STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AUDIT

For the Year Ended June 30, 2018

Performed as Special Assistant Auditors
For the Auditor General, State of Illinois

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AUDIT
For the Year Ended June 30, 2018

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STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AUDIT
For the Year Ended June 30, 2018

AGENCY OFFICIALS

Director	Felicia Norwood (through 6/15/2018) Teresa Hursey, Interim (6/16/2018 to 7/10/2018) Patricia Bellock (7/11/2018 to 1/18/2019) Vacant (1/19/2019 to 1/20/2019) Theresa Eagleson (1/21/2019 to current)
Assistant Director	Vacant
Chief of Staff	Ray Marchiori (through 8/18/2017) Vacant (8/17/2017 to 12/15/2017) Shawn McGady (12/16/2017 to 7/15/2018) Vacant (7/16/2018 to 5/19/2019) Benjamin Winick (5/20/2019 to current)
Deputy Directors	
Community Outreach	Vacant (through 4/15/2018) Kimberly McCullough-Starks (4/16/2018 to current)
Administrative Operations	Richard Foxman (through 12/18/2017) Vacant (12/19/2017 to 7/15/2018) Shawn McGady (7/16/2018 to 2/28/2019) Vacant (3/1/2019 to current)
Human Resources	Vacant
Strategic Planning	Douglas O'Brien (through 8/11/2017) Vacant (8/12/2017 to 6/16/2019) Robert (Andy) Allison (6/17/2019 to current)
General Counsel	Mollie Zito (through 1/31/2018) Vacant (2/1/2018 to 2/22/2018) Christopher Gange, Acting (2/23/2018 to current)
Inspector General	Bradley Hart
Administrators	
Division of Child Support Services	Pamela Lowry (through 6/29/2018) Mary Bartolomucci (7/1/2018 to current)
Division of Finance	Michael Casey
Division of Medical Programs	Teresa Hursey, Acting (through 12/31/2018) Vacant (1/1/2019 to 2/18/2019) Douglas Elwell (2/19/2019 to current)

Division of Personnel and Administrative Services	Terri Shawgo (through 10/31/2018) Vacant (11/1/2018 to current)
Chiefs	
Office of Legislative Affairs	Shawn McGady (through 12/15/2017) Vacant (12/16/2017 to 2/28/2019) Shawn McGady (3/1/2019 to current)
Office of Fiscal Management	Jack Dodds (through 7/31/2018) Vacant (8/1/2018 to 4/15/2019) Gary Casper (4/16/2019 to current)
Office of Information Services	Graham Osmonson

Department administrative offices are located at:

201 South Grand Avenue East
Springfield, IL 62763

2200 Churchill Road
Springfield, IL 62702

401 South Clinton
Chicago, IL 60607

STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AUDIT
For the Year Ended June 30, 2018

FINANCIAL STATEMENT REPORT

SUMMARY

The audit of the accompanying financial statements of the State of Illinois, Department of Healthcare and Family Services (Department) was performed by Sikich LLP.

Based on their audit, the auditors expressed an unmodified opinion on the Department's basic financial statements.

SUMMARY OF FINDINGS

The auditors identified matters involving the Department's internal control over financial reporting they considered to be material weaknesses. The material weaknesses are described in the accompanying Schedule of Findings on pages 52-107 of this report as items:

- 2018-001 (Statewide Failure to Execute Interagency Agreements and Perform Essential Project Management Functions over Provider Enrollment in the Medicaid Program)
- 2018-002 (Inadequate General Information Technology Controls over IMPACT)
- 2018-003 (Insufficient Review and Documentation of Provider Enrollment Determinations
- 2018-004 (Failure to Perform Essential Project Management Functions over the Integrated Eligibility System)
- 2018-005 (Deletion of Four Months of Intake Eligibility Files and Significant Problems Determining Eligibility for Human Service Programs)
- 2018-006 (Backlog of Applications and Redeterminations for Human Service Programs)
- 2018-007 (Lack of Controls over Changes to the Integrated Eligibility System)
- 2018-008 (Lack of Security Controls over the Integrated Eligibility System (IES))
- 2018-009 (Financial Statement Preparation Weaknesses)
- 2018-010 (Inadequate Controls over Fiscally Monitoring Managed Care Organizations)
- 2018-011 (Duplicate Payments to Medicaid Managed Care Organizations)
- 2018-012 (Inaccurate Rates Used to Pay Managed Care Organizations)
- 2018-013 (Incorrect Claim Payments)
- 2018-014 (Failure to Review External Service Providers' Internal Controls)
- 2018-015 (Inadequate and Untimely Disclosures)

EXIT CONFERENCE

The Department waived an exit conference in correspondence received by Jamie Nardulli, Chief Internal Auditor, on July 29, 2019.

The Department's responses to the recommendations were provided by Theresa Eagleson, Director, in correspondence dated May 17, 2019 and August 6, 2019. The Department of Children and Family Services' responses to Finding 2018-001, 2018-002, and 2018-003 were provided by Joe McDonald, Associate Deputy Director, in correspondence dated May 17, 2019. The Department of Human Services' responses to Findings 2018-001, 2018-002, 2018-003, 2018-004, 2018-005, 2018-006, 2018-007, and 2018-008 were provided by Amy DeWeese, Chief Internal Auditor, in correspondence dated May 17, 2019 and August 6, 2019. The Department on Aging's responses to Findings 2018-001, 2018-002, and 2018-003 were provided by Nicholas Barnard, Chief Internal Auditor, in correspondence dated May 16, 2019.

SIKICH

CERTIFIED PUBLIC ACCOUNTANTS & ADVISORS
Members of American Institute of Certified Public Accountants

132 South Water Street., Suite 300
Decatur, IL 62723
217.423.6000

SIKICH.COM

INDEPENDENT AUDITOR'S REPORT

Honorable Frank J. Mautino
Auditor General
State of Illinois

Report on the Financial Statements

As Special Assistant Auditors for the Auditor General, we have audited the accompanying financial statements of the governmental activities, the major fund, and the aggregate remaining fund information of the State of Illinois, Department of Healthcare and Family Services (Department), as of and for the year ended June 30, 2018, and the related notes to the financial statements, which collectively comprise the Department's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinions

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities, the major fund, and the aggregate remaining fund information for the Department, as of June 30, 2018, and the respective changes in financial position thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matters

As discussed in Note 2 to the financial statements, the financial statements of the Department are intended to present the financial position and the changes in financial position of only that portion of the governmental activities, the major fund, and the aggregate remaining fund information of the State that is attributable to the transactions of the Department. They do not purport to, and do not, present fairly the financial position of the State of Illinois as of June 30, 2018, and the changes in its financial position for the year then ended in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 2 to the financial statements, the Department adopted the reporting and disclosure requirements of Governmental Accounting Standards Board (GASB) Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* during the year ended June 30, 2018. The implementation of GASB Statement No. 75 resulted in a restatement of July 1, 2017, net position as described in Note 15.

As discussed in Note 12 to the financial statements, the Department has experienced significant issues and noncompliance in its administration of human services programs, including a significant backlog in the processing of new applications for benefits and annual redeterminations of benefits as well as issues with its documentation of eligibility decisions. In addition, as a result of the lack of communication of denied admission reports to long-term care providers from March 2016 through October 2018, the Department has determined it will allow the resubmission of any admission reports the providers believe were adjudicated incorrectly and, if not denied, will allow the provider to retroactively submit bills for unpaid claims.

As discussed in Note 15 to the financial statements, the Department's financial statements have been restated, as of July 1, 2017, to correct prior year misstatements.

As discussed in Note 2 to the financial statements and above, the Department is not legally separate from the State of Illinois, and it relies heavily on the State's ability to appropriate resources for the continuation of the Department's health and social services programs. For the year ended June 30, 2018, approximately 28% of the Department's expenditures were funded with appropriations from the State of Illinois rather than from grants, fees and other revenues of the Department.

Our opinion is not modified with respect to these matters.

Other Matters

Required Supplementary Information

Management has omitted management's discussion and analysis and budgetary comparison information for any of its funds and related pension and other postemployment benefit information for its Department-wide financial statements that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Other Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the Department's basic financial statements. The combining General Fund schedules and nonmajor governmental and agency funds financial statements are presented for purposes of additional analysis and are not a required part of the basic financial statements.

The combining General Fund schedules and nonmajor governmental and agency funds financial statements are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the combining General Fund schedules and nonmajor governmental and agency funds financial statements are fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated August 6, 2019 on our consideration of the Department's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Department's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Department's internal control over financial reporting and compliance.

Restricted Use of this Auditor's Report

This report is intended solely for the information and use of the Auditor General, the General Assembly, the Legislative Audit Commission, the Governor, the Comptroller, and Department management and is not intended to be and should not be used by anyone other than these specified parties.

SIGNED ORIGINAL ON FILE

Decatur, Illinois
August 6, 2019

State of Illinois
Department of Healthcare and Family Services

Statement of Net Position and Governmental Funds Balance Sheet

June 30, 2018 (Expressed in Thousands)

	General Fund	Other Nonmajor Funds	Total Governmental Funds	Adjustments	Statement of Net Position
ASSETS					
Unexpended appropriations	$ (2,735,086)	$ 15,033	$ (2,720,053)	$ -	$ (2,720,053)
Cash equity with State Treasurer	517,985	25,024	543,009	-	543,009
Cash and cash equivalents	4,418	-	4,418	-	4,418
Securities lending collateral equity with State Treasurer	159,626	2,374	162,000	-	162,000
Due from other government - federal	2,099,893	34,377	2,134,270	-	2,134,270
Due from other government - local	56,602	-	56,602	-	56,602
Taxes receivable, net	37,202	-	37,202	-	37,202
Other receivables, net	565,147	9,310	574,457	-	574,457
Due from other Department funds	-	16,200	16,200	(16,200)	-
Due from other State funds	83,766	-	83,766	-	83,766
Due from other State fiduciary funds	769	1,696	2,465	-	2,465
Due from State of Illinois component units	8,089	-	8,089	-	8,089
Prepaid expenses	-	-	-	345	345
Capital assets not being depreciated	-	-	-	9,234	9,234
Capital assets being depreciated, net	-	-	-	2,861	2,861
Total assets	798,411	104,014	902,425	(3,760)	898,665
DEFERRED OUTFLOWS OF RESOURCES					
Deferred outflows of resources - SERS pensions	-	-	-	166,885	166,885
Deferred outflows of resources - OPEB	-	-	-	36,819	36,819
Total deferred outflows of resources	-	-	-	203,704	203,704
Total assets and deferred outflows of resources	$ 798,411	$ 104,014	$ 902,425	$ 199,944	$ 1,102,369
LIABILITIES					
Accounts payable and accrued liabilities	$ 2,292,311	$ 24,367	$ 2,316,678	-	2,316,678
Due to other government - federal	486,542	5,939	492,481	(20,592)	471,889
Due to other government - local	341,421	5,998	347,419	-	347,419
Due to other Department funds	16,200	-	16,200	(16,200)	-
Due to other State funds	13,964	13,364	27,328	-	27,328
Due to other State fiduciary funds	1,144	2,499	3,643	-	3,643
Due to State of Illinois component units	50,119	845	50,964	-	50,964
Unearned revenue	170	-	170	-	170
Obligations under securities lending of State Treasurer	159,626	2,374	162,000	-	162,000
Long-term obligations:					
Due within one year	-	-	-	103,981	103,981
Due subsequent to one year	-	-	-	51,156	51,156
Net pension liability - SERS	-	-	-	1,128,224	1,128,224
Total OPEB liability	-	-	-	780,745	780,745
Total liabilities	3,361,497	55,386	3,416,883	2,027,314	5,444,197

State of Illinois
Department of Healthcare and Family Services

Statement of Net Position and Governmental Funds Balance Sheet

June 30, 2018 (Expressed in Thousands)

	General Fund	Other Nonmajor Funds	Total Governmental Funds	Adjustments	Statement of Net Position
DEFERRED INFLOWS OF RESOURCES					
Unavailable revenue - Federal operating grants	$ 779,633	$ 7,631	$ 787,264	$ (787,264)	-
Unavailable revenue - License and fees	3,961	186	4,147	(4,147)	-
Unavailable revenue - Other taxes	448	-	448	(448)	-
Unavailable revenue - Other operating grants	22,554	-	22,554	(22,554)	-
Unavailable revenue - Other revenues	14,629	-	14,629	(14,629)	-
Deferred inflows of resources - SERS pensions	-	-	-	113,285	113,285
Deferred inflows of resources - OPEB	-	-	-	122,220	122,220
Total deferred inflows of resources	821,225	7,817	829,042	(593,537)	235,505
Total liabilities and deferred inflows of resources	$ 4,182,722	$ 63,203	$ 4,245,925	$ 1,433,777	$ 5,679,702
FUND BALANCES (DEFICITS)/NET POSITION					
Fund balances (deficits):					
Committed for health and social services	1,129,942	40,811	1,170,753	(1,170,753)	-
Unassigned	(4,514,253)	-	(4,514,253)	4,514,253	-
Net investment in capital assets	-	-	-	12,008	12,008
Unrestricted net position	-	-	-	(4,589,341)	(4,589,341)
Total fund balances (deficits)/net position	(3,384,311)	40,811	(3,343,500)	$ (1,233,833)	$ (4,577,333)
Total liabilities, deferred inflows of resources, and fund balances (deficits)	$ 798,411	$ 104,014	$ 902,425		

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The accompanying notes to the financial statements are an integral part of this statement.

State of Illinois
Department of Healthcare and Family Services
Reconciliation of Governmental Funds Balance Sheet
to Statement of Net Position
June 30, 2018
(Expressed in Thousands)

Total fund balances (deficits) - governmental funds	$	(3,343,500)
Amounts reported for governmental activities in the Statement of Net Position are different because:		
Capital assets used in governmental activities are not financial resources and therefore are not reported in the funds.		12,095
Prepaid expenses for governmental activities are current uses of financial resources for funds.		345
Revenues in the Statement of Activities that do not provide current financial resources are deferred in the funds.		829,042
Deferred outflows of resources related to pension liability are not reported in the governmental funds since they do not provide current financial resources.		166,885
Deferred inflows of resources related to pension liability are not reported in the governmental funds since they do not use current financial resources.		(113,285)
Deferred outflows of resources related to OPEB liability are not reported in the governmental funds since they do not provide current financial resources.		36,819
Deferred inflows of resources related to OPEB liability are not reported in the governmental funds since they do not use current financial resources.		(122,220)
Some liabilities reported in the Statement of Net Position do not require the use of current financial resources and, therefore, are not reported as liabilities in governmental funds. These activities consist of:		
Capital lease obligations		(87)
Compensated absences		(10,252)
Disproportionate Share Hospital (DSH) payments liability		(124,206)
Net pension liability - SERS		(1,128,224)
Total OPEB liability		(780,745)
Net position of governmental activities	$	(4,577,333)

The accompanying notes to the financial statements are an integral part of this statement.

State of Illinois
Department of Healthcare and Family Services

Statement of Activities and Governmental Revenues, Expenditures, and Changes in Fund Balances

For the Year Ended June 30, 2018 (Expressed in Thousands)

	General Fund	Other Nonmajor Funds	Total Governmental Funds	Adjustments	Statement of Activities
Expenditures/expenses:					
Health and social services	$ 17,084,374	$ 355,967	$ 17,440,341	$ 217,783	$ 17,658,124
Debt service principal	9	8	17	(17)	-
Debt service interest	3	2	5	-	5
Capital outlays	30,148	54	30,202	(30,202)	-
Total expenditures/expenses	17,114,534	356,031	17,470,565	187,564	17,658,129
Program revenues:					
Charges for services:					
Licenses and fees	26,813	646	27,459	3,294	30,753
Other, net	-	10,285	10,285	-	10,285
Total charges for services	26,813	10,931	37,744	3,294	41,038
Operating grant revenue:					
Federal, net	12,913,920	167,532	13,081,452	(1,777,127)	11,304,325
Other	1,037,894	-	1,037,894	(26,309)	1,011,585
Total operating grant revenue	13,951,814	167,532	14,119,346	(1,803,436)	12,315,910
Net program revenues (expenses)	(3,135,907)	(177,568)	(3,313,475)	(1,987,706)	(5,301,181)
General revenues:					
Interest and investment income	3,437	86	3,523	-	3,523
Medical provider assesment tax	1,586,240	-	1,586,240	(24,233)	1,562,007
Other taxes, net	395,481	-	395,481	7	395,488
Other	7,650	-	7,650	(26,526)	(18,876)
Total general revenues	1,992,808	86	1,992,894	(50,752)	1,942,142
Other sources (uses):					
Appropriations from State resources	7,655,440	200,600	7,856,040	-	7,856,040
Lapsed appropriations	(2,896,414)	(105)	(2,896,519)	-	(2,896,519)
Receipts collected and transmitted to State Treasury	(5,291,997)	(27,270)	(5,319,267)	-	(5,319,267)
Capital transfers to other State agencies	-	-	-	(141,181)	(141,181)
Amount of SAMS transfers-in	(80,000)	-	(80,000)	-	(80,000)
Amount of SAMS transfers-out	20,000	-	20,000	-	20,000
Transfers-in	7,322	36,700	44,022	(36,700)	7,322
Transfers-out	(67,000)	(500)	(67,500)	36,700	(30,800)
Capital lease financing	50	54	104	(104)	-
Total other sources (uses)	(652,599)	209,479	(443,120)	(141,285)	(584,405)
Change in fund balances/net position	(1,795,698)	31,997	(1,763,701)	(2,179,743)	(3,943,444)
Fund balances (deficits)/net position, July 1, 2017, as restated	(1,588,613)	8,814	(1,579,799)	945,910	(633,889)
Fund balances (deficits)/net position, June 30, 2018	$ (3,384,311)	$ 40,811	$ (3,343,500)	$ (1,233,833)	$ (4,577,333)

The accompanying notes to the financial statements are an integral part of this statement.

State of Illinois
Department of Healthcare and Family Services
Reconciliation of Statement of Revenues, Expenditures, and Changes in Fund Balances of Governmental Funds to Statement of Activities
For the Year Ended June 30, 2018
(Expressed in Thousands)

Net change in fund balances - governmental funds	$ (1,763,701)
Amounts reported for governmental activities in the Statement of Activities are different because:	
Governmental funds report capital outlays as expenditures while governmental activities report depreciation expense to allocate those expenditures over the life of the assets. This is the amount by which capital outlays exceeded depreciation and losses on disposals in the current period.	28,389
Transfers of capital assets to other State agencies are not recorded in governmental funds. This amount represents the net transfers of capital assets at no cost to other State funds in the Statement of Activities.	(141,181)
Prepaid expenses in the Statement of Activities are not reported as expenses in governmental funds.	(39)
Revenues in the Statement of Activities that do not provide current financial resources are not reported as revenues in the funds. This amount represents the decrease in unavailable revenue over the prior year.	(1,850,894)
Deferred outflows of resources related to pension liability in the Statement of Activities that do not provide current financial resources are not reported in the governmental funds. This amount represents the decrease in deferred outflows over the prior year.	(95,591)
Deferred inflows of resources related to pension liability in the Statement of Activities that do not use current financial resources are not reported in the governmental funds. This amount represents the increase in deferred inflows over the prior year.	(29,987)
Deferred outflows of resources related to OPEB liability in the Statement of Activities that do not provide current financial resources are not reported in the governmental funds. This amount represents the increase in deferred outflows over the prior year.	26,176
Deferred inflows of resources related to OPEB liability in the Statement of Activities that do not use current financial resources are not reported in the governmental funds. This amount represents the increase in deferred inflows over the prior year.	(122,220)
Repayment of long-term debt is reported as an expenditure in governmental funds, but the repayment reduces long-term liabilities in the Statement of Net Position.	17
Capital lease repayments and related adjustments are reported as an expenditure in governmental funds, but the repayment reduces long-term liabilities in the Statement of Net Position.	(104)
Some expenses reported in the Statement of Activities do not require the use of current financial resources and therefore are not reported as expenditures in governmental funds. These include:	
Increase in compensated absences obligation	(699)
Increase in Disproportionate Share Hospital (DSH) payments liability	(124,206)
Decrease in net pension liability - SERS	64,373
Decrease in total OPEB liability	66,223
Change in net position of governmental activities	$ (3,943,444)

The accompanying notes to the financial statements are an integral part of this statement.

State of Illinois
Department of Healthcare and Family Services

Statement of Fiduciary Net Position

June 30, 2018 (Expressed in Thousands)

	Agency Funds
ASSETS	
Cash equity with State Treasurer	$ 16,105
Cash and cash equivalents	1,861
Other receivables, net	196,719
Total assets	$ 214,685
LIABILITIES	
Accounts payable and accrued liabilities	$ 17,726
Other liabilities	196,959
Total liabilities	$ 214,685

The accompanying notes to the financial statements are an integral part of this statement.

(1) Organization

The Department of Healthcare and Family Services (Department) is a part of the executive branch of government of the State of Illinois (State) and operates under the authority of and review by the Illinois General Assembly. The Department generally operates under a budget approved by the General Assembly in which resources primarily from the State's General Revenue Fund are appropriated for the use of the Department. Activities of the Department are subject to the authority of the Office of the Governor, the State's chief executive officer, and other departments of the executive and legislative branches of government (such as the Department of Central Management Services, the Governor's Office of Management and Budget, the State Treasurer's Office, and the State Comptroller's Office) as defined by the Illinois General Assembly. All funds appropriated to the Department and all other cash received are under the custody and control of the State Treasurer, with the exception of the Child Support Enforcement Trust Fund – SDU.

The Department is organized to provide for the improvement of the lives of Illinois' families through healthcare coverage and child support enforcement.

(2) Summary of Significant Accounting Policies

The financial statements of the Department have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP), as prescribed by the Governmental Accounting Standards Board (GASB). To facilitate the understanding of data included in the financial statements, summarized below are the more significant accounting policies.

(a) Financial Reporting Entity

As defined by GAAP, the financial reporting entity consists of a primary government, as well as its component units, which are legally separate organizations for which the elected officials of the primary government are financially accountable. Financial accountability is defined as:

1) Appointment of a voting majority of the component unit's board and either (a) the primary government's ability to impose its will, or (b) the possibility that the component unit will provide a financial benefit to or impose a financial burden on the primary government; or

2) Fiscal dependence on the primary government and the possibility that the component unit will provide a financial benefit to or impose a financial burden on the primary government.

Based upon the required criteria, the Department has no component units and is not a component unit of any other entity. However, because the Department is not legally separate from the State of Illinois, the financial statements of the Department are included in the financial statements of the State of Illinois. The State of Illinois' Comprehensive Annual Financial Report may be obtained by writing to the State Comptroller's Office, Division of Financial Reporting, 325 West Adams Street, Springfield, Illinois, 62704-1871.

(b) Basis of Presentation

The financial statements of the State of Illinois, Department of Healthcare and Family Services, are intended to present the financial position and the changes in financial position of only that portion of the governmental activities, major fund, and the aggregate remaining fund information of the State of Illinois that is attributable to the transactions of the Department. They do not purport to, and do not, present fairly the financial position of the State of Illinois as of June 30, 2018, and the changes in financial position for the year then ended in conformity with accounting principles generally accepted in the United States of America.

The financial activities of the Department, which consist only of governmental activities, are reported under the health and social services function in the State of Illinois' Comprehensive Annual Financial Report. For reporting purposes, the Department has combined the fund and government-wide financial statements using a columnar format that reconciles individual line items of the fund financial data to government-wide data in a separate column. A brief description of the Department's government-wide and fund financial statements is as follows:

Government-wide Statements. The government-wide statement of net position and statement of activities report the overall financial activity of the Department, excluding fiduciary activities. Eliminations have been made to minimize the double-counting of internal activities of the Department. The financial activities of the Department consist of governmental activities, which are generally financed through taxes and intergovernmental revenues.

The statement of net position presents the assets, deferred outflows of resources, liabilities, and deferred inflows of resources of the Department's governmental activities with the difference being reported as net position. The assets and liabilities are presented in order of their relative liquidity by class of asset or liability with liabilities whose average maturities are greater than one year reported in two components – the amount due within one year and the amount due in more than one year.

The statement of activities presents a comparison between direct expenses and program revenues for the functions of the Department's governmental activities. Direct expenses are those that are clearly identifiable with a specific function. Program revenues include (a) charges paid by the recipients of goods or services offered by the programs and (b) grants and contributions that are restricted to meeting the operational or capital requirements of a particular program. Revenues that are not classified as program revenues, including all taxes, are presented as general revenues.

Fund Financial Statements. The fund financial statements provide information about the Department's funds, including fiduciary funds. Separate statements for each fund category – governmental and fiduciary – are presented. The emphasis on fund financial statements is the major governmental fund, which is displayed in a separate column. All remaining governmental funds are aggregated and reported as nonmajor funds.

The Department administers the following major governmental fund (or portions thereof in the case of shared funds – see note 2 (d)):

General – This is the State's primary operating fund. It accounts for all financial resources of the general government, except those required to be accounted for in another fund. The services which are administered by the Department and accounted for in the General Fund include, among others, promoting access to quality healthcare and child support. Certain resources obtained from federal grants and used to support general governmental activities are accounted for in the General Fund consistent with applicable legal requirements. The Department's portion of the General Fund is composed of eight primary sub-accounts (General Revenue, U of I Hospital Services, County Provider Trust, Long-Term Care Provider, Hospital Provider, Drug Rebate, and Healthcare Provider Relief) and eight secondary sub-accounts.

Additionally, the Department reports the following fund types:

Governmental Fund Types:

Special Revenue – These funds account for transactions related to resources obtained from specific revenue sources that are restricted or committed to expenditures for specific purposes other than debt service or capital projects. The Department does not have any major special revenue funds to disclose.

Fiduciary Fund Types:

Agency – These funds account for transactions related to assets collected by the Department, acting in the capacity of an agent, for distribution to other governmental units or designated beneficiaries.

(c) Measurement Focus and Basis of Accounting

The government-wide and fiduciary fund financial statements are reported using the economic resources measurement focus (except for agency funds which do not have a measurement focus) and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded at the time liabilities are incurred, regardless of when the related cash flow takes place. Non-exchange transactions, in which the Department gives (or receives) value without directly receiving (or giving) equal value in exchange, include nursing home assessments, hospital assessments and intergovernmental grants. On an accrual basis, revenues from the nursing home assessments are recognized in the fiscal year in which the underlying exchange transaction occurs. Revenue from grants, entitlements, and similar items are recognized in the fiscal year in which all eligibility requirements imposed by the provider have been met.

Governmental funds are reported using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized as soon as they are both measurable and available. Revenues are considered to be available when they are collected within the current period or soon enough thereafter to pay liabilities of the current period. For this purpose, the State considers revenues to be available if they are collected within 60 days of the end of the current fiscal year. Expenditures generally are recorded when the liability is incurred, as under accrual accounting. However, principal and interest on formal debt issues, claims and judgments, and compensated absences are recorded only when the payment is due. Capital asset acquisitions are reported as expenditures in governmental funds. Proceeds of general long-term debt and acquisitions under capital leases are reported as other financing sources.

Significant revenue sources which are susceptible to accrual include the nursing home assessment, hospital assessments, federal matching revenues, drug rebates, intergovernmental transfer agreement revenues, and child support. Other miscellaneous revenue sources are considered to be measurable and available only when cash is received.

(d) Shared Fund Presentation

The financial statement presentation for the General Fund accounts, General Revenue, Care Provider for Persons with Developmental Disabilities, and the Trauma Center, as well as the nonmajor governmental funds, the Department of Corrections Reimbursement and Education Fund and the Tobacco Settlement Recovery Fund, represent only the portion of the shared fund that can be directly attributed to the operations of the Department. Financial statements for total fund operations of the shared State funds are presented in the State of Illinois' Comprehensive Annual Financial Report.

In presenting these financial statements, certain unique accounts are used for the presentation of shared funds. The following accounts are used in these financial statements to present the Department's portion of shared funds:

Unexpended Appropriations

This "asset" account represents lapse period warrants issued by the State Comptroller's Office after June 30 annually, in accordance with the Statewide Accounting Management System (SAMS) records, plus any liabilities relating to obligations re-appropriated to the subsequent fiscal year and voucher, interfund payments, and mandatory SAMS transfer transactions held by the State Comptroller's Office at June 30.

Appropriations from State Resources

The "other financing source" account represents the final legally adopted appropriation according to SAMS records.

Lapsed Appropriations

Lapsed appropriations are the legally adopted appropriations less net warrants issued for the 14 month period from July to August of the following year and re-appropriations to subsequent years according to SAMS records. Lapsed appropriations for certain Medicaid expenditures are the legally adopted appropriations less net warrants issued for the up to 18 month period from July to December of the following year. Although HFS generally adheres to an October lapse period close-out for Medicaid expenditures. For fiscal year 2018, the state's general lapse period was extended through October 2018.

Receipts Collected and Transmitted to State Treasury

This "other financing use" account represents all cash receipts received during the fiscal year from SAMS records.

Amount of SAMS Transfers-In

This "other financing use" account represents cash transfers made by the Office of the Comptroller in accordance with statutory provisions to the corresponding fund during the fiscal year per SAMS records in which the Department did not make a deposit into the State Treasury.

Amount of SAMS Transfers-Out

This "other financing source" account represents cash transfers made by the Office of the Comptroller in accordance with statutory provision from the corresponding fund during the fiscal year per SAMS records in which a legally adopted appropriation was not charged.

(e) Eliminations

Eliminations have been made in the government-wide statement of net position to minimize the "grossing-up" effect on assets and liabilities within the governmental activities column of the Department. As a result, amounts reported in the governmental funds balance sheet as interdepartmental interfund receivables and payables have been eliminated in the government-wide statement of net position. Amounts reported in the governmental funds balance sheet as receivable from or payable to fiduciary funds have been included in the government-wide statement of net position as receivable from and payable to external parties, rather than as internal balances.

(f) Cash and Cash Equivalents

Cash equivalents are defined as short-term, highly liquid investments readily convertible to cash with maturities of less than 90 days at the time of purchase. Cash and cash equivalents include cash on hand and cash in banks for locally held funds.

(g) Investments

Most investments are reported at fair value. The Illinois Funds, a 2a7-like pool is reported at amortized cost.

(h) Interfund Transactions and Transactions with State of Illinois Component Units

The Department has the following types of interfund transactions between Department funds and funds of other State agencies:

Services provided and used – sales and purchases of goods and services between funds for a price approximating their external exchange value. Interfund services provided and used are reported as revenues in seller funds and expenditures or expenses in purchaser funds. Unpaid amounts are reported as interfund receivables and payables in the governmental funds balance sheet and the government-wide statement of net position.

Reimbursements – repayments from the funds responsible for particular expenditures or expenses to the funds that initially paid for them. Reimbursements are reported as expenditures in the reimbursing fund and as a reduction of expenditures in the reimbursed fund.

Transfers – flows of assets (such as cash or goods) without equivalent flows of assets in return and without a requirement for repayment. In governmental funds, transfers are reported as other financing uses in the funds making transfers and as other financing sources in the funds receiving transfers.

The Department also has activity with various component units of the State of Illinois for medical programs, intergovernmental transfer agreements and payments for services.

(i) Capital Assets

Capital assets, which includes property, plant, and equipment, and intangible assets, are reported at cost or estimated historical cost based on appraisals. Contributed assets are reported at acquisition value at the time received. Capital assets are depreciated and amortized using the straight-line method. Intangible assets (purchased computer software and internally generated computer software) are assets that do not have a physical existence, are nonfinancial in nature, are not in a monetary form, and have a useful life of over one year.

Capitalization thresholds and the estimated useful lives are as follows:

Capital Asset Category	Capitalization Threshold	Estimated Useful Life (in Years)
Equipment	$ 5,000	3-10
Purchased Computer Software	$ 25,000	3-5
Internally Generated Computer Software	$1,000,000	5-20

(j) Deferred Outflows/Inflows of Resources

In addition to assets, the statement of net position will sometimes report a separate section for deferred outflows of resources. This separate financial statement element, deferred outflows of resources, represents a consumption of net assets that applies to a future period(s) and so will not be recognized as an outflow of resources (expense) until then. In addition to liabilities, the statement of net position will sometimes report a separate section for deferred inflows of resources. This separate financial statement element, deferred inflows of resources, represents an acquisition of net assets that applies to a future period(s) and so will not be recognized as an inflow of resources (revenue) until that time. The Department has recorded deferred outflows and inflows of resources in the government-wide financial statements in connection with the net pension liability reported and explained in Note 8 and the total post-employment benefits liability reported and explained in Note 9. Unavailable revenues in governmental funds include receivables not “available” to finance the current period.

(k) Compensated Absences

The liability for compensated absences reported in the government-wide statement of net position consists of unpaid, accumulated vacation and sick leave balances for Department employees. A liability for these amounts is reported in governmental funds only if they have matured, for example, as a result of employee resignations and retirements. The liability has been calculated using the vesting method, in which leave amounts for both employees who currently are eligible to receive termination payments and other employees who are expected to become eligible in the future to receive such payments upon termination are included. The liability has been calculated based on the employees' current salary level and includes salary related cost (e.g., Social Security and Medicare taxes).

Legislation that became effective January 1, 1998 capped the paid sick leave for all State Employees' Retirement System members at December 31, 1997. Employees continue to accrue twelve sick days per year, but will not receive monetary compensation for any additional time earned after December 31, 1997. Sick days earned between 1984 and December 31, 1997 (with a 50% cash value) would only be used after all days with no cash value are depleted. Any sick days earned and unused after December 31, 1997 will be converted to service time for purposes of calculating employee pension benefits.

(l) Pensions

In accordance with the Department's adoption of GASB Statement No. 68, *Accounting and Financial Reporting for Pensions – an amendment of GASB Statement No. 27,* and GASB Statement No. 71, *Pension Transition for Contributions Made Subsequent to the Measurement Date – an amendment of GASB Statement No. 68*, the net pension liability, deferred outflows of resources, deferred inflows of resources, and pension expense have been recognized in the government-wide financial statements.

The net pension liability is calculated as the difference between the actuarially calculated value of the projected benefit payments attributed to past periods of service and the plan's fiduciary net position. The total pension expense is comprised of the service cost or actuarial present value of projected benefit payments attributed to the valuation year, interest on the total pension liability, plan administrative expenses, current year benefit changes, and other changes in plan fiduciary net position less employee contributions and projected earnings on plan investments. Additionally, the total pension expense includes the annual recognition of outflows and inflows of resources due to pension assets and liabilities.

For purposes of measuring the net pension liability, deferred outflows of resources, deferred inflows of resources, pension expense and expenditures associated with the Department's contribution requirements, information about the fiduciary net position of the plan and additions to/deductions from the plan's fiduciary net position have been determined on the same basis as they are reported within the separately issued plan financial statements. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with terms of the plan. Investments are reported at fair value.

(m) Postemployment Benefits Other Than Pensions (OPEB)

The State provides health, dental, vision and life insurance benefits for certain retirees and their dependents through the State Employees Group Insurance Program (SEGIP). The total OPEB liability, deferred outflows of resources, deferred inflows of resources, expense, and expenditures associated with the program have been determined through an actuarial valuation using certain actuarial assumptions as applicable to the current measurement period (see Note 9).

The OPEB liabilities, deferred outflows of resources, deferred inflows of resources, and OPEB expense have been recognized in the government-wide financial statements.

(n) Fund Balances

In the fund financial statements, governmental funds report fund balances in the following categories:

Nonspendable – This consists of amounts that cannot be spent because they are either: a) not in spendable form or b) legally or contractually required to be maintained intact.

Restricted – This consists of amounts that are restricted to specific purposes, that is, when constraints placed on the use of resources are either: a) externally imposed by creditors, grantors, contributors, or laws or regulations of other governments or b) imposed by law through constitutional provisions or enabling legislation.

Committed – This consists of amounts that can only be used for specific purposes pursuant to constraints imposed by formal action of the Department's highest level of decision-making authority. Committed amounts cannot be used for any other purpose unless the Department removes or changes the specified use by taking the same type of action it employed to previously commit those amounts. The Department's highest level of decision-making authority rests with the Illinois State legislature and the Governor. The State passes "Public Acts" to commit their fund balances.

Assigned – This consists of net amounts that are constrained by the Department's intent to be used for specific purposes, but that are neither restricted nor committed.

Unassigned – This consists of residual fund balance that has not been restricted, committed, or assigned within the General Fund and deficit fund balances of other governmental funds.

In the General Fund, it is the Department's policy to consider restricted resources to have been spent first when an expenditure is incurred for which both restricted and unrestricted (i.e. committed, assigned or unassigned) fund balances are available, followed by committed and then assigned fund balances. Unassigned amounts are used only after the other resources have been used.

In other governmental funds (special revenue), it is the Department's policy to consider restricted resources to have been spent last. When an expenditure is incurred for purposes for which both restricted and unrestricted fund balances are available, the Department first utilizes any assigned amounts, followed by committed and then restricted amounts.

(n) Net Position

In the government-wide statement of net position, net position is displayed in three components as follows:

Net investment in capital assets – This consists of capital assets, net of accumulated depreciation less the outstanding balances of any bonds, mortgages, notes or other borrowings that are attributable to the acquisition, construction, or improvement of those assets.

Restricted – This consists of net position that is legally restricted by outside parties or by law through constitutional provisions or enabling legislation. When both restricted and unrestricted resources are available for use, generally it is the State's policy to use restricted resources first, then unrestricted resources when they are needed.

Unrestricted – This consists of net position that does not meet the definition of "restricted" or "net investment in capital assets".

(p) Use of Estimates

The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets, deferred outflows of resources, liabilities, deferred inflows of resources, and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(q) Adoption of New Accounting Pronouncements

Effective for the year ending June 30, 2018, the Department adopted the following GASB statements:

GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions,* which replaces the requirements of GASB Statement No. 45 and requires governments to report a liability on the face of the financial statements for the other postemployment benefits (OPEB) they provide. This statement requires governments in all types of OPEB plans to present more extensive note disclosures and required supplementary information (RSI) about their OPEB liabilities. Among the new note disclosures is a description of the effect on the reported OPEB liability of using a discount rate and a healthcare cost trend rate that are one percentage point higher and one percentage point lower than assumed by the government. The new RSI includes a schedule showing the causes of increases and decreases in the OPEB liability and a schedule comparing a government's actual OPEB contributions to its contribution requirements. The implementation of this statement significantly impacted the Department's government-wide financial statements and footnote disclosure with the recognition of a net OPEB liability, deferred outflows of resources and deferred inflows of resources on the Statement of Net Position and OPEB expense on the Statement of Activities. Additionally, the requirements of this statement resulted in the restatement of beginning net position as discussed in Note 15. Information regarding participation in the State Employees Group Insurance Program is disclosed in Note 9.

GASB Statement No. 81, *Irrevocable Split-Interest Agreements*, which improves accounting and financial reporting guidance for irrevocable split-interest agreements by providing recognition and measurement guidance for situations in which a government is a beneficiary of the agreement. The implementation of this statement had no financial impact on the Department's net position or results of operations.

GASB Statement No. 85, *Omnibus 2017*, which is intended to address practice issues that have been identified during implementation and application of certain GASB statements. This statement addresses a variety of topics including issues related to blending component units, goodwill, fair value measurement and application, and postemployment benefits. The provisions related to postemployment benefits of this statement were incorporated with the implementation of GASB Statement 75.

GASB Statement No. 86, *Certain Debt Extinguishment Issues*, which is intended to improve consistency in accounting and financial reporting for in-substance defeasance of debt by providing guidance for transactions in which cash and other monetary assets acquired with only existing resources (resources other than the proceeds of refunding debt) are placed in an irrevocable trust for the sole purpose of extinguishing debt. In addition, this statement improves accounting and financial reporting for prepaid insurance on debt that is extinguished and notes to financial statements for debt that is defeased in substance. The implementation of this statement had no financial impact on the Department's net position or results of operations.

(r) Future Adoption of GASB Statements

Effective for the year ending June 30, 2019, the Department will adopt the following GASB statements:

GASB Statement No. 83, *Certain Asset Retirement Obligations*, which addresses accounting and financial reporting for certain asset retirement obligations (AROs) and establishes criteria for determining the timing and pattern of recognition of a liability and a corresponding deferred outflow of resources for AROs.

GASB Statement No. 88, *Certain Disclosures Related to Debt, including Direct Borrowings and Direct Placements*, which addresses improvements in information disclosures in notes to government financial statements related to debt, including direct borrowings and direct placements and clarifies which liabilities governments should include when disclosing information related to debt.

Effective for the year ending June 30, 2020, the Department will adopt the following GASB statements:

GASB Statement No. 84, *Fiduciary Activities*, which is intended to improve guidance regarding the identification of fiduciary activities for accounting and financial reporting purposes and how those activities should be reported. In addition, this Statement establishes criteria for identifying fiduciary activities of all state and local governments. The focus of the criteria generally is on (1) whether a government is controlling the assets of the fiduciary activity and (2) the beneficiaries with whom a fiduciary relationship exists. Separate criteria are included to identify fiduciary component units and postemployments benefit arrangements that are fiduciary activities.

GASB Statement No. 90, *Majority Equity Interests – An Amendment of GASB Statements No. 14 and No. 61*, is intended to improve the consistency and comparability of reporting a government's majority equity interest in a legally separate organization and to improve the relevance of financial statement information for certain component units.

Effective for the year ending June 30, 2021, the Department will adopt the following GASB statements:

GASB Statement No. 87, *Leases*, which is intended to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. This statement increases the usefulness of governments' financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. It establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset.

GASB Statement No. 89, *Accounting for Interest Cost Incurred Before the End of a Construction Period*, which is intended to (1) enhance the relevance and comparability of information about capital assets and the cost of borrowing for a reporting period and (2) to simplify accounting for interest cost incurred before the end of a construction period.

The Department has not yet determined the impact of adopting these statements on its financial statements.

(3) Deposits and Investments

(a) Deposits

The State Treasurer is the custodian of the State's cash and cash equivalents for funds maintained in the State Treasury. Deposits in the custody of the State Treasurer are pooled and invested with other State funds in accordance with the Deposit of State Moneys Act of the Illinois Compiled Statutes (15 ILCS 520/11). Funds held by the State Treasurer have not been categorized as to credit risk because the Department does not own individual

securities. Detail on the nature of these deposits and investments are available within the State of Illinois' Comprehensive Annual Financial Report.

Cash on deposit for locally held funds of fiduciary activities had carrying amounts and bank balances of $1.861 million and $13.525 million, respectively, at June 30, 2018. Balances in excess of FDIC depository insurance were covered by collateral held by an agent in the Department's name.

(b) Investments

Section 2 of the Public Funds Investment Act limits the State's investments outside the State Treasury to securities of the U.S. government or its agencies, short-term obligations of domestic corporations exceeding $500 million in assets that are rated in the three highest categories by at least two nationally recognized statistical ratings organizations not to exceed ten percent of the domestic corporations outstanding obligations, money market mutual funds invested in the U.S. government and/or its agencies, and repurchase agreements securities of the U.S. government or its agencies or money market mutual funds invested in the U.S. government or its agencies. Investments of public funds in a Public Treasurers' Investment Pool created under Section 17 of the State Treasurer Act are also permitted.

As of June 30, 2018, the Department had $4.418 million invested with the Illinois Funds. The Illinois Funds is an investment pool managed by the State of Illinois, Office of the Treasurer, which allows governments within the State to pool their funds for investment purposes. The Illinois Funds is a GASB Statement No. 79 qualified external investment pool that measures, for financial reporting purposes, all its investments at amortized cost. There are no limitations or restrictions on withdrawals from the pool.

Interest Rate Risk: The Department does not have a formal investment policy that limits investment maturities as a means of managing its exposure to fair value losses arising from increasing interest rates.

Credit Risk: The Department does not have a formal investment policy that limits investment choices. The Illinois Funds were rated AAAm by Standard & Poor's.

(c) Reconciliation to Statement of Net Position and Statement of Fiduciary Net Position

The Statement of Net Position and the Statement of Fiduciary Net Position account cash and cash equivalents contains certain short-term investments (included as investments above) to reflect their liquidity. A reconciliation (amounts expressed in thousands) follows:

	Deposits	Investments
Governmental Activities		
Amount per note	$ -	$ 4,418
Cash equivalents	4,418	(4,418)
Amounts per Statement of Net Position	$ 4,418	$ -
Fiduciary Funds		
Cash on deposit	$ 13,525	$ -
Outstanding checks	(11,664)	-
Amounts per Statement of Fiduciary Net Position	$ 1,861	$ -

(4) Accounts Receivable

(a) Taxes Receivable

Taxes receivable (amounts expressed in thousands) at June 30, 2018 are as follows:

	General Fund
Taxes receivable	$ 56,202
Less: allowance for uncollectible taxes	(19,000)
Taxes receivable, net	$ 37,202

(b) Other Receivables

Other receivables (amounts expressed in thousands) at June 30, 2018 are as follows:

	General Fund	Nonmajor Governmental Funds	Fiduciary Funds
Other receivables	$ 653,686	$ 753,686	$5,507,102
Less: allowance for uncollectible accounts	(88,539)	(744,376)	(5,310,383)
Other receivables, net	$ 565,147	$ 9,310	$ 196,719

(5) Interfund Balances and Activity

(a) Balances Due to/from Other Funds

The following balances (amounts expressed in thousands) at June 30, 2018 represent amounts due from Department funds, other State funds, and other State fiduciary funds.

	Due from			
Fund	Other Department Funds	Other State Funds	Other State Fiduciary Funds	Description/Purpose
General	$ -	$ 83,766	$ 769	Due from other State funds for subgrants received and for unapplied credits.
Nonmajor governmental funds	16,200	-	1,696	Due from other Department and other State fiduciary funds for subgrants received and for unapplied credits.
	$ 16,200	$ 83,766	$ 2,465	

The following balances (amounts expressed in thousands) at June 30, 2018 represent amounts due to Department funds, other State funds, and other State fiduciary funds for purchases of services.

	Due to		
Fund	Other Department Funds	Other State Funds	Other State Fiduciary Funds
General	$ 16,200	$ 13,964	$ 1,144
Nonmajor governmental funds	-	13,364	2,499
	$ 16,200	$ 27,328	$ 3,643

(b) Transfers to/from Other Funds

Interfund transfers in (amounts expressed in thousands) for the year ended June 30, 2018 were as follows:

	Transfers in from		
Fund	Other Department Funds	Other State Funds	Description/Purpose
General	$ -	$ 7,322	Transfer from other State agencies' General Fund.
Nonmajor governmental funds	36,700	-	Transfer from General Fund per State appropriation.
	$ 36,700	$ 7,322	

Interfund transfers out (amounts expressed in thousands) for the year ended June 30, 2018 were as follows:

	Transfers out to		
Fund	Other Department Funds	Other State Funds	Description/Purpose
General	$ 36,700	$ 30,300	Transfers to Department nonmajor governmental funds and other State agencies' funds per State appropriation.
Nonmajor governmental funds	-	500	Transfer from General Fund per State appropriation.
	$ 36,700	$ 30,800	

(c) ***Balances Due to/from State of Illinois Component Units***

The following balances (amounts expressed in thousands) at June 30, 2018 represent amounts due from State of Illinois Component Units to the General Fund for intergovernmental agreement reimbursements.

Component Unit	Due From General Funds
Southern Illinois University	$ 5,030
University of Illinois	3,059
	$ 8,089

The following balances (amounts expressed in thousands) at June 30, 2018 represent amounts due to State of Illinois Component Units for medical reimbursements.

	Due To	
Component Unit	General Funds	Nonmajor Governmental Funds
Illinois State University	$ 11	$ -
Northern Illinois University	355	-
Southern Illinois University	16,058	209
Illinois Toll Highway Authority	1	-
University of Illinois	33,694	636
	$ 50,119	$ 845

(6) Capital Assets

Capital asset activity (amounts expressed in thousands) for the year ended June 30, 2018 is as follows:

	Balance July 1, 2017	Additions	Deletions	Net Transfers	Balance June 30, 2018
Governmental Activities:					
Capital assets not being depreciated/amortized:					
Internally generated intangible assets in development	$ 123,538	$ 26,877	$ -	$ (141,181)	$ 9,234
Total capital assets not being depreciated/amortized:	123,538	26,877	-	(141,181)	9,234
Capital assets being depreciated:					
Equipment	5,241	1,601	1,930	-	4,912
Capital leases-equipment	-	104	-	-	104
Non-internally generated software	2,878	1,620	-	-	4,498
Less accumulated depreciation:					
Equipment	(4,394)	(327)	(1,563)	-	(3,158)
Capital leases-equipment	-	(17)	-	-	(17)
Non-internally generated software	(2,376)	(1,102)	-	-	(3,478)
Total capital assets being depreciated, net	1,349	1,879	367	-	2,861
Governmental activity capital assets, net	$ 124,887	$ 28,756	$ 367	$ (141,181)	$ 12,095

Depreciation expense for governmental activities (amounts expressed in thousands) for the year ended June 30, 2018 was charged as follows:

Health and social services	$ 1,447

(7) Long-Term Obligations

Changes in Long-Term Obligations

Changes in long-term obligations (amounts expressed in thousands) for the year ended June 30, 2018 were as follows:

	Balance July 1, 2017	Additions	Deletions	Balance June 30, 2018	Amounts Due Within One Year
Governmental Activities:					
Compensated absences	$ 9,553	$ 9,880	$ 9,181	$ 10,252	$ 989
Capital leases	-	104	17	87	33
Repayment to federal government of disallowed Disproportionate Share Hospital payments	-	144,798	-	144,798	102,959
Net OPEB liability	846,968	-	66,223	780,745	-
Net pension liability	1,192,597	-	64,373	1,128,224	-
Total Governmental Activities	$ 2,049,118	$ 154,783	$ 139,795	$ 2,064,106	$ 103,981

Compensated absences will be liquidated by the applicable governmental funds that account for the salaries and wages of the related employees. The repayment to the federal government will be liquidated according to a re-payment plan over a remaining period of seven quarters plus interest. Net pension liabilities and net OPEB liabilities will be liquidated through the General Revenue Fund, and the special revenue funds that report wages.

Capital Lease Obligations

The Department has acquired certain office equipment through capital lease arrangements. Future debt service requirements under capital leases (amounts expressed in thousands) at June 30, 2018 were as follows:

Year Ending June 30,	Principal	Interest	Total
2019	$ 33	$ 7	$ 40
2020	36	4	40
2021	18	-	18
	$ 87	$ 11	$ 98

(8) Defined Benefit Pension Plan

Plan Description. Substantially all of the Department's full-time employees who are not eligible for participation in another state-sponsored retirement plan participate in the State Employees' Retirement System (SERS), which is a single-employer defined benefit pension trust fund in the State of Illinois reporting entity. SERS is governed by article 14 of the Illinois Pension Code (40 ILCS 5/1, et al.). The plan consists of two tiers of contribution requirements and benefit levels based on when an employee was hired. Members who first become an employee and participate under any of the State's retirement plans on or after January 1, 2011 are members of Tier 2, while Tier 1 consists of

employees hired before January 1, 2011 or those who have service credit prior to January 1, 2011. The provisions below apply to both Tier 1 and 2 members, except where noted. The SERS issues a separate CAFR available at www.srs.illinois.gov or that may be obtained by writing to the SERS, 2101 South Veterans Parkway, PO Box 19255, Springfield, Illinois, 62794-9255.

Benefit Provisions. SERS provides retirement benefits based on the member's final average compensation and the number of years of service credit that have been established. The retirement benefit formula available to general State employees that are covered under the Federal Social Security Act is 1.67% for each year of service and for non-covered employees it is 2.2% for each year of service. The maximum retirement annuity payable is 75% of final average compensation for regular employees and 80% for alternative formula employees. The minimum monthly retirement annuity payable is $15 for each year of covered service and $25 for each year of non-covered service.

Members in SERS under the Tier 1 and Tier 2 receive the following levels of benefits based on the respective age and years of service credits.

Regular Formula Tier 1	Regular Formula Tier 2
A member must have a minimum of eight years of service credit and may retire at: • Age 60, with 8 years of service credit. • Any age, when the member's age (years & whole months) plus years of service credit (years & whole months) equal 85 years (1,020 months) (Rule of 85) with eight years of credited service. • Between ages 55-60 with 25-30 years of service credit (reduced 1/2 of 1% for each month under age 60). The retirement benefit is based on final average compensation and credited service. Final average compensation is the 48 highest consecutive months of service within the last 120 months of service. Under the Rule of 85, a member is eligible for the first 3% increase on January 1 following the first full year of retirement, even if the member is not age 60. If the member retires at age 60 or older, he/she will receive a 3% pension increase every year on January 1, following the first full year of retirement. If the member retires before age 60 with a reduced retirement benefit, he/she will receive a 3% pension increase every January 1 after the member turns age 60 and has been retired at least one full year. These pension increases are not limited by the 75% maximum.	A member must have a minimum of 10 years of credited service and may retire at: • Age 67, with 10 years of credited service. • Between ages 62-67 with 10 years of credited service (reduced 1/2 of 1% for each month under age 67). The retirement benefit is based on final average compensation and credited service. For regular formula employees, final average compensation is the average of the 96 highest consecutive months of service within the last 120 months of service. The retirement benefit is calculated on a maximum salary of $106,800. This amount increases annually by 3% or one-half of the Consumer Price Index, whichever is less. If the member retires at age 67 or older, he/she will receive a pension increase of 3% or one-half of the Consumer Price Index for the preceding calendar year, whichever is less, every year on January 1, following the first full year of retirement. The calendar year 2017 rate is $112,408. If the member retires before age 67 with a reduced retirement benefit, he/she will receive a pension increase of 3% or one-half of the Consumer Price Index for the preceding calendar year, whichever is less, every January 1 after the member turns age 67 and has been retired at least one full year. These pension increases are not limited by the 75% maximum.

Additionally, the Plan provides an alternative retirement formula for State employees in high-risk jobs, such as State policemen, fire fighters, and security employees. Employees qualifying for benefits under the alternative formula may

retire at an earlier age depending on membership in Tier 1 or Tier 2. The retirement formula is 2.5% for each year of covered service and 3.0% for each year of non-covered service. The maximum retirement annuity payable is 80% of final average compensation as calculated under the alternative formula.

SERS also provides occupational and non-occupational (including temporary) disability benefits. To be eligible for non-occupational (including temporary) disability benefits, an employee must have at least eighteen months of credited service to the System. The non-occupational (including temporary) disability benefit is equal to 50% of the monthly rate of compensation of the employee on the date of removal from the payroll. Occupational disability benefits are provided when the member becomes disabled as a direct result of injuries or diseases arising out of and in the course of State employment. The monthly benefit is equal to 75% of the monthly rate of compensation on the date of removal from the payroll. This benefit amount is reduced by Workers' Compensation or payments under the Occupational Diseases Act.

Occupational and non-occupational death benefits are also available through the System. Certain non-occupational death benefits vest after eighteen months of credited service. Occupational death benefits are provided from the date of employment.

Contributions. Contribution requirements of active employees and the State are established in accordance with Chapter 40, section 5/14-133 of the Illinois Compiled Statutes. Member contributions are based on fixed percentages of covered payroll ranging between 4.00% and 12.50%. Employee contributions are fully refundable, without interest, upon withdrawal from State employment. Tier 1 members contribute based on total annual compensation. Tier 2 members contribute based on an annual compensation rate not to exceed $106,800 with limitations for future years increased by the lessor of 3% or one-half of the annual percentage increase in the Consumer Price Index. For 2018, this amount was $113,665.

The State is required to make payment for the required departmental employer contributions, all allowances, annuities, any benefits granted under Chapter 40, Article 5/14 of the ILCS and all administrative expenses of the System to the extent specified in the ILCS. State law provides that the employer contribution rate be determined based upon the results of each annual actuarial valuation.

For fiscal year 2018, the required employer contributions were computed in accordance with the State's funding plan. This funding legislation provides for a systematic 50-year funding plan with an ultimate goal to achieve 90% funding of the plan's liabilities. In addition, the funding plan provided for a 15-year phase-in period to allow the State to adapt to the increased financial commitment. Since the 15-year phase-in period ended June 30, 2010, the State's contribution will remain at a level percentage of payroll for the next 35 years until the 90% funded level is achieved. For fiscal year 2018, the employer contribution rate was 47.342%. The Department's contribution amount for fiscal year 2018 was $37.197 million. In addition, the Department recorded $26.661 million of revenue and expenditures in the General Revenue account of the General Fund to account for on-behalf payments to SERS for Department employees.

Pension liability, deferred outflows of resources, deferred inflows of resources and expense related to pensions. At June 30, 2018, the Department reported a liability of $1,128.224 million for its proportionate share of the State's net pension liability for SERS on the statement of net position. The net pension liability was measured as of June 30, 2017 (current year measurement date), and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The Department's portion of the net pension liability was based on the Department's proportion of employer contributions relative to all employer contributions made to the plan during the year ended June 30, 2017. As of the current year measurement date of June 30, 2017, the Department's proportion was 3.4285%, which was a decrease of .0642% from its proportion measured as of the prior year measurement date of June 30, 2016.

For the year ended June 30, 2018, the Department recognized pension expense of $125.184 million. At June 30, 2018, the Department reported deferred outflows and deferred inflows of resources related to the pension liability, as of the measurement date of June 30, 2017, from the following sources (amounts expressed in thousands):

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 664	$ 35,734
Changes of assumptions	116,368	23,523
Net difference between projected and actual investment earnings on pension plan investments	984	-
Changes in proportion	11,672	54,028
Department contributions subsequent to the measurement date	37,197	-
Total	$ 166,885	$ 113,285

$37.197 million reported as deferred outflows of resources related to pensions resulting from Department contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the year ended June 30, 2019. Other amounts reported as deferred outflows and deferred inflows of resources related to pensions will be recognized as pension expense as follows (amounts expressed in thousands):

Year ended June 30,	
2019	$ 15,840
2020	9,701
2021	3,240
2022	(12,378)
Total	$ 16,403

Actuarial Methods and Assumptions. The total pension liability was determined by an actuarial valuation as of June 30, 2017, using the following actuarial assumptions, applied to all periods included in the measurement:

Mortality: 105 percent of the RP2014 Healthy Annuitant mortality table, sex distinct, with rates projected to 2015; generational mortality improvement factors were added.

Inflation: 2.75%

Investment Rate of Return: 7.00%, net of pension plan investment expense, including inflation.

Salary increases: Salary increase rates based on age related productivity and merit rates plus inflation.

Post-retirement benefit increases of 3.00%, compounded, for Tier 1 and the lessor of 3.00% or one-half of the annual increase in the Consumer Price Index for Tier 2.

Retirement Age: Experience-based table of rates specific to the type of eligibility condition. Table was last updated for the June 30, 2014, valuation pursuant to an experience study of the period July 1, 2009 to June 30, 2013.

The long-term expected real rate of return on pension plan investments is determined using the best estimates of geometric real rates of return for each major asset class. These returns are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation. For each major asset class that is included in the pension plan's

target asset allocation, calculated as of the measurement date of June 30, 2017, the best estimates of geometric real rates of return as summarized in the following table:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return
U.S. Equity	23%	5.50%
Developed Foreign Equity	13%	5.30%
Emerging Market Equity	8%	7.80%
Private Equity	7%	7.60%
Intermediate Investment Grade Bonds	14%	1.50%
Long-term Government Bonds	4%	1.80%
TIPS	4%	1.50%
High Yield and Bank Loans	5%	3.80%
Opportunistic Debt	8%	5.00%
Emerging Market Debt	2%	3.70%
Core Real Estate	5.5%	3.70%
Non-core Real Estate	4.5%	5.90%
Infrastructure	2%	5.80%
Total	**100%**	

Discount Rate. A discount rate of 6.78% was used to measure the total pension liability as of the measurement date of June 30, 2017 as compared to a discount rate of 6.64% used to measure the total pension liability as of the prior year measurement date. The June 30, 2017 single blended discount rate was based on the expected rate of return on pension plan investments of 7.00% and a municipal bond rate of 3.56%, based on an index of 20 year general obligation bonds with an average AA credit rating as published by the Federal Reserve. The projection of cash flows used to determine this single discount rate assumed that plan member contributions will be made at the current contribution rate and that contributions will be made based on the statutorily required rates under Illinois law. Based on these assumptions, the pension plan's fiduciary net position and future contributions will be sufficient to finance the benefit payments through the year 2073. As a result, the long-term expected rate of return on pension plan investments was applied to projected benefit payments through the year 2073, and the municipal bond rate was applied to all benefit payments after that date.

Sensitivity of the Net Pension Liability to Changes in the Discount Rate. The net pension liability for the plan was calculated using the stated discount rate, as well as what the net pension liability would be if it were calculated using a discount rate that is 1-percentage point lower or 1-percentage point higher than the current rate as shown below (amounts expressed in thousands):

	1% Decrease 5.78%	Discount Rate 6.78%	1% Increase 7.78%
Department's Proportionate Share of the Net Pension Liability	$ 1,365,175	$ 1,128,224	$ 934,302

Payables to the pension plan. At June 30, 2018, the Department reported a payable of $1.447 million to SERS for the outstanding amount of contributions to the pension plans required for the year ended June 30, 2018.

(9) Postemployment Benefits

Plan description. The State Employees Group Insurance Act of 1971 (Act), as amended, authorizes the Illinois State Employees Group Insurance Program (SEGIP) to provide health, dental, vision, and life insurance benefits for certain retirees and their dependents. Substantially all of the Department's full-time employees are members of SEGIP. Members receiving monthly benefits from the State Employees' Retirement System of Illinois (SERS) are eligible for these other post-employment benefits (OPEB). The eligibility provisions for each of the retirement systems are defined within Note 8.

The Department of Central Management Services administers these benefits for annuitants with the assistance of the public retirement systems sponsored by the State (SERS). The State recognizes SEGIP OPEB benefits as a single-employer defined benefit plan. The plan does not issue a stand-alone financial report.

Benefits provided. The health, dental, and vision benefits provided to and contribution amounts required from annuitants are the result of collective bargaining between the State and the various unions representing the State's and the university component units' employees in accordance with limitations established in the Act. Therefore, the benefits provided and contribution amounts are subject to periodic change. Coverage through SEGIP becomes secondary to Medicare after Medicare eligibility has been reached. Members must enroll in Medicare Parts A and B to receive the subsidized SEGIP premium available to Medicare eligible participants. The Act requires the State to provide life insurance benefits for annuitants equal to their annual salary as of the last day of employment until age 60, at which time the benefit amount becomes $5,000.

Funding policy and annual other postemployment benefit cost. OPEB offered through SEGIP are financed through a combination of retiree premiums, State contributions, and Federal government subsidies from the Medicare Part D program. Contributions are deposited in the Health Insurance Reserve Fund, which covers both active State employees and retirement members. Annuitants may be required to contribute towards health and vision benefits with the amount based on factors such as date of retirement, years of credited service with the State, whether the annuitant is covered by Medicare, and whether the annuitant has chosen a managed health care plan. Annuitants who retired prior to January 1, 1998, and who are vested in the SERS do not contribute toward health and vision benefits. For annuitants who retired on or after January 1, 1998, the annuitant's contribution amount is reduced five percent for each year of credited service with the State allowing those annuitants with twenty or more years of credited service to not have to contribute towards health and vision benefits. All annuitants are required to pay for dental benefits regardless of retirement date. The Director of Central Management Services shall, on an annual basis, determine the amount the State shall contribute toward the basic program of group health benefits. State contributions are made primarily from the General Revenue Fund on a pay-as-you-go basis. No assets are accumulated or dedicated to funding the retiree health insurance benefit and a separate trust has not been established for the funding of OPEB.

For fiscal year 2018, the annual cost of the basic program of group health, dental, and vision benefits before the State's contribution was $10,926.24 ($6,145.92 if Medicare eligible) if the annuitant chose benefits provided by a health maintenance organization and $14,939.04 ($5,165.04 if Medicare eligible) if the annuitant chose other benefits. The State is not required to fund the plan other than the pay-as-you-go amount necessary to provide the current benefits to retirees.

Total OPEB liability, deferred outflows of resources, deferred inflows of resources and expense related to OPEB. The total OPEB liability, as reported at June 30, 2018, was measured as of June 30, 2017, with an actuarial valuation as of June 30, 2016. At June 30, 2018, the Department recorded a liability of $780.745 million for its proportionate share of the State's total OPEB liability. The Department's portion of the OPEB liability was based on the Department's proportion of employer contributions relative to all employer contributions made to the plan during the year ended June 30, 2017. As of the current year measurement date of June 30, 2017, the Department's proportion was 1.8893%, which was a decrease of 0.0577% from its proportion measured as of the prior year measurement date of June 30, 2016.

The Department recognized OPEB expense for the year ended June 30, 2018, of $41.691 million. At June 30, 2018, the Department reported deferred outflows and deferred inflows of resources, as of the measurement date of June 30, 2017, from the following sources (amounts expressed in thousands):

Deferred outflows of resources		
Differences between expected and actual experience	$	250
Changes in proportion and differences between employer contributions and proportionate share of contributions		27,578
Department contributions subsequent to the measurement date		8,991
Total deferred outflows of resources	$	**36,819**
Deferred inflows of resources		
Changes of assumptions	$	74,132
Changes in proportion and differences between employer contributions and proportionate share of contributions		48,088
Total deferred inflows of resources	$	**122,220**

The amounts reported as deferred outflows of resources related to OPEB resulting from Department contributions subsequent to the measurement date will be recognized as a reduction to the OPEB liability in the year ended June 30, 2019. Other amounts reported as deferred outflows and deferred inflows of resources related to OPEB will be recognized in OPEB expense as follows (amounts expressed in thousands):

Year ended June 30,		
2019	$	(21,219)
2020		(21,219)
2021		(21,219)
2022		(21,219)
2023		(9,516)
Total	$	(94,392)

Actuarial methods and assumptions. The total OPEB liability was determined by an actuarial valuation using the following actuarial assumptions, applied to all periods included in the measurement unless otherwise specified. The actuarial valuation for the SEGIP was based on General Assembly Retirement System (GARS), Judges Retirement System (JRS), SERS, Teachers Retirement System (TRS), and State University Retirement System (SURS) active, inactive, and retiree data as of June 30, 2016, for eligible SEGIP employees, and SEGIP retiree data as of June 30, 2016.

Valuation Date	June 30, 2016
Measurement Date	June 30, 2017
Actuarial Cost Method	Entry Age Normal
Inflation Rate	2.75%
Projected Salary Increases*	3.00% - 15.00%
Discount Rate	3.56%
Healthcare Cost Trend Rate:	
Medical (Pre-Medicare)	8.0% grading down 0.5% in the first year to 7.5%, then grading down 0.01% in the second year to 7.49%, followed by grading down of 0.5% per year over 5 years to 4.99% in year 7
Medical (Post-Medicare)	9.0% grading down 0.5% per year over 9 years to 4.5%
Dental	7.5% grading down 0.5% per year over 6 years to 4.5%
Vision	3.00%
Retirees' share of benefit-related costs	Healthcare premium rates for members depend on the date of retirement and the years of service earned at retirement. Members who retired before January 1, 1998, are eligible for single coverage at no cost to the member. Members who retire after January 1, 1998, are eligible for single coverage provided they pay a portion of the premium equal to 5 percent for each year of service under 20 years. Eligible dependents receive coverage provided they pay 100 percent of the required dependent premium. Premiums for plan year 2017 and 2018 were projected based on actual premiums. Premiums after 2018 were projected based on the same healthcare cost trend rates applied to per capita claim costs but excluding the additional trend rates that estimates the impact of the Excise Tax.

* Dependent upon service and participation in the respective retirement systems. Includes inflation rate listed.

Additionally, the demographic assumptions used in the OPEB valuation are identical to those used in the June 30, 2016 valuations for GARS, JRS, SERS, TRS, and SURS as follows:

	Retirement age experience study^	Mortality^^
SERS	July 2009 – June 2015	105 percent of the RP-2014 Healthy Annuitant mortality table, sex distinct, with rates projected to 2015; generational mortality improvement factors were added

^ The actuarial assumptions used in the respective actuarial valuations are based on the results of actuarial experience studies for the periods defined. A modified experience review was completed for SERS for the 3-year period ending June 30, 2015. Changes were made to the assumptions regarding investment rate of return, projected salary increases, inflation rate, and mortality based on this review. All other assumptions remained unchanged.
^^ Mortality rates are based on mortality tables published by the Society of Actuaries' Retirement Plans Experience Committee.

Discount rate. Retirees contribute a percentage of the premium rate based on service at retirement. The State contributes additional amounts to cover claims and expenses in excess of retiree contributions. Because plan benefits are financed on a pay-as-you-go basis, the single discount rate is based on a tax-exempt municipal bond rate index of 20-year general obligation bonds with an average AA credit rating as of the measurement date. A single discount rate of 2.85% at June 30, 2016, and 3.56% at June 30, 2017, was used to measure the total OPEB liability.

Sensitivity of total OPEB liability to changes in the single discount rate. The following presents the plan's total OPEB liability, calculated using a single discount rate of 3.56%, as well as what the plan's total OPEB liability would be if it were calculated using a single discount rate that is one percentage point higher (4.56%) or lower (2.56%) than the current rate (amounts expressed in thousands):

	1% Decrease (2.56%)	Current Single Discount Rate Assumption (3.56%)	1% Increase (4.56%)
Department's Proportionate Share of the Total OPEB Liability	$ 885,749	$ 780,745	$ 676,333

Sensitivity of the total OPEB liability to changes in the healthcare cost trend rate. The following presents the plans total OPEB liability, calculated using the healthcare cost trend rates as well as what the plan's total OPEB liability would be if it were calculated using a healthcare cost trend rate that is one percentage point higher or lower, than the current healthcare cost trend rates (amounts in table expressed in thousands). The key trend rates are 8.0% in 2018 decreasing to an ultimate trend rate of 4.99% in 2025, for non-Medicare coverage, and 9.0% decreasing to an ultimate trend rate of 4.5% in 2027 for Medicare coverage.

	1% Decrease	Current Healthcare Cost Trend Rates Assumption	1% Increase
Department's Proportionate Share of the Total OPEB Liability	$ 667,140	$ 780,745	$ 874,534

(10) Fund Deficits

The following fund had a deficit balance at June 30, 2018 (amounts expressed in thousands):

Major Governmental Funds:	Fund Deficit
General Fund	$ 3,384,311

The deficit is expected to be recovered from future years' State appropriations and federal funds.

(11) Risk Management

The Department is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; errors and omissions; workers compensation and natural disasters. The State retains the risk of loss (i.e., self-insured) for these risks except computer equipment insurance purchased by the Department.

Liabilities are reported when it is probable that a loss has occurred and the amount of that loss can be reasonably estimated. Liabilities include an amount for claims that have been incurred but not reported (IBNR). Claims liabilities are based upon the estimated ultimate cost of settling the claims including specific, incremental claim adjustment expenses, salvage, and subrogation and considering the effects of inflation and recent claim settlement trends including frequency and amount of payouts and other economic and social factors.

The Department's risk management activities for self-insurance, unemployment insurance and workers' compensation are financed through appropriations to the Illinois Department of Central Management Services and are accounted for in the General Fund of the State. The claims are not considered to be a liability of the Department, and accordingly, have not been reported in the Department's financial statements for the year ended June 30, 2018.

(12) Commitments and Contingencies

(a) Operating Leases

The Department leases equipment, buildings, and office space under terms of noncancelable operating lease agreements not extending past the end of the fiscal year, that require the Department to make minimum lease payments plus pay a pro rata share of certain operating costs. Rent expense under operating leases was $4.4 million for the year ended June 30, 2018.

(b) Disproportionate Share Hospital Payments

In October 2004, the U.S. Department of Health and Human Services, Office of Inspector General (OIG) issued its reports, "Review of Illinois Medicaid Disproportionate Share Hospital Payments to the University of Illinois at Chicago Hospital" and "Review of Illinois Medicaid Disproportionate Share Hospital Payments to Mount Sinai Hospital of Chicago". The reports recommended that the State refund $140.282 million and $4.516 million respectively, in federal financial participation (FFP) to the federal government because of alleged overpayment to the hospitals of $280.6 million and $9.032 million above the hospital-specific limitation on Disproportionate Share Hospital (DSH) payments to the hospitals during State fiscal years 1997-2000. The State has strongly disagreed with the OIG's findings. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (Federal CMS) concurred with the audit findings but stated "we interpret this recommendation as a prospective resolution and not a requirement to recoup any Federal payments associated with these findings". After approximately 12 years of no official action, in July 2016, the State received a formal disallowance from Federal CMS for these two audits. It is the State's position that it has followed Federal CMS published guidelines, and its methodology for calculating the hospital-specific limitation has been consistently been approved by Federal CMS. The Department subsequently sought reconsideration, which was denied, and appealed the disallowances to the U.S. Department of Health and Human Services' Departmental Appeals Board

(DAB). On April 2, 2018, the DAB sustained both disallowances and the Department sought reconsideration of the decision on June 1, 2018. Subsequent to June 30, 2018, the DAB denied the Department's motions for reconsideration and the Department exercised its right to further appeal the disallowances in the United States District Court for the Northern District of Illinois, which remains pending at this time.

Repayment of a disallowance is not tolled during a motion for reconsideration pending before the Departmental Appeals Board or during the appeal before the federal courts. The Department had chosen to engage in a repayment plan with Federal CMS to repay $144.8 million plus interest, at the federal funds rate, over a two-year period. However, HFS finished repayment of the disallowance in June 2019.

(c) Litigation

A class action lawsuit existed at June 30, 2018. This is a class action consisting of "all Medicaid eligible children under the age of 21 who have been diagnosed with a mental health or behavior disorder; and for whom a licensed practitioner of the healing arts has recommended intensive home and community based services to correct or ameliorate their disorders". The Plaintiffs seek to require the provision of appropriate services and support to qualified persons in the community, including community based services and residential treatment of children in Psychiatric Residential Treatment Facilities (PRTF's), under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). This case has been resolved by a Consent Decree, entered January 16, 2018 and is in the early stages of implementation. An estimate of the loss cannot be made.

A class action lawsuit existed at June 30, 2018 consisting of Medicaid-eligible children under the age of 21 who have been approved for in-home shift nursing services by the Department, but who are not receiving in-home shift nursing at the level approved. The class includes children participating in the Medically Fragile Technology Dependent Waiver (MFTD) program and children in the Nursing and Personal Care Services (NPCS) program. This suit seeks to require the Department to take all steps necessary to ensure class members receive all nursing services for which they are approved. An estimate of the possible loss cannot be made.

A class action lawsuit existed at June 30, 2018. This is a class action consisting of "all individuals who on or after February 1, 2015, have applied to be determined eligible for long-term care Medicaid benefits from the State of Illinois, and have not received a final eligibility determination or notice of an opportunity for a hearing within 45 days of the date of application in non-disability cases or 90 days in disability cases." On March 29, 2018, the Court entered a Preliminary Injunction Order requiring the Defendants to (1) determine, on or before June 28, 2018, the eligibility of class members for long-term care benefits for which they have applied, (2) implement policies and processes to ensure Defendants prospectively comply with the Medicaid Act's deadlines for eligibility determinations, and (3) beginning June 28, 2018, pay the long-term care and other benefits to (or for the benefit of) class members while their applications remain pending beyond the Medicaid Act's deadlines for eligibility determinations. Relief in other similar individual federal lawsuits will be subsumed in Koss. The Department has estimated the loss at $197.7 million.

A class action lawsuit existed at June 30, 2018. This is a class action consisting of a Plaintiff class seeking enforcement of a consent order that was entered in this class action in 1980. The order provides that Class members, whose Medicaid (without a cash grant) applications are pending at least 15 days over federally established time limits due to the State's delay, and who make a request pursuant to a notice sent by the State informing them that their application is beyond the federal time limits, are entitled to a temporary medical card providing coverage for the full range of Medicaid benefits (except long-term care benefits) during the remaining period during with their applications are pending. The class is alleging the Defendants (the Department of Healthcare and Family Services and the Department of Human Services) are not in compliance with the consent order. An estimate of the possible loss cannot be made.

(d) Backlog of Applications within the Integrated Eligibility System (IES)

The State implemented a new IES for the intake and processing of applications in order to determine eligibility for various health and human services programs in October 2013. The State has experienced delays in processing applications due to an increase in the number of applications for the expanded Medicaid programs and open enrollment periods, insufficient caseworker resources, and other factors. These delays resulted in applications not being reviewed and approved or denied within the mandated 45-day timeframe. As of June 30, 2018, the Department, along with the Department of Human Services, had 125,044 unprocessed applications. A portion of these 125,044 unprocessed applications seek Medicaid long-term care benefits. A preliminary order in a class-action lawsuit was issued on March 29, 2018 indicating the Department was to give provisional eligibility and ordered the Department to begin paying for those benefits beginning on June 28, 2018. The value of the estimated liability associated with the backlogged applications, including the applications for which provisional eligibility was granted as well as the remaining unprocessed applications, is assumed to be in the historic data used in the calculation of the Department's overall medical accrual liability estimate recorded in the financial statements as accounts payable.

(e) Noncompliance with Federal Regulations

During Fiscal Year 2018, the Department and the Department of Human Services implemented additional functionality within the automated eligibility system. During this transition, the State experienced several significant issues, including problems with (1) the transfer of data files, (2) documentation of eligibility decisions, and (3) noncompliance with federal regulations requiring the timely determination and redetermination of eligibility for programs. Due to these problems, the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services (Federal CMS) required the Department to finalize and submit a corrective action plan for approval no later than August 31, 2019. Some of these problems have been categorized into two distinct populations: (1) the general backlog and (2) extended redeterminations where the Department extended a case's redetermination date by one year for redeterminations due from October 2017 through December 2017, when the additional functionality within the automated eligibility system came online.

General Backlog

As of June 30, 2018, the Department had a backlog of 125,044 applications for medical assistance. As of November 1, 2018, the Department had worked 59,192 of these cases.

Extended Redeterminations

On July 11, 2019, the Department identified:

1) 23,748 cases remain unprocessed and await redetermination with total expenditures of $60.76 million ($37.19 million in federal financial participation (FFP)) through June 30, 2018;
2) 208,330 cases which had been processed were either (1) cancelled as the recipient was deemed ineligible or (2) closed before the redetermination was completed, with total expenditures of $551.51 million ($383.71 million in FFP) through June 30, 2018; and,
3) 274,656 cases which had been processed were redetermined and found the recipient was eligible for continued participation in Medicaid.

Federal CMS has indicated to the Department that, provided an acceptable corrective action plan is implemented by the State and the State adheres to the timeframes and milestones contained therein, no disallowances or withholding of FFP is anticipated; however, if Federal CMS determines the State either ultimately (1) does not submit an acceptable corrective action plan or (2) does not adhere to the requirements of the corrective action plan, Federal CMS may initiate formal compliance proceedings.

(f) Communication of Denied Admission Reports

The State has experienced ongoing challenges in determining eligibility for long-term care services, primarily care provided in nursing homes. Each individual recipient must be (1) eligible for Medicaid and (2) functionally need assistance performing certain activities of daily living, including bathing, dressing, and eating. As a part of this process, a long-term care admission report must be filed with the Department for the Department of Human Services to determine eligibility. From March 2016 until the implementation of Public Act 100-0665 by the Department and the Department of Human Services in October 2018, long-term care providers were not always notified the admissions report had been rejected. Given this condition, the Department has allowed the long-term care providers to resubmit admission reports the providers believed were adjudicated incorrectly. The Department of Human Services will review this information and, if not denied, the Department will allow the provider to bill the State for unpaid claims. While the Department has received resubmitted admission information representing roughly 625 thousand unpaid days of care provided, the actual amount that will be owed upon adjudication cannot be fully estimated at this time. Approximately one-half of the liability amount, once known, will be eligible for federal financial participation.

(g) Federal Grants

The Department receives other federal grants which are subject to review and audit by federal grantor agencies. Certain costs could be questioned as not being an eligible expenditure under the terms of the grants. At June 30, 2018, other than identified above, there were no material questioned costs that have not been resolved with the federal awarding agencies. However, questioned costs could still be identified during audits to be conducted in the future. Management of the Department believes there will be no material adjustments to the federal grants and, accordingly, has not recorded a provision for possible repayment.

(13) Securities Lending Transactions

Under the authority of the Treasurer's published investment policy developed in accordance with State statute, the State Treasurer lends securities to broker-dealers and other entities for collateral that will be returned for the same securities in the future. The State Treasurer has, through a Securities Lending Agreement, authorized Deutsche Bank AG to lend the State Treasurer's securities to broker-dealers and banks pursuant to a form of loan agreement.

During fiscal year 2018, Deutsche Bank AG lent U.S. Agency securities and U.S. Treasury securities and received as collateral U.S. dollar denominated cash. Borrowers were required to deliver collateral for each loan equal to at least 100% of the aggregate fair value of the loaned securities. Loans are marked to market daily. If the fair value of collateral falls below 100%, the borrower must provide additional collateral to raise the fair value to 100%.

The State Treasurer did not impose any restrictions during fiscal year 2018 on the amount of loans of available, eligible securities. In the event of borrower default, Deutsche Bank AG provides the State Treasurer with counterparty default indemnification. In addition, Deutsche Bank AG is obligated to indemnify the State Treasurer if Deutsche Bank AG loses any securities, collateral, or investments of the State Treasurer in Deutsche Bank AG's custody. There were no losses during fiscal year 2018 resulting from a default of the borrowers or Deutsche Bank AG.

During fiscal year 2018, the State Treasurer and the borrowers maintained the right to terminate all securities lending transactions on demand. The cash collateral received on each loan was invested in repurchase agreements with approved counterparties collateralized with securities approved by Deutsche Bank AG and marked to market daily at no less than 102%. Because the loans are terminable at will, their duration did not generally match the duration of the investments made with cash collateral. The State Treasurer had no credit risk as a result of its securities lending program as the collateral held exceeded the fair value of the securities lent. The securities lending collateral invested in repurchase agreements and the fair value of securities on loan for the State Treasurer as of June 30, 2018 were $4,521,091,000 and $4,451,198,793, respectively.

(14) Subsequent Events

(a) Four Demand Letters

In December 2018, the Department received a total of four Demand Letters from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (Federal CMS) for the return of federal financial participation (FFP) related to certain optical service/supply, inpatient psychiatric and Disproportionate Share Hospital (DSH) payments. The total dollar value of the FFP identified in those letters was approximately $121.5 million and was related to services that go back as far as the year 2000 in some instances. The Demand Letters do not represent formal disallowances of the identified FFP although such notification could be forthcoming in the future. The Department has notified Federal CMS in writing that it does not plan to return the FFP and strongly disagrees with the assertions made within the Demand Letters.

While the Department is not in agreement with Federal CMS' position, the possible loss related to these Demand Letters could range from $0 to approximately $121.5 million dollars depending upon the content of any potential substantiated disallowance.

(b) Solvency of a Managed Care Organization (MCO)

In March 2019, the Department became aware of potential solvency concerns involving a MCO and its related affiliate with whom the Department had contracted for medical services. At June 30, 2018, the Department had outstanding receivables of $22.1 million. Due to the presumed uncollectible nature of the amount owed, the Department recorded an allowance for doubtful accounts of $22.1 million to these financial statements.

(c) Settlement of a Class Action Lawsuit

A class action lawsuit consisting of children under the age of 21 who received in-home shift nursing services or applied for in-home shift nursing services and received notices from the Department that their requests for in-home shift nursing services has been denied or reduced, approved at a lower level than requested, or terminated by the Department on or after January 1, 2014, was settled and approved by the court on December 21, 2018. The settlement requires the Department prospectively undertake certain actions regarding notices and the medical necessity determinations related to in home shift nursing needs of children under the age of 21, but no new services or rates are required, and the Department is in the early stages of effectuating the requirements of the settlement.

(15) Prior Period Adjustment

The Department's financial statements have been restated as of July 1, 2017, due to the following (expressed in thousands):

The General Revenue Fund (Fund 0001) Due from Other Government – Federal was overstated at June 30, 2017 by $1,412 due to an error in the prompt pay interest amount included in the medical accrual calculation. Beginning fund balance was adjusted by $1,412 for the error. In addition, the General Revenue Fund Other Receivables was understated at June 30, 2017 by $16,953 due to incorrect capitation rates for calendar years 2013 – 2015. Because of the understated receivable, the Federal share of the amount due back, reported as Due to Other Government – Federal, was understated by $8,528. Beginning fund balance was adjusted by $8,425 for the error.

The County Provider Trust Fund (Fund 0329) Due to Other Government – Local liability was understated at June 30, 2017 by $13,391. The Department had accrued for recoupment due from managed care organizations (MCOs) related to the MCOs' medical liability loss ratio (MLR), but the related liability (Due to Other Government – Local) was not recorded. Beginning fund balance was adjusted by $13,391 for the error.

The Drug Rebate Fund (Fund 0728) Due to Other Government - Federal was overstated at June 30, 2017 by $14,345 due to cash on hand being double counted in the Public Aid Recoveries Trust Fund (Fund 0421); thereby overstating the amount owed from Fund 0421 to Fund 0728 and the amount subsequently owed from Fund 0728 to the Federal Government. In addition, the amount Due From the Federal Government was overstated by $91,334 due an error in the Federal Financial Participation rate. Beginning fund balance was adjusted by $105,679.

The Department's financial statements have also been restated due to adoption of GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*, which replaces the requirements of GASB Statement No. 45 and requires governments to report a liability on the face of the financial statements for the OPEB they provide.

As a result, the financial statements have been restated as of July 1, 2017, as shown in the table below (amounts expressed in thousands).

	General	Governmental Activities
Fund balance (deficit)/net position July 1, 2017 as previously reported	$ (1,476,556)	$ 314,493
Fund 0001 overstated receivable	(1,412)	(1,412)
Fund 0001 understated receivable	8,425	8,425
Fund 0329 understated liability	(13,391)	(13,391)
Fund 0728 overstated receivable	(105,679)	(105,679)
OBEP liability	-	(836,325)
Fund balance (deficit)/net position July 1, 2017, as restated	$ (1,588,613)	$ (633,889)

State of Illinois
Department of Healthcare and Family Services

Combining Schedule of Accounts - General Fund

June 30, 2018 (Expressed in Thousands)

	General Revenue 0001	U of I Hospital Services 0136	County Provider Trust 0329	Care Provider for Persons with DD 0344	Long-Term Care Provider 0345	Hospital Provider 0346	Special Education Medicaid Matching 0355	Trauma Center 0397	Public Aid Recoveries Trust 0421
ASSETS									
Unexpended appropriations	$ (2,736,439)	$ -	$ -	$ 7	$ -	$ -	$ -	$ 1,346	$ -
Cash equity with State Treasurer	1,005	16,110	23,184	1	32,156	72,088	-	-	206,080
Cash and cash equivalents	4,418	-	-	-	-	-	-	-	-
Securities lending collateral equity with State Treasurer	-	3,909	10,334	-	7,712	57,274	-	-	-
Due from other government - federal	821,201	13,793	93,904	9,638	47,601	103,309	39,502	4,231	138,099
Due from other government - local	-	-	56,591	-	-	-	11	-	-
Taxes receivable, net	-	-	-	338	9,227	25,337	-	-	-
Other receivables, net	22,220	16	41	-	31	84,380	-	-	415,937
Due from other Department funds	-	20,000	-	-	-	-	-	-	4,200
Due from other State funds	39	-	-	-	-	-	-	-	80,000
Due from other State fiduciary funds	-	-	58	3	16	-	-	-	686
Due from State of Illinois component units	-	3,059	-	-	-	-	-	-	-
Total assets	$ (1,887,556)	$ 56,887	$ 184,112	$ 9,987	$ 96,743	$ 342,388	$ 39,513	$ 5,577	$ 845,002
LIABILITIES									
Accounts payable and accrued liabilities	$ 1,194,374	$ -	$ 97	$ 27	$ 79,103	$ -	$ -	$ 1,244	$ 33,340
Due to other government - federal	205,700	-	7	2	2	-	-	-	23,348
Due to other government - local	110,712	-	173,597	-	9,882	-	39,513	102	4,080
Due to other Department funds	727,456	-	-	-	-	-	-	-	591,834
Due to other State funds	4,828	-	31	1	32	-	-	-	2,573
Due to other State fiduciary funds	-	-	46	13	12	-	-	-	1,067
Due to State of Illinois component units	9,726	19,024	-	-	-	-	-	-	2,414
Unearned Revenue	-	-	-	-	-	-	-	-	-
Obligations under securities lending of State Treasurer	-	3,909	10,334	-	7,712	57,274	-	-	-
Total liabilities	2,252,796	22,933	184,112	43	96,743	57,274	39,513	1,346	658,656
DEFERRED INFLOWS OF RESOURCES									
Unavailable revenue - Federal operating grants	434,811	6,594	32,402	692	12,464	103,309	5,202	1,174	129,720
Unavailable revenue - License and fees	3,951	-	-	-	-	-	-	-	-
Unavailable revenue - Medical provider assessment tax	-	-	-	-	-	-	-	-	-
Unavailable revenue - Other taxes	-	-	-	-	48	-	-	-	-
Unavailable revenue - Other operating grants	-	3,059	14,465	-	-	-	-	-	-
Unavailable revenue - Other revenues	46	-	-	-	-	-	-	-	-
Total deferred inflows of resources	438,808	9,653	46,867	692	12,512	103,309	5,202	1,174	129,720
FUND BALANCES (DEFICITS)									
Committed for health and social services	-	24,854	-	9,252	-	-	-	3,057	56,626
Unassigned	(4,579,160)	(553)	(46,867)	-	(12,512)	181,805	(5,202)	-	-
Total fund balances (deficits)	(4,579,160)	24,301	(46,867)	9,252	(12,512)	181,805	(5,202)	3,057	56,626
Total liabilities, deferred inflows of resources, and fund balances (deficits)	$ (1,887,556)	$ 56,887	$ 184,112	$ 9,987	$ 96,743	$ 342,388	$ 39,513	$ 5,577	$ 845,002

State of Illinois
Department of Healthcare and Family Services

Combining Schedule of Accounts - General Fund

June 30, 2018 (Expressed in Thousands)

	Electronic Health Record Incentive 0503	Juvenile Rehab Services Medicaid Matching 0575	Medical Interagency Program 0720	Drug Rebate 0728	Medicaid Buy-in Program Revolving 0740	Healthcare Provider Relief 0793	Medical Special Purposes Trust 0808	Eliminations	Total
ASSETS									
Unexpended appropriations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (2,735,086)
Cash equity with State Treasurer	3	8	435	142,372	1,076	19,311	4,156	-	517,985
Cash and cash equivalents	-	-	-	-	-	-	-	-	4,418
Securities lending collateral equity with State Treasurer	-	-	266	51,928	418	27,785	-	-	159,626
Due from other government - federal	496	28	15,969	2,761	-	772,092	37,269	-	2,099,893
Due from other government - local	-	-	-	-	-	-	-	-	56,602
Taxes receivable, net	-	-	-	-	-	2,300	-	-	37,202
Other receivables, net	-	-	1	208	64	42,249	-	-	565,147
Due from other Department funds	-	-	1,781	591,834	-	678,056	9,000	(1,304,871)	-
Due from other State funds	-	-	3,225	-	-	502	-	-	83,766
Due from other State fiduciary funds	-	-	-	-	6	-	-	-	769
Due from State of Illinois component units	-	-	5,030	-	-	-	-	-	8,089
Total assets	$ 499	$ 36	$ 26,707	$ 789,103	$ 1,564	$ 1,542,295	$ 50,425	$ (1,304,871)	$ 798,411
LIABILITIES									
Accounts payable and accrued liabilities	$ 499	$ -	$ 10,192	$ 56,255	$ 14	$ 870,183	$ 46,983	$ -	$ 2,292,311
Due to other government - federal	-	-	-	257,482	1	-	-	-	486,542
Due to other government - local	-	36	549	-	-	2,950	-	-	341,421
Due to other Department funds	-	-	-	-	-	1,781	-	(1,304,871)	16,200
Due to other State funds	-	-	100	-	1	6,398	-	-	13,964
Due to other State fiduciary funds	-	-	-	-	6	-	-	-	1,144
Due to State of Illinois component units	-	-	15,600	69	-	3,099	187	-	50,119
Unearned Revenue	-	-	-	-	-	-	170	-	170
Obligations under securities lending of State Treasurer	-	-	266	51,928	418	27,785	-	-	159,626
Total liabilities	499	36	26,707	365,734	440	912,196	47,340	(1,304,871)	3,361,497
DEFERRED INFLOWS OF RESOURCES									
Unavailable revenue - Federal operating grants	-	26	12,910	2,761	-	685	36,883	-	779,633
Unavailable revenue - License and fees	-	-	-	-	10	-	-	-	3,961
Unavailable revenue - Medical provider assessment tax	-	-	-	-	-	-	-	-	-
Unavailable revenue - Other taxes	-	-	-	-	-	400	-	-	448
Unavailable revenue - Other operating grants	-	-	5,030	-	-	-	-	-	22,554
Unavailable revenue - Other revenues	-	-	-	-	-	14,583	-	-	14,629
Total deferred inflows of resources	-	26	17,940	2,761	10	15,668	36,883	-	821,225
FUND BALANCES (DEFICITS)									
Committed for health and social services	-	-	-	420,608	1,114	614,431	-	-	1,129,942
Unassigned	-	(26)	(17,940)	-	-	-	(33,798)	-	(4,514,253)
Total fund balances (deficits)	-	(26)	(17,940)	420,608	1,114	614,431	(33,798)	-	(3,384,311)
Total liabilities, deferred inflows of resources, and fund balances (deficits)	$ 499	$ 36	$ 26,707	$ 789,103	$ 1,564	$ 1,542,295	$ 50,425	$ (1,304,871)	$ 798,411

State of Illinois
Department of Healthcare and Family Services

Combining Schedule of Revenues, Expenditures, and Changes in Fund Balance - General Fund

For the Year Ended June 30, 2018 (Expressed in Thousands)

	General Revenue 0001	U of I Hospital Services 0136	County Provider Trust 0329	Care Provider for Persons with DD 0344	Long-Term Care Provider 0345	Hospital Provider 0346	Special Education Medicaid Matching 0355	Trauma Center 0397	Public Aid Recoveries Trust 0421
REVENUES									
Operating grants - federal, net	$ 5,111,180	$ 68,870	$ 1,302,350	$ 16,145	$ 160,072	$ 1,702,468	$ 184,413	$ 6,126	$ 59,905
Other operating grants	243,700	4,608	783,393	-	-	-	-	-	-
Licenses and fees	26,155	-	-	-	-	-	-	-	-
Other charges for services, net	-	-	-	-	-	-	-	-	(125,242)
Interest and other investment income	-	158	281	-	413	1,151	-	-	-
Medical provider assessment tax	-	-	-	17,003	158,677	1,410,560	-	-	-
Other taxes, net	-	-	-	-	19,418	-	-	-	-
Other	1,517	-	-	-	-	-	-	-	-
Total revenues	5,382,552	73,636	2,086,024	33,148	338,580	3,114,179	184,413	6,126	(65,337)
EXPENDITURES									
Health and social services	6,251,324	117,759	2,084,933	216	346,617	2,734,425	166,663	8,879	(279,595)
Debt service principal	-	-	-	-	1	-	-	-	8
Debt service interest	-	-	-	-	-	-	-	-	2
Capital outlays	4,049	-	-	-	-	-	-	-	190
Total expenditures	6,255,373	117,759	2,084,933	216	346,618	2,734,425	166,663	8,879	(279,395)
Excess (deficiency) of revenues over (under) expenditures	(872,821)	(44,123)	1,091	32,932	(8,038)	379,754	17,750	(2,753)	214,058
OTHER SOURCES (USES) OF FINANCIAL RESOURCES									
Appropriations from State resources	7,642,248	-	-	1,192	-	-	-	12,000	-
Lapsed appropriations	(2,892,298)	-	-	(995)	-	-	-	(3,121)	-
Receipts collected and transmitted to State Treasury	(5,257,269)	-	-	(29,725)	-	-	-	(5,003)	-
Amount of SAMS transfers-in	(80,000)	-	-	-	-	-	-	-	-
Amount of SAMS transfers-out	20,000	-	-	-	-	-	-	-	-
Transfers-in	290,000	20,000	-	-	30,000	-	-	-	4,200
Transfers-out	(1,177,481)	-	-	-	(10,000)	(334,900)	-	-	(210,000)
Capital lease financing	-	-	-	-	-	-	-	-	44
Net other sources (uses) of financial resources	(1,454,800)	20,000	-	(29,528)	20,000	(334,900)	-	3,876	(205,756)
Net change in fund balances	(2,327,621)	(24,123)	1,091	3,404	11,962	44,854	17,750	1,123	8,302
Fund balances (deficits), July 1, 2017, as restated	(2,251,539)	48,424	(47,958)	5,848	(24,474)	136,951	(22,952)	1,934	48,324
FUND BALANCES (DEFICITS), JUNE 30, 2018	$ (4,579,160)	$ 24,301	$ (46,867)	$ 9,252	$ (12,512)	$ 181,805	$ (5,202)	$ 3,057	$ 56,626

State of Illinois
Department of Healthcare and Family Services

Combining Schedule of Revenues, Expenditures, and Changes in Fund Balance - General Fund

For the Year Ended June 30, 2018 (Expressed in Thousands)

	Electronic Health Record Incentive 0503	Juvenile Rehab Services Medicaid Matching 0575	Medical Interagency Program 0720	Drug Rebate 0728	Medicaid Buy-in Program Revolving 0740	Healthcare Provider Relief 0793	Medical Special Purposes Trust 0808	Eliminations	Total
REVENUES									
Operating grants - federal, net	$ 61,124	$ 39	$ 29,071	$ -	$ -	$ 4,209,403	$ 2,754	$ -	$ 12,913,920
Other operating grants	-	-	6,193	-	-	-	-	-	1,037,894
Licenses and fees	-	-	-	-	658	-	-	-	26,813
Other charges for services, net	-	-	-	-	-	-	-	125,242	-
Interest and other investment income	-	-	13	(81)	14	1,488	-	-	3,437
Medical provider assessment tax	-	-	-	-	-	-	-	-	1,586,240
Other taxes, net	-	-	-	-	-	376,063	-	-	395,481
Other	-	-	-	-	-	6,133	-	-	7,650
Total revenues	61,124	39	35,277	(81)	672	4,593,087	2,754	125,242	15,971,435
EXPENDITURES									
Health and social services	61,124	28	54,675	119,267	156	5,267,232	25,429	125,242	17,084,374
Debt service principal	-	-	-	-	-	-	-	-	9
Debt service interest	-	-	-	-	-	1	-	-	3
Capital outlays	-	-	-	-	57	702	25,150	-	30,148
Total expenditures	61,124	28	54,675	119,267	213	5,267,935	50,579	125,242	17,114,534
Excess (deficiency) of revenues over (under) expenditures	-	11	(19,398)	(119,348)	459	(674,848)	(47,825)	-	(1,143,099)
OTHER SOURCES (USES) OF FINANCIAL RESOURCES									
Appropriations from State resources	-	-	-	-	-	-	-	-	7,655,440
Lapsed appropriations	-	-	-	-	-	-	-	-	(2,896,414)
Receipts collected and transmitted to State Treasury	-	-	-	-	-	-	-	-	(5,291,997)
Amount of SAMS transfers-in	-	-	-	-	-	-	-	-	(80,000)
Amount of SAMS transfers-out	-	-	-	-	-	-	-	-	20,000
Transfers-in	-	-	10,811	-	-	1,312,956	9,000	(1,669,645)	7,322
Transfers-out	-	-	-	-	(300)	(3,964)	-	1,669,645	(67,000)
Capital lease financing	-	-	-	-	-	6	-	-	50
Net other sources (uses) of financial resources	-	-	10,811	-	(300)	1,308,998	9,000	-	(652,599)
Net change in fund balances	-	11	(8,587)	(119,348)	159	634,150	(38,825)	-	(1,795,698)
Fund balances (deficits), July 1, 2017, as restated	-	(37)	(9,353)	539,956	955	(19,719)	5,027	-	(1,588,613)
FUND BALANCES (DEFICITS), JUNE 30, 2018	$ -	$ (26)	$ (17,940)	$ 420,608	$ 1,114	$ 614,431	$ (33,798)	$ -	$ (3,384,311)

State of Illinois
Department of Healthcare and Family Services

Combining Balance Sheet - Nonmajor Governmental Funds

June 30, 2018 (Expressed in Thousands)

	Special Revenue					
	Provider Inquiry Trust 0341	Money Follows the Person Budget Transfer 0522	Department of Corrections Reimbursement and Education 0523	Tobacco Settlement Recovery 0733	Child Support Administrative 0757	Total
ASSETS						
Unexpended appropriations	$ -	$ -	$ -	$ 15,033	$ -	$ 15,033
Cash equity with State Treasurer	1,337	5,870	-	-	17,817	25,024
Securities lending collateral equity with State Treasurer	-	2,374	-	-	-	2,374
Due from other government - federal	-	285	4,588	8,475	21,029	34,377
Other receivables, net	307	9	-	-	8,994	9,310
Due from other Department funds	-	-	-	-	16,200	16,200
Due from other State fiduciary funds	-	-	-	-	1,696	1,696
Total assets	$ 1,644	$ 8,538	$ 4,588	$ 23,508	$ 65,736	$ 104,014
LIABILITIES						
Accounts payable and accrued liabilities	$ -	$ -	$ -	$ 14,602	$ 9,765	$ 24,367
Due to other government - federal	-	-	-	-	5,939	5,939
Due to other government - local	-	-	-	165	5,833	5,998
Due to other State funds	138	-	-	-	13,226	13,364
Due to other State fiduciary funds	-	-	-	-	2,499	2,499
Due to State of Illinois component units	-	434	-	411	-	845
Obligations under securities lending of State Treasurer	-	2,374	-	-	-	2,374
Total liabilities	138	2,808	-	15,178	37,262	55,386
DEFERRED INFLOWS OF RESOURCES						
Unavailable revenue - Federal operating grants	-	285	17	1,846	5,483	7,631
Unavailable revenue - License and fees	186	-	-	-	-	186
Total deferred inflows of resources	186	285	17	1,846	5,483	7,817
FUND BALANCES						
Committed for health and social services	1,320	5,445	4,571	6,484	22,991	40,811
Total fund balances	1,320	5,445	4,571	6,484	22,991	40,811
Total liabilities, deferred inflows of resources, and fund balances	$ 1,644	$ 8,538	$ 4,588	$ 23,508	$ 65,736	$ 104,014

State of Illinois
Department of Healthcare and Family Services

Combining Statement of Revenues, Expenditures and Changes in Fund Balances - Nonmajor Governmental Funds

For the Year Ended June 30, 2018 (Expressed in Thousands)

	Special Revenue					
	Provider Inquiry Trust 0341	Money Follows the Person Budget Transfer 0522	Department of Corrections Reimbursement and Education 0523	Tobacco Settlement Recovery 0733	Child Support Administrative 0757	Total
REVENUES						
Operating grants - federal, net	$ -	$ 441	$ 4,717	$ 33,643	$ 128,731	$ 167,532
License and fees	646	-	-	-	-	646
Other charges for services, net	-	-	-	-	10,285	10,285
Interest and other investment income	-	86	-	-	-	86
Total revenues	646	527	4,717	33,643	139,016	178,549
EXPENDITURES						
Health and social services	610	647	-	200,587	154,123	355,967
Debt service principal	-	-	-	-	8	8
Debt service interest	-	-	-	-	2	2
Capital outlays	-	-	-	-	54	54
Total expenditures	610	647	-	200,587	154,187	356,031
Excess (deficiency) of revenues over (under) expenditures	36	(120)	4,717	(166,944)	(15,171)	(177,482)
OTHER SOURCES (USES) OF FINANCIAL RESOURCES						
Appropriations from State resources	-	-	-	200,600	-	200,600
Lapsed appropriations	-	-	-	(105)	-	(105)
Receipts collected and transmitted to State Treasury	-	-	(146)	(27,124)	-	(27,270)
Transfers-in	-	-	-	-	36,700	36,700
Transfers out	(500)	-	-	-	-	(500)
Capital lease financing	-	-	-	-	54	54
Net other sources (uses) of financial resources	(500)	-	(146)	173,371	36,754	209,479
Net change in fund balances	(464)	(120)	4,571	6,427	21,583	31,997
Fund balances (deficits), July 1, 2017	1,784	5,565	-	57	1,408	8,814
FUND BALANCES (DEFICITS), JUNE 30, 2018	$ 1,320	$ 5,445	$ 4,571	$ 6,484	$ 22,991	$ 40,811

State of Illinois
Department of Healthcare and Family Services

Combining Statement of Fiduciary Net Position - Agency Funds

June 30, 2018 (Expressed in Thousands)

	Child Support Enforcement Trust 0957	Child Support Enforcement Trust - SDU 2957	Total
ASSETS			
Cash equity with State Treasurer	$ 16,105	$ -	$ 16,105
Cash and cash equivalents	279	1,582	1,861
Other receivables, net	196,707	12	196,719
Total assets	$ 213,091	$ 1,594	$ 214,685
LIABILITIES			
Accounts payable and accrued liabilities	$ 16,132	$ 1,594	$ 17,726
Other liabilities	196,959	-	196,959
Total liabilities	$ 213,091	$ 1,594	$ 214,685

State of Illinois
Department of Healthcare and Family Services

Combining Statement of Changes in Assets and Liabilities - Agency Funds

For the Year Ended June 30, 2018 (Expressed in Thousands)

	Balance at July 1, 2017	Additions	Deletions	Balance at June 30, 2018
Child Support Enforcement Trust (0957)				
ASSETS				
Cash equity with State Treasurer	$ 18,590	$ 136,695	$ 139,180	$ 16,105
Cash and cash equivalents	265	79,218	79,204	279
Other receivables, net	202,364	131,038	136,695	196,707
Total assets	$ 221,219	$ 346,951	$ 355,079	$ 213,091
LIABILITIES				
Accounts payable and accrued liabilities	$ 19,239	$ 4,604	$ 7,711	$ 16,132
Other liabilities	201,980	205,652	210,673	196,959
Total liabilities	$ 221,219	$ 210,256	$ 218,384	$ 213,091
Child Support Enforcement Trust - SDU (2957)				
ASSETS				
Cash and cash equivalents	$ 1,613	$ 1,189,939	$ 1,189,970	$ 1,582
Other receivables, net	19	174	181	12
Total assets	$ 1,632	$ 1,190,113	$ 1,190,151	$ 1,594
LIABILITIES				
Accounts payable and accrued liabilities	$ 1,632	$ 1,189,932	$ 1,189,970	$ 1,594
Total liabilities	$ 1,632	$ 1,189,932	$ 1,189,970	$ 1,594
Total				
ASSETS				
Cash equity with State Treasurer	$ 18,590	$ 136,695	$ 139,180	$ 16,105
Cash and cash equivalents	1,878	1,269,157	1,269,174	1,861
Other receivables, net	202,383	131,212	136,876	196,719
Total assets	$ 222,851	$ 1,537,064	$ 1,545,230	$ 214,685
LIABILITIES				
Accounts payable and accrued liabilities	$ 20,871	$ 1,194,536	$ 1,197,681	$ 17,726
Other liabilities	201,980	205,652	210,673	196,959
Total liabilities	$ 222,851	$ 1,400,188	$ 1,408,354	$ 214,685

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INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Honorable Frank J. Mautino
Auditor General
State of Illinois

As Special Assistant Auditors for the Auditor General, we have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the governmental activities, the major fund, and the aggregate remaining fund information of the State of Illinois, Department of Healthcare and Family Services, as of and for the year ended June 30, 2018, and the related notes to the financial statements, which collectively comprise the State of Illinois, Department of Healthcare and Family Services' basic financial statements, and have issued our report thereon dated August 6, 2019.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the State of Illinois, Department of Healthcare and Family Services' internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the State of Illinois, Department of Healthcare and Family Services' internal control. Accordingly, we do not express an opinion on the effectiveness of the State of Illinois, Department of Healthcare and Family Services' internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. We did identify certain deficiencies in internal control, described in the accompanying schedule of findings as items 2018-001 through 2018-015 that we consider to be material weaknesses.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the State of Illinois, Department of Healthcare and Family Services' financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and which are described in the accompanying schedule of findings as items 2018-001 through 2018-008 and 2018-010 through 2018-015.

State of Illinois, Department of Healthcare and Family Services' Responses to Findings

The State of Illinois, Department of Healthcare and Family Services' responses to findings identified in our audit are described in the accompanying schedule of findings. The State of Illinois, Department of Healthcare and Family Services' responses were not subjected to the auditing procedures applied in the engagement to audit of the financial statements and, accordingly, we express no opinion on the responses.

State of Illinois, Department of Children and Family Services' Response to Findings

The State of Illinois, Department of Children and Family Services' responses to the items 2018-001, 2018-002, and 2018-003 are described in the accompanying schedule of findings. The State of Illinois, Department of Children and Family Services' responses were not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the responses.

State of Illinois, Department of Human Services' Response to Findings

The State of Illinois, Department of Human Services' responses to items 2018-001, 2018-002, 2018-003, 2018-004, 2018-005, 2018-006, 2018-007, and 2018-008 are described in the accompanying schedule of findings. The State of Illinois, Department of Human Services' responses were not subjected to the auditing procedures applied to the audit of the financial statements and accordingly, we express no opinion on the responses.

State of Illinois, Department on Aging's Response to Findings

The State of Illinois, Department on Aging's responses to items 2018-001, 2018-002, and 2018-003 are described in the accompanying schedule of findings. The State of Illinois, Department on Aging's responses were not subjected to the auditing procedures applied to the audit of the financial statements and accordingly, we express no opinion on the responses.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the State of Illinois, Department of Healthcare and Family Services' internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the State of Illinois, Department of Healthcare and Family Services' internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Signed original on file

Decatur, Illinois
August 6, 2019

SCHEDULE OF FINDINGS

CURRENT FINDINGS
(GOVERNMENT AUDITING STANDARDS)

2018-001 **FINDING** (Statewide Failure to Execute Interagency Agreements and Perform Essential Project Management Functions over Provider Enrollment in the Medicaid Program)

The Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), the Department of Children and Family Services (DCFS), and the Department on Aging (DoA) (collectively, the "Departments") failed to execute adequate internal controls over the implementation and operation of the State of Illinois' Illinois-Michigan Program Alliance for Core Technology system (IMPACT). Specifically, management of the Departments did not enter into interagency agreements (IA) defining each agency's roles and responsibilities and did not perform essential project management functions over the implementation of IMPACT.

Project Background

Throughout calendar years 2012-2015, the Departments and the State of Michigan's Department of Community Health (DCH) began studying possible modifications to Michigan's existing Medicaid Management Information System (MMIS) to allow Illinois to share it and its related infrastructure with the goal being to eventually replace HFS' outdated MMIS to accommodate the processing of the State of Illinois' Medicaid provider enrollment determinations and all Medicaid claim payments to such providers. In 2015, HFS and DCH signed an intergovernmental agreement formally establishing IMPACT. The implementation of IMPACT was scheduled to be rolled out in three phases. Phase 1 was placed in service in November 2013 and March 2014, and encompassed providing financial assistance for the development and implementation of the Electronic Health Record Medicaid Incentive Payment Program (eMIPP) module. Phase 2 was placed in service in July 2015 and encompassed the development and the implementation of the Provider Enrollment (PE) module. The PE module was designated by HFS to be the State of Illinois' book of record for the eligibility determinations of providers offering services for and on-behalf of the State of Illinois' Medicaid recipients. Both the eMIPP and PE modules interface with the existing State of Illinois' MMIS and are the basis for which providers are determined eligible to provide Medicaid services and receive Medicaid claim payments. Phase 3 includes the final development and implementation stages of IMPACT and was scheduled to be placed in service in calendar year of 2018; however, implementation had not taken place as of the end of our fieldwork. HFS staff stated IMPACT is not ready to accommodate the managed-care-rate payment structure and is currently targeted to be placed in service in March 2020. According to filings with the U.S. Department of Health & Human Services, the IMPACT project was expected to cost the State of Illinois approximately $103 million. As of September 30, 2018, after only implementing two phases of the project, HFS had expended over $50 million with the largest part of the system conversion outstanding. As of the end of our fieldwork, HFS has increased the original budget to approximately $173 million.

HFS' and Delegated Agencies' Roles

As set by the State of Illinois' State Plan under Title XIX of the *Social Security Act* (State Plan) (Section 1.1), the State's designated agency responsible for administering and supervising the administration of the Medicaid Program is HFS. However, Section 1.1 of the State Plan also allows for HFS to delegate specific functions to other State entities to assist with the administration of the Medicaid Program, pursuant to a written IA defining each agency's roles and responsibilities. During our testing, we identified the following delegated agencies, which we will refer to as HFS' Delegated Agencies, and examples of the Medicaid services they provide which utilizes IMPACT for enrollment of their providers. DHS administers several human service programs under the Medicaid Program, including

developmental disabilities support services, rehabilitation services, and substance abuse (prevention and recovery) services. DCFS administers the State's child welfare program which includes cooperating in the establishment of Medicaid eligibility for children who are wards of the State. DoA administers the State's programs for residents aged 60 and older, including Home and Community Based Services to Medicaid recipients who meet Community Care Program requirements.

Auditor Testing and Results

In order to determine if the Departments complied with federal and State laws, rules, and regulations when they developed, implemented, and operated IMPACT, we reviewed the Departments' applicable policies and procedures governing IMPACT. Our testing identified the following material weaknesses in internal control:

- The Departments did not have current, formal written agreements defining the roles and responsibilities of HFS or its Delegated Agencies of the Medicaid Program.

- While DHS utilized IMPACT to formally approve providers for the purposes of granting payments of their Medicaid claims, it did not utilize IMPACT as its book of record or rely on it to verify the providers met certain federal requirements. In this instance, the book of record means the mandatory system designated by HFS to be used for the tracking of the State's activities, events, or decisions when approving or denying the enrollment of Medicaid providers. When we inquired of DHS as to why it did not retain the documentation within IMPACT to support its determination of enrollment, DHS management stated it chose to maintain the supporting documentation outside of IMPACT as it could not rely on IMPACT.

- When we inquired of DCFS and DoA as to what their processes were regarding the use of IMPACT, they both stated they did not use IMPACT after formally approving the providers for the purpose of granting payments of their Medicaid claims. They both believed HFS was doing the subsequent review of, and maintenance of, provider enrollment information for them. After asking HFS to confirm if DCFS' and DoA's statements were accurate, HFS management stated that was not the case and both DCFS and DoA had the responsibility to subsequently review their providers' eligibility for enrollment in the Medicaid program.

- The Departments implemented IMPACT despite the inability of IMPACT to allow Illinois officials to generate customary and usual system internal control reports, including such information as provider data, security measures, or updates made to IMPACT. The Departments must go through the third-party service provider (TSP) in order to obtain any reports needed by the State.

- Based on testing of the documented procedures governing IMPACT, we noted the following:
  - the procedures only addressed the actions that should have been taken by HFS and did not include the procedures to be followed or taken by the Delegated Agencies;
  - the procedures contained contradictory provisions; and,
  - the procedures did not depict the actual actions taken by HFS staff during the audit period.

- The Departments failed to establish and maintain adequate general information technology controls over IMPACT. (See Finding 2018-002 for further details.)

- The Departments had inadequate project management over the implementation of IMPACT. According to the Intergovernmental Agreements, Amendments, and Statements of Work signed between HFS and the TSP, who maintains and hosts IMPACT, the TSP

was to provide HFS various deliverables throughout the implementation of the project for its timely review and approval. During our testing of the deliverables required to be provided, we noted the following:

- HFS did not receive 9 of the 60 (15%) required deliverables,
- For 39 of the 51 (76%) deliverables received, there was no supporting documentation to demonstrate HFS had approved them, and
- One of the 51 (2%) deliverables received, the PE Implementation Plan, was noted as "draft". As a result, HFS does not have supporting documentation to show it received and approved the "final" version of the deliverable. The purpose of the PE Implementation Plan was to define the overall approach for the implementation of the PE module of IMPACT.

- As a result of inadequate project management, the Departments did not implement adequate security controls over IMPACT. (See Finding 2018-002 for further details)

- The Departments did not design and establish an adequate internal control structure over provider enrollment determination *such that sufficient and appropriate evidence, maintained in a paperless format, existed to support each provider met various compliance requirements at the time when the Departments determined each provider's eligibility*. Further, management at the Departments failed to adequately monitor manual provider enrollment determinations, as (1) staff did not consistently document their review of the provider applications in accordance with HFS' Process Checklists and (2) HFS did not establish a system of supervisory reviews of work performed by staff. (See Finding 2018-003 for further details.)

Auditing standards applicable to financial audits and compliance examinations contained in the *Government Auditing Standards* issued by the Comptroller General of the United States Sections 1.01-1.02 state:

> The concept of accountability for use of public resources and government authority is key to our nation's governing processes. Management and officials entrusted with public resources are responsible for carrying out public functions and providing service to the public effectively, efficiently, economically, ethically, and equitably within the context of the statutory boundaries of the specific government program. As reflected in applicable laws, regulations, agreements, and standards, management and officials of government programs are responsible for providing reliable, useful, and timely information for transparency and accountability of these programs and their operations. Legislators, oversight bodies, those charged with governance, and the public need to know whether (1) management and officials manage government resources and use their authority properly and in compliance with laws and regulations; (2) government programs are achieving their objectives and desired outcomes; and (3) government services are provided effectively, efficiently, economically, ethically, and equitably.

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

In addition, the Fiscal Control and Internal Auditing Act (Act) (30 ILCS 10/3001) requires all agencies to establish and maintain a system of internal fiscal and administrative controls, which shall provide assurance that: (1) resources are utilized efficiently, effectively, and in compliance with applicable laws; (2) obligations and costs are in compliance with applicable laws; and (3) funds, property, and other assets

and resources are safeguarded against waste, loss, unauthorized use, and misappropriation and funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources. In addition, generally accepted information technology guidance endorses the implementation of project management techniques to certify computer system development activities meet management's objectives.

The Departments' management indicated the above control deficiencies were due to the limited reporting capabilities of IMPACT and employee oversight.

Failure to execute IAs and failure to perform essential project management functions could expose the State to unnecessary and avoidable litigation, approval of ineligible providers, excessive expenditures, over-reliance on contractors, and could result in a system that does not meet the needs of the State and the individuals dependent on the State for Medicaid services. In addition, the Departments' lack of due diligence in performing project management responsibilities has contributed to a significant increase in project timeline and associated costs. (Finding Code No. 2018-001)

RECOMMENDATION

We recommend management of the Departments execute detailed IAs which define the roles and responsibilities of each agency regarding the Medicaid Program. The IAs should sufficiently address necessary procedures to enforce monitoring and accountability provisions over IMPACT as required by the Code of Federal Regulations, the State Plan, and the Act so the enrollment of providers offering services to recipients of the Medicaid program is carried out in an effective, compliant, efficient, and economical manner. We further recommend the Departments obtain and review/approve the remaining deliverables from the TSP and, in the future, the Departments should establish adequate controls over project management for the development and implementation of major projects, such as IMPACT.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE

The Department of Healthcare and Family Services (HFS) accepts the recommendation. The above control deficiencies were due to management not prioritizing creation of new interagency agreements in line with the new system and performing quality checks of employee performance.

HFS currently has interagency agreements with the agencies processing provider medical claims through HFS. HFS will update these agreements to include the roles and responsibilities of each agency that is using the Provider Enrollment module of the IMPACT system as necessary.

The Department processes payments for deliverables and contractual obligations via invoice vouchers which include the statement "I certify that the goods or services specified on this voucher were for the use of this agency and that the expenditure for such goods or services was authorized and lawfully incurred; that such goods or services meet all the required standards set forth in the purchase agreement or contract to which this voucher relates; and that the amount shown on this voucher is correct and is approved for payment. If applicable, the reporting requirements of Section 5.1 of the Governor's Office of Management and Budget Act have been met." The invoice vouchers are signed by the receiving officer, head of unit and agency head. All deliverables were received, reviewed and paid in accordance with State requirements; however, this particular contract outlined additional requirements for deliverable approval and the Department could not provide all items due to staff turnover. Additional processes were implemented in response to a previous audit finding related to this same issue; however, the deliverables and approvals noted by the auditor during this audit pre-date the new process that was implemented.

AUDITOR'S COMMENT TO DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE

As noted above, the Department had not received all the required deliverables, therefore, the auditors are unclear as to how the Department of Healthcare and Family Services could have reviewed and paid for all contract deliverables in accordance with the State requirements.

DEPARTMENT OF HUMAN SERVICES' RESPONSE

The Department of Human Services (DHS) agrees with the recommendation. DHS will work with the Department of Healthcare and Family Services (HFS) to execute a detailed Intergovernmental Agreement (IGA) which defines the roles and responsibilities of each agency to enforce monitoring and accountability provisions over IMPACT as required. In addition, DHS will work with HFS to establish adequate controls over project management for the development and implementation of major projects, such as IMPACT.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES' RESPONSE

The Department of Children and Family Services (DCFS) agrees with the auditor's recommendation. DCFS looks forward to discussions and will work towards executing agreement(s) that will define its role, responsibilities and cooperation with other State agencies with regard to IMPACT and the State's Medicaid Program.

DEPARTMENT ON AGING'S RESPONSE

The Illinois Department on Aging (IDoA) partially agrees with the finding. IDoA believes that HFS, as the State Medicaid Agency, should be the Agency that initiates an Interagency Agreement (IA) with the operating agencies. However, the Department will coordinate with HFS to enter into an IA related to IMPACT.

IDoA disagrees with other elements of the finding. IDoA is a limited user within IMPACT, having just one employee who accesses the system. In the third bullet, the finding states that IDoA believes HFS was completing subsequent review of provider enrollment information. IDoA has controls in place that are used when a provider is certified by the Department. These controls are outside of IMPACT and are performed in accordance with IDoA rules to become a provider for the Department. IDoA is not party to the enrollment information review. The Department, in accordance with internal rules and ultimately its Medicaid Waiver, certifies providers for programs administered by the Department. Additionally, IDoA doesn't classify providers as Medicaid or not, IDoA classifies participants in their programs.

There are elements of the finding, such as receipt of deliverables, security controls, and policies and procedures that would not be items that would exist within IDoA. When an IA is entered into with HFS, IDoA will focus on including items in the IA that would affect the way that the system is currently utilized and controls necessary to certify to HFS that IDoA is fulfilling their responsibility as it relates to IMPACT.

2018-002 **FINDING** (Inadequate General Information Technology Controls over IMPACT)

The Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), the Department of Children and Family Services (DCFS), and the Department on Aging (DoA) (collectively, the "Departments") failed to execute adequate internal controls over the implementation and operation of the State of Illinois' Illinois-Michigan Program Alliance for Core Technology system (IMPACT). Specifically, the Departments did not establish and maintain general information technology controls (general IT controls) over IMPACT which was developed to document and monitor provider enrollment for those providers offering services to recipients of the Medicaid Program administered throughout the State of Illinois.

Auditor's Note: In this finding, we want to point out to the reader that our testing was mostly conducted at and through HFS, as it is the State's designated Medicaid agency and has the ultimate responsibility for administering and supervising the Medicaid Program. However, as described in Finding 2018-001, HFS is allowed to and has delegated certain responsibilities to other State agencies to carry out the Medicaid Program. In addition, each of the listed above State agencies expends and/or receives a material amount of federal and State dollars which is accounted for in either its entity-wide financial statements or is essential to the auditors opining on its compliance assertions. Finally, when reviewing documentation of the development and implementation of IMPACT, we identified that management of both HFS and the delegated State agencies took part in the discussions. As a result of this reasoning and the material weaknesses in internal control we noted in Finding 2018-001 that describe managements' failure to formally outline each of the State agencies' responsibilities, we believe there is a shared fiduciary responsibility to guarantee the Medicaid services administered at each of the listed State agencies are provided in accordance with federal and State laws, rules, and regulations and that management of each of the State agencies failed to perform those essential fiduciary responsibilities.

Auditor Testing and Results

During our testing, we noted the Departments did not have access to or control over IMPACT and its infrastructure. IMPACT and its infrastructure is hosted by and maintained through a third party service provider (TSP). As a result, we were unable to perform adequate procedures to satisfy ourselves that certain general IT controls (i.e. security over the environment, disaster recovery assurance, and change management procedures) over IMPACT were operating effectively during the audit period. The TSP did not obtain or provide the Departments with a System and Organization Control (SOC) report, which would provide the State and the auditors information on the design and effectiveness of internal control over IMPACT.

Security over Illinois Users Testing

As part of the audit process, we requested HFS provide us the population of all State staff who had access to IMPACT. Although HFS provided a population to us, documentation demonstrating the completeness and accuracy of the population could not be provided. HFS stated it could not provide the necessary documentation, as the TSP controls it. Due to these conditions, we were unable to conclude that the population records were sufficiently precise and detailed under the Professional Standards promulgated by the American Institute of Certified Public Accountants (AU-C § 330, AU-C § 530, and AT-C § 205.35).

Even given the population limitations noted above, we tested a sample of State users who had access to IMPACT. Our testing revealed the following:

- 28 of the 49 (57%) users tested had access rights to IMPACT as of June 30, 2018, however, we noted the users had in fact terminated employment prior to June 30, 2018; and,
- Due to both 1) the lack of reporting functionality within IMPACT and 2) the Departments not requesting the TSP to develop and provide ad hoc reports, the

Departments' management did not perform access reviews on an ongoing basis during the audit period.

As a result of the Department's failure to establish appropriate security controls over IMPACT, we cannot determine if IMPACT and the State's data contained within the system are adequately protected from unauthorized access and accidental or intentional destruction or alteration.

Edits Testing

As part of the audit process, we requested HFS provide us the population of all active edits from IMPACT. In response to this request, HFS provided us the Detailed System Design Document (DSDD). Upon reviewing the 359 individual documents which comprised the DSDD, we noted the DSDD did not contain a concerted listing of active edits, as the documents outlined the overall system design assuming all edits would be implemented. Our testing revealed not all of the design features included in the DSDD had been implemented. Further, in order to use the DSDD for population purposes, we would have to have the knowledge as to which "edits" were active and were not during the audit period.

An edit check, or test, checks data entered into a system for validity before it is processed. It is commonly used by businesses, organizations, and agencies that need to perform numerous checks on information before it is passed along to someone who can process the data. An edit check can verify the eligibility of applicants or claims. Submissions that fail an edit check often are returned so that they can be corrected. As the Departments were unable to provide us a complete listing of active edits, we cannot test them to determine if they are functioning properly, which would provide some assurance that the data in IMPACT is accurate and in accordance with applicable laws, rules, and regulations governing providers of services for the Medicaid Program of the State.

Disaster Recovery Testing

In response to our requests to review the Departments' disaster recovery plan related to IMPACT, HFS provided a preliminary Business Continuity Plan which we noted was a "draft" version; and, therefore, had not been finalized and approved by HFS management.

We also requested documentation demonstrating the Departments had conducted disaster recovery activities during the audit period. HFS provided the State of Michigan's Department of Health and Human Services, NGDICloudDisaster Recovery Report (Report), dated October 26, 2017. Our review of the Report noted the following weaknesses as it related to the State of Illinois's portion of IMPACT:

- A significant amount of information had been redacted; therefore, we were unable to determine the extent of the disaster recovery exercise and its relationship to Illinois data.
- The Departments had neither reviewed the Report nor been involved in the actual recovery exercise.

In addition, we requested documentation regarding the backup (including due diligence in ensuring backups were successfully generated) of the Departments' IMPACT data; however, HFS management stated, per the intergovernmental agreement, the State of Michigan is responsible for providing the State of Illinois with sufficient storage for operations and backups, along with establishing the disaster recovery environment.

As a result of the Departments' failure to obtain, review, and fully understand the TSP's disaster recovery controls, including guaranteeing backups were successfully completed, and because we were not able to determine the extent of the TSP's disaster recovery exercise as it related to Illinois' data covered by the Report, we believe the Departments failed to adequately protect IMPACT and the State's data against the possibility of major disruptions of services and loss of data, and we are

unable to determine if IMPACT and the State's data were adequately protected during the audit period.

Change Management

As a result of the Departments' failure to obtain a SOC report, as noted above, or conduct their own timely independent internal control reviews over how changes were made by the TSP to IMPACT and its environment, we are unable to determine that changes made to IMPACT during the audit period were proper and approved.

The Code of Federal Regulations (42 C.F.R. §95.621(f)(1)), *Automated Data Processing (ADP) System Security Requirements*, requires State agencies to be responsible for the security of all ADP projects under development, and operational systems involved in the administration of the U.S. Department of Health & Human Services programs. State agencies are required to determine the appropriate security requirements based on recognized industry standards or standards governing security of federal ADP systems and information processing.

Generally accepted information systems technology guidance (including the National Institute of Standards and Technology and Government Accountability Office) endorses the development of well-designed and well-managed controls to protect computer systems and data, and endorse the formal development and testing of disaster recovery plans. Tests of disaster recovery plans (and the associated documentation of the test results) verify that the plan, procedures, and resources provide the capability to recover critical systems within the required timeframe. Generally accepted information technology guidance endorses the implementation of suitable change management procedures to control changes to computer systems. Effective change management procedures reduce the risk of unauthorized, improper, or erroneous changes to computer systems.

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

The Departments' management indicated the above control deficiencies were due to limited reporting capabilities of IMPACT and employee oversight.

As a result of the Departments' failure to obtain, review, and fully understand the TSP's general IT controls as it related to IMPACT and because we were not able to determine the adequacy of the TSP's general IT controls over IMPACT, we are not able to rely on IMPACT with respect to our testing of provider eligibility and related compliance requirements over the enrollment of providers and subsequent payments made to approved providers who provide services to recipients of the State's Medicaid Program. (Finding Code No. 2018-002)

RECOMMENDATION

We recommend management of the Departments implement adequate internal control over the implementation and design of IMPACT, including regular reviews of user access rights, reviews of edit checks on data integrity, disaster recovery activities, and change management procedures.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE

The Department of Healthcare and Family Services (HFS) accepts the recommendation. The above control deficiencies were due to management not prioritizing negotiating appropriate documentation from its third-party service provider (TSP) and the differences in audit requirements between the two states.

IMPACT provider enrollment and the electronic Medicaid Incentive Payment Program (eMipp) were implemented in a modular fashion from the rest of the IMPACT Core Medicaid Management Information System (MMIS) functionality. The modular implementation did not include a reporting tool for general reports. When the core IMPACT MMIS components are fully implemented these reports will exist and will be available to Illinois state staff to generate on demand. However, while the Department is still operating in production with the two live modules only, Illinois will obtain these reports from the third-party service provider and periodically review user access.

Illinois is sharing, with the TSP, a single code base with two separate instances of the database. For provider enrollment there is a change management process that is in place for making changes to the IMPACT code base. There are Tier 1 and Tier 2 approvals from Illinois before any changes are made. Illinois recognizes there was no System and Organization Controls (SOC) report obtained from the TSP. In lieu of a SOC report, the TSP will be sharing a copy of the TSP Centers for Medicare and Medicaid Services Security Assessment Report when it is completed. The Department will continue to work with the TSP to obtain documentation to support general IT controls are adequate. The disaster recovery tests performed for the Illinois provider enrollment and eMipp servers will be obtained and reviewed by the Department on a routine basis.

AUDITOR'S COMMENT TO DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE

The Department states the State of Illinois and the State of Michigan have different audit requirements which resulted in part to the noted deficiencies. When being audited, both States are considered governmental entities whose auditing standards are set forth by the American Institute of Certified Public Accountants (AICPA) and the United States Government Accountability Office (GAO). In the case of IMPACT, for the State of Illinois, IMPACT is hosted and maintained by a TSP. As a result, the Departments are required to obtain a SOC report or perform another type of independent review over the system's general IT internal control (as mentioned in the above finding). For the State of Michigan, IMPACT is hosted and maintained by the State itself and, therefore, the State of Michigan is not required to obtain a SOC report or perform another type of independent review over IMPACT's general IT internal controls as the State of Michigan has control over it. In summary, as required by auditing standards, the State of Illinois needs an independent review over IMPACT's general IT internal control and the State of Michigan does not.

DEPARTMENT OF HUMAN SERVICES' RESPONSE

The Department of Human Services agrees with the recommendation. DHS will work with the Department of Healthcare and Family Services (HFS) to implement adequate internal controls over the implementation and design of IMPACT.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES' RESPONSE

The Department of Children and Family Services (DCFS) accepts this finding and will cooperate with HFS in determining what, if any, responsibilities related to the auditor's recommendation apply to DCFS and will ensure those responsibilities are defined in the interagency agreement referenced in Finding 2018-001. DCFS will develop processes or procedures to comply with the roles and responsibilities defined in the agreement.

DEPARTMENT ON AGING RESPONSES

The Illinois Department on Aging (IDoA) disagrees with the applicability of this finding to IDoA. The finding asserts that internal controls over the implementation and operation of the system were lacking. IDoA does not have any purview over implementation or operation of the system and therefore has no responsibility in establishing and maintaining general information technology controls over the system.

AUDITOR'S COMMENT TO DEPARTMENT ON AGING'S RESPONSE

As noted in Finding 2018-001, the Departments do not have current, formal written agreements defining the roles and responsibilities of HFS or its Delegated Agencies of the Medicaid Program. Until such time as the Departments define the roles and responsibilities of each agency, we are unable to determine which agency is responsible for what actions.

2018-003 FINDING (Insufficient Review and Documentation of Provider Enrollment Determinations)

The Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), the Department of Children and Family Services (DCFS), and the Department on Aging (DoA) (collectively, the "Departments") failed to design and implement adequate internal controls over the implementation and operation of the State of Illinois' Illinois-Michigan Program Alliance for Core Technology system (IMPACT) sufficient to prevent inaccurate determinations and approvals of provider enrollment for those providers offering services to recipients of the Medicaid Program administered throughout the State. Specifically, we noted the Departments did not sufficiently review and document approval for provider enrollments and, as a result, did not maintain all necessary documentation supporting provider enrollment approvals.

Auditor's Note: In this finding, we want to point out to the reader that our testing was mostly conducted at and through HFS, as it is the State's designated Medicaid agency and has the ultimate responsibility for administering and supervising the Medicaid Program. However, as described in Finding 2018-001, HFS is allowed to and has delegated certain responsibilities to other State agencies to carry out the Medicaid Program. In addition, each of the listed above State agencies expends and/or receives a material amount of federal and State dollars which is accounted for in either its entity-wide financial statements or is essential to the auditors opining on its compliance assertions. Finally, when reviewing documentation of the development and implementation of IMPACT, we identified that management of both HFS and the delegated State agencies took part in the discussions. As a result of this reasoning and the material weaknesses in internal control we noted in Finding 2018-001 that describe managements' failure to formally outline each of the State agencies' responsibilities, we believe there is a shared fiduciary responsibility to guarantee the Medicaid services administered at each of the listed State agencies are provided in accordance with federal and State laws, rules, and regulations and that management of each of the State agencies failed to perform those essential fiduciary responsibilities.

The Departments implemented the Provider Enrollment module of IMPACT in July 2015 for the intake and processing of applications in order to determine enrollment for providers offering services to recipients of the Medicaid Program administered throughout the State.

Auditor Testing and Results

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

Population Completeness
We requested HFS management to provide us the population of all provider applications approved during Fiscal Year 2018. Although HFS provided a population, it could not provide documentation demonstrating the completeness and accuracy of the population. Due to these conditions, we were unable to conclude the population records were sufficiently precise and detailed under the Professional Standards promulgated by the American Institute of Certified Public Accountants (AU-C § 330, AU-C § 530, and AT-C § 205.35).

Even given the population limitations noted above, we performed testing on a sample of the approved provider applications from the population provided.

Detail Sample Testing
Based on the population provided by HFS, during Fiscal Year 2018, the Departments approved 27,886 provider applications. In order to determine if the providers' applications were approved in accordance with federal and State laws/rules/regulations, a sample of 138 approved applications were selected for testing. Our testing of the 138 provider files revealed that 26 of the provider files

contained multiple exceptions, 74 provider files contained 1 exception, and 38 of the provider files contained no exceptions. The specific exceptions noted are as follows:

- Seventy of the 138 (51%) provider files sampled were for providers who requested the applicable Department to backdate their eligibility beginning dates. Our testing revealed that all 70 (100%) of those provider files did not contain documentation of the applicable Department's exception for allowing the backdating of eligibility for the providers. As a result, it could not be determined if the backdating of eligibility, and the subsequent payments made by the State for the providers' retroactive billings, were proper.

  The *Medicaid Provider Enrollment Compendium* notes it is incumbent on the Departments to mitigate the risk of an improper enrollment, as payments for the backdated period are improper unless an exception applies.

- Forty-two of the 138 (30%) provider files sampled did not contain documentation or comments of the applicable Department's staff review of the providers' required professional licenses to confirm the licenses were valid at the time the application was approved. After our initial testing results were provided to the Departments, the Departments were subsequently able to provide us with documentation demonstrating that each of the 42 providers were appropriately licensed at the time of application.

  The Code of Federal Regulations (Code) (42 C.F.R. § 455.412(a)) requires the Departments to have a method for verifying that any provider claiming to be licensed in accordance with the laws of any State is licensed by such State.

  In addition, HFS' *Approval Process Document, applicable to Atypical Individuals and Individuals,* requires Department staff reviewing licenses to document their review of ensuring the licenses were valid and current in the comments section in IMPACT.

- Nine of the 138 (7%) provider files sampled contained a license or certification which had an open ended expiration date. As such, when the provider file was compared to the monthly screenings, IMPACT registered an error that the provider was not properly licensed/certified at that specific point in time. We noted the provider file did not contain documentation to demonstrate Department staff followed up on the results of these matches to verify enrollment when the review was performed by staff. After our initial testing results were provided to the Departments, the Departments were subsequently able to provide us with documentation demonstrating that each of the nine providers were appropriately licensed/certified during the audit period.

  The Code (42 C.F.R. § 455.412(b)) requires the Departments to confirm the provider's license has not expired and that there are no current limitations on the provider's license/certification. In addition, HFS' *Approval Process Document, applicable to Atypical Individuals and Individuals,* requires the end date for required licenses/certifications to be current in IMPACT.

- Four of the 138 (3%) provider files sampled did not contain documentation of the applicable permanent professional license(s). The providers' profile contained the applicable temporary professional license(s) which had expired. As such, when the provider file was compared to the monthly screenings, IMPACT registered an error that the provider was not properly licensed since the temporary license(s) was expired. We noted the provider file did not contain contemporaneous documentation to demonstrate Department staff followed up on the results of these matches to verify proper licensure. After our initial testing results were provided to the Departments, the Departments were subsequently able to provide us with documentation demonstrating that each of the four providers were appropriately licensed during the audit period.

The Code (42 C.F.R. § 455.412(b)) requires the Departments to confirm that the provider's license has not expired and that there are no current limitations on the provider's license.

- One of the 138 (1%) provider files sampled indicated a significant risk existed that the provider had been sanctioned; however, the Department lacked contemporaneously prepared documentation the provider was appropriately approved after the sanction was reviewed and disposed of by either a supervisor or HFS' Office of the Inspector General (OIG). As a result, we cannot determine if the provider was appropriately approved.

  HFS' *Approval Process Document, applicable to Atypical Individuals and Individuals,* requires Department staff to send applications with sanctions to their supervisor or the OIG for review and determination.

- One of the 138 (1%) provider files sampled, who would provide transportation services, did not contain documentation that the provider's driver's license was reviewed to confirm it was valid and current at the time of approval. As a result, we cannot determine if the provider was appropriately approved.

  HFS' *Handbook for Providers of Medical Services, Chapter 100, General Policy and Procedures* requires IMPACT to verify the driver's license to determine validity at a specific point in time.

- One of the 138 (1%) provider files sampled showed the provider had the potential to be deceased as a result of IMPACT's database checks; however, the provider file did not contain documentation to demonstrate Department staff followed up on the error to determine if the provider was in fact deceased. After our initial testing results were provided to the Departments, the Departments were subsequently able to provide us with documentation demonstrating that the provider was not deceased and properly approved.

  HFS' *Approval Process Document, applicable to Atypical Individuals and Individuals,* requires Department staff to manually review all screening results that return a 90% or less precision match. The precision rate percentage of less than 100% indicates that when the provider entered its information into IMPACT to enroll in the Medicaid program, the information entered did not match certain attributes in the IMPACT verification process.

- One of the 138 (1%) provider files sampled showed "no results were found" when the IMPACT screenings were performed on the provider; however, the provider file did not contain documentation to demonstrate Department staff followed up on the results prior to verifying enrollment. As a result, we cannot determine if the provider was appropriately approved.

  HFS' *Approval Process Document, applicable to Atypical Individuals and Individuals,* requires Department staff to review the results of all screenings. Any screenings that are documented as invalid are to be manually verified.

- In addition to our testing of the 138 provider applications and their related files, we tested information systems which interfaced with IMPACT during the audit period. Our testing revealed that for the months of December 2017, January 2018, and February 2018, none of the provider profiles were checked against the National Council for Prescription Drug Program (NCPDP) database to determine if the applicable licenses and certifications were valid and current, as required.

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

In response to these matters, HFS officials indicated IMPACT's current functionality does not include a module which would allow for the retention of electronic records reviewed by staff.

The Code (2 C.F.R. § 200.303) requires nonfederal entities to, among other things, establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. Effective internal controls should include establishing procedures to ensure internal controls over eligibility determinations to ensure only eligible providers receive payments under federal programs at the time the expenditure is made. Further, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Departments to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance resources are utilized efficiently, effectively, and in compliance with applicable law. Inherent within this requirement is showing, at the time when eligibility was determined and payments were made, the Departments had documentation showing the provider was eligible to participate.

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

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

The Departments were not able to quantify the amount of billings, including retroactive billings, paid to these providers, for each impacted State agency. As a result, we were not able to assess the potential misstatement of the financial statements caused by unsupported retroactive billings and other noncompliance with the Code.

Inadequate controls over the operation of IMPACT, such as insufficient review and approval of provider enrollment information, may result in providers being inaccurately determined eligible, the State expending federal and State funds for which provider enrollment has not been adequately demonstrated or documented, and may result in future expenditures to providers who are ineligible to provide services to recipients of the State's Medicaid Program. Noncompliance with federal laws and regulations could lead to denied claims, sanctions and/or loss of future federal funding and result in misstatement of agency financial statements. (Finding Code No. 2018-003)

RECOMMENDATION

We recommend management of the Departments improve controls to better ensure Department staff and supervisors are properly obtaining, reviewing, and retaining documentation in IMPACT to support Medicaid provider enrollment. As a part of improved controls, we recommend the Departments increase the level of staff training and oversight.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE

The Department of Healthcare and Family Services (HFS) partially accepts the recommendation.

The IMPACT system requires staff to review and update any information that cannot be systematically verified. The system does not currently include functionality which allows staff to retain electronic

records reviewed by staff; however, the system does retain an audit trail which indicates the portion of the system that has been updated along with a date, time and employee stamp. The Department could substantiate that staff updated the portion of the record requiring manual review as required. The Department provided post audit documentation to substantiate all providers were eligible during the time they were approved. The Department, however, did not maintain an electronic copy of the documentation manually reviewed. HFS will improve controls by instituting a quality assurance program that tests whether staff are reviewing appropriate documentation and using the system appropriately. This will target any needs for additional training and oversight.

AUDITOR'S COMMENT TO DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE

The Department contends they provided post audit documentation to demonstrate all providers were eligible during the time they were approved. However, as noted above, the Department did not provide documentation that seventy providers requesting the Department to backdate their eligibility beginning date had a documented exception to allow for the backdating as required by the *Medicaid Provider Enrollment Compendium*.

In addition, the Department did not provide documentation demonstrating, as required by their own process: (1) a provider had a proper driver's license; (2) proper followup action was taken for any provider who was a significant risk of having a sanction; and (3) proper followup action was taken for any provider who yielded no screening results.

DEPARTMENT OF HUMAN SERVICES' RESPONSE

The Department of Human Services (DHS) agrees with the recommendation. DHS will work with the Department of Healthcare and Family Services (HFS) to improve controls to ensure DHS staff and supervisors are properly obtaining, reviewing and retaining documentation in IMPACT to support provider enrollment. As part of improved controls, DHS will also work with HFS to increase oversight and staff training where necessary.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES' RESPONSE

The Department of Children and Family Services (DCFS) accepts this finding, and will cooperate with HFS in determining what, if any, responsibilities related to the auditors recommendation apply to DCFS and will ensure those responsibilities are defined in the interagency agreement referenced in Finding 2018-001. DCFS will develop processes or procedures to comply with the roles and responsibilities defined in the agreement.

DEPARTMENT ON AGING'S RESPONSE

The Illinois Department on Aging (IDoA) disagrees with the finding as it relates to IDoA. The Department maintains an All Willing and Qualified (AWAQ) certification process for all providers in the Community Care Program. That process certifies providers to be qualified under the programmatic and administrative requirements outlined in Administrative Rule. Only after the certification process is complete and an agreement to provide services to participants has been executed is a provider's information entered into IMPACT to either be located in the system or added as a Community Care Program provider.

There is no part of the certification process at IDoA that utilizes IMPACT. All provider monitoring is performed at the Department and outside IMPACT.

AUDITOR'S COMMENT TO DEPARTMENT ON AGING'S RESPONSE

As noted in Finding 2018-001, the Departments do not have current, formal written agreements defining the roles and responsibilities of HFS or its Delegated Agencies of the Medicaid Program.

Until such time as the Departments define the roles and responsibilities of each agency, we are unable to determine which agency is responsible for what actions.

With regards to the process noted by DoA, we understand the Department performs the AWAQ certification process for its providers in the Community Care Program outside of IMPACT. However, as also noted in Finding 2018-001, IMPACT is the State's designated book of record for providers certified in the Medicaid Program.

2018-004 **FINDING** (Failure to Perform Essential Project Management Functions over the Integrated Eligibility System)

The Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) (collectively, the "Departments") did not adequately execute internal controls over the implementation and operation of the State of Illinois' Integrated Eligibility System (IES) Phase II. Specifically, management of the Departments did not perform adequate project management functions over the implementation of IES Phase II.

Project Background

In order to meet the requirements of the Affordable Care Act of 2010 and the Code of Federal Regulations (Code) (45 C.F.R. § 95.626), the Departments, with the aid of a development vendor (DV), undertook a project to consolidate and modernize recipient eligibility functions for several human services programs through the use of IES. The DV took the State of Illinois' human service programs' business rules and customized IES which had been obtained from another state. The DV also maintained the environment in which IES resided until May 1, 2018. Thereafter, the responsibilities of the maintenance of IES' environment was moved to the Department of Innovation and Technology (DoIT). IES replaced the State's legacy recipient eligibility systems, including the Client Database System (CDB) and other ancillary systems. The implementation of IES was scheduled to be rolled out in two phases.

IES Phase I was placed into service on October 1, 2013, and encompassed a self-service application and initial eligibility determination intake for recipients of the State's medical programs, cash programs (including the Temporary Assistance for Needy Families (TANF) program), and Supplemental Nutrition Assistance Program (SNAP). Utilizing IES Phase I, caseworkers either approved or denied the initial application for benefits. After the initial determination of eligibility was made, the recipient's information was transferred into CDB. Once the information was in CDB, any subsequent changes to eligibility requirements (referred to as "maintenance" of the case) or redeterminations were documented in CDB by the caseworkers. As such, prior to IES Phase II, the Departments considered CDB the book of record for the human service programs' recipient eligibility determinations, maintenance, and redeterminations.

Auditor's Note: As detailed in Findings 2015-001 and 2015-006 reported in HFS' and DHS' Fiscal Year 2015 financial statement audit reports, respectively, the Departments went live with IES Phase I even though it had known problems, required manual workarounds, and encountered data integrity and downtime issues. In addition, we have reported a significant number of material weaknesses in internal control over IES Phase I since Fiscal Year 2015. Finally, as noted above, IES Phase II is maintained and hosted by DoIT. The Auditor General's Service Organization Control Report and Reports Required under Government Auditing Standards – 2018 for DoIT contained an adverse opinion. This opinion covered the environment in which IES Phase II resides, including each of the material weaknesses in internal control identified within that report. As a result, we are unable to rely on the general information technology controls for IES Phase II.

According to the original project timeline communicated to the Federal government, IES Phase II was scheduled to go live in October 2015; however, it was not placed into service until October 25, 2017. IES Phase II replaced IES Phase I, as well as CDB. As a result of IES Phase II going live, IES was designated by the Departments as the State's book of record for the eligibility determinations of new applicants as well as for the maintenance and redeterminations of eligibility for recipients receiving benefits for the medical, SNAP, and TANF programs.

According to HFS' filings with the U.S. Department of Health and Human Services (HHS), the development of IES was expected to cost the State approximately $136.9 million. As of February 9, 2018, the Departments reported to HHS that projected development costs had increased to approximately $320 million. In addition, the Departments stated in this same report the State anticipated to incur roughly $200 million in annual operating costs, primarily for caseworker personnel who use IES to administer benefits for the State's residents, in order to obtain enhanced federal reimbursement

of such costs. Also, because IES has gone live, IES requires expanded maintenance costs in addition to the annual operating costs. As reported in the filing on February 9, 2018, maintenance and operating costs are estimated to total approximately $1.2 billion over the life of the project. An unknown portion of these costs would have been incurred, regardless, under the CDB and ancillary systems. The federal financial participation (FFP) rate for these expenditures ranges from 50% to 90% depending on the type of cost incurred.

Auditor Testing and Results

In order to determine if the Departments had complied with Federal and State laws, rules, and regulations when the Departments developed, implemented, and operated IES Phase II, we tested the Departments' applicable policies and procedures governing IES Phase II. Our testing identified the following:

- The Departments did not have current, formal written agreements, policies, or procedures defining the roles and responsibilities of HFS, DHS, and DoIT regarding the operation of IES.

  HFS management believed existing policies and procedures were sufficient. DHS management stated the finding was caused by transitions in staffing.

- During our analysis and review of IES Phase II data, 128 individuals were identified in which each individual's Social Security number had been overwritten when a data update was done after the conversion to IES Phase II. These identified errors, when coupled with the fact officials at the Departments were not previously aware of this matter, indicates an increased risk that the Departments' internal controls to prevent the loss of data were not always operating effectively during the audit period and that other data losses could have occurred and not been detected by the Departments during Fiscal Year 2018.

  Departments' management indicated the overlaying of the data was due to a technical error.

- During our review of the Departments' User Acceptance Test Plan (Plan) which was used to implement IES Phase II into production, we noted the Plan did not document the Departments' controls over all aspects of the Departments' user testing. Specifically, the Plan did not address controls governing the Departments' Adverse Action Testing and the Requirements Traceability Matrix (RTM) Scripts for Test Scripts for Technology. As such, we are unable to determine if the testing was properly conducted and if any problems noted during the testing were subsequently corrected before being moved into the IES' production environment. (*Auditor's Note: User acceptance testing (UAT) is the last phase of the software testing process. During UAT, actual software users test the software to make sure it can handle required tasks in real-world scenarios, according to specifications. UAT is one of the final and most critical software project procedures that must occur before newly developed software is rolled out to the market. UAT is also known as beta testing, application testing, or end user testing. A well-managed UAT process will give the project management team and end users confidence that the software being delivered meets the requirements for which it was built.*)

  Departments' management indicated the reason for the two aspects not being included in the Plan was due to oversight when writing the Plan.

- The Departments' review and approval of required contract deliverables for the implementation of IES Phase II were inadequate. Specifically:

  - During our review of the contract amendments and the Task Orders, we noted five Task Orders were executed after the services had started.

- We also reviewed the vendor's contract and Task Orders to determine if the DV provided the required deliverables and the Departments reviewed and approved such deliverables. Our review of the 205 required deliverables noted:
  - 3 (2%) of the deliverables were not received from the vendor;
  - 2 (1%) of the deliverables received were marked draft or dated after the Departments' approval; and,
  - 82 (40%) of the deliverables were not approved by the Departments.

According to the contract signed between the Departments and the DV (Section 2.9), the State was responsible for reviewing the DV's deliverables to ensure compliance with the contract and applicable Federal and State laws. In addition, the contract (Section 4.21) states **all decisions** related to, or in connection with, the implementation were the responsibility of the State. In addition, good internal controls over a system development require the approval of amendments and Task Orders prior to the start of services.

Departments' management indicated the above exceptions were due to staffing turnover and human error.

- The Departments implemented IES Phase II even though IES Phase II did not take into consideration information being retained by a third party service provider (TSP) that was sending and accepting redetermination paperwork and reporting functions for the State. Management at the Departments indicated a decision was made to extend the redetermination dates within IES (medical case redeterminations) to prevent the recipients' benefits from being systematically terminated on each recipient's original redetermination date.

  Management at the Departments indicated the reason for these actions was because the documentation for redeterminations, sent in by the recipients, resided in the TSP's system prior to IES Phase II implementation. As the data in the TSP's system was not converted into IES Phase II, the documentation was not available to stop the automated cut-off feature contained in IES Phase II. Further, management claims the subsequent expenditures would have been incurred even if the TSP data was converted into IES Phase II, as these cases would have been added to the existing redetermination backlog and benefits may not cease until the Departments' staff actually performs the redetermination (see Finding 2018-006).

  Specifically, we noted the Departments made the decision to extend redetermination dates for medical cases, by one year, for any case that was to be redetermined in October 2017 through December 2017. For example, if a case was to be redetermined for eligibility in November 2017, the Departments changed the redetermination date to November 2018. **The Departments continued to pay existing benefits until the redetermination was performed.**

  In November 2018 and again in February 2019, HFS provided differing data regarding the number of cases affected by these decisions and the subsequent results once the redetermination was completed. After HFS was provided with this draft finding on May 10, 2019, Department officials once again determined the data was inaccurate.

  On July 11, 2019, HFS provided the data below for medical cases for which the redetermination date was extended. *(Auditor's Note: The data within this chart **does not include** the extended redeterminations that were subsequently worked and resulted in continued eligibility/benefits.)*

	Number of Cases	Total Expenditures	FFP (U.S. Share)
Cases Not Worked	23,748	$60,760,767	$37,194,196
Cases Closed*	147,375	$403,052,935	$287,186,307
Cases Canceled*	60,954	$148,454,459	$96,521,041
Total	232,077	$612,268,161	$420,901,544

* According to HFS, these cases were deemed ineligible or closed for various reasons; however, HFS officials were unable to provide the reason(s). Further, HFS officials stated the total expenditures for the closed and canceled cases are an **estimate** due to the inability of the Departments to timely determine and summarize the reason why a case was either closed or canceled.

Furthermore, DHS waived the requirement for the SNAP December 2017, January 2018, and February 2018 Mid-Point Reports (MPRs); however, DHS continued to pay benefits. DHS management indicated they did this in order to ensure recipients were not negatively affected during the infancy stages of system changes that would have automatically stopped SNAP benefits if the MPR wasn't returned. DHS determined they had expended $243,615,680 on 176,129 cases which had the required MPRs waived.

Although we understand the Departments' continuation of paying the benefits until such time as the redeterminations and the MPRs were worked, we are concerned with the:

1) significant noncompliance with federal law mandating an annual redetermination and MPR filings;
2) management override of the Departments' internal control when officials extended the original redetermination due dates and waived the MPRs within the official book of record; and,
3) potential unintended consequences of the action taken.

Federal Government Communications with the Departments

Notably, on September 4, 2018 (see note below), DHS received correspondence from the U.S. Department of Agriculture, Food and Nutrition Service (FNS) Program Development Division that it **did not approve** DHS' request for waiving the December 2017, January 2018, and February 2018 MPRs. In a second letter dated September 4, 2018, from the FNS Regional Administrator – Midwest Region, FNS specifically stated it was "concerned that issues arising from the implementation of IES resulted in over-issuance of benefits to a significant portion of the SNAP caseload." The letter went on to state "as provided in Section 13(b) of the Food and Nutrition Act, [DHS] is required to collect any over-issuance of benefits provided to a SNAP household. However, if the over-issuance is the result of a major systemic error by [DHS], under Section 13(b)(5), FNS is required to establish a claim in the amount of the over-issuance against the State and FNS may prohibit [DHS] from collecting over-issuances from households."

Auditor's Note: On two occasions (October 16, 2018 and January 8, 2019), we specifically requested DHS provide any and all correspondence received from the Federal government pertaining to the SNAP MPR requirement waiver request, and were either told no correspondence had been received, or DHS management did not provide a response to the request. On April 22, 2019, we discovered from an external source that correspondence had in fact been received and we asked DHS for a third time to provide the correspondence. After our third request, on May 6, 2019 management provided a copy of the correspondence.

Further, we requested from HFS correspondence with the HHS, Centers for Medicare and Medicaid Services (Federal CMS) regarding HFS' decision to extend the redetermination date for Medicaid recipients. According to HFS, they had determined such communication was not necessary since the Code (42 C.F.R. § 435.930) required HFS to continue to furnish benefits until recipients were deemed ineligible (*see note below*).

Auditor's Note: In a letter from Federal CMS dated July 2, 2019, Federal CMS stated:

It is a beneficiary protection described in 42 CFR 435.930 that states not terminate eligibility for beneficiaries until the state has determined them to be ineligible. [sic] While this protection ensures that coverage is maintained until the beneficiary is determined ineligible, it does not eliminate the requirement for the state to complete renewals on the prescribed basis. CMS expects that states will conduct all renewals timely.

- The Departments failed to establish and maintain adequate general information technology controls over IES. Specifically, we noted the Departments did not implement adequate security or change management controls over IES (see Findings 2018-007 and 2018-008 for further details).

- The Departments had insufficient review and documentation of recipient eligibility determinations (see Finding 2018-005 for further details).

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

Further, the Fiscal Control and Internal Auditing Act (Act) (30 ILCS 10/3001) requires the Departments to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance:

1) resources are utilized efficiently, effectively, and in compliance with applicable laws;
2) obligations and costs are in compliance with applicable laws;
3) funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation; and,
4) funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

In addition, generally accepted information technology guidance endorses the implementation of project management techniques to certify computer system development activities meet management's objectives.

Responses of the Federal Oversight Agencies Regarding Federal Funding

In order to determine the likelihood the Departments will be required to return federal funding received for ineligible medical services and SNAP and TANF benefits claimed, or incur other types of financial sanctions due to the extension of redetermination dates for medical cases, and the waiver of MPRs for SNAP, the Departments sent correspondence on May 31, 2019, and June 3, 2019, to FNS and Federal CMS, respectively, requesting such determination.

On June 21, 2019, FNS responded stating DHS had "resumed the issuance of the [MPRs] in March 2018 to address the needed corrective action in this area." The correspondence also stated, "While FNS retains its authority under federal regulations to impose fiscal sanctions, liabilities, and suspend/disallow administrative funding to address the failure to comply with SNAP requirements, our goal is to help

DHS avoid fiscal sanctions, liabilities, and suspension of administrative funding and ensure the efficient and effective administration of SNAP in Illinois and the integrity of the program."

Additionally, on July 2, 2019, Federal CMS responded stating "as long as Illinois continues to work with us in good faith in addressing the issues outlined in the December 26[, 2018,] request for corrective action plan letter, submits an approval [corrective action plan] to [Federal] CMS by August 31, 2019, and adheres to the timeframes and milestones approved by [Federal] CMS in the [corrective action plan], we do not anticipate having to disallow federal financial participation." (*Auditor's Note: This statement was referring to the initial request from Federal CMS for HFS to submit a corrective action plan on December 26, 2018. HFS submitted its first corrective action plan on February 25, 2019, which was rejected by Federal CMS on March 11, 2019. Subsequently, HFS was extended an August 31, 2019, due date to submit an acceptable corrective action plan to Federal CMS*).

The Departments' lack of due diligence in performing comprehensive and effective project management functions has led to a significant increase in the project timeline and associated costs, a system that may not completely meet the needs of the State, and recipient information being incomplete or inaccurate, thus resulting in potentially inaccurate benefits. Further, due to the lack of general information technology controls, we are unable to rely on IES with respect to our testing of eligibility and related expenditures. Finally, the Departments' noncompliance with federal laws, rules, and regulations creates significant uncertainty with regards to future action that may be taken by the Federal government. (Finding Code No. 2018-004)

RECOMMENDATION

We recommend the Departments cooperate fully with FNS and Federal CMS to timely implement all corrective actions necessary to alleviate the potential for future acts of material noncompliance, which requires the immediate attention of management at the Departments.

In addition, management of the Departments should execute written agreements, policies, and procedures defining the roles and responsibilities of HFS, DHS, and DoIT regarding the operation of IES for each of the applicable human service programs. These written agreements, policies, and procedures should sufficiently address necessary actions to enforce monitoring and accountability provisions over IES as required by the Code and the Act, so the enrollment and maintenance of recipients receiving services for the human services programs is carried out in an effective, compliant, efficient, and economical manner. Further, the Departments should obtain, review, and approve the remaining deliverables from the DV and, in the future, the Departments should take action to establish adequate controls over project management for the development and implementation of major projects, such as IES.

Furthermore, the Departments should consistently provide accurate and timely responses to auditor requests.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE

The Department of Healthcare and Family Services (HFS) accepts the recommendation. HFS will continue to cooperate with Federal CMS on implementation of corrective actions. The letter sent by HFS on February 25, 2019 contained an initial draft plan in response to the Federal CMS request. Their March 11, 2019 response was not a rejection, it was part of continued negotiations between HFS and Federal CMS to develop a plan that is acceptable to both agencies. The most recent draft plan was submitted by HFS on July 31, 2019.

HFS will continue to work with DHS and DoIT on improving project management. While acknowledging that written agreements, policies and procedures may not be sufficient on their own to achieve the outcomes identified in the recommendation, HFS is undertaking other actions to improve IES management and operations such as increasing staffing levels, enhancing training, policy streamlining, process simplification.

HFS feels that it has worked cooperatively to respond accurately and timely to requests from the auditors.

DEPARTMENT OF HUMAN SERVICES' RESPONSE

The Department of Human Services (DHS) accepts the recommendation and defers to the Department of Healthcare and Family Services (HFS) for any oversight to the Corrective Action Plan with Federal CMS mentioned in the audit report. DHS will continue to work with FNS in the efficient and effective administration of SNAP, and to mitigate the potential for any fiscal sanctions.

DHS will work to execute written agreements, policies, and procedures defining the operational roles and responsibilities of HFS, DHS, and DoIT staff regarding the operation of IES for each of the applicable human service programs. DHS will create Corrective Action Plans to address each deficiency.

Finally, DHS will continue to work cooperatively to respond accurately and timely to auditor requests.

2018-005 **FINDING** (Deletion of Four Months of Intake Eligibility Files and Significant Problems Determining Eligibility for Human Service Programs)

The Department of Healthcare and Family Services and the Department of Human Services (collectively, the "Departments") lacked controls over eligibility determinations and retention of intake documentation for the State of Illinois' human service programs.

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

Applications for Human Service Programs

Both IES Phase I and Phase II had the capability to perform automated verifications of new applicant/recipient residency, citizenship, and the validity of the Social Security number provided, through feeds to other State and Federal systems, such as systems run by the Department of Employment Security, the Secretary of State, and the Social Security Administration. At times, an applicant will assert that a negative verification is not valid, and they are instructed by the caseworker that they are allowed 45 or 90 days, under the law depending on the program, to provide documentation to support their assertion. At the time of the assertion (during the meeting between the applicant and the caseworker), the caseworker will override the negative verification result to indicate the applicant is eligible for the criteria, based solely on the applicant's assertion. However, when received, the supporting documentation is required to be scanned into IES by the caseworker and at such time the file is "certified" indicating the applicant has met all eligibility requirements and is approved for the benefit(s).

July 1, 2017 through October 24, 2017 – IES Phase I

During this timeframe, the Departments utilized IES Phase I for the intake of recipient applications and the determination of eligibility. In order to determine if the Departments' determination of applicants' eligibility was proper, we requested the population of all applications received during this period. However, on October 26, 2018, the Departments informed us the development vendor had not saved a backup of the IES Phase I database prior to the transition to IES Phase II. As such, the benefits application data was not available for testing.

After extensive discussions with the Departments, it was determined a file of approved application numbers could be provided; however, the detailed data for each application would not be available. As a result, we had to modify our audit procedures in order to determine if eligibility was properly determined.

Although, the detailed data for each approved application was not available, we selected a sample of 137 approved applications from the file provided to determine if the recipient met certain non-financial criteria: residency, citizenship, and possession of a valid Social Security number.

We worked with the Departments in reviewing legacy system reports and applicable documentation in IES Phase II (results of automated verifications as well as scanned documents supporting eligibility criteria). From the results of our testing of the non-financial criteria, we noted 16 out of 137 (11.7%) new applications did not contain sufficient documentation supporting the recipient's eligibility at time of certification. Specifically, documentation was not maintained:

- confirming the recipient's Social Security number (SSN) had been verified prior to certification;
- indicating the recipient's citizenship or alien (immigration) status had been verified prior to certification;
- confirming the recipient's residency was verified prior to certification; and,

- demonstrating the recipient's receipt of Medicare and Social Security Insurance.

For 15 of the 16 (94%) exceptions noted above, after our initial testing results were provided to the Departments, the Departments were subsequently able to provide us with documentation to support eligibility. The documentation demonstrated support of the recipients' eligibility 75 to 502 days **after** the recipients were certified.

In addition, we selected a subsample of 50 of these approved applications to determine if the recipient met the required financial criteria, noting 6 out of 50 (12%) approved applications tested did not contain documentation that the recipient's income had been verified at time of certification.

Due to the nature of the exceptions and the unique nature of each applicant, we could not use the exceptions from the testing above to accurately approximate the amount of benefits paid to all recipients who were likely certified prior to all eligibility criteria being documented.

The Departments' management indicated the exceptions were due to caseworker error.

October 25, 2017 through June 30, 2018 – IES Phase II

On October 25, 2017, the Departments implemented IES Phase II. IES Phase II not only included the intake and processing of applications, it conducted redeterminations of eligibility and case management, thus becoming the State's book of record.

Data Analysis over Approved Applications

IES Phase II data tested for this purpose was limited to information from the recipient's application, automated verification data, and caseworker entries into the system which indicate if an eligibility criterion was met or unmet, based solely on an interview with the recipient (recipient assertion), for SNAP and TANF cases and medical individuals. For instances in which the recipient was indicated as eligible based solely on their assertion to a caseworker, we did not review to determine if documentation was subsequently provided and scanned/retained in IES Phase II in support of the recipient's assertion and the caseworker's initial override.

Based on the IES Phase II data, we noted 129 of 105,820 (0.12%) SNAP and TANF cases and 406 of 188,643 (0.22%) Medicaid individuals were inappropriately approved at the time of determination, based on non-financial criteria. Specifically, the IES data analytics showed:

- The recipient did not assert that they were a citizen;
- The recipient did not assert that immigration requirements had been met;
- The recipient did not assert their physical residency was in the State of Illinois;
- The recipient's residency was not documented as the State of Illinois;
- The recipient's residency had not been verified through an automated system check or information provided by recipient;
- The recipient had claimed a SSN; however, it had not been verified through an automated system check or information provided by recipient;
- The recipient had applied for a SSN; however, verification of the applications had not been conducted;
- The recipient's SSN had not been verified; and,
- The recipient did not provide a SSN or the SSN provided was not valid.

As a result of the exceptions noted, the Departments may have improperly paid SNAP and TANF program benefits to ineligible recipients, totaling $117,153 for these 129 cases during Fiscal Year 2018. However, due to the significant backlog of unpaid Medicaid payments, at both June 30, 2018 and at the end of our fieldwork, we were unable to determine the total amount that may have been improperly paid for medical services relating to our sample of recipients with exceptions.

Detailed Testing of Sample of Approved Applications

In addition, we selected a sample of 88 cases for detailed testing to determine if the cases were properly approved based on non-financial and financial criteria. Our testing included all the documentation

contained with the case, including the scanned documentation supporting caseworker overrides required prior to certification. Our testing noted 20 cases (22.7%) did not contain documentation supporting eligibility upon certification for one or more criteria.

Specifically, the cases:

- did not contain documentation of an application on file;
- did not contain documentation the residency was verified timely;
- did not contain documentation citizenship was verified timely; and,
- had a budgeted income which did not agree with the income calculations.

For 5 of the 20 (25%) cases noted above, the Departments were able to provide us with documentation to support eligibility. The documentation demonstrated support of the recipients' eligibility 1 to 238 days **after** the recipients were certified.

Due to the nature of the exceptions and the unique nature of each applicant, we could not use the exceptions from the testing above to accurately approximate the amount of benefits paid to all recipients who were likely certified prior to all eligibility criteria being documented.

The Departments' management indicated the above errors were due to caseworker error.

Redetermination of Eligibility for Human Service Programs

As noted above, as of October 25, 2017, the Departments began utilizing IES Phase II to process redeterminations of eligibility. In order to determine if recipients were properly redetermined, we requested a population of all redeterminations completed from October 25, 2017, through June 30, 2018. We performed certain data analytics of the IES Phase II data, which is comprised of information provided by the recipient for purposes of redetermination and from the automated verification data run process performed at the time of redetermination, for SNAP and TANF cases and Medicaid individuals. *(Auditor's Note: Any additional information provided by the recipient at the request of the caseworkers which may have been added to IES Phase II after the initial redetermination was performed was not included in this testing.)*

Based on the IES Phase II redetermination data, we noted 891 of 361,380 (0.25%) SNAP and TANF cases and 326 of 568,172 (0.06%) Medicaid individuals were inappropriately approved, based on non-financial criteria. Specifically, the IES data documented:

- The recipient's citizenship had not been verified;
- The recipient's immigration requirements had not been met;
- The recipient's physical residency was not the State of Illinois;
- The recipient's residency was not documented as the State of Illinois;
- The recipient's residency had not been verified;
- The recipient had applied for a SSN; however, verification of the applications had not been conducted;
- The recipient had claimed they had a SSN; however, it had not been verified;
- The recipient provided documentation of a SSN; however, recipient's SSN had not been verified; and,
- The recipient did not provide a SSN or the SSN provided was not invalid.

As a result of the exceptions noted above, the Departments may have improperly paid out SNAP and TANF benefits to recipients that were not eligible, totaling $684,819 (for the 891 exceptions noted above). As noted previously, due to the significant backlog of unpaid Medicaid payments, and due to limitations with the population provided, we are unable to estimate the amount of improper payments related to the Medicaid recipients with exceptions, or determine amounts improperly paid by the Departments during Fiscal Year 2018 for the population as a whole.

The Departments' management indicated the exceptions were due to caseworker error.

Auditor's On-site Observations of Caseworkers Processing of Recipient Cases

In May and August 2018, we conducted on-site observations at four regional offices (facilities at which the caseworkers assist recipients in the eligibility process) throughout the State. During these on-site observations, we observed specific instances of the types of issues caseworkers had regarding the utilization of IES Phase II while working recipient cases in real time. These observation procedures were designed to assist us in evaluating the operating effectiveness of the Departments' internal controls for the prevention, or detection and correction, of IES errors by the caseworker (user level), in combination with our other tests of controls.

Specifically, we noted during the observations:

1) Several caseworkers stated during our interviews that they were inadequately trained;
2) changes to IES are not adequately communicated to the caseworkers by Departments' management for the caseworkers to know how to use the system effectively;
3) caseworkers have to remember numerous workarounds as a result of business rules not being coded into IES properly; and,
4) caseworkers expressed frustration that requests for help were not responded to in a timely or correct manner.

As such, these observations confirmed what our other IES testing has shown, which is that there are problematic systemic performance issues and/or defects and the end users have inadequate knowledge of the policies and procedures governing the system due to inadequate training and lack of communication from management. An information system is only effective if both the system design is working as intended and the end users have the knowledge or resources available to use it correctly.

The Code of Federal Regulations (Code) (42 C.F.R. § 435) requires recipients of Medicaid to provide documentary evidence of their citizenship, residency, SSNs and income. Additionally, the Code (7 C.F.R. § 273) requires individuals receiving SNAP and TANF to provide documentary evidence of their citizenship, residency, SSN, and income.

Further, the Code (42 C.F.R. § 431.17) requires the Medicaid agency to maintain records of each applicant and beneficiary, including records which support the determination of eligibility.

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

Furthermore, the State Records Act (5 ILCS 160/9) requires the Departments to establish and maintain an active and continuing program for creating, maintaining, and using records and to ensure electronic records are retained in a trustworthy manner in accordance with the Electronic Commerce Security Act (5 ILCS 175/5-135), which requires electronic records and associated information:

1) remain accessible such that the records are usable for subsequent reference at all times when such information must be retained;
2) are retained either:
    a. in the format in which it was originally generated, sent, or received; or,
    b. in a format which accurately represents the information originally generated, sent, or received; and,
3) are able to:
    a. identify the origin and destination of the information;

b. support the authenticity and integrity of the information; and,
c. the date and time when it was sent or received, if any, is retained.

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

Responses of the Federal Oversight Agencies Regarding Federal Funding

In order to determine the likelihood the Departments will be required to return federal funding received, or incur other types of financial sanctions, the Departments sent correspondence on May 31, 2019, and June 3, 2019, to the U.S. Department of Agriculture, Food and Nutrition Service (FNS) and the Department of Health and Human Services, Centers for Medicare and Medicaid Services (Federal CMS), respectively, requesting such determination.

On June 21, 2019, FNS responded stating FNS was "committed to continuing to work in partnership with [the Department of Human Services] to implement needed corrective actions to improve the efficiency and effectiveness of program administration." The response also stated FNS "retained the authority under federal regulations to impose fiscal sanctions, liabilities, and suspend/disallow administrative funding to address the failure to comply with SNAP goals."

According to the correspondence received from Federal CMS on July 2, 2019, as long as the Department of Healthcare and Family Services continued to work in "good faith" in addressing the issues identified, Federal CMS would not "anticipate having to disallow federal financial participation".

Inadequate controls over the operation of IES have resulted in eligibility that has not been demonstrated or documented prior to recipient certification, and the State expending Federal and State funds for recipients that may not have been eligible to receive benefits. Additionally, noncompliance with Federal laws and regulations could lead to sanctions and/or loss of future Federal funding, disallowance of costs, and the requirement to return Federal funds previously received. (Finding Code No. 2018-005, 2017-008, 2016-001, 2015-002)

RECOMMENDATION

We recommend the Departments continue to work with Federal CMS and FNS to ensure all corrective actions are timely implemented as required by Federal CMS and FNS.

In addition, management of the Departments should work together to:

1) provide adequate training and supervision of caseworkers;
2) timely communicate changes to IES throughout the Departments; and,
3) implement controls to ensure appropriate documentation of eligibility is obtained at the time of certification and retained in IES.

Additionally, the Departments should work with the development vendor to ensure appropriate backups of the databases are completed and retained and that all IES data is retained in strict adherence with the State Records Act and the Electronic Commerce Security Act.

Finally, the internal audit functions of the Departments should periodically audit adherence to the established systemic IT controls and programmatic controls.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE

The Department of Healthcare and Family Services (HFS) accepts the recommendation. HFS will continue to cooperate with Federal CMS on implementation of corrective actions. HFS is working to improve staff training and communications as well as better control documentation.

HFS has worked in conjunction with the Department of Human Services and the Department of Innovation and Technology (DoIT) to ensure that the appropriate backups of the databases are completed and retained, and that all IES data is retained in adherence with the State Records Act and the Electronic Commerce Security Act.

DEPARTMENT OF HUMAN SERVICES' RESPONSE

The Department of Human Services (DHS) accepts the recommendation and will continue to partner with Federal CMS and FNS to ensure all corrective action plans are timely implemented.

DHS will review training and supervision processes; will timely communicate changes to IES to staff; and will review controls to ensure appropriate documentation of eligibility is obtained and retained properly. DHS would like to note that the observations referenced in the audit report were made at four (4) out of seventy-two (72) different Family and Community Resource Centers (FCRCs). Many of the observations viewed as system flaws or defects by the auditors are viewed as positive and intentional system features by DHS. Some of the observations noted describe the system working as designed. For DHS, the movement to a completely different system has been accompanied by a massive learning curve, ongoing training, ongoing training enhancements, and constant communication to front line staff. In addition, the level of personal reception to and understanding of training varies greatly among our 2,600 caseworkers. Temporary operating procedures (TOPs) are readily available, and sufficiently communicated to staff.

DHS will work with the development vendor to ensure appropriate backups of the databases are completed and retained and that all IES data is retained in strict adherence with the State Records Act and the Electronic Commerce Security Act. This has been completed, as the DoIT Infrastructure Team assumed the responsibility for Fiscal Year 2019.

Finally, the Department of Human Services' Office of Internal Audit will continue to audit systemic IT and programmatic controls within the internal audits as prescribed by its internal audit plan. The Office of Internal Audit will continue to function in accordance with the Fiscal Control and Internal Auditing Act and the International Standards for the Professional Practice of Internal Audit as adopted by the State Internal Audit Advisory Board.

2018-006 FINDING (Backlog of Applications and Redeterminations for Human Service Programs)

The Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) (collectively, the "Departments") did not maintain adequate controls to ensure applications for human service programs were reviewed and approved or denied within the mandated 45 or 30 day timeframes. Additionally, the Departments did not conduct timely redeterminations of eligibility for the Supplemental Nutrition Assistance Program (SNAP), the Temporary Assistance for Needy Families (TANF) Program, and the Medicaid (medical) Program recipients.

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

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

Initial Applications

According to the Code of Federal Regulations (Code) (42 C.F.R. § 435.912(c)(3)), the Departments are required to determine eligibility of applicants to medical programs within 45 days of receipt of the application for assistance. Also according to the Code (7 C.F.R. § 273.2(g)), the Departments are required to determine eligibility of applicants for SNAP benefits no later than 30 calendar days following the date the applications are received.

As of June 30, 2018, the Departments had a backlog of 125,044 medical applications and 24,859 SNAP applications for which eligibility was not yet determined (worked) within the 45 day or 30 day requirements, as applicable. The oldest medical applications dated back to 2013 and the oldest SNAP applications dated back to 2014.

- As of November 1, 2018, the Departments had worked 59,192 of the 125,044 (47%) backlogged medical applications.

- As of November 1, 2018, the Departments had worked 9,686 of the 24,859 (39%) backlogged SNAP applications.

For the 9,686 SNAP applications that were subsequently worked by November 1, 2018, for Fiscal Year 2018 benefits, it was determined the State had unpaid benefits owed to recipients totaling $695,478. For the 59,192 medical applications that were subsequently worked by November 1, 2018, for Fiscal Year 2018 benefits, it was determined the State owed medical providers or capitation payments totaling at least $31.6 million. (*Auditor's Note: Because medical providers have 18 months to submit billings for services and the State has a backlog of unpaid warrants for medical providers and MCO capitation payments being held at the Office of the Comptroller as a result of the State's cash flow crisis, the Departments are unable to provide a full estimated amount of underpayment as of the end of fieldwork. The $31.6 million represents the amount the State paid on behalf of the 59,192 applications for Fiscal Year 2018 services which were paid after June 30, 2018, but before the end of fieldwork.*)

Redeterminations

According to the Code (42 C.F.R. § 435.916(a)(1) and 7 C.F.R § 273.14), the Departments are required to redetermine eligibility of the SNAP, the TANF, and the medical programs every 12 months. Additionally, the Code (42 C.F.R. § 435.916(d)(1)) states the Departments must promptly redetermine eligibility upon receipt of information affecting eligibility.

As of June 30, 2018, the Departments had incurred a backlog of 96,979* medical redeterminations and 23,199* SNAP and TANF redeterminations *(see note below)*. The oldest medical redeterminations dated back to 2016 and the oldest SNAP and TANF redeterminations dated back to 2017.

- As of November 1, 2018, the Departments had worked 42,277 of these 96,979 (44%) redeterminations.

- As of November 1, 2018, the Departments had worked 12,766 of these 23,199 (55%) SNAP and TANF redeterminations.

For the 12,766 SNAP and TANF redeterminations that were subsequently worked by November 1, 2018, for Fiscal Year 2018 benefits, it was determined the State owed benefits to recipients totaling $1.29 million. For the 42,277 medical redeterminations that were subsequently worked by November 1, 2018, because medical providers have 18 months to submit billings for services and the State has a backlog of unpaid warrants for medical providers and capitation payments being held at the Office of the Comptroller as a result of the State's cash flow crisis, the Department was unable to provide an estimated amount of the underpayment/overpayment as of the end of fieldwork.

**** Auditor's Note: As described in the Finding 2018-004, upon implementation of IES Phase II, the Departments extended the due dates for cases that were to be redetermined in October 2017 through December 2017. As of June 30, 2018, there were 173,331 such cases that had not yet been redetermined. These cases were not included in the 120,178 redetermination cases (96,979 medical and 23,199 SNAP) discussed in this finding. As a result, our testing indicated a total known redetermination backlog of 293,509 cases.***

Change Documentation Received by the Departments (a/k/a Maintenance)

According to the Code (42 C.F.R. § 435.916(d) and 42 C.F.R. § 435.952(a)), the Departments must promptly redetermine eligibility between regular renewals of eligibility whenever information is received about a change in a beneficiary's circumstances that may affect eligibility.

As of June 30, 2018, there were 85,736 backlogged documents (60,992 medical and 24,744 SNAP and/or TANF documents) on hand that have been received from active recipients to update eligibility information pertaining to their cases, which were not related to either their initial application or annual redetermination. For example, a recipient who got a new job between the date of original application, but before his/her scheduled annual redetermination date, would need to supply the Departments with new income information, which would in turn likely impact their benefit levels.

- As of November 1, 2018, the Departments had worked 64,245 of these 85,736 (75%) documents.

Departments' management indicated staff turnover and availability contributed to the delays in working the applications, redeterminations, and other information.

Responses of the Federal Oversight Agencies Regarding Federal Funding

In order to determine the likelihood the Departments will be required to return federal funding received for ineligible medical services and SNAP and TANF benefits claimed, or incur other types of financial sanctions, the Departments sent correspondence on May 31, 2019, and June 3, 2019, to the U.S. Department of Agriculture, Food and Nutrition Service (FNS) and the Department of Health and Human Services, Centers for Medicare and Medicaid Services (Federal CMS), respectively, requesting such determination. On June 21, 2019, FNS responded stating they had "initiated the formal warning process in our letter dated March 22, 2019 related to DHS' failure to comply with program requirements for the timely processing of SNAP applications." FNS went on to state that "if the State meets all established milestones and sustains an acceptable timeliness rate, FNS will terminate the formal warning process."

Additionally, on July 2, 2019, Federal CMS responded stating "as long as Illinois continues to work with us in good faith in addressing the issues outlined in the December 26[, 2018,] request for corrective

action plan letter, submits an approval [corrective action plan] to [Federal] CMS by August 31, 2019, and adheres to the timeframes and milestones approved by [Federal] CMS in the [corrective action plan], we do not anticipate having to disallow federal financial participation." (*Auditor's Note: This statement was referring to the initial request from Federal CMS for HFS to submit a corrective action plan on December 26, 2018. HFS submitted its first corrective action plan on February 25, 2019, which was rejected by Federal CMS on March 11, 2019. Subsequently, HFS was extended an August 31, 2019, due date to submit an acceptable corrective action plan to Federal CMS.*)

Significant delays in meeting the Code's requirements for timely processing of applications and redeterminations and other information is noncompliance with the Code and could result in the loss of future federal awards, disallowed costs, and/or fines and penalties. Additionally, untimely eligibility determinations and redeterminations may cause hardships on the applicants. Finally, by not conducting redeterminations or reviews of changes in a timely manner, the Departments may have incurred expenditures for ineligible individuals and claimed federal financial participation in connection therewith inappropriately. (Finding Code No. 2018-006, 2017-006)

RECOMMENDATION

We recommend management of the Departments provide significant oversight to ensure the corrective action plans are submitted and approved within the required timeframe. Further, the Departments should ensure every provision within the corrective action plans is strictly adhered to and fully implemented.

Additionally, management of the Departments should work together to implement controls to comply with the requirement that applications are reviewed and approved or denied within 45 or 30 days, as applicable. Furthermore, the Departments should establish appropriate controls to both monitor the progress of eligibility redeterminations and ensure those redeterminations occur timely. Additionally, the internal audit functions of the Departments should periodically audit adherence to the established systemic IT controls and programmatic controls.

Finally, the Departments should assign and train any additional personnel necessary so that initial applications are worked and redeterminations and maintenance of eligibility are performed within the timeframes required by the Code.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE

The Department of Healthcare and Family Services (HFS) accepts the recommendation. HFS will continue to cooperate with Federal CMS on implementation of corrective actions. Negotiations with Federal CMS on developing a corrective action plan that is acceptable to both agencies continues. The most recent draft plan was submitted by HFS on July 31, 2019. HFS will continue to work with DHS on implementing system and business process improvements to meet federal requirements on processing timeframes. In addition, as of this response, August 1, 2019, staffing levels are being increased and training enhanced to improve both quality and timeliness.

DEPARTMENT OF HUMAN SERVICES' RESPONSE

The Department of Human Services (DHS) accepts the recommendation and defers to the Department of Healthcare and Family Services (HFS) for any oversight to the Corrective Action Plan with Federal CMS mentioned in the audit report. DHS will properly monitor the SNAP timeliness rate in order to address the formal warning process imposed by FNS.

DHS will continue to work with HFS to implement controls to comply with the requirement that applications are reviewed and approved or denied timely. DHS will assign and train additional personnel to ensure initial applications are worked and redeterminations and maintenance of eligibility are performed within the timeframes required by the Code. DHS has implemented Special Processing Centers to handle workloads from larger offices with heavy caseloads, and effectively redistribute tasks to areas of the field that have the capacity to handle additional assignments. The

expected result is timely performance of task completion within IES; increased SNAP application timeliness; a reduction in the backlog of medical applications; lower wait times for customers who enter the Family and Community Resource Center (FCRC); and improved customer service in the distribution of timely and accurate benefits.

Finally, the Department of Human Services' Office of Internal Audit will continue to audit systemic IT and programmatic controls within the internal audits as prescribed by its internal audit plan. The Office of Internal Audit will continue to function in accordance with the Fiscal Control and Internal Auditing Act and the International Standards for the Professional Practice of Internal Audit as adopted by the State Internal Audit Advisory Board.

2018-007 FINDING (Lack of Controls over Changes to the Integrated Eligibility System)

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

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

As first reported by us beginning in the Departments' Fiscal Year 2015 financial statement audit reports, management of the Departments had not developed IES change control policies and procedures. As such, we were unable to determine if IES system changes were properly controlled. For the current audit, the Departments had not developed IES change control policies and procedures until April 2018.

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

In April 2018, the Departments developed an IES change process document. However, the document contains substantial deficiencies. Specifically,

- Defects, enhancements, or incidents were not defined;
- Individuals authorized to enter the changes into the tracking system, or what information should be entered, was not defined;
- Individuals who were authorized to approve defects or enhancements were not defined;
- Requirements for prioritization of changes were not defined;
- Individuals responsible for carrying out the various activities, reviewing the activities, or the documentation requirements of the activities were not documented;
- Requirements for the Departments' approval prior to movement to the various environments were not defined;
- Testing or documentation requirements were not defined; and,
- Requirements for post implementation reviews were not defined.

Due to substantial deficiencies in the document as outlined above, we could not design suitable audit procedures to test managements' compliance with the IES change control document. As such, we were unable to determine if changes made to IES during the audit period were properly controlled.

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

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

Internal Control Integrated Framework issued by the Committee of Sponsoring Organization of the Treadway Commission (COSO).

Additionally, generally accepted information technology guidance (National Institute of Standards and Technology, Internal Organization for Standardization, CoBiT, etc.) states:

- The type of change should be defined in order to properly prioritize and classify the change.
- The policies/procedures are to define the information required to be provided with each change in order to ensure a complete depiction of the change is maintained and properly reviewed.
- The individuals authorized to enter changes should be documented.
- The individuals who are responsible for the initial review of the changes, and the type of changes they are to review should be documented.
- Changes are to be prioritized at initiation, thus defined, in order to assist in the determination of the impact to the system/application.
- Policies/procedures are to define the specific requirements of each stage of the changes to complete and the individuals responsible for completing the activities of each change.
- Requirements for approvals at each stage of the change and the individuals authorized to make such approval should be documented.
- Requirements for testing of changes, format, and type of information (test plan/scripts, schedule, and detailed testing results) should be documented.
- Requirements for post implementation reviews are to be documented to confirm that the change to the application/infrastructure was implemented as approved and to determine the impact, if any, to applications/systems.

Departments' management agreed that a change control policy was not formally documented prior to April 2018; however, they believe the process they had in place as of April 2018 was sufficient.

Failure to establish and document robust change controls over the IES hampers managements' ability to secure the IES system as well as recipients' data which should be adequately protected against unauthorized changes and accidental or intentional destruction or alteration. (Finding Code No. 2018-007, 2017-009)

RECOMMENDATION

We recommend management of both Departments work together to implement robust controls over changes to IES. The Departments should develop policies and procedures which conform to industry standards or standards governing security of federal ADP systems.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE

The Department of Healthcare and Family Services (HFS) accepts the recommendation. Documentation of policy and procedures for IES applications changes need to be completed to support the application change control procedures that have been followed since the system went live. Infrastructure changes have controls and documentation in place as they follow the current Department of Innovation and Technology (DoIT)/Department of Human Services (DHS) infrastructure using Remedy, the same as all technical systems at DHS. All access to IES have controls and documentation in place as they follow the current DoIT/DHS access controls through the 4144 form as do all other technical systems at DHS.

DEPARTMENT OF HUMAN SERVICES' RESPONSE

The Department of Human Services (DHS) accepts the recommendation. DHS will complete documentation of policies and procedures for IES applications changes to support the Application Change Control Procedures that DHS has followed since the system went live. Infrastructure changes have controls and documentation in place as they follow the current DoIT/DHS Infrastructure using Remedy, the same as all technical systems at DHS. All access to IES has controls

and documentation in place as such access follows the current DoIT/DHS access controls through the Request for MIS Hardware, Software, and Services form (IL 444-4144), as do all other technical systems at DHS.

2018-008 **FINDING** (Lack of Security Controls over the Integrated Eligibility System (IES))

The Department of Healthcare and Family Services and the Department of Human Services (collectively, the "Departments") failed to implement adequate security controls over the Integrated Eligibility System (IES).

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

On October 25, 2017, IES Phase II became the State's book of record for a recipient's eligibility for the State's various human service programs. As such, IES Phase II contains personal and medical information of individuals and families (recipients) who have submitted benefit applications and/or redetermination information to the State, including individuals who were denied benefits.

Our testing of security controls over IES required that we obtain complete populations of certain information in order to select a representative sample to test. We requested that management provide the following populations:

1) All IES servers;
2) All individuals who terminated employment during Fiscal Year 2018;
3) All individuals who had rights as an IES developer or database administrator; and,
4) All network administrator accounts.

Although management of the Departments provided the populations requested above, management was unable to provide sufficient evidence for us to conclude the populations were complete and accurate under the Professional Standards promulgated by the American Institute of Certified Accountants (AU-C § 330, AU-C § 530, and AT-C § 205.35). Even given the population limitations noted, we performed testing over security controls using the populations provided as described more fully below.

Environment

In order to determine the adequacy of security over the environment in which IES resides, we tested 100% of IES servers identified by the Departments. The results of our testing noted:

- Several servers being used for IES which were not on the population listing provided by management;
- 216 of 332 (65%) servers were running operating systems that were no longer supported by the vendor; and,
- 50 of 332 (15%) servers were not running the latest version of antivirus software.

As a result of the exceptions noted above, we believe there is a risk IES and the recipients' data are susceptible to possible malicious attacks and exposure.

User Access Security

In order to determine if the Departments had adequate internal control over logical security of IES, we requested the policies governing access provisioning. However, the Departments **did not have documented policies governing access provisioning, approving access, maintaining access, or deactivation of access.**

In order to determine if individuals who were hired during the audit period had been approved to have access to IES, we tested a sample of individuals who were newly hired during the fiscal year and who

had had access to IES as of June 30, 2018. Our testing of user security for the population provided noted:

- 2 of 90 (2%) IES users tested were not approved to have access to IES.

In order to determine if individuals who had terminated employment during the audit period had their access deactivated on the date of termination, we tested a sample of individuals who were terminated during the fiscal year. Our testing of user security for the population provided noted:

- 11 of 52 (21%) IES users' access tested was not timely deactivated. In fact, access was terminated up to 128 days after termination of employment.

As a result of the exceptions noted above, there is a risk that unauthorized and/or inappropriate individuals could gain access to recipients' data in IES.

Developer and Database Administrator Security

In order to determine if developer rights and database administrator rights were appropriate, we tested all individuals with these rights from the population provided and noted:

- 1 of 12 (8%) IES developers tested had access to production accounts for the period from April through June 2018, thus allowing the individual the opportunity to introduce malicious code or to make unauthorized changes.

- We were unable to test the appropriateness of the database administrator accounts due to **the vendor hardcoding their employees' names into the database administrator accounts**. For example, the account name was Fred Jones, rather than service account XYZ. As a result, the Departments are unable to determine ownership or modify the database administrator accounts without a major disruption to IES' performance. Further, this vendor's contract was terminated on May 1, 2018; however, as of June 30, 2018, the vendor's access remained active.

Network Administrator Security

We tested the network administrators identified by the Departments to determine the appropriateness of their accounts. During testing of all network administrators' security for the population provided, we noted:

- 12 of 36 (33%) network administrator accounts were no longer required. The 12 network administrator accounts had been assigned to a vendor whose contract had terminated on May 1, 2018; however, the Departments had not removed their access, thus continuing to allow the vendor access to IES' environment and databases.

Departments' Security Review

During the Departments' own security review it did as a part of its Federal CMS Plan of Action: Milestones from FY2018 report it was required to prepare for the Federal government, they noted the following significant security threats:

- Protected health information is exposed to shared service areas;
- Audit logs are not generated;
- Inadequate access provisioning;
- Inadequate server configurations; and,
- Inadequate system performance.

Additionally, soon after IES Phase II went live, the Chief Information Security Officer wrote, "There were many individual issues regarding [personally-identifiable information] exposure in the months following Phase II Go-live [sic]."

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

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

Furthermore, the Department of Innovation and Technology's (DoIT) Enterprise Security Policy, Access Control, which applies to each agency utilizing DoIT, requires the Departments to establish standards and/or procedures for the creation, modification, and disabling of information system accounts.

Additionally, the Fiscal Control and Internal Auditing Act (Act) (30 ILCS 10/3001) requires the Departments to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance:

1) resources are utilized efficiently, effectively, and in compliance with applicable laws;
2) funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation; and,
3) funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

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

Departments' management indicated that a lack of resources and a lack of oversight contributed to the weaknesses.

Due to the Departments' failure to maintain internal controls over the security of IES, the Departments have left the IES environment, application, and data exposed to malicious attacks, security breaches, and the possibility of unauthorized changes to the IES application and data. (Finding Code No. 2018-008, 2017-010)

RECOMMENDATION

We recommend management of the Departments enhance security controls over the IES environment, application, and databases. Further, the Departments should adopt and document policies governing access provisioning and rights. Finally, the Departments should ensure it can show the completeness and accuracy of populations provided to auditors.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES RESPONSE

The Department of Healthcare and Family Services (HFS) accepts the recommendation.

General Controls – DoIT-DHS, along with IES partners (development vendor, DoIT-Central and

DoIT-HFS) has worked to obtain complete and accurate list of IES servers, users with IES admin rights as Developers, Database Administrators and Network Administrators.

Environment – DoIT-DHS will work with DoIT-Central, the consolidated data center, to reduce the risk of malicious attacks and data exposure.

IES Change Management – DoIT-DHS staff is currently working to develop and publish standardized Change Management policy and procedures documentation for IES.

User Access Security – DoIT-DHS is currently assisting DHS Family and Community Services Division to develop documented policies governing access provisioning, approving access, maintaining access, and deactivation of access to reduce risk of unauthorized and/or inappropriate access to recipients' data in IES.

Developer and Database Security – DoIT-DHS will work with IES developer (vendor) to remove all hard-coded employee names from the Administrator Database.

Network Administrator Security – DoIT-DHS will work with DoIT-Central to closely monitor Network Administrator listings to be sure access is removed for offboarded individuals in a timely manner.

Departments' Security Review – DoIT-DHS currently has POA&M items in place to remediate issues found during the IES Security Review. These POA&M items are updated and shared with Federal CMS quarterly.

DEPARTMENT OF HUMAN SERVICES RESPONSE

The Department of Human Services (DHS) accepts the recommendation.

General Controls – DoIT-DHS, along with IES partners (development vendor, DoIT-Central and DoIT-HFS) has worked to obtain a complete and accurate list of IES servers, users with IES administrative rights as Developers, Database Administrators and Network Administrators.

Environment – DoIT-DHS will work with DoIT-Central, the consolidated data center, to reduce the risk of malicious attacks and data exposure.

IES Change Management – DoIT-DHS staff is currently working to develop and publish standardized Change Management policy and procedures documentation for IES.

User Access Security – DoIT-DHS is currently assisting DHS Family and Community Services Division to develop documented policies governing access provisioning, approving access, maintaining access, and deactivation of access to reduce the risk of unauthorized and/or inappropriate access to recipients' data in IES.

Developer and Database Security – DoIT-DHS will work with IES developer (vendor) to remove all hard-coded employee names from the Administrator Database.

Network Administrator Security – DoIT-DHS will work with DoIT-Central to closely monitor Network Administrator listings to be sure access is removed for offboarded individuals in a timely manner.

Departments' Security Review – DoIT-DHS currently has POA&M items in place to remediate issues found during the IES Security Review. These POA&M items are updated and shared with Federal CMS quarterly.

2018-009 FINDING (Financial Statement Preparation Weaknesses)

The Department of Healthcare and Family Services (Department) did not ensure its annual financial reports were prepared in conformity with U.S. generally accepted accounting principles (GAAP).

Adjustments Directly Related to Financial Reporting Errors

During testing, we noted the Department did not perform a sufficient review of all accounts and amounts recorded within its financial statements, GAAP Package reports prepared for the Office of the State Comptroller (Comptroller) to prepare the State's Comprehensive Annual Financial Report (CAFR), and various additional supporting schedules. As a result, we noted the following errors:

- The Department applied a similar methodology to estimate its liability for medical costs (medical accrual) at June 30, 2018, as had been utilized in prior fiscal years. However, in addition to the calculated liability estimate, the Department added $197.7 million to the reported medical accrual in connection with a court order requiring provisional eligibility on backlogged long-term care applications. Because the Department's estimation methodology historically has intended to encompass backlogged applications for all medical assistance, including long-term care applications, the Department essentially duplicated the portion of the medical accrual attributed to long-term care backlogged applications. After this was questioned by the auditors, the Department performed an analysis of subsequent payments of Fiscal Year 2018 medical liabilities paid through April 30, 2019. With this additional data, the Department reviewed its overall estimate of medical liabilities at June 30, 2018, and determined a $130.8 million reduction of the liability was needed. The Department adjusted its financial statements accordingly.

- We noted the Department did not update its Medical Loss Ratio (MLR) recoupment receivable amount for information received after initially drafting the financial statements, but before the statements were issued. As part of its medical accrual calculation, the Department included amounts due back from Managed Care Organizations (MCO) as a result of its MLR calculations, as provided for by the MCO contracts. However, estimates of amounts expected to be received from the MLR recoupments were not updated to be responsive to information available to the Bureau of Managed Care's staff after the financial statements were drafted. Taking the relevant information into consideration, we noted the MLR recoupment receivable should have been adjusted to $31,622,288 instead of the previously recorded $57,570,938, a difference of $25,948,650. The Department adjusted its financial statements accordingly.

  Department management stated inadequate communication between program areas and the Department's accounting and budget areas caused the errors in the medical accrual calculation.

- In accordance with the Department's contracts with the MCOs, the Department withholds a percentage from each MCO's monthly capitation payment and holds these amounts within an incentive pool. At the end of the coverage period (reporting year), the MCO is entitled to receive the withheld payments if the MCO met certain performance measures.

  In the Fiscal Year 2017 audit, we noted the Department did not record an estimated liability for accounts payable to the MCOs where the Department and the MCO had not yet finalized the performance process at either June 30, 2017, or June 30, 2016. The Department subsequently made the noted adjustments.

  In the current year, we noted the Department did record an estimated liability for accounts payable to the MCOs. However, the amount recorded as payable for reporting

year 2017 was based on an incorrect number of met performance measures, resulting in an overstatement in the amount of $2,014,848 payable to MCOs.

Additionally, the Department erroneously changed the estimate calculation methodology for reporting year 2018. The 2018 methodology failed to use the updated number of reporting year 2017 met performance measures to calculate the percentage of withheld payments, which resulted in an overstatement of the accounts payable to MCOs by $15,052,721.

Department management indicated the errors noted above were due oversight.

- During our testing to verify the Department had paid the MCOs in accordance with the State of Illinois' State Plan under Title XIX of the Social Security Act, the various MCO contracts, and the actuarially approved rate settings during the audit period, we noted instances in which the Department's own internal controls had identified errors when it made original capitation and Health Insurer Fee (HIF) payments to the MCOs during the audit period. However, our testing identified that the errors, totaling a net overpayment of $14,660,402, had not been communicated to the Department's financial reporting division and, therefore, had not been recorded as an asset in the Department's financial statements in accordance with GAAP.

  Department management indicated the errors in the calculation were due to human error.

- The Department did not record the estimated amount of Disproportionate Share Hospital (DSH) adjustment amounts payable to two hospitals. In July 2018, information was received from the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services which indicated an additional $35.4 million was payable from the Department's County Provider Trust Fund to the hospitals above what had previously been disbursed. The Department adjusted its financial statements accordingly.

  Department management stated inadequate communication between the applicable program areas and the Department's accounting and budget areas resulted in the omission of this accrual from its originally drafted financial statement.

Adjustments Not Directly Related to Financial Reporting Errors

In addition to the financial reporting errors noted above, we identified other instances of misstatements to the Department's draft financial statements that were not a direct result of the Department's financial reporting process. These errors were identified during our testing of the Department's underlying transactions and are described in Finding 2018-010.

The Department is required to report its financial information within both its financial statements and its GAAP Packages used by the Comptroller to compile the State's CAFR in accordance with GAAP. Under GAAP, the Department must report government-wide and fiduciary transactions under the economic resources measurement focus and the accrual basis of accounting and report governmental funds using the current financial resources measurement focus and the modified accrual basis of accounting.

In accordance with the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001), the Department must establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance revenues, expenditures, transfers, assets, resources, and funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial reports. Further, the State Comptroller Act (15 ILCS 405/19.5(a)) requires the Department to provide all financial information deemed necessary by the Comptroller to compile and publish the State's CAFR by October 31. Good internal controls over financial reporting and compliance require

the Department to ensure its GAAP Packages and other reported data is accurate and complete to enable the timely preparation and audit of the State's CAFR.

Failure to ensure financial transactions are reported properly in accordance with GAAP resulted in material errors within the Department's draft financial statements, negatively impacted the information compiled within the State's CAFR, significantly delayed the State's financial reporting process, and represents noncompliance with State law. (Finding Code No. 2018-009, 2017-003, 2016-004)

RECOMMENDATION

We recommend the Department take action to ensure all of its transactions are properly recorded and presented in its financial statements and GAAP Packages in accordance with GAAP. Further, the Department should ensure the accuracy and completeness of its financial and non-financial information used during the financial reporting process by reviewing both the source for, and the manual and electronic processing of, its underlying transactions.

DEPARTMENT RESPONSE

The Department accepts the recommendation.

- The Department used the best information and knowledge available when the FY18 medical accrual estimate was derived in August 2018. While the Department did add $197.7 million related to the back-logged long-term care admission application issue, it did so because it believed that when combined with the high-level historical data generally utilized to forecast the medical accrual the result would be the best comprehensive liability estimate possible at that time. The Department often adjusts its historical data when developing medical accrual estimates based upon major known items of change.

  As noted in the finding, the medical accrual liability was ultimately reduced by $130.8 million ($2.59 billion total original General Revenue and Related Fund estimate) based upon actual FY18 accrual results through data as of April 30, 2019, eight months after the original estimate was developed (further FY18 date of service liability will continue to be received past that date). Absent the addition of the $197.7 million related to the long-term care application backlog, the annual accrual liability would appear to be coming in almost $67 million higher than what the unmodified August 2018 historical data alone would have suggested ($197.7 million less the $130.8 million noted reduction). While prior year experience is the best forecasting tool available, variances compared to medical accrual estimates will occur each year given the size and impacting variables within the State's Medical Assistance program.

- The remaining finding dot-points involve items where information was challenged by organizational communication. As a part of annual financial statement development, financial reporting staff engages relevant program area employees in various oral and written communication, including face-to-face meetings, E-mail and development of supporting documentation. The Department will reinforce its efforts at organizational communication throughout the year, so that all Department staff are even more aware of the need to continually communicate changes and other items potentially impacting the financial statements.

2018-010 **FINDING** (Inadequate Controls over Fiscally Monitoring Managed Care Organizations)

The Department of Healthcare and Family Services (Department) failed to implement adequate monitoring controls over its Managed Care Organizations (MCOs) in accordance with the Code of Federal Regulations (Code) and provisions outlined in the MCOs' contracts.

The Department is the State's designated agency responsible for providing healthcare coverage for adults and children who qualify for Medicaid. In conjunction with the Federal government, the Department ensures medical services are provided to approximately 25% of the State's population.

Since 2011, the Department has implemented changes to the Medicaid Program which emphasizes managed care and other care coordination services instead of fee-for-service arrangements. Managed care highlights service delivery reforms (access to care), cost containment strategies (structure and operations), program integrity enhancements, and agency efficiencies (quality measurement improvement). During Fiscal Year 2018, the Department paid 12 MCOs approximately $9.5 billion and had an additional $1.18 billion outstanding liability balance due to the 12 MCOs at June 30, 2018.

While testing certain provisions of the MCO contracts and the Code which would have had a material impact on the Department's financial statements, we noted the Department **did not**:

- **Develop and implement a review process** to ensure MCO capitation payments were paid at the federally-approved actuarial rate settings. As a result, we noted instances, totaling $6,899,317, where the Department had a net overpayment to the MCOs for services paid during Fiscal Year 2018 (see Findings 2018-012 and 2018-013).

- **Develop and implement a review process** to ensure the correct percentage of MCO incentive payments, which are manually calculated, were withheld in accordance with the MCO contracts. As a result, we noted instances totaling $263,061 for which the Department underpaid the MCOs during Fiscal Year 2018 by failing to withhold at the rate established by the contracts (see Finding 2018-012).

- **Have or perform** procedures to ensure that enrollee encounter data submitted by the MCOs to the State was accurate and complete, as required by the MCO contracts and by the Code (42 C.F.R. § 438.242(d)). Furthermore, for contracts beginning on or after July 1, 2018 (which is for the seven HealthChoice of Illinois contracts and the eight Medicare-Medicaid Alignment Initiative (MMAI) contracts), the Code (42 C.F.R. § 438.818(a)(2)) conditions financial federal participation (FFP) on whether the State has validated the accuracy and completeness of the encounter data. **As of the end of fieldwork, the Department had not met these requirements.**

  Under the Code (42 C.F.R. § 438.818(c)) the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services is authorized to defer and/or disallow FFP as a result of noncompliance with the encounter date validation requirements of the Code (42 C.F.R. § 438.818(a)(2)). **As such, we are unable to determine if FFP drawdowns subsequent to the audit period for the seven HealthChoice Illinois and MMAI contracts were allowable.**

- **Review or monitor** claims denied by the MCOs to determine whether the MCOs had appropriately denied claims submitted to them by Medicaid providers. As such, the Department could not demonstrate medical providers were paid for all eligible Medicaid services they provided to Medicaid recipients in accordance with the State Plan.

- **Adequately review** three MCOs' non-benefit/administrative or benefit costs to ensure the MCOs were correctly reporting expense data it supplied to the State's actuary used

in connection with the MCOs Medical Loss Ratio (MLR) estimate calculations. Without performing a review of the self-reported cost data submitted by the three MCOs, the Department cannot have any assurance the information the MCOs supplied for the MLR calculation was complete and accurate.

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

Department management stated limited staffing resources to perform a detailed review/audit of MCO costs and data led to the noted noncompliance.

Failure to implement adequate internal controls could expose the State to unnecessary and avoidable litigation, excessive expenditures, overreliance on contractors, disallowance or loss of FFP, and may result in a system that does not meet the needs of the Department and the individuals dependent on the State for medical services. (Finding Code No. 2018-010, 2017-001)

RECOMMENDATION

We recommend the Department take immediate action to exercise and enforce monitoring and accountability provisions established in the contracts with the MCOs and required by the Code. Further, it is imperative the Department develop and perform procedures over encounter data to exercise its fiduciary responsibility as well as to avoid any disruption in the Federal funding of its Medicaid program.

DEPARTMENT RESPONSE

The Department accepts the recommendation. The Department continues to implement actions to enhance MCO operational quality and accountability. While a review process is in place with respect to MCO capitation payments, in the time since the period audited, the Department has implemented an additional layer of review of the manual rate entry process in order to reduce the incidence of errors in the rate entries. Extensive review already takes place with respect to encounter data that is received from MCOs. Further, the quality of the encounter data continues to improve and a higher percentage of encounter data is successfully passing to the Department. The MCOs and the Department meet weekly to discuss encounter data. Finally, new managed care contracts, effective January 1, 2018, increased managed care accountability, provided additional internal controls and helped to ensure that the State’s Medicaid program is carried out in an effective, efficient and economical manner. Further, the new requirements for disputed claims and tighter overall processes required post July 1, 2019 will also help.

2018-011 FINDING (Duplicate Payments to Medicaid Managed Care Organizations)

The Department of Healthcare and Family Services (Department) lacked adequate controls over payments to Managed Care Organizations (MCOs), resulting in duplicate payments.

In accordance with the MCOs' contracts, the Department is to pay the MCOs a fixed-rate monthly capitation payment per enrollee (i.e., recipient), regardless of whether the enrollee received covered services in that month.

As part of our testing, we obtained and analyzed the Department's Fiscal Year 2018 managed care paid claims data in order to identify any anomalies within the payment data. During our review, we identified 3,999 capitation payments paid multiple times for recipients containing the same Social Security number and having the same dates of service. The total paid for these recipients was $1,423,478; however, we are unable to determine how much was proper.

Department management indicated the exceptions noted were due to system internal control oversight.

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

Inadequate internal controls over payments being made on behalf of recipients to MCOs creates the opportunity for waste and abuse and resulted in overpayments to MCOs and erroneous reimbursement from the federal government. (Finding Code No. 2018-011)

RECOMMENDATION

We recommend the Department strengthen its internal controls to ensure payments made to the MCOs are proper. Additionally, the Department should determine how much was overpaid to the MCOs and seek reimbursement.

DEPARTMENT RESPONSE

The Department accepts the recommendation. The duplicate payments have been corrected and recouped.

2018-012 FINDING (Inaccurate Rates Used to Pay Managed Care Organizations)

The Department of Healthcare and Family Services (Department) made inaccurate payments to Managed Care Organizations (MCOs) as a result of utilizing incorrect capitation rates.

During Fiscal Year 2018, the Department paid capitation payments, totaling $10.6 billion, to the MCOs for Medicaid recipient's healthcare services under five different plans:

- Affordable Care Act (ACA): The plan served the newly eligible adults who gained coverage under the Medicaid expansion provisions of the Affordable Care Act;
- Family Health Plan (FHP): The plan served children and caretaker adults;
- Integrated Care Program (ICP): The plan served individuals who were non-Medicare eligible disabled adults who were over the age of 18;
- Medicare-Medicaid Alignment Initiative (MMAI): The plan served individuals who were "dually" Medicare-Medicaid eligible; and,
- HealthChoice Illinois (HCI): Beginning January 2018, all Medicaid, Children's Health Insurance Program (CHIP), and some State-funded medical recipients were required participate in the mandatory Managed Care Program. This included participants in the Long-term Care Program, Home and Community Based Waiver services, and CHIP.

The State of Illinois' State Plan under Title XIX of the Social Security Act, *Medical Assistance Program*, requires capitation payments and bonuses/incentive payments to meet all the federal requirements, as outlined in the Code of Federal Regulations (42 C.F.R. § 438.6), and to be actuarially sound.

In order to determine if the capitation rates in effect during the audit period were in accordance with the actuarially-determined rate, we compared the capitation rate tables to the actuarial reports which outline the approved capitation rates to be used by the Department for the various medical programs. Our testing noted the following exceptions:

- ACA
  - Incorrect risk adjustment factors of the rate calculations were utilized for three MCOs. As a result of the error, the MCOs were underpaid $228,674.

- ICP
  - The Department withheld the incorrect percentage for the incentive pools, as 2% was withheld when 1.5% should have been withheld. As a result, an MCO was underpaid $263,061.
  - An incorrect risk adjustment factor of the rate calculation was utilized for one MCO. As a result of the error, the MCO was overpaid $18,666.
  - An incorrect percentage of one MCO's incentive payments was utilized. The error resulted in an underpayment to the MCO, totaling $260,273.
  - The Department was unable to code the ICP Plus Rates into the Department's payment system. Therefore, the Department manually paid the claims at the date of submission and, after the end of the 18-month lookback period, completed a reconciliation. The reconciliation for Calendar Years 2013-2015 determined the Department had overpaid the MCOs $16,952,515.
  - An incorrect capitation rate was utilized to pay seven MCOs ICP Plus Rates. The error resulted in an overpayment of $5,908,208.

- MMAI
  - Incorrect risk adjustment factors of the rate calculations were utilized for seven MCOs. As a result of the error, the MCOs were overpaid $9,575,997.

- HCI
  - An incorrect rate was utilized to pay one MCO and, due to rounding errors in the rates utilized, six other MCOs were paid incorrectly. As a result of these seven errors, the MCOs were overpaid $250,527.

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

Department management indicated these exceptions were due to human error, as the inputting of the actuarially-approved rates into the rate tables utilized by the Department to make payments to the MCOs was done manually.

As a result of making incorrect payments, the Department has incurred expenditures and sought federal financial participation which were not in compliance with federal and State laws. (Finding Code No. 2018-012, 2017-004)

RECOMMENDATION

We recommend the Department ensure payments made to the MCOs are in accordance with the actuarially-determined rates. Additionally, the Department should implement controls for a secondary review of the input of rate components to ensure their accuracy. Finally, the Department should determine how much was overpaid/underpaid and seek reimbursement or make a deficiency payment.

DEPARTMENT RESPONSE

The Department accepts the recommendation and has already implemented an additional layer of review of all rates being manually entered and the components of the calculation. All errors have been corrected in the Department's systems, and all overpayments or underpayments are being paid or recouped through adjustments to the payment records. It should be noted that the Department takes every error very seriously and routinely makes correction adjustments to MCOs.

2018-013 FINDING (Incorrect Claim Payments)

The Department of Healthcare and Family Services (Department) made incorrect payments to medical providers and Managed Care Organizations (MCOs).

In order to administer the State's Medicaid Program, the Department's Medicaid Management Information System (MMIS) processes Medicaid claims submitted by medical providers and MCOs for services rendered to Medicaid-eligible recipients and generates the related payments. During Fiscal Year 2018, the Department processed approximately 207,867,952 claims, totaling $15.5 billion.

The Department reimburses medical providers using two methods: fee-for-service and managed care payment methods. Under managed care, the Department makes fixed payments called capitation payments to MCOs for recipients enrolled in the program. Long-term care (LTC) payments are paid to medical providers for individuals requiring long-term assistance in nursing facilities, supportive living facilities, and intermediate care facilities. Inpatient Diagnosis Related Group (DRG) payments are made to hospitals based on the recipient's diagnoses and procedures performed. Pharmacy payments are paid to medical providers for medications that are medically necessary for Medicaid recipients, which includes both prescription and over-the-counter products.

We selected a sample of all claim types (capitation, LTC, Inpatient DRG, and pharmacy) paid by the Department during Fiscal Year 2018 to ensure payments were consistent with the applicable rate tables. (*Auditor's Note: Finding 2018-012 addresses the use of incorrect rates used to generate payments to MCOs.*)

We tested all claims paid for the period from July 1, 2017, through June 30, 2018, to determine if the Department properly paid the claims. Our testing identified 441,042 claims paid in error, **resulting in a net underpayment totaling $2,240,660**. Specifically, we noted the following:

- Capitation payments
  - 1,193 claims did not have accurate provider information and should not have been paid. As a result, the Department overpaid the MCOs $561,128.
  - 361,744 claims had a rate used to make the payment which was different from the defined rate (actuarially approved rate), resulting in the Department underpaying the MCOs $3,226,686.

- Pharmacy payments
  - 69,177 claims had a net liability amount which did not agree to our recalculated net liability. The net error for these claims is an underpayment to the medical providers of $249,223.
  - 6,391 compound drug claims had a net liability amount which did not agree to our recalculated net liability. The net error for these claims is an underpayment to medical providers of $57,651.
  - 67 claims were paid to regular pharmacies at the Critical Care Provider rate. The error resulted in an overpayment of $27,152 to the pharmacies.
  - 1,271 claims did not have pricing information in the defined rates. As a result, the Department overpaid medical providers $657,826.
  - 1,199 Critical Care Providers were not paid the defined rate. The Department stated they had determined the error and requested an adjustment. However, the Department's draft financial statements did not reflect the $46,794 overpayment.

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

Department management indicated, as they did last year, that these errors were due to system issues and adjustments that had not yet been processed.

Failure to establish internal controls to ensure medical providers submit proper claims, MCO payments are generated correctly, and the Department furnishes proper reimbursements resulted in erroneous payments by the State and inaccurate reimbursements from the Federal government. (Finding Code No. 2018-013, 2017-005)

RECOMMENDATION

We recommend the Department implement controls to confirm claims are properly processed at the approved rate. Specifically, the Department should ensure all claims are paid at the correct rate and all required information is provided by the medical providers and the MCOs. In the event all information is not provided by the medical provider or the MCO, the claim should be voided.

DEPARTMENT RESPONSE

The Department accepts the recommendation. However, MCOs are free to pay claims at different rates than the Department if the provider has agreed. This is the basis for trying to promote innovation and value-based purchasing. To ensure payments are appropriate, providers have access to a complaint portal that must be responded to by the MCOs. The rules around this portal were tightened early in the 2020 fiscal year. Additionally, in late 2019 fiscal year a series of meetings were called by the Department and presided over by the Department to review and come to agreement on claims issues between providers and MCOs.

2018-014 **FINDING** (Failure to Review External Service Providers' Internal Controls)

The Department of Healthcare and Family Services (Department) did not obtain or conduct timely independent internal control reviews over its external service providers.

We requested the Department provide the population of service providers utilized in order to determine if the Department had reviewed the internal controls over its service providers. In response to our request, the Department provided a listing of service providers utilized during the audit period. However, during testing, we noted one additional service provider that was not on the Department's original list.

Due to these conditions, we were unable to conclude the Department's population records were complete and accurate under the Professional Standards promulgated by the American Institute of Certified Public Accountants (AU-C § 330, AU-C § 530, and AT-C § 205.35).

Even given the population limitations noted above, we performed testing of the 11 service providers utilized by the Department from the listing provided by the Department and the service provider we identified.

These service providers provide the Department:

- Software used in the data matching and verification, process management, and reporting of client's eligibility redeterminations. The vendor processed 3,019,636 client redeterminations during the audit period.
- Administration and payment of claims for the enrollees of the State's dental program. The vendor processed claims totaling $24,980,717 during the audit period.
- An externally developed and hosted application to process the Medicaid Incentive Payment Program (eMIPP) and provider credentialing certifications. During the audit period, $60,040,835 of eMIPP payments and 28,244 provider credentialing certifications were processed. (*Auditor's Note: See Finding 2018-001 for further information regarding our testing over this provider.*)
- Software and infrastructure for the Department's Pharmacy Benefits Management System. During the audit period, $1,050,552,451 in drug rebate invoices and $553,176,813 in pharmacy claims were processed.
- Management and operations of the State's Disbursement Unit for the collection and disbursement of payments under child support orders. During the audit period, $7,462,769 in transactions were processed.
- IT hosting, software, and data entry services, as well as the establishment of rates and review of information related to the State's Managed Care Program.

During testing of the 12 service providers, we noted:

- The Department did not obtain System and Organization Control (SOC) reports or conduct independent internal control reviews for four external service providers.
- Although the Department had received a SOC report from seven of the external service providers, an analysis of the reports had not been conducted to determine the impact of the modified opinions or the noted deviations.
- The Department had not conducted an analysis of the complementary user entity controls (CUECs) documented in the SOC reports.
- Four agreements between the Department and the external service providers did not contained a requirement for an independent review to be completed.

Department management indicated, as it did in the prior years, that staff were unaware of the requirements to obtain and review SOC reports.

The Department is responsible for the design, implementation, and maintenance of internal controls related to information systems and operations to assure its critical and confidential data are adequately safeguarded. **This responsibility is not limited due to the processes being outsourced.**

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources. In addition, generally accepted information technology guidance endorses the review and assessment of internal controls related to information systems and operations to assure the accurate processing and security of information.

Without having obtained and reviewed a SOC report or another form of independent internal controls review, the Department does not have assurance the external service providers' internal controls are adequate to ensure program payments and claims are accurate and secure. (Finding Code No. 2018-014, 2017-011, 2016-003, 2015-004)

RECOMMENDATION

We recommend the Department identify all third-party service providers and determine and document if a review of controls is required. If required, the Department should:

- Obtain SOC reports or perform independent reviews of internal controls associated with outsourced systems at least annually.
- Monitor and document the operation of the CUECs relevant to the Department's operations.
- Either obtain and review SOC reports for subservice organizations or perform alternative procedures to satisfy itself that the usage of the subservice organizations would not impact the Department's internal control environment.
- Document its review of the SOC reports and review all significant issues with subservice organizations to ascertain if a corrective action plan exists and when it will be implemented, any impacts to the Department, and any compensating controls.
- Review contracts with service providers to ensure applicable requirements over the independent review of internal controls are included.

In addition, the Department should train its staff to both identify service providers and inform its staff of the need to obtain and review SOC reports.

DEPARTMENT RESPONSE

The Department accepts the recommendation.

As of July 2019:

- The Department has reviewed current contracts to determine if a SOC is required.
- The Department has added a service organization review to its procurement process to ensure that SOC language is included in relevant contracts.
- The Department is developing a formal process for ensuring that necessary SOCs and CUECs are received and reviewed and any necessary compensating controls are put in place.

However, we do not expect the IMPACT vendor will conduct a SOC review until we implement more of the system. We are looking for mitigating controls that can be implemented in fiscal year 2020.

2018-015 **FINDING** (Inadequate and Untimely Disclosures)

The Department of Healthcare and Family Services (Department) did not ensure its financial statement note disclosures were complete and appropriate and did not timely communicate significant matters to the auditors.

During testing of the Department's disclosures, we noted the following:

- The Department failed to disclose a contingent liability arising from when Department officials asked the Department of Human Services (DHS), the entity which determines eligibility for long-term care medical assistance, to cease sending out "courtesy letters" informing providers their admission reports had been denied in 2016. Thereafter, DHS did not always communicate with providers about denied admission reports until after the implementation of Public Act 100-0665 in October 2018. Due to this lack of communication, providers have argued for DHS to reopen previously denied admission reports, which could lead to the Department incurring a significant liability for claims that may be processed upon a processable admission report filed by the providers.

  During meetings held with the auditors in late May 2019, DHS officials indicated they had been aware of this since August 2018 and Department officials indicated they had been aware of this since December 2018; however, neither DHS nor the Department communicated this information to the auditors and the Department did not disclose this contingent liability within its notes to the financial statements. Department officials subsequently drafted new disclosures to describe this loss contingency and then provided these new disclosures to the auditors on July 12, 2019.

  GASB Statement No. 62 (Paragraph 102) requires the Department to accrue a loss contingency if (1) it is probable one or more future events will confirm a liability existed as of the date of the financial statements and (2) the amount of the loss can be reasonably estimated. In the event an accrual is not recorded as one or both of the conditions of Paragraph 102 have not been met, GASB Statement No. 62 (Paragraph 107) requires a disclosure indicating the nature of the contingency and either (1) an estimate of the possible loss or range of loss or (2) a statement that such an estimate cannot be made.

  Department officials indicated the failure to initially disclose the contingent liability was due to internal communication problems.

- The Department failed to disclose contingent liabilities arising from known noncompliance with federal regulations and various communications with the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (Federal CMS).

  Federal CMS conducted an on-site Operational Readiness Review during September 2017 and formally communicated serious concerns about 11 high defects affecting Medicaid benefits, benefit amount calculation mismatches between the legacy system and the new Integrated Eligibility System (IES) Phase II, and the implementation of hospital presumptive eligibility in a letter dated October 17, 2017.

Subsequently, IES Phase II was implemented on October 25, 2017. On November 3, 2017, the Department responded to Federal CMS with its first corrective action plan to address these matters.

On October 26, 2018, the Department submitted its first draft of its notes to the financial statements to the auditors. In this draft, the Department did not disclose this matter.

Subsequently, the Department received (1) four demand letters for $121.5 million related to the disallowance of federal financial participation for prior period events on December 21, 2018, and (2) a letter from Federal CMS requiring the Department to submit a corrective action plan addressing the State's noncompliance with the timely determination and redetermination of eligibility, timely appeal processing, and the implementation of hospital presumptive eligibility on December 26, 2018.

The Department communicated the four demand letters to the auditors on January 2, 2019, and provided the second revision of its notes to the financial statements to describe this event on January 25, 2019. The Department did not, however, either disclose the existence of the December 26, 2018, letter to the auditors or describe the impact of this letter in either the **second or third revision** to its notes to the financial statements on January 25, 2019, and March 7, 2019, respectively.

In accordance with Federal CMS's directions in the December 26, 2018, letter, the Department provided Federal CMS with a draft corrective action plan on February 25, 2019. On March 11, 2019, Federal CMS notified the Department that the draft plan was inadequate and needed "more specific objectives, milestones, and timeframes related to the actions the State intends to take to address each issue" raised in Federal CMS's letter from December 26, 2018. Also, the letter indicated Federal CMS would continue to work cooperatively with the Department to develop an approvable corrective action plan and that it did not anticipate disallowing federal financial participation; however, if the State did not make progress on the corrective action plan, Federal CMS would consider disallowing federal financial participation and take further compliance actions.

The Department again did not disclose the existence of these letters until a March 12, 2019, meeting with us to discuss the problematic results of our eligibility testing (see Findings 2018-004 and 2018-005) as an argument that federal financial participation was not at risk unless the State failed to work with Federal CMS in receiving approval for, and subsequently implementing, a corrective action plan. However, the Department still did not disclose this condition in the **fourth** revision to its notes to the financial statements sent on April 18, 2019. Subsequently, Department officials drafted new disclosures to describe this loss contingency and then provided these new disclosures to us in the **fifth revision to its notes to the financial statements on July 12, 2019**.

GASB Codification 2300, *Notes to Financial Statements*, (Paragraph .102) states:

> The notes to the financial statements should communicate information essential for fair presentation of the basic financial statements that is not displayed on the face of the financial statements. As such, the notes form an integral part of the basic financial statements.

Further, GASB Codification 2300 (Paragraph .901) states disclosure of significant contingencies includes both litigation and compliance audits associated with federally-assisted programs.

Department officials indicated internal communication problems caused this problem.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to permit the preparation of accounts and reliable financial reports and to maintain accountability over the State's resources. A good system of internal controls includes timely communicating identified issues for analysis by the Department's financial reporting personnel and subsequent communication to the external auditors and ensuring the notes to the financial statements are complete, accurate, and fairly communicate information essential for a user's understanding of the nature of the Department's contingencies.

Failure to adequately disclose the Department's contingencies and potential losses could have, if not detected by the auditors and corrected by management, resulted in an incomplete presentation of the Department's financial statements. Further, failure to timely disclose these conditions to the auditors and provide note disclosure that communicated essential information for a financial statement user's understanding of these events delayed the completion of both the Department's audit and the State's Comprehensive Annual Financial Report. (Finding Code No. 2018-015)

RECOMMENDATION

We recommend the Department implement internal controls, including training to help staff identify potential contingencies and establishing reporting protocols to both timely communicate this information to the Department's financial reporting staff and timely disclose these matters to the external auditors, to ensure the Department's contingencies are properly and timely disclosed within its financial statements.

DEPARTMENT RESPONSE

The Department accepts the recommendation.

- Department senior management was unaware the auditors were without knowledge of the previously denied long-term care (LTC) admission application issue detailed in the first finding dot-point. The issue was generally known by HFS staff, the LTC industry, and some members of the General Assembly. The Medicaid eligibility determination process, redeterminations of eligibility, and the Integrated Eligibility System were also thoroughly reviewed as part of this audit.

  The Department had assumed its estimated annual medical accrual liability would cover the potential cost associated with the LTC admission application issue. Since the resulting fiscal impact could not be specifically estimated, the auditors instead recommended the Department reduce its annual medical accrual liability estimate as referenced in finding #9 and reflect this issue in a footnote disclosure to the financial statements (the Department made the requested adjustment).

  Department management regrets the apparent unintended lapse in communication on the LTC admission application issue.

- The Department financial reporting staff was not made aware of the referenced October 17, 2017 letter from the Federal CMS. As a part of financial statement development, financial reporting staff engages program area employees in detailed oral and written communication, including face-to-face meetings, E-mail and production of supporting documentation. The Department will reinforce its efforts at organizational communication throughout the year, so that all Department staff are even more aware of the need to continually communicate changes or other items potentially impacting the financial statements.

  The Department did not initially include a financial statement footnote reference to the December 26, 2018 Federal CMS letter or the March 11, 2019 follow-up because based

upon discussions with CMS staff and the prior experience of Department management it was believed unlikely that a disallowance of federal matching revenue would result. Department management further believes that position was supported by the July 2, 2019 letter from Federal CMS referenced in finding #4. The Department did ultimately include the footnote disclosure to alleviate any possible uncertainty regarding the issue.

The Department plans to engage in early dialogue with the auditors regarding any future such federal notifications should they occur.

SCHEDULE OF FINDINGS

PRIOR FINDINGS NOT REPEATED

A. **FINDING** (Department did not seek potential refunds from Managed Care Organizations)

During the previous engagement, the Department of Healthcare and Family Services (Department) did not calculate the annual Medical Loss Ratios (MLRs) of the State's Medicaid Managed Care Organizations (MCOs) for mandatory enrollment for Coverage Years (CY) 2013, 2014, and 2015. As a result, the Department did not seek or collect potential refunds due back from the MCOs to the State.

During the current engagement, we noted the Department calculated and began seeking recoupment of the MLR refunds due back to the State. (Finding Code No. 2017-002)

B. **FINDING** (Untimely redetermination of eligibility)

During the previous engagement, the Department and the Department of Human Services did not conduct timely redeterminations of eligibility for Medicaid recipients. The Code of Federal Regulations (42 C.F.R. § 435.916) requires states to conduct redeterminations of an individual's eligibility every 12 months.

During the current engagement, we noted timely redeterminations of eligibility for Medicaid recipients had still not occurred; however, the description of the redeterminations not completed were included in the Integrated Eligibility System (IES) backlog as IES Phase II was implemented, merging the testing that was conducted. For further details, see Finding No. 2018-006. (Finding Code No. 2017-007)

C. **FINDING** (Inadequate controls over drug rate changes)

During the previous engagement, the Department did have controls in place to ensure the drug rates paid to medical providers were in accordance with the State Plan and properly loaded into the Pharmacy Benefits Management System. Specifically, the Department was unable to provide supporting documentation of its due diligence in ensuring the updated rates were reviewed and the load process was properly completed.

During the current engagement, we noted the Department provided supporting documentation that it received and reviewed information regarding the updated rates and ensured they were properly uploaded. (Finding Code No. 2017-012)

D. **FINDING** (Inadequate project management over the Pharmacy Benefits Management System)

During the previous engagement, the Department did not establish adequate controls to conduct due diligence or to ensure project management over the Pharmacy Benefits Management System (PBMS).

During the current engagement, the Department had not yet implemented the next phase of PBMS. Upon the completion of the next phase of PBMS' implementation, we will review the Department's controls over the development project. However, we noted the Department did implement other major projects relating to its operations during the audit period for which we noted material weaknesses in internal control and material noncompliance (see Findings 2018-001 and 2018-004). (Finding Code No. 2017-013)