LEGISLATIVE AUDIT COMMISSION

Performance Audit of the
Medical Assistance Program
Long Term Care Eligibility Determination

September 2009

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RECOMMENDATIONS – 9

Accepted – 3
Partially Accepted – 4
Not Accepted - 2

Background

The federal statute, Title XIX of the Social Security Act, the Code of Federal Regulations, the Illinois Public Aid Code, and the Illinois Administrative Code guide the Illinois Medical Assistance or Medicaid program.

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and State governments jointly fund and administer the Medicaid program. DHFS is responsible for the State's Medicaid program in Illinois. According to the DHFS website, its Bureau of Long Term Care administers the program that reimburses more than 750 nursing facilities for care provided to approximately 57,000 Medicaid-eligible residents each month. In FY07, Healthcare and Family Services paid $1.5 billion for long term care out of a total spent for medical assistance of $11.3 billion.

DHFS and DHS entered into an Interagency Agreement in 2000 regarding the administration of the medical programs and the child support enforcement program. DHFS has sole responsibility for developing and establishing policy with regard to eligibility for medical programs. DHFS is to consult with DHS in the development, dissemination, and implementation of policy. The parties are to jointly incorporate policy and procedure in manuals and other publications. DHFS shall have final approval of all policies regarding medical programs. DHS is to accept applications and make timely eligibility determinations and redeterminations, including spenddown requirements, for individuals applying for benefits under the medical programs.

This audit was initiated based on a case where the State had data problems related to the nursing home group care credit of a client. The group care credit is the amount that the long term care client and the community spouse of the client have to pay monthly for nursing home care. The client had been in a nursing home since 2005. His wife was still living in the community and was making a monthly contribution to his care. The problem was identified when the amount the client's wife was required to pay toward the client's care tripled when her income had not changed significantly. The State has an income-

based formula to determine how much of a co-payment Medicaid long term care patients are charged. When there is a spouse in the community, there are additional calculations that must be done.

Eventually DHS acknowledged the error. DHS recalculated the charge and said she owed nothing for 2008. According to DHS/HFS officials, the nursing home reimbursed the community spouse for amounts overcharged in 2006 and 2007. According to a newspaper article, when DHS was asked if other seniors had been overcharged, DHS officials said they had no way of knowing.

When auditors reviewed the case file, based on the Department's rules and procedures, the spouse should not have had to pay anything for the nursing home care from the very beginning. Because there was a spouse still living in the community, the client's income and assets should all have been transferred to the community spouse.

House Resolution 1295 directed the Auditor General to audit the Medical Assistance Program jointly administered by the Departments of Healthcare and Family Services and Human Services with respect to the accuracy and impact of eligibility determination standards and procedures regarding persons applying for or receiving assistance for long term care, with particular emphasis on the nature and scope of errors in the assessment of the client's financial resources and financial liability.

Report Conclusions

Auditors identified significant and pervasive problems in the processes and data used by the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) which resulted in long term care clients, with spouses residing in the community (community spouse), being overcharged for their nursing home care. The eligibility determination process, specifically the processes used by both Departments related to determining how much income a client with a community spouse must pay to the long term care facility for his or her care, is complex, cumbersome, and confusing.

In their response to the audit report, the agency directors acknowledged that: **"The policies, procedures and systems reviewed are highly complex and confusing."** Auditors are accustomed to dealing with complex and confusing processes. However, the real significance of, and difficulty with, this statement lies with the elderly and vulnerable population who ultimately must deal with these highly complex and confusing policies on a regular basis. Among the issues auditors noted were:

- **The eligibility determination process**, specifically the processes used by both Departments related to determining how much income a client with a community spouse (a spouse residing in the community) must pay to the long term care facility, **is complex, cumbersome, and confusing**.

- **Auditors identified significant and pervasive problems in the processes and data used** by the Departments which resulted in long term care clients with community spouses being overcharged for their nursing home care.

- The most significant problem was that **the Departments automatically add the annual Social Security cost of living increase to the client's group care credit** (the amount that the client and the client's community spouse have to pay monthly for nursing home care).

- This automatic cost of living adjustment **almost always results in the new group care credit being incorrect**, since most or all of the income can be given to the community spouse. If not corrected in a timely manner, it results in the client being overcharged for their care.

- **In 7 of 23 cases** reviewed, there were **14 instances** where more than **two months passed before the group care credit was manually corrected by the caseworker. In 3 of 23 cases,** the group care credits **were not corrected for two years.** In these cases, **the clients were overcharged $9,204, $1,056, and $1,012,** for their care**.**

- The Departments send two notices within a two week period to long term care clients that **provide conflicting, or at best confusing, information** regarding the handling of the clients' Social Security increases.

RECOMMENDATIONS

1. **The Departments of Healthcare and Family Services and Human Services should review the Medical Assistance Program computer systems, specifically for long term care cases with a community spouse, and ensure the systems are working together and serving their intended purpose. The Departments should take the necessary actions to assure that the data contained in those systems is consistent, reliable, and timely updated.**

Findings: Auditors had significant concerns regarding the reliability and validity problems of the electronic data provided by the Departments. Both DHS and HFS operate their own data systems which process data related to long term care. The DHS system is largely a case management system, while the HFS MMIS system is used to process payments to providers.

Healthcare and Family Services Data

Auditors requested data for all nursing home cases that had a community spouse. That data was to include the amount the community spouse was supposed to pay. Auditors received the requested data from HFS in December 2008. The data provided by HFS included 2,756 cases. Previously DHS reported that there were 3,552 in 2008.

Human Services Data

Because there was a discrepancy of 796 cases (29%) between the number of cases with community spouses reported by HFS (2,756) and DHS (3,552), auditors requested the same detailed data from DHS for the same time period (December 2008) to better understand the discrepancies in the data. Auditors received the requested data from DHS in January 2009. The data provided by DHS included 3,866 cases, which meant there was a discrepancy of 1,110 cases in numbers provided by HFS and DHS. There were 2,169 cases that appeared in both data sets, while 587 cases appeared only in HFS data and 1,697 cases appeared only in DHS data. Auditors also identified 13 cases which were duplicates within the HFS data set and one case that was duplicated within the DHS data.

To attempt to identify why there were such discrepancies, auditors analyzed the 2,169 cases that appeared in both data sets to see if the amount that the client or spouse was supposed to pay agreed. Upon comparison, there were only 319 cases, or less than 15%, where the dollar amount agreed.

Revised Data from Agencies

In June 2009, agencies were offered one more opportunity to attempt to address the serious concerns regarding the accuracy and reliability of their data. Both agencies used data as of June 4, 2009. In this comparison, DHS had 2,910 cases while HFS had 3,447 – an 18% difference. The agencies noted that 581 of the HFS cases included spousal diversion codes (referred to as "670" codes) that have been closed by DHS, but not reflected in HFS' Data Warehouse. Agency officials noted that other discrepancies were due to up to a two day lag between DHS extracting the data and HFS loading the Data Warehouse.

Although the total universes, with explanations and adjustments, were closer than before, they still did not match. In addition, the new data runs did not include group care credit amounts, the most important information for this audit, so no assessment of their reliability could be attempted.

In preparing new data sets to reconcile, DHS and HFS discovered new weaknesses in coordination between the two agencies' systems.

HFS and DHS Response: Partially Agree. HFS and DHS agree that our data systems should be improved. Both departments are currently engaged in exhaustive planning efforts to replace our aging data systems with state of the art technology that can operate efficiently and eliminate the kinds of data confusion experienced by the audit team. Over the next several years, the departments will be seeking legislative support for substantial financial investment to implement these new and improved systems.

In the short term, the departments agree to consider whether aspects of the computer systems can and should be modified to enhance service to our long term care customers with community spouses. The departments also agree to review and clarify policy with an eye toward eliminating any requirement for updating irrelevant information.

Nonetheless, the audit has shown no evidence of a lack of data integrity in the existing systems. The auditors found differences in the agencies' data but those differences were not indications of errors. The differences in data resulted from the timing of the data reports and the purpose for which the data was used.

Auditor Comment #6: *The Departments are wrong in their assertion that there is no evidence of a lack of data integrity. The audit* ***documents numerous data issues*** *within the Departments' existing systems. In fact, during the course of the audit,* ***the Departments identified significant limitations with their own systems.*** *DHS and HFS officials noted in jointly provided written responses:*

- *"I believe we overemphasized the need to coordinate the timing of our data pulls* ***without fully taking into account the limitations*** *of the Medicaid Management Information System and the Client Information System* ***in presenting directly comparable documentation of patient care credit*** *[emphasis added];"*
- *"****DHS data may not be correct*** *because entry of patient credit data into the CIS system would be a duplication of effort for DHS staff [emphasis added];"*
- *"While some history is maintained, it is often overwritten when new information is used to update a client's status;" and*
- *We have recently discovered that the Data Warehouse [MMIS] maintains codes [spousal diversion case code] that may have been closed out by DHS. Department officials noted there were* ***581*** *HFS cases that had that code.*

Auditors also noted that:

- *There were corrections made to group care credits in hardcopy files that were not entered into the computerized MMIS system, thereby making the group care credit amounts in the MMIS system incorrect;*
- *In 2 of 23 cases reviewed by auditors, DHS data still showed the cases as active spousal diversion cases even though in one case the client had died, and in the other case, the community spouse had died;*
- *In 7 of 23 cases auditors examined, there were 14 instances where the group care credits were wrong for four months or more. In three of those cases, the group care credit amount was wrong for two years or more. These incorrect amounts were in the Departments' computerized systems; and*
- *For nursing home cases with a community spouse, the central adjustment to Social Security* ***almost always results in the new group care credit being incorrect. These amounts are included in both DHS and HFS systems and are all issues of data integrity.***

All of these issues are specified and discussed in Chapter One of this report.

Agencies Response Continued

For example, HFS's Medicaid Management Information System (MMIS) is the only system used to document the amount of the group care credit. While policy states that DHS's

Client Information System (CIS) is to be updated with the group care credit amount, the data reported in that system is used for informational purposes only, and has no impact on the patient's group care credit. The audit process included a comparison of the group care credit as held in MMIS in July 2008 to the group care credit held in CIS in December 2008. This comparison is flawed and led to the auditors' erroneous conclusion that the data held in each agency's system were negatively affecting our customers. The comparison is flawed because the data comes from two different time periods and is used for different purposes by the departments.

Auditor Comment #7: *The auditors did not reach an "erroneous conclusion." The auditors spent a significant amount of time trying to understand why a case's group care credit in the DHS system would be* ***substantially different*** *than the group care credit in the HFS system. The reasons for the differences in the 23 cases reviewed are detailed graphically and accurately in Exhibit 1-2.*

The Departments are wrong to assert that the data in their systems does not negatively affect their customers. When group care credit amounts are corrected by caseworkers but not corrected in the computer systems, clients are impacted. Furthermore, when their elderly and vulnerable clients ***receive a notice telling them to pay an incorrect amount*** *– an amount that is contained in DHS/HFS data systems – directly to the nursing facility, their clients* ***are negatively affected****.*

HFS and DHS Updated Response: Partially Accepted. DHS and HFS are putting system changes in place to minimize the occurrences of Long Term Care cases containing incorrect and/or inconsistent data.

To ensure that the two systems used to document a client's group care credit amount contain consistent, reliable and timely information, DHS and HFS will implement the following system changes to DHS Client Information System (CIS) and HFS Medicaid Management Information System (MMIS). These changes will be completed in calendar year 2010.

- Updating the patient credit amount in HFS MMIS Long Term Care system whenever the group care credit amount is changed in DHS CIS system.

- Maintaining an electronic history of centrally generated calculation forms (Form 2500) in Mobius (DHS Report Server), to be available upon request.

- Entering a 6 digit date in CIS, indicating the date of change, whenever the group care credit amount is entered or changed.

- Developing an automated module for Long Term Care calculations. Currently the process is manual.

To ensure that staff are currently taking the appropriate actions to update both systems, DHS posted a policy reminder on DHS OneNet system 12/02/09. DHS Regional Administrators and Local office Administrators will follow up with staff to ensure that the information is entered consistently, correctly and timely.

2. The Departments of Healthcare and Family Services and Human Services should work together to undertake a review of cases with group care credits to verify that the amounts are accurate. Furthermore, the Departments should take the steps necessary to ensure that group care credits revised as a result of the redetermination process are timely entered into the MMIS system and other systems.

Findings: In addition to significant differences in the universes of cases provided by both agencies, auditors also found significant differences between the group care credit amounts when they compared the case files with the electronic data received from HFS and DHS. Auditors reviewed 23 long term care cases with a community spouse and checked whether the amount the community spouse was to pay for their spouse's care, or group care credit, agreed among the three sources. The three sources were from: the case file (the most recent LTC Resource Calculation Form); the computerized DHS data; and the computerized HFS data.

The following case illustrates a specific example found during a review of case files. While reviewing case files, auditors determined that they could not identify the group care credit amount which is in the HFS system and the amount that the client has to pay solely through documentation in the files.

Case Example #1: In one case that was reviewed, the client's case file showed that his group care credit amount should be $0. However, the HFS database showed his group care credit amount as $30 and the DHS database showed his group care credit amount as $116.

Only one of the case files with a community spouse reviewed by auditors had the same group care credit amounts in the case file as both sets of electronic data from the two agencies.

To demonstrate that the data in both systems were accurate at the point in time they applied to, the agencies offered to create detailed timelines for each of the 23 cases. The offer noted that explanations could describe the manual process for each case, at which point data was entered into either agency's data system (or why something may not have been entered) and how each case was communicated between agencies to implement the final payment adjustment. Those timelines were provided by the agencies in June 2009.
There were two primary reasons for the differences in group care credits among the three sources. Timing appears to be the first primary factor. The second primary reason for

differences between the data sources was that the DHS case files did not contain any documentation of the 2009 COLA increases.

Review of Sampled Cases

The agencies provided detailed timelines and additional information for each of the 23 cases sampled. The most significant problem auditors identified related to the Departments' handling of the annual Social Security cost of living increases received by clients with community spouses. The Departments **automatically add** the cost of living increase to the client's group care credit (the amount of money the client is required to pay the long term care facility). To correct the amount that the client owes requires either a request from the long term care client and/or a review by a DHS caseworker. In either instance, the DHS caseworker must correct the group care credit information in the HFS MMIS system. This automatic adjustment almost always results in the new group care credit being **incorrect,** since most or all of the income can be given to the community spouse. If not corrected in a timely manner, it results in the client being overcharged for their care.

Although the auditors requested "Copies of any communications that were sent to the client or the family and, in particular, any notices informing them of the amount the client or community spouse was instructed to pay for nursing home services," DHS and HFS did not provide copies or include documentation of all such communications to auditors when providing support for the 23 cases sampled. Also, since the client makes payments directly to the long term care facility for his or her care, DHS and HFS did not have documentation showing how much the clients were paying the long term care facility. Consequently, auditors had to rely on the group care credit amounts shown in HFS' MMIS system as the amount the client was required to contribute to his or her care.

A review of the detailed documentation provided by DHS and HFS for the 23 cases sample identified the following deficiencies:

- **Incorrect/Overstated Group Care Credits:** In many of the long term care cases reviewed, the client was overcharged for months, and in some cases years, because either the client had not requested the additional income to go to the community spouse or because DHS had not conducted the necessary recalculation to correct the amount the client is required to pay. In most cases, at least one or two months passed before the automatic increase in the group care credit due to the Social Security cost of living increase was corrected. There were, however, **14 instances** in seven of the 23 cases auditors examined where the clients' group care credits were incorrect **for more than a two month period** before the group care credit was manually corrected by the caseworker.

- **Delays in Entering Changes into the HFS MMIS System:** In several cases, changes made by caseworkers to correct the client's group care credit were not timely entered into the HFS MMIS system, which is the system used to pay the long term care facilities.

- **Medicare Premium:** In one case the Medicare premium was not netted out of the client's income in 2008, thereby overstating the amount the client had to pay toward his care.

- **Spouse Death:** In one case, a spouse died in November 2008, but the client was still in DHS' system as having a community spouse case in December.

In addition, there are instances where the information provided by the Department to the auditors did not contain adequate documentation to support the changes made to the group care credit amounts. For example:

- In one case, the client's group care credit was $0 from the time of admission in 2007 until January 2009. In January 2009, the group care credit increased to $64 as a result of the Social Security cost of living increase, but the DHS caseworker changed it back to $0 in March 2009. The timeline provided by the Departments then shows the group care credit **increasing to $329** on May 18, 2009, **but did not contain a report or other support** for this adjustment.

- In another case, the client's group care credit was $0 through October 2007. Beginning in November the group care credit began to increase significantly, up to $1,164 as of January 2009. DHS officials stated that the community spouse entered a long term care facility in October 2007, thus there was no more diversion of the client's income to the community spouse, and the client's group care credit increased accordingly. However, the case file did not document this reason and, in fact, contained documentation to the contrary, including a March 2009 DHS "Authorization of Assistance Action" form with $1,088 designated as income to be diverted to a community spouse.

- In another case, the client had a group care credit of $382 in 2008, which increased to $427 in January 2009 due to the 2009 Social Security increase. However, in February 2009, the timeline provided by the Departments showed that the DHS caseworker changed the group care credit to $0. The change was made **retroactive to 2007**. Although the provided timeline contains a notation that information was received from the long term care facility, neither the case file nor other documentation provided support this adjustment. However, **one month later**, in March 2009, the DHS caseworker again changed the group care credit back to $382 for 2008 and to $299 for 2009. Finally, the 2009 group care credit was **changed again** to $329 **one month later** in April 2009 by a DHS caseworker.

HFS and DHS Response: Partially Agree. The departments agree that a review of cases with group care credits would be a constructive task, however, we disagree with some of the audits conclusions.

We agree that, in some instances, caseworker entry of updates into MMIS may not be timely but the timeliness is not always under State control. While some lateness may

result from extremely large caseloads, timeliness is also affected by the lack of response from clients and their families, as well as the long term care facilities; and difficulties in obtaining information from spouses who are not our clients. The departments agree to explore efficient ways of performing a review of cases with group care credits to verify accuracy. In addition, we agree to explore enhancements to our procedures to ensure that the information gathered as part of redeterminations are used in timely calculations of the group care credits of long term care customers with community spouses.

However, the departments disagree with the conclusion that the auditors identified significant and pervasive problems in the processes and data used by the two departments, which resulted in clients being overcharged for their care. The report alleges that in seven cases, there were instances in which the client or client's spouse was inconvenienced by an overcharge for their care, during the time that the Social Security Cost of Living Adjustment (COLA) resulted in a positive group care credit for the client. For six of the seven cases cited, that audit presents no evidence of any client or spouse incurring the hardship of paying the alleged overcharge amount. In contrast to the audit report, the alleged overcharge amount was never collected from the client or spouse in those six cases.

Auditor Comment #8: *When 7 of 23 (30%) cases have incorrect group care credit amounts that were not corrected for 4 months or longer, there are significant and pervasive problems in the processes used by the Departments. Contrary to the Departments' assertions, the audit report does not conclude that the clients were overpaying for their care based on incorrect group care credit amounts. As reported in the audit, the Departments could not provide documentation to show how much the client was actually paying the long term care facility. Consequently, the auditors had to rely on the group care credit amounts shown in HFS' MMIS system as the amount the client was required to contribute to his or her care.*

While the Departments assert that they contacted the nursing homes and determined that in 6 of 7 cases the clients did not overpay for their care, no documentation of such inquiries was shared with auditors. Also, this contact with nursing homes did not occur until after the auditors brought these cases to the Departments' attention. There are likely many other similar cases where elderly and vulnerable clients may have been overcharged for their care which have not been followed up by the Departments. However, the Departments have maintained that it is not their responsibility to determine whether its clients are being overcharged, and as noted in the Departments' response to Recommendation Number 6, "it is not a DHS role to oversee repayments."

Agencies Response Continued

There are specific case citations in the report that require annotation:

- In the two cases described on page 17 of the audit report (also described on page 2 and 3), there were no inaccurate group care credit payments made to the facility by the client or spouse. This has been confirmed by the facilities.

- In the third dot point on page 18 of the audit report, the $329 was a typo in the submitted timelines, and should be removed from the report. The client's group care credit has been $0 since his admission in 2007.

Auditor Comment #9: *The Departments' error has been noted in the audit report.*

Updated HFS and DHS Updated Response: Partially Accepted. The Social Security Administration has announced that there will not be a cost of Living Adjustment (COLA) this year. As a result, Long Term Care residents will not receive additional federal income to divert to community spouses. The next opportunity for COLA will occur in calendar 2011.

- To ensure that active Long Term Care cases with diverted income have the correct group care credit amount, DHS developed a new report identifying Long Term Care cases diverting income. This report will be forwarded to the Family Community Resource Centers. Long Term Care casework staff will review and take appropriate steps to ensure that each case has the correct group care credit amount and that the information in the DHS CIS system and HFS MMIS system is consistent. Regional staff will follow up to ensure appropriate actions are taken. The expected completion date for this review is March 31, 2010.

- To ensure that the group care credit amount is correctly and timely entered, DHS is changing the annual redetermination date for all Long Term Care cases with diverted income. The redetermination for these cases will be completed at the beginning of the year. This will allow the timely diversion of the COLA increase to eligible community spouses and will minimize the instances of clients being overcharged.

- System changes will also be implemented, as outlined in the response to recommendation #1.

- To ensure that the notice is clarified before the next COLA occurs, no later than October 1, 2010, HFS and DHS will collaborate to redesign the centrally generated notices related to COLAs and the opportunity to divert additional income. The two notices that are currently sent to Long Term Care residents with community spouses will be combined into a single notice. The departments will simplify the notice to make certain it provides clear instructions on what must be done to divert the increase.

- When the next federal COLA is announced, HFS will generate a notice to Long Term Care facilities reminding them of the policies they must follow regarding diversion of income.

3. The Departments of Healthcare and Family Services and Human Services should revise and clarify Social Security cost of living notifications sent to clients with community spouses. Notices should tell clients what they should do and not tell them to pay amounts they do not owe.

Findings: In addition to the automatic adjustment made to the client's group care credit, the manner in which the Departments inform clients of the process they must follow to ensure the Social Security increase is not added to their group care credit contributes to the problem. The Departments send two letters within a two week period to long term care clients that provide conflicting, or at best confusing, information regarding the handling of the clients' Social Security increases.

In early December, the agencies send a form letter only to long term care clients with community spouses which states that the client will be getting a Social Security cost of living increase in January, and if they want the increase to go to their community spouse, they need to contact their DHS caseworker. The second notice, which is mailed within two weeks of the first, tells the client the total amount of their new Social Security and the amount which is available each month to pay to the nursing home. The notice says: "**You must pay this money directly to the facility** [emphasis added]." Given that in most cases the client can transfer most or all of this income to the community spouse, this second letter is both misleading and confusing. There is **no mention** in the second letter of the client's ability to give the increase to his or her community spouse.

HFS and DHS Response: Agree. The departments agree to review the Social Security cost of living adjustment notifications and clarify them as needed. Most long term care residents receive only one notice. Two notices have been used in the case of a resident with a community spouse to ensure that each long-term care client is aware of the financial impact of the Social Security increase on their respective case.

Although there is no erroneous information contained in the notices, the departments agree that we may be able to revise them to clarify the action that must be taken if the resident spouse is eligible to and wishes to divert all or a portion of the Social Security increase to their spouse in the community.

Auditor Comment #10: *Contrary to the Departments' assertion,* ***there is erroneous information in the notices.*** *The statement in the second notice which, when referring to the Social Security cost of living increase, states "You must pay this money directly to the facility"* ***is erroneous information*** *when an assessment of the liability of a client with a community spouse has not been made.*

Updated HFS and DHS Response: Accepted. The Social Security Administration has announced that there will not be a Cost of Living Adjustment (COLA) this year. As a result, Long Term Care residents will not receive additional federal income to divert to community spouses. The next opportunity for COLAs will occur in calendar year 2011.

Corrective action to be implemented:

- To assure that the notice is clarified before the next COLA occurs, no later than October 1, 2010, HFS and DHS will collaborate to redesign the centrally generated notices related to COLAs and the opportunity to divert additional income. The two notices that are currently sent to Long Term Care residents with community spouses will be combined into a single notice. The departments will simplify the notice to make certain it provides clear instructions on what must be done to divert the increase.

- HFS will review privacy policies governed by the Health Insurance Portability and Accountability Act as well as other state and federal laws to determine under what circumstances duplicate notices regarding future COLA increases may be sent simultaneously to community spouses in those cases where the community spouse has not already been named the responsible relative able to act on behalf of the resident spouse.

4. The Departments of Healthcare and Family Services and Human Services should stop centrally adjusting the group care credit amount for clients who are diverting income to a community spouse. Instead, caseworkers should adjust the group care credit manually based on current information.

Findings: As noted earlier in this Chapter, the primary cause of the group care credits being inaccurate was the automatic addition of the client's annual Social Security cost of living increase to his or her group care credit. During interviews with DHS field office officials auditors discussed the central budgeting process and how overwhelming a responsibility it can be for some caseworkers.

All but one of the cases sampled had Social Security increases that were centrally budgeted (i.e., the cost of living was automatically added to the client's group care credit). However, this central adjustment almost always results in a group care credit that is incorrect and that needs to be manually corrected by the caseworker. Given the problems caused by the central adjustments and since the DHS caseworkers need to compute them manually anyway, the Departments should consider discontinuing the central budgeting of Social Security cost of living increases for long term care clients who are diverting income to a community spouse.

HFS and DHS Response: Disagree. The departments agree to work together to review and make any appropriate changes to the centrally budgeted group care process for clients with community spouses.

The departments, however, cannot agree to cease centrally adjusting increases in Social Security income received by the resident of a long term care facility. HFS' as Illinois' single state Medicaid agency, must establish policy that comports with federal

requirements. On the other hand in the face of extremely limited resources, DHS must seek to use the most efficient means to fulfill its responsibility for processing the eligibility determinations.

Auditor Comment #11: *Departments' policies already exempt certain cases from central budgeting of the Social Security cost of living increase. One of the 23 cases auditors reviewed* ***was not*** *centrally budgeted. Because all long term care cases with community spouses need to be manually reviewed and adjusted by a caseworker anyway,* ***centrally adjusting them to a wrong amount*** *which the* ***caseworker then has to manually correct*** *does not appear to be an "efficient means" as stated by the Departments in their response.*

Agencies Response Continued

Medicaid eligibility is dependent on income and allowable diversions of that income. The state must presume that a resident's income will be used to offset the cost of the resident's long term care *unless* evidence is presented by the resident, spouse or other authorized party that the couple's total current income makes them eligible for diversion of income from the resident to the community spouse.

The actual central updating of the increase in the clients Social Security benefit and the possible diversion of that income to a spouse are two independent actions. The central budgeting of the SSA COLA is not incorrect, as DHS receives the increase in income data directly from the Social Security Administration.

The state may not allow the increase in the client's income to be diverted to the spouse without additional information. The departments must depend on the client, the client's spouse, or the nursing home facility acting on behalf of the client to provide income verification from several different sources, such as the spouse's SSA amount, private pensions, earned income, other government benefits, investment income, and any other source that may be used in the determination of the eligibility for the diversion.

Automatically allowing diversion of Social Security COLA increases to the community spouse without determining and documenting whether that individual's total income has changed would not assure that the diversion was allowable. Establishing policy that ignores the increase would jeopardize federal Medicaid matching dollars.

Auditor Comment #12: *Auditors concur that federal Medicaid match should not be jeopardized. However, based on documentation provided by the Departments, federal regulations require the State must reduce its payment to a nursing home by the amount that remains* ***after*** *deducting the amount for the maintenance needs of a community spouse. The* ***correct*** *maintenance needs of the community spouse is determined* ***after*** *the caseworker conducts a review of information submitted by the client or the community spouse. Removing long term care cases with a community spouse from the central budgeting process could help to relieve the confusion and stress for this elderly and vulnerable population when they receive an erroneous joint Departmental notice telling*

them to pay an incorrect amount to the nursing facility.

Updated HFS and DHS Response: Not Accepted. The Social Security Administration has announced that there will not be a Cost of Living Adjustment (COLA) this year. As a result, Long Term Care residents will not receive additional federal income to divert to community spouses. The next opportunity for COLAs will occur in calendar year 2011.

The Departments will implement the following corrective action:

- HFS and DHS will enhance efforts to assure residence with community spouses understand the process for changing amounts of income diverted to the community spouse.

- As described previously, HFS and DHS are working to significantly improve the notice that describes the opportunity and process for diverting future federal COLA increases.

- HFS and DHS will collaborate to develop a new notice that will be issued annually after COLA changes have occurred. The new notice will be generated for all Long Term Care residents with a community spouse for whom no adjustment to diverted income has been requested to again advise them of the opportunity to make an adjustment and to describe the process for requesting it.

- DHS and HCD are also implementing the actions previously identified to ensure that the correct maintenance needs of the community spouse is determined, including:

    - Automating the calculation process for Long Term Care cases.

    - Making system changes to ensure that both agencies systems contain consistent information.

    - Changing the redetermination date on all Long Term Care cases with diverted income to the beginning of the year.

    - A special review of Long Term Care cases with diverted income to ensure current information is correct.

    - Providing FCRC staff a report of Long Term Care cases with diverted income every December, to ensure all cases are reviewed for correctness.

5. The Department of Human Services should take the necessary steps to ensure that the client's response or failure of response is recorded in the case notes, which would result in more complete documentation of actions taken regarding the client's group care credit.

Findings: The agencies note that in some cases the increase in the client's group care credit may be due to the fact that the client or community spouse failed to contact the DHS field office as the first notice sent out in December requires.

Documentation of client contacts or client's failure to contact DHS was not included in documentation for any of the cases auditors reviewed. DHS/HFS policy requires that the date and reason for all contacts, actions taken, and decisions made are to be documented in the DHS automated intake system as a case note. Recording the failure of a client or community spouse to contact DHS would provide a better documentation of why an action was taken to increase the client's group care credit amount.

HFS and DHS Response: Disagree. Both departments take the position that it would be impractical to document lack of response to notices. Requiring staff to document lack of response in all cases would be an inefficient use of time, and given current staffing levels, would create further delay in eligibility processing and proper benefit calculations.

Auditor Comment #13: *The audit report states that "Documentation of client contacts or client's failure to contact DHS was not included in documentation for any of the cases auditors reviewed." The Departments stress the critical importance of receiving financial information from the client or community spouse in determining the proper group care credit amount. Given the importance of this interaction, or attempted interaction, it would be reasonable and logical to expect that such interactions be documented so that agency management and third parties would have assurance that appropriate steps were taken to obtain this critical information from the aging clients or community spouses.*

Updated HFS and DHS Response: Not Accepted. However, the Departments will implement the following corrective action:

- HFS and DHS will collaborate to develop a new notice that will be issued annually after COLA changes have occurred. The new notice will be generated for all Long Term Care residents with a community spouse for whom no adjustment to diverted income has been requested to again advise them of the opportunity to make an adjustment and to describe the process for requesting

- To ensure that Long Term Care casework staff are alerted on the importance of documentation, DHS will stress through training and policy alerts the importance of documenting the actions taken on Long Term Care cases. Training will be completed by March 31, 2010.

6. The Departments of Healthcare and Family Services and Human Services should implement a control to ensure that any overpayments made by a client as a result of the Departments' eligibility determination process are repaid to the client by the long term care facility.

Findings: Basic controls to ensure the amounts paid by clients are correct were ineffective in several cases reviewed. The documentation that DHS and HFS provided did not allow auditors to determine if any overpayments made by the client to the long term care facility were repaid to the client and community spouse. Documentation did show HFS' nursing home payment adjustments but no documentation showed any consideration of whether the client payments were checked, corrected, or adjusted.

In the cases where DHS determined that clients had overpaid the long term care facility for their care, DHS retroactively reduced the amount that the client was required to pay to the facility and increased the State's payment to the long term care facility to cover the amount overpaid by the client. Department officials stated that then the long term care facility may be responsible for refunding the money to the client.

When auditors asked Department officials whether they followed-up to ensure that the long term care facilities had reimbursed the clients for any overpayments that the client may have made, Department officials stated that a review of ongoing eligibility includes a review of each client's personal funds and room and board accounts. In the files reviewed there was little evidence to suggest that room and board accounts are checked. Also, in other meetings DHS representatives had said that it is not their responsibility to do this and an HFS representative said they do not check client accounts.

HFS and DHS Response: Partially agree. The departments agree to work toward eliminating situations in which long term care customers may be notified to make a payment to the facility that could result in an overpayment.

The audit report states that DHS or HFS had no documentation that would allow the auditors to determine if any of the overpayments made by the client to the facilities were repaid to the client and/or community spouse. The report erroneously assumes that the clients or community spouses made the overpayments, and contrary to the report, DHS has confirmed that in six of the seven cases cited in the audit, there were no overpayments made by clients to their respective facilities. Additionally, it is not a DHS role to oversee repayments. This is a nursing home accounting function. Any alternative that requires state oversight will require additional funding.

Auditor Comment #14: *The audit report does not "erroneously assume" that in all cases where there was an incorrect group care credit for an extended period of time, that the client "overpaid" for their care. To the contrary, the report goes to great length to disclose that the Departments did not have this information, so auditors could not determine how much, if any, the clients overpaid for their care. While the Departments assert that they contacted the nursing homes and determined that in 6 of 7 cases, the clients did not overpay for their care, no documentation of such inquiries was shared with auditors. Also, this contact with nursing homes did not occur until* ***after*** *the auditors brought these cases to the Departments' attention. There are likely many other similar cases where elderly and vulnerable clients may have been overcharged for their care which have not been followed up by the Departments. However, as noted in the*

Departments' response below to this Recommendation, "it is not a DHS role to oversee repayments."

Finally, if payments made by the State to long term care facilities are reduced for a long period of time because an amount has been erroneously charged to the client (for instance in case 16 profiled in Exhibit 1-3, payments by the State to the nursing facility were reduced by $9,204 over two years to offset amounts that were to have been paid by the client), it would be logical to assume those nursing homes attempted to collect, or did in fact collect, that money from the client and/or the community spouse rather than simply be out that amount.

Updated HFS and DHS Response: Partially Accepted. The Social Security Administration has announced that there will not be a Cost of Living Adjustment (COLA) this year. As a result, Long Term Care residents will not receive additional federal income to divert to community spouses. The next opportunity for COLAs will occur in calendar year 2011.

Correction action to be implemented:

- When the next federal COLA is announced, HFS will generate a notice to Long Term Care facilities reminding them of the policies they must follow regarding diversion of income and their responsibility to refund any retroactive adjustment as well as their obligation to document that action.

- To minimize the instances of clients overpaying the facilities, DHS will change the redetermination date for all Long Term Care cases with diverted income to the beginning of the year. This will allow the timely diversion of the COLA increase to eligible community spouses and will reduce the instances of clients being overcharged.

- Estimated completion date December 2010.

- DHS will also complete a special review of currently active Long Term Care cases with diverted income to ensure that the case is budgeted correctly and that the client is not overpaying the facility. To be completed by March 31, 2010.

7. The Departments of Healthcare and Family Services and Human Services should work together to clarify policies. In particular, attention should be given to:

- **Assuring that using the Mail-In Application for Medical Benefits Form allows clients to get the assistance they need in applying for benefits;**
- **Conducting Annual Facility Visits as is required by established policy;**

- **Clarifying Responsible Relative Policy, so that only applicable long term care clients' spouses are referred for appropriate collection; and**
- **Ensuring that Outdated Forms are not referenced in policy manuals or used by caseworkers.**

The Departments should also assure the established policies are followed by the local offices.

Findings: The Policy Manual used by field offices and caseworkers is written by HFS and administered by DHS. Auditors identified potential policy issues including those related to forms, annual facility visits, and responsible relative policy and identified two areas, the use of the Mail-In Application for Medical Benefits form and the annual facility visit policy, where requirements in the Policy Manual differed from practices occurring at some local field offices.

Mail-In Application for Medical Benefits Form

Auditors reviewed a sample of 27 case files to determine if a completed Mail-In Application for Medical Benefits was in the case files. In a review, case files either contained a paper Mail-In Application for Medical Benefits form or the required signature page. Some files contained a computer print-out of a client's application information input by a caseworker via the computer intake system.

Among four DHS field offices, two used face-to-face interviews and two used mail-in applications. However, DHS central office officials did not know which process was used in each office and said it was at the discretion of the local office.

HFS officials stated it was acceptable to have a caseworker input data from a client electronically since the same information is collected; however, a caseworker must ensure a signed signature page is obtained from applicants or their representative and placed in the case file. An HFS official stated the intent of the policy was to be as flexible as possible for the applicant.

Annual Facility Visits

Some of DHS' local field office caseworkers are not completing or documenting annual facility visits as required by the Policy Manual. The Policy Manual requires the completion of a redetermination at least once a year for all long term care cases. In the 23 case files reviewed where this requirement was applicable, 20 had not received the required facility visits.

Responsible Relative

The Policy Manual does not clearly explain the steps and procedures involved with handling long term care cases with responsible relatives. A responsible relative is a parent or spouse of a client who may be responsible for paying for a portion of the client's care. Caseworkers are instructed to complete and forward a Support Referral Form to the

Bureau of Collections at intake for new applicants. However, the policy is not clear on how a caseworker determines which cases may involve a responsible relative.

Outdated Forms

During a review of case files, auditors found some required forms may be outdated as they had not been updated for many years. Auditors checked with HFS to determine if there had been any significant changes to the updated forms since some of the local offices were using forms with older revision dates and whether the use of outdated forms could negatively affect the eligibility determination process. They concluded that there were not significant changes made to the current revised forms.

One important form erroneously indicates that it should be distributed to Data Entry. However, data has been entered directly by caseworkers for many years. This form is important because it is the link that allows DHS caseworkers to input the group care credit amount which is used in the HFS system. Although there are other forms and processes that electronically calculate and input the group care credit into DHS systems, they are not used to update the HFS system.

HFS and DHS Response: Partially agree. The audit has not presented evidence of overall lack of clarity in policy. HFS and DHS will review the specific concerns raised as explained below. Some of the instances require annotations in the final report.

- **Assuring that the Mail In Application for Medical Benefits Form allows clients to get the assistance they need in applying for benefits.**

  It is DHS policy to help applicants with the application process, as needed, including providing options on how the application can be submitted. DHS accepts walk-in applications, mail-ins and applications via the Internet. Applicants are able to obtain the assistance needed in order to apply for benefits.

  The audit presented no evidence of a family or client not being able to obtain the assistance necessary to complete the application process.

Auditor Comment #15: *Given the complex nature of the application process and the vulnerable population served by this program, the auditors stand by their recommendation that the policy on mail-in applications should be clarified. In two large DHS field offices we were told that long term care applications were done through a mail-in only process. The long term care application process is very complex. Completing a mail-in application is very difficult. Clarifying Department policy to local office officials, to help assure that applicants get the assistance they need from the Departments, is reasonable.*

Agencies Response Continued

- **Conducting Annual Site Visits as is required by established policy.**

  DHS staff in Cook County conduct site visits as required. In other Regions with larger geographical areas and limited resources, staff complete this process by other means,

including telephone and mail. As a result, HFS and DHS will review this policy and revise it as needed.

- **Clarifying Responsible Relative Policy, so that only applicable long term care cases are referred for appropriate collections.**

  The Responsible Relative Policy contained in PM 09-02-04-b is clear and adequately identifies when to and when not to refer cases to the Bureau of Collections. The audit report infers that most referrals to the Bureau of Collections are invalid. The departments disagree with this statement. A referral that does not result in a responsible relative paying for a client's care does not equate to an invalid referral. In addition, to preserve and maximize the State's revenues, it is good business practice to refer cases to the Bureau of Collections for a determination of financial responsibility. That is the only way to protect against inappropriate shifting of financial responsibility from a responsible relative to the taxpayers.

Auditor Comment #16: *The auditors' conclusion that the responsible relative policy either needs to be clarified or more effectively communicated to caseworkers is based largely on input provided by HFS'* ***own*** *Bureau of Collections personnel. Collections personnel reported to auditors that of approximately 60 spousal cases referred each month, only approximately 20 cases* ***should have been referred****. As such, auditors concluded that if two-thirds of the cases being referred to Collections should not have been referred, there is either a problem with the Departments' policies or there is a problem with the Departments' implementation of such policies.*

- **Ensuring that outdated forms are not referenced in policy manuals or used by caseworkers.**

  The Departments note that the audit did not find that any of the forms used resulted in an error or incorrect calculation of a benefit. HFS agrees to review forms to eliminate outdated forms in the Policy Manual and DHS agrees to work to assure that caseworkers do not use outdated forms.

- **Ensuring the established policies are followed by local offices.**

  The departments agree.

Updated HFS and DHS Response: Partially Accepted. Corrective action to be implemented:

- To ensure that DHS casework staff fully understand and correctly apply the Responsible Relative policy, DHS will provide training on the policy to Long Term Care casework staff. Training will be completed by March 31, 2010.

- Until additional resources are available, DHS staff will obtain eligibility information required as part of the annual site visit, via telephone and mail. If deemed appropriate a site visit to the nursing home will also be conducted.

- To ensure that forms and procedures are updated, DHS and HFS are:

  - updating and automating Long Term Care Calculation Form 2500.

  - making Long Term Care Authorization Document Form 2449 available to DHS staff via the Mobius System (DHS Report Server).

- HFS will continue to review all DHS recommendations and in continuing consultation with DHS, will update forms and policies as appropriate.

8. The Department of Human Services should ensure that caseworkers are receiving proper guidance and supervisory review to carry out their required responsibilities. This should include developing and using applicable computerized management reports.

Findings: There were weaknesses in management oversight that related to the Medicaid long term care program. These weaknesses included Overdue for Redetermination reports not being used effectively and supervisory review of caseworkers not performed at DHS. In addition, there were computer system oversight issues and policy coordination issues that are the shared responsibility of HFS and DHS.

Overdue for Redetermination Reports
Auditors reviewed an Overdue for Redetermination report from a field office. The report contained old cases for which eligibility had not been redetermined. Old cases included one dating back **four years** that remained overdue for redetermination as of September 2008.

Auditors then requested a subsequent Overdue for Redetermination report for this same field office. For the two different months reviewed (September and December), they found that nine old cases were repeated on the second report. This included the four year old case.

Lack of Supervisory Review
Based on interviews with field office staff, supervisors are not reviewing most DHS caseworker's eligibility determination results. This is true even though long term care eligibility determination can be a very complex process that is guided by layers of requirements including federal laws and rules, as well as State laws and administrative rules, and Departmental policies and procedures.

At the Medical Field Office in Cook County, an official explained that review is usually done with new hires or when there have been some identified proficiency problems. She said that due to the volume of work, there is no way to systematically have a supervisory review.

Computer Systems Management
Problems identified with data reliability are internal control problems over electronic data for HFS and DHS. These problems may result from weakness in management. There are numerous computer programs used by the LTC caseworkers and it is not clear if or how these systems work together.

DHS Response: Agree. DHS agrees to ensure casework staff receive proper training and guidance. Supervisory review is utilized for new staff, as well as staff that have exhibited performance deficiencies. Due to the increasingly large caseloads and limited number of supervisory personnel it is impossible to review every action taken by a caseworker on each case.

Computerized management reports are necessary, and utilized by local, regional, and central office staff and management. Each Family Community Resource Center (FCRC) is sent a report, which lists the cases that are overdue for a redetermination. The report is separated by caseload, so each caseworker has a listing of his or her cases that require attention.

Central and Regional office staff have the need for a larger picture view of overall redetermination currency. Several reports are available for their use. The Activity Reporting System reports give central office staff the ability to see the redetermination currency for different categories of cases, including long term care, for the State, a region, or a FCRC. In addition, reports can be run that allow central or regional staff to see this information at any given point in time.

Updated DHS Response: Accepted. Corrective action to be implemented:

- By changing the Redetermination date to the beginning of the year for Long Term Care cases with diverted income, and utilizing new and existing reports, DHS Central office and regional staff will ensure that Family Community Resource Center (FCRC) staff have the guidance needed to carry out their responsibilities.

- DHS will also provide Family Community Resource Center (FCRC) staff a report of Long Term Care cases with diverted income every December, to ensure all cases are reviewed for correctness.

9. The Department of Healthcare and Family Services should implement the required provisions of the federal Deficit Reduction Act of 2005.

Findings: HFS has not implemented any changes in the federal law that relate to Medicaid long term care services. The federal Deficit Reduction Act of 2005 made several changes related to eligibility determinations for Medicaid long term care clients. The law was signed in February 2006. The federal law made changes that make the look-back period for asset transfers longer; change when the penalty period is to be applied when a nonallowable asset transfer occurs; require that states use a provision called the income first rule; place a limit on the equity that an applicant can have in a home that is sheltered; and treat the purchase of annuities as an uncompensated and nonallowable transfer.

Look-Back Period
The federal law changed the look-back period for asset transfers from three years to five years. If an applicant transfers assets to someone but does not receive compensation or does not receive adequate compensation, they are to be penalized.

Penalty Period
The federal law requires a change in when the penalty period is applied if there was a nonallowable asset transfer during the look-back period. If property has been transferred for less than it is worth, the applicant may be subject to a penalty period for nursing home services. The length of the penalty period is determined by dividing the dollar value of the nonallowable transfer by the monthly nursing home rate.

Under the new law, the penalty period begins the month that the client is admitted to a nursing home and needs Medicaid assistance. If the client has no available assets to pay for the care during the penalty period, they may have to try to get the money from the recipient of the transfer, or other family members or friends.

Case Example #3 - Old Law	**Case Example #4 - New Law**
A client applies for Medicaid coverage of her long term nursing home care on February 1, 2006, and is otherwise qualified for coverage. The client discloses when she applies that she made $20,000 in gifts, $10,000 to each of two grandchildren, on July 1, 2003. The client's transfer was uncompensated and occurred during her 36-month look-back period. Thus, a penalty period calculation must be employed. Assume that the average monthly cost of nursing home care is $4,000. Dividing the amount of the transfer by the average monthly cost of care results in 5 ($20,000/$4,000 = 5), which represents the number of	A client applies for Medicaid coverage of her long term nursing home care on March 1, 2011, and is otherwise qualified for coverage. The client discloses when she applies that she made $20,000 in gifts, $10,000 to each of two grandchildren, on July 1, 2006. The client's transfer was uncompensated and occurred during her 60-month look-back period. Thus, a penalty period calculation must be employed. Assume that the average monthly cost of nursing home care is $4,000. Dividing the amount of the transfer by the average monthly cost of care results in 5 ($20,000/$4,000 = 5), which represents the number of

months that the penalty period will last. Under the old law, the penalty period would begin on July 1, 2003 (the date of the transfer) and would run through November 2003 (five months). As a result, the client's penalty period would have already expired by the time she applied for Medicaid on February 1, 2006.	months that the penalty period will last. Under the new law, the penalty period would begin on March 1, 2011 (the date of application) and would run through July 2011 (five months). As a result, the client would have to find some way to pay for those five months of care, possibly by recovering the money given to the grandchildren five years earlier.

Income First Rule

Another change made by the federal Deficit Reduction Act requires states to implement a rule related to transferring income or assets to a community spouse to protect against spousal impoverishment. Before the Deficit Reduction Act, states had the option of using the income first method or the resource first method. After the Deficit Reduction Act, states are required to use the income first method.

The ***income first method*** requires the couple to first transfer as much as possible of the institutionalized spouse's income to the community spouse. After that transfer, if the community spouse's income is not as high as the maintenance needs allowance, additional assets can be transferred to purchase an annuity that would increase the community spouse's income up to the maintenance needs allowance. If the transfer of the institutionalized spouse's income brings the community spouse's income up to the maintenance needs allowance, no additional resource transfers would be allowed.

Illinois has used the resource first method. Under the ***resource first method*** a couple would appeal to transfer additional assets (like money in a savings account) to purchase an annuity and increase the community spouse's income up to the maintenance needs allowance. Under this method the additional resource transfer happens first, before considering income of the institutionalized spouse that could be transferred to the community spouse. After using the resource first method, if the institutionalized spouse has additional income, like Social Security, it could be used to pay for a portion of the care in the nursing home.

One negative impact of the income first method is if the institutionalized spouse dies before the community spouse, the community spouse is left with fewer assets to survive on. The spouse may also be left with less income because the surviving spouse could not receive Social Security for both members of the couple. Instead, they would receive the higher amount of the two, but the second income would be lost.

Other Changes

The federal law also requires that annuities purchased during the look-back period specify the State government as the primary beneficiary, after the community spouse's death. So

the annuity that could be purchased to raise the community spouse's income and prevent spousal impoverishment would require the State to be the beneficiary when the community spouse dies.

The new law also places a cap on home equity on a home that is exempted from consideration as an asset in an initial eligibility determination. The limit on home equity would generally be $500,000, but the state could elect to raise the amount to $750,000.

Finally, the law changes two requirements that can be used by a client to avoid a penalty period that should or could affect states:

1. States are barred from "rounding down" fractional periods of ineligibility when determining ineligibility periods resulting from asset transfers.
2. States are permitted to treat multiple transfers of assets as a single transfer and begin any penalty period on the earliest date that would apply to such transfers.

HFS Response: Agree. HFS is drafting administrative rules to implement the DRA mandates.

Auditor Comment #17: *The federal Deficit Reduction Act was passed in February 2006, and contains sweeping changes to the long term care program that will have a significant impact on clients and their community spouses. Three and a half years later, the Department states it is only now in the drafting stage of administrative rules to implement this federal mandate. The auditors do not find the Department's actions to be timely.*

HFS Updated Response: Accepted. Administrative rules to implement the Deficit Reduction Act mandates related to Long Term Care are in the final stage of review prior to filing first notice.