



STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

**PERFORMANCE AUDIT
OF
MEDICAID ELIGIBILITY
DETERMINATIONS
FOR LONG-TERM CARE**

MARCH 2019

FRANK J. MAUTINO

AUDITOR GENERAL

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OFFICE OF THE AUDITOR GENERAL
FRANK J. MAUTINO

*To the Legislative Audit Commission, the Speaker
and Minority Leader of the House of Representatives,
the President and Minority Leader of the Senate, the
members of the General Assembly, and the
Governor:*

This is our report of the performance audit of Medicaid eligibility determinations for long-term care.

The audit was conducted pursuant to the Illinois Public Aid Code at 305 ILCS 5/11-5.4 (enacted by Public Act 100-380 and amended by Public Act 100-665). This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

Springfield, Illinois
March 2019



STATE OF ILLINOIS OFFICE OF THE AUDITOR GENERAL

Frank J. Mautino, Auditor General

REPORT DIGEST

PERFORMANCE AUDIT

**Release Date:
March 2019**

Audit performed in
accordance with
Public Act 100-380

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EXECUTIVE SUMMARY

Medicaid Eligibility Determinations for Long-Term Care

The Illinois Public Aid Code at 305 ILCS 5/11-5.4 (enacted by Public Act 100-380 and amended by Public Act 100-665) required the Office of the Auditor General to conduct a performance audit of Medicaid eligibility determinations for long-term care (LTC). The audit was to review and evaluate:

- Compliance with federal regulations on timeliness of eligibility determinations;
- The accuracy and completeness of the monthly report required by the Illinois Public Aid Code;
- The efficacy and efficiency of the application processing approach used for making eligibility determinations, including the role of the Integrated Eligibility System, compared to the prior application processing approach; and
- Any issues affecting eligibility determinations related to the Department of Human Services (DHS) completing Medicaid eligibility determinations instead of the designated single State Medicaid agency in Illinois, the Department of Healthcare and Family Services (HFS).

Key findings of the audit include the following:

- Auditors reviewed data consisting of 39,146 long-term care applications received in calendar years 2015 through 2017. However, due to issues with the data, calculating timeliness for the population of applications was not possible. Therefore auditors selected a sample of applications for testing.
- For the 61 applications tested, the applications were, on average, 69 days overdue. Twelve of 61 applications (20%) had an eligibility determination within the required timeline, 14 applications (23%) were between 2 and 26 days overdue, and the remaining 35 applications (57%) were overdue by more than 30 days.
- HFS and DHS do not track extensions in a manner that makes it easy to identify the dates of the extensions or the number of extensions that have been granted for each case. As a result, the timeliness of pending applications will appear worse than it actually is. Testing showed that processing times for 28 of 61 applications (46%) could have been shortened by up to 60 days by subtracting extension days from eligibility determination processing time.
- LTC reports were not being posted on both the DHS and HFS websites on a monthly basis as required, did not always contain all elements required by statute, and were not accurate due to issues with the source data and a potential overstatement of the number of days applications are pending.
- While it is difficult to ascertain the efficiency and efficacy of the task-based process compared to the caseworker-based process, the decision to switch to the task-based approach appeared to be based upon business process research and reasonable assumptions. The switch was complicated by the concurrent implementation of the Integrated Eligibility System.

The audit contains a total of 8 recommendations to HFS, HFS Office of the Inspector General, and DHS.

AUDIT SUMMARY AND RESULTS

On August 25, 2017, the Governor signed into law Public Act 100-380, which amended the Illinois Public Aid Code and required the Auditor General to report on the performance and compliance of the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), and the Department on Aging concerning eligibility determinations for Medicaid long-term care services and supports. Specifically, the audit was to review and evaluate:

- compliance with federal regulations on furnishing long-term care services promptly to beneficiaries under 42 CFR 435.930;
- compliance with federal regulations on the timely determination of eligibility as provided under 42 CFR 435.912;
- the accuracy and completeness of the monthly monitoring report of long-term care eligibility processing required by Section 11-5.4(e)(9) of the Illinois Public Aid Code (Section 11-5.4(f) after amendment by Public Act 100-665 effective August 2, 2018);
- the efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of the Department of Human Services for long-term care services, including the role of the State's Integrated Eligibility System, as opposed to the traditional caseworker-specific process from which the central offices converted; and
- any issues affecting eligibility determinations related to the Department of Human Services' staff completing Medicaid eligibility determinations instead of the designated single State Medicaid agency in Illinois, the Department of Healthcare and Family Services (prior to Public Act 100-665, 305 ILCS 5/11-5.4(f); following, 305 ILCS 5/11-5.4(g)).

During the course of the audit, Section 11-5.4 of the Public Aid Code was amended by Public Act 100-665, effective August 2, 2018. In instances in which the Public Aid Code citations changed as a result of Public Act 100-665, auditors provided both the Public Aid Code citation prior to the change and the citation following the change.

Timeliness of Eligibility Determinations

Auditors reviewed data consisting of 39,146 long-term care (LTC) applications received in calendar years 2015 through 2017. Upon review of the data, which was pulled from the LTC application tracking database utilized by HFS and DHS, auditors determined calculating timeliness for the population of applications using the data provided was not possible. The data did not capture all dates necessary to accurately determine the timeliness of each application's eligibility determination. In addition, the data contained duplicate entries and a co-mingling of information among records for applicants who had submitted multiple applications. For these reasons, an accurate calculation of timeliness required testing individual applications as opposed to being able to test and report on the timeliness of all applications in the population. Auditors focused on the timeliness of the

eligibility determinations; auditors did not assess if eligibility was determined correctly.

According to HFS data, 12,787 LTC applications were submitted for Medicaid eligibility determinations in calendar year 2017. Auditors selected a sample of 55 individuals, which consisted of 61 total applications.

Twelve of 61 applications tested (20%) had an eligibility determination within the required timeline.

Auditors found that 12 applications (20%) had an eligibility determination within the required timeline (45 days, 60 days for applications on the basis of a disability, or 135 days if referred for asset investigation).

An additional 14 applications (23%) were completed between 2 and 26 days beyond the required timeline. The remaining 35 applications (57%) were overdue by more than 30 days, ranging from 36 to 381 days.

Digest Exhibit 1 DAYS OVERDUE FOR APPLICATION TESTING Sample of Applications Tested	
Days Overdue	# of Applications
0	12
1-30	14
31-45	5
46-60	5
61-90	6
91-120	10
121+	9
Source: OAG analysis of application testing.	

For the 61 applications tested, the applications were, on average, 69 days overdue.

Digest Exhibit 1 provides a breakdown of the days overdue for the 61 applications tested. When calculating days overdue, auditors subtracted extensions requested by the applicants. On average, the 61 applications were 69 days overdue. Auditors made a recommendation in this area.

Ten of the 61 applications tested were referred to the HFS OIG for asset discovery investigations. Prior to August 2, 2018 (the effective date of Public Act 100-665), the Public Aid Code (305 ILCS 5/11-5.4(a)) allowed an extension of up to 90 days (i.e., 135 day total processing time limit). Applications involving asset discovery investigations were overdue (beyond the 135 day time limit) by 114 days on average. However, auditors found that the delay is a combination of time the application is being worked at the HFS OIG and at DHS. On average, the 10 applications in our sample were at the HFS OIG for 127 days after extension days were subtracted. For four of the applications (40%), completion of the asset investigation took less than the 90 days allowed by the Public Aid Code. The asset investigation for the remaining six (one of which was ongoing at the time of our testing in August 2018) took between 118 and 253 days.

Auditors found that in 5 of 10 asset investigation cases (50%), once an asset investigation was concluded and the HFS OIG notified DHS of the recommendation on the application, DHS implemented the recommendation from the HFS OIG promptly within 5 days. In 4 cases (40%), DHS did not take action on the case (implement the recommendation from the HFS OIG) for between 19 and 88 days. The remaining asset investigation was ongoing at the time of our testing, and therefore, the HFS OIG had not yet made a recommendation to DHS. Auditors made a recommendation in this area.

HFS and DHS do not adequately track extensions. As a result, the timeliness of pending applications will appear worse than it actually is.

HFS and DHS do not adequately track extensions. HFS and DHS do not track extensions in a manner that makes it easy to identify the dates of the extensions or the number of extensions that have been granted for each case. The Public Aid Code requires the time limits for processing an application to be tolled, or paused, during the period of an applicant-requested extension, essentially subtracting time granted through these extensions from the application processing times (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(8); following, 305 ILCS 5/11-5.4(e)). However, if extensions or extension dates are not easy to identify or not captured at all, then the extension processing times cannot be subtracted from the eligibility determination processing time as required. As a result, the timeliness of pending applications will appear worse than it actually is. Additionally, when extensions are not tracked adequately, it is difficult to ensure that DHS and HFS are limiting applications to two extensions.

Processing times for 28 of 61 applications (46%) could have been shortened by up to 60 days by subtracting extension days from eligibility determination processing time as required by statute.

Auditors tested 61 applications and found evidence of a request for an extension by the applicant in 28 of these 61 applications (46%). In total, 38 extensions were granted for the 28 applications. Auditors found that the processing time for these 28 applications could have been shortened by up to 60 days (12 to 60 days). Also, one application received three extensions in violation of the Public Aid Code and Administrative Code. Auditors made a recommendation in this area. (pages 21-27)

Although discrepancies exist due to different data sources, the reports on HFS’ website and the reports to the federal Centers for Medicare and Medicaid Services both showed that not all applicants are receiving their determination of eligibility within the timelines established by federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 Ill. Adm. Code 110.20 and 10.420). (pages 19-21)

LTC Monthly Reporting

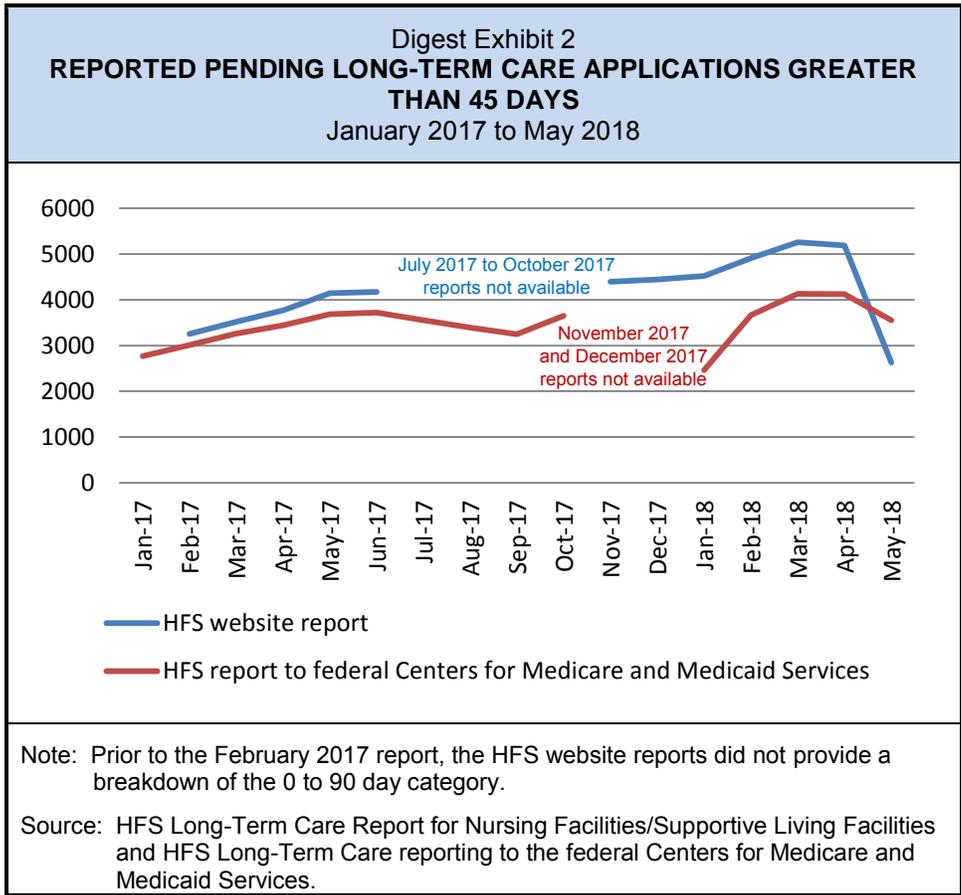
Auditors found various issues with LTC monthly reports required by the Public Aid Code.

Auditors found various issues with the LTC monthly reports required by the Public Aid Code including:

- Reports were not being posted on both the DHS and HFS websites on a monthly basis as required;
- Reports did not always contain all elements required by statute (some elements were not included for a period and others were not included in any of the monthly reports tested); and
- Reports were not accurate due to duplicate entries and other issues with the source data and a potential overstatement of the number of days applications are pending.

Auditors also found discrepancies in LTC pending application numbers reported by HFS. Auditors compared numbers posted to the HFS website to reports submitted to the federal Centers for Medicare and Medicaid Services and found various discrepancies. According to HFS officials, these differences occurred because the reports had two different data sources, an application tracking database and the Integrated Eligibility System; however, beginning in September 2018, both reports will be produced using data from the Integrated Eligibility System. Digest Exhibit 2 shows the pending applications reported in the LTC monthly reports and to the federal Centers

for Medicare and Medicaid Services for January 2017 through May 2018. Auditors made recommendations in this area. (pages 30-38)



Application Processing Approaches

By November 2014, DHS moved from a caseworker-based approach to application processing to a Statewide task-based approach. This change to task-based processing was implemented at both Family Community Resource Centers (local offices) and Long-Term Care hubs.

Auditors were asked to evaluate the efficacy and the efficiency of the task-based process used for making eligibility determinations, including the role of the State’s Integrated Eligibility System, as opposed to the caseworker-based process. Assessing the efficiency and efficacy of the task-based process was complicated by the fact that the switch to the task-based approach happened concurrently with the implementation of the Integrated Eligibility System. While it is difficult to ascertain the efficiency and efficacy of the task-based process compared to the caseworker-based process, the decision to switch to the task-based approach appeared to be based upon business process research and reasonable assumptions. (pages 39-43)

The switch to the task-based approach to case processing appeared to be based upon business process research and reasonable assumptions.

Delegation of Medicaid Eligibility Determination

Auditors found it is not unusual for the designated single State Medicaid agency to delegate authority to determine eligibility. Illinois' State Plan for Medicaid delegated authority to DHS effective July 1, 1997. This delegation of authority was approved by the federal Centers for Medicare and Medicaid Services on August 30, 1999. Additionally, to determine if other states were delegating the Medicaid eligibility function, auditors reviewed State Plan documents for 26 other states. Auditors found that 14 of the 26 states reviewed delegate Medicaid eligibility determinations in varying degrees, similar to Illinois.

Although HFS develops the policies DHS utilizes, HFS is not directly involved in the determination of eligibility for Medicaid. DHS caseworkers review the application, request additional information from the applicant, if necessary, and determine eligibility. Auditors found no apparent issues affecting eligibility determinations related to DHS staff completing these determinations instead of HFS, the single State Medicaid agency. (pages 15-16)

RECOMMENDATIONS

The audit report contains eight recommendations: two recommendations directed to HFS, three directed to HFS and DHS, and three directed to HFS, DHS, and the HFS OIG. The agencies agreed with the recommendations. Appendix E to the audit report contains the agency responses.

This performance audit was conducted by staff of the Office of the Auditor General.

SIGNED ORIGINAL ON FILE

JOE BUTCHER
Division Assistant 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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TABLE OF CONTENTS

	Auditor General’s Transmittal Letter Report Digest Table of Contents	i
Chapter One INTRODUCTION AND BACKGROUND	Report Conclusions Introduction Background Agencies Involved with LTC Eligibility Determinations LTC Eligibility Determination Process Updates to LTC Policy Manual • Recommendation 1: Update LTC Policy Manual Guidance Delegated Authority to Determine Eligibility	1 4 5 5 10 14 15 15
Chapter Two TIMELINESS OF ELIGIBILITY DETERMINATIONS	Chapter Conclusions LTC Medicaid Eligibility Determination Timeliness Timeliness Testing • Recommendation 2: Eligibility Determination Timeliness • Recommendation 3: HFS OIG Application Referrals • Recommendation 4: Tracking of Extensions	17 18 21 23 26 27
Chapter Three LTC MONTHLY REPORTING	Chapter Conclusions LTC Monthly Report LTC Monthly Reports Not Posted as Required • Recommendation 5: Required Posting of LTC Monthly Report to Websites LTC Monthly Report Completeness • Recommendation 6: LTC Monthly Report Completeness LTC Monthly Report Accuracy	29 29 30 31 31 32 33

	<ul style="list-style-type: none"> • Recommendation 7: LTC Monthly Report Accuracy • Recommendation 8: Consistency in LTC Pending Application Reporting 	<p>36</p> <p>38</p>
<p>Chapter Four</p> <p>APPLICATION PROCESSING APPROACHES</p>	<p>Chapter Conclusions</p> <p>Task-Based vs. Caseworker-Based Approach</p> <p>Application Processing Approach Background</p> <p>Comparison of Task-Based vs. Caseworker-Based Approaches</p> <p>Other States Research</p>	<p>39</p> <p>39</p> <p>40</p> <p>41</p> <p>43</p>
APPENDICES		
<p>Appendix A</p> <p>Appendix B</p> <p>Appendix C</p> <p>Appendix D</p> <p>Appendix E</p>	<p>Audit Authority</p> <p>Audit Scope and Methodology</p> <p>Long Term Care Report for Supportive Nursing Facility/Supportive Living Facility in Response to 305 ILCS 5/11-5.4</p> <p>Work Support Strategies Initiative Implementation Phase Results</p> <p>Agency Responses</p>	<p>47</p> <p>51</p> <p>59</p> <p>65</p> <p>69</p>

Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

On August 25, 2017, the Governor signed into law Public Act 100-380, which amended the Illinois Public Aid Code and required the Auditor General to report on the performance and compliance of the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), and the Department on Aging concerning eligibility determinations for Medicaid long-term care services and supports (see Appendix A). Specifically, the audit was to review and evaluate:

- compliance with federal regulations on furnishing long-term care services promptly to beneficiaries under 42 CFR 435.930;
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Auditors found that 12 applications (20%) had an eligibility determination within the required timeline (45 days, 60 days for applications on the basis of a disability, or 135 days if referred for asset investigation). An additional 14 applications (23%) were completed between 2 and 26 days beyond the required timeline. The remaining 35 applications (57%) were overdue by more than 30 days, ranging from 36 to 381 days. On average, the 61 applications were 69 days overdue.

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Auditors found that in 5 of 10 asset investigation cases (50%), once an asset investigation was concluded and the HFS OIG notified DHS of the recommendation on the application, DHS implemented the recommendation from the HFS OIG promptly within 5 days. In 4 cases (40%), DHS did not take action on the case (implement the recommendation from the HFS OIG) for between 19 and 88 days. The remaining asset investigation was ongoing at the time of our testing, and therefore, the HFS OIG had not yet made a recommendation to DHS.

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INTRODUCTION

On August 25, 2017, the Governor signed into law Public Act 100-380, which amended the Illinois Public Aid Code. This amendment to the Public Aid Code requires that beginning July 1, 2017, the Auditor General is to report every three years to the General Assembly on the performance and compliance of the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), and the Department on Aging in meeting the requirements placed upon them by Section 11-5.4 of the Public Aid Code and federal requirements concerning eligibility determinations for Medicaid long-term care services and supports (see Appendix A). Specifically, the audit is to review and evaluate the following:

- compliance with federal regulations on furnishing services as related to Medicaid long-term care services and supports as provided under 42 CFR 435.930;
- compliance with federal regulations on the timely determination of eligibility as provided under 42 CFR 435.912;
- the accuracy and completeness of the monthly report required by Section 11-5.4(e)(9) of the Illinois Public Aid Code and for the purposes of monitoring long-term care eligibility processing (Section 11-5.4(f) after amendment by Public Act 100-665 effective August 2, 2018);
- the efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of the Department of Human Services for

long-term care services, including the role of the State's Integrated Eligibility System, as opposed to the traditional caseworker-specific process from which these central offices have converted; and

- any issues affecting eligibility determinations related to the Department of Human Services' staff completing Medicaid eligibility determinations instead of the designated single State Medicaid agency in Illinois, the Department of Healthcare and Family Services (prior to Public Act 100-665, 305 ILCS 5/11-5.4(f); following, 305 ILCS 5/11-5.4(g)).

BACKGROUND

The U.S. Department of Health and Human Services defines long-term care services as services that include medical and non-medical care for people with a chronic illness or disability. Long-term care helps individuals meet health or personal care needs. Long-term care can be provided at home, in the community, or in a facility. For purposes of Medicaid eligibility and payment, long-term care services are those provided to an individual who requires a level of care equivalent to that received in a Nursing Facility.

In order for Medicaid to pay for long-term care services, an applicant must meet general Medicaid eligibility requirements as well as financial and functional eligibility criteria. Eligibility requirements are established by federal regulations and State law.

- **Financial eligibility** requires an assessment of a person's available **income** and **assets**.
- **Functional eligibility** is defined as an assessment of a person's **care needs**, which may include a person's ability to perform activities of daily living (bathing, dressing, using the toilet, eating, etc.) or the need for skilled care.

If either financial or functional eligibility requirements are not met, Medicaid will not pay for long-term care services. However, over time individuals may deplete their resources or income and become financially eligible, or their functioning may deteriorate to the point where they eventually meet functional eligibility criteria.

AGENCIES INVOLVED WITH LTC ELIGIBILITY DETERMINATIONS

Illinois' process for determining long-term care (LTC) eligibility involves three State agencies: the Department of Human Services (DHS), the Department on Aging, and the Department of Healthcare and Family Services (HFS). DHS has the responsibility of determining an applicant's eligibility (financial eligibility). The Department on Aging has the responsibility to conduct a long-term care needs screening (functional eligibility). HFS has the responsibility to develop policy related to long-term care eligibility, investigate assets (if needed) to assist in determining an applicant's financial eligibility, and ensure payment is made to the long-term care provider.

Department of Human Services

Individuals who want Medicaid to cover long-term care services apply to DHS’ Aid to the Aged, Blind, and Disabled program. The Aid to the Aged, Blind, and Disabled program provides financial assistance and medical benefits to seniors, persons who are blind, and persons with disabilities with income of 100 percent or less of the federal poverty level and no more than \$2,000 of non-exempt resources. A person is eligible for this program if he or she:

- Lives in Illinois;
- Is a U.S. citizen or meets certain requirements for noncitizens;
- Receives Supplemental Security Income or is ineligible for Supplemental Security Income due to income or due to expiration of the federal time limit on assistance to certain immigrants who have not yet become U.S. citizens;
- Is either blind, disabled, or 65 years or older; and
- Does not have any non-exempt resources in excess of \$2,000.

When determining eligibility, DHS exempts certain assets up to a specific dollar amount, such as one automobile up to \$4,500 and a place of residence up to \$572,000 equity value in 2018 (this amount is to be increased annually based on the percentage increase in the Consumer Price Index).

An individual can apply by going to a local DHS Family Community Resource Center or online, through the Application for Benefits Eligibility (ABE) online portal. According to DHS, most applications are submitted electronically through the Application for Benefits Eligibility online portal. All providers who apply on behalf of an LTC resident are required to use the Application for Benefits Eligibility online portal. DHS processes nearly all of its LTC applications through three field operations offices (or LTC hubs) created specifically for LTC eligibility determinations.

Once an application for Medicaid has been submitted, a DHS caseworker will review the application, request additional information if necessary, and determine eligibility. The length of time to process an application varies based upon several financial and non-financial factors; however, federal regulations and the Illinois Administrative Code establish timelines for eligibility determinations. Federal regulations require that determinations of eligibility for any Medicaid applicant cannot exceed 90 days for applicants who apply for Medicaid on the basis of a disability and 45 days for all other applicants. Illinois imposes more strict timelines for Medicaid eligibility determinations for individuals applying on the basis of a disability and requires these determinations to be completed within 60 days as opposed to 90 days. Chapter Two discusses the timeliness of LTC Medicaid eligibility determinations in Illinois.

Eligibility determination timelines

Determination based on disability:

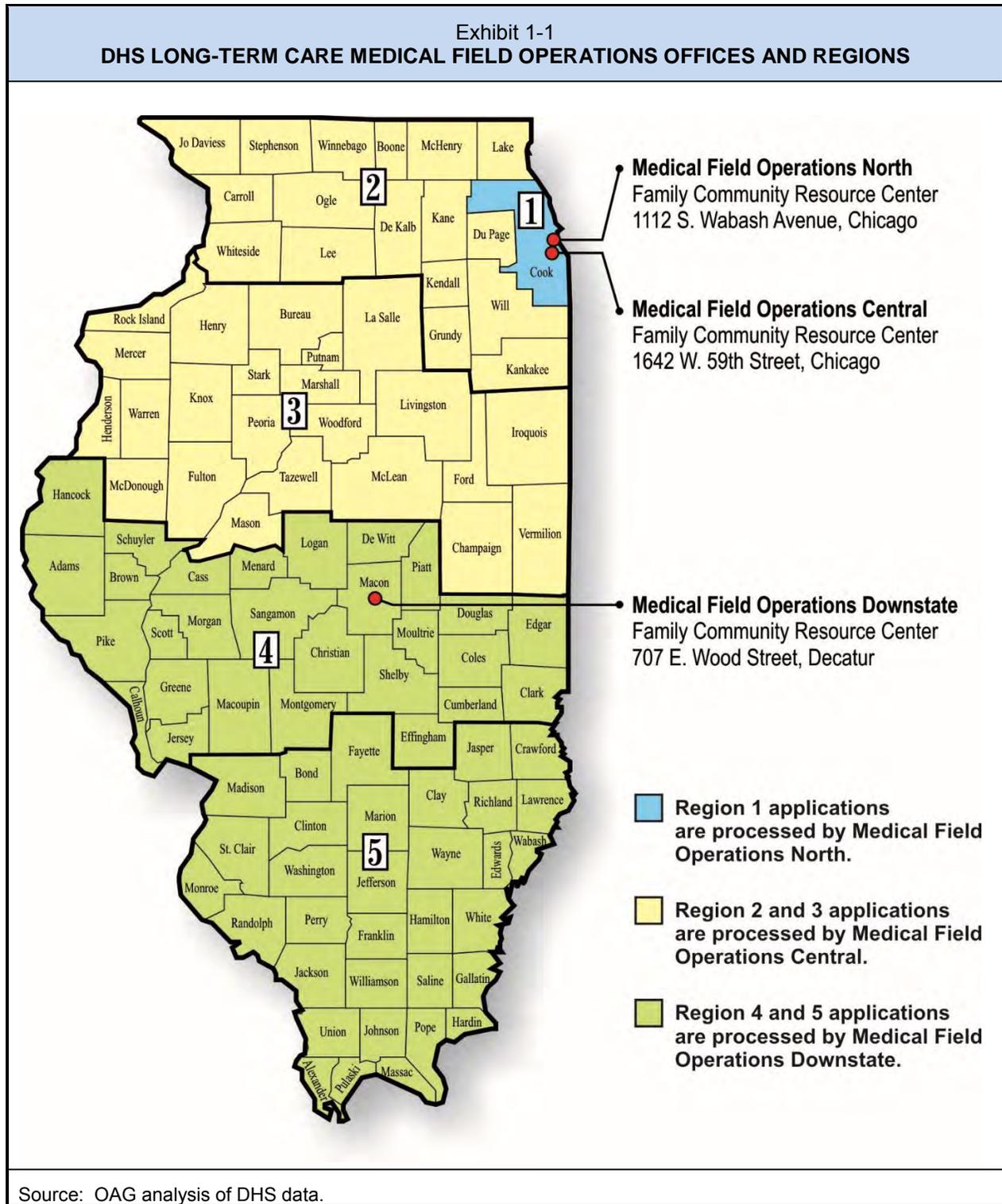
- 90 days - Federal Regulations
- 60 days - Illinois Administrative Code

Determination for all others:

- 45 days - Federal Regulations and Illinois Administrative Code

Exhibit 1-1 shows the locations of the LTC hubs as well as the regions covered by each hub. Prior to March 2017, there were only two hubs: the Medical Field Operations North (1112 S. Wabash Ave. in Chicago) and the Medical Field Operations Downstate (707 E. Wood St. in Decatur). Medical Field Operations Central opened in April 2017 and is also located in Chicago (1642 W. 59th St.). Each hub processes applications based on DHS Regions:

- **Medical Field Operations North** processes LTC applications for **Region 1**.
- **Medical Field Operations Central** processes all new LTC applications submitted on or after April 1, 2017, for **Region 3**. The office also processes all new LTC applications for **Region 2** submitted on or after May 1, 2017.
- **Medical Field Operations Downstate** processes LTC applications for **Regions 4 and 5**.



Department on Aging

The Department on Aging is required to conduct Preadmission Screening and Resident Reviews (prescreenings) of LTC applicants, and if there is a suspicion of serious mental illness

and/or developmental disability, refer applicants to DHS for further screening. These prescreenings are a federal requirement (42 CFR 483.100) and are intended to help ensure individuals are not inappropriately placed in nursing facilities for long-term care and ensure individuals are offered the most appropriate setting for their needs.

The Department on Aging arranges for prescreenings to be conducted to determine the need for long-term care for individuals age 60 or older and prior to placement in a nursing facility or supportive living facility or to determine if they can remain in the community with services and supports. Ideally, these prescreenings happen prior to placement in a nursing facility or supportive living facility, but sometimes post-screenings must be conducted. According to Department on Aging policy, prescreening should be viewed as an opportunity to prevent unnecessary institutionalization, all options for community-based services and supports must be explained in detail to the individual, and the individual must be afforded choice of available services.

Care Coordination Units are entities under contract with the Department on Aging, which conduct prescreenings upon referral from hospitals, Supportive Living Program providers, nursing facilities, or the community. Care Coordination Units serve as central access points for older adults who have intensive long-term care needs. A Care Coordination Unit is often a local agency and may be located in a senior center or other social service agency. Care Coordination Units must have the capacity to complete face to face prescreenings seven days a week, at a minimum of seven business hours per day.

When a Care Coordination Unit receives a referral for a prescreening, a care coordinator from the Care Coordination Unit will conduct the prescreening, complete required forms such as the Determination of Need, and inform the individual of his/her care options. The Determination of Need is a standardized form which specifies the factors that together determine an individual's need for long-term care. The Determination of Need assesses an individual's functional ability to perform basic and instrumental activities of daily living, identifies unmet needs, and serves as the mechanism to develop a service plan. A score of 29 or greater indicates a need for long-term care, which meets the standard for functional eligibility for Medicaid.

Department of Healthcare and Family Services

As the designated Medicaid single State agency, the Department of Healthcare and Family Services is responsible for the Medicaid LTC program for eligible residents in 738 nursing facilities in Illinois. As of June 30, 2017, approximately 43,000 individuals were receiving Medicaid long-term care services. HFS' mission is to ensure that LTC services for which the Department pays are appropriate and meet the needs of recipients, meet standards of quality, and are in compliance with federal and State regulations.

HFS staff is responsible for developing policy in accordance with State and federal regulations and enrolling providers. HFS staff also works with billing issues to ensure correct payment to providers is made by a system of ongoing pre- and post-payment review adjustments. In addition, HFS staff provide billing assistance and information to providers, resolve billing discrepancies, and coordinate billing with the DHS local offices.

HFS Office of the Inspector General

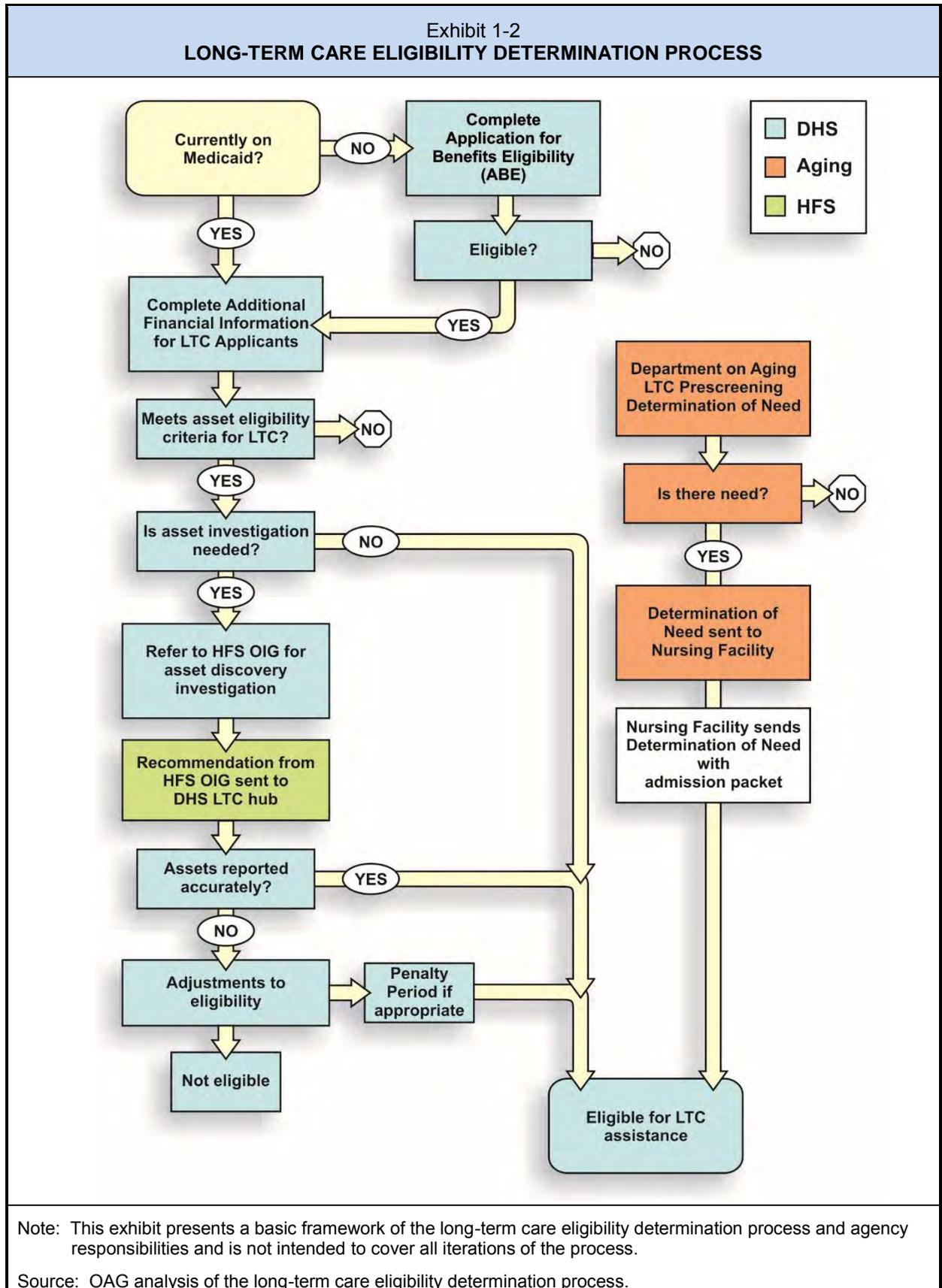
The HFS Office of the Inspector General (HFS OIG) conducts long-term care asset discovery investigations (asset investigations) for long-term care applications referred by DHS caseworkers that meet specified criteria. A specialized unit within the HFS OIG (Long-Term Care Asset Discovery Investigation) is charged with ensuring the resource disclosure and transfer policies are appropriately enforced. This unit completes its asset investigations and provides resource directives on long-term care applications referred by DHS. A resource directive provides a DHS caseworker guidance on how to proceed with the referred applications. For example, a resource directive might recommend an application be approved with spenddown until the assets in excess of the allowed limits are expended.

The LTC Asset Discovery Investigation unit's purpose is to prevent ineligible persons from receiving long-term care benefits and to deter improper sheltering of assets and resources. The purpose of the asset investigations is to uncover undisclosed resources and unallowable resource transfers that occurred during the lookback period, which is five years prior to the date of the application. These asset investigations often include reviewing five years of financial records and legal documents, including but not limited to bank statements, tax returns, annuity documentation, pension documents, trust documents, and information about land owned.

The HFS OIG annual reports noted that 3,565 and 2,702 asset investigations were completed in FY16 and FY17, respectively. In FY16, 68 percent of cases resulted in excess resource savings, penalty savings, or a combination; 22 percent of cases resulted in denials; and 10 percent of cases resulted in no savings. In FY17, 52 percent of cases resulted in excess resource savings, penalty savings, or a combination; 32 percent of cases resulted in denials; and 16 percent of cases resulted in no savings. According to the annual reports, these investigations yielded over \$300 million in gross savings in fiscal years 2016 and 2017 (\$167,636,859 and \$146,029,786 respectively).

LTC ELIGIBILITY DETERMINATION PROCESS

In Illinois, for Medicaid to pay for nursing facility care, an individual must: 1) apply for medical benefits through DHS, and 2) obtain a needs prescreening through the Department on Aging or DHS. Exhibit 1-2 is a general overview of the process of determining LTC eligibility, but is not intended to cover all iterations of the process.



DHS Processing of LTC Applications

LTC eligibility is primarily determined by staff at one of the three LTC hubs in Illinois as discussed previously. An application moves through the Integrated Eligibility System (IES), a public benefits eligibility and case management system, which has been in various stages of implementation since October 2013.

Most applications for long-term care are received electronically through the Application for Benefits Eligibility (ABE) online portal, where new customers can apply for benefits. Nursing facility and supportive living facility providers submitting applications on behalf of clients are required to complete and submit the applications electronically through the Application for Benefits Eligibility online portal. Additionally, some paper applications are received at either Family Community Resource Centers or LTC hubs. When a paper application is received at a Family Community Resource Center, it is forwarded to the appropriate LTC hub for processing. Since providers are required to submit applications through the Application for Benefits Eligibility online portal, paper applications are usually only received from the client or family members of the client.

A Public Aid Eligibility Assistant initiates the application review process when an application is received. Public Aid Eligibility Assistants:

- receive and review the application;
- conduct Social Security Number clearances;
- indicate whether the application was received electronically or is a paper application;
- ensure the application has the correct county;
- ensure the application is at the correct LTC hub; and
- complete other necessary preliminary checks (such as verifying if the applicant is already receiving benefits).

After these checks, the Public Aid Eligibility Assistant registers the application, and the application enters the Integrated Eligibility System and is placed in the Data Collection queue.

According to DHS officials, applications in the Data Collection queue are assigned by a supervisor to a caseworker and worked on a first in, first out basis (meaning the oldest cases are worked first). A caseworker reviews the application to determine if all necessary documentation was provided and attached to the Integrated Eligibility System case record. If additional documentation is needed, a request is to be electronically generated by the Integrated Eligibility System and mailed. After the request is generated, the Integrated Eligibility System then routes the application from the Data Collection queue to the Ready to Certify queue.

If an applicant appears to have transfers of \$10,000 or less, the caseworker will determine whether the transfers were allowable and, if not, calculate the length of the penalty period. However, if an application shows transfers greater than \$10,000 in the five-year lookback period, DHS caseworkers are required to refer the application to the HFS OIG's Long-Term Care Asset Discovery Investigation unit. Once an asset investigation is complete, a resource directive is issued to the LTC hub. The resource directive might, for example, recommend an application be approved with spenddown until the applicant's assets in excess of the allowed limits are

expended. HFS OIG cases are then assigned to a specific DHS caseworker to complete the eligibility determination.

Once in the Ready to Certify queue, applications are again worked on a first in, first out basis. A caseworker reviews the application and all documentation to determine if the case can be approved or denied. If additional information is needed, a request generated by the Integrated Eligibility System is to be issued and mailed. This process may be repeated multiple times until a decision is made to approve or deny the application.

HFS OIG Asset Discovery Investigation Process

Auditors met with officials from the HFS OIG's Long-Term Care Asset Discovery Investigation unit to discuss their role in the eligibility determination process. The unit receives referrals from the LTC hubs via email. After an initial prescreening, HFS OIG staff send an information request to the applicant (or an approved representative) for up to five years of financial records and legal documents, which may include bank statements, tax returns, annuity documentation, pension documents, trust documents, and information about land owned.

According to HFS OIG officials, cases cannot be assigned until all requested information has been received. If the information is not received, the case is denied. If the information is received, staff enter the case in the HFS OIG tracking system, and the case is assigned to an analyst who reviews the information and makes a recommendation. After a supervisor reviews the case and recommendation, the resource directive is returned to the LTC hub. The case is then assigned to a DHS caseworker to implement the HFS OIG's resource directive. The HFS OIG follows up on the case about 60 to 90 days after the directive is uploaded to the Integrated Eligibility System to assess if the asset investigation portion of the case can be closed. According to HFS OIG officials, they choose to follow up in this time frame because clients have 60 days to appeal a decision.

Department on Aging Prescreening Process

The Department on Aging prescreening process begins when notification is given that an individual is at risk of entering a nursing facility. When a patient at a hospital is in need of prescreening, the hospital contacts a Care Coordination Unit. A prescreening is needed if an individual: 1) requires placement in a nursing facility or supportive living facility; 2) contemplates/requests placement in a nursing facility or supportive living facility; or 3) may need home and community-based services. The hospital must give the Care Coordination Unit at least 24-hour notice prior to discharge. The Care Coordination Unit receiving the referral is to check various systems to determine if a prescreening has been completed by that or another Care Coordination Unit within the past 90 calendar days. If the individual has not been prescreened within the past 90 calendar days, the Care Coordination Unit is to proceed with conducting a face to face prescreening. The date the request was received and the time the prescreening was completed must be documented by the Care Coordination Unit on the Case Record Recording Sheet.

The Department on Aging has a policy describing the prescreening procedures and required timeframes for completing the prescreening. Generally, the prescreening is to be

completed within one calendar day from notification. If the individual has been screened within the past 90 calendar days, the Care Coordination Unit will not complete another screen; instead, the Care Coordination Unit should proceed by completing a Services Screening Verification Form noting the date the individual was last screened.

The prescreening and Determination of Need are sent to the nursing facility. Proof of the prescreening and Determination of Need are sent by the nursing facility to DHS with other admission information to start the payment process.

UPDATES TO LTC POLICY MANUAL

While reviewing DHS policy manuals related to LTC application processing, auditors discovered policy manual documents that should be updated to avoid confusion for caseworkers. HFS has the responsibility to develop and update policy related to LTC eligibility.

Resource and Income Transfer Threshold

Previously, an application with reported transfers of resources and income of \$5,000 or greater in the five-year lookback period was referred to the HFS OIG for an asset investigation. On August 10, 2016, HFS revised the threshold for referral from \$5,000 to \$10,000; however, DHS policy manual and workers action guide documents providing instructions for transfers of resources and income to caseworkers (Policy Manual 07-02-20, Workers Action Guide 07-02-20 and related links) still reflect the \$5,000 transfer threshold. This could result in confusion for caseworkers and a waste of processing time and resources for applications unnecessarily referred to the HFS OIG.

Homestead Equity Limit

When determining eligibility for Medicaid LTC services, a place of residence is exempt up to a specified dollar amount. According to HFS' administrative rules, a person is not eligible if the person's equity interest in his or her place of residence exceeds the home equity allowed under federal law, which was \$525,000 for calendar year 2012 (89 Ill. Adm. Code 120.385(c)). This amount is required by federal law to be increased annually based on the percentage increase in the Consumer Price Index for all urban consumers (42 USC 1396p(f)(1)(C)) and was \$572,000 for calendar year 2018. Policy Manual 07-02-04-a was last updated February 6, 2014, and notes the home equity value limit as \$536,000. This could result in confusion for caseworkers and an applicant being mistakenly found ineligible based on an incorrect amount in the policy manual.

UPDATE LTC POLICY MANUAL GUIDANCE	
RECOMMENDATION NUMBER 1	<p><i>The Department of Healthcare and Family Services should ensure policy manual guidance is updated as appropriate. Specifically:</i></p> <ul style="list-style-type: none"> • <i>Policy Manual 07-02-20, Workers Action Guide 07-02-20, and any related links should be updated to reflect the resource and income transfer criteria change from \$5,000 to \$10,000 during the lookback period; and</i> • <i>Policy Manual 07-02-04-a should be updated to reflect the annual increase in the home equity interest limit in accordance with the Illinois Administrative Code and federal law (89 Ill. Adm. Code 120.385(c) and 42 USC 1396p(f)(1)(C)).</i>
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES	<p>The Department accepts the recommendation. The Department will make the changes recommended above in the online Cash, SNAP and Medical manual.</p>

DELEGATED AUTHORITY TO DETERMINE ELIGIBILITY

Public Act 100-380 requests the Auditor General to determine if there are any issues affecting eligibility determinations related to DHS’ staff completing Medicaid eligibility determinations instead of HFS, the designated single State Medicaid agency in Illinois.

It is not unusual for the designated single State Medicaid agency to delegate authority to determine eligibility. Each state is required by federal regulations to submit a State Plan to the federal Centers for Medicare and Medicaid Services for review and approval. A State Plan is an agreement between the state and the federal government describing how the state administers its Medicaid program. Federal regulations (42 CFR 431.10) stipulate that a State Plan must “specify a single State agency established or designated to administer or supervise the administration of the plan” (emphasis added). The federal regulations also state the Medicaid agency:

(A) May, in the approved state plan, delegate authority to determine eligibility for all or a defined subset of individuals . . .

(B) Must in the approved state plan specify to which agency, and the individuals for which, authority to determine eligibility is delegated.

Illinois’ State Plan for Medicaid delegated authority to DHS effective July 1, 1997. This delegation of authority was the result of the formation of DHS and the transfer of duties and eligibility determination staff from the designated single State Medicaid agency to the newly formed DHS. This delegation of authority was approved by the federal Centers for Medicare and Medicaid Services on August 30, 1999.

HFS and DHS have an interagency agreement in place which discusses the roles of each agency. The primary interagency agreement, effective May 14, 2000, states that HFS will establish all eligibility policy, process DHS claims, and maintain, administer, and ensure compliance with State Medicaid plans. The interagency agreement states that it is DHS' responsibility to comply with all rules, regulations, and policies governing medical programs and provide information necessary for HFS to function effectively as the single State Medicaid agency. The interagency agreement also states that DHS will accept applications and make timely eligibility determinations for individuals applying for benefits under the medical programs.

Although HFS develops the policies DHS uses, HFS is not directly involved in the determination of eligibility for Medicaid. DHS caseworkers review the application, request additional information from the applicant, if necessary, and determine eligibility. **Auditors found no apparent issues affecting eligibility determinations related to DHS staff completing these determinations instead of HFS, the single State Medicaid agency.**

Other States' Delegation of Authority

To determine if other states were delegating the Medicaid eligibility function, auditors reviewed State Plan documents for 26 other states. Auditors found that 14 of the 26 states delegate Medicaid eligibility determinations in varying degrees, similar to Illinois.

Chapter Two

TIMELINESS OF ELIGIBILITY DETERMINATIONS

CHAPTER CONCLUSIONS

Auditors reviewed data consisting of 39,146 long-term care applications received in calendar years 2015 through 2017. Upon review of the data, which was pulled from the long-term care (LTC) application tracking database utilized by the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS), auditors determined calculating timeliness for the population of applications using the data provided was not possible. The data did not capture all dates necessary to accurately determine the timeliness of each application's eligibility determination. In addition, the data contained duplicate entries and a comingling of information among records for applicants who had submitted multiple applications. For these reasons, an accurate calculation of timeliness required testing individual applications as opposed to being able to test and report on the timeliness of all applications in the population. Auditors focused on the timeliness of the eligibility determinations; auditors did not assess if eligibility was determined correctly.

According to HFS data, 12,787 LTC applications were submitted for Medicaid eligibility determinations in calendar year 2017. Auditors selected a sample of 55 individuals, which consisted of 61 total applications.

Auditors found that 12 applications (20%) had an eligibility determination within the required timeline (45 days, 60 days for applications on the basis of a disability, or 135 days if referred for asset investigation). An additional 14 applications (23%) were completed between 2 and 26 days beyond the required timeline. The remaining 35 applications (57%) were overdue by more than 30 days, ranging from 36 to 381 days. On average, the 61 applications were 69 days overdue.

Ten of the 61 applications tested were referred to the HFS Office of the Inspector General (HFS OIG) for asset discovery investigations. Prior to August 2, 2018 (the effective date of Public Act 100-665), the Public Aid Code (305 ILCS 5/11-5.4(a)) allowed an extension of up to 90 days (i.e., 135 day total processing time limit). Applications involving asset discovery investigations were overdue (beyond the 135 day time limit) by 114 days on average. However, auditors found that the delay is a combination of time the application is being worked at the HFS OIG and at DHS. On average, the 10 applications in our sample were at the HFS OIG for 127 days after extension days were subtracted. For 4 of the applications (40%), completion of the asset investigation took less than the 90 days allowed by the Public Aid Code. The asset investigation for the remaining 6 (one of which was ongoing at the time of our testing in August 2018) took between 118 days and 253 days.

Auditors found that in 5 of 10 asset investigation cases, once an asset investigation was concluded and the HFS OIG notified DHS of the recommendation on the application, DHS

implemented the recommendation from the HFS OIG promptly within 5 days. In 4 cases (40%), DHS did not take action on the case (implement the recommendation from the HFS OIG) for between 19 and 88 days. The remaining asset investigation was ongoing at the time of our testing, and therefore, the HFS OIG had not yet made a recommendation to DHS.

HFS and DHS do not adequately track extensions. HFS and DHS do not track extensions in a manner that makes it easy to identify the dates of the extensions or the number of extensions that have been granted for each case. The Public Aid Code requires the time limits for processing an application to be tolled, or paused, during the period of an applicant-requested extension, essentially subtracting time granted through these extensions from the application processing times (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(8); following, 305 ILCS 5/11-5.4(e)). However, if extensions or extension dates are not easy to identify or not captured at all, then the extension processing times cannot be subtracted from the eligibility determination processing time as required. As a result, the timeliness of pending applications will appear worse than it actually is. Additionally, when extensions are not tracked adequately, it is difficult to ensure that DHS and HFS are limiting applications to two extensions.

Auditors tested 61 applications and found evidence of a request for an extension by the applicant in 28 of these 61 applications (46%). In total, 38 extensions were granted for the 28 applications. Auditors found that the processing time for these 28 applications could have been shortened by up to 60 days (12 to 60 days). Also, one application received three extensions in violation of the Public Aid Code and Administrative Code.

Although discrepancies exist due to different data sources, the reports on HFS' website and the reports to the federal Centers for Medicare and Medicaid Services both showed that not all applicants are receiving their determination of eligibility within the timelines established by federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 Ill. Adm. Code 110.20 and 10.420).

LTC MEDICAID ELIGIBILITY DETERMINATION TIMELINESS

Public Act 100-380 requests the Auditor General to determine if the agencies are in compliance with the following federal regulations:

- 42 CFR 435.930 – Was Medicaid (related to Medicaid long-term care services) furnished promptly to beneficiaries without any delay caused by the agencies' administrative procedures; and
- 42 CFR 435.912 – Was the determination of eligibility for all applicants determined within 90 days for applicants who apply for Medicaid on the basis of disability or within 45 days for all other applicants.

Federal regulations require that determinations of eligibility for any Medicaid applicant cannot exceed 90 days for applicants who apply for Medicaid on the basis of a disability and 45 days for all other

Eligibility determination timelines
<u>Determination based on disability:</u> <ul style="list-style-type: none"> • 90 days - Federal Regulations • 60 days - Illinois Administrative Code
<u>Determination for all others:</u> <ul style="list-style-type: none"> • 45 days - Federal Regulations and Illinois Administrative Code

applicants. Illinois imposes more strict timelines for Medicaid eligibility determinations for individuals applying on the basis of a disability. According to HFS and DHS' administrative rules (89 Ill. Adm. Code 110.20 and 10.420), determination of eligibility for LTC must be completed within 60 days for all persons seeking to qualify on the basis of a disability (and 45 days for all other applicants).

Certain extensions of the time limitations for determining eligibility are allowed. The applicant, his or her spouse, an approved representative, or the facility in which the applicant lives may request a 30 day extension to provide verification of current resources or resources transferred during the lookback period. Upon request, DHS or the HFS OIG may also allow a second 30 day extension, if needed. Additionally, prior to August 2, 2018, the effective date of Public Act 100-665, an extension of up to 90 days was also permissible when the HFS OIG determined there was a likelihood of non-allowable transfers of assets. These extensions are authorized by the Illinois Public Aid Code (prior to Public Act 100-665, 305 ILCS 5/11-5.4(a) and 5.4(e)(8); following, 305 ILCS 5/11-5.4(a) and 5.4(e)).

Timeliness Reporting

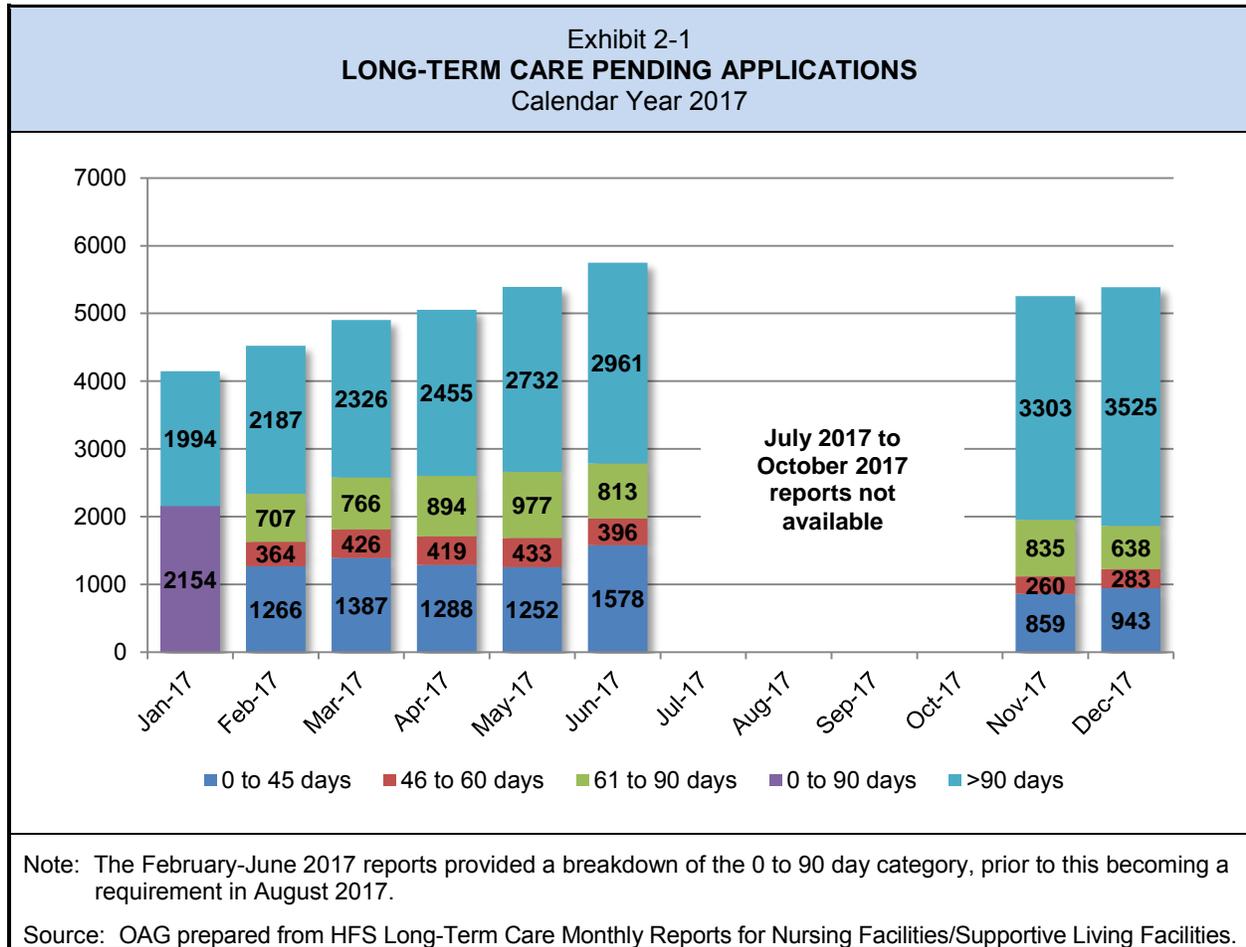
Although discrepancies exist due to different data sources, the reports on HFS' website and the reports to the federal Centers for Medicare and Medicaid Services both showed that not all applicants are receiving their determination of eligibility within the timelines established by federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 Ill. Adm. Code 110.20 and 10.420).

LTC Monthly Reports

HFS' LTC monthly reports indicate that not all applicants are receiving their determination of eligibility within the timelines established by federal regulations (45 days or 90 days on the basis of a disability) and the Illinois Administrative Code (45 or 60 days on the basis of a disability). The Public Aid Code requires DHS and HFS to jointly compile data on pending applications, denials, appeals, and redeterminations into a monthly report and post that report on each Department's website for the purposes of monitoring long-term care eligibility processing (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)). Auditors requested and received monthly reports for calendar years 2015 to 2017. Four monthly reports were not available (for July to October 2017). Chapter Three discusses the problems auditors found with the accuracy of the reports. The problems included duplicate entries in the source data and a lack of tolling of application processing time limits for statutorily allowed extensions. However, according to HFS officials, the source data for the LTC monthly reports has changed, as of October 2018, and HFS officials believe the new source data (the Integrated Eligibility System) to be accurate.

According to HFS' monthly report, as of January 19, 2018 (December 2017 report), 3,525 of 5,389 pending applications (65%) had been in the process for greater than 90 days. An additional 921 applications had been in the process for greater than 46 days and up to 90 days. This means that 4,446 of 5,389 pending applications (83%) were beyond the 45 day processing requirement at that point.

Exhibit 2-1 summarizes HFS’ monthly reporting on long-term care pending applications for 2017. The January 2017 report did not provide a breakdown of the 0 to 90 day category; therefore, only the 0 to 90 day is presented. While providing a detailed breakdown of the 0 to 90 day category was not a requirement until August 2017, the February 2017 report began the breakdown of the 0 to 90 day category. As discussed further in Chapter Three, four monthly reports were not posted or available (for July to October 2017).



According to the LTC monthly reports, on average each month during calendar year 2017, the hubs approved 340 LTC applications and denied 321 LTC applications. On average, 37 applications a month were withdrawn by the applicant. According to HFS data, the LTC hubs received an average of 1,066 LTC applications a month during calendar year 2017.

Reports to the Federal Centers for Medicare and Medicaid Services

Based on HFS’ LTC reporting to the federal Centers for Medicare and Medicaid Services, it would appear that not all applicants are receiving their determination of eligibility within the timelines established by federal regulations (42 CFR 435.912) and the Illinois Administrative Code (89 Ill. Adm. Code 110.20 and 10.420). The federal Centers for Medicare and Medicaid Services requires reports as part of bi-weekly check-in calls to monitor Medicaid application processing. Auditors reviewed the portions of the reports related to LTC application processing that Illinois provided the federal Centers for Medicare and Medicaid Services.

According to HFS officials, the federal reports use application numbers from the Integrated Eligibility System. Auditors were provided reports dating back to May 2016. These reports show LTC applications pending longer than 45 days, ranging from 2,131 applications in June 2016 to 4,238 in April 2018.

TIMELINESS TESTING

Auditors reviewed data consisting of 39,146 LTC applications received in calendar years 2015 through 2017. Upon review of the data, which was pulled from the LTC application tracking database utilized by HFS and DHS, auditors determined calculating timeliness for the population of applications using the data provided was not possible. The data did not capture all dates necessary to accurately determine the timeliness of each application. In addition, the data contained duplicate entries and a co-mingling of information among records when applicants had submitted multiple applications. For these reasons, an accurate calculation of timeliness required testing individual applications as opposed to being able to test and report on the timeliness of all applications in the population. Auditors focused on the timeliness of the eligibility determinations; auditors did not assess if eligibility was determined correctly.

According to HFS data, 12,787 LTC applications were submitted for Medicaid eligibility determinations in calendar year 2017. Auditors selected a sample of 55 individuals, which consisted of 61 applications (some individuals selected had submitted more than one application in 2017).

Auditors found that 12 applications (20%) had an eligibility determination within the required timeline (45 days, 60 days for applications on the basis of a disability, or 135 days if referred for asset investigation). An additional 14 applications (23%) were completed within 30 days (between 2 and 26 days) beyond the required timeline. The remaining 35 applications (57%) were overdue by more than 30 days, ranging from 36 to 381 days. As of testing (July/August 2018), eligibility determinations had not been completed for 3 of the 61 applications, all of which were overdue by more than 90 days. Exhibit 2-2 provides a breakdown of the days overdue for the 61 applications sampled.

Exhibit 2-2 DAYS OVERDUE FOR APPLICATION TESTING Sample of Applications Tested	
Days Overdue	# of Applications
0	12
1-30	14
31-45	5
46-60	5
61-90	6
91-120	10
121+	9
Source: OAG analysis of application testing.	

Exhibit 2-3 provides a breakdown of the average days overdue by processing location. On average, the 61 applications were 69 days overdue. The applications were evaluated against the State requirement of 60 days for an application on the basis of a disability and the federal/State requirement of 45 days for all other applications. If an application was referred to the HFS OIG, auditors allowed an additional 90 days for processing, in accordance with the Public Aid Code (305 ILCS 5/11-5.4(a), prior to amendment by Public Act 100-665, effective

August 2, 2018). When calculating days overdue, auditors subtracted extensions requested by applicants.

For the 61 applications sampled, it took on average 142 days from receipt of application to disposition or, for the 3 cases for which eligibility determinations had not been completed, the date of testing (July/August 2018). However, when extension days were subtracted, the average decreased to 125 days. Exhibit 2-4 presents the timeliness results of the application processing sample.

Exhibit 2-3 APPLICATION PROCESSING DAYS OVERDUE Sample of 61 Applications Tested	
Applications processed by DHS only	Average days overdue ¹
MFO Downstate	36
MFO North	54
MFO Central	95
DHS Only Application Average	61
Applications processed by DHS and HFS OIG	Average days overdue ¹
DHS and HFS OIG	114 ²
Overall Sample Average	69

¹Three applications were not completed (1 DHS only; 1 completed by HFS OIG, but no action by DHS; 1 HFS OIG ongoing investigation). For these cases, auditors used the testing date for calculation purposes.

²Days overdue the 135 day processing time limit (45 days plus 90 days HFS OIG referral extension).

Source: OAG analysis of application testing.

Exhibit 2-4 APPLICATION PROCESSING TIMELINESS Sample of Applications Tested					
	Number tested	Average days from receipt to final disposition ¹		Average days (less days due to requested extensions ¹)	
		Days at DHS	Days at HFS OIG	Days at DHS	Days at HFS OIG
DHS only applications	51	114	N/A	102	N/A
DHS & HFS OIG applications	10	122	161	116	127
Total	61	142		125	

¹Three applications were not completed (1 DHS only; 1 completed by HFS OIG, but no action by DHS; 1 HFS OIG ongoing investigation). For these cases, auditors used the testing date for calculation purposes.

Source: OAG analysis of application testing.

Of the 61 applications sampled, 10 applications were referred to the HFS OIG for an asset discovery investigation. LTC Medicaid eligibility was determined solely by a DHS long-term care hub (without referral to the HFS OIG) in 51 of the applications tested. The average days to determine eligibility by Medical Field Operations (MFO) Downstate, North, and Central with allowable extension days subtracted were 74, 96, and 140 respectively. Exhibit 2-5 presents the application processing sample by long-term care hub.

Exhibit 2-5 APPLICATION PROCESSING TIMELINESS BY HUB Sample of Applications Tested			
Location	Number tested	Average days from receipt to final disposition ¹	Average days (less days due to requested extensions ¹)
MFO Downstate	18	90	74
MFO North	17	104	96
MFO Central	16	151	140
Total	51	114	102

¹One application was not completed as of the date of testing. For this case, auditors used the date of testing for calculation purposes.

Source: OAG analysis of application testing.

Federal regulations require Medicaid be furnished promptly to beneficiaries without any delay caused by the agency’s administrative procedures. Federal regulations also require the timely determination of eligibility. If eligibility is not determined timely, it could delay Medicaid benefits being provided to applicants and create hardships for the applicants.

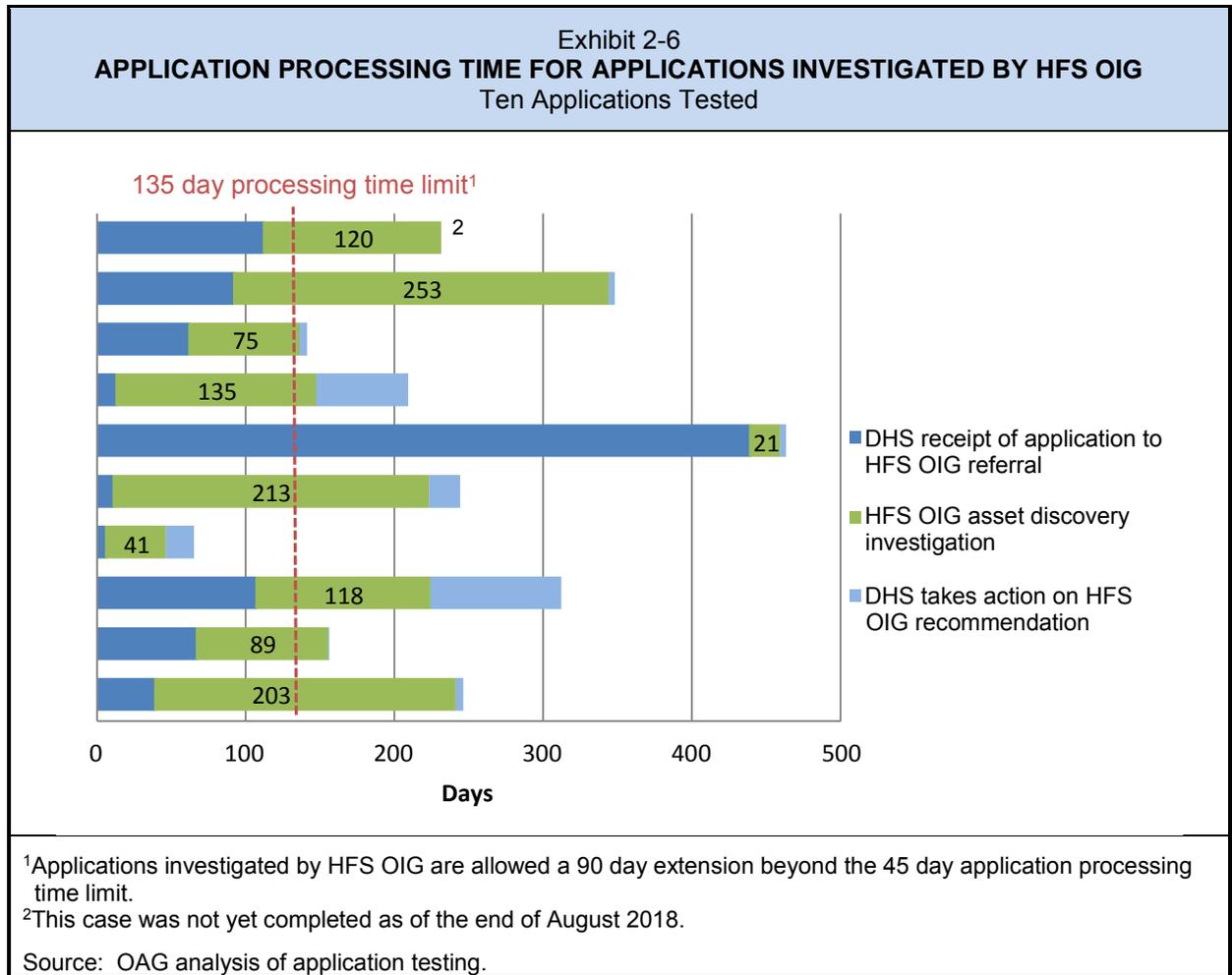
ELIGIBILITY DETERMINATION TIMELINESS	
<p>RECOMMENDATION NUMBER</p> <p>2</p>	<p><i>The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should work together to implement controls to improve the timeliness of long-term care eligibility determinations to comply with timelines contained in federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 Ill. Adm. Code 10.420).</i></p>
<p>DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES RESPONSE</p>	<p>The Department accepts the recommendation. HFS has been working over the last several months to refine the LTC data to better identify the age of pending LTC applications and admissions. The OIG will create a desk aid and provide training to the DHS caseworkers to assist in identifying applications that meet referral criteria for an asset investigation. In addition, the Integrated Eligibility System will be used for referrals instead of the current email system.</p>
<p>DEPARTMENT OF HUMAN SERVICES RESPONSE</p>	<p>The Department of Human Services agrees with the recommendation. Collaborative efforts among the Department of Human Services (DHS), the Department of Healthcare and Family Services (HFS) and the HFS Office of the Inspector General (OIG) are necessary to improve timeliness and ensure compliance with the timelines contained in Federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 ILL. Adm Code 10.420). DHS and HFS partnered in a ‘Rapid Results’ workshop to review the flow of eligibility determination and identify areas that would streamline the process and improve timeliness. The agencies continue to work together to identify additional steps that can be taken to improve timeliness.</p>

Applications with HFS OIG Asset Discovery Investigations

Ten of 61 applications tested were referred to the HFS OIG for asset discovery investigations. The HFS OIG reviews complex financial and legal documents as part of an asset discovery investigation; as a result, processing an application referred for an asset investigation requires additional time. Prior to August 2, 2018 (the effective date of Public Act 100-665), the Public Aid Code (305 ILCS 5/11-5.4(a)) allowed an extension of up to 90 days (i.e., a 135 day total processing time limit). Applications in the sample involving asset discovery investigations were overdue (beyond the 135 day time limit) by 114 days on average; however, as can be seen in Exhibit 2-6, auditors found that the delay was not due solely to the time the application is being worked at the HFS OIG.

DHS worked on these applications from 6 days to 439 days before referring them to the HFS OIG. According to HFS OIG officials, the HFS OIG receives most referral cases via email. Referral emails are sent to one HFS OIG email account. One application was not referred until 439 days had passed. DHS worked the case for 169 days then attempted to refer the case via email; however, the email was not properly addressed to the HFS OIG. This email error was realized nearly nine months later and the application was quickly referred and worked at the HFS OIG and then returned to DHS. For the 10 applications in our sample, the average and median number of days from receipt of application to referral to the HFS OIG were 101 days and 81 days respectively. According to a DHS official, a system enhancement projected to be rolled out in November 2018 is designed to enable DHS caseworkers to notify the HFS OIG of a referral through the Integrated Eligibility System, and allow the HFS OIG to let the DHS office know quickly when a referral has been rejected. According to an HFS OIG official, as of August 2018, in addition to receiving emails, the HFS OIG can now view application specific tasks that have been assigned to them in the Integrated Eligibility System.

On average, the 10 applications in our sample were at the HFS OIG for 127 days after extension days were subtracted (one of which was ongoing as of August 27, 2018). For 4 of the applications, the asset investigation took less than 90 days to complete. The remaining 6 (one of which was ongoing) took between 118 days and 253 days.



Auditors found that in 5 of 10 cases (50%), once an asset investigation was concluded and the HFS OIG notified DHS of the recommendation on the application, DHS implemented the recommendation from the HFS OIG promptly within 5 days. In 4 cases (40%), DHS did not take action on the case (implement the recommendation from the HFS OIG) for between 19 and 88 days. In November 2018, a system enhancement was projected to be rolled out which was designed to allow the HFS OIG, upon conclusion of an asset investigation, to notify DHS through the Integrated Eligibility System instead of by email.

Processing delays associated with applications referred to the HFS OIG could delay the determination of eligibility, delay the furnishing of Medicaid benefits, and create hardships for the applicants.

HFS OIG APPLICATION REFERRALS	
RECOMMENDATION NUMBER 3	<p><i>The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should, in order to decrease the opportunity for application processing delays, work together to implement changes to improve the process of:</i></p> <ul style="list-style-type: none"> • <i>referring applications to the HFS OIG to ensure referrals are received by the HFS OIG; and</i> • <i>receiving and acting upon recommendations from the HFS OIG upon completion of its asset investigations.</i>
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES RESPONSE	<p>The Department accepts the recommendation. The OIG began working in the Integrated Eligibility System (IES) in January 2019. IES will be used for the referral process rather than the current system of using emails to ensure proper and efficient case flow.</p>
DEPARTMENT OF HUMAN SERVICES RESPONSE	<p>The Department of Human Services agrees with the recommendation. Each of the three Long Term Care Hubs has created a team whose responsibilities include responsiveness to HFS OIG recommendations and implementation of the recommendation of the HFS OIG. A system enhancement is scheduled to roll out in February 2019 that would allow DHS to notify the HFS OIG of referrals.</p>

Extension Tracking

DHS and HFS do not adequately track extensions. DHS and HFS do not track extensions in a manner that makes it easy to identify the dates of the extensions or the number of extensions that have been granted for each case. The Public Aid Code requires the time limits for processing an application to be tolled, or paused, during the period of an applicant-requested extension, essentially subtracting time granted through these extensions from the application processing times (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(8); following, 305 ILCS 5/11-5.4(e)). However, if extensions or extension dates are not easy to identify or not captured at all, then the extension processing times cannot be subtracted from the eligibility determination processing time as required.

Auditors tested 61 applications and found evidence of a request for an extension by the applicant in 28 of these 61 applications (46%). While 5 extensions granted were less than 30 days (12 to 28 days), most extensions were for 30 days. Eight of the 28 applications (29%) had 2 extensions and 1 application (4%) had 3 extensions. In total, 38 extensions were granted for the 28 applications. Auditors found that the processing times for these 28 applications could have been shortened by up to 60 days (12 to 60 days). By not tolling the time limits, the number of days that cases are pending is overstated, and the accuracy of the required LTC monthly report is impacted.

While some of these 38 extensions were noted in the database DHS and HFS used for LTC application tracking and reporting, extension dates are not tracked in a manner that makes it

easy to identify the dates of the extensions or the number of extensions that have been granted for each case. For example, 6 of 38 extensions were identified only when auditors read case notes. Three of these six were first extensions that were likely overwritten with second extension dates due to the inability of the tracking database to capture more than one extension without utilizing case notes. Auditors identified an additional 16 extensions by reviewing case file documents. When extensions are identified only by reading case notes or looking through case file documents, it is difficult to accurately and efficiently track extensions.

Sixteen of the 38 extensions were captured in the tracking database in a somewhat usable way; however, auditors noted that the extension dates for these 16 were wrong in 4 instances. If extensions are not tracked adequately, then extension processing times cannot be accurately subtracted from the eligibility determination processing time as required. As a result, the timeliness of pending applications will appear worse than it actually is. Additionally, as discussed in Chapter Three, this impacts the accuracy of the LTC monthly reports.

Auditors also found one application for which three extensions were granted. Statute and the Administrative Code allow only two extensions per application. One extension was granted by DHS and two extensions were granted by the HFS OIG. According to an HFS OIG official, OIG staff check the application tracking database to see if any extensions have been granted, so the allowable number of extensions is not exceeded. However, in this case, the extension granted by DHS was not noted in the tracking database. When extensions are not tracked adequately, it is difficult to ensure that DHS and HFS are limiting applications to the two allowable extensions.

TRACKING OF EXTENSIONS	
RECOMMENDATION NUMBER 4	<p><i>The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should ensure extensions are tracked so processing times can be tolled, as required by the Public Aid Code, for extension days granted (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(8) & 305 ILCS 5/11-5.4(e)(9)(B); following, 305 ILCS 5/11-5.4(e) and 305 ILCS 5/11-5.4(f)(B)). Specifically, the Departments should ensure:</i></p> <ul style="list-style-type: none"> • <i>Extensions are captured in a usable manner;</i> • <i>Extensions are captured accurately; and</i> • <i>Only the allowable number of extensions are granted per application.</i>
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES RESPONSE	The Department accepts the recommendation. The OIG began working in the Integrated Eligibility System (IES) in January 2019. The use of IES will assist in the tracking of extensions.
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department of Human Services agrees with the recommendation. Proper monitoring is needed to ensure that DHS and HFS track extensions and that extensions do not exceed the two that are allowed. DHS is to document all extensions in the case notes within the Integrated Eligibility System (IES) system. An enhancement request to

	<p>the IES that allows identification of an extension request is in process. This would allow DHS and HFS to be aware of and then toll a request for an extension that has been made by the customer, facility, or power of attorney.</p>
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Impact of Integrated Eligibility System on Application Processing Timeliness

The Integrated Eligibility System is a public benefits eligibility and case management system that was implemented in two phases starting in October 2013. The Integrated Eligibility System has been the subject of findings in prior Office of the Auditor General financial audits, compliance examinations, and Statewide Single Audits for both the Department of Healthcare and Family Services and the Department of Human Services.

The Integrated Eligibility System resulted in “multiple reports of significant system slowness” according to a DHS Integrated Eligibility System alert issued on October 25, 2017. Various system issues continued to occur in the next several months. These system issues decrease a caseworker’s ability to process applications in a timely manner.

Beginning in October 2013, the Integrated Eligibility System was used to process all new applications for Medicaid, SNAP (Supplemental Nutrition Assistance Program), and TANF (Temporary Assistance for Needy Families); however, case maintenance still required accessing the old eligibility systems. On October 24, 2017, the State implemented case maintenance functionality in the Integrated Eligibility System; however, caseworkers still often had to switch between the new system and the old systems to review case history for applications received in different phases of the Integrated Eligibility System’s implementation or when the new system experienced issues. Working in multiple systems for case maintenance also impacts a caseworker’s ability to process applications in a timely manner.

In addition, time spent training and learning the system caused delays in processing. As with many new computer systems, there was a learning curve. DHS caseworker staff were required to spend substantial time participating in training for the Integrated Eligibility System. For example, LTC caseworkers received a four-day training for LTC processing in the Integrated Eligibility System.

Chapter Three

LTC MONTHLY REPORTING

CHAPTER CONCLUSIONS

Public Act 100-380 requested the Office of the Auditor General (OAG) to evaluate the accuracy and completeness of the monthly report required by the Public Aid Code to be posted on both the Department of Human Services (DHS) and Department of Healthcare and Family Services (HFS) websites for the purpose of monitoring long-term care (LTC) eligibility processing (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)). These monthly reports are prepared by HFS.

Auditors found various issues with the long-term care monthly reports including:

- Reports were not being posted on both the DHS and HFS websites on a monthly basis as required;
- Reports did not always contain all elements required by statute (some elements were not included for a period and others were not included in any of the monthly reports tested); and
- Reports were not accurate due to duplicate entries and other issues with the source data and a potential overstatement of the number of days applications are pending.

Auditors found discrepancies in LTC pending application numbers reported by HFS. Auditors compared numbers posted to the HFS website to reports submitted to the federal Centers for Medicare and Medicaid Services and found various discrepancies. According to HFS officials, these differences occurred because the reports had two different data sources, an application tracking database and the Integrated Eligibility System; however, beginning in September 2018, both reports will be produced using data from the Integrated Eligibility System.

LTC MONTHLY REPORT

Public Act 100-380 requested the Auditor General to evaluate the accuracy and completeness of the monthly report required by the Public Aid Code to be posted on both the DHS and HFS websites for the purpose of monitoring long-term care eligibility processing (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)). These monthly reports are to specify the number of applications and redeterminations pending LTC Medicaid eligibility determination and admission, and the number of appeals and denials in the following categories:

- Length of time applications, redeterminations, and appeals are pending: 0 to 45 days, 46 days to 90 days, 91 days to 180 days, 181 days to 12 months, over 12 months to 18 months, over 18 months to 24 months, and over 24 months.

- Percentage of applications and redeterminations pending in DHS' Family Community Resource Centers, in DHS' long-term care hubs, with HFS' Office of Inspector General, and those applications which are being tolled due to requests for extension of time for additional information.
- Status of pending applications, denials, appeals, and redeterminations.

Appendix C contains an example of the LTC monthly report.

Source of Data

The LTC monthly reports are prepared by HFS. The reports contain information on pending applications, admissions, redeterminations, and LTC appeals. Six of the 10 tables in the report summarize pending LTC applications and admissions and are created from a database DHS and HFS used for LTC application and admission tracking and reporting. According to HFS officials, the database was set up for reporting purposes, so the Departments could report on timeliness. The tracking database facilitated HFS' ability to report on the timeliness of application data and was used as a work-around. According to HFS officials, prior to the Integrated Eligibility System, it was more difficult to get good application data. The reports for June, July, and August 2018 were not posted on the website; however, in early October 2018, the September report was posted. According to HFS officials, the application source data for the September report and future reports will be the Integrated Eligibility System instead of the application tracking database previously used.

One table in the LTC monthly report summarizes pending redetermination timeliness. A State vendor provided the redetermination data for the audit period of calendar years 2015 through 2017. HFS then categorized the redetermination data into the proper days pending group for the table in the monthly report. Beginning in 2018, the pending redetermination table in the LTC monthly report was created from data in the Integrated Eligibility System. In October 2018, auditors received redetermination data from the Integrated Eligibility System but were unable to use the data to assess the accuracy of the redetermination data in the LTC monthly reports because there were problems with the data, and it potentially contained more than redetermination cases.

The three LTC appeals tables in the monthly reports are provided by DHS' Bureau of Hearings. Auditors reviewed the data used to create the LTC appeals tables and walked through how these reports are run with DHS Bureau of Hearing officials. From these reviews, auditors determined that the LTC appeals tables presented are accurate and complete.

LTC MONTHLY REPORTS NOT POSTED AS REQUIRED

HFS and DHS did not post all LTC reports required under paragraph (9) of subsection (e) of the Public Aid Code on a monthly basis as required. These reports are required to be posted on "each Department's website for the purposes of monitoring long-term care eligibility processing" (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)). These LTC monthly reports were created by HFS and appear to have been posted somewhat regularly to HFS' website; however, these reports were not posted to DHS' website as

required by the Public Aid Code. As of August 2, 2018, DHS added a link on its website to the HFS webpage where the LTC monthly report is posted.

Auditors requested and received monthly reports for calendar years 2015 to 2017. Four monthly reports were not available (July to October 2017). According to HFS officials, reports were not posted for these months because they were fixing a problem, which impacted the reporting of admission numbers. DHS determined that pending admissions were not being logged in by one LTC hub until caseworkers began working on them, and reports were not run for July through October 2017 to allow time for entering the missing admissions.

Also, the reports for June, July, and August 2018 were not posted on the website; however, in early October 2018, the September report was posted, and according to HFS officials, the application source data for this report and future reports will be the Integrated Eligibility System instead of the application tracking database previously used.

If LTC monthly reports are not posted to each Department’s website, it is difficult for the public to monitor long-term care eligibility processing. Not posting LTC monthly reports also decreases LTC application processing transparency.

REQUIRED POSTING OF LTC MONTHLY REPORT TO WEBSITES	
RECOMMENDATION NUMBER 5	<i>The Department of Healthcare and Family Services and the Department of Human Services should post LTC reports to each Department’s website on a monthly basis as required by the Illinois Public Aid Code (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).</i>
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES RESPONSE	The Department accepts the recommendation. The Department will ensure LTC monthly reports are posted timely.
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department of Human Services agrees with the recommendation. A link to the HFS Long Term Care Report is on the DHS’s website.

LTC MONTHLY REPORT COMPLETENESS

The LTC monthly reports did not contain all elements required by statute. Auditors reviewed monthly reports for calendar years 2015 to 2017 and found some elements were not included for a period and others were not included in any of the monthly reports tested.

The monthly reports are required to provide the percentage of applications pending which are being tolled, or paused, due to requests for extension of time for additional information (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9)(B); following, 305 ILCS 5/11-5.4(f)(B)). HFS reported that the current reports do not account for tolling of the extension periods because the extensions are not consistently entered into the same area of the tracking database. For example,

sometimes the period for an extension granted may be in the notes, other times it may be in an extension requested or extension due field. Additionally, multiple extensions might not be tracked because the original extension dates might be overwritten with a second extension.

Public Act 99-153, effective July 28, 2015, changed the Public Aid Code and required the monthly reports to include information not only on the length of time applications are pending, but also the length of time redeterminations and appeals are pending. Nine monthly reports dated August 2015 to April 2016 did not include this information (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9)(A); following, 305 ILCS 5/11-5.4(f)(A)).

Public Act 99-153 also required the monthly reports, after the effective date of July 28, 2015, to include where the pending applications and redeterminations are by location (i.e., DHS Family Community Resource Center, DHS LTC hub, or HFS OIG). This information is provided for pending applications, as required, but not for redeterminations (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9)(B); following, 305 ILCS 5/11-5.4(f)(B)).

If LTC monthly reports do not contain all required elements, the usefulness and transparency of the report is diminished, which impacts the public’s ability to monitor long-term care eligibility processing.

LTC MONTHLY REPORT COMPLETENESS	
RECOMMENDATION NUMBER 6	<i>The Department of Healthcare and Family Services and the Department of Human Services should ensure monthly reports contain all elements required by Section 11-5.4(e)(9) of the Illinois Public Aid Code (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).</i>
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES RESPONSE	The Department accepts the recommendation. Data fields that have not been captured and reported previously have been logged as change requests for the Integrated Eligibility System.
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department of Human Services agrees with the recommendation. The monthly report should contain all elements required by Section 11-5.4(e) (9) of the Illinois Public Aid Code. The Department will work with HFS to include all elements or request IES enhancements to ensure the required elements may be reported.

LTC MONTHLY REPORT ACCURACY

The monthly reports posted on HFS’ website pursuant to statute were not accurate (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)). Auditors reviewed monthly reports for calendars years 2015 to 2017 and found:

- the monthly reports potentially overstate the number of days pending for applications; and
- the data used to create several tables in the reports contains duplicate entries.

Potential for Overstating Number of Days Pending for Applications

The monthly reports potentially overstate the number of days pending for applications. DHS and the HFS OIG can, upon request, allow an applicant additional time to submit information and documents needed as a part of a review of available resources or resources transferred during the look-back period. DHS and the HFS OIG can allow two extensions, neither of which can exceed 30 days. The Public Aid Code notes that the **time limits for processing an application are to be tolled during the period of any extension granted** (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(8); following, 305 ILCS 5/11-5.4(e)). According to HFS officials, the numbers in the monthly reports do not take into account days for which the time limits for processing applications are authorized to be tolled, or paused, due to extensions requested by applicants.

Extensions upon request by applicant

Initial extension:

- Up to 30 days

Second extension:

- Up to 30 days

Auditors tested 61 applications and found evidence of a request for an extension by the applicant in 28 of these 61 applications. While five extensions granted were shorter than 30 days (12 to 28 days), most extensions were for 30 days. Eight of the 28 applications had two extensions and one application had three extensions. Auditors found that these 28 applications could have been tolled for between 12 and 60 days. This could change what “number of days pending” category an application is reported in and could also reduce the number of applications that are not in compliance with the processing time limits.

Also, prior to August 2, 2018 (the amendment of the Public Aid Code by Public Act 100-665), if a case was transferred to and accepted by the HFS OIG for an asset discovery investigation, then the Public Aid Code allowed an extension of up to 90 days. Ten of 61 (16%) applications tested were referred to and accepted by the HFS OIG. The LTC monthly reports provide the number of applications pending at the HFS OIG; however, the table that provides the number of applications pending in each day range does not distinguish between non HFS OIG cases and HFS OIG cases, which, during our audit period, were allowed an extra 90 days. As a result, HFS OIG cases might appear in higher “number of days pending” categories (such as 91 to 180 days) and appear overdue (compared to the 45 or 60 day time limit), but may not be overdue because of the 90 day extension.

The reports also do not identify applications on the basis of a disability. Because the Illinois Administrative Code allows 60 days for processing applications on the basis of a

disability, some of the applications in the 46 to 60 day category might not be overdue if the applicant applied on the basis of a disability.

LTC Monthly Report Source Data Issues

Six of the 10 tables in the reports summarize pending LTC applications and admissions and are created from the LTC application tracking database. As a result, these tables contain inaccuracies. As discussed previously, the LTC application tracking database is used by HFS and DHS to assist in tracking and reporting on applications and admissions. Auditors received data from this tracking database for applications received in calendar years 2015 to 2017. Upon reviewing the data provided, auditors found nearly 3,000 out of approximately 39,000 entries that appeared to be duplicates (two or more entries that had the same social security number and application date). According to HFS and DHS officials, duplicate records in the tracking database occur for a variety of reasons; the most common reasons are: multiple or duplicate submissions are made from families, representatives, and facilities; caseworker error; and re-opens/reinstatements of cases.

Auditors asked how HFS avoids counting these entries as separate applications when preparing the monthly reports. HFS officials noted that they make every attempt to identify and remove duplicate entries; however, duplicate entries can occur because it requires a caseworker to recognize a duplicate, update the original entry, and dispose of the duplicate entry in the tracking database. As a result, some categories in the applications pending tables will likely be overstated. Also, when there were duplicate entries, there was often a co-mingling of information among these entries. Each row might contain different pieces of information based on which entry was updated when an action was taken on the case. For example, an application which was denied in April 2017 might show extension dates in October 2017 which correspond to a new application submitted in September 2017; the record for the September 2017 application might not capture these dates at all.

Testing Related to Source Data Accuracy

Testing identified various inaccuracies and omissions in the LTC application data provided to auditors, which is the source for 6 of 10 tables (summarizing pending items and timeliness) in the LTC monthly reports. Auditors tested the accuracy of the data for 55 applicants consisting of 61 applications received in calendar year 2017. The data from the LTC application tracking database was compared to the information and documents contained in the Integrated Eligibility System, the prior eligibility system, and case file documents. Information and documents examined included applications, correspondence sent to the client, and case notes. Auditors found various inaccuracies and missing dates which would impact the accuracy of the LTC monthly report.

According to HFS officials, the Application Status field was used to determine data for three pending application tables. These three tables present information on total pending LTC applications by number of days pending, number of applications pending at each hub, and number of applications pending at the HFS OIG. The Application Status field is categorized by the status of an application at that point in time. For example, if an application was categorized as Approved, Denied, or Withdrawn, it would be assumed that the application was closed and

therefore would not be reflected in the three tables that present information on pending applications. However, if the application status was Pending DHS or Pending OIG, then it would be assumed that this was an application still being worked.

Auditors found that the Application Status field was incorrect in 12 of 61 applications (20 percent). Seven of these 12 were listed as Pending DHS when, as of the date the data was provided to auditors, 3 of the applications should have had a status of Approved; 2 a status of Denied, and 2 a status of Pending OIG. The 6 approved and denied applications mistakenly noted as pending are especially impactful as these are cases that have been disposed of, yet are likely counted in the LTC applications days pending table. The remaining 5 had a status of Denied; however, they were re-opened and then approved.

The LTC application tracking database contains fields for DHS' input of dates for HFS OIG referral, referral acceptance/rejection, and date returned from the HFS OIG. The HFS OIG referral date was input for 6 of the 10 cases; however, one of the dates was not accurate. Of the 10 HFS OIG applications, three had been finished by the date the LTC application data was downloaded from the tracking database; however, the tracking database did not contain the dates these referrals were returned to DHS. There are also fields that are designated for HFS OIG to input data; however, according to an HFS OIG official, the HFS OIG has an internal tracking system and does not use nor always fill in the fields in the LTC application tracking database.

Auditors also noted issues with data in other fields. For example, the dates were not always input or correct in the LTC application tracking database indicating the date information was requested from the applicant and the date the information was due back. Similarly, extensions were not always noted in the extension fields or the dates were incorrect. Many times dates were input in the case notes instead of in fields that would allow timeliness calculations. If these dates are wrong or not input, DHS is less able to monitor cases effectively.

The accuracy of the LTC monthly report is reliant on the data in the tracking database, and the data in the tracking database is reliant on the caseworker accurately entering the data and identifying and removing duplicates. Application dates and documents are captured in the Integrated Eligibility System, but then caseworkers must enter dates and other case information into the tracking database for application tracking and reporting purposes. Also, according to HFS officials, due to size constraints of the tracking database, not all actions taken on a case can be reported in the tracking database. Given the inaccuracies in the LTC application tracking database, which is the source data for 6 of the 10 tables in the LTC monthly reports, auditors question the accuracy of these tables in the LTC monthly reports.

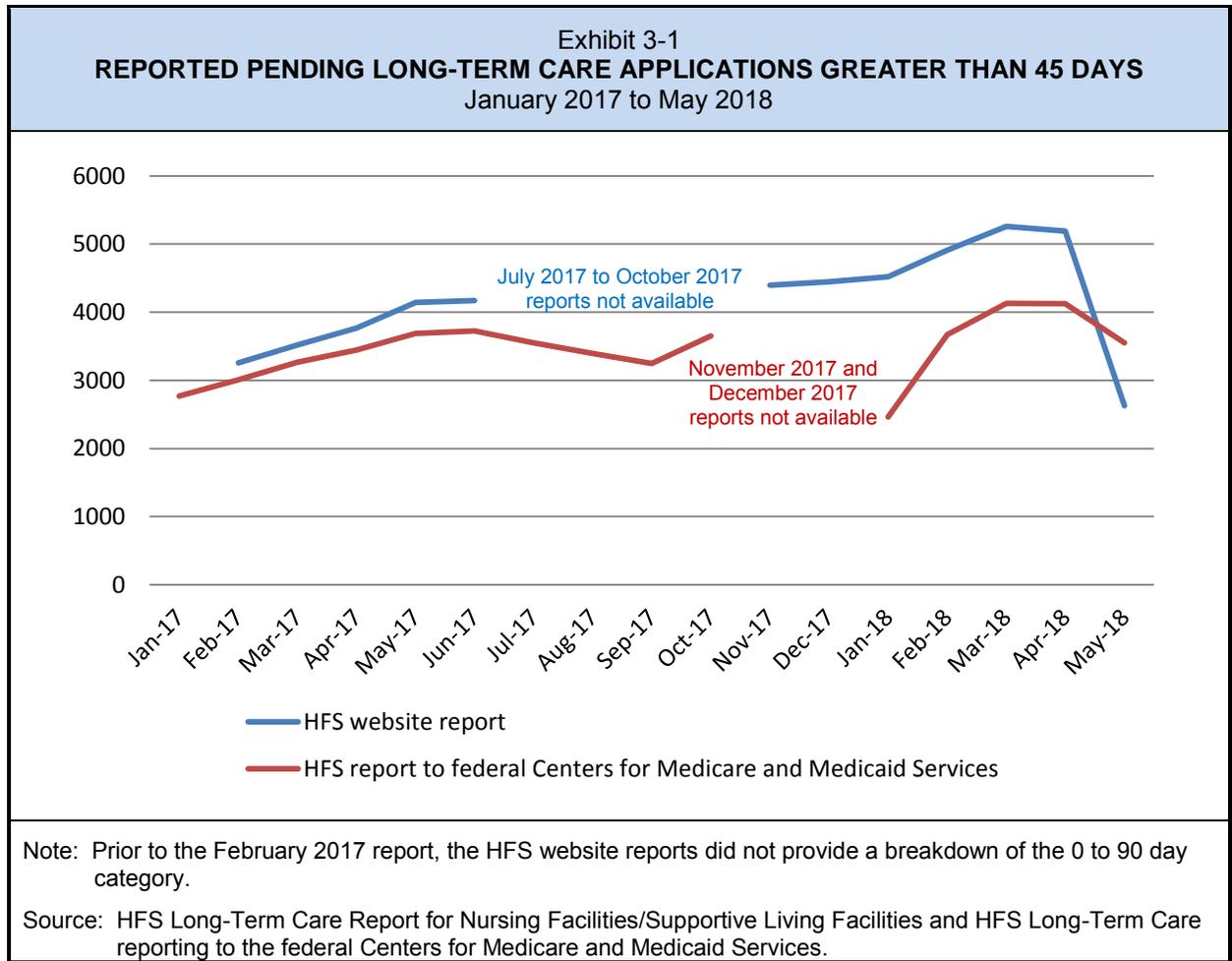
If LTC monthly reports are not accurate, the usefulness and transparency of the report is diminished, which impacts the public's ability to monitor long-term care eligibility processing.

LTC MONTHLY REPORT ACCURACY	
RECOMMENDATION NUMBER 7	<i>The Department of Healthcare and Family Services and the Department of Human Services should develop controls to ensure monthly reports required by Section 11-5.4(e)(9) of the Public Aid Code are accurate (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).</i>
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES RESPONSE	The Department accepts the recommendation. The Department started using the Integrated Eligibility System as the source for the LTC application data in October 2018 to provide accurate application data on the LTC monthly report.
DEPARTMENT OF HUMAN SERVICES RESPONSE	The Department of Human Services agrees with the recommendation. During the time of the audit the data contained in the monthly report was reliant upon the data in a manual tracking base. The monthly report will no longer extract data from the manual tracking base and will pull data from the Integrated Eligibility System (IES).

Monthly Report Posted to HFS Website vs. Report Submitted to Federal Government

Auditors found discrepancies in LTC pending application numbers reported by HFS. Auditors compared numbers in the LTC monthly reports posted to the HFS website to the LTC numbers in Medicaid reports submitted to the federal Centers for Medicare and Medicaid Services as part of bi-weekly check-in calls and found various discrepancies.

Auditors found that the reports to the federal Centers for Medicare and Medicaid Services usually reported a lower number of LTC applications pending greater than 45 days than HFS’ LTC monthly reports. For months in which data was available, the difference in reported numbers in early 2017 was 345 on average; however, the variance grew in 2018. The largest difference was reported for January 2018 when LTC applications pending greater than 45 days were noted on the HFS LTC monthly report as 4,519 and 2,462 on the federal report (difference of 2,057). Exhibit 3-1 shows the pending applications reported in the LTC monthly reports and to the federal Centers for Medicare and Medicaid Services for January 2017 through May 2018.



According to HFS officials, the federal reports use application numbers from the Integrated Eligibility System, and the report posted to the HFS website uses numbers from the LTC application tracking database; the two reports differ because everything in the Integrated Eligibility System was not entered into the tracking database. Previously, HFS officials stated that the LTC application tracking database facilitated HFS’ ability to report on the timeliness of application data and was used as a work-around.

The reports for June, July, and August 2018 were not posted on the website; however, in early October 2018, the September report was posted, and according to HFS officials, the application source data for this report and future reports will be the same as the federal reports (the Integrated Eligibility System). Reporting conflicting numbers for pending LTC applications in different reports creates confusion about the accuracy of the information.

CONSISTENCY IN LTC PENDING APPLICATION REPORTING	
RECOMMENDATION NUMBER 8	<i>The Department of Healthcare and Family Services should ensure LTC pending application reporting is consistent among the reports required by the Public Aid Code and reports submitted to the federal government (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).</i>
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES RESPONSE	The Department accepts the recommendation. The Department started using the Integrated Eligibility System as the source for the LTC application data in October 2018 to eliminate discrepancies between the LTC monthly report and the LTC application data reported to the Federal government.

Chapter Four

APPLICATION PROCESSING APPROACHES

CHAPTER CONCLUSIONS

By November 2014, DHS moved from a caseworker-based approach to application processing to a Statewide task-based approach. This change to task-based processing was implemented at both Family Community Resource Centers (local offices) and Long-Term Care hubs.

According to DHS officials, DHS switched to a task-based approach to processing applications with the intent of providing benefits to clients more quickly and accurately and with less burden on clients and staff.¹ This switch was the result of a multiyear initiative to test and implement more effective and integrated approaches to the delivery of services. Six states, including Illinois, participated in the multiyear initiative.¹ All six states pursued a shift toward a task-based approach for eligibility determination and case maintenance.¹

Auditors were asked to evaluate the efficacy and the efficiency of the task-based process used for making eligibility determinations, including the role of the State's Integrated Eligibility System, as opposed to the caseworker-based process. Assessing the efficiency and efficacy of the task-based process was complicated by the fact that the switch to the task-based approach happened concurrently with the implementation of the Integrated Eligibility System. While it is difficult to ascertain the efficiency and efficacy of the task-based process compared to the caseworker-based process, the decision to switch to the task-based approach appeared to be based upon business process research and reasonable assumptions.

TASK-BASED VS. CASEWORKER-BASED APPROACH

Public Act 100-380 requests the Auditor General to review and evaluate the efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of DHS for LTC services, including the role of the State's Integrated Eligibility System, as opposed to the traditional caseworker-specific process from which the central offices converted.

The **caseworker-based** approach entails a caseworker being assigned after intake and then serving as a primary contact for the client from that time forward, including figuring out what benefits the client is eligible for, collecting necessary documentation, and taking care of periodic case updates and changes. A single caseworker is seen for all aspects of a client's case.

With the **task-based** approach, clients no longer see a single caseworker for all aspects of their cases but instead work with different workers for different tasks. No individual caseworker "owns" a case; instead, it is owned by a team of caseworkers. A supervisor assigns tasks to a

worker based on what needs to be done in a given day or week and the assignment can change each day given what the supervisor determines to be the most urgent tasks. For example, new cases might be the priority one day, but the next, the priority might be a case in which requested documents were received.

APPLICATION PROCESSING APPROACH BACKGROUND

By November 2014, DHS moved from a caseworker-based approach to application processing to a statewide task-based approach. This change to task-based processing affected both Family Community Resource Centers and Long-Term Care hubs. According to DHS officials, the transition from caseworker-based to task-based began in the spring of 2013 when the Family Community Resource Centers (local offices) were allowed to choose whether they used the caseworker-based or task-based approach. Initially, DHS gently pushed its local offices to adopt best practices in their own ways, recognizing value in diversity and some flexibility.¹ However, in the spring 2014, it became apparent that the diverse business processes created undue complications for designing the new Integrated Eligibility System that would need to work seamlessly in all offices.¹ By November 2014, DHS had moved to a statewide standardized task-based approach amongst all Family Community Resource Centers and the two existing LTC hubs.

Basis for Switch

According to DHS officials, DHS switched to a task-based approach to processing applications with the intent of providing benefits to clients more quickly and accurately and with less burden on clients and staff.¹ This switch was the result of a multiyear initiative, which Illinois participated in, to test and implement more effective and integrated approaches to the delivery of services.

Work Support Strategies Initiative

In the fall of 2010, the Work Support Strategies Initiative invited states to apply for one-year planning grants, with the opportunity to continue to a three-year implementation phase. The Work Support Strategies Initiative was directed by the Center for Law and Social Policy in partnership with the Urban Institute and the Center on Budget and Policy Priorities.

Illinois was 1 of 27 states which submitted applications and, in 2011, became 1 of 9 states selected for the planning phase. During the planning phase, the selected states received approximately \$250,000, technical assistance, and peer support from other states. With these resources, according to a Work Support Strategies Initiative report, the grantees performed intensive diagnostic self-assessments, explored business process strategies, established leadership structures, and developed data-driven action plans that address policy and practice changes.

In 2012, six of the nine states that participated in the planning phase received an implementation grant.¹ Illinois was chosen to be one of six states that received an implementation grant and continued participation in a multiyear initiative.¹ Illinois received on average \$255,000 per year in grant funding to test and implement more effective and integrated

approaches to the delivery of key work support benefits. The Work Support Strategies Initiative focused on three work support programs: the Supplemental Nutrition Assistance Program (SNAP), Medicaid and the Children’s Health Insurance Program (CHIP), and child care subsidies through the Child Care and Development Block Grant.

According to a 2013 report detailing early lessons from the initiative:

“During the planning year, Illinois’ primary goal was to develop and test a strategy for improving its processes ‘on the ground’ in the local offices. Illinois officials felt that the status quo of inefficient business process, antiquated technology, and paper case files was unsustainable. Families were not being effectively served and staff were overburdened and saddled with inefficient processes. State officials believed that improving local office operations was a critical first step if technology and policy changes had any hope of success. Increasing the urgency was the prospect of health reform, enacted early in the planning year, which was expected to enroll hundreds of thousands of people in Medicaid in a short amount of time. . . . With no hope of hiring more staff in the near future, the only solution seemed to be improving efficiency, making it easier and faster for staff to do their jobs.”

LTC Hub Switch to Task-Based

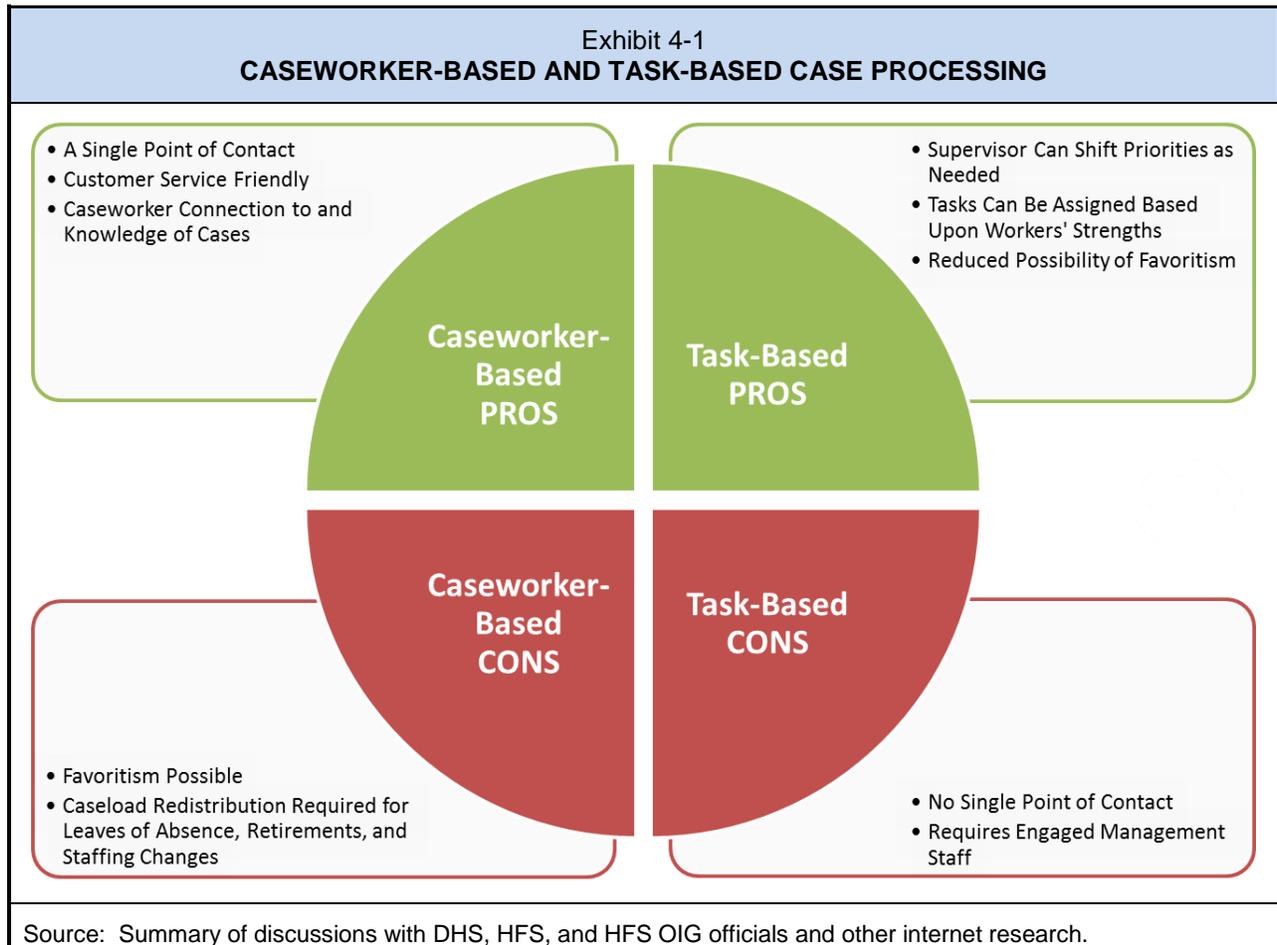
While the transition times varied, the change to task-based processing was an agency-wide change for all Family Community Resource Centers and Long-Term Care hubs alike. The Downstate and North LTC hubs began working cases using the task-based approach in 2014. The Central hub opened in April 2017 and switched to task-based in February 2018. According to HFS and DHS officials, the switch to task-based was driven both by the introduction of the Integrated Eligibility System and a desire to be more efficient in processing LTC applications.

COMPARISON OF TASK-BASED VS. CASEWORKER-BASED APPROACHES

Prior to the switch to task-based processing, when a long-term care application was received, it was assigned to a caseworker based on geographic area of the client’s county or facility. The assigned caseworker was responsible for the case beginning with application receipt through eligibility determination, which included all categories of work as previously discussed (Registration, Data Collection, Ready to Certify, Case Approved/Denied) and case maintenance. In the traditional caseworker-based process, one caseworker is assigned to work with specific Nursing or Supportive Living Facilities.

In the task-based process, caseworkers are assigned a specific function of case processing (such as accepting applications or collecting documentation) instead of all functions as with the traditional caseworker-based approach. Typically, newer workers are assigned to a less intensive type of work, such as document collection (Data Collection), and more experienced workers are assigned to a more complex type of work, such as Ready to Certify. When applications come back from the HFS OIG after receiving an asset investigation, they are assigned to specific caseworkers.

Both the caseworker-based process and the task-based process have advantages and disadvantages. Exhibit 4-1 summarizes the pros and cons of the two case processing approaches.



Some pros and cons of the traditional **caseworker-based** process, as discussed with DHS officials, are:

- The traditional caseworker-based process provides one person/contact for customer service concerns and questions, which is preferable for many nursing home administrators.
- A drawback of the caseworker-based system is that favoritism can occur. Certain long-term care facilities get preference based on relationships built between the caseworker and the facility employee. According to one LTC hub administrator, favoritism was a contributing factor at one hub when there was a large backlog.
- When one caseworker is assigned to a county/facility, caseworker vacations, leaves of absences, retirement, or turnover could leave cases unattended for weeks or months. When these cases are reassigned, there is a learning curve for the newly assigned caseworker with the long-term care facilities.

Some pros and cons of the **task-based** process, as discussed with DHS officials, are:

- Work can be distributed more equitably with the task-based process.
- In the task-based system, there is a decreased risk of favoritism regarding which applications are worked first, such as working a certain preferred facility's case first. All work assignments are based upon the date of submission.
- Because a specific caseworker is no longer assigned to a county or facility, there is no longer one person to contact if there are questions or issues.

According to DHS officials, DHS switched to a task-based approach to processing applications with the intent of providing benefits to clients more quickly and accurately and with less burden on clients and staff.¹ Similar to Illinois, a shift to a task-based approach to processing cases was pursued by the other five Work Support Strategies Initiative states.²

Auditors were asked to evaluate the efficacy and the efficiency of the task-based process used for making eligibility determinations, including the role of the State's Integrated Eligibility System, as opposed to the caseworker-based process. Assessing the efficiency and efficacy of the task-based process was complicated by the fact that the switch to the task-based approach happened concurrently with the implementation of the Integrated Eligibility System.

The Integrated Eligibility System resulted in multiple reports of significant system slowness, which decreased caseworkers' ability to process applications in a timely manner. In addition to the system running slowly, staff spent time training to learn how to navigate the new system, and in some cases, worked in both the old systems and the new Integrated Eligibility System to work around system glitches.² Other states experienced similar issues and slowdowns in case processing during early stages of implementation of new integrated eligibility systems.² The concurrent change makes it difficult to attribute outcomes to either task-based processing or the Integrated Eligibility System definitively.

While it is difficult to ascertain the efficiency and efficacy of the task-based process compared to the caseworker-based process, the decision to switch to the task-based approach appeared to be based upon business process research and reasonable assumptions.

OTHER STATES RESEARCH

In the fall of 2010, the Work Support Strategies Initiative invited states to apply for one-year planning grants, with the opportunity to continue to a three-year implementation phase. The Work Support Strategies Initiative was a multiyear initiative intended to simplify the process of getting work support benefits by improving administrative efficiency and reduce the burden on states and working families.¹ Six states, including Illinois, were chosen to participate in this multiyear initiative to test and implement more effective and integrated approaches to delivery of key work support benefits, including health coverage, nutrition benefits, and child care assistance.¹

During the planning phase, the selected states each received \$250,000, technical assistance, and peer support from other states. With these resources, according to Work Support Strategies Initiative reports, the grantees performed intensive diagnostic self-assessments, explored business process strategies, established leadership structures, and developed data-driven action plans that address policy and practice changes. During the implementation phase, Illinois received approximately \$1.3 million.

According to a March 2016 Work Support Strategies Initiative research report on Improving Business Processes, all six Work Support Strategies Initiative states pursued a shift toward a task-based approach for eligibility determination and case maintenance.¹ For some Work Support Strategies Initiative states, the move to a statewide, task-based caseload model allowed them to more easily share work and helped address workload crunches, especially during times of the month normally tied to renewals.² Several states also upgraded technology systems.³ Appendix D provides examples of changes implemented by the six Work Support Strategies Initiative states that received the implementation grants.

Work Support Strategies Initiative Reports Terms of Use: Three of the Work Support Strategies Initiative reports noted above are licensed under a Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License and are free to use in accordance with license conditions:

- ¹ Hahn, H., Amin, R., Kassabian, D., Gearing, M. (March 29, 2016). *Improving Business Processes for Delivering Work Supports for Low-Income Families (Findings from the Work Support Strategies Evaluation)*.
- ² Isaacs, J., Katz, M., and Amin, R. (November 16, 2016). *Improving the Efficiency of Benefit Delivery (Outcomes from the Work Support Strategies Evaluation)*.
- ³ Loprest, P., Gearing, M., Kassabian, D. (March 29, 2016). *States' Use of Technology to Improve Delivery of Benefits (Findings from the Work Support Strategies Evaluation)*.

These reports are attributed to the Urban Institute and can be found at: <https://www.urban.org/work-support-strategies>.

APPENDICES

APPENDIX A

AUDIT AUTHORITY

**(Prior to Public Act 100-665, 305 ILCS 5/11-5.4(f);
following, 305 ILCS 5/11-5.4(g))**

Appendix A

AUDIT AUTHORITY

Excerpt from the Illinois Public Aid Code

305 ILCS 5/11-5.4

Sec. 11-5.4. Expedited long-term care eligibility determination and enrollment.

(f) Beginning on July 1, 2017, the Auditor General shall report every 3 years to the General Assembly on the performance and compliance of the Department of Healthcare and Family Services, the Department of Human Services, and the Department on Aging in meeting the requirements of this Section and the federal requirements concerning eligibility determinations for Medicaid long-term care services and supports, and shall report any issues or deficiencies and make recommendations. The Auditor General shall, at a minimum, review, consider, and evaluate the following:

(1) compliance with federal regulations on furnishing services as related to Medicaid long-term care services and supports as provided under 42 CFR 435.930;

(2) compliance with federal regulations on the timely determination of eligibility as provided under 42 CFR 435.912;

(3) the accuracy and completeness of the report required under paragraph (9) of subsection (e);

(4) the efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of the Department of Human Services for long-term care services, including the role of the State's integrated eligibility system, as opposed to the traditional caseworker-specific process from which these central offices have converted; and

(5) any issues affecting eligibility determinations related to the Department of Human Services' staff completing Medicaid eligibility determinations instead of the designated single-state Medicaid agency in Illinois, the Department of Healthcare and Family Services.

The Auditor General's report shall include any and all other areas or issues which are identified through an annual review. Paragraphs (1) through (5) of this subsection shall not be construed to limit the scope of the annual review and the Auditor General's authority to thoroughly and completely evaluate any and all processes, policies, and procedures concerning compliance with federal and State law requirements on eligibility determinations for Medicaid long-term care services and supports.

(Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14; 99-153, eff. 7-28-15; 100-380, eff. 8-25-17.)

(Effective Date: 8/25/2017)

Following Public Act 100-665, effective 8-2-18, the citation for this section became 305 ILCS 5/11-5.4(g).

APPENDIX B
AUDIT SCOPE AND METHODOLOGY

Appendix B

AUDIT SCOPE AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The objectives of the audit were identified in Public Act 100-380, which amended the Illinois Public Aid Code and requires that beginning July 1, 2017, the Auditor General is to report every three years to the General Assembly on the performance and compliance of the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), and the Department on Aging in meeting the requirements placed upon them by Section 11-5.4 of the Public Aid Code and federal requirements concerning eligibility determinations for Medicaid long-term care services and supports. Public Act 100-380 was signed into law on August 25, 2017. Appendix A provides the statutory excerpt requiring the audit.

In conducting the audit, we reviewed applicable federal regulations, State statutes, and administrative rules. We reviewed compliance with those laws and rules to the extent necessary to meet the audit objectives. We reviewed policies and procedures relevant to the audit areas. We also reviewed risk and internal controls related to the audit objectives. A risk assessment was conducted to identify audit areas that needed closer examination. Any significant weaknesses in those controls are included in this report.

We interviewed representatives of HFS, HFS Office of the Inspector General (HFS OIG), DHS, and the Department on Aging. We reviewed the previous financial audits and compliance attestation engagements released by the Office of the Auditor General for the Department of Healthcare and Family Services, Department of Human Services, and the Department on Aging. We also reviewed the Auditor General's 2014 review of the Expedited Long Term Care Eligibility Determination and Enrollment System. This included reviewing applicable findings and background information.

We requested all LTC applications received in calendar years 2015 through 2017. We received data from the LTC application tracking database utilized by HFS and DHS consisting of 39,146 LTC applications. We did not receive any data from the Integrated Eligibility System.

Upon review of the data from the LTC application tracking database, we determined that we could not calculate timeliness on the population of applications using the data provided. The data did not capture all dates necessary to accurately determine timeliness of each application. For example, if an extension is requested by an applicant, the process can be tolled for 30 days

for the first extension and an additional 30 days if a second extension is requested. The database used to collect and report on the timeliness of Medicaid LTC eligibility determinations might: note an extension in an extension field (ideal); note dates for a second extension, but write over the first extension dates; and/or note extensions in the case notes (which requires manually pulling out applicable dates). There were also duplicate entries in the data received and a co-mingling of information among entries when applicants had submitted multiple applications. For example, an application which was denied in April 2017 might show extension dates in October 2017, which correspond to a new application submitted in September 2017; the entry for the September 2017 application might not capture these dates at all. For these reasons, an accurate calculation of timeliness required testing individual applications as opposed to being able to test the population for timeliness.

We checked the validity of the data provided. According to HFS data, 12,787 LTC applications were submitted for Medicaid eligibility determinations in calendar year 2017. We selected a stratified sample of 55 individuals who submitted applications in 2017. We chose 15 applicants from each of the three hubs and an additional 10 that were identified as referred to the HFS OIG. We also chose a mix of applications, based on the population's distribution, that had an application status (in the data provided by HFS) of approved, denied, pending, or withdrawn.

Some applicants selected had submitted more than one application in 2017. Because of the co-mingling of data amongst applications in the data provided by HFS, we sampled all applications submitted for an individual in 2017. As a result, we sampled a total of 66 applications. As a part of validity testing for our sample, with the assistance of DHS staff, we compared the application data we received from the LTC application tracking database to information and documents contained in the Integrated Eligibility System, the prior eligibility system, and case file documents. Information and documents examined included applications, correspondence sent to the client, and case notes. We also captured applicable action dates that were not in the data we were provided. We did not assess if eligibility was determined correctly; our focus was on examining whether or not the eligibility determinations were made timely. During the course of our testing, we determined that 5 of the 66 applications were duplicates; therefore, our analysis is based on 61 applications. The applicants were not selected using a statistically valid method utilizing confidence intervals and confidence levels; therefore, results in this audit have not been, and should not be, projected to the population.

We calculated application timeliness for the 61 applications in our sample. The applications were evaluated against the State requirement of 60 days for an application on the basis of a disability and the federal/State requirement of 45 days for all other applications. If an application was referred to the HFS OIG, we allowed an additional 90 days (in accordance with the Public Aid Code prior to amendment by Public Act 100-665, effective August 2, 2018). Three applications, as of the date of our testing, were still awaiting an eligibility determination; for these three applications, we used the testing date (July/August 2018) for calculation purposes.

When calculating the amount of time an application was pending a determination of eligibility, we subtracted extensions requested by applicants, in accordance with the Public Aid Code. We found that three of the applications selected had been referred to the HFS OIG for asset investigations but were not identified as such in the LTC application data provided by HFS. Some of the applications were referred to the HFS OIG after an initial determination had been

made (such as a re-open of a denied case). For the purpose of calculating timeliness of cases with HFS OIG involvement, we included the additional HFS OIG applications discovered and excluded the applications that were referred after an initial eligibility determination was already made because the cases are no longer subject to the 45 day or 60 day timeliness standards. Results from our timeliness review are presented in Chapter Two.

We reviewed January 2015 through May 2018 monthly reports posted to HFS' website. We were provided all monthly reports except July 2017 to October 2017. During our application testing, we tested the validity of the data provided. This data is used to create the LTC monthly report that is required to be posted to the HFS and DHS websites; therefore, we conducted validity testing, as previously discussed, in order to test the accuracy and completeness of the monthly reports, as directed by an audit determination. Results from our review of the monthly reports are presented in Chapter Three.

We spoke with HFS and DHS officials in order to discuss the switch to a task-based from a caseworker-based process. We reviewed documentation related to the Work Support Strategies Initiative, in which Illinois was one of six participants. We also reviewed other documentation related to task-based and caseworker-based models of human services eligibility processing. The switch to a task-based process is discussed in greater detail in Chapter Four.

We were asked to identify any issues affecting eligibility determinations related to the Department of Human Services' staff completing Medicaid eligibility determinations instead of the Department of Healthcare and Family Services, which is the designated single State Medicaid agency in Illinois. In order to address this determination, we reviewed applicable federal and State laws, Illinois' approved State Plan for Medicaid, DHS and HFS interagency agreements, and documentation related to the responsibilities each agency has in the LTC process. We also reviewed, to the extent possible, other states' State Plans in order to determine if other states delegate eligibility determinations to other entities. These issues are further discussed in Chapter One.

This audit did not include home and community-based services waivers. Home and community-based services are services provided to individuals in their homes, which help them remain in the community and avoid institutionalization. The Community Care Program, a State program operated by the Department on Aging, is one of the waivers for home and community-based services under the Medicaid program. Individuals in the Community Care Program can have income and assets above the Medicaid limits and still be eligible for home and community-based services. The audit determinations are focused on Nursing Facilities and Supportive Living Facilities, timeliness of Medicaid LTC eligibility determinations, and timeliness of reporting in accordance with federal regulations. Home and community-based services waivers are not subject to the same timeliness standards as those federal regulations referenced in the audit determinations, and the recipients may or may not qualify for or receive Medicaid assistance.

The dates of exit conferences, along with the principal attendees, are noted below:

Date: January 28, 2019

Agency

Department on Aging

Name and Title

- Jean Bohnhoff, Director
- Jaime Ewing, Deputy Director
- Anna O'Connell, Chief Financial Officer
- Nick Barnard, Chief Internal Auditor
- Teri McKeon, Bureau Chief, Fiscal
- Lora McCurdy, Manager, Division of Planning, Training, Research & Development
- John Eckert, Division of Planning, Training, Research & Development

Office of the Auditor General

- Tricia Wagner, Audit Manager
- Patrick Rynders, Audit Supervisor
- Alison Storm, Audit Staff

An exit conference was held with the Department on Aging. No recommendations were directed to the Department; therefore, the Department did not submit a formal response to the audit.

Date: January 29, 2019

Agency

Department of Human Services

Name and Title

- Corey-Anne Gulkewicz, Chief of Staff
- Robert Brock, Chief Financial Officer
- Amy DeWeese, Chief Internal Auditor
- Albert Okwuegbunam, Audit Liaison
- Diane Grigsby-Jackson, Director, Family and Community Services
- Paul Thelen, Chief, Bureau of Performance Management
- Barrett Sheeley, Bureau of Performance Management
- Willie Haywood, Region 1 Central Administrator, Family and Community Services

Office of the Auditor General

- Tricia Wagner, Audit Manager
 - Patrick Rynders, Audit Supervisor
 - Alison Storm, Audit Staff
-

Date: January 29, 2019

Agency

Department of Healthcare and Family Services

Name and Title

- Theresa Eagleson, Director
- Brad Hart, Inspector General (HFS OIG)
- Jamie Nardulli, Chief Internal Auditor
- Kelly Cunningham, Acting Medicaid Administrator
- Lynne Thomas, Deputy Administrator for Eligibility Policy
- Mike Casey, Finance Administrator
- Elizabeth Lithila, Bureau Chief of Eligibility Integrity
- Mark McCurdy, Acting Chief, Bureau of Long-Term Care
- Phronsie Spaulding, Asst. Bureau Chief, Bureau of Medicaid Integrity (OIG)
- Kathy Butcher, Manager of Long-Term Care Asset Discovery Investigations

Office of the Auditor General

- Tricia Wagner, Audit Manager
 - Patrick Rynders, Audit Supervisor
 - Alison Storm, Audit Staff
-

APPENDIX C

**LONG TERM CARE REPORT FOR
SUPPORTIVE NURSING FACILITY/
SUPPORTIVE LIVING FACILITY
IN RESPONSE TO 305 ILCS 5/11-5.4**

As of December 31, 2017

Long Term Care Report for SNF/SLF
In response to 305 ILCS 5/11-5.4
1/19/2018

Pending Items Summary

Table 1: Total Pending LTC Applications & Admissions by Number of Days Pending

Date Range	LTC Pending Application	LTC Pending Admit
0-45 Days	943	5,666
46-60 Days	283	1,240
61-90 Days	638	2,123
91-180 Days	1,769	2,686
181 Days-12 Months	1,559	1,663
12-18 Months	180	140
19-24 Months	16	29
Over 24 Months	1	18
Total	5,389	13,565
Items Pending > 45 Days	4,446	7,899
Items Pending > 90 Days	3,525	4,536

Table 2: Pending LTC Admissions Resulting from Delay with State

Total Pending Admits due to State Delay	Pending Number
Total Pending Admits	12,283
Items Pending > 90 Days	3,804

Table 3: Pending LTC Admissions Not Resulting from Delay with State

Pending Admissions	Pending Number
Pending Admits - Asset Penalty Period	57
Pending Admits - Resource Spenddown	212
Pending Admits - Income Spenddown	1,013
Total	1,282
Items Pending > 90 Days	732

Pending Application and Admission Detail Summary

Table 4: Total Pending LTC Applications & Admissions at LTC Hubs

Hub Location	Application Pending	Admit Pending
Macon LTC - 163	873	1,816
Medical Field Operations - 200	1,496	5,151
Medical Field Operations Central - 244	1,950	4,849
Other DHS FCRC Offices	20	28
Sub Total	4,339	11,844

Table 5: Total Pending LTC Applications and Admissions at OIG

Office of Inspector General	Application Pending	Admit Pending
Office of Inspector General	1,048	436

Redetermination, Appeal and Denial Summary

Table 6: Total Pending LTC Medical Only Redeterminations

Redetermination Date	Total LTC Redes Pending
0-45 Days	6,437
46-60 Days	2,026
61-90 Days	-
91-180 Days	4,426
181 Days-12 Months	200
12-18 Months	12
19-24 Months	4
Over 24 Months	-
Total	13,105
Items Pending > 90 Days	4,642

Table 7: Applications Disposed in the Month of December

Status	
Applications Withdrawn	30
Applications Approved	301
Applications Denied	222

Long Term Care Appeals

Table 8: Pending LTC Appeals by Status

Appeal Status	Total
Hearing Held (currently writing Final Administrative Decision)	6
Hearing Held (waiting for document submission from parties)	1
Hearing Scheduled	458
Hearing To Be Scheduled	787
Total	1252

Table 9: Total Pending LTC Appeals by Age

Appeal Status (in gross days)	Total
0 – 45 Days	270
46 – 60 Days	122
61 – 90 Days	218
91 – 180 Days	500
181 days – 12 Months	141
12 – 18 Months	1
19 – 24 Months	0
Over 24 Months	0
Total	1252

Table 10: 2017 Closed LTC Appeals Year To Date

Appeal Status	Total
Dismissed	173
Withdrawn	1,861
Rejected	1,440
Issued/Implemented	262
Total	3,736

NOTES:

Table 1

A. **HEADER DEFINITIONS LTC Pending Application:** Individual (or a facility on behalf of client) submitted an application to determine Medicaid eligibility. If an individual is already Medicaid eligible, an application is not necessary. **LTC Pending Admit:** Information from LTC Facility necessary to admit person into that facility. An admit request can be processed at the same time as application, but cannot be processed without an application.

B. When a client has both an application and an admit request, each of these shows in its respective columns. (In other words, the number of individuals affected is less than the sum of applications and admit requests.)

C. Total pending applications over 90 days have increased by 11.55% since the beginning of July while total pending admits over 90 days have increased by 56.58% for the same period. Total pending applications have decreased by 8.54% since the beginning of July, and total pending admits have increased by 110.6% for the same period.

Table 2

A. The total number of pending admits in progress that are a result of a state delay are outlined.

Table 3

A. The total pending admits include admissions that are not the result of a state delay.

B. The pending admit totals contain 1046 admits that cannot be completed by the State. These cases are waiting for a client income or resource spenddown to be met or for an asset penalty period that has been imposed to expire.

C. An LTC asset penalty period results from non-allowable transfers.

D. When a person has both countable income and excess resources, countable income is applied first, then excess resources are applied to meet the cost of care, if necessary. The amount of remaining excess resources available to apply to the person's care is refigured for each month as excess resources are applied to NH or SLF charges, and the remaining excess resource amount to be used for the following month(s) is reduced.

Table 4

A. The report shows that consolidation by DHS into LTC case processing the hubs is virtually complete for applications. While there are still a number of admits in a few other offices, they are declining.

B. The LTC hubs have also been focused on completing applications on which the client has been denied and has later provided the necessary information to be reopened along with redeterminations and Personal Needs Adjustments.

Table 6

A. Redeterminations being reported only contain cases without other benefits. Not all of the redeterminations are pending due to state inaction. Many of the cases are pending based on waiting for additional information from the client.

Table 7

A. Reporting for the activity in a month is not a review of cases received in that month. In other words, applications are not always processed in the same month in which they are received. Applications approved include those with a penalty period of spenddown.

305 ILCS 5/11-5.4 requires reporting of “the number of appeals of denials” for pending appeals. Many appeals involve approved cases, rather than denied cases. The issues involved in an appeal are often not articulated by the client to the State at the time of filing. In most cases it is unknown whether an appeal is of a denial, or whether the appeal involves some other issue on an approved case. In order to show all potential appeals of denials, this report contains numbers on all LTC appeals.

Hearing Held = The final hearing in the appeal has been held, and the State is drafting the Final Administrative Decision.

Hearing Scheduled = The appeal has been scheduled for a hearing date in the future, and all involved parties have been notified.

Hearing To Be Scheduled = The appeal was recently filed or continued, and is in a queue to be scheduled for a hearing date.

Dismissed = The appeal is closed. This happens if the client does not show up for the hearing, or if the client is present but refuses to participate in the hearing.

Withdrawn = The client has voluntarily decided to close the appeal with no Final Administrative Decision to be issued by the Department.

Rejected = The client or an unsupported representative attempted to file an appeal, but the appeal request did not meet the legal requirements of an appeal. Rejected appeal requests can be resubmitted and registered as an appeal, in which case the appeal would count once toward the Rejected total and once toward the Pending total.

Issued/Implemented = A Final Administrative Decision has been issued by the Department and all involved parties have been notified.

Source: HFS website.

APPENDIX D

**WORK SUPPORT STRATEGIES
INITIATIVE IMPLEMENTATION PHASE
RESULTS**

Appendix D
WORK SUPPORT STRATEGIES INITIATIVE IMPLEMENTATION PHASE RESULTS

State	Examples of Changes Implemented
Illinois	<ul style="list-style-type: none"> • Redesigned business practices including elements of the task-based approach • Tested new initiatives with pilot programs • Upgraded technology systems
Colorado	<ul style="list-style-type: none"> • Redesigned business practices including elements of the task-based approach • Used a front desk to triage client needs • Limited application “touches” • Upgraded technology systems
Idaho	<ul style="list-style-type: none"> • Redesigned business practices including elements of the task-based approach • Upgraded technology systems • Invested in data analysts and developed structures for systematically and routinely reviewing data
North Carolina	<ul style="list-style-type: none"> • Redesigned business practices including elements of the task-based approach • Tested new initiatives with pilot programs • Upgraded technology systems
Rhode Island	<ul style="list-style-type: none"> • Redesigned business practices including elements of the task-based approach • Limited application “touches” • Introduced lobby management software
South Carolina	<ul style="list-style-type: none"> • Redesigned business practices including elements of the task-based approach • Moved from paper files to a paperless system • Developed consistency tools, so tasks are standardized

Source: OAG summary of Urban Institute Work Support Strategies Initiative Reports.

Work Support Strategies Initiative Reports Terms of Use: Three of the Work Support Strategies Initiative reports noted above are licensed under a Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License and are free to use in accordance with license conditions:

1. Hahn, H., Amin, R., Kassabian, D., Gearing, M. (March 29, 2016). *Improving Business Processes for Delivering Work Supports for Low-Income Families (Findings from the Work Support Strategies Evaluation)*.
2. Isaacs, J., Katz, M., and Amin, R. (November 16, 2016). *Improving the Efficiency of Benefit Delivery (Outcomes from the Work Support Strategies Evaluation)*.
3. Loprest, P., Gearing, M., Kassabian, D. (March 29, 2016). *States' Use of Technology to Improve Delivery of Benefits (Findings from the Work Support Strategies Evaluation)*.

These reports are attributed to the Urban Institute and can be found at: <https://www.urban.org/work-support-strategies>.

APPENDIX E
AGENCY RESPONSES

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

February 13, 2019

Honorable Frank J. Mautino
Auditor General
740 East Ash
Springfield, IL 62703

Dear Auditor General Mautino:

The Department of Healthcare and Family Services (HFS) appreciates the work performed by your office in conducting the audit of the "Medicaid Eligibility Determinations for Long-Term Care".

Enclosed with this letter are detailed responses that address each of the recommendations.

If you have any questions or comments about our responses to the recommendations, please contact Amy Lyons, External Audit Liaison, at (217) 558-4347 or through email at amy.lyons@illinois.gov.

Sincerely,

SIGNED ORIGINAL ON FILE

Theresa Eagleson
Director

Attachment Responses

Report: Medicaid Eligibility Determinations for Long-Term Care

Recommendation Number 1: Update LTC Policy Manual Guidance

The Department of Healthcare and Family Services should ensure policy manual guidance is updated as appropriate. Specifically:

- Policy Manual 07-02-20, Workers Action Guide 07-02-20, and any related links should be updated to reflect the resource and income transfer criteria change from \$5,000 to \$10,000 during the lookback period; and
- Policy Manual 07-02-04-a should be updated to reflect the annual increase in the home equity interest limit in accordance with the Illinois Administrative Code and federal law (89 Ill. Adm. Code 120.385(c) and 42 USC 139p(f)(1)(C))

Department Response: The Department accepts the recommendation. The Department will make the changes recommended above in the online Cash, SNAP and Medical manual.

Recommendation Number 2: Eligibility Determination Timeliness

The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should work together to implement controls to improve the timeliness of long-term care eligibility determinations to comply with timeliness contained in federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 Ill Adm. Code 10.420).

Department Response: The Department accepts the recommendation. HFS has been working over the last several months to refine the LTC data to better identify the age of pending LTC applications and admissions. The OIG will create a desk aid and provide training to the DHS caseworkers to assist in identifying applications that meet referral criteria for an asset investigation. In addition, the Integrated Eligibility System will be used for referrals instead of the current email system.

Recommendation Number 3: HFS OIG Application Referrals

The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should, in order to decrease the opportunity for application processing delays, work together to implement changes to improve the process of:

- referring applications to the HFS OIG to ensure referrals are received by the HFS OIG; and
- receiving and acting upon recommendations from the HFS OIG upon completion of its asset investigations.

Department Response: The Department accepts the recommendation. The OIG began working in the Integrated Eligibility System (IES) in January 2019. IES will be used for the the referral process rather than the current system of using emails to ensure proper and efficient case flow.

Recommendation Number 4: Tracking of Extensions

The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should ensure extensions are tracked so processing times can be tolled, as required by the Public Aid Code, for extension days granted (prior to Public Act 100-665, 305 ILCS 5/11-

5.4(e)(8) & 305 ILCS 5/11-5.4(e)(9)(B); following, 305 ILCS 5/11-5.4(e) and 305 ILCS 5/11-5.4(f)(B)). Specifically, the Departments should ensure:

- Extensions are captured in a usable manner;
- Extensions are captured accurately; and
- Only the allowable number of extensions are granted per application.

Department Response: The Department accepts the recommendation. The OIG began working in the Integrated Eligibility System (IES) in January 2019. The use of IES will assist in the tracking of extensions.

Recommendation Number 5: Required Posting of LTC Monthly Report to Websites

The Department of Healthcare and Family Services and the Department of Human Services should post LTC reports to each Department's website on a monthly basis as required by the Illinois Public Aid Code (prior to Public Act 100-665, 305 ILCS 5111- 5.4(e)(9); following, 305 ILCS 5/11-5.4(1)).

Department Response: The Department accepts the recommendation. The Department will ensure LTC monthly reports are posted timely.

Recommendation Number 6: LTC Monthly Report Completeness

The Department of Healthcare and Family Services and the Department of Human Services should ensure monthly reports contain all elements required by Section 11-5.4(e)(9) of the Illinois Public Aid Code (prior to Public Act 100-665, 305 ILCS 5/11- 5.4(e)(9);following, 305 ILCS 5/11-5.4(j)).

Department Response: The Department accepts the recommendation. Data fields that have not been captured and reported previously have been logged as change requests for the Integrated Eligibility System.

Recommendation Number 7: LTC Monthly Report Accuracy

The Department of Healthcare and Family Services and the Department of Human Services should develop controls to ensure monthly reports required by Section 11-5.4(e)(9) of the Public Aid Code are accurate (prior to Public Act 100-665, 305 JLCS 5/11- 5.4(e)(9);following, 305 JLCS 5/11-5.4(j)).

Department Response: The Department accepts the recommendation. The Department started using the Integrated Eligibility System as the source for the LTC application data in October 2018 to provide accurate application data on the LTC monthly report.

Recommendation Number 8: Consistency in LTC Pending Application Reporting

The Department of Healthcare and Family Services should ensure LTC pending application reporting is consistent among the reports required by the Public Aid Code and reports submitted to the Federal government (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(j)).

Department Response: The Department accepts the recommendation. The Department started using the Integrated Eligibility System as the source for the LTC application data in October 2018 to eliminate discrepancies between the LTC monthly report and the LTC application data reported to the Federal government.



Bruce Rauner, Governor • James T. Dimas, Secretary

February 5, 2019

Tricia Wagner
Performance Audit Manager
Office of the Auditor General
Iles Park Plaza
740 East Ash
Springfield, Illinois 62703-3154

Dear Ms. Wagner,

Attached, please find the Department's official responses to the findings identified during the 2017 performance audit of Medicaid eligibility determinations for long-term care services and supports.

Please review the attached Departmental responses and let me know if you have any questions or concerns.

You can reach me at Amy.DeWeese@Illinois.gov or (217) 558-6931.

Sincerely,

SIGNED ORIGINAL ON FILE

Amy De Weese, CPA
Chief Internal Auditor

cc: Diane Grigsby Jackson, Director Division of Family and Community Services
Robert Brock, Chief Financial Officer
Corey-Anne Gulkewicz, Chief of Staff
James Dimas, Secretary

RECOMMENDATION-2: ELIGIBILITY DETERMINATION TIMELINESS.

AUDIT RECOMMENDATION:

The Department of Healthcare and Family Services, including the Office of Inspector General, and the Department of Human Services should work together to implement controls to improve the timeliness of long-term care eligibility determinations to comply with timeliness contained in federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 ILL. Adm. Code 10.420).

DEPARTMENT RESPONSE:

The Department of Human Services agrees with the recommendation. Collaborative efforts among the Department of Human Services (DHS), the Department of Healthcare and Family Services (HFS) and the HFS Office of the Inspector General (OIG) are necessary to improve timeliness and ensure compliance with the timelines contained in Federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 ILL. Adm Code 10.420). DHS and HFS partnered in a 'Rapid Results' workshop to review the flow of eligibility determination and identify areas that would streamline the process and improve timeliness. The agencies continue to work together to identify additional steps that can be taken to improve timeliness.

RECOMMENDATION-3: HFS APPLICATION REFERRALS

AUDIT RECOMMENDATION:

The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should, in order to decrease the opportunity for application processing delays, work together to implement changes to improve the process of:

- Referring applications to the HFS-OIG to ensure referrals are received by the HFS-OIG; and
- Receiving and acting upon recommendations from the HFS-OIG upon completion of its asset investigations.

DEPARTMENT RESPONSE:

The Department of Human Services agrees with the recommendation. Each of the three Long Term Care Hubs has created a team whose responsibilities include responsiveness to HFS OIG recommendations and implementation of the recommendation of the HFS OIG. A system enhancement is scheduled to roll out in February 2019 that would allow DHS to notify the HFS OIG of referrals.

RECOMMENDATION-4: TRACKING OF EXTENSIONS

AUDIT RECOMMENDATION:

The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should ensure extensions are tracked so processing times can be tolled, as required by the Public Aid Code, for extension days granted (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(8) & 305 ILCS 5/11-5.4(e)(9)(B); following, 305 ILCS 5/11-5.4(e) and 305 ILCS 5/11-5.4(f)(B)). Specifically, the Departments should ensure:

- Extensions are captured in a usable manner;
- Extensions are captured accurately; and
- Only the allowable number of extensions are granted per application.

DEPARTMENT RESPONSE:

The Department of Human Services agrees with the recommendation. Proper monitoring is needed to ensure that DHS and HFS track extensions and that extensions do not exceed the two that are allowed. DHS is to document all extensions in the case notes within the Integrated Eligibility System (IES) system. An enhancement request to the IES that allows identification of an extension request is in process. This would allow DHS and HFS to be aware of and then toll a request for an extension that has been made by the customer, facility, or power of attorney.

RECOMMENDATION-5: REQUIRED POSTING OF LTC MONTHLY REPORT

AUDIT RECOMMENDATION:

The Department of Healthcare and Family Services and the Department of Human Services should post LTC reports to each Department's website on a monthly basis as required by the Illinois Public Aid Code (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).

DEPARTMENT RESPONSE:

The Department of Human Services agrees with the recommendation. A link to the HFS Long Term Care Report is on the DHS's website.

RECOMMENDATION-6: LTC MONTHLY REPORT COMPLETENESS

AUDIT RECOMMENDATION:

The Department of Healthcare and Family Services and the Department of Human Services should ensure monthly reports contain all elements required by Section 11-5.4(e)(9) of the Illinois Public Aid Code (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).

DEPARTMENT RESPONSE:

The Department of Human Services agrees with the recommendation. The monthly report should contain all elements required by Section 11-5.4(e) (9) of the Illinois Public Aid Code. The Department will work with HFS to include all elements or request IES enhancements to ensure the required elements may be reported.

RECOMMENDATION-7: LTC MONTHLY REPORT ACCURACY

AUDIT RECOMMENDATION:

The Department of Healthcare and Family Services and the Department of Human Services should develop controls to ensure monthly reports required by Section 11-5.4(e)(9) of the Public Aid Code are accurate (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).

DEPARTMENT RESPONSE:

The Department of Human Services agrees with the recommendation. During the time of the audit the data contained in the monthly report was reliant upon the data in a manual tracking base. The monthly report will no longer extract data from the manual tracking base and will pull data from the Integrated Eligibility System (IES).

