STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
Frank J. Mautino, Auditor General

SUMMARY REPORT DIGEST

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

Financial Audit
For the Year Ended June 30, 2019

Release Date: April 28, 2020

FINDINGS THIS AUDIT: 11

	New	Repeat	Total
Category 1:	**1**	**8**	**9**
Category 2:	**1**	**1**	**2**
Category 3:	**0**	**0**	**0**
TOTAL	**2**	**9**	**11**

FINDINGS LAST AUDIT: 15

AGING SCHEDULE OF REPEATED FINDINGS

Repeated Since	Category 1	Category 2	Category 3
2018	9, 10		
2017	2, 3, 4,	8	
2016	7		
2015	1, 11		

This digest covers the Department of Healthcare and Family Services' Financial Audit as of and for the year ended June 30, 2019. The Department's Compliance Examination covering the two years ended June 30, 2019 will be issued at a later date.

SYNOPSIS

- (**19-01**) The Departments (HFS and DHS) lacked controls over eligibility determinations, redeterminations and Mid-Point Reporting requirements for Federal programs where such determination/requirement is documented using the Integrated Eligibility System.
- (**19-03**) The Departments (HFS and DHS) did not maintain adequate internal control to ensure applications for benefits and redeterminations of eligibility for benefits were completed timely.
- (**19-07**) The Department's internal controls were not sufficient to ensure its annual financial statements were updated for known changes affecting account balances for the year ended June 30, 2019.
- (**19-09**) The Departments (HFS and DHS) failed to design and implement adequate internal controls over the operation of the State of Illinois' Illinois Medicaid Program Advanced Cloud Technology system (IMPACT).

Category 1: Findings that are **material weaknesses** in internal control and/or a **qualification** on compliance with State laws and regulations (material noncompliance).

Category 2: Findings that are **significant deficiencies** in internal control and **noncompliance** with State laws and regulations.

Category 3: Findings that have **no internal control issues but are in noncompliance** with State laws and regulations.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AUDIT
For the Year Ended June 30, 2019

FINANCIAL INFORMATION - Governmental Funds (in thousands)	FY 2019	FY 2018
REVENUES		
Program revenue: charges for service	$ 32,000	$ 37,744
Program revenue: operating grants	12,380,653	14,119,346
General revenue: taxes, interest and other	2,121,331	1,992,894
Total revenue	14,533,984	16,149,984
EXPENDITURES		
Health and social services	18,619,881	17,440,341
Debt service - principal	86	17
Debt service - interest	23	5
Capital outlays	14,237	30,202
Total expenditures	18,634,227	17,470,565
OTHER SOURCES (USES)		
Appropriations from State resources	8,201,356	7,856,040
Transfers in	27,000	44,022
Transfers out	(67,000)	(67,500)
Receipts collected & transmitted to the State Treasury	(3,717,240)	(5,319,267)
Lapsed appropriation	2,907,973	(2,896,519)
Other	20,210	(59,896)
Total other sources (uses)	7,372,299	(443,120)
Increase in fund balance	3,272,056	(1,763,701)
Fund balance, July 1, as restated	(3,460,229)	(1,579,799)
Fund balance, June 30	$ (188,173)	$ (3,343,500)

SELECTED ACCOUNT BALANCES - June 30, Governmental Funds (in thousands)	FY 2019	FY 2018
ASSETS		
Cash and cash equivalents & investments	$ 2,045,583	$ (2,010,626)
Due from other governments - federal & local	1,848,777	2,190,872
Loans, taxes and other receivables, net	568,628	611,659
Due from other Department and State funds	246,929	110,520
Total assets	$ 4,709,917	$ 902,425
LIABILITIES		
Accounts payable and other liabilities	$ 2,742,430	$ 2,316,678
Unearned revenue	-	170
Obligations under securities lending of State Treasurer	155,449	162,000
Due to other funds - State, federal, local & Department	871,320	938,035
Total Liabilities	3,769,199	3,416,883
DEFERRED INFLOWS OF RESOURCES	1,128,891	829,042
FUND BALANCE	(188,173)	(3,343,500)
TOTAL LIABILITIES AND FUND BALANCE	$ 4,709,917	$ 902,425

DIRECTOR
During Audit Period through Current: Ms.Teresa Hursey (Interim, 7/1/18 to 7/10/18); Ms. Patricia Bellock (7/11/18 to 1/18/19); Ms. Theresa Eagleson (effective 1/21/19)

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

INADEQUATE CONTROLS OVER ELIGIBILITY DETERMINATIONS, REDETERMINATIONS AND MID-POINT REPORTING REQUIREMENTS

Inadequate internal controls over eligibility determinations

The Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) (collectively, the "Departments") lacked controls over eligibility determinations, redeterminations and Mid-Point Reporting requirements for Federal programs where such determination/requirement is documented using the Integrated Eligibility System.

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

21.7% of cases tested did not have adequate documentation of proper certification

In order to conclude if the determination of eligibility was proper during the audit period, we selected a sample of 60 cases (29 new applications and 31 redeterminations) and tested whether the cases were properly certified (approved or denied) based on non-financial, financial and timeliness criteria. For SNAP cases we also tested whether the Mid-Point Report (MPR) was timely certified, where applicable. Our testing considered all the documentation contained within the case file, including the scanned documentation supporting caseworker overrides required prior to certification. In 13 of the 60 cases tested (21.7%) we noted 15 exceptions where either the case was not certified timely and/or the case file did not contain documentation supporting eligibility upon certification.

On-site auditor observations noted utilization deficiencies of IES

In order to understand the functions performed by the caseworkers more fully, we conducted on-site observations at three of the Department of Human Services' local offices. We noted the following types of issues the caseworkers encountered in their utilization of IES while working with recipients:

- IES timed out and sent the caseworker back to the login screen while entering recipients' information. Consequently, the caseworker had to reenter information.
- IES indicated a recipients' information contained errors; however, the caseworker's review of the information noted no errors.
- IES had technical errors while interfacing the other applications to conduct verification of the recipients' information.

- IES had errors in determining the benefits for recipients.
- IES had issues determining recipients' eligibility.
- IES was unable to produce correspondence to recipients.

Insufficient communication between IES operating units, financial reporting units, and auditors

Further, we noted insufficient communication between the Departments' internal operating units which administer IES and related systems and the Departments' financial reporting units, along with a lack of communication between the Departments and the auditors. We discovered that in September 2019, HFS' Bureau of Eligibility Integrity identified system defects which resulted in temporary eligibility status recipients, or presumptively eligible recipients, maintaining their eligibility status in error after the Departments had deemed them ineligible. However, this condition was not reported to HFS' financial reporting unit to determine the impact of this defect on the Departments' financial statements, and it was not made known to the auditors. In fact, it was not until February 2020, during testing for the Statewide Single Audit performed by other auditors, that exceptions in the other auditors' testing and further inquiries related thereto led to HFS' disclosure of the existence of these system defects. At our request, HFS performed an analysis of the impact of this defect on the Departments' financial statements and determined HFS paid benefits of $4.7 million in error for recipients who had been determined ineligible and received $217 thousand in federal financial participation (FFP) from those disbursements, pertaining to fiscal year 2019.

IES deficiency not discovered by financial reporting units or auditors until February 2020

The lack of a formal process to communicate matters such as those identified above represents a significant weakness in internal control over the Departments' financial reporting. It is essential that financial-related consequences of system defects be communicated with appropriate fiscal personnel to determine the potential impact on the financial statements. Further, full and timely disclosure of potential or known problems to the auditors is essential to avoiding delays in the audits, including audits of the Departments' financial statements, the Statewide Single Audit, and the Statewide Comprehensive Annual Financial Report. (Finding 1, pages 52-55) **This finding has been repeated since 2015.**

We recommended management of the Departments provide adequate training and supervision of caseworkers, implement additional controls to ensure appropriate documentation of eligibility is obtained at the time of certification and retained in IES, complete certifications of applications and redeterminations timely, establish formal lines of communication between operating unit personnel and financial reporting personnel, and correct IES application errors.

HFS accepted the recommendation

HFS officials accepted the recommendation and stated the Department will work with DHS and the Department of Innovation and Technology to improve staff training materials

and communication, maintain better documentation through use of electronic case records, address timeliness issues with both applications and redeterminations through staff hiring and process simplification, and prioritize defects and enhancements for release into IES to improve performance and accuracy. Further, HFS stated the HFS Division of Medical Programs and the Division of Finance will develop a formal process to communicate any system defects that may have financial impact.

UNTIMELY PROCESSING OF APPLICATIONS FOR BENEFITS AND REDETERMINATIONS OF ELIGIBILITY FOR BENEFITS

The Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) (collectively, the "Departments") did not maintain adequate internal control to ensure applications for benefits and redeterminations of eligibility for benefits were completed timely.

Applications and redeterminations were not reviewed and approved or denied within mandated timeframes

As part of our audit procedures, we tested the Departments' compliance with the federal time requirements for approving or denying applications, conducting redeterminations, and working any changes communicated by recipients for the SNAP, TANF, and Medical programs.

Backlog of 127,199 applications as of June 30, 2019

We were unable to determine timeliness of 1,279 backlogged applications

- For initial applications – The Departments had a backlog of 107,242 Medical applications, 19,957 SNAP applications, and 6,476 TANF applications, for which the determination of eligibility to receive benefits was not complete as of June 30, 2019. Additionally, there were 1,279 applications in which the applicant did not specify the program; therefore, we were unable to determine the timeliness of the application.

Backlog of 171,700 redeterminations as of June 30, 2019

We were unable to determine timeliness of 70,758 backlogged redeterminations

- For redeterminations - The Departments had incurred a backlog of at least 170,720 medical redeterminations, and 980 SNAP and TANF redeterminations as of June 30, 2019. In addition to the known redetermination backlog, because of a defect within IES, the date information was received was not documented and we were unable to determine the timeliness of the redeterminations for 68,612 Medical recipients and 2,146 SNAP and TANF recipients.

Backlog of 51,903 change documents as of June 30, 2019

- For change documentation (a/k/a maintenance) - The Departments had a backlog of 51,903 cases for which information had been received by the Departments but not reviewed as of June 30, 2019. Because the information had not been reviewed, the Departments did not know which program(s) might be impacted.

As such, we were unable to determine the timeliness of processing the information. (Finding 3, page 59-61) **This finding has been repeated since 2017.**

We recommended the Departments work together to implement controls to comply with the requirement that applications are reviewed and approved or denied within 45 or 30 days, as applicable, and the Departments should establish appropriate controls to both monitor the progress of eligibility redeterminations and ensure those redeterminations occur timely along with any change documentation received.

HFS accepted the recommendation

HFS accepted the recommendation and stated all backlogs are being addressed through a combination of staff hiring, enhanced training, process simplifications, policy streamlining and system enhancements.

FINANCIAL STATEMENT PREPARATION WEAKNESSES

Department did not update its financial statements for known changes affecting account balances

The Department of Healthcare and Family Services' (Department) internal controls were not sufficient to ensure its annual financial statements were updated for known changes affecting account balances for the year ended June 30, 2019.

Information received subsequent to drafting financial statements was not taken into consideration, and as a result, the medical accrual was reduced by $70.2 million

Annually, the Department reports a liability on its balance sheet for obligations for various medical claims incurred during the fiscal year. The Department refers to this liability as the medical accrual. One component of the calculation of the medical accrual liability at June 30, 2019, was an estimated amount owed related to changes in capitation rates. Although the Department received its 2019 calendar year rates in November of 2018, for various reasons it delayed implementing rate changes until an amendment of the 2019 rates was received. From January 2019 through June 2019 the Department had paid claims at the 2018 calendar year rates until such time as the 2019 calendar year rates amendment was approved and implemented. When the Department initially drafted its financial statements it estimated the amount payable for the difference of the amounts paid previously using the old rates compared to what would be owed and retroactively payable under new 2019 rates. However, on September 25, 2019, the Department received the final 2019 amended rates and therefore should have corrected its liability calculation using the final 2019 amended rates for its financial statements. The Department's failure to update its medical accrual calculation resulted in an overstatement of liabilities in its financial statements totaling $70.2 million for this issue. The Department corrected its financial statements after the auditors made it aware of the misstatement. (Finding 7, pages 69-70) **This finding has been repeated since 2016.**

We recommended the Department strengthen its internal controls to ensure its financial statements are updated for known changes affecting year end account balances.

Department accepted the recommendation

The Department accepted the recommendation and stated the Department will strengthen its controls to obtain monthly updates on significant estimates used in the calculation of the medical accrual liability.

INSUFFICIENT REVIEW AND DOCUMENTATION OF PROVIDER ENROLLMENT DETERMINATIONS AND FAILURE TO EXECUTE INTERAGENCY AGREEMENTS

Failure to establish and implement controls over IMPACT

The Department of Healthcare and Family Services (HFS), and the Department of Human Services (DHS) (collectively, the "Departments") failed to design and implement adequate internal controls over the operation of the State of Illinois' Illinois Medicaid Program Advanced Cloud Technology system (IMPACT). Specifically, we noted the Departments

Insufficient review of enrollment determinations

did not sufficiently review and document approval for provider enrollments and had not entered into interagency agreements (IA) defining each agency's roles and responsibilities.

HFS' and DHS' Roles

As set by the State of Illinois' State Plan under Title XIX of the Social Security Act (State Plan) (Section 1.1), the State's designated agency responsible for administering and supervising the administration of the Medicaid Program is HFS. However, Section 1.1 of the State Plan allows for 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) services.

Auditor Testing and Results

Interagency Agreements

Departments did not have IAs defining roles and responsibilities

We noted the Departments did not have interagency agreements defining the specific roles and responsibilities.

Quality/Supervisory Reviews Not Conducted

Departments did not perform quality/supervisory reviews

We noted the Departments do not have a process for supervisors to perform, at least on a sample basis, quality reviews of the activities performed by staff to obtain independent evidence that staff members are acting within the scope of their authority and that transactions and events comport with management's expectations.

Detail Sample Testing

Based on the population provided by HFS, during Fiscal Year 2019, 26,529 provider applications were approved. In order to determine if the providers' applications were approved in accordance with federal and State laws/rules/regulations, a sample of 40 approved applications were selected for testing. Our testing of the 40 provider files noted:

Inadequate controls over backdating provider eligibility dates for 32 of 38 (84%) provider files tested

- 38 approved provider applications included requests for the applicable Department to backdate their enrollment beginning dates. Of those 38 approved applications, 28 (74%) provider files did not contain documentation of the Department's reason for allowing an exception and thereby backdating the provider's enrollment. As a result, we could not determine if the backdating of enrollment, and the subsequent payments was proper. Also, 4 of the 38 (11%) provider files were backdated in excess of HFS' policy, ranging from 19 to 413 days past the 180 day limit.

- 8 (20%) provider files did not contain documentation the applicable Department reviewed the provider's required professional license or board certification to confirm the licenses/certifications were valid at the time the application was approved.

- 3 (8%) provider files did not have documentation the applicable Department confirmed the provider's national board certification end date. In fact the certifications were recorded with open ended expiration dates within IMPACT.

- 1 (3%) provider file noted a felony charge during the screening process. However, there was no documentation the application was sent to the Office of Inspector General (OIG) for detailed review and approval.

DHS Testing

DHS did not utilize IMPACT as book of record

During our testing, we determined DHS did not utilize IMPACT as the book of record or rely on it to verify their providers met certain Medicaid requirements prior to approving them to provide services. In fact, DHS was performing procedures to determine if the providers met certain Medicaid eligibility requirements outside of IMPACT. Upon completion of those procedures, DHS entered the information into IMPACT and approved the provider in order to grant the approval for payment. However, DHS did not regularly follow-up on discrepancies identified upon IMPACT completing verification of information, background checks, and professional licensing. Additionally, on a monthly basis IMPACT checks provider profiles against several databases to determine if the provider licenses are valid and current, and identifies suspected criminal activity. However, we

DHS did not follow-up on provider eligibility discrepancies after initial eligibility determination

determined DHS was not regularly following up on noted issues.

Although DHS performed various procedures in determining if providers met the Medicaid eligibility requirements, we noted there was no consistent process for reviewing issues identified and reporting to HFS to ensure only eligible providers were paid with federal and/or State funds. (Finding 9, page 73-76)

We recommended management of the Departments improve controls to ensure each Departments' staff and supervisors are properly obtaining, reviewing, and retaining documentation in IMPACT to support Medicaid provider enrollment and execute detailed interagency agreements defining the roles and responsibilities of each agency regarding the Medicaid program. Furthermore, we recommended DHS utilize IMPACT as their book of record for provider enrollment. DHS should also develop controls to review any noted issues and notify HFS of any issues affecting eligibility.

HFS accepted the recommendation

HFS accepted the recommendation and stated the Department has adopted a formal quality assurance process that has been memorialized in a new Standard Operating Procedure (SOP). In addition, HFS stated the Department is updating existing SOPs, where appropriate, to clearly outline the comment requirements and providing sample comment suggestions to standardize the process amongst all staff and these updates will be shared with staff during future staff training sessions. Lastly, HFS stated all SOPs have also been incorporated into the sister agency Interagency Agreements that have been drafted.

OTHER FINDINGS

The remaining findings pertain to the lack of security controls over the IES, insufficient internal controls over changes to the IES and recipient data, inadequate disaster recovery over the IES, the lack of a detailed agreement with the Department of Innovation & Technology, incorrect claim payments, inadequate general information technology controls over IMPACT, and failure to review external service providers' internal controls. We will review the Department's progress towards the implementation of our recommendations in our next financial audit.

AUDITOR'S OPINION

The auditors stated the financial statements of the Department of Healthcare and Family Services as of and for the year ended June 30, 2019 are fairly stated in all material respects.

This financial audit was performed by Sikich LLP.

SIGNED ORIGINAL ON FILE

JANE CLARK
Division Director

This report is transmitted in accordance with Section 3-14 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

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