator who will forward a request as soon as possible to the Department of Human Services' Management Information Services staff.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the functions and procedures of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls which provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable law.

Department management indicated the errors were due to oversight. Also, Department management stated that upon termination employees are required to return cellular phones to their direct supervisor. In some instances, the cellular phones are retained by the supervisor and not returned to the Property Control Coordinator so that it may be utilized by a newly hired employee.

Failure to document the return of cellular phones represents noncompliance with DoIT's policies and the State Records Act. Further, failure to adequately track and monitor the

assigned individual to cellular phones could result in misuse of State assets and improper telecommunication expenditures.

DEPARTMENT RESPONSE:
The Department accepts the recommendation. The Office of Business Services will work with Executive Leadership, Human Resources, and Division Directors to develop internal processes to ensure timely notification of employee separations, allowing equipment to be appropriately dispositioned and documentation of the same.

UPDATED RESPONSE:
Implemented.

The Department accepts the recommendation. The Office of Business Services will work with Executive Leadership, Human Resources, and Division Directors to develop internal processes to ensure timely notification of employee separations, allowing equipment to be appropriately dispositioned and documentation of the same.

Corrective Action Complete
Work to develop internal processes with Executive Leadership, Human Resources and Division Directors to ensure notification of employee separation, transfer, or retirement and to ensure notification of return of equipment is documented accordingly.

Date of Completion: 02/28/2022

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 five 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 a statement with the Procurement Policy Board and the Auditor General 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.

- In the first quarter of FY20: Estimated Cost - $103,250.00 to establish a Court ordered, appropriate rate for residential services for individuals with developmental disabilities. After the Court's approval of the Ligas Consent Decree, which established the right to placement in community-based settings and receipt of community-based services, the Court ruled that the rates that the Department paid for residential services were too low, and that the Department must expeditiously procure a qualified rate developer, execute their contract, and swiftly commence work to establish an adequate rate. Emergency procurement was crucial to mitigate the amount of time these individuals are subjected to inadequate care and to prevent the Department being in contempt of Court.
- In the second quarter of FY20: Estimated Cost - $1,096,100 in federal funds to extend a current contract for income and employment verification services provided by Equifax/TALX.
- In the fourth quarter of FY20, there were 9:
    - Actual Cost - $159,301.75 in state funds to purchase critical medical supplies needed for the Shapiro Center to address a COVID-19 outbreak. The Center was notified that hospitals were at surge capacity and unable to accept and care for individuals from the Center; therefore, the Center was forced to order the supplies necessary to be able to medically care for their patients.
    - Estimated Cost - $3,672,500 in federal funds to purchase 10,000 gloves, 15,000 face shields, 1,000,000 surgical masks, and 1,000,000 KN95 masks or equivalent from an established vendor in a relatively short timeframe.
    - Estimated Cost - $108,000 in state funds to purchase 7,200 durable face shields customized to Department specifications within a short timeframe.
    - Estimated Cost - $124,240 in federal funds to purchase 6 machines, 1,600 test kits, and onsite training for quick result tests for COVID-19. Abbott Labs was the only vendor selling these types of test kits and their corresponding equipment.
    - Estimated Cost - $1,370,000 in state funds to pay an established vendor to provide crisis communication, manage media relations, direct communications strategies that includes paid media purchases, and produce messaging, content, and collateral for

internal and external audiences for the State related to the COVID-19 pandemic.
    - Actual Cost - $125,000 to purchase surgical masks for the Choate Developmental Center from a vendor who was able to deliver them within two weeks.
    - Estimated Cost - $100,000 to increase the Warm Line hours. The Warm Line is a phone service that offers support to persons with mental health challenges and their families. Service hours need to be expanded to take forwards from the COVID-19 hotline to focus on individuals in isolation.
    - Estimated Cost - $303,541.35 in federal funds to purchase 5,130 gallons of FDA approved, industrial grade and concentrated disinfectant cleaning solution related to the COVID-19 pandemic.
    - Estimated Cost - $1,207,500 in federal funds to procure nitrile gloves from an established vendor to help prevent spread of the Novel Corona Virus.
- In the first quarter of FY21, there were 2:
    - Estimated Cost - $1,660,234.50 in federal funds to purchase 378,450 disposable medical gowns in compliance with FDA Level 2 certification and 28,790 face shields.
    - Actual Cost - $180,000 in federal funds to purchase 20,000 16.9-ounce and 40,000 8-ounce bottles of alcohol-based gel hand sanitizer with a pump dispenser.
- In the second quarter of FY21: Estimated Cost - $150,000 in state funds to have staff receive the required crisis prevention training required for accreditation. In mid-October, DHS lost their crisis prevention trainer that was on staff.
- In the third quarter of FY21, there were 3:
    - Estimated Cost - $415,400 in state funds to purchase a 90-day supply of coal on behalf of the Choate and Murray facilities in order to ensure continued heat and electricity at the facilities.
    - Estimated Cost - $150,000 in state funds to provide continued delivery of Personal Protective Equipment to residential facilities, schools and offices.
    - Estimated Cost - $150,000 in state funds to provide continued delivery of Personal Protective Equipment to residential facilities, schools and offices. This procurement is to a different vendor than the immediately aforementioned emergency procurement.
- In the fourth quarter, there were 2:
    - Estimated Cost - $236,570 in state funds to purchase coal on behalf of the Choate and Murray Centers in order to ensure continued heat and electricity at the facility. The previous vendor filed for bankruptcy and the new vendor is the only supplier with immediate availability in the area.
    - Estimated Cost - $102,492 in state funds to procure a chiller that temporarily replaced an old chiller that could not be fixed due to age.

The vendor delivered, installed and provided maintenance as needed and then removed the chiller once a permanent replacement was found.

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 its officers and employees for whom official headquarters have been designated at any location other than that at which official duties require them to spend the largest part of their working time.

As of July 6, 2021, the Department had 150 employees assigned to locations others than official headquarters.