Review: 4464
Statewide Single Audit
Year Ended June 30, 2015
Illinois Department of Healthcare and Family Services

FINDINGS/RECOMMENDATIONS – 8
Repeated – 6

Accepted & Partially Implemented – 5
Implemented – 3

15-19. The auditors recommend DHFS evaluate the known Integrated Eligibility System (IES) issues, implement monitoring procedures to identify potential noncompliance relative to its federal programs resulting from these items, and consider the changes necessary with respect to internal controls over eligibility determinations to ensure only eligible beneficiaries receive assistance under its federal programs. The auditors also recommend DHFS implement adequate general information technology control procedures for the IES system.

Finding: The Illinois Department of Human Services (IDHS) and the Department of Healthcare and Family Services (DHFS) did not have appropriate controls over the Integrated Eligibility System (IES) used for certain eligibility determinations performed for the Supplemental Nutrition Assistance Program (SNAP) Cluster, Temporary Assistance for Needy Families (TANF) Cluster, Children's Health Insurance Program (CHIP), and Medicaid Cluster programs.

During testwork, auditors noted several deficiencies in the controls over the implementation of IES. Specifically, auditors noted the IDHS and DHFS had not adequately completed and documented system testing performed prior to going live with IES. At the time IDHS and DHFS began using IES for eligibility determinations, there were several known system issues identified in user testing which had not been resolved. As of the date of fieldwork (March 3, 2016), the IDHS and DHFS had not adequately documented its risk assessments relative to the known system issues and had not established procedures to monitor potential noncompliance with program requirements. While the IDHS and DHFS had identified and established manual workarounds for certain known errors, procedures had not been established to monitor or evaluate potential noncompliance resulting from those issues.

Auditors were also unable to perform adequate procedures to satisfy themselves that certain general information technology controls over the IES system were operating effectively. Specifically, auditors noted IDHS and DHFS could not provide all information necessary to test system access security controls and several system changes did not follow the established change management policies of either IDHS or DHFS.

Accordingly, auditors were not able to rely on IES with respect to testing of the eligibility and related allowability compliance requirements for beneficiary payments made under the TANF Cluster, CHIP, and Medicaid Cluster programs. Auditors were also not able to rely on IES with respect to the special test and provision – ADP System for SNAP related to the SNAP Cluster program.

In addition to the control deficiencies identified above, auditors noted several instances of noncompliance during a review of system data obtained from IES. Specifically, cases were approved in IES despite beneficiaries not meeting eligibility requirements related to citizenship status or residency (immigration status). Also, cases were approved in IES without valid social security numbers or submission of an application for a social security number.

Details of the beneficiary payments paid by the State during the year ended June 30, 2015 for the SNAP Cluster, TANF Cluster, CHIP, and Medicaid Cluster programs are as follows:

Major Program	Total Beneficiary Payments in FY15	Total FY15 Program Expenditures	Percentage
SNAP Cluster	$ 3,293,986,000	$ 3,392,532,000	97.1%
TANF Cluster	69,143,000	590,890,000	11.7%
CHIP	272,858,000	298,905,000	91.3%
Medicaid Cluster	10,369,578,000	11,021,872,000	94.1%

In discussing these conditions with DHFS officials, they stated the exceptions noted can be attributed to the complexity of the federal laws governing each program's eligibility rules. Additionally, the eligibility rules for medical programs were changing while IES was being designed and built because the Federal Centers for Medicare and Medicaid Services continued issuing guidance and promulgating regulations. In addition, the short timeline for implementing IES and the limited number of state employees with expertise needed to manage the program contributed to the findings.

Response: The Department accepts the recommendation. Following are some of the steps taken since June 2015 to establish improved controls over general information technology control procedures:

- Implemented observation sessions to validate results of System Test stage before moving into User Acceptance Test stage.
- Extended timeline for Phase 2 to increase User Acceptance Test stage from 12 to 43 weeks.
- Created detailed requirements traceability matrix to enable thorough due diligence of defects and workarounds.
- Refocusing on quality by requiring vendor quality reviews and joint quality review meetings with vendor.

- Redefining project deliverables jointly with vendor to focus on quality and acceptable defect levels for deployment.
- Revamping change management, decision management and documentation of deliverable approvals.

The Department has implemented a sophisticated system for documenting, tracking and prioritizing correction of all identified defects. Because of the size and complexity of the benefit programs IES controls, the Department will review IES on an ongoing basis to assure accuracy of all eligibility determinations, both approvals and denials.

The Department has reviewed the data in IES for October 1, 2013 through June 30, 2015, and found:

Fiscal Year	Applications Submitted via IES	Applications Approved via IES	Expenditures Associated with Applications Approved via IES	Individuals Potentially Inappropriately Approved	IDHS Services Expenditures Potentially in Error	DHFS Services Expenditures Potentially in Error
2014	625,672	514,499	$861,730,573	751	$138,940	$1,294,177
2015	1,116,179	894,680	$3,307,145,211	2,469	$338,931	$6,508,701

The potentially incorrect expenditures referenced for fiscal year 2015 represent approximately two tenths of one percent of all expenditures associated with applications approved via IES. As was the case the cost for of the errors found during this review, the Department expects any additional errors that may be found will not affect more than a small percentage of enrollees or expenditures and that a substantial majority of eligibility decisions made by IES are correct.

Updated Response: Accepted and Partially Implemented. HFS instituted joint management of a comprehensive project schedule encompassing state and vendor responsibility. The Department added a qualified project manager who is a state employee to the project management team. In addition, the Department implemented controls and IES operations are now complete and fully documented. We have established on-going data analysis processing to identify eligibility errors and document, track and prioritize correction of identified high priority Phase I IES defects.

15-20. The auditors recommend DHFS review its current process for maintaining documentation supporting eligibility determinations and consider changes necessary to ensure all eligibility determination documentation is properly maintained. (Repeated-2014)

Finding: DHFS could not locate case file documentation supporting eligibility determination for beneficiaries of the Children's Health Insurance Program (CHIP) and the Medicaid Cluster Programs.

Details of the beneficiary payments selected in the samples for the CHIP and Medicaid Cluster programs are as follows:

Case Type	Number of Cases Tested	Total Amount of Payments for Cases Tested	Total Amount of Payments Made on Behalf of Beneficiaries for FY15	Total FY15 Program Expenditures
CHIP	65	$ 576	$ 272,858,000	$ 298,905,000
Medicaid Cluster	125	5,738	10,369,578,000	11,021,872,000

During testwork, auditors selected eligibility files to review for compliance with eligibility requirements and for the allowability of the related benefits provided, and noted the following exceptions:

- In two CHIP case files (with medical payments sampled of $47), DHFS could not locate any case file documentation supporting the eligibility determinations performed on or prior to the service date sampled. Medical payments made on behalf of this beneficiary of the CHIP Program were $28,892.
- In 15 CHIP case files (with medical payments sampled of $528), DHFS could not locate documentation supporting the completion of redetermination procedures. Missing documentation includes signed applications, paystubs, redetermination applications, and verification cross-matches. Medical payments made on behalf of these beneficiaries for the CHIP program were $35,494.
- In 15 CHIP case files (with medical payments sampled of $528), DHFS did not complete redetermination procedures within required time frames. For 13 of the cases, the delay in completing these redeterminations was between 31 and 132 months after the required time frame, and for two of the CHIP case files, the redetermination was performed subsequent to the service date sampled. Medical payments made on behalf of these beneficiaries for the CHIP program were $35,494.

In discussing these conditions with DHFS officials, the Department stated, in conjunction with IDHS, DHFS has been working to refine the renewal process. The process has taken time and utilized different vendor systems and storage methods.

Updated Response: Accepted and Partially Implemented. Documentation for eligibility determinations made in IES from October 2013 through the time of IES implementation will be uploaded into Content Manager prior to full implementation of IES. Documents are currently maintained electronically at individual FCRCs pending uploading to the IES system. Documents related to medical only redeterminations are contained in Max-IL and Content Manager until IES begins handling redeterminations. Once the IES goes live, all initial and ongoing eligibility determinations will be made in one system, IES. All documentation will be maintained in IES or automatically uploaded into Content Manager.

15-21. The auditors recommend DHFS implement procedures to ensure all per diem rates are updated and adjustments are made in a timely manner for government owned hospitals. (Repeated-2010)

Finding: DHFS did not update per diem rates and make related adjustments in a timely manner for government-owned hospitals participating in the Medicaid Cluster.

During testwork of 65 CHIP and 125 Medicaid beneficiary payments, auditors reviewed provider reimbursements for accuracy and the allowability of the related benefits provided. During those procedures, auditors noted DHFS did not finalize the 2015 per diem rates for two providers until December 2014 and November 2015, respectively. Because DHFS did not set the provider per diem rates for 2015 until December 2014 and November 2015, these hospitals' reimbursements for State FY15 were subsequently adjusted by $3,374,312 for inpatient rates and $8,549,542 for outpatient rates in June 2015 and February 2016.

In discussing these conditions with DHFS officials, they stated the inpatient rates were not timely due to ongoing negotiations with these large, government owned hospitals.

Response: The Department accepts the recommendation. The Department filed State Plan Amendment 14-0012 at the beginning of calendar year 2014. The amendment changes our historical cost inflator from a hospital specific inflator to an inflator based on the Centers for Medicare and Medicaid Services Input Price Index (CIPI) for both Cook and U of I hospital inpatient rates. The hospital specific cost inflator is a more volatile inflator that can vary drastically from year to year. The CIPI inflator is based on national industry standards and is generally more consistent over time. With the approval of SPA 14-0012, the implementation of CIPI cost inflators should alleviate the lengthy negotiation process. The State fiscal year 2016 rate letters were sent July 2015; the rates were in the system shortly thereafter.

Updated Response: Implemented. The SFY2016 rates were set and letters were sent to Cook County and U of I hospitals in July 2015. However, the Department has submitted a State Plan Amendment that intends to set cost based inpatient rates for Cook County and U of I, through the new APR DRG system, rather than the per diem reimbursement that has been used for years. As the new pending SPA 15-019 will be effective 1/1/2016, the SFY 2016 rate will change as of that date, and retroactive adjustments will occur.

15-22. The auditors recommend DHFS implement procedures to verify with recipients whether services billed by providers were received. (Repeated-2010)

Finding: DHFS does not have adequate procedures in place to verify with beneficiaries of the Medicaid Cluster program whether services billed by providers were actually received.

During testwork, auditors noted DHFS procedures for verifying whether services billed by providers were actually received by Medicaid Cluster beneficiaries consisted of special

projects performed by the DHFS Office of Inspector General and Bureau of Comprehensive Health Services. However, the current projects only cover procedures billed by non-emergency transportation providers, optometric providers, and dental providers which only account for less than 1% of total provider reimbursements. Further, DHFS does not perform any verification procedures for services billed by the following provider types:

- Hospitals
- Mental Health Facilities
- Nursing Facilities
- Intermediate Care Facilities
- Physicians
- Other Practitioners
- Managed Care Organizations
- Home and Community-Based Service Providers
- Physical Therapy Providers
- Occupational Therapy Providers

Payments made to non-emergency transportation providers, optometric providers, and dental providers totaled $93,109,000 during the year ended June 30, 2015. Payments made to providers on behalf of all beneficiaries of the Medicaid Cluster totaled $10,369,578,000 during the year ended June 30, 2015.

In discussing these conditions with DHFS officials, they stated the Department used a risk based approach to determine which provider services were verified as received by recipients.

Response: The Department accepts the recommendation. The new Medicaid Management Information System will fully implement this process through various requirements that include:

- Validation of Explanation of Benefits (EOB) online through the recipient portal;
- Dynamic system functionality that support EOB sample selections;
- Ability to include laymen's description of procedure and diagnosis codes on EOBs; and
- Functionality that support linguistically and culturally appropriate EOBs.

Updated Response: Accepted and Partially Implemented.

15-23. The auditors recommend DHFS review its current process for monitoring agencies operating Home and Community-Based Waivers to ensure monitoring is in accordance with the federal regulations. (Repeated-2012)

Finding: DHFS does not have an adequate process to monitor agencies operating the Home and Community-Based Services Waiver programs.

During review of monitoring procedures performed by DHFS and its service providers, auditors noted DHFS does not have a formalized process to follow up on deficiencies

identified during on-site reviews for the Brain Injury, HIV and AIDS, and Persons with Disabilities waiver programs. Following each on-site review, DHFS sends the other state agencies a letter notifying them of the deficiencies identified, with a request to respond within 60 days with plans for individual and systemic correction. However, no formal follow-up procedures are performed to ensure the corrective action plans were implemented or whether the deficiencies may still exist.

In discussing these conditions with DHFS officials, they stated the Bureau of Quality Management had not updated its policy and procedures for monitoring home and community based waiver providers and had not completed development of a methodology for remediation verification.

Updated Response: Implemented. The Department has finalized policy and procedures for monitoring home and community-based waiver providers, as well as developed a methodology for remediation verification and a remediation tool. This finding may be repeated in the current audit because it wasn't implemented until FY16.

15-24. The auditors recommend DHFS establish procedures to accurately report federal expenditures used to prepare the Schedule of Expenditures of Federal Awards (SEFA) to the Illinois Office of the Comptroller (IOC). (Repeated-2014)

Finding: DHFS did not accurately report federal expenditures under the Medicaid Cluster program.

DHFS inaccurately reported federal expenditures, which were used to prepare the Schedule of Expenditures of Federal Awards (SEFA), to the Illinois Office of the Comptroller (IOC). Specifically, auditors noted the following errors for DHFS' major programs for the year ended June 30, 2015:

Program	Amounts per DHFS' Records	Amounts Initially Reported to IOC	Difference
Medicaid Cluster	$ 11,021,861,000	$ 11,021,872,000	$ (11,000)

A correction to the SEFA was necessary to accurately identify DHFS' federal expenditures under the ARRA – Medical Assistance program of $71,405,000.

Additionally, the following differences were identified relative to amounts passed through to subrecipients for the following major program:

Program	Amounts per DHFS' Records	Amounts Initially Reported to IOC	Difference
Medicaid Cluster	$ 53,629,000	$ 62,649,000	$ (9,020,000)

Although the errors identified in the table above are not quantitatively material to the SEFA as a whole, the State does not have a process in place to evaluate errors of this nature outside of the audit process.

In discussing these conditions with DHFS officials, they stated the expenditure difference was noted, but not adjusted due to the late timing and small dollar amount. The subrecipient difference represents the federal share of cost adjustment payments to local health departments.

Response: The Department accepts the recommendation. Steps will be added to compare subrecipient amounts reported in the GAAP packages to the amounts reported on the SEFA.

As the state Medicaid agency, DHFS assumes the responsibility for reporting the Medicaid cluster amounts on the SEFA, even though DHFS is not the grantee or program agency for three of the four programs in the Medicaid cluster. The amounts reported for the Medicaid program include expenditures from other state agencies and multiple local governments and school districts. The $11,000 difference that the auditors noted was an adjustment made by another state agency very late in the process and DHFS elected to not adjust the SEFA at that time.

The $9,020,000 difference in subrecipient expenditures represents payments to local health departments for the federal share of their costs above the service rates originally paid. These payments have not been included as sub-recipient payments on the SEFA in prior years. The amount shown as reported to the IOC is the total of all federal share pass through payments on the modified accrual basis. In DHFS' opinion the cost adjustment payments to the local health departments were not included as subrecipient payments because they are not administrative in nature.

Updated Response: Implemented.

15-25. The auditors recommend DHFS establish procedures to ensure that vendors contracting with DHFS are not suspended or debarred or otherwise excluded from participation in Federal assistance programs. The auditors also recommend DHFS work with agencies contracting with vendors on the behalf of DHFS to ensure the suspension and debarment certifications are included or the System for Award Management (SAM) is checked. (Repeated-2009)

Finding: DHFS did not obtain required certifications that vendors or medical providers were not suspended or debarred from participation in federal assistance programs for the Child Support Enforcement (Child Support); Children's Health Insurance Program (CHIP); and Medicaid Cluster programs.

During review of 20 vendors of the Child Support program and 20 vendors allocated to all federal programs, auditors noted certifications were not obtained from five vendors to indicate whether or not these vendors were suspended or debarred from participation in

federal assistance programs. Additionally, DHFS did not perform a verification check with the System for Award Management (SAM) maintained by the U.S. Government. DHFS also has not developed procedures to perform verification checks of medical providers with SAM as required by federal regulations.

Payments to vendors allocated to the Child Support, CHIP, and Medicaid Cluster Programs totaled $9,948,000, $10,494,000, and $482,803,000, respectively, during FY15. Payments made to providers on the behalf of beneficiaries of the CHIP and Medicaid programs were $272,858,000 and $10,369,578,000, respectively, during FY15.

In discussing these conditions with DHFS officials, they stated that the five vendors identified as exceptions were procured by the Illinois Department of Central Management Services (DCMS) under master contracts and the Department relied on procedures performed by DCMS.

Updated Response: Accepted and Partially Implemented. HFS vendor contracts include the required suspension and debarment language. CPO Notice 2012.07 was issued requiring certification language to be included in all Statewide master Contracts. HFS will develop a mechanism to capture complete information on all providers and applicable persons on a monthly basis once access to such a searchable database is federally granted and/or with the implementation of the new/updated MMIS.

15-26. The auditors recommend DHFS follow its established policies and procedures to ensure access to its information systems are adequately secured.

Finding: DHFS does not have adequate program access controls over information systems used to pay medical benefits to beneficiaries and record program expenditures.

During testwork over user access to the State's network and DHFS' applications, auditors noted DHFS requires an annual certification to be completed for each user granted access. The annual certification requires each user's immediate supervisor to view the user's access permissions and certify those permissions continue to be appropriate. During testing of 25 users, the auditors noted two individuals for which certifications were not completed during FY15.

In addition, the password settings for access to the PAAS server do not conform to the State's policy for minimum password length and the account lockout requirements.

In discussing these conditions with DHFS officials, they stated there is a system operating issue that cannot conform to the password expiration requirement. In addition, the account lockout requirement and missing employee user access permission was an oversight.

Response: The Department accepts the recommendation. The Department will remind supervisors to perform user access reviews on an annual basis and implement a requirement to lock users out after three attempts. The Department however, will be unable to update the password length requirement until there is a system update.

Updated Response: Accepted and Partially Implemented. The Department and DoIT management are currently reviewing and revising draft policy and procedures. These procedures include an HFS Security Assessment Policy, DoIT Incident Response Plan and an Information Security Incident Management Policy.