# LEGISLATIVE AUDIT COMMISSION

Review of
Department of Human Services
Two Years Ended June 30, 2019

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**REVIEW: 4523**
**DEPARTMENT OF HUMAN SERVICES**
**TWO YEARS ENDED JUNE 30, 2019**

**FINDINGS/RECOMMENDATIONS – 38**

**IMPLEMENTED – 21**
**PARTIALLY IMPLEMENTED – 17**
**ACCEPTED – All**

**REPEATED RECOMMENDATIONS – 30**
**PRIOR AUDIT FINDINGS/RECOMMENDATIONS – 42**

This review summarizes the auditors' report on the Department of Human Services, Compliance Examination for the year ended June 30, 2019, filed with the Legislative Audit Commission on July 7, 2020. The auditors conducted a financial audit in accordance with state law and Government Auditing Standards.

This review summarizes the report on the Department of Human Services, which includes the facilities operated by DHS which includes:

- 6 Developmental Centers;
- 6 Mental Health Centers;
- 1 combined Mental Health and Developmental Center;
- 1 Treatment and Detention Facility; and
- 3 Rehabilitation Services Facilities.

The auditors performed a financial audit for FY18 and FY19 filed with the Legislative Audit Commission on August 22, 2019 and April 28, 2020, respectively; and a compliance examination for FY18-19, filed on July 7, 2020. The reports were performed in accordance with *Government Auditing Standards* and the Illinois State Auditing Act. The auditors stated that the financial statements were fairly presented. However, the accountants stated that because of the significance and pervasiveness of the findings described within the report, they expressed an adverse opinion on DHS' compliance. The Codification of Statements on Standards for Attestation Engagements (AT-C § 205.72) states a practitioner "should express an adverse opinion when the practitioner, having obtained sufficient appropriate evidence, concludes that misstatements, individually or in the aggregate, are both material and pervasive to the subject matter."

Illinois House Bill 2632 created the Illinois Department of Human Services (DHS) which on July 1, 1997 consolidated the Departments of Alcoholism and Substance Abuse, Mental Health, Developmental Disabilities and Rehabilitation Services, along with the client-centered services provided through the Departments of Children and Family Services, Healthcare and Family Services and Public Health. DHS established as its primary mission to assist Illinois residents to achieve self-sufficiency, independence and

health, to the maximum extent possible, by providing integrated family-oriented services, promoting prevention and establishing measurable outcomes, in partnerships with communities.

The Secretary of DHS during the audit period was Mr. James T. Dimas who served from May 2015 until March 2019 when Grace Hou was appointed Secretary and continues to serve in that capacity. Ms. Hou served as Assistant Secretary at DHS from 2003 until 2012. Ms. Hou also recently served as the President of Woods Fund Chicago from February 2012 to March 2019. Woods Fund Chicago is a bold grant making foundation. Early in her career, she was the Executive Director of the Chinese Mutual Aid Association (CMAA) and has been a vocal advocate for immigrants' rights.

The number of employees by division at June 30 appears:

| Division | FY17 | FY18 | FY19 |
|---|---|---|---|
| Administrative & Program Support | 762 | 721 | 713 |
| Division of Alcohol & Substance Abuse | 39 | 43 | 43 |
| Division of Rehabilitative Services | 1,541 | 1,487 | 1,456 |
| Division of Developmental Disabilities | 3,768 | 3,727 | 3,786 |
| Division of Mental Health Services | 2,510 | 2,413 | 2,343 |
| Division of Family & Community Services | 3,880 | 3,993 | 4,031 |
| **TOTAL** | **12,500** | **12,384** | **12,372** |

## Appropriations and Expenditures

DHS' expenditure authority in FY19 was $6.64 billion compared to $6.61 billion in FY18. Total expenditures were $5.61 billion in FY19 compared to $5.42 billion in FY18, an increase of $185 million, or 3.4%. Total non-appropriated funds were $164.1 million in FY19 compared to $118.1 million in FY18, an increase of $46 million, or 38.9%.

Lapse periods for FY18 and FY19 were extended through October 31. Lapse period expenditures for DHS in FY18 were almost $574 million, or 10.6% of total appropriated expenditures. In FY19 lapse period expenditures were approximately $598 million, or 10.7% of total appropriated expenditures. Statistical tabulation charges accounted for most of both fiscal years' lapse period spending.

Total facility expenditures were $486.7 million in FY18 compared to $487.6 million in FY19. DHS had an average of 3,756 residents/students at centers in FY18 compared to 3,755 in FY19. Cost of care in FY19 ranged from a high of $448,284 per resident/student at John J. Madden Mental Health Center to a low of $65,185 at the School for the Deaf. The average number of employees at the facilities was 6,317 in FY19.

## Cash Receipts

DHS' cash receipts totaled $1.9 billion in FY19. Cash receipts decreased by $6.7 million, or about 0.4%, from FY18.

- A decrease of $134.4 million during FY18 and FY19 in the Employment and Training Fund occurred because the Temporary Assistance to Needy Families grant (TANF) were less due to timing of expenditures and the resulting draw of federal funds.
- An increase of $82.8 million from FY17 and FY19 in DHS Special Purposes Fund due to a number of receipts to the U.S. Department of Agriculture, Education, HHS, and for the Illinois State Board of Education.
- A decrease of about $31 million in the FY18 and then an $81 million increase in FY19 due to Title XX Block Grant funds not being released in a timely manner, which resulted in delays in the Department being able to draw on the funds.

## Changes in Property

The value of DHS' property, which includes equipment, land and land improvements, buildings and building improvements, site improvements, and capital lease equipment, was $760,219,230 at the beginning of FY18 and increased to $776,207,965 in FY19. The majority of the increase was due to net transfers in buildings and buildings improvements of approximately $19 million.

## Accounts Receivable

DHS' net accounts receivable totaled $453 million as of June 30, 2019. About $312 million in receivables is due from the Federal Departments of Health and Human Services, Agriculture, Education and the Social Security Administration. Other receivables, net, included an increase of $134 million in amounts due from Other State Funds for FY19. Weaknesses in accounts receivable were noted in findings three and four.

## Emergency Purchases

The Illinois Procurement Code (30 ILCS 500/) states, "It is declared to be the policy of the state that the principles 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 when there exists a threat to public health or public safety, or when immediate expenditure is necessary for repairs to state property in order to protect against further loss of or damage to state property, to prevent or minimize serious disruption in critical state services that affect health, safety, or collection of substantial state revenues, or to ensure the integrity of state records; provided, however that the term of the

emergency purchase shall not exceed 90 days. A contract may be extended beyond 90 days if the chief procurement officer determines additional time is necessary and that the contract scope and duration are limited to the emergency. Prior to the execution of the extension, the chief procurement officer must hold a public hearing and provide written justification for all emergency contracts. Members of the public may present testimony.

Notice of all emergency procurement shall be provided to the Procurement Policy Board and published in the online electronic Bulletin no later than five business days after the contract is awarded. Notice of intent to extend an emergency contract shall be provided to the Procurement Policy Board and published in the online electronic Bulletin at least 14 days before the public hearing.

A chief procurement officer making such emergency purchases is required to file a statement with the Procurement Policy Board and the Auditor General to set forth the circumstance requiring the emergency purchase. The Legislative Audit 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.

Per DHS' records, six affidavits were filed for emergency purchases in FY18 totaling $2,525,784 as follows:

- $306,787 to repair or replace failing steel support poles at the Mabley facility;
- $744,000 for critical services for the Mental Health Division
- $104,700 for an emergency state plan for independent living for the Department of Rehabilitation Services;
- $367,421 to prepare the mental health provider community to provide Evidence Based Practices;
- $96,285 to purchase meat for all 15 facilities;
- $906,591 for the Bureau of Early Interventions' Central Billing Office to continue services to direct service providers.

Per DHS' records, during FY19, six affidavits were filed for emergency purchases totaling $2,492,035 as follows:

- $732,209 to upgrade mailing equipment for the Office of Business Management;
- $13,031 to stop leaks in the steam lines at the Choate Center;
- $45,407 for repairs on Elgin Mental Health Center's boilers;
- $599,950 for Sole Source Hospital to PMP website connections for the Elgin facility;
- $680,734 to address an electrical outage at the Elgin facility;
- $420,704 for continued fiscal, payroll and bill payment services for the Developmental Disabilities Division.

## 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.

As of July 2020, DHS had 214 employees assigned to locations other than official headquarters.

## Accountants' Findings and Recommendations

Condensed below are the 38 findings and recommendations included in the audit report. Of these, 30 are repeated from the previous audit. The following recommendations are classified on the basis of information provided by DHS, via electronic mail received July 7, 2020.

**1. The auditors recommend DHS assume more responsibility for the transactions and balances reported in its financial statements that are initiated/estimated by other State agencies, including the following:**

- **DHS should work with management of HFS to gain a detailed understanding of the internal control system established over DHS transactions and reporting, and enter into an interagency agreement with HFS that details the responsibilities of each agency and how this will be monitored. Subsequently, on a regular basis, DHS should determine if the control system and related monitoring is sufficient to prevent and detect significant financial statement errors.**

**Expenditure and accrual amounts provided by HFS in connection with year-end reporting of Federal MAP receivables should be reconciled to CARS or agreed to reports and source data compiled by HFS.**

**FINDING:** (*Medical Assistance Program Financial Information)*

During testing of the financial statements and supporting documentation, auditors noted the following:

- DHS could not provide documentation of the preparation for expenditure reconciliations for Federal Medical Assistance Program (MAP) funds (Funds 0120, 0142, 0365, 0502, 0718) between amounts reported in DHS' Consolidated Accounting and Reporting System (CARS) and amounts reported in the Grant/Contract Analysis Forms (Form SCO-563s) provided to the Comptroller's

Office (IOC) which support the receivable calculation for financial reporting. Additionally, there is no documentation maintained by DHS to support the calculation and methodology used by HFS in preparing the federal receivable amount.

- During testing of expenditures and liabilities, auditors determined that DHS is not monitoring or reviewing the payments submitted by HFS, or the liabilities calculated by HFS, on behalf of DHS and reported in DHS' financial statements. When HFS submits a request for payment to the IOC, a summary file is also sent to DHS which goes through an interface and is recorded into CARS. An employee in DHS' Fiscal Services Bureau reconciles the payments between CARS and the IOC before accepting them into CARS. Auditors selected and tested multiple expenditures and liabilities initially processed by HFS. Currently, DHS receives summarized information from HFS and records the transactions into CARS and the GAAP packages without performing sufficient procedures to determine the accuracy of the information.

DHS management indicated they have not performed a detailed review or analysis of the system used by HFS to accumulate information reported in DHS' Funds that report Medical program transactions and balances, and instead they have placed a significant amount of reliance on information that is easily assessable such as HFS audit and examination reports.

**RESPONSE:**
DHS accepts the recommendation. DHS will prepare documentation, at a high level, of HFS' internal controls over transactions and institute annual monitoring. DHS will implement a process to verify data provided by HFS is reconciled to source data.

**UPDATED RESPONSE:** Implemented.

**Corrective Action in Progress:**

1. Elevate the need for a statewide IGA for Medicaid processes to Executive Staff and determine path forward.
2. Research and document our Medicaid programs and transaction flows with attention specifically on internal controls.
3. Explore reconciliation options for expenditure and accrual amounts provided by HFS.

**(Estimated Date of Completion: CAP 1 - 12/31/2021 CAP's 2 & 3 – 8/31/2021)**

**2. The auditors recommend DHS obtain SOC 1 Type 2 reports, or perform independent reviews of internal control associated with TPPs, at least annually. The independent reviews should include an assessment of the following five key system attributes, as applicable:**

- **Security - The system is protected against both physical and logical unauthorized access.**
- **Availability - The system is available for operation and use as committed or agreed.**
- **Processing integrity - System processing is complete, accurate, timely and authorized.**
- **Confidentiality - Information designated as confidential is protected as committed or agreed.**
- **Privacy - Personal information is collected, used, retained, disclosed, and disposed of in conformity with Department requirements.**

**An independent review should also encompass the design and effectiveness of controls over the processing of DHS transactions for food instruments (WIC), Early Intervention and Home Based Services. When SOC 1 Type 2 reports are obtained, DHS should perform a timely review of the reports, assess the effect of any noted modifications to the opinion and deficiencies, and identify and implement any compensating controls. DHS' reviews and corrective actions taken by the TPP (third party providers) should be documented and maintained. In addition, DHS should perform an analysis to determine the need to obtain information as to any subservice organization's internal controls and perform reviews as needed.**

**FINDING:** (*Lack of Adequate Controls over the Review of Internal Controls over Service Providers)*

During the audit period, DHS identified ten third-party service providers (TPP) which provided various services. Additionally, DHS determined five of the TPPs provided services which were material to their financial reporting process.

The services these five TPPs provided were:

- Processing of negotiable food instruments (WIC program) – TPP validates food instruments by performing data entry and system edits that either allow payment or cause return of the food instrument to the bank of first deposit. The TPP processed approximately $160 million in WIC vouchers during the audit period.
- Home Based Services (developmental disabilities program) – TPP processes timesheets for home based service workers, pays the workers, and files the related payroll tax returns. The TPP processed approximately $150 million of transactions during the audit period.
- Provider claims processing for the Early Intervention (EI) program – TPP receives, reviews and approves claims from Providers, and provides claims data to the Department for payment. Approximately $128 million in claims was approved for payment to the TPP during the audit period. The TPP also bills EI participants for their family participation fee (approximately $5 million) and bills Medicaid for qualified services provided to EI participants (approximately $41 million).

- Electronic visit verification system for the Home Services program (HSP) personnel – The TPP processed approximately $571 million of transactions during the audit period.
- Processing of SNAP and cash assistance benefits for the Illinois LINK program– The TPP processed approximately $2.7 billion of transactions during the audit period.

During testing, auditors noted DHS did not obtain a System Organization and Control (SOC) examination, SOC 1 Type 2, report for the first three of the five TPPs listed above, which are material to DHS' financial reporting process. Due to the lack of suitable SOC reports, auditors were unable to determine if these three TPP's internal controls were adequate or if they utilized subservice providers which should be assessed.

In addition, for the two SOC reports received, auditors noted:

- For the TPP which processes SNAP benefits (Electronic Benefit Transfer "EBT" of food stamps), the Independent Service Auditor issued a qualified opinion for the second year in a row. The TPP processed approximately $2.7 billion in SNAP benefits during the audit period.

- DHS management indicated they had not performed any monitoring of the TPP and did not assess the impact of the control deficiencies on DHS' internal controls over their financial reporting processes, DHS' compliance with the provisions of laws, regulations and grant agreements, or the potential impact on the SNAP clients because of recent turnover in the Illinois Link /EBT Program Director position.

For the second SOC 1 Type 2 report received, the report had an unmodified opinion (provision of the electronic verification system for the Home Service personnel). However, DHS was unable to provide documentation supporting they had reviewed the report and concluded as to whether any follow up or further action was warranted.

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

**RESPONSE:**
DHS accepts the recommendation. DHS agrees that internal controls associated with external party service providers should be strengthened.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action in Progress:**

1. DHS established a procedure to ensure all contracted third party service providers are reviewed and considered when compiling a contracted third party service provider population annually, that procedure is being revised to ensure it also contains IT controls for SOC 2 Report third party service providers.

2. DHS has partially implemented the process of obtaining all contracted third-party service provider SOC Reports.

3. DHS is continuing to establish and implement processes and procedures for reviewing all contracted third-party service provider annual SOC Reports.
4. DHS is in the process of establishing procedures to ensure gaps in timing between the contracted third-party service providers SOC Reports and DHS' financial data are adequately addressed by alternate process within the DHS program areas or divisions.

**(Estimated Date of Completion: 12/31/2022)**

**3. The auditors recommend management increase the level and quality of supervisory review of year-end financial reporting including the following:**
- **Perform an analysis of grant receivables and revenues in total for each significant Federal award to make sure balances recorded in individual funds are accurate.**
- **For disclosures of estimates in the Notes to the Financial Statements, such as the contingencies note, review all supporting documentation that is used as a basis for disclosing the information.**

**FINDING:** *(Weaknesses in Preparation of Year-End Department Financial Statements)*

DHS does not have adequate controls over the completeness and accuracy of year-end financial reporting which resulted in errors in the GAAP basis financial statements and supporting schedules provided to the auditors. DHS does not perform a sufficient supervisory review of all amounts recorded in its financial statements and footnotes.

The auditors noted the following issues while testing the year-end financial reporting process:

1. The amounts recorded for Due from Other Governments - Federal (receivable) pertaining to the Temporary Assistance to Needy Families grant (General Fund 0001) and the Vocational Rehabilitation (VR) grant (Vocational Rehabilitation Fund 0081) were understated by approximately $70.4 million and $4.3 million, respectively. An adjustment to correct the error in Fund 001 was recorded by DHS management.

2. Financial statement Note 13 *Commitments and Contingencies*, pertaining to SNAP overpayment claims was overstated when first provided to the auditors due to a formula error contained in the supporting calculation. As a result, the disclosure of the net receivable from beneficiaries was overstated by $53 million and the liability to the federal government was overstated by $42 million. An adjustment to correct the error was recorded by DHS management.

DHS' federal grants are predominantly reimbursement-type grants wherein eligibility requirements are fulfilled upon incurring qualified expenditures.

DHS management indicated of the issues noted, the first resulted from a change in grant management that was not communicated to General Accounting and the second resulted from human error.

**RESPONSE:**
DHS accepts the recommendation. DHS will review internal procedures for enhancements to address these inaccuracies.

**UPDATED RESPONSE:** Implemented.

**Corrective Action in Progress:**

1. Review and modify procedures for deposit of federal award revenues and accounting for grant receivables and revenues.
2. Review statutory language relating to DHS funds and forward documentation to DHS Legal for analysis.

**(Estimated Date of Completion: 8/31/2021)**

**4. The auditors recommend DHS review all legislation that influences revenues and receivables prior to preparing the Comptroller SCO-563 forms to ensure revenues and receivables are not significantly misstated due to the impact of legislative limitations on depositing money into various funds.**

**FINDING:** *(Failure to Deposit Federal Funds According to Statute)*

DHS did not comply with statutory requirements relating to depositing federal funds in accordance with the Mental Health and Developmental Disabilities Administrative Act (MH Act) and overstated receivables in the Community Developmental Disability Services Medicaid Trust Fund (Fund 0142) and the Home Services Medicaid Trust Fund (Fund 0120).

Additionally, the DR Act limits the amount of Title XIX and Title XXI funds to be deposited into Fund 0120 to $234 million. During FY19, approximately $233 million was deposited into the fund, which was allowable and represented the total to be received for the year.

However, DHS also recorded a receivable in Fund 0120 for an additional $16.2 million of federal funds. This situation resulted in an overstatement of the receivable of $16.2 million.

Correcting adjustments for Funds 0142 and 0120 were recorded by DHS in the financial statements.

DHS management indicated that FY19 was the first year of the new funding language limiting the amount of revenues to be deposited into Fund 0142 to $60,000,000. DHS worked with HFS staff to establish a bi-monthly deposit plan for that amount. However, in addition to the planned bi-monthly deposit HFS deposited federal reimbursement received for two children's waivers for individuals with developmental disabilities. The effect of the change in legislation limiting deposits for Title XIX and Title XXI funds into Funds 0120 and 0142 was not considered when determining the Federal Receivable amount calculated on the SCO-563s for these funds.

**RESPONSE:**
DHS accepts the recommendation. DHS will review and account for legislative changes which influence revenues and receivables.

**UPDATED RESPONSE:** Partially Implemented.

**5. The auditors recommend DHS work together to:**

- **provide adequate training and supervision of caseworkers;**
- **implement additional controls to ensure appropriate documentation of eligibility is obtained at the time of certification and retained in IES,**
- **complete certifications of applications and redeterminations timely,**
- **establish formal lines of communication between operating unit personnel and financial reporting personnel, and**
- **correct IES application errors.**

**FINDING:** *(Inadequate Controls over Eligibility Determinations, Redeterminations and Mid-Point Reporting Requirements)*

HFS and DHS (collectively, the "Departments") lacked controls over eligibility determinations, redeterminations and Mid-Point Reporting requirements for Federal programs where such determination/requirement is documented using the Integrated Eligibility System.

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

In order to conclude if the determination of eligibility was proper, auditors selected a sample of 60 cases (29 new applications and 31 redeterminations) and tested whether the cases were properly certified (approved or denied) based on non-financial, financial and timeliness criteria. For SNAP cases auditors also tested whether the Mid-Point Report (MPR) was timely certified, where applicable. The testing considered all the documentation contained within the case file, including the scanned documentation supporting caseworker overrides required prior to certification. In 13 of the 60 cases tested (21.7%) auditors noted 15 exceptions where either the case was not certified timely and/or the case file did not contain documentation supporting eligibility upon certification.

Specifically auditors noted:

- For 6 cases (10%) the application, redetermination or mid-point report was not approved or denied timely. For 6 SNAP cases, the approval or denial was between 4 and 264 days late. For 2 Medical cases, the approval or denial was 32 and 175 days late. (The 2 Medical cases were also SNAP cases.)
- For 1 case (1.7%) the file did not contain documentation of an application for benefits.
- For 1 case (1.7%) the file did not contain the redetermination form.
- For 6 cases (10%) the recipients' reported income was not fully supported or not accurately supported.
- For 1 case (1.7%) the file did not include verification of non-citizen status.

Departments' management indicated the above errors were due to caseworker error. Caseworkers did not complete eligibility determinations timely and did not sufficiently scan and upload all necessary eligibility documentation into the IES case file.

Auditors noted the following types of issues the caseworkers encountered in their utilization of IES while working with recipients:

- IES timed out and sent the caseworker back to the login screen while entering recipients' information. Consequently, the caseworker had to reenter information.
- IES indicated a recipients' information contained errors; however, the caseworker's review of the information noted no errors.
- IES had technical errors while interfacing the other applications to conduct verification of the recipients' information.
- IES had errors in determining the benefits for recipients.
- IES had issues determining recipients' eligibility.
- IES was unable to produce correspondence to recipients.

DHS management indicated the above errors and problems were due to IES technical defects.

Further, auditors noted insufficient communication between the Departments' internal operating units which administer IES and related systems and the Departments' financial reporting units, along with a lack of communication between the Departments and the auditors. Auditors discovered that in September 2019, HFS' Bureau of Eligibility Integrity identified system defects which resulted in temporary eligibility status recipients, or

presumptively eligible recipients, maintaining their eligibility status in error after the Departments had deemed them ineligible. However, this condition was not reported to HFS' financial reporting unit to determine the impact of this defect on the Departments' financial statements, and it was not made known to the auditors. In fact, it was not until February 2020, during testing for the Statewide Single Audit performed by other auditors, that exceptions in the other auditors' testing and further inquiries related thereto led to HFS' disclosure of the existence of these system defects. At auditor's request, HFS performed an analysis of the impact of this defect on the Departments' financial statements and determined HFS paid benefits of $4.7 million in error for recipients who had been determined ineligible and received $217 thousand in federal financial participation (FFP) from those disbursements, pertaining to FY19. The Departments concluded these errors were not material to the financial statements, and as such no changes to the financial statements resulted.
The more significant eligibility errors identified in the PERM report were:

- Documentation to support eligibility determinations was not maintained.
- Verification/documentation not done/collected at the time eligibility was determined.
- Eligibility was not re-determined within timeliness criteria (See Finding 2019-007).

**DEPARTMENT OF HUMAN SERVICES' RESPONSE:**
DHS accepts the recommendation. Training of staff continues to be an important factor for the successful operation of IES. DHS continues to adjust and improve mandated IES training as needed.

DHS agrees to work with all staff, including Regional Administration and Policy experts in order to identify any potential additional controls that would assist in ensuring appropriate documentation of eligibility is obtained and retained in IES.

The timely certification of applications and redeterminations are a constant and continuous priority. DHS agrees to continue to communicate to staff the importance of timeliness. Since late in calendar year 2018, the SNAP timeliness rate has successfully climbed from below 65% to above 95% in early calendar year 2020.

The portion of this finding related to insufficient lines of communication from operating unit personnel and financial reporting personnel is specific to HFS. DHS has no comment.

DHS, HFS, and DoIT continue to work on system defects and enhancement requests to ensure that IES is running optimally and handles applications according to relevant policy.

**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**
HFS and DHS are working together to improve staff training materials and communication as well as better documentation through use of electronic case records. HFS submitted corrective action plans to Federal CMS to address the PERM report. HFS and DHS continue to address timeliness issues with both applications and redeterminations through staff hiring and process simplification. The HFS Division of Medical Programs

and the Division of Finance will develop a formal process to communicate any system defects that may have financial impact. HFS continues to work with DoIT / DHS to prioritize defects and enhancements for release into IES to improve performance and accuracy.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action in Progress:**

1. A management review will be held to determine if current guidelines and quality checks for maintaining accurate and thorough case records are functioning as needed.

2. Targeted training on correct calculation and data entry of income will continue to be assessed and as needed targeted training will be implemented regarding current policy requirements and business process procedures.

3. Working with the Statewide Processing Unit and DoIT, extract reports identifying pending requests for benefits coming due for certification will be identified and assigned for processing. The additional reports will allow for the identification of requests needing targeted action.

4. Two statewide processing centers have been created to work to address pending requests coming due on a statewide level.

5. A third statewide processing center is in the planning stages and will be created to aid in timely processing of requests.

**(Estimated Date of Completion: 12/31/2021)**

**6. The auditors recommend management of the Departments (DHS and HFS) enhance security controls over the IES environment, application, and databases. Specifically, the Departments should enhance controls to address back-ups of all servers on a regular basis and update operating systems for servers which are running software no longer supported by the vendor. Further, the Departments should enhance policies governing termination of IES access rights. The policy should be specific in describing the maximum period of time allowed for terminating the access rights. Finally, the Departments should ensure a complete and accurate record of all servers on which IES resides is maintained.**

**FINDING:** *(Lack of Security Controls over the Integrated Eligibility System (IES))*

Environment Security

Auditors requested the Departments provide the population of servers in which IES resided. In response, the Departments provided a population; however, testing noted the population was incomplete.

Even though the populations was incomplete, auditors tested the population of servers the Departments provided noting 139 of 198 (70%) servers were running operating systems which were no longer supported by the vendor. In addition, 36 of 198 servers (18%) were not being backed up. Furthermore, the Departments did not provide documentation demonstrating antivirus software had been installed on the servers hosting IES and its data.

Additionally, during the Departments' internal security review completed as part of its Plan of Actions and Milestones (2019) report to the Centers for Medicare and Medicaid Services, the following significant security threats were identified:

- Protected health information and personal identifiable information was exposed to shared service areas,
- Audit logs were not generated,
- Inadequate access provisioning,
- Inadequate server configurations, and
- Multifactor authentication was not enabled.

The Departments indicated the lack of resources and oversight contributed to the weaknesses.

User Access Security

During testing of the Departments' access provisioning policies, auditors noted the policies did not define the time period in which the Departments were required to disable a terminated individuals' system access. In the review of 26 terminated IES users, auditors noted 12 (46%) had their access terminated 2 to 90 days after termination of employment.

The Departments' management indicated they believe their access provisioning activities were in accordance with Departments' policy, industry standards and the Code.

The Departments' failure to maintain adequate internal controls over the security of the IES application and data increases the risk IES may be exposed to malicious attacks, security breaches, and unauthorized access to recipients' personal and health information.

**DEPARTMENT OF HUMAN SERVICES' RESPONSE:**

DHS accepts the recommendation. DHS and HFS continue to work with DoIT on the acquisition and organization of servers and other infrastructure to support the Integrated Eligibility System (IES). The current focus of these efforts is to migrate IES system

Databases from end-of-life servers, in order to resolve existing vulnerabilities and allow for backup of all active IES servers. A complete and accurate configuration listing of active IES servers is in development and will be maintained throughout this infrastructure reorganization.

DoIT and DHS continue to work with the State's IES development vendor, toward resolution of outstanding Plan of Action and Milestones (POAM) items, which includes the addition of detailed audit logs in IES.

DoIT and DHS will assist DHS Family and Community Services (FCS) Division in documenting policies governing access provisioning, approving access, maintaining access, and deactivation of access to reduce the risk of unauthorized and/or inappropriate access to IES.

**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**
HFS accepts the recommendation. HFS will work with DoIT / DHS to ensure a complete and accurate record of all servers is maintained and servers are backed up. HFS will enhance its policy governing system access.

**7. The auditors recommend management of the Departments (HFS and DHS) work together to implement controls to comply with the requirement that applications are reviewed and approved or denied within 45 or 30 days, as applicable. Furthermore, the Departments should establish appropriate controls to both monitor the progress of eligibility redeterminations and ensure those redeterminations occur timely along with any change documentation received.**

**FINDING:** (*Untimely Processing of Applications for Benefits and Redeterminations of Eligibility for Benefits)*

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

Initial Applications

At June 30, 2019, the Departments had a backlog of 107,242 Medical applications, 19,957 SNAP applications, and 6,476 TANF applications, for which the determination of eligibility to receive benefits was not complete. Of the 26,433 SNAP and TANF applications, there were 4,194 applications which had applied for both programs.

Additionally, there were 1,279 applications in which the applicant did not specify the program; therefore, auditors were unable to determine the timeliness of the application.

Redeterminations

As of June 30, 2019, the Departments had a backlog of recipients for which eligibility redeterminations were required and redetermination information was provided by the recipients. The backlog at June 30, 2019 included at least 170,720 medical redeterminations, and 980 SNAP and TANF redeterminations.

In addition to the above known redetermination backlog, because of a defect within IES, the date information was received was not documented and we were unable to determine the timeliness of the redeterminations for 68,612 Medical recipients and 2,146 SNAP and TANF recipients.

The 239,332 individuals above (170,720 redeterminations that contained a date and 68,612 redeterminations which did not contain a date) were part of 152,425 cases with pending medical redeterminations that were incomplete. In addition, there were 863 recipients with pending medical redeterminations for which information was provided, however it did not document the receipt date.

Change Documentation

When a recipient encounters a change in their situation, which may have an impact on eligibility, the recipient is to notify the Departments of such change. As of June 30, 2019, the Departments had a backlog of 51,903 cases for which information had been received but not reviewed. Because the information had not been reviewed, the Departments did not know which program(s) might be impacted. As such, we were unable to determine the timeliness of processing the information.

Center for Medicare and Medicaid Services

In the Centers for Medicare and Medicaid Services (CMS) findings from its Payment Error Rate Measurement (PERM) reporting year 2019 report, it was projected that $977 million of federal benefits were considered errors because the determination was not conducted timely. Specifically, the Departments could not provide evidence they conducted an eligibility determination or the eligibility determination was not in accordance with timeliness standards (does not apply to application timely processing) as defined in the federal regulations. However CMS did not impose eligibility recoveries or disallowances for reporting year 2019.

The Departments indicated lack of staff contributed to the delays in completing the applications, redeterminations and other information within the required timeline.

**DEPARTMENT OF HUMAN SERVICES' RESPONSE:**

DHS accepts the recommendation. DHS agrees to work with HFS to implement controls to comply with the requirement that applications are reviewed and approved or denied timely.

DHS will continue the practice of assigning and training additional personnel so that initial applications are worked and redeterminations and maintenance of eligibility are performed within the timeframes required. DHS has recently implemented Statewide Processing Centers (SPCs) in order to handle work from larger offices with heavy caseloads, and effectively redistribute tasks to areas of the field that have the capacity to handle additional assignments. This has resulted in more timely performance of task completion within IES; a substantial increase in SNAP application timeliness; a reduction in the backlog of medical applications; lower wait times for customers who enter the FCRC; and improved customer service in the timely and accurate distribution of benefits.

**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**
HFS accepts the recommendation. HFS will continue to cooperate with Federal CMS regarding corrective actions. All backlogs are being addressed through a combination of staff hiring, enhanced training, process simplifications, policy streamlining and system enhancements.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action in Progress:**

1. Working with the Statewide Processing Unit and DoIT, extract reports identifying pending requests for benefits coming due for certification will be identified and assigned for processing. The additional reports will allow for the identification of requests needing targeted action.

2. Two statewide processing centers have been created to work to address pending requests coming due on a statewide level.

3. A third statewide processing center is in the planning stages and will be created to aid in timely processing of requests.

**(Estimated Date of Completion: 12/31/2021)**

**8. The auditors recommend management of both Departments work together to determine and document controls in the Change Management Policy and Procedure for the following:**
- **Definitions of the various types of changes,**
- **Specific requirements for the prioritization or classification of changes,**
- **Specific information required to be entered into the tracking system for each change,**
- **Definitions of the numerical grading for determining impact,**
- **Detailed documentation requirements for test scripts and results, impact analysis, design documentation, or other required documentation, and**

- **Definitions of when changes are required to include a specific requirement, who should review the various steps, and when, and by whom approvals are required.**

**The Departments should improve monitoring of established internal control to improve adherence to the control system by Department employees. The Departments should also document internal controls over changes to recipient data residing in IES. This documentation should include the timing for required approvals for recipient data changes. Finally, the Departments should prepare minutes for each UAT Status Meeting and publish them on the Department of Healthcare and Family Services website.**

**FINDING:** *(Insufficient Internal Controls over Changes to the Integrated Eligibility System (IES) and Recipient Data)*

IES Application Changes Policies and Procedures

The Departments did not have documented internal controls over changes to IES during the audit period. However, on August 31, 2019, the Departments memorialized the change control process in writing. According to the Departments, this process was to have been followed during the audit period.

Auditor's review of the August 31, 2019 Change Management Policy and Procedure, noted the Policy and Procedure did not:

- Define the various types of changes,
- Define the requirements for the prioritization or classification of changes,
- Define the information required to be entered into the tracking system for each change,
- Define the numerical grading for determining impact,
- Define the detailed documentation requirements for test scripts and results, impact analysis, design documentation, or other required documentation, and
- Define when changes were required to include a specific requirement, who was to review the various steps and when and by whom approvals were required.

Recipient Data Changes Policies and Procedures

The Department did not have documented internal controls over changes to recipient data residing in IES during the audit period.

Testing of IES Application Changes

Auditors selected a sample of 60 changes to IES to determine if they complied with the requirements described above, noting 53 (88%) did not have the Customer Impact, Caseworker Impact, Level of Urgency, and Regulatory Impact scores completed.

Furthermore, auditors requested a sample of meeting minutes from the UAT Status Meetings, which were to be held twice a week. However, DHS stated UAT Status Meeting minutes were not maintained for the period of July through November 2018.

Testing of Recipient Data Changes

Due to the lack of documented internal controls auditors could not determine if fixes to recipients' data were properly approved. However, auditors selected a sample of 40 fixes to recipients' data to determine if there were documented approvals for the recipient data changes. Testing noted, although verbal approval appeared to have been obtained prior to implementation, approvals for 7 (17.5%) recipient data changes were documented one to five days after implementation.

The Departments' management indicated although they did not have a documented process during the audit period, they believed the process formalized in the August 31, 2019 Change Management Policy and Procedure was adequate. In addition, the Departments' indicated the weaknesses identified during detailed testing were the result of a lack of understanding of the Change Management Policy and Procedure.

**DEPARTMENT OF HUMAN SERVICES' RESPONSE:**
DHS accepts the recommendation. The current IES Change Control Document is under review by DHS, HFS, and DoIT. The IES system has moved from a project to a system in production and with that movement the departments are determining, documenting, and implementing procedures that best fit maintaining a system of this size and importance; while being flexible enough to meet the fast pace changes needed by the business users and the clients. Each agency will strive to improve the internal controls of the Change Management Procedures as we move forward.

**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**
HFS accepts the recommendation. HFS will work with DoIT / DHS to ensure controls over IES changes are adequate.

**UPDATED RESPONSE:** Implemented.

**Corrective Action in Progress:**

1. Review Change Management policy and procedure to assure proper prioritization of changes, impact (numeric grading) designation, test scripts and results, impact analysis design and other documentation.
2. Review and modify documentation of the various steps and responsible individuals in the Change Management approval process.

**(Estimated Date of Completion: 1/31/2022)**

**9. The auditors recommend management of the Departments enhance the Disaster Recovery Plan to include:**

- **Detailed recovery scripts,**
- **Support staff and vendor contact information,**
- **Responsibilities for the recovery of IES,**
- **Documentation on backups, and**
- **Changes to the current environment.**

**Additionally, the Departments should perform disaster recovery testing on a regular basis as defined in the Plan.**

**FINDING:** *(Inadequate Disaster Recovery Controls over the Integrated Eligibility System (IES))*

DHS Disaster Recovery Plan (Plan) addresses the recovery and operation of IES. However, auditors noted the Plan did not include:

- Detailed recovery scripts,
- Support staff and vendor contact information,
- Responsibilities for the recovery of IES,
- Documentation on backups, and
- Was not updated to reflect changes to the current environment.

In addition, the Departments had not conducted disaster recovery testing during the audit period.

**DEPARTMENT OF HUMAN SERVICES' RESPONSE:**
DHS accepts the recommendation. The current IES Information System Contingency Plan v4.0 (10/2018) is under review at this time by the Acting DoIT – DHS Information Security Officer. Detailed scripts, state and the IES development vendor support / responsible contact information, system backup information are all to be updated on the v5.0 (04/2020) IES Contingency Plan.

DoIT/HFS is currently working on a multi-phase project to upgrade all IES hardware/software, these systems include a full DR component that will allow for an annual off-site DR test. At such time the IES Infrastructure is fully implemented and ready for DR testing, exercises will commence annually.

**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**
HFS accepts the recommendation. HFS will work with DoIT / DHS to ensure the Disaster Recovery Plan is enhanced and tested as soon as possible.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action in Progress:**

1. Continue working with DoIT to complete an IES Information System Contingency Plan and conduct a tabletop DR exercise in order to update documented emergency procedures with the results (Began 4/20/20). However, effective/accurate recovery scripts will not be possible until the IES DR infrastructure build is complete in Phase 7 of IES Tech Refresh.

2. Continue working with DoIT to determine requirements for obtaining needed resources in order to do a full recovery of IES.

3. Continue working with DoIT to complete the IES IT modernization Technical Refresh project, including a full build at the Alternate Data Center to facilitate IES disaster recovery capabilities and testing.

**(Estimated Date of Completion: 4/30/2022)**

**10. The auditors recommend management of the Departments execute a detailed agreement with DoIT to ensure the IES System roles and responsibilities required to be performed by each party, are formally documented.**

**FINDING:** *(Lack of Detailed Agreement with the Department of Innovation and Technology (DoIT))*

The Departments have the ultimate responsibility to ensure their critical and confidential data are adequately safeguarded.

The Departments' management indicated they believed the existing general agreement regarding the relationship between the Departments and DoIT was sufficient.

The Departments' failure to execute an agreement with DoIT increases the risk that IES functions won't be performed by each party in accordance with their assigned responsibility.

**DEPARTMENT OF HUMAN SERVICES' RESPONSE:**
DHS accepts the recommendation. DHS will work with HFS to review the need to execute an agreement with DoIT regarding IES responsibilities.

**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**
HFS accepts the recommendation. HFS will work with DHS to review the need to execute an agreement with DoIT regarding IES responsibilities.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action in Progress:**

1. Create draft of IGA. Circulate to HFS and DoIT.
2. Review and incorporate any updates from HFS and DoIT.
3. Submit final IGA for approval at executive level of all 3 agencies (DHS, HFS, DoIT).
4. Finalize IGA.

**(Estimated Date of Completion: 4/1/2022)**

**11. The auditors recommend management of the Departments improve controls to ensure each Departments' staff and supervisors are properly obtaining, reviewing, and retaining documentation in IMPACT to support Medicaid provider enrollment.**

**Additionally, they recommend the Departments execute detailed interagency agreements defining the roles and responsibilities of each agency regarding the Medicaid program. The interagency agreements should sufficiently address the necessary procedures to enforce monitoring and accountability provisions over IMPACT as required by the Code of Federal Regulations and the State Plan so the enrollment of providers offering services is carried out in an efficient and compliant manner.**

**Furthermore, the auditors recommend DHS utilize IMPACT as their book of record for provider enrollment. DHS should also develop controls to review any noted issues and notify HFS of any issues affecting eligibility.**

**FINDING:** *(Insufficient Review and Documentation of Provider Enrollment Determinations and Failure to Execute Interagency Agreements)*

DHS and HFS failed to design and implement adequate internal controls over the operation of the State of Illinois' Illinois Medicaid Program Advanced Cloud Technology system (IMPACT).

**Auditor Testing and Results**

*Interagency Agreements*

Auditors noted the Departments did not have interagency agreements defining the specific roles and responsibilities.

*Quality/Supervisory Reviews Not Conducted*

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

*Detail Sample Testing*

Based on the population provided by HFS, during FY19, 26,529 provider applications were approved. In order to determine if the providers' applications were approved in accordance with federal and state laws/rules/regulations, a sample of 40 approved applications were selected for testing. Auditor's testing of the 40 provider files noted:

- 38 approved provider applications included requests for the applicable Department to backdate their enrollment beginning dates. Of those 38 approved applications auditors noted:
  - 28 (74%) provider files were for providers who requested the applicable Department to backdate their eligibility beginning date. However, the provider's file did not contain documentation of the Department's reason for allowing an exception and thereby backdating the provider's enrollment. As a result, auditors could not determine if the backdating of enrollment, and the subsequent payments was proper.
  - 4 (11%) provider files were backdated in excess of HFS' policy, ranging from 19 to 413 days past the 180-day limit.

- 8 (20%) provider files did not contain documentation the applicable Department reviewed the provider's required professional license or board certification to confirm the licenses/certifications were valid at the time the application was approved.

- 3 (8%) provider files did not have documentation the applicable Department confirmed the provider's national board certification end date. In fact the certifications were recorded with open ended expiration dates within IMPACT.

- 1 (3%) provider file noted a felony charge during the screening process. However, there was no documentation the application was sent to the Office of Inspector General (OIG) for detailed review and approval.

In the prior audit, Departments' management indicated the control deficiencies were due to employee oversight. In the current audit, Departments' management indicated they had not had sufficient time to collect information and develop interagency agreements. Additionally, the Departments' management indicated the errors associated with the approved applications were due to employee oversight.

**DEPARTMENT OF HUMAN SERVICES' RESPONSE:**
DHS accepts the recommendation. DHS will provide written documentation in IMPACT of the documentation and databases that were used to manually verify eligibility. Documentation such as a provider's license or certification will be maintained on file with the Department. DHS will continue to cooperate and comply with the guidance provided by HFS during the interim while the Interagency Agreement is being developed.

**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**
HFS accepts the recommendation. The IMPACT Provider Enrollment Subsystem requires staff to review and update any information that cannot be systemically verified. HFS has adopted a formal quality assurance process that has been memorialized in a new Standard Operating Procedure (SOP). All SOPs have also been incorporated into the sister agency Interagency Agreements that have been drafted.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**

Discussions about the Interagency agreement began in 2019 to address potential audit findings with IMPACT. In May 2021, DHS-DDD and DHS-DRS held a meeting to discuss the IA due to HFS drafting an IA that would be shared with both Divisions. Meetings were held in June with HFS Provider Enrollment Services, HFS Office of Inspector General, DHS-DDD and DHS-DRS to review the draft language as a group instead of relying on email communications. On 6/24/2021, all parties settled on the language and the DHS Secretary signed the Agreement on July 20, 2021. It is currently with HFS awaiting the HFS Director's signature.

**(Estimated Date of Completion: 9/30/2021)**

**12. The auditors recommend management of the Departments implement adequate internal control over the implementation and design of IMPACT, including regular reviews of user access rights, disaster recovery activities, and change management procedures.**

**FINDING:** *(Inadequate General Information Technology Controls over IMPACT)*

During testing, auditors noted the Departments did not have access to or control over IMPACT and its infrastructure. As a result, auditors were unable to perform adequate procedures to satisfy ourselves that certain general IT controls (i.e. security over the environment, disaster recovery assurance, and change management procedures) over IMPACT were operating effectively during the audit period.

Security over Illinois Users

During testing of the Departments' access provisioning policies, auditors noted the policies did not define the time period in which the Departments were required to disable a terminated individuals' IMPACT access. In testing of 8 terminated IMPACT users, auditors noted 6 (75%) users had their access terminated 14 to 482 days after their termination of employment.

As a result of the Departments' failure to establish appropriate security controls over IMPACT, auditors cannot determine if IMPACT and the state's data are adequately protected from unauthorized access and accidental or intentional destruction or alteration.

Disaster Recovery and Backups

The Departments did not have a disaster recovery plan for IMPACT and had not conducted recovery testing of IMPACT during the audit period.

Change Management

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

The Departments' management indicated the above control deficiencies were due to limited reporting capabilities of IMPACT, employee oversight, and their belief the TSP was responsible for some of the internal controls.

**DEPARTMENT OF HUMAN SERVICES' RESPONSE:**
DHS accepts the recommendation. DHS will work with HFS to ensure controls over the implementation and design of IMPACT are adequate.

**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE:**
HFS accepts the recommendation. HFS has implemented a user access review process for IMPACT.

**UPDATED RESPONSE:** Implemented.

**Corrective Action in Progress:**

Healthcare and Family Services has a contract with the IMPACT service provider and is responsible for ensuring controls over IMPACT, data, and the infrastructure are adequate. HFS, DHS-DRS and DHS-DDD accepted draft language in the IMPACT IA that established this as a role and responsibility of HFS Provider Enrollment Services. The DHS Secretary signed the IA on 7/20/21. DHS forwarded the IA for HFS to obtain the signature of HFS Director.

**(Estimated Date of Completion: 9/30/2021)**

**13. The auditors recommend DHS management and staff strengthen controls over records maintenance for each area in which a compliance requirement is present. To every extent possible, population records should be sequentially numbered.**

**FINDING:** *(Complete Populations not Provided)*

DHS was unable to provide adequate records substantiating the completeness of populations for one or more laws, regulations, or other requirements selected for testing, as of the end of fieldwork. Due to these conditions, auditors concluded DHS' population records were not sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.35) to test DHS' compliance with the following:

- While Elgin Mental Health Center, Ludeman Developmental Center, and Illinois Center for Rehabilitation and Education provided listings, auditors were unable to verify the accuracy and completeness of these populations because users were not consistent between the Central office and facility listings.
- Also of note:
    - Chicago-Read Mental Health Center, the Ludeman Developmental Center, were unable to provide adequate records substantiating the population of employees trained to use restraints issued during the examination period.
    - Murray Developmental Center was unable to provide adequate records substantiating the population of clients released from the facility during the examination period.
    - For the Mental Health and Developmental Disabilities Administrative Act (MH Administrative Act) (20 ILCS 1705/47), the Ann M. Kiley Developmental Center, Ludeman Developmental Center, McFarland Mental Health Center, John J. Madden Mental Health Center, and Murray Developmental Center were unable to provide adequate records substantiating the populations of visitor entry logs (for visitors who visited the facilities' residents) during the examination period.
    - The William G. Murray Developmental Center did not provide an accurate population of residents admitted to the Facility during the examination period.
    - John J. Madden Mental Health Center was unable to provide adequate records substantiating the population of dually diagnosed individuals as the reports are only able to be generated once an individual has been discharged from the Center.
    - John J. Madden Mental Health Center was unable to provide adequate records substantiating the population of all recipients who received dental treatment during the examination period as the reports are only able to be generated once an individual has been discharged from the Center.
    - Illinois Center for Rehabilitation and Education was unable to provide adequate records substantiating the population of instances of suspected

patient abuse or neglect. The reports provided included instances ranging from minor bumps and bruises to cases of suspected abuse or neglect.

***Even given the population limitations noted above which hindered auditor's ability to conclude whether the selected sample was representative of the population as a whole***, auditors obtained the population provided by DHS for each of the areas above, selected a sample, and tested for compliance.

DHS management indicated that substantiating a complete population for the areas listed was difficult based on the nature of the populations.

Without DHS providing complete and adequate documentation to enable testing, auditors were impeded in completing procedures and providing useful and relevant feedback to the General Assembly regarding DHS' compliance for the above areas. Further, DHS is unable to demonstrate it has met each compliance requirement it is subject to when sufficient records are not maintained.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will work to strengthen its controls over records maintenance.

DHS will implement a tracking system to monitor obsolete or unused property at the Mental Health Centers, ensure proper tracking of employees trained to use restraints, enhance visitor entry logs, and investigate system changes that would assist in tracking patient details prior to discharge from a Mental Health Center.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
The BIP /Telecom Unit has developed a procedure to track telecom devices for separated employees. If phone is to be reissued, the location is to complete an IL 444-4144 request so that DHS Telecom can assign the phone and request the addition of employee to the Mobile Iron server in order to receive Outlook emails via phone. These are used as backup support of the completed process.

SOH (Elgin) Implemented new procedures to review and track all obsolete and unused property at the facility. This resulted in over 1200 pieces of obsolete and unused property from its inventory in the first year of implementation.

SOH **(**McFarland) Policy MAS110 was updated on 12-17-19 to include requirement to maintain Sign-in and Sign-out records for 5 years. Education was provided to staff regarding this requirement on 12-18-19.

SOH (Chicago Read) will review all property control reports and determine the age and functionality of all property. Unused property in storage areas will be removed.

SOH (Chicago Read) will track all Notice of Discharge. Will conduct chart audits. All general audit findings will be reported at every Executive Committee Meeting.

SOH (Madden) Quarterly inventories have been established assessing obsolete and unused property items, returning to the Property Control Unit for reassignment and purging. All obsolete and unused property items are tracked through the State Warehouse Control System. All damaged furniture and equipment is inventoried and routed to Property Control for approval to scrap and or destroy. A small budget has been created for this process.

SOH (Madden) will track all Notice of Discharge. Will conduct chart audits. All general audit findings will be reported at every Executive Committee Meeting.

SOH (Madden) All direct staff that receive CPI and restraints application training have their trainings mark on their employee training transcripts which is located in the OneNet system.

SOH (Madden) maintains visitor logs at the main entryway and on the Units. All visitors are to sign in at both locations. Audit all visitor logs be completed by comparing Security Desk against the logs on the units. All general audit findings will be reported at every Executive Committee Meeting.

OBS: Assigned security/access review and made updates where necessary.

SODC: Retraining occurred at Ludeman regarding Payroll Timekeeping System access monitoring.

SODC Operations implemented monthly monitoring at Ludeman to ensure PTS access is accurate.

DD Centers retrained appropriate staff regarding Clinical Inpatient input and Crystal Reports to ensure valid populations for admissions and discharges are achieved.

SODC Operations will ensure internal Center Visitor Policies reflect DHS' retention policy of 5 years.

**14. The auditors recommend DHS management re-train staff on compliance with statutory requirements regarding the use of restraints. This training should include documentation requirements when restraints are ordered. They also recommend DHS management establish a process to monitor that annual training requirements are complied with.**

**FINDING:** *(Noncompliance with Statutory Requirements Regarding the Use of Restraints)*

During fieldwork auditors performed on-site testing regarding the use of restraints at eight of DHS' state-operated facilities.

Although auditors were unable to obtain the above complete populations, across all eight facilities sampled and tested a total of 108 employees who administered restraints and 159 residents who were placed in restraints, which resulted in the following exceptions at seven of DHS' facilities:

Elgin Mental Health Center

- For 1 out of 8 (13%) residents placed in restraints, the facility did not maintain adequate documentation that the employee who administered the restraint had a non-expired restraint training certification at the time that the restraint was administered. The training records for this individual could not be located.
- For 7 out of 24 (29%) residents placed in non-emergency restraints, the facility did not maintain adequate documentation supporting the restraint was employed only upon a written order.
- For 4 out of 24 (17%) residents placed in non-emergency restraints, adequate documentation was not maintained that the facility director or designee was informed in writing of the use of the restraint, within 24 hours by the person who ordered the restraint.
- For 1 out of 24 (4%) residents placed in non-emergency restraints, the facility did not maintain adequate documentation the employee who administered the restraint had a non-expired restraint training certification at the time that the restraint was administered. Upon review of the training records provided by the facility, the restraint was administered 23 days after the restraint training certification expired.

Ludeman Developmental Center

- For 1 out of 8 (13%) residents placed in restraints, the Order for Restraint (IL 462-0044 RD) did not include the signature of the employee who ordered the restraint**.** As a result, we could not determine if the employee was trained as required.
- For 3 out of 8 (38%) residents placed in restraints, the facility was unable to locate the Order for Restraint (IL 462-0044 RD) and other restraint records.
- For 5 out of 8 (63%) residents placed in restraints, adequate documentation was not maintained that the facility director or designee was informed in writing of the use of the restraint, within 24 hours by the person who ordered the restraint.
- For 1 out of 8 (13%) residents placed in restraints, the recipient was not examined by a physician or supervisory nurse, within two hours after the initial employment of the emergency restraint.
- Twelve out of 22 (55%) employees tested did not receive the required annual training in the safe and humane application of the type of restraint used and type of restraint that was authorized by the facility.

McFarland Mental Health Center

- For 16 out of 20 (80%) residents placed in restraints, the facility did not require the instructor to sign the Competency Skills Checklist for 36 associated employees.
- For 7 out of 20 (35%) residents placed in restraints, the facility was unable to provide

the annual Competency Skills Checklist for three employees.

- For 10 out of 20 (50%) residents placed in restraints, the facility had five employees whose training requirements were not complete within a year of the restraint being ordered. The five employees' trainings were complete between 35 to 265 days late.
- For 3 out of 20 (15%) residents placed in restraints, adequate documentation was not maintained that the facility director or designee was informed in writing within 24 hours of the use of the restraint by the person who ordered the restraint.
- For 4 out of 8 (50%) residents placed in restraints in which a secondary restraint was employed within a 24-hour period, the facility did not obtain prior written authorization from the facility director.
- For 4 out of 10 (40%) residents placed in non-emergency restraints, the facility could not provide documentation to show who applied the restraints. As a result, auditors could not determine if the employee was trained as required.

Chicago-Read Mental Health Center

- For 2 out of 13 (15%) employees tested who administered restraints, the facility employee administering the restraint did not have training in the safe and humane application of administering the restraint.

Jack Mabley Developmental Center

- For 1 out of 18 (6%) residents placed in restraints, the facility did not record the length of time the restraint was to be employed or the clinical justification for the length of time.

John J. Madden Mental Health Center

- For 2 out of 10 (20%) residents placed in restraints, the facility did not maintain adequate documentation that the restraint order was reviewed by the facility director on a daily basis. Supporting documentation for one resident had been disposed of and the other could not be located.
- For 3 out of 10 (30%) residents placed in restraints, adequate documentation was not maintained that the facility director or designee was informed in writing within 24 hours of the use of the restraint by the person who ordered the restraint.
- For 1 out of 10 (10%) residents placed in restraints in which a secondary restraint was employed within a 24-hour period, the facility did not obtain prior written authorization from the facility director.

Murray Developmental Center

- For 1 out of 1 (100%) residents placed in restraints who use sign language as the primary means of communication, the facility did not complete all required documentation. Specifically, page 7 of the Supplemental Report for Restraint and/or Emergency Behavior Intervention Procedures document was not complete.

DHS management indicated the conditions noted were due to a combination of human error, the practice of issuing verbal restraint orders and signing the written order after the restraint is applied, and policies and procedures not being followed.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will implement corrective action plans that include re-training staff and monitoring compliance to ensure requirements regarding the use of restraints are met.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**

SOH (Elgin) Nurse starting restraint enters order with same time as restraint, and scan of order sent to designee within 24 hours

SOH (McFarland) Restraint training is completed annually by our Staff Development Coordinator and tracked monthly. Information regarding compliance is sent to the Hospital Clinical Management Team monthly outlining compliance level. The Staff Development Coordinator and training facilitators were educated on the requirement to sign all the competency forms.

SOH (Chicago Read) A MS Access database was developed to track all in person restraint trainings.

SOH (Chicago Read) All general audit findings will be reported at every Executive Committee Meeting.

SOH (Madden) Direct care staff receive annual training on the best practice procedure on application of restraints and de-escalation techniques. As of January 2021, compliance report Madden direct care staff is 100% compliance of CPI and restraints training.

SODC Operations will ensure corrective action plans at each of these Centers is implemented and includes re-training and a compliance monitoring by the Center.

**15. The auditors recommend DHS management enforce policies and procedures to ensure compliance with the MH Act regarding visitors to facilities. The policies and procedures should include training personnel on compliance requirements and implement management oversight over compliance requirements. They also recommend each facility retain visitor logs for 5 years as required. Further, auditors recommend DHS improve controls over building access and monitoring.**

**FINDING:** *(Noncompliance with Statutory Requirements Regarding the Monitoring of Facility visitors)*

Auditors sampled and tested 96 entry logs across the eight facilities. Our testing of entry logs resulted in the following exceptions:

Elgin Mental Health Center

- For 6 out of 8 (75%) entry logs tested at the administrative building, the facility could not provide documentation to show visitors signed in at the home of the individual being visited (unit home).
- The facility did not retain a copy of all administrative building entry logs created during the examination period. Specifically, the facility was unable to provide the logs for the period July 1, 2017 through December 31, 2018.
- The facility's administrative building entry log appeared to be incomplete. Missing information included several visitors' organizations, patient/area/staff, relationship/purpose, arrival times, and dates.

Ann M. Kiley Developmental Center

- For 2 out of 8 (25%) entry logs tested at the unit homes, visitors signed in at the unit home but did not sign in at the administrative building.
- For 5 out of 8 (63%) entry logs tested at the administrative building, visitors signed in at the administrative building but did not sign in at the unit home.
- The facility's unit home logs contain a statement indicating sign-in sheets would be retained for 3 months, whereas DHS' record retention policy (Policy 95-85 #7) states sign-in sheets must be retained for a period of 5 years.
- The facility's administrative building entry log appeared to be incomplete. Missing information included several visitors' organizations, patient/area/staff, relationship/purpose, departure times, and dates.
- The facility did not maintain adequate physical safeguards regarding building access and monitoring.

Ludeman Developmental Center

- The facility did not retain a copy of all unit home entry logs created during the examination period because the facility's internal policy (ELC #77) over unit home entry logs states visitor logs should be retained for six months, whereas the Department's record retention policy (Policy 95-85 #7) states the entry logs should be retained for a period of 5 years.
- The facility did not retain a copy of all business building entry logs throughout the examination period. Specifically, the facility was unable to provide the visitor sign in-logs for the months of December 2017, August 2018, September 2018, and December 2018 (4 out of 24 months, 16.7%) located in the business building (Building 60). The facility was also unable to provide any visitor sign-in logs for the unit I neighborhood house for FY 2018 (12 out of 24 months, 50%).
- For 1 out of 8 (13%) House 53 entry logs tested, the entry log for February 25, 2019 could not be located.
- For 2 out of 8 (25%) entry logs tested at the administrative building, visitors signed in at the administrative building but did not sign in at the unit home.
- The facility's main building entrances entry logs appeared to be incomplete. Missing information included relationship/purpose, arrival and departure times, and dates.

McFarland Mental Health Center

- The facility's Procedural Guide outlines that logs will be retained for six months, whereas, the Department's records retention policy states the logs should be retained for five years.
- The facility's entry logs at the business building and unit homes appeared to be incomplete. Missing information included relationship/purpose, arrival and departure times, and dates.
- The facility's policies and procedures state that if a visitor is visiting a civil patient, the visitors are to only write the first name of the patient(s) they are visiting to ensure patient confidentiality. Auditors noted numerous instances where patients' full names were included in the visitor logs.

Chicago-Read Mental Health Center

- For 5 out of 8 (63%) entry logs tested at the administrative building, visitors signed in at the administrative building but the facility could not provide documentation to show any sign in at the unit homes.
- The facility's administrative building entry log appeared to be incomplete. Missing information included several visitors' organizations, patient/area/staff, relationship/purpose, arrival and departure times, and dates.

Jack Mabley Developmental Center

- The facility's entry logs appeared to be incomplete. While reviewing the facility's entry logs for completeness, auditors noted 27 instances where a time out was not recorded.
- The facility did not maintain adequate physical safeguards regarding building access and monitoring.

John J. Madden Mental Health Center

- The facility did not retain a copy of all entry logs created during the examination period because the practice is to discard the entry logs after a period of one year.
- The facility did not retain a copy of all pavilion entry logs created during the examination period. Specifically, the facility was unable to provide logs for the months of May 2019 and June 2019.
- For 5 out of 8 (63%) entry logs tested at the pavilions, visitors signed in at the pavilion but did not sign in at the security desk.
- For 6 out of 8 (75%) entry logs tested at the security desk, visitors signed in at the security desk but did not sign in at the pavilion.

Murray Developmental Center

- For 4 out of 8 (50%) entry logs tested at the main administrative building, visitors signed in at the administrative building but the facility could not provide documentation to show the visitor signed in at the unit homes.
- For 7 out of 8 (88%) visitors tested, the visitor signed in at the resident's home but did not also sign-in at the administrative building.
- The facility did not retain a copy of all entry logs created during the examination

period because the practice is to discard the entry logs after a period of two years, whereas the Department's record retention policy (Policy 95-85 #7) states the entry logs should be retained for a period of 5 years.
- The facility failed to enforce its visitor policy and procedures after regular business hours (4:30 pm Monday through Friday and on weekends).
- The facility's administrative building entry log appeared to be incomplete. Missing information included several visitors' organizations, patient/area/staff, relationship/purpose, and arrival and departure times.
- The facility did not maintain adequate physical safeguards regarding building access and monitoring.

Illinois Center for Rehabilitation and Education

- The facility's administrative building entry log appeared to be incomplete. Missing information included several visitors' name, relationship/purpose, arrival and departure times, and dates.

DHS management indicated the conditions noted were due to lack of training and resources, human error and failure to follow policy and procedures.

**DEPARTMENT RESPONSE:**
The Department accepts the recommendation. DHS management will enforce policies and procedures to ensure compliance with the MH Act regarding visitors in MH Facilities. Furthermore, DHS will ensure staff are properly trained regarding visitor compliance requirements and retention of visitor logs.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
SOH (Elgin) Removed Unit entry logs; Facility entry logs now kept and routinely reviewed to confirm all fields are filled in by all visitors and staff is retrained as needed to ensure compliance.

SODC Operations created a standardized Visitor Protocol Guide for Centers to follow.

DD Centers will review, update and re-train all staff on their updated Visitor Policy that compiles with the Guide.

SODC Operations will ensure internal Center Visitor Policies reflect the Department's retention policy of 5 years.

**16. The auditors recommend DHS management review its systems of internal control over compliance to ensure:**

**1. DHS' policies and procedures at each facility are up-to-date with current law and communicated to all staff;**

2. **Facility-level and Department-wide training on DHS' policies and procedures for areas with recurrent noncompliance or complexity are performed; and,**
3. **A monitoring process is functioning to timely identify areas of noncompliance with state laws and policies at the facilities and implement corrective action.**

**FINDING:** *(Noncompliance with Statutory Requirements Regarding Residents' Admissions and Discharges)*

DHS did not comply with statutory requirements regarding residents' admissions and discharges.

During fieldwork, auditors performed on-site testing at eight of DHS' state-operated facilities regarding resident admissions. Although auditors were unable to obtain a complete population of individuals requesting information on residents' admissions from four facilities during the examination period (Ludeman Developmental Center, Chicago-Read Mental Health Center, John J. Madden Mental Health Center, and Murray Developmental Center, see Finding 2019-013), auditors sampled and tested 64 residents and 49 requests for information across the eight facilities which resulted in the following exceptions at six facilities:

Elgin Mental Health Center

- For 1 out of 8 (13%) new admissions tested, the facility did not maintain a Notice of Admission record for the resident.
- For 11 out of 16 (69%) residents tested, resident files lacked documentation of any requests for information pertaining to the resident.
- For 5 out of 16 (31%) residents tested, facility staff did not record all required information from the requestors. The missing information included the requestor's address, reason for the request, and the relationship to the resident.
- For 16 out of 16 (100%) residents tested, facility staff did not respond to individuals requesting information regarding a resident.
- For 1 out of 16 (6%) residents tested, facility staff did not inform the resident of the request for information.

Ludeman Developmental Center

- For 1 out of 8 (13%) new admissions tested, facility staff failed to make contact with a designated individual at the resident's consent within the 24-hour time frame. The notice was sent in the mail one day late.
- The facility has inadequate controls over documentation supporting requests for information were responded to within two working days.

Chicago-Read Mental Health Center

- For 5 out of 32 (16%) residents tested, facility staff did not record all required information from the individual requesting information. The missing information included the requestor's phone number, relationship to the resident, and address.

Jack Mabley Developmental Center

- Although the facility indicated there were no external inquiries for information that were rejected during the examination period, the facility does not have a policy requiring the maintenance of documentation in residents' files regarding requests for information that have been rejected, when applicable.

John J. Madden Mental Health Center

- For 1 out of 1 (100%) new admissions tested where there was an inquiry regarding admission, facility staff did not record all required information from the requestor. The missing information included the requestor's relationship to the resident and address.

Murray Developmental Center

- For 2 out of 8 (25%) new admissions tested, adequate documentation was not maintained indicating an attempt was made by facility staff to contact at least two designated persons or agencies concerning their admission.

During fieldwork, auditors performed on-site testing at four of DHS' state-operated facilities regarding residents with intellectual disabilities and mental illness. Although we were unable to obtain a complete population of residents under the care of the John. J. Madden Mental Health Center during the examination period (as noted in Finding 2019-013), auditors sampled and tested 60 residents across the four facilities, which resulted in the following exceptions at three of DHS' facilities:

Elgin Mental Health Center

- For 1 out of 15 (7%) residents tested, adequate documentation was not maintained indicating the resident received an evaluation every 30 days after the initial admission evaluation. The evaluations were missing for November 2018 and March 2019.
- For 3 out of 15 (20%) residents tested, facility staff did not maintain monthly notices of certification in the residents' records.
- For 2 out of 15 (13%) residents tested, facility staff did not prepare treatment plans within 3 days of admission. The treatment plans were completed between 1 and 2 days late.
- For 1 out of 15 (7%) residents tested, facility staff did not send the monthly certification to the resident's guardian.

Chicago-Read Mental Health Center

- For 1 out of 15 (7%) residents tested, the resident did not receive an evaluation every 30 days after the initial admission evaluation. The evaluation for July 2017 was 3 days late.

John J. Madden Mental Health Center

- For 8 out of 15 (53%) residents tested, the resident was diagnosed as having an intellectual disability, but never evaluated or certified by the Qualified Intellectual Disabilities Professional (QIDP).
- For 3 out of 15 (20%) residents tested, the resident did not receive an intellectual

disability evaluation within 14 days of admission. The evaluations were completed between 16 and 90 days late.

- For 3 out of 15 (20%) residents tested, facility staff did not include a written assessment of whether the individual needed a habilitation plan.
- The facility did not file any certifications with the office of the Secretary of the Department during the examination period.
- For 1 out of 4 (25%) monthly reports tested, facility staff did not adequately complete the reports for dually diagnosed persons. The April 2019 report did not include (1) the date, facility, and unit of admission or continuing care, (2) the recipient's diagnosis, (3) the date, facility, and unit of transfer or discharge, (4) whether or not there is a public or private guardian, (5) whether the facility director has certified that appropriate treatment and habilitation are available for and being provided to such person pursuant to Section 4-203 of this Chapter, and (6) whether the person or a guardian has requested review as provided in Section 4-209 of this Chapter and, if so, the outcome of the review.

***Noncompliance with Resident Discharge Rules and Regulations***

During fieldwork, auditors performed on-site testing at four of DHS' state-operated facilities regarding discharge rules and regulations. Although auditors were unable to obtain a complete population of residents discharged from the Murray Developmental Center, auditors sampled and tested a total 55 resident files across the four developmental facilities and 60 resident files across the four mental health facilities, which resulted in the following exceptions at five DHS' facilities:

Ludeman Developmental Center, McFarland Mental Health Center, Chicago-Read Mental Health Center, John J. Madden Mental Health Center, and Murray Developmental Center.

DHS management indicated the conditions noted were due to human error, lack of training, and failure to follow procedures.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will review its systems of internal control over compliance to ensure policies and procedures are up-to-date and communicated to all staff. Necessary training for staff will be provided and DHS will create a monitoring process to identify and correct areas of noncompliance with State laws and Department policies.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
SOH (Elgin) Log created and implemented, and staff trained on same to keep track of requests for information, including information from the requestor, response to requests and informing patient of request for information

SOH (Chicago Read) has developed a MS Access database to track all policies and procedures. This database maintained by Administration and responsible staff are

notified when a policy needs revision. It is the policy of Chicago-Read to review and revise as needed or every 3 years. All general audit findings will be reported at every Executive Committee Meeting. Hospital Administrator to address in staff evaluations

SODC Operations will ensure re-training.

SODC Operations will ensure that compliance monitoring checks are implemented at these Centers for admissions and notice of discharge.

**17. The auditors recommend DHS provide dental services to residents as required. Further auditors recommend DHS improve internal control over the retention of information pertaining to facility residents such as examination records, medication records and reports of suspected abuse or neglect. They also recommend DHS install the remaining bus scan safety system.**

**FINDING:** *(Noncompliance with Statutory Requirements Regarding Residents' Dental, Mental, Physical Examinations, and Instances of Suspected Abuse or Neglect)*

During fieldwork, auditors performed on-site testing at eight of DHS' state-operated facilities regarding resident dental, mental and physical examinations. Auditors also performed on-site testing at nine of DHS' state-operated facilities regarding DHS' requirement to maintain copies of all suspected abuse and neglect reports. Although auditors were unable to obtain a complete population of residents who were under the care of the John J. Madden Mental Health Center or instances of suspected abuse or neglect for the Illinois Center for Rehabilitation and Education during the examination period (see Finding 2019-013), auditors sampled and tested 64 residents treated for dental examinations, 69 residents prescribed medication, and 65 instances of suspected abuse or neglect across eight of the nine facilities, which resulted in the following exceptions at four of DHS' facilities: Elgin, Ludeman, Chicago-Read and Murray.

DHS management indicated the conditions noted were due to human error and inadequate maintenance of records.

**DEPARTMENT RESPONSE:**
DHS the recommendation. DHS will provide dental services to residents as required where the patient consents to dental treatment. Additionally, DHS will work to improve internal controls over retaining information pertaining to facility residents. State-Operated Developmental Centers (SODC) operations will ensure Murray Center installs the scan safety system on the bus identified in the audit finding.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
SOH (Elgin) Facility conducts routine chart audits to ensure copies of doctor order for Rx is maintained and that initial physical exam is in chart for patients that receive Rx.

SOH (Chicago Read) has developed a MS Access database to track all dental appointments. This database calculates the next dental examination within 18 months of their prior dental examination. The dental suite has been closed since the pandemic outbreak and is being retrofitted to comply with CDC safety requirements for COVID. A new dental suction machine was purchased/received and a HEPA filter is being purchased. All general audit findings will be reported at every Executive Committee Meeting.

SODC Operations will ensure Ludeman Center retrains all pertinent staff on the completion of Medication Administration Records.

SODC Operations will ensure Murray Center installs the bus scan safety system.

**18. The auditors recommend DHS obtain and retain approval documentation for administering pregnancy tests to a resident prior to conducting the test. They also recommend DHS retain a record of all residents' menstrual cycles and pregnancy tests administered. Further, they recommend DHS establish comprehensive Department-wide internal controls over compliance with the MH Act regarding pregnancy testing and residents' menstrual cycles, which should include training personnel on compliance requirements and outline management oversight over compliance requirements.**

**FINDING:** *(Noncompliance with Statutory Requirements Regarding Administering Pregnancy Tests and Recording Resident's Menstrual Cycles)*

During fieldwork, auditors performed on-site testing at eight of DHS' state-operated facilities. Auditors sampled and tested 64 residents across the eight facilities, which resulted in the following exceptions regarding resident records at four of DHS' facilities:

Elgin Mental Health Center

- For 3 out of 8 (38%) residents tested, adequate documentation was not maintained that facility staff obtained the resident's consent or the consent of the resident's guardian to test for pregnancy upon admission.
- For 2 out of 8 (25%) residents tested, facility staff did not maintain the menstruation record (Form IL462-0034) in the resident's file.

Ludeman Developmental Center

- For 1 out of 2 (50%) residents tested, facility staff did not maintain the menstruation record (Form IL462-0034) in the resident's file.
- For 1 out of 2 (50%) residents tested, adequate documentation was not maintained that facility staff obtained the resident's consent or the consent of the resident's guardian to test for pregnancy upon admission.
- The facility's policies and procedures do not address on-site prenatal care to residents who are not verbal or who otherwise cannot communicate with a provider because of severe disability.

- The facility does not perform a pregnancy test on individuals transferred in from another Department facility.
- The facility does not perform a pregnancy test on a resident unless it has been indicated by the resident or his/her guardian that the resident has been recently sexually active.

McFarland Mental Health Center

- For 1 out of 8 (13%) residents tested, adequate documentation was not maintained that facility staff obtained the resident's consent or the consent of the resident's guardian to test for pregnancy upon admission.

Murray Developmental Center

- For 2 out of 9 (22%) residents tested, a pregnancy test was administered before the guardian signed a consent form. The forms were signed 6 to 47 days after the pregnancy test was administered.
- For 1 out of 9 (11%) residents tested, facility staff were unable to provide pregnancy test results, or documentation that a test was not required.
- For 3 out of 9 (33%) residents tested, facility staff did not maintain the menstruation record (Form IL462-0034) in the resident's file.
- For 6 out of 9 (67%) residents tested, the resident's menstruation record (Form IL462-0034) was located in the resident's file; however, it was not completed for all months during the resident's stay. Specifically, for 27 out of the 83 (33%) months these six residents resided in the facility, the menstruation record was not completed.
- For 1 out of 9 (11%) residents tested, the Consent for Services form indicates the resident did not sign the form due to the resident's legal incompetency; however, another resident's name was referenced on the face of the form.
- The facility had inconsistent policies regarding pregnancy testing of women of child bearing age. The facility's Women's Health Services Standard Operating Policy and Procedure, dated June 13, 2018, indicates women of child bearing age will undergo a pregnancy test, if indicated, on the next business day following an admission. However, the facility's Pregnant Individuals Standard Operating Policy and Procedure, dated June 4, 2008, indicates any woman of child bearing age will be tested for pregnancy upon admission and one week following admission.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will obtain and retain approval documentation for administering pregnancy tests prior to conducting the test and will work to improve the monitoring of menstrual cycles and train staff on the compliance requirements. Quality control checks to monitor compliance will be developed and implemented.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
SOH (Elgin) retrained staff to keep track of consents for pregnancy tests and maintaining tracking in menses log. Facility audited both for six months that showed compliance.

SOH (McFarland) had one incident when the patient refused to consent to the pregnancy test. The test was not completed but the physician did not mark this on the consent form. This physician has been re-educated regarding requirements.

SODC Operations will work with Ludeman and Murray to ensure their policies meet these statutory requirements.

SODC Operations will ensure Ludeman and Murray implement plans of corrections for these areas that includes policy revision review and re-training.

SODC Operations will ensure a quality control compliance check is randomly performed.

**19. The auditors recommend DHS management establish comprehensive Department-wide policies, procedures, and internal controls over compliance with state mandates regarding the use of seclusion that is applicable to all facilities. These policies, procedures, and internal controls should include requirements for training personnel on compliance requirements and should outline management oversight over compliance requirements.**

**FINDING:** *(Noncompliance with Statutory Requirements Regarding the Use of Seclusion)*

Auditors performed on-site testing regarding the use of seclusion at three of the DHS' state-operated facilities that use seclusion on the resident population. Auditors sampled and tested a total of 22 residents who were placed in seclusion, which resulted in the following exceptions at three of DHS' facilities:

Elgin Mental Health Center

- For 3 out of 11 (27%) residents tested who were placed in seclusion, the facility director was not informed in writing within 24 hours by the person who ordered seclusion. The facility director was notified of the seclusion between 25 and 28 hours after the seclusion was ordered.

McFarland Mental Health Center

- The facility does not have procedures in place for the facility director to approve, in writing, any seclusion ordered twice within 48 hours for the same patient, prior to administering the second seclusion.

John J. Madden Mental Health Center

- For 3 out of 11 (27%) residents placed in seclusion, the seclusion order did not include evidence of the facility director's review.
- For 1 out of 11 (9%) residents placed in seclusion in which a subsequent employment of seclusion occurred within 48 hours following the previous 16 hour period of seclusion, the facility did not obtain prior written authorization from the facility director.

DHS management indicated the conditions noted were due to a combination of human error, staff turnover, lack of training, and insufficient documentation retention procedures.

**DEPARTMENT RESPONSE:**
The Department accepts the recommendation. DHS will create policies and procedures regarding the use of seclusion, train personnel on compliance requirements and provide management oversite over compliance requirements.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action Implemented:**
SOH (Elgin) Seclusion orders scanned to Hospital Administrator's assistant so that HA may review daily.

SOH (McFarland) has not utilized seclusion in several years but will follow any policies and procedures implemented. McFarland administration will work on developing a procedure to obtain permission in writing of any seclusion ordered twice within 48 hours for the same patient, prior to administering the second seclusion.

SOH (Madden) Training department having Computer basic learning modules which help staff become more aware of new policies, procedures and training compliance requirements and in-service personnel on any recent policies and procedures. Madden Quality Strategies Liaison is responsible for creating new policies and procedure on seclusion and other compliance requirements etc.

**Corrective Action in Progress:**
DHS will create policies and procedures regarding the use of seclusion, train personnel on compliance requirements and provide management oversite over compliance requirements. (0% Complete)

**Expected Implementation Date: 06/30/2022**

**20. The auditors recommend DHS management and staff strengthen internal controls and compliance over the Home Services Program as follows:**

- **Increase monitoring by assigning additional staff resources or by enacting alternative means for monitoring program activities, including third party designees.**
- **Annually obtain and assess a SOC 1 Type 2 report for functions performed by the pre-screening service provider, or perform a review of the service provider using DHS staff who have the requisite expertise.**
- **Establish an interagency agreement with the Department on Aging.**

**FINDING:** *(Internal Control Weaknesses in the Home Services Program)*

These weaknesses were first noted in a review of the Home Services Program that Department management had performed in FY2005.

The Home Services Program allows individuals with disabilities (customers) who are at risk of placement in a nursing home to remain in their homes. According to DHS, this is accomplished through the use of a variety of services, the most prevalent of which is the use of individual caregivers known as Personal Assistants. During FY18 and FY19, the Home Services Program maintained 46 field offices and, over the course of FY19 and FY 18, on behalf of the customers, paid 42,981 Personal Assistants $530,409,830 and 41,153 Personal Assistants $462,897,953, respectively. There was an approximate 8% increase in the number of personal assistants since FY17 (39,713). Personal Assistants are hired, supervised, and fired by the customer. Therefore, 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 timesheets.

Through testing and discussions with Home Services Program personnel, auditors noted the following:

- There was insufficient monitoring of case files to ensure program objectives were being met. There was an average of 31 supervisors at 46 field offices to monitor Home Services Program activities. On average, each supervisor was responsible for approximately 1,055 case files during FY19. During the previous examination period, the statewide average responsibility per supervisor was approximately 792 case files. There was an average of 125 counselors during FY19 and 137 counselors during FY18. There was an average of 262 case files per counselor during FY19 and 213 during FY18. For FY2017, the statewide average per counselor was approximately 217 case files.
- A required increase in hourly wage paid by DHS to Home Services Program personal assistants and individual maintenance home health workers was to be effective by August 5, 2017 but was not implemented until April 1, 2019, or 604 days late. For the compliance period ending June 30, 2019, DHS paid back wages in the amount of $28.6 million.
- DHS did not provide documentation of interagency agreements between DHS and Aging regarding the intake procedures and eligibility criteria for persons who may need long term care.
- DHS could not document that it sufficiently monitored third party providers who perform prescreening for Home Services Program eligibility on the Department's behalf, in order to determine if the processes are being reasonably performed in accordance with Department policy.

DHS management indicated that staffing levels and the overall scale of the program contributed to the issues identified. DHS management also indicated litigation over personal assistants' bargaining unit agreement delayed the required wage increase.

**DEPARTMENT RESPONSE:**

DHS accepts the recommendation. DHS will continue to review staffing levels to ensure levels are appropriate for workloads in the Home Services Program. Furthermore, DHS

will establish an Intergovernmental Agreement with Aging and work to increase reviews of pre-screening service providers.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action Implemented:**
The Division continues to review staffing levels for appropriateness and works to fill vacancies as appropriate. This will be an ongoing effort as staffing levels and staff vacancies is an ongoing and ever changing situation.

The Division had begun working with Aging regarding prescreens. With the shift to work from home there has been no progress on this topic in recent months.

**Corrective Action in Progress:**
DHS will continue to review staffing levels to ensure levels are appropriate for workloads in the Home Services Program.

DHS will establish an Intergovernmental Agreement with the Department on Aging and work to increase reviews of pre-screening service providers. The IGA is still in process. Division staff report that the agreement is currently with Aging to review.

With the Pandemic changing many areas of operations, the Division is reviewing its record retention methodologies and looking for ways to more efficiently operate the program with additional controls where appropriate.

**Expected Implementation Date: 6/30/2022**

**21. The auditors recommend DHS management strengthen internal control over the investigation of all job applicants. Additionally, DHS should retrain employees on DHS directives pertaining to safeguarding confidential information.**

**FINDING:** *(Noncompliance with Employment Requirements at the Illinois Center for Rehabilitation – Roosevelt)*

Auditors tested a sample of 57 current employees employed at the Illinois Center for Rehabilitation - Roosevelt and noted the following:

- For 2 out of 57 (4%) employees tested, the facility could not provide a Child Abuse and Neglect Tracking System (CANTS) Authorization Form.
- For 6 out of 57 (11%) employees tested, the facility could not provide a CANTS Authorization Form dated prior to the employees' start date. After being notified of our exceptions, the facility investigated the six employees and were able to demonstrate that none of the six employees was on DCFS' Central Register.
- The facility does not encrypt the CANTS Authorization Forms when they are emailed to DCFS.

DHS management indicated the conditions noted were due to human error.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will ensure all current and future employees, as a condition of employment, are vetted through DCFS as defined in the Abused and Neglected Child Reporting Act. Additionally, DHS will ensure the CANTS form is submitted and cleared prior to date of employment. DHS will also work to ensure employees are properly trained regarding the safeguarding of confidential information.

**UPDATED RESPONSE:** Implemented.
Human Resources Department will ensure that all individuals, volunteer, new employees or those interacting with Students have been cleared through CANTS. Once cleared through CANTS, information is logged and shared with Administrative and Security staff.

**22. The auditors recommend DHS management execute all interagency agreements as required by law. In addition, all parties to the IGAs should sign the agreement prior to the effective date. Further, DHS management should enter into interagency agreements with the applicable state agencies and the sheriffs' offices of every Illinois County which do not have signed agreements.**

**FINDING:** *(Inadequate Execution of Interagency Agreements)*

During the examination period, auditors noted the following:

- During testing of interagency agreements between DHS and various other state agencies, 4 out of 22 (18%) interagency agreements tested were not signed before the effective date. These agreements were signed between 60 and 492 days after the effective date.

- DHS management indicated the agreements were signed late for various reasons including one agreement was new and took longer than expected to complete, and requests for language changes were made late in the approval process.

- DHS did not enter into intergovernmental agreements (IGAs) with all sheriff offices, in order to collect incarceration data to determine if those individuals were still eligible for benefits administered by the Department.

  DHS management indicated coordination with other governmental agencies initially caused the delays. Additionally, due to a change in the law, the Department is in the process of entering into new IGAs with all sheriff offices.

- DHS did not have an interagency agreement with the State Board of Elections (SBOE), to provide the information necessary to transmit member data under the Electronic Registration Information Center (ERIC) Membership Agreement. A Data Sharing Agreement with the SBOE was signed by the Department on July 29, 2019, which was after the examination period and is 28 days late.

DHS management indicated the delay was partially due to the necessary coordination of both internal and external partners including two agency divisions, DoIT, the Integrated Eligibility System (IES) development vendor, and SBOE. Furthermore, DHS had to coordinate with the IES development vendor on implementation of the voter registration as it affected the IES. The competing priorities of updating IES and concern for timely processing of benefits also contributed to the delay.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will remind office and unit leadership of the importance of executing agreements prior to their effective date.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action Implemented:**
FCS staff to work with Legal and DoIT to create a Data Sharing Agreement with the sheriff's offices that will communicate the data submission requirements and provide instructions for all sheriffs to submit monthly data.

**Corrective Action in Progress:**
FCS staff to send Data Sharing Agreements to all sheriffs, accompanied by a cover letter informing sheriffs of the requirement to submit monthly jail roster information.

02/09/21-Bureau of Performance Management and IDHS-DoIT are working to have test files submitted from a small number of jails to verify new match process works accurately.
12/10/21- Working with DHS-DoIT a detailed and specific process by which county jails could submit a file in a format able to be utilized by the match process was created. The process instructions to be utilized by individual jails went through several revisions based off input from those submitting data. The process is a mostly manual process, but allows for the submission of files utilizing MoveIT file transfer. Nine counties have been able to make the transition.

- In review of the match logic being utilized once the information is received, a defect in the logic was identified and is being worked on to be updated.
- Due to the manual requirements still involved the potential for purchasing the data and utilizing within IES in a systematic manner is being reviewed. Working with the Office of FCRC a review is being done with procurement to determine if the data could be purchased from Equifax a third party provider.

**Expected Implementation Date: 12/31/2022**

**23. The auditors recommend DHS management and staff comply with current laws, regulations, and policies and procedures regarding locally held funds, petty cash, and postage. They also recommend management segregate duties over the receipt, recording, and deposit of cash at the Elgin Mental Health Center.**

**FINDING:** *(Inadequate Administration of Locally Held Funds, Petty Cash, and Postage)*

During fieldwork, auditors tested quarterly reporting of receipts and disbursements of locally held funds at five of DHS' state-operated facilities. Auditors sampled and tested a total of 120 Other Special Trust Fund (Fund 1139) transactions, 157 Resident Trust Fund (Fund 1143) transactions, 120 Rehabilitation Fund (Fund 1144) transactions, 104 Special Revenue Trust Fund (Fund 1149) transactions, 18 Permanent Fund (Fund 1150) transactions, and 40 Burr Bequest Fund (Fund 1272) transactions.

Auditors also performed on-site testing of DHS' petty cash funds and postage meters at four of DHS' state-operated facilities. Auditors selected 101 petty cash transactions and tested the postage meter balances for the years-ended FY18 and FY19 across the four facilities. Based on the locally held fund, petty cash, and postage procedures, auditors noted the following exceptions at five of the Department's facilities: Elgin Mental Health Center, Ann M. Kiley Developmental Center, Elisabeth Ludeman Developmental Center, Shapiro Developmental Center and Illinois Center for Rehabilitation and Education.

DHS management indicated the conditions noted were due to human error, lack of training and inadequate staffing.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will work to comply with all current laws, regulations, and policies/procedures regarding locally held funds, petty cash, and postage. The Elgin Mental Health Center has implemented procedures to ensure duties are properly segregated.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action:**
SODC Operations implemented a plan of correction that included remediation of problem areas, re-training and oversight to prevent re-occurrence at Shapiro (Implemented), Kiley and Ludeman (In Progress).

SOH (Elgin) Staffing changes and the addition of new staff along with training have addressed the deficiencies in Trust Fund. Facility tries to better estimate postage when replenishing machine so as not to exceed 12-month Procurement Code requirement.

**Expected Implementation Date: 06/30/2022**

**24. The auditors recommend DHS management and staff comply with current processes and procedures regarding employee evaluations and properly calculate employee pay deductions. Further, they recommend Department management provide additional training to supervisors pertaining to its Administrative Directive and the Act and hold staff accountable for maintaining appropriate time records.**

**FINDING:** *(Inadequate Controls Over Personal Services)*

### *Employee File Testing*

During testing of employee payroll and personnel files at the Central Office, auditors noted the following:

- For 6 out of 60 (10%) employee files tested, the daily staff attendance reports were not signed by the employee's supervisor.
- For 5 out of 16 (31%) tested employees that had overtime paid during the period, approval support was not provided.
- Auditors tested 60 employees noting some employees were not required to have a performance evaluation due to being a new hire or terminated during the period. For FY19, 10 out of 46 (22%) required employee evaluations were not completed timely, ranging from 2 to 309 days late. For FY18, 14 out of 45 (31%) required employee evaluations were not completed timely, ranging from 16 to 628 days late.

### *Fringe Benefit Testing*

During testing of fringe benefits for employees with personally-assigned vehicles, auditors noted the following exception:

- For 2 out of 6 (33%) employees tested, the reported personal use of an assigned vehicle indicated a larger benefit than the amount deducted on the employee's paycheck, totaling $534.

### *Employee Time Records Testing*

Auditors testing resulted in the following exceptions with employee Monthly Attendance Records (MARs) and Staff Requests for Time Off (IL444-4140) at four of the Department's facilities:

Elgin Mental Health Center

- For 2 out of 84 (2%) MARs tested, the MARs did not contain all required signatures and/or dates from the employee, supervisor, and/or timekeeper.
- For 2 out of 84 (2%) MARs tested, we could not determine that the MARs were signed by the timekeeper within 10 working days of receipt by the employee.
- For 39 out of 84 (46%) MARs tested, the facility could not provide the completed Staff Request for Time Off (IL444-4140) for employee absences.

Ann M. Kiley Developmental Center

- For 1 out of 90 (1%) MARs tested, the MAR was signed and dated prior to the month's end.
- For 4 out of 90 (4%) MARs tested, the MARs were signed by the timekeeper between 1 and 21 days late.
- For 3 out of 90 (3%) MARs tested, the MARs were not signed by the employee or the supervisor.

- For 1 out of 90 (1%) MARs tested, the MAR was not completed timely by the employee, supervisor, and timekeeper. The MAR for January 2018 was not signed until March 7, 2018.

Ludeman Developmental Center

- For 3 out of 90 (3%) MARs tested, the employees did not have a MAR located within their personnel file for the tested month.
- For 8 out of 81 (10%) MARs tested, the MARs did not contain all required signatures from the employees, supervisors, and/or timekeepers.
- For 14 of 81 (17%) MARs tested, the MARs did not include the date(s) reviewed by the employees, supervisors, and/or timekeepers. As a result, auditors were unable to verify whether or not the MARs were reviewed within 10 working days.
- The facility maintains official timekeeping information by month instead of within an employee's official timekeeping file as required.
- While reviewing Staff Requests for Time Off (IL444-4140), auditors noted the following:
    - For 5 out of 180 (3%) days tested, the Daily Staff Attendance Reports (IL444-4141) were not retrievable.
    - For 94 out of 180 (52%) days tested, Staff Requests for Time Off (IL444-4140), Work Away Records (IL444-4604) if applicable, and Daily Staff Attendance Reports (IL444-4141) were not retrievable.
    - For 4 out of 180 (2%) days tested, Staff Requests for Time Off (IL444-4140) were not properly completed.
    - For 1 out of 180 (1%) days tested, the Daily Staff Attendance Report (IL444-4141) was not properly completed by the timekeeper.
    - For 5 out of 180 (3%) days tested, Staff Requests for Time Off (IL444-4140) were not properly approved by the supervisors.
    - For 42 out of 180 (23%) days tested, the MARs did not agree to the Daily Staff Attendance Reports (IL444-4141).
    - For 20 out of 180 (11%) days tested, the Staff Request for Time Off (IL444-4140) or the Work Away Records (IL444-4604) did not agree to the Daily Staff Attendance Reports (IL444-4141).

Illinois Center for Rehabilitation and Education

- For 1 out of 72 (1%) MARs tested, the MAR did not contain the required signature from the supervisor.
- For 1 out of 72 (1%) MARs tested, the MAR did not include the date reviewed by the supervisor.
- The facility maintains official timekeeping information by month and pay-code instead of within an employee's official timekeeping file as required.
- While testing Staff Requests for Time Off auditors noted the following:
    - For 15 out of 180 (8%) days tested, the Staff Requests for Time Off (IL444-410), Work Away Records (IL444-4604), or Daily Staff Attendance Reports (IL444-4141) were not properly approved by the supervisors and/or timekeepers.

  - For 22 out of 180 (12%) days tested, the Staff Requests for Time Off, Work Away Records, Daily Staff Attendance Reports, or other support was not retrievable.
  - For 33 out of 180 (18%) days tested, the MARs did not agree to the Daily Staff Attendance Records, and the Staff Requests for Time Off or the Work Away Records did not agree to the Daily Staff Attendance Reports .
  - For 11 out of 180 (6%) days tested, the Staff Requests for Time Off and/or Daily Staff Attendance Reports were not properly completed.
- While testing support for employee absences during our site observation, auditors noted the following:
  - For 2 out of 8 (25%) Staff Requests for Time Off (IL444-4140) tested, the forms were not properly completed.
  - For 1 out of 8 (13%) Staff Requests for Time Off (IL444-4140) tested, the form was not approved by the supervisor.

DHS management indicated the conditions noted were due to human error.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will work to ensure compliance with current processes and procedures regarding employee evaluations, calculations of employee pay deductions and maintaining appropriate time records.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
Provide joint seminars with Facility payroll staff for training on timekeeping and payroll procedures.

Continue to provide reports to Divisions when evaluations are due.

SOH (Elgin) filled a vacancy in Timekeeping so that staff can better track completed RTO's and signed MARS.

ICRE-R: Checks and balance procedures have been instituted to ensure that all timekeeping documents are in order and filed correctly. Once the state is operating at full capacity all timekeepers will be retained on all aspects of timekeeping.

SODC: All staff at Kiley and Ludeman will receive re-training on the Administrative Directive for MARs.

SODC Operations will review and revise as needed Ludeman's MAR procedure and tracking to ensure compliance and provide training to supervisors on the timely completion of evaluations.

SODC: Ludeman implemented a routine monitoring check of Daily Staff Attendance Records to review for compliance.

**25. The auditors recommend DHS management and staff comply with current policies and procedures regarding property and equipment, and follow the control system in place. Additionally, DHS should adequately maintain buildings and facilities to prevent further deterioration.**

**FINDING:** *(Lack of Physical Control Over State Property)*

As of June 30, 2019, DHS valued its State property at $301.3 million.

Even given the limitations, auditors obtained the populations provided by the facilities, selected a sample, and tested for compliance. We noted the following:

Central Office and Central Office Site Locations:

During fieldwork, auditors performed on-site testing of property and equipment at 5 of DHS' Central Office Site locations. Auditors tested a sample of 40 equipment items, 20 selected from property records, and 20 selected from physical observation. Auditors testing resulted in the following exceptions at 2 of DHS' Central Office locations:

- For 1 out of 5 (20%) equipment items tested from the inventory listing at Macon County Family Community Resource Center (FCRC) totaling $1,950, the item could not be located.
- For 4 out of 6 (67%) equipment items tested from the inventory listing at Cook County-Woodlawn FCRC totaling $3,590, the items could not be located.
- While testing lease and installment purchase agreements, we noted the Department did not provide complete information within the Accounting for Leases – Lessee Forms (SCO-560). Three out of 3 (100%) SCO-560 forms tested, totaling $475,761, did not include the required information for leases. All forms were missing net lease information. One form was missing the estimated total economic life and the estimated remaining economic life.

During fieldwork, auditors performed on-site property and equipment testing at four of DHS' state-operated facilities. Auditors tested a sample of 197 inventory items across the four facilities. The testing resulted in the following exceptions at the four facilities:

Elgin Mental Health Center

- For 4 out of 15 (27%) equipment items tested from the inventory listing, totaling $1,299, the items could not be located at the facility.
- For 2 out of 15 (13%) equipment items tested from the inventory listing, totaling $2,172, the items were not located in the areas indicated on the inventory listing.
- For 4 out of 15 (27%) equipment items tested from the facility floor, the items were not included in the inventory listing and auditors were unable to determine the cost of the items.
- For 5 out of 25 (20%) surplus (unused) equipment items tested, totaling $10,091, the items could not be traced from the facility floor to the property listing. Additionally, 13 out of the 25 (52%) surplus items were tagged as federal property and did not appear on the inventory listing.

Ann M. Kiley Developmental Center

- For 2 out of 30 (7%) items tested, totaling $599, the items were found in locations that did not match the locations listed on the inventory listing.
- For 2 out of 30 (7%) items tested and physically observed at the facility, the items could not be located on the facility's property listing and we were unable to determine the cost of the items.
- During a walkthrough of the facility, auditors noted donated items at the facility were not tagged and were not recorded in the inventory listing at acquisition value at the time of the donation.

Ludeman Developmental Center

- For 4 out of 15 (27%) equipment items tested from the inventory listings, totaling $2,256, the item could not be located at the facility.
- During a walkthrough of the facility, auditors noted the grounds were not properly maintained. Auditors observed several instances of property deterioration while touring facility grounds, including sidewalks that were cracked and roads with potholes.
- For 19 out of 32 (59%) large equipment transactions tested, the items were recorded at incorrect dollar amounts, causing an overstatement of $122,086 on the inventory listing.

Illinois Center for Rehabilitation and Education

- During a walkthrough of the facility, auditors noted the grounds were not properly maintained. Auditors observed several instances of property deterioration while touring facility grounds, including a deteriorated pool previously used for student rehabilitation.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. Current policies and procedures will be reviewed and reiterated to all DHS locations. Furthermore, additional Property Control Coordinator training sessions will be provided quarterly. DHS Capital Projects is aware of grounds maintenance requests and information continues to be provided to the Capital Development Board (CDB) for review and possible funding for CDB projects to be initiated.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
The Business Administrator will continue to solicit for funds via DHS, PIF (Permanent Improvement Fund) to repair the damaged swimming pool. Also, waiting for CDB to fund ICRE-R project which will also repair the swimming pool. (CDB-RQNumber- 13094). (ON GOING).

Grounds requests added to yearly CDB Project Lists for funding. Property Control Manual is available via hard copy and via DHS OneNet.

The facility continues to notify and work with CMS to assure that all repairs to the State of Illinois property and grounds are taken care of in a timely manner. (ON GOING).

This will be an ongoing operation in order to continually update with any identified needs.

Training Sessions- Property Control. Due to Covid restrictions, in person sessions were unable to be implemented during Spring/Fall 2020. Training, upon request was made available via phone with Property Control Manuals also being provided.

SODC Operations have ensured Kiley and Ludeman implement re-training of property control procedures at their Centers which included donated property items. DHS Property Control will work with SODC operations to provide ongoing staff training on property control procedures. Present staff have been provided up to date information and have received instruction to contact Property Control with any questions or needs for assistance.

SOH (Elgin) has reorganized the area responsible for property control, assigning the duties to a new Storekeeper III position instead of an Office Coordinator being responsible for both property control and telecom duties.

**26. The auditors recommend DHS management and staff do the following:**

- **comply with current policies and procedures regarding accounts receivable and follow internal control systems put in place at the facilities;**
- **maintain detailed records of all billings and the corresponding collections to facilitate proper reporting of accounts receivable activity;**
- **consider writing off delinquent or uncollectible accounts to reflect only realizable amounts; and**
- **Finally, allocate sufficient staff so that job duties are performed as required and accounts receivable transactions are processed and accounts are properly maintained.**

**FINDING:** *(Inadequate Controls Over Accounts Receivable)*

Auditors sampled and tested 45 residents (with receivables) across the three facilities. Testing resulted in the following exceptions regarding accounts receivable at three facilities:

Elgin Mental Health Center

- For 5 out of 15 (33%) resident files tested with receivables totaling $40,106, residents were sent a Notice of Determination between 40 and 3,877 days after the recommended 60-day period.
- For 3 out of 15 (20%) resident files tested with receivables totaling $26,363, the facility assigned a payment due date that was less than 90 days of the Notice of

Determination form mailing date. The due dates listed were between 43 and 79 days after the Notice of Determination form date.

- For 2 out of 15 (13%) resident files tested with receivables totaling $23,096, the receivables went unpaid for over 180 days. The age of the receivables were 52 and 71 months and were not submitted to the Department's Central Office Bureau of Collections (BOC) for collection.
- For 2 out of 15 (13%) resident files tested with receivables totaling $1,475, the facility did not write off Medicare B billings along with the rest of the patient's account.
- For 1 out of 15 (7%) resident files tested with receivables totaling $291, the receivable balance was not accurate due to system entry limitations.
- Payments from Medicare, Medicaid, and the Social Security Administration were not applied to individual patient accounts resulting in an overpayment of $2,107,173 that might need to be refunded.

Ann M. Kiley Developmental Center

- The facility did not maintain adequate controls over its accounts receivable procedures. Specifically, the facility did not ensure ILL-1/IL-462 forms were completed fully as follows:
  - Forms containing recipient resource information, income information, asset information, or signature were not fully completed for 8 out of 15 (53%) resident financial case records tested.
  - Five out of 15 (33%) resident financial case records tested did not contain the resident's city of birth.
  - Three out of 15 (20%) resident financial case records tested did not contain the resident's age.
  - Two out of 15 (13%) resident financial case records tested were missing a witness signature authorizing the release of information and assignment of benefits.

Ludeman Developmental Center

- For 1 out of 15 (7%) clients tested, the guardian who was receiving the benefits did not receive a Notice of Determination detailing the rates being charged.

DHS management indicated the conditions noted were due to human error, under-staffing, lack of knowledge regarding DHS directives, lack of communication between the applicable facility and the Central Office, and lack of staff training.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will work to ensure compliance with current policies and procedures regarding accounts receivables, follow internal control systems, keep better records of all billings and collections, and consider writing off delinquent or uncollectable debt.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
SOH (Elgin) New staff along with additional staff added to Reimbursement Office and additional training to address deficiencies.

SODC Operations will ensure Kiley and Ludeman Centers implement corrective action plans that address completely filling out RE2 forms as well as procedure on sending Notice of Determinations.

**27. The auditors recommend DHS management increase the level of supervisory review of the voucher process. Supervisors should allocate adequate resources to the area and direct that staff follow established policies so that invoice vouchers are reviewed and approved in a timely manner, and interest payment penalties are submitted timely.**

**FINDING:** *(Voucher Processing, Policies, Approvals and Payment)*

| | Using "Level 3" Approval | | | Using "Level 1" Approval | | |
|---|---|---|---|---|---|---|
| Area: | No. of Exceptions | Range of Days Late | Voucher Sample Total | No. of Exceptions | Range of Days Late | Voucher Sample Total |
| Printing | 6 | 2 to 128 | $ 48,606 | 5 | 2 to 119 | $ 48,173 |
| Operation of Automotive | 7 | 1 to 47 | 6,417 | 4 | 7 to 44 | 5,967 |
| EDP | 21 | 1 to 146 | 102,971 | 12 | 8 to 145 | 50,706 |
| Travel | 22 | 2 to 50 | 4,899 | 17 | 1 to 37 | 2,901 |
| Contractual Services | 8 | 1 to 228 | 3,686 | 4 | 4 to 225 | 609 |
| Commodities | 10 | 1 to 45 | 58,540 | 6 | 4 to 38 | 23,626 |
| Property and Equipment | 13 | 4 to 94 | 74,532 | 7 | 3 to 50 | 26,154 |
| Total | 87 | | $ 299,651 | 55 | | $158,136 |
| Total Rate of Occurrence | 13.2% | | | 8.3% | | |

Also, our voucher testing noted the following:

- For 1 out of 60 (2%) printing vouchers with required interest penalty payments, the interest penalty payment was not submitted to the Illinois Office of the Comptroller (IOC). The voucher totaled $41,000 and computed interest due totaled approximately $82.
- For 1 out of 60 (2%) property and equipment vouchers with required interest penalty payments, the interest penalty payment was not submitted to the Illinois Office of the Comptroller (IOC). The voucher totaled $43,600 and computed interest due totaled approximately $504.
- For 2 out of 60 (3%) property and equipment vouchers with newly acquired assets, the assets were not found on the Department's Addition Property Control Listings. The vouchers totaled $8,207.
- For 1 out of 60 (2%) operation of automotive vouchers tested, totaling $191, the voucher did not have an invoice received date.

DHS management indicated the conditions noted were due to untimely approval of vendor invoices and lack of maintaining the supporting documentation.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will reiterate supervisory responsibilities within the vouchering process and the need for staff to follow established policies.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
Office of Fiscal Services have reiterated responsibilities within the vouchering process and the need for staff to follow established policies in a document distributed to Executive staff and all CARS users.

Since moving from CARS to SAP, Fiscal Services will utilize the 6 month SAP Financials User Access Review process to cover this requirement. The Access Review is targeted to those with system access so we ensured we were targeting the correct people. Within the access review, the employee agrees to:

I understand that applying an approval in SAP or related systems indicates that I have:

- Opened and reviewed the document and all relevant text records, and
- Reviewed all fields of the document, including associated relevant text records , and
- Ensured the coding and dates on the document follow Agency, State and Federal rules, to the best of my knowledge.
- I understand that I should apply approvals or rejections to a document immediately after reviewing it.

**28. The auditors recommend DHS management and staff comply with current policies and procedures regarding commodities and follow the control system in place.**

**FINDING:** *(Inadequate Controls Over Commodities)*

DHS does not maintain adequate internal control and oversight over commodities. Inventory control includes responsibilities at DHS' state-operated facilities, multiple Central Office warehouses, and other Central Office locations.

DHS incurred commodities expenditures of $25.7 million and $26.3 million during FY19 and FY18, respectively. In addition, DHS recorded ending commodities inventories of $6.7 million and $7.9 million for the Fiscal Years ended June 30, 2019 and June 30, 2018, respectively.

During fieldwork, auditors performed procedures over inventory at three facilities. On-site inventory testing was performed at two facilities. Auditors sampled and tested 180

inventory items across these two facilities. Auditor's inventory procedures resulted in the following exceptions at three of the Department's facilities:

Elgin Mental Health Center

- For 2 out of 12 (17%) general stores inventory adjustments, the number of units did not agree to supporting documentation. The adjustments resulted in the number of items on hand being reduced by 6 units and 24 units when no adjustment was necessary for either item.
- For 4 out of 15 (27%) general stores vouchers tested in the amount of $59, the purchase prices did not agree to the unit prices on the Monthly Commodity Status Report. This resulted in a difference between the unit price per the purchase order and the Monthly Commodity Status Report in the amount of $32.
- For 1 out of 30 (3%) general stores requisitions tested in the amount of $2,253, the requisition did not agree to the Activity Status Report. The number of units and amount were recorded correctly in the Activity Status report; however, the description of the item was incorrect.
- There is a segregation of duties issue within the general stores inventory cycle, as two employees have the ability to order, receive, record, maintain custody, and count the inventory items. Additionally, a single employee has the ability to receive, record, maintain custody, and count the inventory.
- For 2 out of 30 (7%) pharmacy inventory items counted during annual inventory, the facility's counts did not agree with our test counts. The discrepancy between counts ranged from 1 to 10 units and totaled $10.

Ann M. Kiley Developmental Center

- During testing, auditors noted the facility made an unnecessary year-end adjustment to one of its pharmacy inventory medications. The quantity physically counted by facility staff and the quantity noted within the inventory system (RX Works) agreed. As a result, no adjustment was necessary. However, an adjustment was made to this medication, reducing the quantity in RX Works by eight units. The improper adjustment resulted in the facility's pharmacy inventory being understated by $14.
- The facility failed to include a substantial amount of its non-perishable food inventory on hand in its FY19 ending inventory balance.
    - The facility held 32 cases of baby lima beans and 32 cases of turnip greens at its off-site warehouse, which were excluded from the year-end inventory count. Facility personnel stated these items were not counted because they were not purchased by the facility; another facility transferred them to the facility. Auditors were unable to calculate the resulting understatement due to the lack of supporting documentation containing information on the value of these items.
- For 1 out of 30 (3%) inventory items counted during the annual inventory at the off-site warehouse, the facility's counts did not agree with our test counts. The difference noted was one unit, totaling $31. The facility subsequently made the proper year-end adjustment to correct the error.

- The facility failed to make proper year-end adjustments to two of its commodities inventory items maintained on the Commodities Control System. Items were overstated by 192 and 20 units, respectively, resulting in a collective overstatement of $980.
- The facility did not include items received following its year-end physical count but prior to June 30, 2019, in its FY 2019 year-end commodities inventory balance. The facility received 32 unique products at various quantities during this time, totaling $16,320, resulting in an equivalent understatement on its ending reported FY 2019 commodities inventory balance.

Ludeman Developmental Center

- The facility did not physically count all of its inventory items located at the General Stores and Ox Cartage locations during year-end inventory counts. There were 9 inventory types (total quantity of 139 items) listed on the Commodity Control System that were not counted.

DHS management indicated the conditions noted were due to human error, limited resources, and lack of knowledge and training of staff responsible for the annual count process.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will re-train staff regarding controls over commodities to ensure compliance with existing policies and procedures.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
SOH (Elgin) hired additional staff and retrained existing staff to address deficiencies, and also implemented weekly inventories reviewed by the Accounting Department to monitor ongoing compliance.

SODC Operations will ensure corrective action plans are implemented that address re-training and compliance monitoring.

**29. DHS has the ultimate responsibility for ensuring confidential information is protected from accidental or unauthorized disclosure. Specifically, auditors recommend that DHS:**

- **Formally establish and communicate DHS' cybersecurity program (formal and comprehensive policies, procedures and processes) to manage and monitor the regulatory, legal, environmental and operational requirements.**
- **Assign responsibility over cybersecurity program and clearly document and communicate cybersecurity responsibilities.**

- **Implement a risk management framework to govern security governance within DHS.**
- **Conduct a comprehensive risk assessment to identify all confidential information in electronic and hardcopy form in an effort to ensure this information is adequately safeguarded. The Assessment should also identify any risks and corrective actions necessary to remediate those risks, as well as management's overall assessment conclusions.**
- **Ensure all confidential information is safeguarded and adequately disposed when no longer needed.**
- **Ensure all confidential information is encrypted if sending via email.**
- **Ensure all employees annually complete cybersecurity training as outlined in the Data Security on State Computers Act.**

**FINDING:** *(Weaknesses in Cybersecurity Programs and Practices)*

The Department is responsible for the protection of sensitive information collected including Social Security Numbers, personally identifiable information, protected health information, and financial information associated with fulfilling its overall mission.

During examination of DHS' cybersecurity program, practices, and control of confidential information, auditors noted that DHS:

- Had not developed a formal, comprehensive, adequate, and communicated security framework (policies, procedures, and processes) to manage and monitor the regulatory, legal, environmental and operational requirements.
- Had not assigned cybersecurity responsibilities to Department staff.
- Had not implemented an IT risk management framework to govern its cybersecurity strategy.
- Had not conducted a comprehensive risk assessment to identify all confidential information in electronic and hardcopy form.
- Had not ensured all confidential information was adequately safeguarded, including adequately disposing confidential information at Department facilities. Specifically, during walkthroughs of various Department facilities we noted the following:
    - Ludeman Developmental Center - For 1 out of 6 (17%) garbage receptacles tested and for 3 out of 4 (75%) dumpsters tested, auditors found documents containing protected health information (PHI).
    - Elgin Mental Health Center - For 1 out of 12 (8%) waste and recycling containers tested, auditors found documents containing PHI.
    - Jack Mabley Developmental Center - For 3 out of 12 (25%) waste containers tested, auditors found documents containing PHI. In addition, one instance was noted where PHI was left easily accessible to the general public.
    - Madden Mental Health Center - For 1 out of 6 (17%) garbage receptacles tested, auditors found documents containing confidential information and PHI.

  - Murray Developmental Center - auditors found documents containing confidential information and PHI located within a cart used by residents to collect documents from staff throughout the Center for shredding.
  - Illinois Center for Rehabilitation and Education - For 1 out of 4 (25%) recycling containers tested and in 1 out of 2 (50%) shredding bins tested, auditors found documents containing PHI.
- Had not ensured confidential information was protected with encryption methods prior to sending via the Internet.
- Had not ensured all employees completed cybersecurity training upon employment and annually thereafter.

DHS management indicated the lack of staffing and resources contributed to the delay in implementing a cybersecurity program. Additionally, DHS management indicated although staff were trained in regards to the protection of confidential information, the staff did not comply with the Directives.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will work with the DoIT to perform a formal Agency Enterprise IT Risk Assessment on DHS systems. Although DHS maintains overall responsibility over cybersecurity for its specific systems and data, DoIT has hired a new Chief Information Security Officer (CISO), who will be assisting with cybersecurity technical responsibilities for DHS systems. DHS will publish verbiage which makes specific reference to its required compliance with DoIT standards.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action Implemented:**
SODCs - Mabley has implemented a plan of correction that includes re-training and compliance monitoring.

DoIT-DHS - New CISO contact information and responsibilities have been updated on the DHS OneNet.

DoIT-DHS MIS Security will work with DoIT-DHS Web Services to track user completion of the required annual Security Awareness Training. DoIT-DHS MIS Security will follow-up with agency divisions with less than 100% completion.

SODCs - Each Center (Ludeman, Mabley and Murray) will implement a plan of correction that includes re-training and compliance monitoring. Mabley is complete.

**Corrective Action in Progress:**
DoIT-DHS and DHS Business system owners will participate in the 2020 DoIT Enterprise Risk Assessment for Agency Systems exercise in June 2020. (50% Complete)

Document Risk Management Framework process and procedures on the DoIT-DHS MIS Standards on the agency intranet. (10% Complete)

**Expected Implementation Date: 12/31/2022**

**30. The auditors recommend DHS implement its policy on charging residents for services and a corresponding rate structure to comply with the Act. They further recommend that DHS take steps to determine whether any costs of services that were provided during the examination period can be recouped.**

**FINDING:** *(Noncompliance with Statutory Requirements Regarding Charging Residents for Services)*

DHS did not comply with statutory requirements regarding charging residents for services at the Rushville Treatment and Detention Facility (Facility).

During testing at the Rushville Facility (which is the only state-operated facility this mandate is applicable to), auditors noted DHS has not implemented a policy and a corresponding rate structure for charging residents for services. Under the existing conditions, a resident may have access to assets to pay for services the facility provides, but the resident would not be required to pay without a documented policy in place.

As of June 30, 2019, the Facility had 564 residents. Facility expenditures for FY19 and FY18 were approximately $37,510,543 and $37,510,480, respectively.

DHS management indicated during the prior examination Title 59 Part 299 required significant revision beyond that initially anticipated to implement the Act, and the revisions were in process. During the current examination, Facility management indicated the revisions were completed and DHS approval was obtained subsequent to the examination period.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will continue to work towards implementing its policy to charge residents for services and identifying whether any costs of services may be recouped.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action Implemented:**
Position descriptions have been created and requests in process for filling positions to charge patients for their service. Update: DHS has successfully hired a staff person in the TDF Business Office to perform these duties.

DMH has hired a new staff person centrally to oversee the fiscal operations of the SOPH's and TDF so they will be brought up to speed on this finding and assist in moving it forward.

**Corrective Action in Progress:**
DHS will continue to work towards implementing its policy to charge residents for services and identifying whether any costs of services may be recouped.

**Expected Implementation Date: 12/31/2022**

**31. The auditors recommend DHS management comply with the law by completing and adopting rules related to the assignment and operations of monitors and receiverships for CILA arrangements as required by statute. They also recommend management fully implement the CILA Performance Audit recommendations in order to adequately monitor the CILA Program.**

**FINDING:** *(Failure to Implement Integrated Living Rules and Adequately Monitor CILAs)*

***Failure to Finalize and Implement Rules***

DHS management indicated the continued delay in finalizing the rules were due to insufficient staff resources, and changes in the Federal Home and Community Based Settings Rule.

***Failure to Adequately Monitor the CILA Program***

In July 2018, the Office of the Auditor General (OAG) released a Performance Audit of the Department's Oversight of the CILA Program (CILA Performance Audit) pursuant to Illinois House of Representatives Resolution Number 34. The OAG's CILA Performance Audit contained 26 recommendations in which DHS was to take corrective actions necessary to ensure all areas responsible for the CILA Program have adequate management oversight to ensure material compliance with all relevant governing laws, regulations, contracts, and grants agreements.

DHS management indicated insufficient staff resources were the cause for the delays.

Failure to adopt rules that govern the assignment and operations of monitors and receiverships for CILAs and adequately monitor the CILA program could adversely impact the care and treatment of each recipient and represents noncompliance with the Act.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. The language for monitoring and receivership has been drafted and the rule in its entirety was forwarded to the Rules Bureau within the Office of General Counsel on February 3, 2020, for review.

With respect to failure to adequately monitor the CILA Program as noted by the Office of the Auditor General in July 2018, DHS accepts the recommendation. As of December 31, 2019, 13 of the Auditor General's original 26 recommendations had been fully implemented. Two additional recommendations will be fully implemented when the CILA rule is published. The remaining recommendations have been partially implemented with the majority relating to DHS' oversight of a contract with an outside entity, not related to CILA licensing or monitoring.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action in Progress:**
Updates/changes to 59 IAC 115 were submitted to JCAR and published for First Notice on February 26, 2021. DHS has reviewed all comments submitted and is preparing for

JCAR Second Notice with final approval/implementation of the updated rule shortly thereafter.

**Expected Implementation Date: 03/01/2022**

**32. The auditors recommend DHS management submit all reports on or before the due date as specified in the applicable state Law.**

**FINDING:** *(Late Submission of Required Reports)*

During the examination period, DHS was required to submit various reports to the Governor, the General Assembly, and other officials. The topics of these reports include the Emancipation of Minors Act and the Rehabilitation of Persons with Disabilities Act. These reports were not filed in a timely manner.

- The Emancipation of Minors Act (750 ILCS 30/2(g)) annual report to the General Assembly, beginning January 1, 2019 and annually thereafter through January 1, 2024, regarding homeless minors older than 16 years of age but less than 18 years of age referred to a youth transitional housing program, for whom parental consent to enter the program is not obtained.

  During testing, auditors noted the Department did not complete the annual report to the General Assembly during the examination period.

  DHS management indicated the conditions noted were due to inadequate staffing level at the time of the required report submission.

- The Rehabilitation of Persons with Disabilities Act (20 ILCS 2405/3(d)) annual report on or before the first day of December.

  During testing, auditors noted DHS could not provide documentation that the required annual reports were prepared or filed with the Governor by December 1, 2017 or December 1, 2018.

  DHS management indicated information regarding program performance is provided to multiple stakeholders on a regular basis regarding all programs within DRS, and combined with DHS reporting. This specific requirement is included in a requested initiative to remove from statute as the intent is met through other manners.

- The Rehabilitation of Persons with Disabilities Act (20 ILCS 2405/3(f)) annual report on programs and services under this Section. The report should be filed with the Governor and General Assembly on or before March 30 each year.

  During testing, auditors noted DHS could not provide documentation that the required annual reports were filed with the Governor and General Assembly by

March 30 of each year. Auditors also noted DHS did not make the 2017 or 2018 annual reports available on its website.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. The Division will work to ensure reports are completed and submitted timely as required by State Law.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
The Division has worked to ensure reports are completed and submitted timely as required by State Law. The latest required reports were submitted on time.

**33. The auditors recommend DHS management appoint the appropriate personnel to the task force, commission and councils and evaluate its processes to make statutorily required appointments to ensure they are made in a timely manner.**

**FINDING:** *(Failure to Make Appointments in Accordance With State Law)*

During the examination period, auditors noted DHS lacked the following representation on a task force, commission, and councils:

- Two DHS division representatives for the Employment and Economic Opportunity for Persons with Disabilities Task Force.

  DHS management indicated it did not make all Task Force appointments for the period noted due to oversight.

- Ex-officio representation by a member of DHS' housing office for the Commission on Environmental Justice.

  DHS management indicated the statewide housing coordinator position, who usually serves as the ex-officio member, was vacant during FY18 and FY19.

- Ex-officio representation by the Chief of the Bureau of Refugee and Immigrant Services for the Illinois Council on Women and Girls.

DHS management indicated this council was formed in 2018; however, ex-officio appointments could not be made until after the newly elected Governor made his appointments in April 2019.

- Ex-officio representation by DHS for the Statewide Independent Living Council. One representative should be from the administration of the vocational rehabilitation program and another from the unit that provides services for individuals with disabilities.

  DHS management indicated the conditions noted were due to oversight.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will work to track the expiration of terms providing ample lead time to refill positions on task forces, commissions, and councils.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action Implemented:**
OSET has identified vacancies and worked to fill them. OSET has created a tracking system to track DHS appointments.

DHS will work to track the expiration of terms providing ample lead time to refill positions on task forces, commissions, and councils.

Update: The Division of Rehabilitation works with central administration to keep track of appointments coming due and making appropriate recommendations for individuals to fill them.

**Corrective Action in Progress:**
The OSET tracking system is being updated to track the expiration of terms as well as the sunsetting of task forces, boards, commissions, and councils.

**Expected Implementation Date: 06/30/2022**

**34. The auditors recommend DHS management enhance its processes and internal controls so that accidents are reported within the CMS required time frame, annual licenses and insurance certificates are submitted timely, and vehicles are properly maintained in compliance with CMS policies.**

**FINDING:** *(Lack of Compliance with Policies for Vehicles)*

***Reporting Requirements for Vehicle Accidents***

During testing of the CMS policies and procedures applicable to DHS vehicles, auditors noted 2 out of 8 (25%) instances of accidents involving state owned vehicles used by DHS employees during the examination period were not reported to CMS within 7 calendar days as required. The reporting ranged from 3 to 8 days late.

DHS management indicated Business Services is not aware of auto accidents unless and until a driver reports it, at which time Business Services promptly enters it into the Risk Management System.

***Annual Certification of Licensure and Liability Insurance***

During testing of individually assigned vehicles, auditors noted for 2 out of 3 (67%) vehicles tested, the annual certifications of licensure and liability insurance were submitted 7 and 156 days late.

DHS management indicated the non-compliance was due to employee oversight.

***Maintenance and Utilization of State Vehicles***

DHS did not comply with CMS policies and procedures to ensure state vehicles are properly maintained and utilized. During testing of maintenance and utilization records for DHS vehicles, auditors noted the following:

- For 15 out of 25 (60%) vehicles tested, oil changes were not done within maximum mileage and/or time requirements.
- For 2 out of 25 (8%) vehicles tested, there was insufficient documentation to support an oil change was timely performed.
- For 5 out of 25 (20%) vehicle tested, tires were not rotated as required during the examination period.
- For 1 out of 25 (4%) vehicles tested, there was no documentation to support an annual inspection was performed in FY18.

DHS management indicated the conditions noted were due to turnover at facilities, some of the vehicles did not have maintenance performed as scheduled.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS is working to review and develop additional edits to help eliminate noted errors and improve maintenance viability and adherence. Information regarding procedures for reporting accidents will be relayed to all facilities.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
Created New Tracking Database. Provide fleet procedures to DHS facilities.

**35. The auditors recommend DHS ensure the Disaster Recovery Plan is updated to include adequate recovery procedures, including business continuity procedures, for DHS' facilities, or references to specific recovery plans maintained by the facilities. Once updated, DHS should ensure the Plan is adequately tested and documented annually, including any appropriate actions necessary to address any weaknesses identified during testing.**

**FINDING:** *(Contingency Planning Weaknesses)*

During the current examination, as well as within the prior year examination, DHS management indicated they believed the facilities had established recovery plans and were testing annually.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will work with DoIT to update the agency Disaster Recovery Plan to include more comprehensive documentation and testing of facility-specific plans and procedures and to test the Alternate Data Center and backups.

**UPDATED RESPONSE:** Partially Implemented.

**Corrective Action Implemented:**
DoIT-DHS and DHS System Owners have made great strides in the documenting of disaster recovery, business impact analysis and continuation of operation plans. As of October 2021, all mission critical DHS systems except for IES (contingency plan is still in progress and to be completed in the next 60 days) – this includes the iWIC, CARS and Clinical family of systems. All external IT vendors procured for DHS system projects are required to provide Disaster Recovery / Information System Contingency plan documentation as a requirement of contract approval. Business Impact Analysis and Continuation of Operation Plans have been completed for each DHS Division.

**Corrective Action in Progress:**
DoIT is working to migrate DHS servers to the Software Driven Data Center (SDDC), in order to provide them better network security and enhanced disaster recovery / failover capabilities. (25% Completed)

**Expected Implementation Date: 06/30/2022**

**36. The auditors recommend DHS:**

- **Ensure adequate procedures, including adequate approval and documentation, exist for access provisioning and de-provisioning for all accesses including training IDs.**
- **Ensure DHS' PTS and CARS administration personnel work with the facilities to ensure system access is reviewed at least annually to ensure access is appropriate or timely removed when no longer needed.**
- **Ensure access within the specific applications is timely removed when no longer needed.**

**FINDING:** *(Access to Systems Not Controlled)*

Auditor's testing noted:

- For a sample of 25 new hires, terminations, and transfers associated with the Payroll and Timekeeping System (PTS), Consolidated Accounting and Reporting System (CARS) and Resource Access Control Facility (RACF) at DHS' Central Office, DHS did not provide documentation for 4 new hires, 3 terminations, and 1 transfer of access approval or timely termination of the access rights.
- DHS did not have a formal process for the provisioning and de-provisioning of training accounts.
- User access to the PTS and/or the CARS was not timely deactivated after termination from the Department's facilities.
- User access was incorrectly assigned to the wrong facility location.
- Adequate segregation of duties over the human resources and payroll functions at DHS' facilities was not maintained.

With regard to facility access weaknesses identified within PTS and CARS, DHS believed access was reasonable as it was an oversight.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS no longer requires RACF IDs for all employees, only for those with a specific need for mainframe access. DHS has begun the process of disabling RACF IDs for individuals with no need for access.

DHS will conduct a thorough review of access to the Payroll Timekeeping System to ensure access within applications is appropriate.

**UPDATED RESPONSE:** Implemented/No Longer Applicable (See Update Below)

**Corrective Action Implemented:**
Bureau of Payroll and Benefits (PTS / Central Payroll) will dedicate specific staff to conduct system access provisioning reviews for the agency.

DoIT-DHS will work with DHS HR to develop a method of communicating employee terminations to DoIT-DHS Security so that de-provisioning of accounts can be better managed.

Update: DHS no longer utilizes 'training only' accounts; these access accounts have been phased out and replaced with standard 'illinois.gov' accounts.

**37. The auditors recommend DHS management develop a methodology to calculate prompt payment interest that results from late medical payments to vendors processed through MMIS. The methodology should include the creation of an interagency agreement with HFS to obtain the necessary detailed documentation to allow DHS to determine that prompt payment interest is calculated and paid accurately as outlined in the Act and the SAMS Manual. They also recommend DHS management estimate a liability for such contingency when preparing its financial statements, where applicable.**

**FINDING:** *(Failure to Ensure Medical Assistance Payments' Prompt Payment Interest was Accurately Calculated and Paid)*

During testing, auditors determined DHS does not have a methodology to calculate prompt payment interest that results from late medical payments to vendors processed through MMIS and, therefore, it cannot determine if it accurately paid all such amounts going back to the year ended June 30, 2010.

DHS was unable to provide detailed supporting documentation for the medical assistance payments recorded against its appropriations. DHS does not have a process to track, and has not determined the amount of prompt payment interest owed for FY19 and FY18 related to the medical assistance payments. DHS provided support for the payment of $39,072 for MMIS Prompt Payment Interest during FY19 and FY18. Auditors were unable

to determine the entire population of MMIS Prompt Pay Interest owed to vendors in order to determine if all amounts were paid.

DHS management stated it only receives summary transactions data for entry into its Consolidated Accounting and Reporting System (CARS).

DHS management indicated a verbal agreement to pay and process MMIS interest payments was initiated back in FY10 between DHS and HFS. However, no written interagency agreement has ever been in place to handle processing MMIS payments or paying interest. DHS also noted that because its access to MMIS data is limited, it felt it was impossible to calculate the full amount of eligible prompt payment interest.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. DHS will coordinate with HFS to establish an Intergovernmental Agreement addressing the calculation and verification of Prompt Payment Interest (PPI) on Medical Assistance payments processed through the Medicaid Management Information System. DHS will also estimate a liability for this contingency when preparing its financial statements.

**UPDATED RESPONSE:** In Process. Partially Implemented.

**Corrective Action Implemented:**

**Corrective Action in Progress:**
DHS will modify GAAP procedures to check for a PPI liability when preparing funds that received FMAP money.

DHS will work with HFS to identify the population of providers that received late payments, and DHS will establish a procedure to verify (on a sample basis) that interest is being paid correctly.

DHS will determine if an IGA is needed once item B (above) is completed.

**Expected Implementation Date: 06/30/2022**

**38. The auditors recommend DHS management work with DoIT to add the required identifiers to its database to capture information on dependents of military service members who are absent from the state due to the member's military service.**

**FINDING:** *(Failure to Track Military Related Identifiers in the Cross-Disability Database)*

The Department of Human Services (Department) failed to comply with the cross-disability database provision of the Department of Human Services Act (Act) (20 ILCS 1305/26). Specifically, we noted the Department did not track military related identifier(s) in its cross-disability database and, therefore, could not identify dependents of military

service members within its cross-disability database in or to determine needs for services upon return to the State.

The Act (20 ILCS 1305/10-26) requires that the Department to compile and maintain a cross-disability database of Illinois residents with a disability who are potentially in need of disability services funded by the Department. The Act (20 ILCS 1305/10-26(d)) requires that the Department allow legal residents who are dependents of a military service member and who are absent from the state due to the member's military service to be added to the cross-disability database to indicate the need for services upon return to the state.

Department management indicated a programming change to their Prioritization of Urgency of Need for Services (PUNS) database to add a military related identifier was not yet implemented by the Department of Innovation and Technology (DoIT).

Failure to comply with the Act could result in dependents of military service members not receiving benefits they are entitled to, if they are not indicated as eligible within the database.

**DEPARTMENT RESPONSE:**
DHS accepts the recommendation. As of November 8, 2019, the programmatic changes to capture this information were added to the database. In addition, as of June 8, 2020, case managers can submit military status data.

**UPDATED RESPONSE:** Implemented.

**Corrective Action Implemented:**
As of November 8, 2019, the programmatic changes to capture this information were added to the database.

As of June 8, 2020, case managers can submit military status data.

As of September 1, 2021, four status types have been added to the PUNS table by DoIT: Active Duty, Not a Veteran, Unknown, and Veteran.