

LEGISLATIVE AUDIT COMMISSION



Review of
Department of Healthcare and Family Services
Year Ended June 30, 2009

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REVIEW: 4344
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
YEAR ENDED JUNE 30, 2009

FINDINGS/RECOMMENDATIONS - 13

ACCEPTED - 8
IMPLEMENTED - 5

REPEATED RECOMMENDATIONS - 8
PRIOR AUDIT FINDINGS/RECOMMENDATIONS - 17

This review summarizes the auditors' reports of the Department of Healthcare and Family Services for the year ended June 30, 2009, filed with the Legislative Audit Commission May 11, 2010. The auditors performed a financial audit and compliance examination in accordance with State law and *Government Auditing Standards*. The auditors expressed unqualified opinions on the Department's financial statements.

The Department of Healthcare and Family Services, formerly the Department of Public Aid was officially renamed July 1, 2005. The Department is committed to empowering Illinois' residents to lead healthier and more independent lives by providing health care coverage for adults, children, seniors, and the disabled. The Department is also devoted to helping ensure that Illinois children receive financial support from both parents by establishing and enforcing child support obligations, improving the energy efficiency of low-income families through energy conservation and bill payment assistance, and the effective management of healthcare purchasing.

In FY09, the average monthly count of enrolled individuals for which the Department provided means-tested medical coverage was over 2.5 million Illinoisans, including children, parents or caretaker relatives raising children younger than 19, pregnant women, seniors 65 years of age or older, persons who have a disability or blindness, people struggling with one-time catastrophic medical bills, and children and adults with chronic health problems.

About two-thirds of the medical program budget is expended for health care to seniors and persons with disabilities. The total number of persons with disabilities on Medicaid was 419,677 in FY09. Long-term care caseloads have remained relatively stable over the last few years. The average monthly resident count age 65 and over for FY09 was 37,578. On the average, 2,721,031 individuals were enrolled in Medicaid in FY09. As of June 30, 2009, more than 1,553,200 children and 562,689 non-senior adults without disabilities (parents) were covered through the Department's medical programs. Annual expenditures for Medicaid were more than \$10.3 billion, and the average expenditure per enrollee was \$3,786.64. Total medical program expenditures were more than \$13.9 billion.

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The Division of Child Support Enforcement served more than 500,000 families composed of TANF clients, mandatory Medical Assistance No Grant (MANG) clients and any other Illinois residents requesting child support enforcement services. More than \$1.38 billion was collected and disbursed in child support and arrearages in FY09. Over 479,400 households received assistance grants through LIHEAP and 7,854 homes were weatherized in FY09. Finally, the Department's Inspector General conducted 3,472 fraud prevention investigations and 159 post-payment audits during FY09 and recovered \$26 million in overpayments.

The Director of the Department during the audit period was Barry Maram. He began serving as Director in February 26, 2003 and resigned on April 15, 2010. Julie Hamos was appointed Director effective April 16, 2010. She had no prior association with the Department. The number of employees during the period under review is summarized as follows:

Average Number of Employees

General Revenue Fund	FY09	FY08	FY07
Program Administration	265	265	261
Office of Inspector General	178	176	176
Attorney General	21	21	22
Medical	549	551	523
Managed Care	20	19	17
Kid Care – Look a Like	122	112	113
Kid Care - Rebate	38	34	33
Prescribed Drugs	29	32	31
Medi Rev*	7	6	3
Other Funds			
Care Provider for Persons with DD	1	1	1
Long-Term Care Provider	10	12	11
Medical Special Purpose Trust	11	12	11
Child Support Administration	1,031	990	980
Public Assistance Recoveries Trust	135	136	136
Energy Assistance	25	28	29
Group Insurance	20	18	18
Total GRF	1,229	1,216	1,179
Other Funds	1,233	1,197	1,186
GRAND TOTAL	2,462	2,413	2,365

* Medical electronic interchange recipient eligibility verification

Expenditures From Appropriations

The General Assembly appropriated \$18,432,334,000 to the Department in FY09. About 52.3% (\$9.6 billion) of the Department's appropriated funds were from the General Revenue Fund. The Department also received appropriations totaling \$8.8 billion from 25

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other funds. Total expenditures from appropriated funds were \$17,334,395,000 in FY09 which represents an increase of \$1.07 billion, or 6.55%. The increase was due to the increase of \$1.4 billion in medical assistance expenditures as a result of an increase in appropriation authority and increased cash flow due to the American Recovery and Reinvestment Act of 2009. Significant changes in expenditures were as follows:

- \$197 million increase in the County Hospital Services Fund for hospital providers;
- \$134 million decrease in provider services in the Long-Term Care Provider Fund; and
- \$799 million decrease in the Hospital Provider Fund due to 2007 and 2008 Hospital Access Improvement Payments being paid in FY08 compared to only the FY09 payments being paid in 2009.

Appendix A contains a summary of appropriations and expenditures for the period under review. During FY09, the Department spent an additional \$1,039,563,000 in non-appropriated funds. Lapse period expenditures were about \$1 billion, or about 6%.

Federal Assistance

Appendix B is a summary of the federal assistance grant awards and disbursements for FY09. Federal assistance disbursements totaled \$8,212,866,000 in FY09 compared to \$7,071,939,000 in FY08. By far, the largest federal assistance program is the Medical Assistance Program which provides financial assistance to states for payments of medical assistance on behalf of cash assistance recipients, children, pregnant women, and the aged who meet income and resource requirements and other categorically eligible groups. The federal government pays 50% of the expenses relating to most administrative costs for Medicaid.

Cash Receipts

Appendix C is a summary of cash receipts for FY09 and FY08. The Department's cash receipts were \$12,494,499,000 in FY09 compared to \$11,886,613,000 in FY08, which is an increase of almost \$608 million, or 5.1%. The \$526.7 million federal stimulus package was the result of ARRA which created a new federal revenue stream to help stabilize State and local government budgets to minimize and avoid reductions in essential services.

There was a \$982 million decrease in the Hospital Provider Fund due to two hospital assessment tax cycles occurring in FY08 and only one assessment being paid in FY09. This was offset somewhat by \$161 million in federal stimulus funds. Other significant changes were as follows:

- \$186 million increase in receipts in the County Hospital Services Fund;
- \$89 million increase in the Drug Rebate Fund was due in part to increased spending, which increased federal financial participation, and \$28 million in federal stimulus funds;

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- \$223 million increase in Tobacco Settlement Recovery Fund was the result of receiving an increased appropriation and \$72 million in federal stimulus funds;
- \$50 million decrease in the Public Assistance Recoveries Trust Fund due primarily to a \$40 million reduction in funds from private organizations or individuals;
- \$91 million increase in the Long-Term Care Provider Fund was primarily due to \$58 million in federal stimulus funds.

Property and Equipment

Appendix D is a summary of property and equipment for FY09. Property and equipment for which the Department was accountable was \$24,480,000 at June 30, 2009, a decrease of \$3.4 million over FY08. The Department's State property is composed of equipment items only.

Accounts Receivable

In FY09 net accounts receivable was about \$347.6 million, and does not include almost \$3.7 billion which is the allowance for uncollectible accounts. The accounts are subject to all manner of collection including internal offsets against future claims for providers with outstanding debt, Comptroller's Offset system, cyclical billings, letters and telephone contacts, private collection agencies, liens and judgments, and notification of credit reporting agencies. The Department has implemented other methods of collection such as: income withholding, unemployment insurance benefit intercept, federal income tax refund offset, professional license revocations, judicial remedies, driver's license revocation, new hire reporting, financial institution data match, agency collectors, Department of Revenue initiative, and referral to the Attorney General's office.

Follow-up on Previous Audits

As a result of the *Management Audit on the KidCare* program released in 2002, the OAG made seven recommendations to the Department. According to an updated response from the Department on the one outstanding recommendation of providing permanent, durable eligibility cards, the Department has addressed its technical limitations, and will proceed to develop an implementation plan. This is substantially the same answer given by the Department in FY08 audit.

The Management Audit of DHFS' Prompt Payment Act Compliance and Medicaid Payment Process released in May 2008 contained 13 recommendations. According to responses provided by the Department in the FY09 audit report, six of the 13 recommendations are fully implemented, five are partially implemented, and two recommendations are not implemented. Recommendations not implemented concern Prompt Payment Act interest calculation and interest payment timeliness. Partially implemented recommendations

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include recommendations concerning the expedited payment process; rejected claim notification; rejected claim resubmission policy; notification for denied interest requests; and exclusion of interest payments. In FY08, the Department stated that only three of 13 recommendations were not fully implemented.

Accountants' Findings and Recommendations

Condensed below are the thirteen findings and recommendations presented in the compliance examination report. There were eight repeated recommendations. The following recommendations are classified on the basis of updated information provided by Peggy Edwards, External Audit Liaison for the Department of Healthcare and Family Services, via electronic mail received November 1, 2010.

Accepted or Implemented

- 1. Ensure audit documentation is provided to the auditors in a timely manner as required by the Illinois State Auditing Act.**

Finding: The Illinois Department of Healthcare and Family Services (Department) did not provide requested documentation to the auditors in a timely manner.

During the compliance examination and financial audit, the auditors made numerous requests from the Department during fieldwork. The auditors provided 277 specific written requests for documentation to perform our testing. These specific written requests could have had multiple items within the requests such as samples of vouchers and receipts.

As requested by the Department, all of the documentation requests were to be routed through an audit liaison. It was established at the beginning of the audit engagement that a two-week turn around period would be acceptable for most document requests. Of the 277 requests, 128 (46%) requests were not fully completed by the Department within the two-week time frame. Twenty-seven requests were received two months or more after the requested due date.

Department management stated the Department and the auditors agreed to a two-week time frame for most document requests. Sometimes requests are complex, involve one area in the Department receiving multiple requests at the same time, or require outside contact for information from another agency, vendor or provider. Therefore, the Department may not be able to meet the two-week time frame on all document requests. The Department made every effort to meet the two-week time frame when feasible.

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Accepted or Implemented – continued

Response: Not Accepted. The Department disagrees with this finding. The auditors have shown no evidence that items provided after the two week time frame caused any delay in completing their audit timely. In fact, the auditors completed this year’s audit in less time than previous years.

The auditor’s chart of “days received after the due date of request” is misleading. According to the backup documents provided by the auditors, a more accurate depiction of the days the items were submitted is as follows:

Days Received after the Due Date of Request	Number of Items
1-4 days	21
5-8 days	36
9-14 days	25
17-22 days	11
26-30 days	8
31-48 days	16
62-86 days	8
91-97 days	3
Total	128

According to the auditors, the audit fieldwork was to be completed by December 29, 2009. According to the backup documents provided by the auditors, we noted the following:

- Eighty-three percent (83%) of all document requests were provided within two weeks of the due date.
- The Department had provided 112 of the 128 items noted in this finding as of the auditors scheduled end of fieldwork date (December 29, 2009).
- Of the 16 items that were provided after December 29, 2009,
 - six of these items were requested by the auditors between December 15-22,
 - five of these items were requested by the auditors in January 2010.
- All of the items, noted as late by the auditors, had been provided nearly two weeks prior to the auditors sending their final request for information on February 16, 2010.

It should also be noted that the auditors made 14 new requests after their anticipated fieldwork end date.

The Department takes the audit process very seriously and provides information to the auditors as quickly as possible. We will continue to strive to meet the two-week turn around when feasible and will continue to communicate with the auditors when we cannot meet the two-week time frame.

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Auditor's Comment: *The Department's response is absurd. The Department is not in a position to evaluate the effect the Department's delays may impose on an audit. The auditors concluded the Department did not provide timely information to the auditors which is noncompliance with the Illinois State Auditing Act. The facts in the finding clearly demonstrate this noncompliance. Audit schedules are established on the premise that information requests will be completed in a reasonable time period. For the Department's audit, a two week timeframe was established to complete audit requests. This is a generous time frame for a routine post audit.*

As noted in the finding and the Department's response, the Department exceeded this two week time frame for 128 requests. Obviously, delays in receiving requested documents will cause a delay in audit completion.

*The auditors disagree with the Department's conclusion that the auditors' chart, as presented in the finding, is misleading. The Department has simply taken the same data and displayed it in arbitrary increments of days in its response. The auditors reported that 46% of the documents were not provided within a two week period. Therefore, the Department did complete 54% of the requests within two weeks. The auditors' chart indicates that the Department completed 82 of 277 (30%) of the requests two weeks after the due date (one **month** from the original request). As reflected in both the auditors' chart and the Department's chart, it took three weeks to three additional **months** after the two week time frame had expired for the Department to complete the remaining 46 (16%) audit requests.*

Both the finding and the Department's response demonstrate the difficulty the auditors experienced in obtaining timely information and cooperation during this post audit.

Updated Response: Implemented. The Director issued a memo to HFS management staff reminding them to make audit requests a priority and to respond in a timely manner. The audit liaisons also held meetings with staff to discuss the audit process and providing adequate documentation and responses in a timely manner.

2. Implement additional internal control procedures to ensure GAAP Reporting Packages are prepared in an accurate and timely manner. (Repeated-2008)

Finding: The Department's year-end financial reporting to the Comptroller contained weaknesses and inaccuracies. In addition, financial reporting was not timely. Several errors were identified during the audit of the Department's draft financial statements. Some of the more significant adjustments were as follows:

- Payments to the federal government totaling \$16.970 million were classified as accounts payable instead of due to federal government.
- Payments to the State's internal service funds totaling \$5.850 million were classified as accounts payable instead of due to other funds.

Accepted or Implemented – continued

- Receivables totaling \$3.207 million were recognized as revenues instead of deferred revenue. The receipts were not collected within the available period of 60 days.
- Revenues from expenditures that qualify for federal reimbursement totaling \$1.701 million were not recorded in the financial statements as due from federal government and federal operating grants.
- Cash transactions were not calculated correctly resulting in the Cash Flows Statement for the two proprietary funds to be incorrect.
- The financial accounting for, and reporting of, revenue and expense accounts for the Pension (and Other Employee Benefit) Trust Funds were incorrect. Specifically, the Department incorrectly classified employer contributions and member contributions resulting in an adjustment totaling \$8.531 million. The Department also did not correctly calculate revenues and expenses resulting in an overall adjustment totaling \$2.815 million to reduce revenues and expenses.

Also, auditors noted 15 of 32 GAAP Reporting Packages were not submitted to the Comptroller timely, ranging from six to 35 days late. In addition, the Comptroller submitted to the Department review comments for the GAAP Reporting Packages on September 28, 2009 and October 13, 2009; however, the Department did not provide a response to those review comments until October 23, 2009. Further, a complete set of the Department's financial statements **was not** provided to the auditors **until** February 26, 2010, eight months **after** the year end.

The Department stated the overall complexity of the financial statements combined with the loss of institutional knowledge in the financial reporting area increased the preparation and review time and contributed to the lack of timeliness in submitting GAAP Reporting Packages and the misstatements in the draft financial statements. In addition, the financial statements were not timely due to the inclusion of the GASB 45 valuation disclosures. The GASB 45 valuation was not completed until January 7, 2010, despite the cooperative efforts between the Department, the state retirement systems and the contracted actuary.

Updated Response: Accepted. The Bureau of Fiscal Operations management has met with key HFS staff to discuss issues related to the prior year and current year that could potentially impact financial reporting to ensure more timely and accurate data. The distribution of GAAP packages has been evaluated in order to match skill levels with preparers and additional training has been provided to staff. The flow of data within the HFS financial reporting area has also been reviewed to ensure maximum efficiency. This includes analysis of the GAAP package review process to maximize institutional knowledge and overall staff availability.

3. Implement additional internal control procedures to ensure that correct reimbursement rates are used and updated in a timely manner. (Repeated-2008)

Finding: The Department did not have adequate controls for hospital rates that are reimbursed to the University of Illinois Hospital and Clinics (Hospital) for services provided to individuals.

The Department and the Board of Trustees of the University of Illinois entered into an Interagency Agreement to require the Department to reimburse the Hospital for services provided by the Hospital. The reimbursable rates are to be recalculated on October 1 of each year. The Department did not recalculate the total per diem rate or the Hospital inpatient payment rate for rate year 2009 (October 1, 2008 through September 30, 2009).

On December 4, 2008, the Department received approval from the Centers for Medicare and Medicaid Services for an amendment to the Medicaid State Plan, which changed the methodology for reimbursing the Hospital and was retro-active as of July 1, 2008. The Department did not update the methodology for reimbursing the Hospital to agree with the Medicaid State Plan amendment until fiscal year 2010. Due to the Department using 2008 rates, the Hospital was overpaid \$5,600,000 during fiscal year 2009. In addition, the Department failed to amend the Interagency Agreement to reflect the new methodology for reimbursing the Hospital.

Department management stated that they believe circumstances involving changes to the Medicaid State Plan created what is expected to be a one-time delay in implementation.

Updated Response: Accepted. A data extraction schedule will be set by the end of this calendar year to ensure timely completion of the rate determination and implementation. The conversion from Medicaid charges (data extracted) to Medicare based costs will be completed each January preceding July of the new rate period. These results will be loaded into a rate model each February and the provider rates will be sent via letter notification each May. The Department will load the final rates into the reimbursement system by June 15th for the July 1 effective date.

4. Ensure health insurance premium rates are set for the Teachers' Retirement Insurance Program as required by the State Employees Group Insurance Act of 1971. Also, ensure adequate rate setting methodologies are established and make annual required reports to the Teachers' Retirement System. (Repeated-2008)

Finding: The Department did not charge the correct health insurance premium rates for the Teachers' Retirement Insurance Program.

The Department set the FY09 health insurance premium rates for Teachers' Retirement System benefit recipient and dependent beneficiaries by increasing the prior year rate by

Accepted or Implemented – continued

5%. The Department did not take into account the percentage that was to be paid by the Teacher Health Insurance Security Fund. As a result, the Department did not have an adequate rate-setting methodology used to determine the amount of the health care premiums to be charged. In addition, the Department did not present the rate-setting methodology (included but not limited to utilization levels and costs) used to determine health care premiums to the Teachers' Retirement System by April 15th as required.

Auditors also noted the following 2009 premium rates of Teachers' Retirement Insurance Program health insurance were not in compliance with parameters established in State statute.

- The monthly health insurance premium rate charged to a Teachers' Retirement System benefit recipient for ages twenty-three through sixty-four selecting the medical coverage program was \$206.77; however, the health insurance premium rate should have only been \$205.12. The benefit recipients were overcharged a total of \$19,744 during fiscal year 2009.
- The monthly health insurance premium rate charged to a Teachers' Retirement System benefit recipient for ages sixty-five and over selecting the medical coverage program was \$310.97; however, the health insurance premium rate should have only been \$307.38. The benefit recipients were overcharged a total of \$6,570 during fiscal year 2009.
- The monthly health insurance premium rate charged to a Teachers' Retirement System benefit recipient for ages twenty-three through sixty-four selecting the major medical coverage program was \$413.53; however, the health insurance premium rate should have only been \$410.25. The benefit recipients were overcharged a total of \$297,703 during fiscal year 2009.
- The monthly health insurance premium rate charged to a Teachers' Retirement System benefit recipient for ages sixty-five and over selecting the major medical coverage program was \$621.93; however, the health insurance premium rate should have only been \$614.76. The benefit recipients were overcharged a total of \$61,103 during fiscal year 2009.
- The monthly health insurance premium rate charged to a Teachers' Retirement System dependent beneficiary who is Medicare primary was \$252.09; however, the health insurance premium rate should have only been \$232.43. The benefit recipients were overcharged a total of \$499,914 during fiscal year 2009.

Department management stated that they did not interpret the statute as requiring premiums to be determined by both an increase of no more than 5% of the prior year and the amount to be paid by the Teacher Health Insurance Security Fund. The Departments'

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failure to present the rate-setting methodology to the Teachers' Retirement System by April 15 was purely oversight.

Updated Response: Implemented. The Department delivered the rate setting methodology to the Teachers' Retirement System on April 8, 2010. Health insurance premium rates have been established according to statute.

5. Follow current procedures and comply with the Illinois Administrative Code by conducting employee performance evaluations in a timely manner. Further, comply with the Employee Handbook and ensure employee timesheets are filled out correctly and employees sign and supervisors approve employee absences prior to their requested time off or the day of the absence. (Repeated-2005)

Finding: The Department did not have adequate controls over personal services. Auditors noted the following:

- The Department did not timely complete performance evaluations for 13 of 60 (22%) employees tested, ranging between 33 and 167 business days late. Department management stated that the Division of Personnel and Administrative Services sends reminders when evaluations are due and will not process any Merit Compensation personnel transactions (i.e., promotions, separations, transfers, etc.), with the exception of address changes, if the employee's performance appraisal is past due.
- During a review of employee timesheets, four of 60 employees had timesheets that were not filled out correctly. The timesheets did not indicate the number of hours worked and/or the number of leave hours used each day.
- During a review of employee absences, seven of 60 employees with absences during work hours had "Employee Absence Request/Reports" Form (HFS 2053) that were not completed by the employee and/or approved by the supervisor prior to the absence. The forms were signed from 2 to 95 business days after the absence. In addition, nine of 60 employees that used sick time had HFS 2053 forms that were not completed by the supervisor the same day of the absence. The forms were completed from two to nine business days after the absence. Department management stated that the errors were due to oversight.

Response: Accepted. The Division of Personnel and Administrative Services will continue to send out notifications monthly indicating when evaluations are due. The Department will make every effort to ensure the forms associated with timekeeping are reviewed for accuracy and employee's absences are approved in advance or within a reasonable time frame. The Division of Personnel and Administrative Services sent staff a reminder on February 25, 2010 to ensure these documents are completed timely and accurately.

Accepted or Implemented – continued

6. Comply with all responsibilities specified in the interagency agreement with the Department of Veterans' Affairs. (Repeated-2007)

Finding: The Department did not follow the Department's responsibilities as specified in an interagency agreement. The Department did not coordinate with the Department of Veterans' Affairs (DVA) to develop written policies and procedures in order to implement the Illinois Warrior Assistance Program. Also, the Department did not transfer \$4 million to the Veterans Assistance Fund or provide DVA with quarterly reports that indicated the estimated yearly costs for the Illinois Warrior Assistance Program.

Department management stated the Illinois Warrior Assistance Program (IWAP) expenditures were considerably less than the cost projections. As a result, the Department determined that it was not necessary to transfer \$4 million to the Veteran's Assistance Fund.

Response: Accepted. The Department and the Illinois Department of Veterans' Affairs (IDVA) continue to communicate and monitor the administration of the Illinois Warrior Assistance Program on a bi-weekly basis. The interagency agreement between the Department and IDVA will be amended to reflect current policies and procedures. The current policies and procedures have been drafted and are currently under review.

7. In coordination with IDPH, implement a reimbursement methodology for all facilities in the demonstration program, keep records of services, and submit an annual report to IDPH. (Repeated-2005)

Finding: The Department failed to comply with the provisions of the Alternative Healthcare Delivery Act since it has not implemented a reimbursement methodology for all services noted in the Act. In addition, the Department did not keep a record of services provided under the program or submit an annual report of that information to the Illinois Department of Public Health (IDPH).

The Alternative Healthcare Delivery Act was intended to foster new innovations in health care delivery through the development of demonstration projects to license and study alternative health care delivery systems.

Department management stated that reimbursement methodologies for providers defined under the Alternative Healthcare Delivery Act have been established for respite care services and data supporting such payments is maintained by the Department. The Department has not established reimbursement methodologies for other types of providers under the Act, since it currently has no appropriation authority to make such payments.

Response: Accepted. However, the Department cannot establish reimbursement methodologies unless it has appropriation authority to make such payments. The

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Department will continue to review provider categories established under the Act and assess the extent to which any could potentially qualify for federal matching dollars. If the Department receives appropriations for any new class of providers, the Department shall establish reimbursement rates at that time.

Updated Response: Implemented. The mandate for HFS to develop and implement a reimbursement methodology for all facilities participating in the demonstration program was removed from state law by Public Act 096-1123 on July 20, 2010.

- 8. Comply with the Illinois Public Aid Code by ensuring the entity contracted to provide external peer-based quality assurance reviews is representative of physicians licensed to practice medicine in Illinois and has statewide geographic representation in all specialties of medical care that are provided in managed health care programs administered by the Department. If at all possible, ensure the review process is developed and conducted by Illinois licensed physicians.**

Finding: The Department contracted with an entity to provide external peer-based quality assurance reviews for the managed health care programs administered by the Department; however, the entity did not have offices in Illinois, nor did the entity have Illinois physicians involved in the review process as required by law.

Department management stated that they followed the Procurement Code competitive bidding process to secure a contractor that met federal requirements. The winning bidder was not Illinois based.

Response: Accepted. Although the current contractor to provide external peer-based quality assurance reviews for the managed health care programs meets federal requirements, the Department will seek another vendor that complies with the statute to review the one Managed Care Community Network operating in the State.

Updated Response: The Department anticipates posting an RFP by July 1, 2011 to secure a new contractor. The contract with the new vendor would begin in March 2012.

- 9. Comply with the Illinois Public Aid Code by procuring a contract with a provider of community mental health services for the purpose of supporting the implementation of time-limited resident review and rapid reintegration.**

Finding: The Department failed to contract with a provider of community mental health services or utilize up to \$2,000,000 of the FY09 appropriations for the purpose of supporting the implementation of time-limited resident review and rapid reintegration.

The Illinois Public Aid Code requires the Department, subject to appropriations, to enter into a contract with a provider of community mental health services that has more than

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700 beds at over 30 service locations in multiple counties for the purpose of supporting the implementation of time-limited resident review and rapid reintegration targeted to residents of federally defined Institutions for Mental Disease.

Department management stated that they have been working with the Department of Human Services, Office of Mental Health to obtain a commitment to fund services for the identified individuals moving from the institutional setting on an ongoing basis following the initial year of HFS funding. Without such a commitment the likelihood of a successful transition and continuity of services for participating individuals could be in jeopardy. Therefore, the Department delayed execution of the contract until this could be resolved.

Response: Accepted. Though discussions ensued with the intended community provider and the Department of Human Services, Office of Mental Health (DHS), the Department did not proceed with a contract due to the uncertainty of ongoing service funding to this high need population following the initial year of HFS funding. The issue was further complicated by the State's negotiations with the plaintiffs in the Williams class action lawsuit. To remedy this finding, the Department will seek to amend this provision to comport with provisions of the lawsuit settlement.

Updated Response: HFS will work with the Department of Human Services, Office of Mental Health to incorporate specifics of this project into intra-agency implementation planning in support of the Williams v. Quinn consent decree.

10. Comply with the Public Aid Code by establishing an interagency committee with the Department of Human Services to act as health care advocates. (Repeated-2008)

Finding: The Department did not jointly create an interagency committee with the Department of Human Services (DHS) to act as health care advocates with the following duties:

- Assist the departments in making recommendations on incorporating health care advocates into education, training, and placement programs.
- Develop more outreach and educational programs to help TANF families make informed decisions about health insurance and health care.
- Develop methods to simplify the process of applying for medical assistance.

Department management stated that they continue to communicate with DHS concerning the establishment of the required interagency committee.

Response: Accepted. The Department has designated a Healthcare and Family Services' member to serve on the jointly established committee for the purpose of assisting the Department in making recommendations on incorporating health care advocates into

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education, training, and placement programs. The Department will continue to work with DHS to establish the new committee in coordination with already existing committees.

Updated Response: HFS has contacted DHS regarding formation of this committee.

11. Comply with the Disabilities Services Act of 2003 by strengthening controls to ensure that the Department submits the annual Medical Assistance Program report to the Governor and the General Assembly on or before April 1, and make the latest report available to the general public, via the Department's website.

Finding: The Department failed to comply with the provisions of the Disabilities Services Act of 2003 when it did not submit the annual Medical Assistance Program report to the Governor and the General Assembly on or before April 1. Additionally, the Department did not make the 2008 annual Medical Assistance Program report available to the public on the Department's website.

Department management stated that new data elements were added to an existing report in order to comply with the Act. Distribution to the Governor's office and posting on the Department's web site were not part of the existing report's requirements. Staff were not aware of the additional requirements per this statute.

Response: Accepted. The Department has implemented internal controls to ensure the annual Medical Assistance Program report is submitted to the Governor and the General Assembly on or before April 1. The most recent report has been made available to the general public, via the Department's website.

12. Comply with the State Finance Act by ensuring that Medicaid Program reports are filed in a timely manner. (Repeated-2008)

Finding: The Department did not comply with the State Finance Act when it did not submit a required annual report which documented information in regard to the State's Medicaid Program until 29 days after the report was due.

Department management stated the delay was the result of the levels of review and scrutiny required due to the overall material impact on the State's financial position.

Response: Implemented. The report due November 30, 2009 was filed timely.

13. Comply with the Illinois Public Aid Code by implementing and operating the pilot project in a timely manner.

Finding: The Department failed to comply with the provisions of the Illinois Public Aid Code when as of June 30, 2009, there was no pilot project to determine the effect of

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raising the income and non-exempt asset eligibility thresholds for certain persons with disabilities to determine if those persons are able to maintain their homes in the community and avoid institutionalization.

Department management stated that staff has committed significant time and effort to develop the program and operations procedures but have not yet implemented the pilot project.

Response: Accepted. The Department will continue to work toward implementation of the pilot project.

Updated Response: This mandate has been put on the list to be repealed.

Emergency Purchases

The Illinois Purchasing Act (30 ILCS 505/1), which was in effect during the two-year period under review, stated that “the principle of competitive bidding and economical procurement practices shall be applicable to all purchases and contracts.” The law recognized that there will be emergency situations when it will be impossible to conduct bidding. It provided 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 or 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 were 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 was to set forth the circumstance requiring the emergency purchase. The Commission received quarterly reports of all emergency purchases from the Office of the Auditor General. The Legislative Audit Commission was directed to review the purchases and to comment on abuses of the exemption.

During FY09 the Department filed two affidavits for emergency purchases totaling \$120,295.50 as follows:

- \$78,668.50 for the services of a process server to allow time for a contract to be re-bid; and
- \$41,627.00 for printing of materials to be included with medical cards.

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 of its officers and employees for whom official headquarters have been designated at any location other than that at which their official duties require them to spend the largest part of their working time. The Department of Healthcare and Family Services reported in July 2009 that it had 46 employees spending more than 50% of their working time away from their official headquarters.