

# LEGISLATIVE AUDIT COMMISSION



Review of  
Department of Human Services  
Two Years Ended June 30, 2009

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**REVIEW: 4349**  
**DEPARTMENT OF HUMAN SERVICES**  
**TWO YEARS ENDED JUNE 30, 2009**

**FINDINGS/RECOMMENDATIONS - 39**

**ACCEPTED - 30**  
**IMPLEMENTED - 9**

**REPEATED FINDINGS - 20**  
**PRIOR RECOMMENDATIONS - 31**

This review summarizes the reports on the Department of Human Services for the two years ended June 30, 2009, filed with the Legislative Audit Commission on June 29, 2010. The auditors performed a financial audit and compliance examination in accordance with *Government Auditing Standards* and the Illinois State Auditing Act. The auditors stated that the financial statements were fairly presented. Compliance audits for the Department's 21 facilities were performed and appear in separate reports.

The Illinois Department of Human Services was created in 1997 and consolidated the Departments of Alcoholism and Substance Abuse, Mental Health and Developmental Disabilities, and Rehabilitation Services, along with the client-centered services provided through the Department of Children and Family Services, Public Aid and Public Health. Its primary mission is to assist Illinois residents to achieve self-sufficiency, independence and health, to the maximum extent possible, by providing integrated family-oriented service, promoting prevention and establish measurable outcomes, in partnerships with communities. The Secretary of the Department during the audit period was Dr. Carol L. Adams. Dr. Adams resigned from the Department effective October 31, 2009. Michelle Saddler served as Secretary of DHS from October 11, 2009 until August 24, 2010. Thereafter, Grace Hong Duffin served as Acting Secretary from August 26, 2010 to December 13, 2010. Then Michelle Saddler was again appointed Secretary, and is still currently serving in that position.

The number of employees by division at June 30 was:

<b>Division</b>	<b>FY09</b>	<b>FY08</b>	<b>FY07</b>
Administrative Services	740	814	777
Community Health and Prevention	181	191	204
Human Capital Development	9	162	128
Disability & Behavioral Health Services	10,981	9,715	9,803
Community Operations	1,877	3,468	3,406
<b>TOTAL</b>	<b>13,788</b>	<b>14,350</b>	<b>14,318</b>

## **Service Efforts and Accomplishments**

Appendix A provides a summary of the Department's service efforts and accomplishments for the years ended June 30, 2009 and 2008, in all major divisions: Developmental Disabilities; Mental Health Services; Rehabilitation Services which included Vocational Rehabilitation, Home Services, Disability Determination Services and Specialized Services; Alcohol and Substance Abuse; Community Health and Prevention; and Human Capital Development, which now includes TANF, Child Care, Food Stamps, Homeless Shelter Program and Supportive Housing Services, Programs for Refugees and Immigrants and Title XX-Social Services Block Grant.

## **Expenditures From Appropriations**

The General Assembly appropriated \$5,345,581,000 to the Department in FY09, an increase of about \$395.8 million, or almost 8%, over FY08. The Department received the third largest appropriation in the State budget for the FY09 budget year, behind the Department of Healthcare and Family Services and the State Board of Education. Total expenditures (including expenditures from non-appropriated funds) were \$4,897,854,000 in FY09 and \$4,697,858,000 in FY08, an increase of almost \$200 million, or 4.2%.

According to the audit report, there was a \$194 million spending increase for awards, grants, lump sums and other purposes. Some of the more significant changes were as follows:

- \$61 million increase for the Home Services Program in GRF,
- \$56.1 million increase for Developmental Disabilities grants-in-aid and purchase of care in the Community DD and HHS Medicaid Trust Funds and the Budget Relief Fund,
- \$36 million increase for Distributive Items in GRF,
- \$19.8 million increase for Community Health in the WIC Fund,
- \$11.2 million increase in Community Youth Services in the Early Intervention Fund, and
- \$9.3 million increase for Employment and Social Service Program.

Appendix B presents a summary of appropriations and expenditures by fund for FY09, FY08, and FY07. Appendix C presents a summary of expenditures by major object code for FY09-FY07. Lapse period expenditures were almost \$275 million or 5.8% in FY09.

## **Cash Receipts**

The Department's cash receipts increased about \$2.7 million, or about 0.14%, from \$1,898 million in FY08 to \$1,896 million in FY09. Some of the changes are the result of funding shifts such as shifting funds million for TANF, Food Stamps and Child Care out of the DCFS Children's Service Fund and the Social Services Block Grant Fund into GRF, the

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Employment and Training Fund and the Special Purposes Trust Fund. Other changes are due to timing of federal grants awards, and the timing of draw downs and transfers.

Appendix D provides a summary of the Department's cash receipts.

### Property and Equipment

Appendix E provides a summary of property and equipment for which the Department's Central Office was accountable during FY09 and FY08. The value of the Central Office's property and equipment was \$85,049,570 at June 30, 2009.

### Accounts Receivable

Appendix F provides a summary of accounts receivable for FY09 and FY08. The Department's net accounts receivable totaled \$234,828,000 as of June 30, 2009. About \$187 million in receivables is due from the Federal Departments of Human Services, Agriculture, Education and the Social Security Administration. Other receivables – net include an allowance for uncollectibles of \$459 million for FY09 and \$453 million for FY08.

### Accountants' Findings and Recommendations

Condensed below are the 39 findings and recommendations included in the audit report. There are 16 previous findings from past reports. The following recommendations are classified on the basis of updated information provided by Matthew Grady, Director of Fiscal Services, in a memo received via email on April 14, 2011.

#### Accepted or Implemented

- 1. Implement procedures and cross-training measures to ensure GAAP Reporting Packages are prepared in a timely, accurate and complete manner, to include allocating sufficient staff resources and the implementation of formal procedures to ensure GAAP financial information is prepared and submitted to the Office of the Comptroller in a timely and accurate manner, and that all supporting documentation is maintained in a contemporaneous manner.**

**Finding:** The Department of Human Services' (Department) year-end financial reporting in accordance with generally accepted accounting principles (GAAP) to the Illinois Office of the Comptroller was not timely and contained numerous inaccuracies and errors which resulted in changes being made to originally submitted information. During the audit of the June 30, 2009 Department financial statements, the following exceptions were noted:

**Accepted or Implemented – continued**

- GAAP reporting packages were not submitted to the Comptroller in a timely manner. GAAP reporting packages were due to the Comptroller on September 11, 2009, but the final packages were not submitted until September 25, 2009. Due to discussions and communication between the Department, Comptroller, and other State agencies and universities, certain forms within the submitted GAAP reporting packages did not receive the Comptroller's final review until February 24, 2010 and the final draft of the financial statements, after adjustments, was provided to the auditors on April 7, 2010, approximately six months late.
- GAAP reporting packages contained numerous inaccuracies and required corrections which delayed audit testing of the financial statements and the Schedule of Expenditures of Federal Awards prepared by the Department. As of April 8, 2010, the Department was still communicating corrections to the auditors that had been discovered in the preparation of the GAAP packages requiring revisions to financial reporting.
- The final draft of the financial statements provided to the auditors on April 7, 2010 did not contain a Department prepared litigation footnote. GAAP requires disclosures regarding significant litigation involving the Department which could effect the financial statements.
- The reconciliation for the Vocational Rehabilitation Fund contained a reconciling amount of \$27.3 million which was not explained. The original reconciliation was dated January 25, 2010. The auditors received the final version of the reconciliation on March 18, 2010 which reduced the reconciling amount significantly to \$116 thousand.
- When reconciling the current year expenditures for the Child Care Cluster, auditors noted the total cash basis expenditures recorded between the General Revenue Fund and the DHS Special Purposes Trust Fund was less than the federal expenditures reported for the State-wide Single Audit. The deficiency of \$10.4 million was due to a miscalculation. The Schedule of Expenditures of Federal Awards (SEFA) was revised as result of the miscalculation.
- During testing of the USDA Women, Infants and Children Fund, it was noted no sub-recipient amounts were included on the original SEFA or the Grant/Contract Analysis Form (SCO-563). Sub-recipient payments for the program totaled \$206 million. The Department did not provide the supporting documentation for the sub-recipient amount until April 8, 2010. The SEFA and the SCO-563 were revised to include the omission.

Department management attributed the noted weaknesses to the lack of sufficient staff in the general accounting unit. Due to understaffing in the general accounting unit, the Department contracted with consultants to provide GAAP reporting assistance. The

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consultants were responsible for preparing 16 of the 57 Department GAAP reporting packages. Even with utilizing a consultant for assistance, delays and errors occurred.

### **Updated Response:** Corrective action to be implemented:

- Perform reconciliation procedures to ensure beginning balances are properly stated.
- Develop procedures to ensure Form 563 is properly stated to account for held-vouchers at the Illinois Office of Comptroller.
- DHS has identified those component units or other State agencies deemed to be high risk. These are the component units and State agencies that have historically been late or otherwise problematic with financial reporting. These entities deemed high risk will be required to reconcile quarterly subrecipient expenditures with DHS.
- A new class of accounting positions will be sought to be created by CMS. These positions will help ensure DHS hire only those individuals that possess the requisite training and experience related to GAAP reporting.

## **2. Continue strengthening the oversight function related to commodities to allow for improved internal controls. Additionally, implement a standardized system to perform periodic counts. (Repeated-1999)**

**Finding:** The Department does not maintain an adequate oversight function over commodities. Inventory control includes responsibilities at individual facilities, multiple warehouses, and Central Office locations.

Audit testing performed at various locations including warehouses, facilities, schools, and centers, identified several exceptions and weaknesses over commodities inventories. The following inventory problems were noted during testing:

- Sixteen facilities failed to perform a complete year-end physical inventory count or the count was not conducted in close proximity to the end of the fiscal year.
- Weaknesses in segregation of duties for annual inventory counting were noted at four of twenty-two locations.
- At four facilities, the auditors were not able to reconcile counts to the inventory system.
- The Department's Warehouse Control System (WCS) does not allow the system user to readily review the purchase history of items to ensure the commodities are accurately priced under the average cost method.

**Accepted or Implemented – continued**

- The Department had several errors on the Summary of Commodity Control System and Other Inventories, which was used to reconcile to the inventory balance reported for year end financial reporting purposes:

The Department stated they have established a centralized oversight for commodities; however, staffing shortages and the outdated system continue to contribute to the weaknesses noted for commodity inventories.

**Updated Response:      Corrective action implemented as of 3/01/2011:**

- In an effort to have adequate control over commodities Office of Business Services (OBS) issued instructions to DHS facilities regarding the need for segregation of duties during the actual inventory process. This exercise was fully implemented by June 7, 2010.
- OBS worked with staff of the various stores at the facilities to assure that data entered into the Warehouse Control System (WCS) is accurate with regard to unit price.
- Fiscal Services provided necessary assistance to Business Services concerning the data requirements from the Inventory Systems for GAAP reporting purposes.

**Corrective action to be implemented:**

- Apart from working with the staff of the various stores and warehouses OBS will develop an RFP for a new Inventory Control system to improve centralized oversight for commodities.
- OBS is still in the process of purchasing a new Inventory Control system.

- 3. Ensure Commodity Control System (CCS) users have access to all necessary information required to manage inventories. In addition, upgrade the CCS or implement a new system that includes a real-time inventory system with capabilities to access current inventory levels so all inventory unit costs are properly recorded. Perform periodic testing of the CCS or an upgraded system to determine if the system is properly calculating inventory values. (Repeated-2005**

**Finding:** The Department's Commodity Control System (CCS) is a batch entry system developed over 30 years ago that does not allow users real time inventory controls regarding inventory management and purchasing. The CCS is utilized for inventory at all mental health and developmental centers and for the Bureau of Pharmacy and Clinical Support Services pharmaceutical warehouse. The CCS had an inventory balance of approximately \$7.1 million at June 30, 2009.

Auditors identified six of 20 items tested had recorded values that varied from supporting documentation by more than 5%.

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Auditors performed inventory test counts on Monday, June 29, 2009. Since the CCS only provides for a weekly report, which is run on Sunday nights, actual quantities of stock are not readily available at any given time. Actual inventory counts are not taken on a regular basis at all locations; therefore, any errors throughout the year would not be detected for some time.

The Department counted their annual inventory for all stores from June 15<sup>th</sup> to June 22<sup>nd</sup> as opposed to June 30<sup>th</sup> which is the fiscal year end. The Department should have counted all inventory in its stores on June 30<sup>th</sup> in order to ensure that inventory was properly stated at the year end.

Department personnel stated they posted a Request for Information (RFI) to investigate the affordability of a new inventory system. Based on vendor responses, Department personnel stated they planned to issue a Request for Proposal for a new system at the end of fiscal year 2010.

### **Updated Response:      Corrective action implemented as of 3/01/2011:**

- A decision memo was drafted and sent to the Executive Leadership Team on 9-15-10 for a review. Discussions between OBS and OCAPS have taken place for funding the projects.
- The Decision Memo (DM) has been completed and approved by the Executive Leadership Team. Evidence of discussion between OBS and OCAPS can be found in the financial section of the DM.

Corrective action to be implemented:

- The Department will continue the process of obtaining a new Asset Management system.

### **4. Review and revise, as necessary, the current system of gathering property control information to improve the accuracy of property system records and devote necessary personnel to these tasks. (Repeated-2007)**

**Finding:** The Department's capital asset GAAP Package Forms contain several accounts that are not supported by the Department's capital asset accounting records.

Department officials stated if additions, deletions, or net transfers are unknown, then the overall net change is used to get to an ending balance that agrees to the Department's property and equipment records. Department records do not always readily reflect the components of addition, deletions, and net transfers.

**Response:** Accepted. The Bureau of General Accounting requested and was provided a report from Department Management Information Services (MIS) that provides property and equipment records inclusive of additions and deletions for GAAP Capital Asset Reporting.

**Accepted or Implemented – continued**

General Accounting will review fiscal year 2009 reports (provided by MIS) to ensure accuracy and completeness. If the report needs to be changed, General Accounting will communicate the changes to MIS. General Accounting will request MIS to run applicable fiscal year 2010 capital asset reports (if fiscal year 2009 reports are deemed accurate) for GAAP reporting. Staff is currently reviewing the MIS provided reports to ensure that they can be used for fiscal year 2010.

**Updated Response:      Corrective action to be implemented:**

- The Capital Asset report needs final revisions to ensure it is complete and accurate.
- The quarterly Form C-15 should present additions, deletions, or transfers based upon information that agrees to the Capital Asset

**5. Continue efforts to recertify Tinley Park Mental Health Center. Also, seek final resolution of issues related to Howe Developmental Center so as to limit the amount of revenue being lost to the State. (Repeated-2007)**

**Finding:** Two of the Department's facilities, Howe Developmental Center and Tinley Park Mental Health Center, continued to remain decertified during FY09 due to failure to comply with requirements to be certified as eligible Medicare or Medicaid service providers.

As a result of the decertification, Howe could not bill or be reimbursed for certain services and has been scheduled for closure with a potential closure date of June 30, 2010. This will mean that nearly 265 patients will need to be transitioned to suitable facilities and 760 employees could potentially lose their jobs or be transferred to a new work location. Department management estimated there is a continuing loss of revenue for this center of approximately \$30 million annually as a result of the decertification.

Tinley Park, which was decertified on February 23, 2007, had applied for its recertification with the CMMS. A three day certification survey was completed on September 16, 2009. On October 21, 2009 CMMS issued their report ruling that Tinley Park remained out of compliance with "Special Conditions of Participation" and that the facility remain decertified. The Department disagreed with the CMMS report and filed an appeal on December 16, 2009 and is currently awaiting final review and ruling on the decertification.

As of June 30, 2009, Tinley maintains housing for only two Medicare/Medicaid patients. The Department stated patients were not transferred to other facilities during the fiscal year and estimated only \$75,000 in revenue was lost due to the continued decertification for 2009.

**Updated Response:**      Corrective action implemented as of 3/01/2011:

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### Howe:

- In an effort to reduce the amount of revenue lost in the General Revenue Fund, the Center, in FY10 (year-to-date 2/25/2010) has facilitated 62 community transitions and 170 State Operated Developmental Center transfers to restore FFP lost revenue.
- In order to further reduce the amount of revenue lost in the General Revenue Fund, the Howe center in FY10 facilitated 75% community transitions and 187 State Operated Developmental Center transfers to restore FFP lost revenue.
- Howe has followed the developed corrective action regarding transferring patients and staff. The closure of Howe is 100% complete. As of June 21, 2010 no individuals resided at the Howe Center.

### Tinley Park:

- The facility continues to monitor the "Currency of discharge summaries" and "Use of interpretive and translation services for Limited English Proficient (LEP) clients". Monthly outcomes fluctuate ranging from a high of 100% to a low of 83%.
- The facility continues to monitor Treatment Plans. Monthly outcomes fluctuate ranging from a high of 100% to a low of 83%.
- The facility continues to monitor the Maintenance of group schedules and increase client participation in scheduled groups. A computerized monitoring system has been developed and implemented.
- An October 2010, consultation meeting has been scheduled with CMS. The purpose of the meeting is for CMS to discuss their findings and the rationale for them and for the facility to use this preparation for another survey.
- The facility had a Peer-to-Peer survey completed 12/08/10. Additional improvements in the treatment plan are needed. Discussions and activities toward continual improvements continue. Monitoring is done on a random sample. Information is used as needed to improve individual staff performance.
- Meeting was held in October 2010 as scheduled. Staff continues ongoing improvements in planning and delivery of psychiatric services.

### **Corrective action to be implemented:**

- The Division of Mental Health (DMH) is continuing its efforts to re-certify Tinley Park Health Center.

## **6. Establish a standard methodology and written procedures to analyze and calculate the estimated uncollectible percentages for the Recoveries Trust Fund (921 fund), and ensure estimated uncollectibles are fairly presented in a consistent manner.**

**Finding:** The Department does not update its calculations for uncollectible accounts receivable in a consistent manner for the DHS Recoveries Trust Fund (921 fund). The Department has no standard methodology or written procedures to calculate and report uncollectible accounts receivable. As a result, uncollectible accounts receivable calculations varied from \$407 million to \$440 million for 921 Fund at June 30, 2009. The

**Accepted or Implemented – continued**

auditors updated the analysis last performed in 2006, the results of which indicated estimated uncollectable accounts receivable would be approximately 92.5% (approximately \$428 million) at June 30, 2009.

**Updated Response: Corrective action implemented as of 3/01/2011:**

- The template has been standardized and is utilized by both the Cash Management Unit and the Collections Unit to calculate an estimated allowance for uncollectable account %. The Department of Collections, Illinois Office of Comptroller (IOC) and Fiscal collaborated and have come up with a template that involved various parties, including GAAP preparation.

**7. Ensure that children for which the State is assisting with child care costs are not placed in arrangements in which the provider or other members of the household are listed on the Sex Offender Registry. Specifically:**

- **Periodically match the addresses of child care providers with those addresses listed in the Illinois Sex Offender Registry; and**
- **Revise the Department’s application for assistance to include space to list all persons residing at the address where care will be provided.**

**Finding:** The Department’s Child Care Assistance Program (CCAP) provides low-income, working families with access to quality, affordable child care that allows them to continue working. Child care services in Illinois are provided through a system of government agencies, not-for profit agencies, regional resource and referral agencies, community child care facilities, and organizations representing the interests of children, families and providers. Participants choose the child care provider. Parents can use licensed or license-exempt child care centers, family homes, licensed group child care homes, in-home and/or relative care. Parents that participate in the program share in the cost of the child care in the form of a co-payment.

**Sex Offender Registry Match**

The Department’s rules require that payments will not be made to a provider (even if operating within a setting exempt from licensing) who has been convicted of crimes enumerated in 89 Ill. Adm. Code 385. Also, payments will not be made to a provider (*even if operating within a setting exempt from licensing*) if anyone resides in a family home in which a child care facility operates who has been included in the Illinois Sex Offender Registry or convicted of committing or attempting to commit a variety of serious criminal offenses.

Auditors matched the addresses of these providers with the addresses of sex offenders contained in the Illinois Sex Offender Registry maintained by the Illinois State Police as of

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November 18, 2009. Ninety instances were identified in which a Department child care provider's address matched an address of a registered sex offender.

Simply because there is a match in addresses does not mean there was a sex offender living at the location where child care was being provided. However, one of the 90 matches was an actual provider who was listed in the Illinois Sex Offender Registry for Aggravated Criminal Sexual Assault. He received two payments in fiscal year 2009 for a total of \$187.69.

For the other 89 addresses that matched, an individual listed in the Illinois Sex Offender Registry had the same address as the provider. According to Department officials, 59 of these 89 providers were no longer providing services. For these 59 cases, the Department entered into its provider database that a sex offender is registered as living at the provider's address. In six other cases, the address of the provider was different than the address in the matched data.

Of the remaining 24 providers, the Department reported:

- 21 providers were related to the children for whom they provided care, and
- three providers were not related to the children.

According to Department officials, the Department has no authority to investigate anyone but the child care provider. Systems were not in place to routinely match to the Sex Offender Registry. Officials stated that according to Department Legal Counsel, they cannot stop payment to these providers. The Department has sent letters to the parents of the children involved notifying them that a sex offender is listed at the same address for these 24 cases. The letter notifies the parent and allows them to check a box if they were aware that a sex offender lived at the provider's address and whether they want to continue care. The Department also sent letters to the providers asking them to certify whether or not a sex offender lives in the home where care was being provided.

### **Public Act 96-632**

Effective August 24, 2009, Public Act 96-632 established a criminal history record checks task force to review and make recommendations to create a more centralized and coordinated process for conducting criminal history record checks. The task force is required to provide a plan to revise the criminal history record checks process to the General Assembly by January 1, 2011. The Department is required to have a representative on this task force. The Department is also required to promulgate rules to set standards for determining when to disqualify an unlicensed child care provider for payment.

**Accepted or Implemented – continued**

**Updated Response: Corrective action implemented as of 3/01/2011:**

- The addresses of the child care providers are periodically matched with those addresses listed in the Illinois Sex Offender Registry.
- DCFS has already implemented this process by matching provider addresses with the Illinois and National Sex Offender Registries for licensed exempt providers based on an intergovernmental agreement with the Department.
- The Department has completed changes to the application and it has been sent to Forms Control.

**Corrective action to be implemented:**

- In an effort to keep accurate information regarding Illinois Sex Offenders Registry the Department is continuing to work on changes to the application to include space to implement background checks on license-exempt where all persons residing at the address where care will be provided.

**8. Strengthen internal controls over the payment of child care funds for school aged children. Specifically:**

- **Ask parents and guardians to disclose whether school age children attending private or parochial schools for care are attending classes with the provider.**
- **Verify for providers receiving full-time reimbursement that the hours in care do not include the school day.**
- **Ensure that providers keep appropriate documentation to show the hours in care.**
- **Seek reimbursement from those providers that were determined to have received overpayments.**

**Finding:** According to Department policy, school age children attending a private or parochial school are not eligible for child care assistance to cover the cost of tuition.

The Department provided a download of school age children that received full-time child care assistance during fiscal year 2009 for certified providers. Full-time care is defined as five hours or more of care during each day. The download provided by the Department contained 80,597 payments for a total of \$37,387,992 in payments for fiscal year 2009.

A sample of 25 payments to providers for school aged clients receiving full-time reimbursement was selected for testing. The following exceptions were found as a result of testing procedures performed:

- Four cases were identified in which a school age child attended a private or parochial school and the Department paid full-time reimbursement when part-time

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reimbursement should have been used. These four cases totaled \$2,330. The school may have used this overpayment to cover the cost of tuition. The Department and the Child Care Resource and Referral (CCR&R) do not ask the parent or guardian to disclose on the application whether the child is attending school at the provider.

- For six other cases, auditors could not determine whether funding was used for tuition or whether reimbursement should have been part-time or full-time because report cards, attendance records, or sign-in/out sheets could not be obtained. These six cases totaled \$3,139. In one case, there was a flood and records could not be obtained. In another, the provider had moved and was operating under a different name and records could not be obtained. For the remaining four providers, one provided sign-out sheets but no sign-in sheets, one provided a report card but no sign-in or sign-out sheets, and two provided no documentation. Providers are not required to submit documentation of time in care to the CCR&R or the Department as part of the payment process. However, without this documentation, the Department cannot ensure that providers are receiving appropriate reimbursements.

Department management stated the cause of the finding is partially oversight and partially human error. Many school age children are eligible for full time care and the Department was not asking enough specific questions about their daily arrangements to adequately determine this in all cases. Department management noted they have now implemented some controls to strengthen its internal controls over the payment of childcare funds for school aged children.

### **Updated Response:      Corrective action implemented as of 3/01/2011:**

- The Department has added the following questions to the child care application:
- Does your child attend school at the same location as your child care provider?
- What hours is your child in school?
- In order to ensure that all necessary information are in the childcare application a provider certification statement was added to the childcare application that says, "I certify that the hours of child care do not include hours the child is in school."
- For the purpose of proper accountability the Department has implemented a process to issue overpayment notice to the providers.

**Accepted or Implemented – continued**

- 9. Follow through and adhere to the Memorandum of Understanding concerning plans to convert to fee-for-service framework. Also, administer contracts in accordance with the terms agreed to with the vendors and documented in writing.**

**Finding:** The Department's Division of Mental Health is in the process of converting from grant based payments to fee-for-service payments to providers of mental health services. During testing, auditors noted numerous weaknesses in this conversion process.

A consultant hired by the Department during FY05 recommended that, due to understaffing and inadequate information technology capability, the Department contract with an administrative service organization (ASO) to implement the conversion process. Department management stated the goal of the conversion was to encourage productivity, efficiency, accountability, improve mental health services, and maximize federal funds earned. The Department continued to contract with the original consultant as well as the ASO and the University of Illinois at a total cost of \$17,306,997 during the engagement period

Auditors noted the following weaknesses with the conversion process and the related contracts.

- The fee-for-service conversion is not complete. Planning began during fiscal year 2005. One consultant estimated the conversion could be in place by July 1, 2007 if the Department adhered to procurement timelines and implementation timeframes. Department officials noted necessary staffing resources were not available in time to move to fee-for-service on July 1, 2007.
- There was no substantiation for payment of \$157,000 to the ASO to implement fee-for-service. Auditors noted a contract for FY08 included a provision for \$157,000 to be paid to the contractor for "amortized expenses. Due to the lack of documentation, auditors were unable to determine the nature of these costs.
- The final payments to the ASO for FY08 and FY09 were processed prior to a final review of performance measurements. The Department subsequently noted it overpaid the ASO \$1,785,185 for FY08. The Department notified the ASO of the overpayment on September 25, 2008 and that the overpayment would be applied toward FY09 contract payments. However, the ASO responded that it would retain this amount for other contract services that it was not able to complete for FY08 due to the late start of the initial contract. Enhancements that had not been detailed on the original deliverables' timeline also were to be funded by this overpayment in FY09. As a result, the ASO was prepaid for services that were not completed until the subsequent fiscal year.

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- The Department failed to timely withhold \$101,557 for the ASO's failure to meet performance standards established by contract for fiscal year 2008. The amount was to be withheld 50% from each of the first two payments (July 2008 and August 2008) for fiscal year 2009; however, the amount was not withheld until March and July 2009. In addition, when the amount was withheld during July 2009, the Department erroneously withheld the entire amount rather than only 50%. The other half had already been withheld during March 2009. This amount was to be netted against the \$1.7 million overpayment.
- The ASO did not provide contract deliverables on a timely basis. These deliverables included a monitoring plan and work plan. Six deliverables were submitted from four to 52 days late. Many deliverables had to be carried over to FY09 due to the delayed delivery of specific information from the Division of Mental Health.
- Auditors noted two retired Department employees who went to work for the ASO and one retired employee who went to work for the consultant who hired the ASO. One employee had a final pay of approximately \$50/hour when he retired from the Department, but was reimbursed 96 hours at \$125/hour by the consultant paid by the Department.
- The Department entered into agreements with the University of Illinois to hire retired Department personnel who had been instrumental in the conversion process or who were involved in the contracting process to hire the ASO. The Department paid the U of I \$234,052 and \$242,422 in fiscal years 2008 and 2009, respectively, directly related to the fee-for-service conversion process. Outside of subcontracting with former retired Department employees there did not appear to be a substantive purpose for utilizing the U of I for these agreements (see also finding 09-10).
- Payments to the ASO, the U of I and the consultant were paid from awards and grants appropriations. Paying the ASO from the same appropriations used to pay providers has had the effect of reducing the funds available to providers.

Department personnel stated the weaknesses over implementing fee-for-service conversion is primarily due to inadequate staffing. The objectives in implementing fee-for-service assumed staffing levels that the Department has been unable to maintain primarily due to lack of funding.

### **Updated Response:      Corrective action implemented as of 3/01/2011:**

- The Fee-for-Service conversion was completed in FY 2011. Beginning in FY 2012 Fee-for-Service billings will be paid directly by the Department of Healthcare and Family Services.
- The Department no longer uses the contracts through the University of Illinois to provide assistance with the conversion.
- The ASO contract is scheduled for re-bid in FY2012 with a revised scope of work that eliminates the need for Fee-for-Service conversion.

Accepted or Implemented – continued

**10. Discontinue the practice of contracting with the U of I, or any entity, to hire former retired Department employees and follow the established contracting processes.**

**Finding:** The Department entered into agreements with the University of Illinois (U of I) without substantive purpose other than what appeared to be to avoid the requirements to competitively procure those types of services. Weaknesses noted included the following:

- Retired Department of Human Services (Department) employees were hired by the U of I as subcontractors to work on various Department projects. Because of this arrangement, there is potential for the retired former employees to work more than the legislatively mandated 75 day maximum while receiving State pension benefits.
- The Department incurred \$226,728 of additional indirect costs by utilizing the U of I for these agreements versus contracting with the subcontractors itself.
- By utilizing the U of I, the Department did not follow its normal contracting processes for competitive procurement of these types of services in accordance with the Illinois Procurement Code.

As part of the contractual agreements the Department paid a 10% administrative fee (indirect cost) to the U of I to administer the contractual agreements. Totals paid by the Department to the U of I under these agreements were as follows:

	<u>FY 2008</u>	<u>FY 2009</u>
Base payments	\$ 677,273	\$ 1,590,004
Indirect costs (10% administrative fee)	<u>67,727</u>	<u>159,001</u>
Total	<u>\$ 745,000</u>	<u>\$ 1,749,005</u>

Auditors noted 23 subcontracts with vendors or former employees under the U of I agreements in excess of \$20,000. The Department has a formalized process for obtaining Professional & Artistic services in compliance with the Code. However, contracts between State agencies are exempt from the Code. By utilizing the U of I to subcontract for these services, the Code and all of the Department's contracting processes are circumvented.

Department personnel stated since contracting with state universities are exempt from the procurement code, the Department views these contracts as not circumventing the contracting process.

By utilizing the U of I to hire these subcontractors, the Department loses direct control over subcontractors working on Department projects. It also incurred \$226,728 in additional administrative costs it would not have incurred had the Department contracted with these subcontractors itself. The Department also indirectly avoided the requirement to

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competitively procure these types of services by utilizing U of I to hire the subcontractors. In addition, the Department was unable to ensure retired employees working as subcontractors did not exceed the mandated maximum allowed days to work for the State and draw their pension benefits.

### **Updated Response:      Corrective action implemented as of 3/01/2011:**

- The Department discontinued the practice of hiring retired state employees on contract with the University of Illinois. Any hiring follows established personnel procedures of the State of Illinois.

**11. Require providers to report only grant related expenditures by individual program on the Grant Report submitted as a part of their financial reporting package. Do not show Medicaid and Non-Medicaid expenditures on the Grant Report. In addition, expenditures should be reconciled by Department personnel who are tracking payments to Mental Health providers. Also, compare the payments to the providers' Medicaid approved billings to identify lapse payments more effectively.**

**Finding:** The Department lacks adequate procedures for reconciling payments to providers for mental health services.

In order to aid the Department in reconciling payments made to providers, providers must submit various reports depending on the amount and types of services or programs for which they receive payments. Near the end of the fiscal year, the Department sends out a notice of the reporting requirements to each provider. The reporting requirements include a Consolidated Financial Report (CFR) and/or a Grant Report.

However, the notice sent by the Department to providers listing which programs were to be reported on the FY08 Grant Reports did not list the individual programs to be reported. Instead the letters referred only to 'mental health programs'.

The Department made payments as grants to providers for Medicaid and non-Medicaid services that should have been made as fee-for-service payments. The Department made these grants due to weaknesses in its plan to convert funding to mental health providers to a fee-for-service basis (see finding 09-9). As a result, the Department is not reconciling these payments against the appropriate expenditures which should be accepted bills processed by the Department of Healthcare and Family Services (HFS) or its agent.

The Department sent out supplemental instructions for mental health service providers that the providers were not expected to separate Medicaid and non-Medicaid costs. These instructions contradict the terms of the attachment to the contract for these services which specifically require any surplus advances be reconciled based on expenses.

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In addition, the Department is not comparing grant funded expenditures reported by providers to grant advances paid to the providers in a consistent manner. The Department performs reconciliations by comparing total payments made to providers for mental health services (reduced by Medicaid approved billings as reported by HFS) to total expenses for all mental health services which are lumped together from the Grant Reports submitted by providers. The contract attachment requires the reconciliations be prepared for each individual program.

Department management stated the Department lacked adequate reconciliation procedures over mental health service payments. The Department, Office of Contract Administration (OCA) will send a memo to all program divisions, explaining which grant programs OCA will closeout and review the material to ensure consistency.

**Response:** Accepted. The Department, Office of Contract Administration (OCA) will send a memo to all program divisions, explaining which grant programs OCA will closeout and review the material to ensure consistency. OCA will also develop materials for Financial Reporting Packets and send each provider material on how to fulfill financial reporting. OCA will hold the Department, Division of Mental Health to same standards as all other divisions.

### **Updated Response: Corrective action implemented as of 3/01/2011:**

- Memo explaining which grant programs OCA will closeout was sent to all program division on 2/9/2011.

### **Corrective action to be implemented:**

- OCA will contact all DHS Divisions and Program Staff to ensure that all grants that need to be reconciled and closed out by OCA are identified.
- For the purpose of ensuring adequate reconciliation procedure over Mental Health service payments, the Department will review material to ensure consistency and also Develop materials for Financial Reporting Packets.
- Each provider will be sent material on how to fulfill financial reporting requirements.

## **12. Assess procedures (including all facility procedures) for safeguarding, retention and subsequent disposal of all confidential information and ensure compliance with all state and federal requirements.**

**Make procedures Department-wide and include procedures for properly disposing of confidential information (shredding is an acceptable method) including clearly defined procedures for disposing of confidential information on electronic media including computer drives that are unable to be cleansed using established cleansing procedures.**

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**Once established, communicate the procedures to all Department personnel, and enforce compliance with the procedures to ensure all confidential information is kept secured until no longer needed, and then properly forwarded for retention until materials can be subsequently disposed. (Repeated-2005)**

**Finding:** The Department had not ensured adequate procedures existed for disposal of documents containing confidential and sensitive information.

While performing walkthroughs at the Department's Central Office, confidential information (print outs with names and social security numbers) were found near printers that had been there for several hours. In addition, several documents containing confidential information were found in trash or recycle bins while performing visits at certain Department facilities. Specifically:

- Clinical Record Face Sheet showing social security numbers, resident and family names/addresses, health changes, consultation, diagnostics, medication list, and special medical needs.
- A list of persons taking anti-epileptic drugs for seizures.
- Laboratory listings with a patient's name and ID.
- Discharge information with name and address and a pharmacy pick list with resident's names and IDs.

The Department stated employees inadvertently disposed of confidential information improperly.

**Updated Response: Corrective action implemented as of 3/01/2011:**

**HIPPA**

- Chief Privacy Officer has contacted administration appropriate DHS facilities to confer and offer assistance in alleviating their audit findings.
- Administrative Directives are being reviewed as an on-going process. Thirteen Directives have been reviewed and submitted to Executive staff for final review.
- The ability to track HIPAA training has been included in the DHS NetLearning data base.

Corrective action to be implemented:

- Creating a culture of confidentiality is an on-going process. The Chief Privacy Officer will meet with Executive Staff to discuss issues related to this process.
- Issues that will be brought to the Executive staff include: adding a training or confidentiality objective to employees' annual performance evaluation; receiving administrative staff support to promote employee responsibility for maintaining the confidentiality of customer information; and creating a DHS confidentiality agreement bringing attention to specific issues of protection and disposal of confidential information, thereby making employees accountable for improper disposal.

**Accepted or Implemented – continued**

- Ongoing training for Department staff will continue by offering NetLearning modules on HIPAA, ARRA, and the Personal Information Protection Act. An annual module for HIPAA covered Divisions was added to the training modules.
- In addition, specific confidentiality related Administrative Directives will be added to NetLearning for all staff to read and acknowledge that they have read them. This information will be added to the NetLearning data base.

- 13. Follow procedures that require all disclosures of financial interest; follow procedures to include all State Board of Elections Certifications; follow procedures to file all emergency purchase affidavits with the chief procurement officer and the Auditor General; develop a comprehensive program to monitor contractual agreements which includes documenting the monitoring efforts; implement procedures to ensure all required reports be submitted by vendors in a timely manner; and strengthen the Contract Agreement Approval Form (CAAF) approval process to ensure all required signatures are obtained in a timely manner on the original CAAF, or consider amending the Administrative Directive to take into consideration the use of teleconferencing.**

**Finding:** The Department failed to ensure proper controls were established in the administration of its contracts during the examination period. During testing of 63 contractual agreements at the Central Office, the following weaknesses were identified in contract administration:

- Fifteen of 63 contracts totaling \$1,274,110 did not include one or more required disclosures of financial interest.
- One of 63 contract agreements totaling \$13,450 did not include the State Board of Elections Certification.
- One of two emergency procurements totaling \$59,811 for software subscription and maintenance did not have an affidavit on file with the Auditor General.
- The Department could not provide evidence 14 of 33 professional or artistic contracts totaling \$1,097,255 were monitored in order to ensure services were received in accordance with the terms of the contracts.
- Four of five contractual agreements totaling \$2,061,025 which required specific reports be submitted by the vendor were not submitted timely. The vendors submitted reports to the Department one to 12 days late.

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- Department policy requires a Contract/Agreement Approval Form (CAAF) be completed for each contract or any amendment which increases the dollar amount contracted.

Department management stated the weaknesses were due to oversight to ensure that Department procedures were followed.

### **Updated Response:            Corrective action implemented as of 3/01/2011:**

#### **SPO**

- During prior contract years the SPO's office ensured that a disclosure of financial interest was completed during the procurement process. The current procedure for FY11 (Central Management Services) updated the contract boilerplate to include a disclosure Section 6.
- The SPO's Office follows the Emergency procedures in DHS's Procurement Manual to ensure that all Emergency Purchase Affidavits are filed with the CPO and the Auditor General.

#### **Office of Contract Administration (OCA)**

- OCA's current procedure ensures that contract Section 5.29 is marked and that if applicable a copy of the State Board of Elections Certification is on file.
- OCA's current procedures (contained in the Procedures Manual for) ensure that all DHS Vendors/Providers that are required to submit annual financial reports to DHS, do so in a timely manner or risk suspension of their funding.
- OCA compiles a monthly suspension recommendation list and a suspension report that is circulated to all DHS Divisions and Program staff.

#### **Secretary's Office**

- The CAAF approval process will be strengthened to ensure that all required signatures are obtained in a timely manner. Or the Administrative Directive will be amended to use teleconferencing.
- Based on the above: Teleconferences are held on a weekly basis to review and ensure that signatures for CAAFs are obtained in a timely manner.

### **Corrective action to be implemented:**

#### **OCA**

- OCA will send a memo to the program area, instructing them to incorporate in their monitoring of contractual agreements, a process or procedure which will include documenting their monitoring efforts.
- FY12 Community Service Agreements (CSA's) will incorporate performance metrics. Also, metrics are being developed for the Programs and Divisions to include contract compliance monitoring. OCA, OFS and Research Evaluation and Performance will be working together to define how such monitoring will be documented.

**Accepted or Implemented – continued**

**14. Implement procedures to ensure contracts are signed before the beginning date as set forth in the contract agreements. (Repeated-2005)**

**Finding:** The Department's Mental Health and Developmental Centers and Schools and Central Office did not sign contracts before their starting date. During contract testing, the following exceptions were noted:

- Facility auditors identified exceptions at nine out of 21 of the Department's facilities. For the nine facilities with identified exceptions, 16 of 148 contract agreements tested were not signed by all parties prior to the beginning date as set forth in the contract agreements. The average length of time between the beginning date of the contract agreements and their final required signature was 71 days, with a range of 8 days to 172 days. The contract agreements were for a variety of goods and services ranging from medical and laboratory services, to repairs and maintenance. The total of the contract exceptions identified was over \$2.4 million.
- During testing of administrative contracts at the Department's Central Office, three of 60 contracts were not signed by all parties prior to the beginning date set forth in the contract agreements. The average length of time between the beginning date of the contract agreements and their final required signature was 91 days, with a range of 76 to 122 days. The contracts were for legal services. The total amount of exceptions identified was \$270,000.

Department management stated contracts were not signed in a timely manner due to the Department's internal process of preparing and approving all required forms, number of contracts processed by the Department, and the time it takes to approve a contract at the facility and route it through the Department.

**Updated Response: Corrective action implemented as of 3/01/2011:**

- The Office of Contract Administration (OCA) has notified all Program Offices and facilities of policy change on start date.
- OCA has been working with the Office of the Comptroller to clarify requirements for execution/late execution of contracts and required affidavits as a result of SB51.
- OCA implemented policies for FY11 contracts consistent with the requirements of SB51 and the Comptroller, as stated above.

**15. Implement procedures to strengthen internal controls over the Home Services Program as follows:**

- **Implement controls to monitor and ensure accuracy in the timekeeping process for personal assistants.**

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- **Review the function of the Quality Assurance Unit as it relates to the Home Services Program. The review of two to four case files per month is clearly inadequate and should be increased to allow for broader coverage.**
- **Due to the size of the program and the caseload that each counselor maintains, counselors do not visit or monitor customers as necessary. Allocate resources so that the caseload per counselor can be reduced to a lower level, or implement alternative controls.**
- **Prohibit coordinators from over-riding system controls with respect to personal assistants' budgeted hours. Local offices should also implement a segregation of duties in a coordinator position.**
- **Implement a procedure at local offices to accept only hand delivered or mailed original, signed in ink, timesheets to prevent double entry to the payroll system. Additionally, report all payroll mistakes reported to the Division of Rehabilitation Services MIS payroll processing so the Department can maintain accurate customer expenditure reports. (Repeated-2005)**

**Finding:** During testing, numerous internal control weaknesses were identified in the Department's Home Services Program (HSP). The Home Services Program allows individuals with disabilities (customer) who are at risk of placement in a nursing home to remain in their homes. According to the Department, this is accomplished through use of a variety of services, the most prevalent of which is the use of individual caregivers known as personal assistants. During FY08 and FY09, the Home Services Program maintained 44 offices and paid 38,850 personal assistants at a cost of \$347,200,000 and paid 39,927 personal assistants at a cost of \$382,200,000, respectively. Personal assistants are hired, supervised, and fired by the customer. The customer may hire a relative or other acquaintance as a personal assistant. Because the customer approves timesheets, and Department reviews are not adequate, personal assistants may be paid for excessive hours. The HSP division also has a fraud division that was established to identify and address fraudulent activities in this area.

The auditors noted through testing and discussions with HSP and fraud division personnel that the following weaknesses were still prevalent during the current engagement period:

- The Home Services Program relies on the customer under an "honor system" to guard against abuse and to ensure compliance. The customer is responsible for approving and signing their personal assistant's timesheet. The supervisor reviews a sample of the case files, but not all timesheets are reviewed.

**Accepted or Implemented – continued**

- The Quality Assurance Unit reviews between 92 and 202 case files per month. This is an average of 2 to 4 case files each month per office. This review process results in less than 10% of case files being reviewed each year which is not adequate to ensure staff are compliant with program requirements.
- There was insufficient monitoring of case files to ensure program objectives were being met. There is only one supervisor at each of the 44 local offices to monitor Home Services Program activities. However, there are two offices currently without supervisors (Elgin and Ford City). On average, each supervisor was responsible for approximately 680 case files during fiscal years 2008 and 2009.
- There are insufficient controls in the payroll system for processing of the personal assistants' payroll. HSP management stated the Home Services' CPS payroll system allows coordinators to override controls to process payroll without taking additional steps or obtaining approval from the counselor or the supervisor when the hours budgeted for the customer have been exceeded.

Department officials stated they had concerns regarding the controls within this program due to staff discovery of instances of fraud and abuse.

In its response to this previous finding, the Department stated it would investigate alternate methods of monitoring timekeeping for personnel assistants for a cost effective and practical method of time monitoring. They further stated DRS would work to ensure active case loads are less than 250 cases per professional staff in each office, and when caseloads exceed this limit, DRS will work through various options to supplement staffing to bring the staff to customer ratio back to acceptable levels.

**Updated Response:      Corrective action implemented as of 3/01/2011:**

- DHS has approved a decision memo to test a telephonic timekeeping system & assuming the successful test to implement the system statewide.
- Four of the five Rehabilitation Service Administrators (RSAs) have been hired and the fifth position has been posted. The four current RSAs have begun to perform a range of management tasks, including the noted tasks.

**Corrective action to be implemented:**

- HSP will inform the field that in the near future the system will be changed to require a supervisory override instead of just a coordinator override.
- The Personal Assistant (PA) payment system will be modified to address the problem of Coordinators automatically overriding service overages. This process is now being developed in regarding to the process timesheets that exceed the plan will take in order to be processed. Staffs have also talked with MIS staff to determine the difficulty from a computer standpoint to implement.

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MIS is confident this can be implemented quickly once the procedural aspects are developed.

- New reports will be developed to identify when service cost maximums have been exceeded and to flag instances where such maximums are repeatedly exceeded.
- The PA timekeeping system will be replaced with a primarily telephonic system supplemented by higher levels of review in instances where the telephone is not used. This is still the primary route program wishes to take, but the initial system staff were hoping to implement proved insufficient to handle the 1.7M calls expected. Program staff reviewing other options for telephonic entry and are preparing to craft an RFP to solicit vendors and systems capable of meeting this need.
- Regional RSAs will be hired and trained to monitor and review case files and to provide guidance to field staff.

### **16. Implement procedures to ensure timely controls over monitoring unemployment insurance benefits claims to Personal Assistants, including timely review and completion of the claims for unemployment (BIS-032 forms) and the quarterly report of claimants (BEN-118R reports) and maintenance of adequate supporting files for each claimant.**

**Finding:** The Department's Home Services Program did not have adequate controls over monitoring unemployment insurance benefits paid by the Illinois Department of Employment Security (IDES) to Personal Assistants (PA) employed by customers of the Program.

The Illinois Unemployment Insurance Act requires IDES to send the Department a report, BEN-118R, which is a quarterly statement of benefits paid to claimants and charged to the Department. The report lists the name of each claimant, the amount paid during the quarter, and the weeks to which the benefits applied. The Department is required by the Act to review the report and protest questionable charges within 20 days after IDES mails the report.

Auditors tested a sample of 25 unemployment claimants of the Program during the audit period and noted the following weaknesses:

- Two of 25 of claimants received unallowable unemployment benefit payments totaling \$7,170 while being employed through the Department's Program.
- Two of 25 claims, for which benefits were paid, did not have the required benefit claim documentation on file at the Department.

Department management stated individuals are assigned the responsibility for reviewing unemployment claims, but the process is not formally documented.

**Accepted or Implemented – continued**

**Updated Response:      Corrective action implemented as of 3/01/2011:**

- A new position has been added to reduce the duties of the Unemployment Insurance (UI) Coordinator. A temporary Workers Compensation contractor was hired to relieve the pressure on the UI Coordinator.
- A research study has been started to gain a better understanding of the nature of claims received & to identify the more significant problems we need to track & to address through procedures.
- A new tracking process has been developed.
- Home Services is beginning regular webinars on a variety of issues for field staff.
- Home Services has begun development of guidance to the field, outlining the responsibilities of customers in managing PAs; including outlining what will constitute excessive turnover, indicating an inability to manage their care independently, which results in several problems, including excessive Unemployment Insurance costs.

**Corrective action to be implemented:**

- A new position will be added to reduce the duties of the Unemployment Insurance Coordinator.
- New systems will be put in place to improve the handling claim paperwork and to track claims better electronically.
  - New procedures will be drafted to improve the management of Unemployment claims.
  - Home services field staff will be provided standard guidance on what they need to know about unemployment insurance and how to deal with claims.

**17. Follow existing procedures outlined in the Grant Funds Recovery Act and Department Administrative Directives when recovering grant funds.**

**Finding:**      The Department failed to recover grant funds by circumventing the provisions of the Grant Funds Recovery Act.

The Department awarded a \$30,000 grant to a provider in fiscal year 2006 for an after school program. The provider failed to file the required DHS Grant Report, which is used to verify if and how the funds were expended. The report was due to the Department by April 30, 2007. The Department did not receive any correspondence from the provider requesting an extension, and the provider was sent certified notices for an informal and formal hearing to resolve the amount due.

Since the provider never answered the numerous requests by the Department for a resolution to the matter, the Department utilized the Illinois Office of the Comptroller's

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offset system to offset current payments to the provider in compliance with the Grant Funds Recovery Act. According to Department records, all funds were recovered through offset. However, there is no provision in the Department's Administrative Directives or the Grant Funds Recovery Act to allow for a provider to keep funds after ignoring Department requests for Grant Reports and failing to participate in the formal hearing process.

After the funds were collected through the offset, the provider then filed the DHS Grant Report during August 2008 for the FY06 grant, requesting all previously offset funds be released. The DHS Grant Report was filed more than six months after the formal hearing notice. According to Department personnel, the offset was then reversed and the funds were released based upon a request from the Secretary's office, circumventing provisions of the Grant Funds Recovery Act and Department Administrative Directives.

Department management stated the provider did submit documentation of the use of grant funds after the grant recovery process had been completed. They further stated Department staff were unaware that releasing the funds after the completion of the grant fund recovery process was not permissible.

**Updated Response:      Corrective action implemented as of 3/01/2011:**

**CHP**

- In order to avoid circumventing the Grant Funds Recovery Act, the Division of Community Health and Prevention informed the Department staff that requests to the IOC to release funds that have been recovered under the Grants Funds Recovery Act are not permissible and no such requests shall be made.
- Office of Contract Administration (OCA) has developed training on the (Grants Funds Recovery Act) for all DHS Divisions, Program Offices and Fiscal Staff and to ensure that each program is correctly following GFRA/DHS process.
- OCA conducted training on Grants Funds Recovery Act (GFRA) for all DHS Divisions, Program Offices and Fiscal Staff during the beginning of February 2011.

**Corrective action to be implemented:**

- OCA will educate all program offices on GFRA and what that means to them and their providers.
- OCA will ensure each program is correctly following GFRA/DHS process.

**18. Either seek a legislative change to the Children and Family Services Act to increase the maximum amount of individual grant payments for the Child Care Expansion Program or comply with the Act in its current form.**

**Finding:** One-time only grants made to persons, organizations, and schools included in the Child Care Expansion Program exceeded the \$10,000 limit as stated in the Children and Family Services Act.

**Accepted or Implemented – continued**

During testing it was noted 193 of 1,304 grants awarded for the Program exceeded \$10,000, with the largest grant totaling 16,087. Department personnel stated language in the statute dates prior to 1997, when the Department of Children and Family Services (DCFS) managed the subsidized child care program. Department personnel further stated they believe the funding source was not transferred to the Department, and they were not aware of the statute, and had created a new program.

**Updated Response:      Corrective action implemented as of 3/01/2011:**

- The Department made the recommended changes to remove statute. Request was sent to DHS' Office of Legislation 9/01/2010.
- The Legislative Proposal was approved for introduction when the 97th General Assembly convened in January 2011.
- SB1235 was introduced to remove language in the statute regarding grant payments for the Child Care Expansion Program.
- The bill was heard in Committee on March 15, 2011 and was put on the Agreement List.

**19. Place scholarship funds in a separate trust as required by the U.S. Department of Education, and implement controls to ensure proper reporting of federal expenditures. (Repeated-2007)**

**Finding:**      The Department administers the Gaining Early Awareness and Readiness for Undergraduate Program. The annual awards for federal fiscal years 2008 and 2009 were \$3.5 million with \$1.9 million budgeted for scholarships and the remainder for administration each year.

The following weaknesses were noted in the Program:

- The Department established a separate, interest-bearing fund in the State Treasury for the deposit of scholarship funds. There are no statutory or rule requirements, but U.S. Department of Education guidance requires grantees to place scholarship funds in a trust fund for the benefit of the participants. An entity other than the grantee must have legal control of the trust and the grantee may not retain any type of reversionary interest in the funds. All scholarship funds are currently on deposit in the State Treasury. Department officials stated they will continue communications with the U.S. Department of Education to determine if, as a State agency, the use of this fund for the deposit of scholarship funds meets federal requirements.
- The Gaining Early Awareness and Readiness for Undergraduate Programs Fund is not classified correctly in the Statewide Accounting Management System (SAMS) manual. The fund is currently classified as a special state fund, and the Department has requested the fund be correctly reclassified as a federal trust fund.

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- Scholarship funds were not reported as an expenditure on the Department's Schedule of Expenditures of Federal Awards (SEFA) for fiscal years 2008 and 2009. The Department correctly reported the funds as deferred revenue in their financial statements for State fiscal years 2008 and 2009 but did not properly report it on the SEFA.

Department Management stated federal funds for the Gaining Early Awareness and Readiness for Undergraduate Program were deposited into the State treasury as opposed to a separate trust as required by the U.S. Department of Education.

### **Updated Response: Corrective action implemented as of 3/01/2011:**

- The DHS Chief Financial Officer is coordinating Agency-wide education and training, updating policies and procedures and in some cases, program compliance.

### **Corrective action to be implemented:**

- The Department will continue to report on the program in its respective financial statement consistent with the way the program is administered.
- The Department's program personnel will investigate the federal guidelines to ensure compliance.

## **20. Determine the availability of grant funds for expenditure or return the funds after proper consultation with the respective grantor. (Repeated-2007)**

**Finding:** Auditors identified ten programs with unspent grant funds of which the Department had not determined the final disposition. Several programs were noted that had concluded in previous years with balances in the deferred revenue and unearned deferred revenue accounts that would indicate unspent balances due to grantor agencies. Some of the specific programs with unspent grant funds noted were as follows:

- The Policy Research and Evaluation Grants reported deferred revenue totaling \$360,000. The grant period ended in fiscal year 2002, with the last receipt coming in June 2002.
- Social Services Research and Demonstration reported deferred revenue totaling \$142,000. The grant period ended in fiscal year 2005, with the last receipt coming in July 2005.
- AmeriCorps reported deferred revenue totaling \$79,000. The grant period ended in fiscal year 2005, with the last receipt coming in February 2003.
- The Cooperative Agreements for State-Based Diabetes Control Program and Evaluation of Surveillance Systems Program reported deferred revenue totaling \$340,000. The grant period began in fiscal year 1999 and is currently still active to this date.

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**Accepted or Implemented – continued**

- The Enforcing Underage Drinking Laws Program reported deferred revenue totaling \$146,000. The grant period ended in fiscal year 2008, with the last receipt coming in January 2006.

The Department stated the final disposition was not determined timely due to staffing shortages; however, they stated they are continuing to review and reconcile the funds.

**Updated Response: Corrective action implemented as of 3/01/2011:**

- The Bureau of General Accounting is reviewing historical GAAP SCO-563 Forms and is working with the Bureau of Federal Reporting to ensure proper reporting of grant funds in applicable fund GAAP packages.

**Corrective action to be implemented:**

- The Bureau of Federal Reporting will continue to provide quarterly information related to a grant where the receipt/disbursement activities are moved from one fund to another on quarterly basis. This information will help the Bureau of General Accounting to identify items which require special review at the time the GAAP packages are done to ensure that an inter-fund receivable/payable is properly accounted for within the multiple funds.
- The Bureau of General Accounting will review the GAAP packages and identify where any inter-fund receivable/payables exists. The Bureau of General Accounting will also work with other Fiscal bureaus to ensure that fund transfers or other activities are completed to resolve the outstanding receivable/payable.

- 21. Work with the State Treasurer and Comptroller to return the \$500,000 to the DHS Private Resources Fund so these funds may be expended in compliance with the agreements for which the funds were provided.**

**Finding:** Transfers were made to the FY09 Budget Relief Fund totaling \$500,000 in FY09 from the DHS Private Resources Fund which violated the restricted purpose for which the funds were designated.

Department management stated this transfer was included as one of many such “fund sweeps” that were part of the FY09 budget implementation legislation. The Department was not involved in any way in the development or passage of this legislation.

**Updated Response: Corrective action implemented as of 3/01/2011:**

- DHS is working with the Governor’s Office of Management and Budget.
- DHS had legislation introduced during the fall veto session to return 690 Fund resources swept in violation of State statutes and agreements requiring that such resources be used for specific purposes.
- HB1512 was passed by the General Assembly and signed by the Governor on January 27, 2011.

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- 22. Ensure all receipt transfers and adjustments be immediately recorded in the CARS accounting system and all receipts be deposited in a timely manner. Further, any adjustments noted when performing Comptroller reconciliations should be promptly investigated and posted. (Repeated-2001)**

**Finding:** The Department lacked an adequate receipt reconciliation process and did not timely deposit all receipts. The following exceptions were identified related to the Department's receipts reconciliation process:

- During receipt reconciliation testing, 39 of 153 revenue source codes tested contained reconciling items that were not corrected within one to two months of identification.
- The Department did not reconcile its receipt records to Comptroller records on a monthly basis. In 43 of the 60 revenue source codes tested, the reconciliation was not completed until after one month was over; in several cases the reconciliations were not completed until four months later.

In addition, nine of 60 nonfederal receipts tested totaling \$445,346 and six of 60 refunds tested totaling \$233,942 were not deposited timely in compliance with the State Officers' and Employees' Money Disposition Act. The deposits ranged between one and 54 days late.

Department personnel stated these problems are a result of staffing turnover. The reason given by the Department for the exceptions is the same as was provided for the June 30, 2007 and June 30, 2005 reports. Additionally, the Department indicated the reconciliations were late due to the number of funds required to be reconciled.

**Response:** Accepted. A lack of automation and staff resources in the Cash Management Unit (CMU) is the major contributing factor for this finding. The Department has made every effort to expeditiously fill vacant positions due to frequent staff turnover. Furthermore, the Office of Fiscal Services, Cash Management Unit (CMU) has worked significant overtime to compensate for the lack of staff. The Bureau of General Accounting has also created a task list that prioritizes and clarifies work assignments with given staffing resources.

**Updated Response:** **Corrective action implemented as of 3/01/2011:**

- A General Accounting Status Report was created.

**Corrective action to be implemented:**

- General Accounting will create a monthly task list that will prioritize and clarify work assignments, and those staff responsible.

**Accepted or Implemented – continued**

**23. Allocate sufficient staff resources to process determinations and follow-up on accounts receivable in a timely manner. (Repeated-2007)**

**Finding:** The Department's Mental Health and Developmental disability centers (Centers) failed to exercise adequate controls over accounts receivable. The Centers did not make timely determinations of residents' ability to pay non Medicare and Medicaid charges and did not follow-up on outstanding accounts receivable in a timely manner.

- Center staff failed to complete a Notice of Determination in a timely manner for 37 of 75 files tested at three Centers. There were many instances where the form was not completed at all.
- Resident financial case records did not have documentation to support the determination of the resident's ability to pay for 15 of 50 files tested at two Centers.
- One Center did not have "Delinquency Notice" forms on file supporting the Center's follow-up on accounts receivable for 11 of 25 files tested. These receivables totaled \$71,916.
- At four Centers, 42 of 100 accounts receivables tested were outstanding for over 180 days and were not submitted timely to the Central Office for collection.
- At one Center, one of 25 files tested did not pertain to a resident at that Center. The receivable totaling \$13,080 actually belonged to another Center and was outstanding over 180 days.
- Staff failed to enter resident data into the receivable system at one Center for 2 of 25 (8%) files tested leaving the accounts with a zero balance. It was determined the residents had income and should have been billed for their stay.

Issues were also identified with the processing of Medicare claims at one Center. One claim totaling \$63,840 was billed to Medicare by both the contractor hired to process billings and the Center. The amount billed by the Center was still outstanding due to the double billing. Another claim totaling \$41,040 was rejected by Medicare due to errors, but was never corrected and resubmitted by the Center.

Issues with receivables were also noted in testing at the Central Office:

- Three of 90 files tested did not contain any indication that the accounts totaling \$81,578 were currently being billed for the outstanding debt.

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- In two of the 90 files tested, the Central Office had not received notice from the facility to begin collections for receivables totaling \$18,368 once 180 days of delinquency had passed.

The Department reported gross resident accounts receivable (excluding Medicare and Medicaid) at Centers totaling \$17.239 million and \$14.325 million for the years ending June 30, 2009 and 2008, respectively. The related uncollectible allowances were \$12.534 million and \$11.658 million, respectively. Also, the total revenue from hospitalization insurance covering individuals for 2009 and 2008 totaled \$17.549 million and \$18.145 million, respectively.

Department personnel stated the deficiencies were due to staff shortages. They further stated this finding was a result of inadequate staffing since the 2003 early retirement. Department personnel stated a consulting report recommended staffing increases to address this issue. Department personnel stated the Department has requested new positions to address this need over the past four fiscal years; however, these requests were never met due to lack of funding.

**Response:** Accepted. As part of the Public Consulting Group (PCG) State Facility Revenue Maximization Project contract, they evaluated the staffing levels of our Patient Resource Units (PRU). The PCG analysis and recommendation for an additional headcount of 12 FTE were submitted to the Department. The Department will resubmit the report and recommendation to the Governor's Office for reconsideration.

**Updated Response:**        **Corrective action implemented as of 3/01/2011:**

- DMH is still working with OMB to develop FY12 budget staffing plan.
- DMH will not know until March/April 2011 if positions will be funded.

**Corrective action to be implemented:**

- Due to the current fiscal condition of the State, the Department does not anticipate an increase in staffing levels as recommended in the audit.
- The Department intends to address the headcount issue when the fiscal climate improves.
- In lieu of hiring staff, the Hospital Administrators and Business Administrators will become more involved with the oversight of the accounts receivables.

**24. Implement a Department wide accounts receivable system, working with the Department of Central Management Services regarding any possible state-wide consolidated accounting system initiatives. (Repeated-2007)**

**Finding:** The Department accounts receivable reporting system is cumbersome, relies on numerous subsystems, and requires manual entries.

During testing of the quarterly Accounts Receivable Activity reports (Form C-97), the auditors noted the reports were manually compiled from multiple accounts receivable

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systems in order to issue a single report. The compilation is complex and cumbersome and, as a result, there is a potential for errors in reporting. The current process takes approximately 15-20 hours to complete over a period of several weeks.

As a result of testing performed it was noted Fund 0025 Group Home Loan Revolving Fund was only included in the C-97 report for the second quarter of 2009. The Group Home Loan Revolving Fund total amount of loans receivable was approximately \$30,000 for fiscal year end 2009.

Department personnel stated these deficiencies were due to staff shortages.

**Updated Response: Corrective action implemented as of 3/01/2011:**

- The Department has coordinated efforts with the Bureau of Early Intervention, Division of Rehabilitation Services, Division of Contract Administration, and the Bureau of Child Care in regards to reviewing Accounts Receivables.
- The Department has an interim solution in place for establishing, reporting, aging and collection of debt owed DHS. Procedures have been developed and back up staff have been trained to complete the Quarterly SCAAR Reporting process.

**Corrective action to be implemented:**

- The Department will continue coordinating efforts and reviewing the Accounts Receivable agency wide

**25. Implement controls to ensure records are maintained to support the disposition of all NSF checks and to ensure the proper establishment and collection of receivables.**

**Finding:** The Department did not maintain adequate internal controls over checks returned for insufficient funds. During testing of 50 not sufficient funds (NSF) or stop payment checks, the following exceptions were identified:

- One of 50 checks had not been entered into the Departments' accounting system by the Cash Management Unit (CMU). The files additionally had not been forwarded to the Bureau of Collections (BOC) for establishment of receivables.
- One of 50 checks was entered into the Departments' accounting system but was never forwarded to the BOC to establish a receivable.
- For one of 50 checks tested, the CMU incorrectly applied a check to the account receivable balance. The NSF check was \$361. The Department applied \$200 to the receivable balance, but since this was an NSF check, nothing should have been applied to the receivable balance.

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- One NSF check totaling \$34,584 for payments for residents at Chicago Read MHC was never posted to residents' accounts. The BOC has tried to contact CMU to properly post the accounts, but the matter has not been resolved.
- The Department failed to deposit a check totaling \$1,111 in a timely manner, thus causing the payment to become void. The copy of the check clearly stated "void if not cashed within ninety days" causing the bank to issue a not sufficient funds.

Department personnel indicated that the exceptions were related to a decrease in staff available to process receipts.

**Updated Response: Corrective action implemented as of 3/01/2011:**

- A "NSF Check Receipt Form" was created and instituted by the Bureau of General Accounting to verify both parties have NSF documentation.

**26. File all quarterly Reports of Locally Held Funds (Form C-17) with the Comptroller in a timely manner.**

**Finding:** The Department did not file ten "Report of Receipts and Disbursements – Locally Held Funds" (Form C-17) in a timely manner.

Department personnel stated it did not receive the completed C-17's from the facilities in a timely manner and therefore were not able to file them with the Comptroller. Also, a process was not in place for the Department to verify that the Comptroller was in receipt of the C-17 reports on the due date.

**Updated Response: Corrective action to be implemented:**

- The Department will have written verification from the Illinois Comptroller's Office (IOC) of receipt of Form C-17's.
- Documentation of timeliness for the last quarter will be requested from the IOC.

**27. Submit all reports on or before the due date specified in State law.**

**Finding:** The Department did not submit required reports to the Governor and the General Assembly in a timely manner as required by State law.

During the engagement period, the Department was required to submit various reports to the Governor and the General Assembly. These reports related to the Task Force on the Condition of African American Men in Illinois, Institutional Services for Children with Development Disabilities, or Severe Emotional Disorders, Current and Potential Uses of Electronic Monitoring, and the Minority Senior Citizens Program. None of these reports were filed in a timely manner.

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Department management stated this finding is the result of inadequate staffing levels to provide timely reports.

**Updated Response:      Corrective action implemented as of 3/01/2011:**

- Division of Human Capital Development (HCD) has been in contact with the Department on Aging (DoA) staff regarding the report for “Minority Senior Citizens Program”.
- DoA has indicated that they will send each participating agency a request for information, including suggested formatting and language, so that the necessary data can be obtained consistently. Upon receipt of the request HCD staff will submit the requested information to DoA on or before the due date set by DoA.
- Office of Legislative Affairs – Each month on the 15<sup>th</sup> the applicable division is being notified that the report coming due in the next 30 days.
- DMH Children & Adolescent Program Administrator is monitoring the progress of the report preparation and ensures timely submittal of the bi-annual report on even-numbered years. The next report is not due until March 2012.

**Corrective action to be implemented:**

- Persons/Divisions staff will be identified and tasked ensuring timelines are met.

**28. Comply with the requirements of the Mental Health and Developmental Disabilities Administrative Act or seek a legislative change to be more in line with the Department’s Division of Mental Health’s current mission and focus; also evaluate the process to make statutorily required appointments to ensure appointments are made in a timely manner.**

**Finding:** The Department did not make appointments to State boards or did not make timely appointments as follows:

- The Secretary of the Department did not appoint five physicians to a medical advisory panel as required by the Mental Health and Developmental Disabilities Administrative Act.
- The Department did not appoint a Deputy State Compact Administrator pursuant to the Unified Code of Corrections in a timely manner. The Deputy State Compact Administrator is to serve on the Interstate Compact for Juveniles.

Department personnel stated staff were unaware of the need to appoint a Deputy State Compact Administrator until July 23, 2009 when the current appointee was established.

**Updated Response:            Corrective action implemented as of 03/ 01/2011:**

**CHP**

- The Department appointed a Deputy State Compact Administrator to serve on the Interstate Compact for Juveniles on July 23, 2009.

**Corrective action to be implemented:**

**DMH**

- The Department has not filled the positions on the Medical Advisory Panel. It is our intent to revise through statute, the focus of the panel from a physician-centered, medically driven system to a recovery oriented and consumer-driven system.

29. **Establish an effective Department-wide security administration function, which would include areas such as computer security, building security, paper document security, HIPAA security, etc. Additionally, establish a formal Department-wide security awareness program to educate users about security policies and procedures, including the need to keep confidential information secured and the means to keep it confidential, and the users responsibilities of safeguarding information resources. Provide periodic information on security responsibilities and issues to personnel. Formalize employee notification of new administrative directives or revisions, including written acknowledgement at least annually stating that the user has received, reviewed, and agree to comply with security policies and procedures. Also, ensure procedures for establishing and reviewing access rights to production data are appropriate and implemented. (Repeated-2007)**

**Finding:** The Department did not have an adequate security administration function. The Department failed to establish a formal security awareness program for effectively communicating its policies to Department personnel. In addition, responsibility for assuring compliance with established security related policies and procedures had not been formally assigned.

The Department stated the merger of seven state agencies to form the Department left the agency with separate and disparate security procedures.

**Updated Response:            Corrective action implemented as of 3/01/2011:**

- Office of Security and Emergency Preparedness has a fully functioning Workplace Violence Awareness and Response Program. A recently released Workplace Safety Guide has been distributed to all staff and is posted on the OneNet, Safety Teams operate in all IDHS locations, and protocols for specific hazards such as severe weather and suspicious packages/mail have been developed, with others under way.
- Agency COOP/COG Plan was developed in collaboration with IEMA, and Facilities Emergency Operations Plans are under revision as components of the overall agency Emergency Operations Plan.

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- Work with CMS to upgrade Security Guard and electronic protection in leased locations is on-going, but hampered by budgetary constraints.
- Centralization of oversight of physical, document, HIPAA/PIPA security is being phased in through collaboration with all IDHS divisions and facilities.
- Merger of HIPAA functions into OSEP has been recommended.
- Emergency preparedness and response activities, State Emergency Operations Center participation, National Incident Management System compliance and training are now centered in OSEP.
- OSEP, MIS and the HIPAA Officer are working together to educate all IDHS staff on security, confidentiality and safeguarding of resources responsibilities, on a periodic basis.
- Bureau of Policy and OSEP have developed a protocol to notify staff of changes in security related administrative directives, including annual certification of receipt, review and compliance with the agency's security policies and procedures. Employee Handbook revisions will be made and posted to the OneNet with annual awareness requirements. All Administrative Directives are sent to supervisors with instructions to disseminate, with confirming receipt, to all staff.

**Corrective action to be implemented:**

- IDHS OSEP is phasing in the centralization of functions to oversee and/or coordinate and administer implementation of appropriate document and computer security, building and HIPAA/PIPA security, currently residing in various divisions.
- OSEP collaborates with CMS on leased facility security needs and improvements, including building and file access, as well as security guard requirements.
- IDHS' OSEP)in collaboration with the DHS HIPAA Officer and MIS will develop an agency-wide security awareness program to educate all DHS staff on the agency's security policies and procedures, including the need to keep confidential, and staff responsibilities of safeguarding DHS information resources. This program will provide periodic information on security responsibilities and issues to all staff.
- IDHS' Office of Security and Emergency Preparedness, in collaboration with the Bureau of Policy, is developing a program of Employee Notification for all security related administrative directives and revisions, including annual certification of receipt, review and compliance with the agency's security policies and procedures. Revisions to the Employee Handbook incorporating the above were made in April 2010, and upon Legal/Labor approval will be published to the OneNet with a required annual signed certification of receipt/awareness by all employees. Additionally, all Administrative Directives are sent to supervisors with instructions to disseminate to staff in their areas with receipt to confirm.

- 30. Formally communicate to DCMS the recovery requirements, and establish and document guidelines that outline both DHS' and DCMS' responsibilities. Specifically:**

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- **Work with DCMS to ensure recovery of critical computer systems within the required 24-hour timeframe;**
- **Perform and document tests of recovery capabilities at least once a year. Due to the critical nature of the recovery requirements, ensure the tests demonstrate the ability to meet the 24-hour timeframe; and,**
- **Continually review and update contingency plan to reflect the current operating environment and ensure all of its facilities have an adequately developed and tested contingency plan. (Repeated-2005)**

**Finding:** The Department had not ensured adequate planning for the recovery of its applications and data. In particular, acceptable disaster recovery capabilities did not exist to ensure that critical computer systems (integral to ensuring the safety and well-being of its clients) could be recovered within the required timeframe.

Many of the Department's IT functions were consolidated into the Department of Central Management Services (DCMS). As a result, the Department and DCMS have a shared responsibility over disaster contingency planning. Although DHS has the ultimate responsibility to ensure it has the capability to recover its applications and data.

The Department stated the combination of required further refinement of Disaster Recovery Plan and training of DCMS/Department employees understanding the technical needs to restore the environment contributed to the contingency planning weaknesses.

**Updated Response:** **Corrective action implemented as of 3/01/2011:**  
DHS MIS will continue to test the Disaster Recovery plan annually to ensure 24 hour recoverability.

- 31. Assess access to production data and limit access only to required individuals. Also, review procedures for granting user access and ensure compliance with the established procedures. Additionally, require programmers to adhere to the change control procedures for all non-emergency changes. Programmers should only be granted access to the payroll production data for emergency changes.**

**Finding:** The Department did not adequately restrict access to its production data.

Programmers were frequently granted access to payroll production data. Testing indicated this access, which was intended for emergency situations, was frequently utilized in non-emergency situations for changes that should follow the Department's change control procedures. Excessive access rights to other production data were also identified. In some cases, all users of an application also had access rights to the actual production data.

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In addition, weaknesses were found in the use of the Department's User ID Action Request form used to assign access rights. 25 employees selected from a list of new Department employees for fiscal year 2009 were tested, and missing and improperly completed forms were found.

Department personnel stated a lack of automated process to capture User ID Action Requests contributed to the failure of adequately restricting access to Department production data.

### **Updated Response:      Corrective action implemented as of 3/01/2011:**

- DHS MIS has made access change based upon the recommendations of the OAG.

### **Corrective action to be implemented:**

- DHS MIS continues to develop a system that will ensure production data is adequately restricted.

### **32. Maintain the necessary required documentation in employee files including payroll deduction authorizations and leaves of absence. The Department should also maintain and review approvals for requested time off and overtime. (Repeated-2007)**

**Finding:** The Department did not maintain all necessary and required supporting documentation in employee payroll and personnel files. During testing of employee payroll and personnel files the following exceptions were noted:

- In six of 60 payroll files tested at the Central Office, voluntary withholding payroll deduction authorization requests were not maintained in the files. The items missing included deferred compensation forms, union deduction cards, or insurance deduction cards.
- In one of 60 payroll files tested at the Central Office, a discrepancy was identified between the actual federal withholding tax and the recalculated tax. The file included no indication of a special withholding arrangement.

During testing of timesheets at the Central Office, the following exceptions were noted:

- For three of 30 employees tested, approvals for time off and overtime were missing.
- For one of 30 employees tested, inaccuracies were identified between overtime approvals and timesheet reports.

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- For one of 30 employees tested, numerous time approval sheets were copied and time was filled in by the employee after the approval date.

During testing of timesheets at ICRE-Wood, the following exceptions were noted:

- During review of timesheets, two of five employee files tested contained discrepancies between time off and overtime requests as compared to attendance records.
- One employee was routinely approved for equivalent earned time that was not in compliance with Department policies. This employee was approved for overtime in increments of less than 30 minutes on 38 instances out of 39 regular workdays during the months of October and November 2008.

During testing of employees on leave of absence, the following exceptions were noted:

- The Department was unable to provide documentation for 3 of 25 (12%) employees tested on leave of absence. The three employees all took a service disability leave. There was no documentation to support the leave request or no doctor's verification to support the disability leave.

Department personnel stated the Department's Payroll Office had been formed in 1998 and the payroll files were obtained from five legacy agencies. Logistically, this caused problems with obtaining complete payroll files.

### **Updated Response:      Corrective action implemented as of 3/01/2011:**

- A memo was distributed to Executive Staff on 9/22/2010 to remind Merit Compensation employees of the Administrative Directive for earning Equivalent Earned Time via memo from the Director Office of Human Resources.

### **Corrective action to be implemented:**

- Timesheet Testing - the ICRE-W timekeeper and management staff will be provided timekeeping training including record keeping and record retention.

### **33. Follow the Personnel Rules and hold management accountable for completing employee performance evaluations on a timely basis. (Repeated-2005)**

**Finding:** The Department did not conduct employee performance evaluations on a timely basis. During testing of personnel expenditures it was noted 29 of 60 Central Office employees sampled did not have a performance evaluation on a timely basis. Many of these employees had not had evaluations for several years. One of the individuals had not had an evaluation in over fourteen years.

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In addition, facility auditors noted 178 of 460 facility employees at eleven of the twenty-one facilities did not have a performance evaluation on a timely basis. One of these employees had not had an evaluation for several years. Eight of the twenty-one facilities could not provide documentation that an employee performance evaluation had been performed during the engagement period for 56 of the 178 employees noted.

Several of the exceptions noted were regarding Merit Compensation employees. Merit Compensation employees usually receive a salary adjustment once a year depending on their employee performance evaluations. In previous years, salary adjustments for Merit Compensation employees had been suspended, but in the past two fiscal years they were reinstated.

Department personnel stated personnel managers sent out reports of upcoming evaluations and managers did not always comply.

**Updated Response:      Corrective action implemented as of 3/01/2011:**

- Notices are sent to areas each month reminding managers of evaluations due.

**34.    Maintain the required documentation in order to substantiate all temporary employee assignments. (Repeated-2007)**

**Finding:**      The Department failed to follow their own administrative directives as well as State administrative rules for administering temporary employee assignments.

During testing of temporary employee assignments, the Department was unable to provide documentation for eight of 25 employees currently working in temporary assignment positions. Because there was no documentation, auditors were unable to determine how long the employees had been functioning in these positions. These exceptions were noted specifically in three of the nine divisions tested, the Illinois School for the Deaf, Fox Developmental Center, and Howe Developmental Center.

Department personnel stated documentation could not be located in the employee files and was not maintained due to oversight.

**Updated Response:      Corrective action implemented as of 3/01/2011:**

Memo was distributed to all DHS timekeepers.

**35.    Remind supervisors and employees of the requirements of the Administrative Directive to timely sign and maintain the Monthly Attendance Records.**

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**Finding:** The Department did not maintain time records in compliance with the State Officials and Employees Ethics Act. Auditors noted the following exceptions at Department facilities:

- 219 of 860 employee Monthly Attendance Records, which document that employee time was spent on official State business were not retained at nine of 21 facilities.
- 105 of 839 employee Monthly Attendance Records were missing required signatures and/or dates from the employee, supervisor, and/or timekeeper at 10 of the 21 facilities tested. As a result, the facility auditors could not determine whether the Monthly Attendance Record was signed and approved within the required time period.
- 42 of 516 employee Monthly Attendance Records were not signed and dated by the employee, supervisor, and/or timekeeper within five working days of the employee's submission at seven of 21 facilities tested. The supervisor or timekeeper signed the Monthly Attendance Records between two and 88 days late.
- One facility could not provide Monthly Attendance Records for 35 of 36 employees.

Department officials stated Monthly Attendance Reports were not completed and forwarded to the appropriate payroll department.

### **Updated Response:**      **Corrective action implemented as of 3/01/2011:**

- Illinois School for the Deaf (ISD) - On December 22, 2009 an all staff e-mail was sent out to address the Monthly Attendance Record.
- Illinois School for the Visually Impaired (ISVI) - On December 22, 2009 an all staff e-mail was sent out to address this issue along with meeting with the Administrative Council.
- ISVI - On January 27, 2010 the school's Superintendent met with the Administrative Council to discuss the importance of properly compiling the form within the five day time frame.
- Chester Mental Health - A memo was sent out to all supervisors and timekeepers to remind them of the Department objective to have all employee time attendance records signed in a timely manner and to keep all records for audit purposes.

### **Corrective action to be implemented:**

- **ISD** - At fiscal year end, Monthly Attendance Records will be sent to the Payroll Department for filing in the employee official timekeeping file.
- **Payroll** - All DHS staff will be reminded of the requirements of the Administrative Directives and the Ethics Law regarding the Monthly Attendance Record.

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36. **Comply with the State Property Control Act and policies and procedures for State property control. Specifically, place inventory decals on all State property, document and control property movements, submit documents to the Property Control Unit timely for updates to the property list, physically inspect State property periodically, and transfer unused State property items to the Department warehouse. (Repeated-2005)**

**Finding:** The Department did not have adequate physical control over or recordkeeping for State property. As of June 30, 2009, the Department's Central Office valued its State property at \$85,049,570, which includes Illinois Center for Rehabilitation and Education – Wood Facility (ICRE-Wood) property valued at \$4,336,732. State property at other Department centers or facilities was tested by other auditors.

The following discrepancies were noted while testing Central Office State property:

- Twenty-one of 585 items on the location property listings, totaling \$26,059, were not able to be physically observed at the respective locations, and the Department was not able to provide support verifying the items were scrapped, surplus, transferred or loaned to a different location. Department personnel stated these errors occurred due to improper application of property control procedures as well as the closure of one warehouse which resulted in the transfer of several items without the completion of required transfer paperwork.
- Six of 320 items physically observed were not recorded on the respective location property listings, and the Department was not able to provide support verifying the items were recently transferred or loaned to the location.
- Three items failed to have inventory decals properly affixed.
- Five equipment items were loaned and the Loaner Temporary Assignment forms documenting the temporary transfer of equipment were not timely completed and approved. Department personnel stated these forms are completed annually for items that are off-site but assigned to a specific location code. However, the items noted as exceptions were not expected to be off-site during the fiscal year, so a form was not completed for these items.
- One equipment item totaling \$2,889 was transferred prior to June 30, 2009, but was still included on the previous location's inventory listing as of the end of the fiscal year, resulting in the overstatement of the location's inventory at year-end.
- One out of eight quarters had delinquent filing of the Quarterly Report of State Property (C-15) with the Illinois Office of the Comptroller.

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The following discrepancies were noted while testing ICRE-Wood State property:

- One of 45 items tested (a computer valued at \$1,563) had been sent for repair and had no supporting documentation available.
- Three of 45 items on the location property listings, totaling \$3,149, were not able to be physically observed at the respective locations.

Department personnel stated staff in various offices and facilities failed to follow Department policies and procedures for State property control.

**Response:** Accepted. The Department accepts the recommendation. The Department has property management rules and procedures in place governing the marking, tracking, monitoring and reporting of state owned property. These procedures are clearly outlined in the Department Property Control Manual that is provided to ALL Property Control Coordinators (PCC) for their use. Any updates or changes are provided to the PCC immediately for their review and incorporation into their duties and responsibilities. The PCC is responsible for adhering and enforcing all agency property rules and procedures within their office. In addition, annual PCC training (as well as one-on-one sessions) are provided to reinforce these policies as set forth in the manual. Furthermore, this agency completes a 100% physical inventory annually. The individual office is responsible for completing and certifying the results to PCU. The Property Control Unit (PCU) has scheduled Annual Property Control Coordinators (PCC) Training Sessions and to review policy and procedures.

**Updated Response:**        **Corrective action implemented as of 3/01/2011:**

- Annual Property Control Coordinators (PCC) Training Sessions scheduled and ongoing to review policy and procedures
- Property Testing sites contacted to enact resolution and corrective action plans.

Office of Fiscal Services contacted to ensure accurate and on-time submission of quarterly C-15 report. DHS Property Control contacted the Office of Fiscal Services to determine their process for securing on-time submission to the Office of the Comptroller.

- 37. Remind employees to follow procedures and submit all telephone calling card cancellation requests to the Property Control Coordinator immediately upon notification of a situation that necessitates cancellation, along with a reason for the cancellation, to ensure adequate documentation and timely compliance. In addition, maintain accurate and up to date records of telecommunications devices in instances where devices have been transferred to other employees.**

**Finding:** The Department is not canceling telephone calling cards, cell phones, and pagers on a timely basis when an employee retires, transfers, or otherwise leaves the

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Department. Twenty five telecommunications cancellation requests processed during the engagement period were tested, and 18 were not cancelled in a timely manner ranging from four months to over 17 years after the employee left the Department.

Department personnel stated the employees' supervisors are not forwarding the proper information to DHS MIS staff in a timely manner, resulting in delays in submitting cancellation requests to CMS. Department personnel further stated all of the devices were ultimately cancelled and in many instances, devices are not cancelled but transferred to a new employee.

**Updated Response: Corrective action implemented as of 3/01/2011:**

- DHS MIS has developed suggested language to update the Administrative Directive, to address the proper transfer and cancellation of telecommunications equipment and calling cards.
- A memo has been developed and is being reviewed; upon approval it will be sent to DHS Property Control Coordinators.
- Updates of the telecommunications equipment Administrative Directive are still being reviewed by DHS Exec Staff and General Counsel.

**Corrective action to be implemented:**

- Update the telecommunications equipment Administrative Directive, 01.03.03.010, to address the proper transfer and cancellation of telecommunications equipment and calling cards to be transacted through MIS Asset Management Bureau, MIS Telecommunication section.
- MIS will send out a reminder communication to the Property Control Coordinators for the timely notification of changes to the telecom inventory.

**38. Enter and maintain complete, accurate and timely information in the fleet database. Further, monitor the assignment of vehicles and ensure all required forms are obtained on a timely basis. (Repeated-2005)**

**Finding:** The Department did not maintain adequate records for Department owned vehicles. The Department had 536 vehicles, 33 of which were specifically assigned to Department employees. Records for all 33 personally assigned vehicles were tested during the engagement period. Auditors identified instances of incomplete mileage records, mileage errors, missing information, and lack of annual certifications related to license and insurance coverage. Specific problems noted were as follows:

- One of 33 personally assigned vehicles tested had missing or incorrect information in the database. Gaps were noted in mileage where beginning and ending odometer readings did not match miles driven.

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- Two employees submitted claims for mileage reimbursement even though they had been issued a personally assigned State vehicle. The employees were reimbursed for mileage totaling \$1,198 claimed on ten separate vouchers. Department personnel could not explain why the individuals did not use their State vehicles and Department records did not indicate the State vehicles were being repaired.
- In seven of the 33 assigned vehicles tested, the employee failed to consistently file the Quarterly Report of Commuting (form IL444-4723). In addition, it was noted two employees used their vehicles during months in which they reported no commuting days. According to the vehicle database, the first employee traveled a total of 2,676 miles from October 2008 to March 2009 and the second employee a total of 8,173 miles from April 2008 to March 2009.

Department personnel stated procedures have been put in place to alleviate the problems and the vehicle database was cleaned up since they have had permanent staff handling this for the last three years. However, problems continued to persist, but at a lesser rate than prior years.

### **Updated Response: Corrective action implemented as of 3/01/2011:**

- A memo was developed and sent to all Divisions regarding the importance of accurate reporting/recording of information related to billings for automotive use.
- The Office of Business Services hired an assistant to the Fleet Coordinator.

### **Corrective action to be implemented:**

- The Office of Business Services (OBS) Fleet Coordinator will implement a process for checking quarterly to assure that documentation has been received from staff with personally assigned vehicles.
- The OBS assistant is working to establish a process for conducting quarterly reviews. He collects the monthly reports and files them in the individuals' files. The current database has no field for monthly reviews. He is in the process of creating a new database that will include a field for monthly reviews, which will allow him to run a report and send out reminders to staff who are not turning in their reports timely.
- Additional staff will be hired, if feasible. In instances where documentation has not been received in a timely fashion, notification will be sent to the appropriate supervisor for appropriate intervention.

### **39. Implement an active eligibility redetermination process and require eligibility redeterminations be completed on an annual basis in compliance with the Act.**

**Finding:** The Department failed to make annual redeterminations of eligibility for KidCare (now known as ALL KIDS). The ALL KIDS program provides health benefits to children of the State. The Department is responsible for eligibility determinations and

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redeterminations for the ALL KIDS Program. The Department of Healthcare and Family Services is responsible for overall Program administration.

During testing of 30 ALL KIDS case files, auditors identified 13 cases in which the eligibility redeterminations were completed using a passive redetermination process. Additionally, auditors identified one of 30 case files where an annual redetermination was not performed as required.

**Auditors' Comment:** The Department in their response has indicated the reasons for utilizing passive redeterminations (referred to as administrative renewals by the Department in their response), but did not address how they would comply with the requirements set forth in the Children's Health Insurance Program Act (Act). Specifically, the Department did not address how they would comply with the requirement for eligible participants to reapply or otherwise establish eligibility at least annually and for redetermining eligibility when no information is provided when passive redeterminations (administrative renewals) are used. The Department's response is directed to the federal law but does not address the requirements in State statute. In addition, the federal law does not prohibit the active redeterminations which include internal controls to maintain accountability over these cases

**Updated Response: Corrective action implemented as of 3/01/2011:**

- The Department has reviewed the federal material that authorizes the administrative renewal process.
- HB5420 commonly referred to as Medicaid Reform Legislation passed the House on 1/05/11 and the Senate on 1/06/11. It was signed into law by Governor Quinn on 1/25/11.
- The legislation requires changes to the All Kids Program including the elimination of passive redetermination process and requiring annual redetermination of eligibility.
- DHS made recommendations to HFS of changes needed as a result of the review of the federal material.

**Corrective action to be completed:**

- DHS is currently working closely with HFS Policy staff on the implementation of these reforms, including formulating a plan to address the increased workload that the elimination of the administrative renewal process will bring to the All Kids Unit and the DHS Family Community Resource Centers.
- DHS and HFS are also developing cross-matches and enhanced utilization of data sources in order to more quickly and accurately complete applications and renewals.

**Emergency Purchases**

## REVIEW: 4349

The Illinois Purchasing Act (30 ILCS 505/1) states that “the principle of competitive bidding and economical procurement practices shall be applicable to all purchases and contracts.” The law also recognizes that there will be emergency situations when it will be impossible to conduct bidding. It provides a general exemption for emergencies “involving public health, public safety, or where immediate expenditure is necessary for repairs to State property in order to protect against further loss of or damage ... prevent or minimize serious disruption in State services, to insure the integrity of State records, or to avoid lapsing or loss of federal or donated funds. The Chief procurement officer may promulgate rules extending the circumstances by which a purchasing agency may make ‘quick purchases’, including but not limited to items available at a discount for a limited period of time.”

State agencies are required to file an affidavit with the Auditor General for emergency procurements that are an exception to the competitive bidding requirements per the Illinois Purchasing Act. The affidavit is to set forth the circumstance requiring the emergency purchase. The Commission receives quarterly reports of all emergency purchases from the Office of the Auditor General. The Legislative Audit Commission is directed to review the purchases and to comment on abuses of the exemption.

During FY08 the Department filed 23 affidavits for emergency purchases totaling \$4,063,468.91, as follows:

- \$1,476,187.56 to extend contracts for various services until bids were awarded;
- \$1,237,385.35 for repairs;
- \$498,000.00 for copier rental until a new contract was awarded;
- \$400,000.00 for manual keys on each door at Rushville Treatment and Detention Center in case of power outage;
- \$300,000.00 for healthcare until a new contract was awarded;
- \$151,896.00 for a monitoring system and keyless door system at McFarland;

During FY09 the Department filed six affidavits for emergency purchases totaling \$1,394,050.00, as follows:

- \$801,100.00 for repairs;
- \$501,830.00 for extension of contracts for various services until bids were awarded; and
- \$91,120.00 for external monitoring at Howe.

### **Headquarters Designations**

The State Finance Act requires all State agencies to make semiannual headquarters reports to the Legislative Audit Commission. Each State Agency is required to file reports of all its officers and employees for whom official headquarters have been designated at any location other than that at which official duties require them to spend the largest part of their working time.

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The Department filed a headquarters report in July 2009 indicating it had 560 employees assigned to locations other than official headquarters.