Review: 4485
Statewide Single Audit
Year Ended June 30, 2017
Illinois Department of Healthcare and Family Services

FINDINGS/RECOMMENDATIONS - 7
Repeated - 4

Implemented - 3
Accepted - 3
Not Accepted - 1

17-17. The auditors recommend DHFS implement adequate general information technology control procedures for the Integrated Eligibility System (IES) system. The auditors also recommend DHFS evaluate the known IES system issues, implement monitoring procedures to identify potential noncompliance relative to its federal programs resulting from these items, and consider the changes necessary with respect to internal controls over eligibility determinations to ensure only eligible beneficiaries receive assistance under its federal programs. (Repeated-2015)

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

DHS administers the SNAP Cluster, the TANF Cluster, and certain Medicaid Cluster waiver programs and DHFS administers the CHIP and Medicaid Cluster programs. Effective October 1, 2013, the State implemented the Integrated Eligibility System (IES) to perform and document eligibility determinations for certain beneficiaries of its Medicaid Cluster program and later expanded to SNAP Cluster, TANF Cluster, and CHIP.

During testwork, the auditors were unable to perform adequate procedures to satisfy themselves that certain general information technology controls over the IES system were operating effectively. Specifically, they noted DHS and DHFS could not provide all information necessary to test system access security controls relative to the network on which IES resides. Additionally, a specific change management policy has not been developed for IES.

Accordingly, the auditors were not able to rely on IES with respect to the testing of the eligibility and related allowability compliance requirements for beneficiary payments made under the TANF Cluster, CHIP, and Medicaid Cluster programs. The auditors were also

not able to rely on IES with respect to the special test and provision – ADP System for SNAP related to the SNAP Cluster program.

In addition to the control deficiencies identified above, the auditors noted several instances of noncompliance during the review of system data obtained from IES. Specifically, the auditors noted cases were approved in IES despite beneficiaries not meeting eligibility requirements related to citizenship status or residency (immigration status). The auditors also noted cases were approved in IES without valid social security numbers or submission of an application for a social security number. While DHS and DHFS were aware of certain system issues and have established manual workarounds for certain known errors, formal procedures were not established to monitor and evaluate noncompliance resulting from the known systems errors during the year ended June 30, 2017.

As a result of DHS' and DHFS' failure to have appropriate controls over the Integrated Eligibility System, the auditors qualified their opinion on the SNAP, TANF, CHIP, and Medicaid Cluster programs.

Details of the beneficiary payments paid by the State during the year ended June 30, 2017 for the SNAP Cluster, TANF Cluster, CHIP, and Medicaid Cluster programs are as follows:

Major Program	Total Beneficiary Payments in Fiscal Year 2017	Total Fiscal Year 2017 Program Expenditures	Percentage
SNAP Cluster	$2,964,118,000	$3,076,531,000	96.3%
TANF Cluster	42,009,000	572,345,000	7.3%
CHIP	280,375,000	312,580,000	89.7%
Medicaid Cluster	9,582,593,000	10,176,779,000	94.2%

In discussing these conditions with DHS officials, they stated the planned corrective action requires significant time and resources and they have prioritized corrective action of the findings noted based upon the risks involved. They also stated the non-financial eligibility issues identified were a combination of caseworker and system defects.

Response: The Departments accept the recommendation and will work together to implement an approval process for changes made to the IES. The Departments will develop formal change control policies and procedures for IES and ensure that programmers do not have direct access to the production environment without proper approval. The security issues were previously identified by the Departments and a Plan of Action and Milestones were developed to track each issue, with the exception of two items which are tracked in the weekly infrastructure technical meeting. The current transition the Departments were undertaking from one system to another comes with an unfamiliarity of processing

procedures and nuances that are still being learned and perfected. During the audit period, casework staff had been required to spend substantial time participating in training of the new system. The transition from paper case records to electronic case records required a massive change in the gathering and maintaining of documentation. Although the new system does allow for proper maintenance of documentation in an electronic format, the conversion to the new process is still being refined. It is expected that as the transition to the new system stabilizes, casework errors will be reduced.

17-18. The auditors recommend DHFS implement procedures to verify with recipients whether services billed by providers were received. (Repeated-2010)

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

During testwork, the auditors noted DHFS procedures for verifying with beneficiaries whether services billed by providers were actually received by Medicaid Cluster beneficiaries consisted of special projects performed by the DHFS Office of Inspector General and Bureau of Comprehensive Health Services. However, the current projects only cover procedures billed by non-emergency transportation providers, optometric providers, and dental providers which only account for less than 0.9% of total provider reimbursements. Additionally, the auditors noted DHFS obtains an annual summary of the results of recipient verification procedures performed by managed care organizations. DHFS does not perform any verification procedures for services billed by the following fee for service provider types:

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

Payments made to non-emergency transportation providers, optometric providers, and dental providers totaled $39,823,785 during the year ended June 30, 2017. Payments made to managed care organizations totaled $4,962,604,000 during the year ended June 30, 2017. Payments made to providers on behalf of all beneficiaries of the Medicaid Cluster totaled $9,582,593,000 during the year ended June 30, 2017.

In discussing these conditions with DHFS officials, they stated that prior to the roll out of managed care the Department used a risk based approach to send verifications so not all provider types were included in the verifications.

Response: The Department respectfully disagrees with this recommendation because it believes it is in compliance with the regulation. The Department has a method for verifying with recipients whether services were billed. Approximately 65% of the Medicaid recipients and 45% of the federal expenditures are within managed care. Managed Care Organizations, acting on the Department's behalf, send recipient verifications to recipients that have received services from various provider types. While the Department does not send verifications to recipients of services of the same provider types the managed care organizations send, the Department focuses its efforts on high risk fee for service providers. The Department believes the combined effort is in compliance with the federal regulation to have a method of verification. The Federal Medicaid Program Integrity auditors review compliance with this regulation every three years. While, the Federal auditors found the Department out of compliance in previous years, the Federal auditors did not find the Department out of compliance with this regulation in the most recent program integrity reviews issued in 2012 and 2015.

Auditors' Comment: As discussed in the finding above, the State must have a method for verifying with recipients whether services billed by providers were received. We do not believe the federal regulations permit the State to exclude more than 50% of the Medicaid expenditures from these verification procedures.

Updated Response: Not Accepted. The Department has a method for verifying with recipients whether services were billed. Approximately 75% of the Medicaid recipients and 55% of the federal expenditures are within managed care. Managed Care Organizations conduct verifications as part of their contractual agreements. With the increase of recipients and federal expenditures related to Managed Care Organizations, the Department will increase its coverage of the services billed.

17-19. The auditors recommend DHFS review its current process for monitoring agencies operating Home and Community-Based Waivers to ensure monitoring is in accordance with the federal regulations. (Repeated-2012)

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

The Illinois Medicaid program, as administered by DHFS, currently has nine federally approved home and community-based waiver programs. Eight of the nine waivers are operated by another State agency. The federal Centers for Medicare and Medicaid Services (CMS) holds DHFS, as the Single State Medicaid agency, responsible for oversight and monitoring of the nine federally-approved home and community-based waiver programs operated by the State. To ensure compliance with these federal requirements, DHFS contracts with a Quality Improvement Organization (QIO) to independently perform onsite participant level review activities. In FY17, the QIO conducted 1,593 Record Reviews at 107 different site locations.

Following each on-site review, DHFS sends the other state agencies a letter notifying them of the deficiencies identified, with a request to respond within 60 days with plans for individual and systemic correction. During the review of monitoring procedures performed by DHFS, the auditors noted DHFS selects a sample of on-site provider reviews with deficiencies to validate corrective action plans were implemented and that deficiencies were remediated. However, the auditors noted the on-site provider reviews performed by DHFS in FY17 were selected based upon the proximity of the providers location to available monitoring personnel and did not take into consideration the severity of the deficiencies identified.

In discussing these conditions with DHFS officials, they stated that they believe the current monitoring of agencies operating home and community-based waivers meets federal requirements.

Response: Implemented. The Department accepts the recommendation but believes its current monitoring of agencies operating home and community-based waivers meets federal requirements. Federal CMS requires that DHFS retain administrative authority and responsibility for the operation of the waiver programs by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies and contracted entities. Federal requirements do not specify how the State Medicaid agency samples records chosen for individual remediation verification. Additionally, DHFS is conducting oversight of the operating agencies monitoring of deficiency remediation. As the operating agency is charged with ensuring that 100% of the deficiencies are remediated, the provider locations and severity of deficiency "sampled" by HFS becomes less significant.

17-20. The auditors recommend DHFS follow its established policies and procedures to ensure access to its information systems are adequately secured. (Repeated-2015)

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

The information technology applications that support the DHFS major programs include the *Programmatic and Administrative Accounting System (PAAS)* – serves as the financial accounting database, *Medicaid Management Information System (MMIS)* – serves as the main system used to process the State's Medicaid activities, *Key Information Delivery System (KIDS)* – serves as the child support system that processes benefit claims for children's healthcare.

During testwork over user access to the State's network and DHFS' applications, the auditors noted the following:

- 22 terminated employees (out of 25 tested) did not have their user access removed timely.
- Three individuals (out of 25 tested) did not have evidence that annual user access reviews were performed during FY17.

During testwork over changes made to the Key Information Delivery System, the auditors also noted DHFS was not able to generate a list of changes made to the System.

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

In discussing these conditions with DHFS officials, they stated the access review process is still limited to the annual performance review process that were not always being performed timely.

Response: Accepted. Access control processes and procedures for DHFS currently in place, are being reviewed and revised to accommodate the changing IT structure in Illinois. Created under Executive Order 16-01, Illinois is currently in the process of modernizing technology by consolidating IT resources and IT services under a single agency, the Department of Innovation and Technology (DoIT). The Agency will continue to collaborate with DoIT in remediation efforts.

17-21. The auditors recommend DHFS establish procedures to ensure the results of single audit report reviews are communicated to its subrecipients on a timely basis.

Finding: DHFS did not communicate the results of its review of single audit reports received from its subrecipients for the Child Support Enforcement (CSE) program on a timely basis.

Subrecipients who receive more than $750,000 in federal awards are required to submit a single audit report to DHFS. DHFS is responsible for reviewing these reports and working with program personnel to issue management decisions on any findings applicable to DHFS programs.

During the review of a sample of single audit desk review files for 16 subrecipients (with expenditures over $5 million), the auditors noted DHFS did not notify four subrecipients (with expenditures totaling $3 million) of the results of single audit desk reviews within six months of acceptance of the single audit report. Delays ranged from 9 to 24 days after the required timeframe.

In discussing these conditions with DHFS officials, they stated Department practice has been to send management decision letters even when they are not required. The four subrecipient audits were reviewed timely; however, a delay in notification that the subrecipients did not have any DHFS specific findings was due to an oversight.

Response: The Department respectfully disagrees with this recommendation because it believes the Department is in compliance with Federal regulations. 2 CFR 200.331(d)(3) states that pass-through entity monitoring of the subrecipient must include "(3) Issuing a management decision for audit findings pertaining to the federal award provided to the

subrecipient from the pass-through entity as required by 2 CFR 200.521 Management decision". 2 CFR 200.521(d) *Time Requirements* states that "The Federal awarding agency or pass-through entity responsible for issuing a management decision must do so within six months of acceptance of the audit report by the FAC" (Federal Audit Clearinghouse). Department practice has included sending management decision letters in instances that are not required; however, Federal regulations only require letters be issued according to Federal timelines when there are specific findings related to DHFS programs. Federal regulations require the cognizant agency to report on cross-cutting findings. All single audit reports are reviewed by the Department prior to the formal issuance of the management decision letter. The reports in question in this audit had been reviewed an average of 102 days prior to the due date. The reports are reviewed to determine whether any audit findings affect DHFS programs. In the case of the reports noted, there were no reports that had findings related to DHFS programs specifically. The management decision letters noted as untimely during this audit were related to cross-cutting findings where DHFS was not the cognizant agency and were not even required to be sent. DHFS will update its procedures to coincide with Federal requirements.

Auditors' Comment: As stated in the finding above, it is DHFS' practice to issue management decision letters to all subrecipient's with findings and the control exceptions reported in this finding are due to an oversight. We noted subrecipients identified as control exceptions in this finding did have findings attributable to the Child Support Enforcement program and it is DHFS' practice to issue management decisions in this instance. This finding has been classified as a control finding given the exception pertains to management's process which applies to all of its subrecipients.

Updated Response: Implemented.

17-22. The auditors recommend DHFS implement procedures to ensure quarterly expenditure reconciliations are performed and completed in a timely manner and adjustments identified in the reconciliation process are made in a timely manner.

Finding: DHFS did not complete quarterly cash management reconciliations of cash draws to actual expenditures for assistance payments made under the Medicaid Cluster, CHIP, and Child Support Enforcement (CSE) programs timely or make adjustments identified as a result of these reconciliations in a timely manner.

Since cash draws are based on estimated expenditures for each quarter, the reconciliations identify the difference between the actual program expenditures and those estimates. The net cash position identified for each program in the quarterly reconciliation process is used to estimate the expenditures to be used for the next quarter's draws and to adjust future draws to ensure amounts drawn equal actual program expenditures.

During testwork, the auditors noted the first through third quarter reconciliations were not timely performed for all three programs and that draws for the CHIP, Medicaid Cluster, and

CSE programs were not adjusted for the quarterly net cash position identified in the reconciliations in a timely manner. The auditors noted the following differences in the review of the quarterly reconciliations of the CSE, CHIP, and Medicaid Cluster programs:

	Medicaid		CHIP		CSE	
Quarter	Over/(Under) Drawn Position	Date Reconciliation Completed	Over/(Under) Drawn Position	Date Reconciliation Completed	Over/(Under) Drawn Position	Date Reconciliation Completed
9/30/16	($66,205,264)	7/17/17	($99,551,194)	7/17/17	($3,966,160)	7/17/17
12/31/16	($341,257,240)	7/17/17	($34,579,458)	7/17/17	$22,715	7/17/17
3/31/17	$90,700,446	7/17/17	($68,143,673)	7/17/17	$1,554,588	7/17/17
6/30/17	$299,714,945	8/23/17	($31,146,273)	8/23/17	$1,421,305	8/23/17

In discussing these conditions with DHFS officials, they stated reconciliations were performed quarterly, but the final supervisory review was late due to staff participation in new IT development for MMIS and accounting systems.

Response: Implemented.

17-23. The auditors recommend DHFS establish procedures to accurately report federal expenditures (including amounts passed through to subrecipients) used to prepare the SEFA to the IOC.

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

	Amount per DHFS' Records	Amount Initially Reported to the IOC	Difference
Federal expenditures	$10,176,779,000	$10,218,833,000	($42,054,000)
Amounts passed through to subrecipients	52,440,000	52,454,000	14,000

Upon further review, the auditors noted the error in the reported federal expenditures was the result of the miscalculation of Medicaid Cluster expenditures made by the Illinois Department of Human Services (IDHS) which was detected during the IDHS departmental financial statement audit. Although the differences identified above are not quantitatively material to the SEFA as a whole, the State does not have a process in place to evaluate items of this nature outside of the audit process. Accordingly, an error which may be material

to the SEFA (in either quantitative or qualitative terms) could occur and not be detected by the State.

In discussing these conditions with DHFS officials, they stated expenditures were reported consistent with prior years' methodology. An audit adjustment to the Illinois Department of Human Services departmental financial statements resulted in the expenditure difference. The difference in the amounts passed through to subrecipients was a human calculation error.

Response: The Department accepts the recommendation. Department officials notified both IOC and Office of the Auditor General (OAG) of these differences, but both entities passed on making further adjustments due to timeliness and materiality. As stated above, DHFS reported the Medicaid Cluster expenditures consistent with prior years' methodology and believes our process would not result in undetected material errors.

Auditors' Comment: The considerations made by DHFS and the IOC relative to the error identified in this finding were in relation to the State's financial statements, not the SEFA. The error identified was not evaluated by State management outside of the audit process related to the SEFA.

Updated Response: Accepted. As the state Medicaid agency, HFS assumes the responsibility for reporting the Medicaid cluster amounts on the SEFA, even though HFS is not the grantee or program agency for a majority of the programs in the Medicaid cluster. The amounts reported for the Medicaid program include expenditures from other state agencies. Sometimes adjustments are made by other state agencies very late in the process and therefore HFS elects to not adjust the SEFA.