



STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

**PERFORMANCE AUDIT OF THE
MEDICAL ASSISTANCE PROGRAM
LONG TERM CARE ELIGIBILITY
DETERMINATION**

SEPTEMBER 2009

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*To the Legislative Audit Commission, the
Speaker and Minority Leader of the House
of Representatives, the President and
Minority Leader of the Senate, the members
of the General Assembly, and
the Governor:*

This is our report of the performance audit of the Medical Assistance Program jointly administered by the Illinois Departments of Healthcare and Family Services and Human Services with respect to the accuracy and impact of eligibility determination standards and procedures regarding persons applying for or receiving assistance for long term care, with particular emphasis on the nature and scope of errors in the assessment of the financial resources and financial liability of the applicants and recipients.

The audit was conducted pursuant to House Resolution Number 1295. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

A handwritten signature in black ink, appearing to read "William G. Holland".

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
September 2009

REPORT DIGEST

PERFORMANCE AUDIT OF THE

MEDICAL ASSISTANCE PROGRAM – LONG TERM CARE ELIGIBILITY DETERMINATION

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State of Illinois
Office of the Auditor General

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SYNOPSIS

House Resolution 1295 directed the Auditor General to audit the Medical Assistance Program jointly administered by the Departments of Healthcare and Family Services and Human Services with respect to the accuracy and impact of eligibility determination standards and procedures regarding persons applying for or receiving assistance for long term care, with particular emphasis on the nature and scope of errors in the assessment of the client's financial resources and financial liability.

In their response to the audit report, the agency directors acknowledged that: **"The policies, procedures and systems reviewed are highly complex and confusing."** As auditors, we are accustomed to dealing with complex and confusing processes. However, the real significance of, and difficulty with, this statement lies with the elderly and vulnerable population who ultimately must deal with these highly complex and confusing policies on a regular basis.

Among the issues auditors noted were:

- **The eligibility determination process**, specifically the processes used by both Departments related to determining how much income a client with a community spouse (a spouse residing in the community) must pay to the long term care facility, **is complex, cumbersome, and confusing.**
- **Auditors identified significant and pervasive problems in the processes and data used** by the Departments which resulted in long term care clients with community spouses being overcharged for their nursing home care.
- The most significant problem was that **the Departments automatically add the annual Social Security cost of living increase to the client's group care credit** (the amount that the client and the client's community spouse have to pay monthly for nursing home care).
- This automatic cost of living adjustment **almost always results in the new group care credit being incorrect**, since most or all of the income can be given to the community spouse. If not corrected in a timely manner, it results in the client being overcharged for their care.
- **In 7 of 23 cases** we reviewed, there were **14 instances** where more than **two months passed before the group care credit was manually corrected by the caseworker. In 3 of 23 cases**, the group care credits **were not corrected for two years.** In these cases, **the clients were overcharged \$9,204, \$1,056, and \$1,012**, for their care.
- The Departments send two notices within a two week period to long term care clients that **provide conflicting, or at best confusing, information** regarding the handling of the clients' Social Security increases.

PERFORMANCE AUDIT OF THE
MEDICAL ASSISTANCE PROGRAM – LONG TERM CARE ELIGIBILITY DETERMINATION

REPORT CONCLUSIONS

Auditors identified significant and pervasive problems in the processes and data used by the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) which resulted in long term care clients, with spouses residing in the community (community spouse), being overcharged for their nursing home care. The eligibility determination process, specifically the processes used by both Departments related to determining how much income a client with a community spouse must pay to the long term care facility for his or her care, is complex, cumbersome, and confusing.

The responsibility for administering the long term care program is shared primarily by two agencies, HFS and DHS. DHS is responsible for eligibility determination for all Medicaid programs. HFS pays for Medicaid long term care. According to the HFS website, its Bureau of Long Term Care administers the program that reimburses more than 750 nursing facilities for care provided to approximately 57,000 Medicaid-eligible residents each month. In Fiscal Year 2007, Healthcare and Family Services paid \$1.5 billion for long term care.

DHS is responsible for determining the initial eligibility of long term care applicants. DHS is also responsible for redetermination of clients' eligibility. The current Illinois Medicaid State Plan requires redetermination of eligibility for all recipients on an annual basis. This determination and redetermination process is handled by caseworkers at the Department's approximately 100 Family Community Resource Centers located throughout Illinois.

In cases where a long term care client has a spouse residing in the community, federal and State law allow clients to give some or all of their income to the community spouse, up to a set amount (called the maintenance needs allowance, which was \$2,610 per month in 2008). The purpose of allowing nursing home clients to give all or a portion of their income to a spouse residing in the community is to prevent the spouse from becoming impoverished.

SOCIAL SECURITY ADJUSTMENTS

The most significant problem auditors identified related to the Departments' handling of the annual Social Security cost of living adjustments (COLA) received by clients with community spouses. Effective January of each year, most clients receive an annual Social Security cost of living increase. Rather than making a determination as to how much of the increase can be given to the community spouse at the time the amount of the Social Security increase is known, the Departments

automatically add the cost of living increase to the client’s group care credit (the amount that the long term care client and the community spouse of the client have to pay monthly for nursing home care). To correct the amount that the client owes requires either a request from the long term care client and/or a review by a DHS caseworker. In either instance, the DHS caseworker must correct the group care credit information in the HFS MMIS (Medicaid Management Information System).

This automatic adjustment almost always results in the new group care credit being **incorrect**, since most or all of the income can be given to the community spouse. If not corrected in a timely manner, it results in the client being overcharged for their care. We reviewed 23 cases where the long term client had a community spouse. This included a review of detailed timelines which the agencies prepared for the 23 cases. Although the auditors requested “Copies of any communications that were sent to the client or the family and, in particular, any notices informing them of the amount the client or community spouse was instructed to pay for nursing home services,” DHS and HFS did not provide copies or include documentation of all such communications to auditors when providing support for the 23 cases sampled. Also, since the client makes payments directly to the long term care facility for his or her care, DHS and HFS did not have documentation showing how much the clients were paying the long term care facility. Consequently, auditors had to rely on the group care credit amounts shown in HFS’ MMIS system as the amount the client was required to contribute to his or her care.

CLIENT LIABILITY

In many of the long term care cases we reviewed, the client was overcharged for months, and in some cases years, because either the client had not requested the additional income to go to the community spouse or because DHS had not conducted the necessary recalculation to correct the amount the client was required to pay. In 7 of 23 cases we reviewed during the audit, we identified **14 instances** where more than two months passed before the group care credit was manually corrected by the caseworker. **In 3 of the 23 cases, the group care credits were not corrected for two years; in 3 other cases, they were not corrected for 11 to 13 months.** In the three cases where the group care credits were not corrected for two years, **the clients were overcharged \$9,204, \$1,056, and \$1,012, respectively, for their long term care.** *The audit recommends that the agencies discontinue automatically adding Social Security increases to the group care credits of clients with community spouses and rather, calculate the group care credit on a case by case basis.*

In addition to the automatic adjustment made to the client's group care credit, the manner in which the Departments inform clients of the process they must follow to ensure the Social Security increase is not added to their group care credit contributes to the problem. The Departments send two notices within a two week period to long term care clients that provide conflicting, or at best confusing, information regarding the handling of the clients' Social Security increases. In early December, the agencies send a form letter only to long term care clients with community spouses which states that the client will be getting a Social Security cost of living increase in January, and if they want the increase to go to their community spouse, they need to contact DHS. About two weeks later, the agencies send another letter to the client which contains the specific dollar amount of the Social Security increase and states that **"You must pay this money directly to the facility [emphasis added]."** This letter is sent to all long term care clients, both those with community spouses and those without. Given that in most cases the client can transfer most or all of this income to the community spouse, this second letter is both misleading and confusing. There is **no mention** in the second letter of the client's ability to give the increase to his or her community spouse.

In the cases where DHS determined that clients had overpaid the long term care facility for their care, DHS retroactively reduced the amount that the client was required to pay to the facility and increased the State's payment to the long term care facility to cover the amount overpaid by the client. Department officials stated that then the long term care facility may be responsible for refunding the money to the client.

Basic controls to ensure the amounts paid by clients are correct were ineffective in several cases we reviewed. The documentation that DHS and HFS provided did not allow auditors to determine if any overpayments made by the client to the long term care facility were repaid to the client and community spouse. Documentation did show the HFS nursing home payment adjustments but no documentation showed any consideration of whether the client payments were checked, corrected, or adjusted. *The audit recommends that the Departments implement a control to ensure that any overpayments made by a client as a result of the Departments' eligibility determination process are repaid to the client by the long term care facility.*

DATA RELIABILITY

Auditors had significant concerns regarding the reliability and validity of the electronic data provided by the Departments. Both DHS and HFS operate their own data systems which process data related to long term care. The DHS system is largely a case management system, while the HFS MMIS system is used to process payments to providers. *The*

audit recommends that the agencies take the necessary actions to assure that the data contained in their systems is consistent, reliable, and timely updated.

OTHER ISSUES IMPACTING ELIGIBILITY DETERMINATIONS

During the course of the audit, we identified other issues which impact the accuracy of the eligibility determination process, as well as the general processing of long term care cases. These issues included the following:

- Some DHS local field office caseworkers were not completing annual facility visits as required by the Policy Manual.
- The redetermination process is designed to update case information and check eligibility. Due to variations in how long term care cases are coded by the various DHS offices, the “Overdue for Redetermination” report is not being used effectively by the central office to monitor the timeliness of long term care case redeterminations.
- Supervisors are not routinely reviewing DHS caseworkers’ eligibility determinations.

HFS has not implemented changes in the federal law that relate to Medicaid long term care services. The federal Deficit Reduction Act of 2005 made several changes related to eligibility determinations for Medicaid long term care clients.

BACKGROUND

House Resolution 1295 directed the Auditor General to audit the Medical Assistance Program jointly administered by the Illinois Departments of Healthcare and Family Services (HFS) and Human Services (DHS) with respect to the accuracy and impact of eligibility determination standards and procedures regarding persons applying for or receiving assistance for long term care, with particular emphasis on the nature and scope of errors in the assessment of the financial resources and financial liability of the applicants and recipients.

The federal statute, Title XIX of the Social Security Act (42 USC 1396a *et seq.*), the Code of Federal Regulations (42 CFR 430 *et seq.*), the Illinois Public Aid Code (305 ILCS 5), and the Illinois Administrative Code (89 Ill. Adm. Code 120.1 through 120.550) guide the Illinois Medical Assistance or Medicaid program.

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and State governments jointly fund and administer the Medicaid program. At the federal level, the Centers for Medicare and Medicaid Services administers the program. Each State runs its Medicaid program in accordance with a Centers-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable federal requirements. HFS administers the State's Medicaid program in Illinois. According to the HFS website, its Bureau of Long Term Care administers the program that reimburses more than 750 nursing facilities for care provided to approximately 57,000 Medicaid-eligible residents each month. In Fiscal Year 2007, Healthcare and Family Services paid \$1.5 billion for long term care out of a total spent for medical assistance of \$11.3 billion.

HFS and DHS entered into an Interagency Agreement in 2000 regarding the administration of the medical programs and the child support enforcement program. HFS has sole responsibility for developing and establishing policy with regard to medical programs' eligibility. HFS is to consult with DHS in the development, dissemination, and implementation of policy. The parties are to jointly incorporate policy and procedure in manuals and other publications. HFS shall have final approval of all policies regarding medical programs. DHS is to accept applications and make timely eligibility determinations and redeterminations, including spenddown requirements, for individuals applying for benefits under the medical programs. (pages 6-7)

MEDICAID LONG TERM CARE PROBLEMS

Auditors identified significant and pervasive problems in the processes and data used by the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) which resulted in long term care clients, with spouses residing in the community (community spouse), being overcharged for their nursing home care. The eligibility determination process, specifically the processes used by both Departments related to determining how much income a client with a community spouse must pay to the long term care facility for his or her care, is complex, cumbersome, and confusing.

This audit was initiated based on a case where the State had data problems related to the nursing home group care credit of a client. The group care credit is the amount that the long term care client and the community spouse of the client have to pay monthly for nursing home care. The client had been in a nursing home since 2005. His wife was still

Auditors identified significant and pervasive problems in the processes and data used by HFS and DHS which resulted in long term care clients, with spouses residing in the community, being overcharged for their nursing home care.

living in the community and was making a monthly contribution to his care. The problem was identified when the amount the client's wife was required to pay toward the client's care tripled when her income had not changed significantly. The State has an income-based formula to determine how much of a co-payment Medicaid long term care patients are charged. When there is a spouse in the community, there are additional calculations that must be done.

Eventually DHS acknowledged the error. DHS recalculated the charge and said she owed nothing for 2008. According to DHS/HFS officials, the nursing home reimbursed the community spouse for amounts overcharged in 2006 and 2007. According to a newspaper article, when DHS was asked if other seniors had been overcharged, DHS officials said they had no way of knowing.

When auditors reviewed the case file, based on the Department's rules and procedures, the spouse should not have had to pay anything for the nursing home care from the very beginning. Because there was a spouse still living in the community, the client's income and assets should all have been transferred to the community spouse.

Electronic Data Concerns

Auditors had significant concerns regarding the reliability and validity of the electronic data provided by the Departments. Both DHS and HFS operate their own data systems which process data related to long term care. The DHS system is largely a case management system, while the HFS MMIS system is used to process payments to providers.

Healthcare and Family Services Data

Because the case files did not allow us to find out what the HFS system showed as the amount the community spouse was actually supposed to pay, we requested electronic data from HFS. Because HFS pays the nursing homes, it needs to receive from DHS the correct amount the spouse should pay, so that HFS can know the portion the State should pay.

We requested data for all nursing home cases that had a community spouse. That data was to include what, if anything, the community spouse was supposed to pay. We received the requested data from HFS in December 2008. The data provided by HFS included 2,756 cases. We had previously requested from DHS a count of cases with a community spouse and it had reported that there were 3,552 in 2008.

Auditors had significant concerns regarding the reliability and validity of the electronic data provided by the Departments.

Human Services Data

Because there was a discrepancy of 796 cases (29 percent) between the number of cases with community spouses reported by HFS (2,756) and DHS (3,552), we requested the same detailed data from DHS for the same time period (December 2008) to better understand the discrepancies in the data. We received the requested data from DHS in January 2009. The data provided by DHS included 3,866 cases. That meant that there was a discrepancy of 1,110 cases in numbers provided by HFS and DHS; DHS data included **40 percent more cases**. There were 2,169 cases that appeared in both data sets. We also identified 13 cases which were duplicates within the HFS data set and one case that was duplicated within the DHS data.

To attempt to identify why there were such discrepancies, we analyzed the 2,169 cases that appeared in both data sets to see if the amount that the client or spouse was supposed to pay agreed. When we compared the group care credit for the 2,169 cases, there were **only 319 cases, or less than 15 percent**, where the dollar amount agreed. In over 85 percent of the cases the amount that the client's spouse was supposed to pay **did not agree** between the two agencies.

Revised Data from Agencies

After auditors analyzed the data and concluded there were significant problems, we shared our concerns regarding the data limitations with HFS and DHS. In a joint meeting with both agencies on April 22, 2009, HFS and DHS officials noted that they thought the differences in amounts and differences in populations were attributable to the criteria they used to select the data and to timing differences in the data. HFS and DHS officials stated that each agency would produce a new data set that would cover the same time period and use the same criteria, which would result in a better match of both the universe of cases and group care credits.

The next day, April 23, 2009, the agencies asked to meet again. At that meeting HFS and DHS officials said that they would not be able to each produce a data set because the two data sets would still not agree. A DHS official noted that their system was not updated automatically when the HFS system is updated. Officials stated the DHS caseworker uses the HFS MMIS system to update financial data, including updating the group care credit, and not the DHS system. Consequently, the data in the DHS system is outdated. HFS and DHS noted that they would need to collaborate and do one data set. Auditors noted that they did not have any confidence in the data being reliable, given the documented inconsistencies between DHS data, HFS data, and case files.

Agencies noted that automatic Social Security adjustments were the reason for many of the differences between the case files and the electronic data. They also noted several limitations and weaknesses in their systems but expressed confidence in the accuracy of the data. Among the weaknesses that the agencies noted were:

- When explaining their inability to produce a new data set, as promised in April 2009, the agencies stated, “. . . I believe we overemphasized the need to coordinate the timing of our data pulls without fully taking into account the **limitations of MMIS and CIS [Client Information System] in presenting directly comparable documentation of patient care credits** [emphasis added].”
- The agencies noted that the CIS program was written in Autocoder **in the 1970's**. “Both the age and long since obsolete programming language of the CIS have prevented DHS from quickly pulling data in ways other than the on-going processes of determining eligibility.”
- Patient care credits, as represented in the HFS MMIS system, are the final result of a caseworker's calculations which are recorded on a 2500 form [LTC Resource Calculation Form] for each payment or patient credit modification. “**Entry of this patient credit data into the CIS system would be a duplication of effort for DHS staff** [emphasis added].” **Consequently, the DHS group care credit information is not reliable.**
- There are limitations on using automated data to replicate largely manual processes, where not all data elements are entered into both data systems. Officials noted, “**While the current system is inefficient and obviously difficult to audit**, we are still confident that the systems work [emphasis added].”

**The agencies noted:
“Both the age and long since obsolete programming language of the CIS have prevented DHS from quickly pulling data in ways other than the on-going processes of determining eligibility.”**

In June 2009, we offered the agencies one more opportunity to attempt to address the serious concerns we had regarding the accuracy and reliability of their data. Auditors requested a reconciliation of the total number of cases in the universes provided by HFS in December 2008 and by DHS in January 2009 discussed earlier. DHS and HFS **did not provide the requested reconciliation**, but instead provided new data files that only included case identification numbers.

Both agencies used data as of June 4, 2009. In this comparison, DHS had 2,910 cases while HFS had 3,447. The agencies noted that 581 of the HFS cases included spousal diversion codes (referred to as “670” codes) that have been closed by DHS, but not reflected in HFS’ Data

Warehouse. Agency officials noted that other discrepancies were due to up to a two day lag between DHS extracting the data and HFS loading the Data Warehouse.

Although the total universes, with explanations and adjustments, are closer than before, they still did not match. In addition, the new data runs did not include group care credit amounts, the most important information for this audit, so no assessment of their reliability could be attempted. (pages 7-11)

Review of Sampled Cases

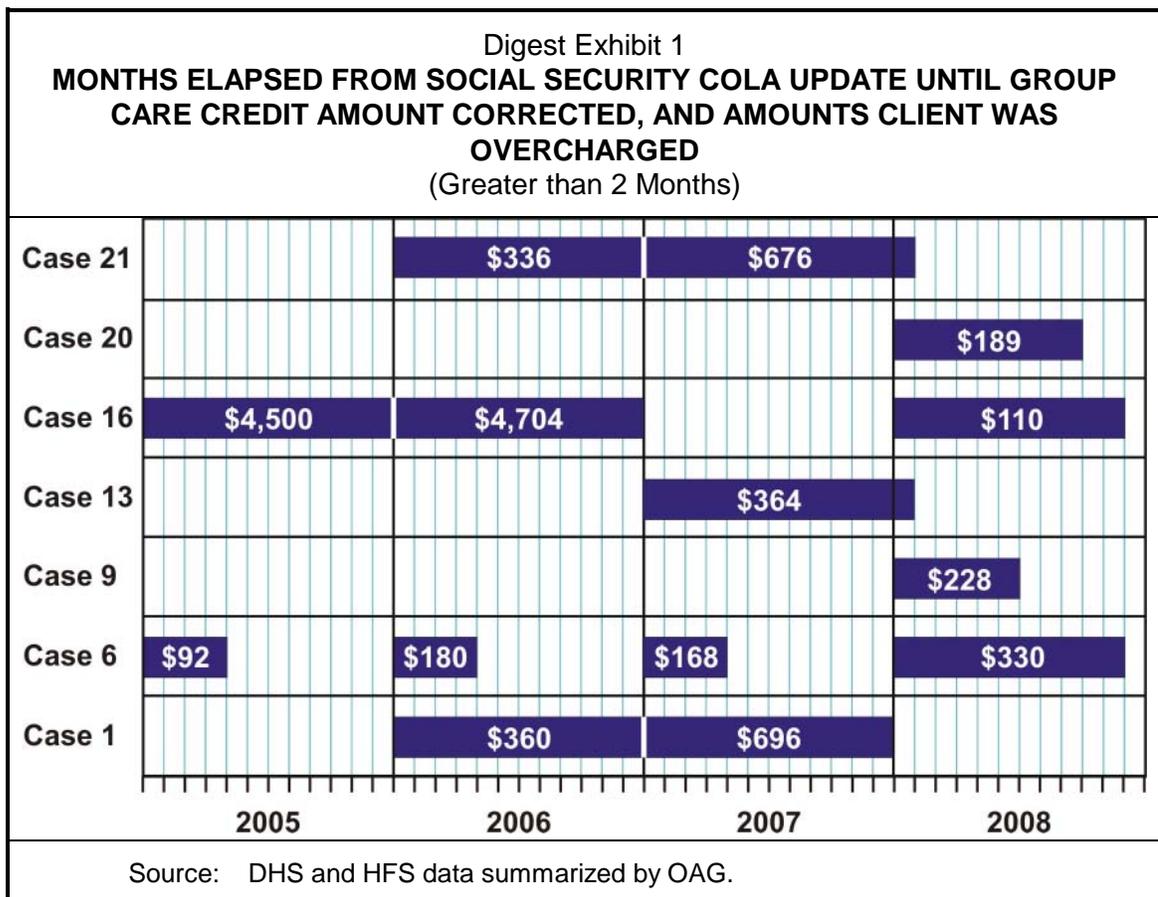
The most significant problem auditors identified related to the Departments' handling of the annual Social Security cost of living increases received by clients with community spouses. Effective January of each year, most clients receive an annual Social Security cost of living increase. Rather than making a determination as to how much of the increase can be given to the community spouse at the time the amount of the Social Security increase is known, the Departments **automatically add** the cost of living increase to the client's group care credit (the amount of money the client is required to pay the long term care facility). To correct the amount that the client owes requires either a request from the long term care client and/or a review by a DHS caseworker. In either instance, the DHS caseworker must correct the group care credit information in the HFS MMIS system.

This automatic adjustment almost always results in the new group care credit being **incorrect**, since most or all of the income can be given to the community spouse. If not corrected in a timely manner, it results in the client being overcharged for their care. Although the auditors requested "Copies of any communications that were sent to the client or the family and, in particular, any notices informing them of the amount the client or community spouse was instructed to pay for nursing home services," DHS and HFS did not provide copies or include documentation of all such communications to auditors when providing support for the 23 cases sampled. Also, since the client makes payments directly to the long term care facility for his or her care, DHS and HFS did not have documentation showing how much the clients were paying the long term care facility. Consequently, auditors had to rely on the group care credit amounts shown in HFS' MMIS system as the amount the client was required to contribute to his or her care.

This automatic adjustment almost always results in the new group care credit being incorrect.

Our review of the detailed documentation provided by DHS and HFS for the 23 cases sample identified the following deficiencies:

- Incorrect/Overstated Group Care Credits:** In many of the long term care cases we reviewed, the client was overcharged for months, and in some cases years, because either the client had not requested the additional income to go to the community spouse or because DHS had not conducted the necessary recalculation to correct the amount the client is required to pay. In most cases, at least one or two months passed before the automatic increase in the group care credit due to the Social Security cost of living increase was corrected. There were, however, **14 instances** in 7 of the 23 cases auditors examined where the clients' group care credits were incorrect **for more than a two month period**. In these cases, the State's payment to the long term care facility would have been reduced by the amount of the COLA and the client would be responsible to pay that amount to the facility. In the 14 instances where this occurred, the amount that the clients' group care credits were overstated **totaled \$12,933**. Digest Exhibit 1 summarizes these 14 instances. In all but one of the instances, once the State retroactively corrected the group care credit amount, it paid the long term care facility the adjusted amount. As discussed below, the State does not then verify to ensure that the long term care facility passed the reimbursement of the overpayment on to the client.



- **Delays in Entering Changes into HFS MMIS System:** In several cases, changes made by caseworkers to correct the client's group care credit were not timely entered into the HFS MMIS system, which is the system used to pay the long term care facilities. For example:

The timeline provided for one case showed the caseworker conducted a redetermination in May 2008 and reduced the client's group care credit to \$0. However, the timeline shows the group care credit was **not changed** to \$0 in the HFS MMIS system until October 2008, when it was made retroactive to January 2008. Consequently, for the period May through October 2008, the payments made by HFS to the long term care facility were incorrectly based on the client contributing income toward his care, which should have been going to the community spouse.

The timeline for another case showed a redetermination was completed in December 2006 and the group care credit was determined to be \$0. The client's group care credit during 2006 had been \$28 per month. However, the timeline shows that the revised group care credit amount of \$0 was **never entered** into HFS' MMIS system. Rather, the group care credit was further **increased** by the 2007 Social Security cost of living increase to \$52 per month. Finally, in February 2008, **13 months after** the December 2006 redetermination had been completed that showed the group care credit was \$0, another redetermination was completed which again showed the group care credit should be \$0. That same month, the HFS MMIS system was updated to reflect the \$0 group care credit, and it was made retroactive to January 2007. However, the group care credit was not made retroactive to 2006 during which the client also had an erroneous \$28 per month group care credit.

- **Medicare Premium:** In one case the Medicare premium was not netted out of the client's income in 2008, thereby overstating the amount the client had to pay toward his care.
- **Spouse Death:** In one case, a spouse died in November 2008, but the client was still in DHS' system as having a community spouse case in December.

In addition, there are instances where the information provided by the Department to the auditors did not contain adequate documentation to support the changes made to the group care credit amounts. After auditors noted the significant differences in the group care credit amounts in the DHS case files, the DHS electronic data, and the HFS electronic data, the Departments requested an opportunity to provide detailed timelines that would show why the amounts differed among the three sources. While in many instances the timelines and supporting documentation explained

such differences, in others, questions remain why certain changes to the group care credits were made. For example:

- In one case, the client’s group care credit was \$0 from the time of admission in 2007 until January 2009. In January 2009, the group care credit increased to \$64 as a result of the Social Security cost of living increase, but the DHS caseworker changed it back to \$0 in March 2009. The timeline provided by the Departments then shows the group care credit **increasing to \$329** on May 18, 2009, **but did not contain a report or other support** for this adjustment. As such, auditors could not examine the basis for or validity of this change. In the agencies’ written response to the audit they noted: “. . . the \$329 was a typo in the submitted timelines.”
- In another case, the client’s group care credit was \$0 through October 2007. Beginning in November the group care credit began to increase significantly, up to \$1,164 as of January 2009. We inquired of DHS officials as to why the significant increase in the group care credit occurred. DHS officials stated that the community spouse entered a long term care facility in October 2007, thus there was no more diversion of the client’s income to the community spouse, and the client’s group care credit increased accordingly. However, the case file did not document this reason and, in fact, contained documentation to the contrary, including a March 2009 DHS “Authorization of Assistance Action” form with \$1,088 designated as income to be diverted to a community spouse. Also, the Departments sent the December “Notice to Long Term Care Residents Giving Income to Family,” which is sent out to cases where income is diverted to a community spouse. This case again raises concerns regarding the validity and reliability of the data the agencies provided since the case was in the universe of cases with community spouses provided by both DHS and HFS, which it should not have been if the community spouse entered a nursing home.
- In another case, a client’s group care credit amount automatically increased in December 2007 (effective January 1, 2008) from \$0 to \$30 due to the annual COLA increase. The timeline and the case file both document that in February 2008 a caseworker completed a LTC Resource Calculation Form changing the group care credit amount back to \$0. Like the previous example, the timeline shows the revised group care credit amount of \$0 was **never entered** into HFS’ MMIS system. Then a year later in December 2008 (effective January 1, 2009) the group care credit increased again from \$30 to \$116 due to the annual COLA increase. Later in December 2008, the group care credit was changed from \$116 back to \$0 for all of 2008.
- In another case, the client had a group care credit of \$382 in 2008, which increased to \$427 in January 2009 due to the 2009 Social

Security increase. However, in February 2009, the timeline provided by the Departments showed that the DHS caseworker changed the group care credit to \$0. The change was made **retroactive to 2007**. Although the provided timeline contains a notation that information was received from the long term care facility, neither the case file nor other documentation provided support this adjustment. However, **one month later**, in March 2009, the DHS caseworker again changed the group care credit back to \$382 for 2008 and to \$299 for 2009. Finally, the 2009 group care credit was **changed again** to \$329 **one month later** in April 2009 by a DHS caseworker.

- In another case, the client had a group care credit of \$357 beginning in July 2003 which had increased to \$406 as of January 2007. In February 2007, a redetermination was completed for the period beginning June 2006, which concluded the client had a group care credit of \$0. The group care credit of \$0 was made retroactive to June 2006. However, based on the client's and community spouse's income documented in the case file, the auditors questioned whether the client should have been assessed **any** group care credit during the period July 2003 through May 2006.

The incorrect group care credits, many of which went uncorrected for extended periods of time, demonstrate the need for both Departments to undertake a review of all cases involving clients in long term care facilities with community spouses. Leaving group care credit amounts uncorrected results in community spouses not getting the income to which they are entitled and increases the risk of them becoming impoverished. (pages 16-19)

Conflicting Notices Sent to Clients and Community Spouses

In addition to the automatic adjustment made to the client's group care credit, the manner in which the Departments inform clients of the process they must follow to ensure the Social Security increase is not added to their group care credit contributes to the problem. The Departments send two letters within a two week period to long term care clients that provide conflicting, or at best confusing, information regarding the handling of the client's Social Security increases. Copies of both notices are included in Appendix B of this report.

In early December, the agencies send a form letter only to long term care clients with community spouses which states that the client will be getting a Social Security cost of living increase in January, and if they want the increase to go to their community spouse, they need to contact their DHS caseworker. The second notice, which is mailed within two weeks of the first, tells the client the total amount of their new Social

The incorrect group care credits, many of which went uncorrected for extended periods of time, demonstrate the need for both Departments to undertake a review of all cases involving clients in long term care facilities with community spouses.

The Departments' notices provide conflicting, or at best confusing, information regarding the handling of the client's Social Security increases.

Security and the amount which is available each month to pay to the nursing home. The notice says: “**You must pay this money directly to the facility** [emphasis added].” Given that in most cases the client can transfer most or all of this income to the community spouse, this second letter is both misleading and confusing. There is **no mention** in the second letter of the client’s ability to give the increase to his or her community spouse. (page 21)

Controls over Client Liability

Basic controls to ensure the amounts paid by clients are correct were ineffective in several cases we reviewed. The documentation that DHS and HFS provided did not allow auditors to determine if any overpayments made by the client to the long term care facility were repaid to the client and community spouse. Documentation did show HFS’ nursing home payment adjustments but no documentation showed any consideration of whether the client payments were checked, corrected, or adjusted. (page 26)

POLICY ISSUES

The Departments of Healthcare and Family Services (HFS) and Human Services (DHS) have policies that were not current or were not clear. Those problems may be negatively affecting the long term care eligibility determination process. In addition, some of DHS’s local field offices were not operating according to the Policy Manual.

DHS had weaknesses in management oversight of the Medicaid long term care program. These weaknesses included Overdue for Redetermination reports not being used and a lack of supervisory review of caseworkers at DHS. In addition, there were computer system oversight issues and policy coordination issues that are the shared responsibility of HFS and DHS.

HFS has not implemented changes in the federal law that relate to Medicaid long term care services. The federal Deficit Reduction Act of 2005 made several changes concerning eligibility determinations for Medicaid long term care clients. (pages 29-42)

RECOMMENDATIONS

The audit report contains nine recommendations. Six recommendations are addressed to both the Department of Human Services and the Department of Healthcare and Family Services. Two

recommendations are addressed to just the Department of Human Services and one recommendation is addressed to just the Department of Healthcare and Family Services.

The Departments provided a joint response to the audit report. In their response to the audit report, the agency directors acknowledged that: **“The policies, procedures and systems reviewed are highly complex and confusing.”** As auditors, we are accustomed to dealing with complex and confusing processes. However, the real significance of, and difficulty with, this statement lies with the elderly and vulnerable population who ultimately must deal with these highly complex and confusing policies on a regular basis.

The Departments agreed with three of the recommendations, partially agreed with four recommendations, and disagreed with two of the recommendations. Appendix C to the audit report contains the agencies’ complete responses.



WILLIAM G. HOLLAND
Auditor General

WGHAEKW
September 2009

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INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

Auditors identified significant and pervasive problems in the processes and data used by the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) which resulted in long term care clients, with spouses residing in the community (community spouse), being overcharged for their nursing home care. The eligibility determination process, specifically the processes used by both Departments related to determining how much income a client with a community spouse must pay to the long term care facility for his or her care, is complex, cumbersome, and confusing.

In cases where a long term care client has a spouse residing in the community, federal and State law allow clients to give some or all of their income to the community spouse, up to a set amount (called the maintenance needs allowance, which was \$2,610 per month in 2008). The purpose of allowing nursing home clients to give all or a portion of their income to a spouse residing in the community is to prevent the spouse from becoming impoverished.

The most significant problem auditors identified related to the Departments' handling of the annual Social Security cost of living adjustments (COLA) received by clients with community spouses. Effective January of each year, most clients receive an annual Social Security cost of living increase. Rather than making a determination as to how much of the increase can be given to the community spouse at the time the amount of the Social Security increase is known, the Departments **automatically add** the cost of living increase to the client's group care credit (the amount that the long term care client and the community spouse of the client have to pay monthly for nursing home care). To correct the amount that the client owes requires either a request from the long term care client and/or a review by a DHS caseworker. In either instance, the DHS caseworker must correct the group care credit information in the HFS MMIS (Medicaid Management Information System).

This automatic cost of living adjustment almost always results in the new group care credit being **incorrect**, since most or all of the income can be given to the community spouse. If not corrected in a timely manner, it results in the client being overcharged for their care. We sampled 23 cases and requested DHS and HFS to provide us with "Copies of any communications that were sent to the client or the family and, in particular, any notices informing them of the amount the client or community spouse was instructed to pay for nursing home services." However, DHS and HFS did not provide copies or include documentation of all such communications to auditors when providing support for the 23 cases sampled. Also, since the client makes payments directly to the long term care facility for his or her care, DHS and HFS did not have documentation showing how much the client was paying the long term care facility.

Consequently, auditors had to rely on the group care credit amounts shown in HFS' MMIS system as the amount the client was required to contribute to his or her care.

In many of the long term care cases we reviewed, the client was overcharged for months, and in some cases years, because either the client had not requested the additional income to go to the community spouse or because DHS had not conducted the necessary recalculation to correct the amount the client is required to pay. In 7 of 23 cases we reviewed during the audit, we identified **14 instances** where more than two months passed before the group care credit was manually corrected by the caseworker. **In 3 of the 23 cases, the group care credits were not corrected for two years; in 3 other cases, they were not corrected for 11 to 13 months.** In the three cases where the group care credits were not corrected for two years, **the clients were overcharged \$9,204, \$1,056, and \$1,012, respectively, for their long term care.** The audit recommends that the agencies discontinue automatically adding Social Security increases to the group care credits of clients with community spouses and rather, calculate the group care credit on a case by case basis.

In addition to the automatic adjustment made to the client's group care credit, the manner in which the Departments inform clients of the process they must follow to ensure the Social Security increase is not added to their group care credit contributes to the problem. The Departments send two notices within a two week period to long term care clients that provide conflicting, or at best confusing, information regarding the handling of the clients' Social Security increases. In early December, the agencies send a form letter only to long term care clients with community spouses which states that the client will be getting a Social Security cost of living increase in January, and if they want the increase to go to their community spouse, they need to contact DHS. About two weeks later, the agencies send another letter to the client which contains the specific dollar amount of the Social Security increase and states that **"You must pay this money directly to the facility [emphasis added]."** Given that in most cases the client can transfer most or all of this income to the community spouse, this second letter is both misleading and confusing. There is **no mention** in the second letter of the client's ability to give the increase to his or her community spouse.

In addition to problems related to the Departments' handling of the annual Social Security cost of living increases, our review of the 23 cases identified additional concerns. These include the following:

- **Delays in Entering Changes into the HFS MMIS System.** In several cases, changes made by caseworkers to correct the client's group care credit were not timely entered into the HFS MMIS system, which is the system used to pay the long term care facilities. For example, a redetermination was completed in December 2006 and the group care credit was determined to be \$0. The client's group care credit during 2006 had been \$28 per month. However, the documentation shows that the revised group care credit amount of \$0 was **never entered** into HFS' MMIS system. Rather, the group care credit was further **increased** by the 2007 Social Security cost of living increase to \$52 per month. Finally, in February 2008, **13 months after** the December 2006 redetermination had been completed that showed the group care credit was \$0, another redetermination was completed which again showed the group care credit should be \$0. That same month, the

HFS MMIS system was updated to reflect the \$0 group care credit, which was made retroactive to January 2007. However, it was not made retroactive to 2006 during which the client also had an erroneous \$28 per month group care credit.

- **Medicare Premium:** In one case the Medicare premium was not netted out of the client's income in 2008, thereby overstating the amount the client had to pay toward his care.
- **Spouse Death:** In one case, a spouse died in November 2008, but the client was still in DHS' system as having a community spouse case in December.
- **Lack of Documentation for Changes:** In one case, the client's group care credit was \$0 through October 2007. Beginning in November the group care credit began to increase significantly, up to \$1,164 as of January 2009. In response to auditors' inquiry as to the cause of the increase, DHS officials stated that the community spouse entered a long term care facility in October 2007, thus there was no more diversion of the client's income to the community spouse. However, the case file did not document this reason and, in fact, contained documentation to the contrary, including a March 2009 DHS "Authorization of Assistance Action" form with \$1,088 designated as income to be diverted to a community spouse. Also, the Departments sent the December "Notice to Long Term Care Residents Giving Income to Family," which is sent out to cases where income is diverted to a community spouse. This case also raises concerns regarding the validity and reliability of the data the agencies provided since the case was in the universe of cases with community spouses provided by both DHS and HFS, which it should not have been if the community spouse entered a nursing home.

In the cases where DHS determined that clients had overpaid the long term care facility for their care, DHS retroactively reduced the amount that the client was required to pay to the facility and increased the State's payment to the long term care facility to cover the amount overpaid by the client. Department officials stated that then the long term care facility may be responsible for refunding the money to the client.

The documentation that DHS and HFS provided did not allow auditors to determine if any overpayments made by the client to the long term care facility were repaid to the client and community spouse. Documentation did show HFS nursing home payment adjustments but no documentation showed any consideration of whether the client payments were checked, corrected, or adjusted.

When auditors asked Department officials whether they followed-up to ensure that the long term care facilities had then reimbursed the clients for any overpayments that the client may have made, Department officials stated that a review of ongoing eligibility includes a review of each client's personal funds and room and board accounts. However, in other meetings DHS representatives had said that it is not their responsibility to do this and an HFS representative said they do not check client accounts. Annually, policy requires that DHS caseworkers conduct facility site visits at long term care facilities and review the accounts of residents receiving State assistance. In the files we reviewed there was little evidence to suggest that room and board accounts are checked. It is not even clear whether facility visits are conducted by all

caseworkers. Auditors recommended that Healthcare and Family Services and Human Services implement a control to ensure that any overpayments made by a client as a result of the Departments' eligibility determination process are repaid to the client by the long term care facility.

Basic controls to ensure the amounts paid by clients are correct were ineffective in several cases we reviewed. DHS policy requires that caseworkers conduct an annual redetermination of the client's eligibility, which includes, among other items, a review of the client's income and group care credit. In one case, there was no documentation in the case file to show an annual redetermination had been conducted for a three year period. In other cases, redeterminations were conducted, but they were not timely. There may be several reasons for redeterminations not being completed in a timely manner, such as high caseworker caseloads, clients or community spouses not providing necessary information, etc. However, if redeterminations are completed, and completed in a timely manner, then there is less likelihood that the client will overpay for his or her long term care, and a greater likelihood that income which legally can go to the community spouse is, in fact, going to the community spouse.

In at least two of the 23 cases we reviewed, redeterminations were conducted, but the results of the redetermination – a reduction in the client's group care credit – were not timely entered into the MMIS system. In one case, 13 months elapsed from the time the redetermination was completed until the MMIS system was updated; in the other case, five months elapsed. Consequently, the client continued to be overcharged for his or her long term care, even though the caseworker determined that no group care credit needed to be paid.

Also, caseworkers are supposed to manually recalculate the client's group care credit after the Social Security cost of living increase is automatically added to the client's income. As evidenced by the number of cases where the group care credit remained incorrect for extended periods of time, this was not being consistently done in a timely manner.

Auditors had significant concerns regarding the reliability and validity of the electronic data provided by the Departments. Both DHS and HFS operate their own data systems which process data related to long term care. The DHS system is largely a case management system, while the HFS MMIS system is used to process payments to providers.

These data concerns included both significant differences in the number of long term care cases which had community spouses, as well as differences in group care credit amounts contained in both of their data systems.

- The number of long term care cases which had community spouses initially reported by DHS and HFS – the cases which were the focus of this audit – varied significantly. Data provided by HFS in December 2008 reported 2,756 cases where there was a community spouse; data provided by DHS in January 2009 reported 3,866 such cases – a **40 percent difference**.

After the large variance in cases was brought to their attention, the Departments cited as reasons for the variation the timing in which each agency pulled their data, as well as inconsistencies by which each agency defined the cases to be pulled.

The auditors provided the Departments with another opportunity to provide a “reconciliation” of the two universes of cases in their two systems. Specifically, the auditors asked the Departments to provide a “...reconciliation of the total number of cases in the universes provided by DHFS in December 2008 and by DHS in January 2009...” The agencies did not provide a reconciliation of the number provided in December 2008 and January 2009. Rather, they provided a new analysis, showing that DHS had 2,910 cases and HFS had 3,447 cases – **an 18 percent difference**. The Departments said the largest reason for the difference between the two agencies’ case totals were 581 cases with codes that had been closed in the DHS system, but not in the HFS system.

As evidenced in their memo accompanying the reconciliation of the data on the two systems, there remain significant concerns regarding the accuracy of the data and awareness of data differences among the two systems and Departments. Their memo stated: “In addition, we have **recently discovered** that the Data Warehouse [HFS’ system] maintains “670” codes [codes that pertain to spousal diversion] that **may have been** closed out by DHS [emphasis added].”

The agencies noted that the DHS’ computer system is limited in the amount of data it maintains to document changes in eligibility and spousal diversion. Consequently, limited information is available to explain and document why certain changes in group care credits were made over the years.

Given that during the audit process DHS and HFS officials were uncertain as to how the two systems interacted and the comparability of data between the systems, we recommended that the agencies take the necessary actions to assure that the data contained in their systems is consistent, reliable, and timely updated.

- In the initial data provided by DHS and HFS in December 2008 and January 2009, there were 2,169 cases that appeared in both data sets. Of the 2,169, 85 percent (1,850 cases) had different group care credit amounts. Upon follow-up with agencies, the primary reason for the differing group care credit amounts was timing for the cost of living adjustment.

The responsibility for administering the long term care program is shared primarily by two agencies, HFS and DHS. DHS is responsible for eligibility determination for all Medicaid programs. HFS pays for Medicaid long term care. According to the HFS website, its Bureau of Long Term Care administers the program that reimburses more than 750 nursing facilities for care provided to approximately 57,000 Medicaid-eligible residents each month. In Fiscal Year 2007, Healthcare and Family Services paid \$1.5 billion for long term care.

DHS is responsible for determining the initial eligibility of long term care applicants. DHS is also responsible for redetermination of clients’ eligibility. The current Illinois Medicaid State Plan requires redetermination of eligibility for all recipients on an annual basis. This determination and redetermination process is handled by caseworkers at the Department’s approximately 100 Family Community Resource Centers located throughout Illinois.

Other Issues Impacting Eligibility Determinations

During the course of the audit, we identified other issues which impact the accuracy of the eligibility determination process, as well as the general processing of long term care cases. These issues included the following:

- Some DHS local field office caseworkers were not completing annual facility visits as required by the Policy Manual.
- The redetermination process is designed to update case information and check eligibility. Due to variations in how long term care cases are coded by the various DHS offices, the “Overdue for Redetermination” report is not being used effectively by the central office to monitor the timeliness of long term care case redeterminations.
- Based on interviews of field office staff, supervisors are not routinely reviewing DHS caseworkers’ eligibility determinations.

HFS had not implemented changes in the federal law that relate to Medicaid long term care services. The federal Deficit Reduction Act of 2005 made several changes related to eligibility determinations for Medicaid long term care clients.

BACKGROUND

On May 28, 2008, the Illinois House of Representatives adopted House Resolution 1295 (Appendix A). The Resolution directed the Auditor General to audit the Medical Assistance Program jointly administered by the Illinois Departments of Healthcare and Family Services (HFS) and Human Services (DHS) with respect to the accuracy and impact of eligibility determination standards and procedures regarding persons applying for or receiving assistance for long term care, with particular emphasis on the nature and scope of errors in the assessment of the financial resources and financial liability of the applicants and recipients. A copy of the resolution is attached as Appendix A.

The federal statute, Title XIX of the Social Security Act (42 USC 1396a *et seq.*), the Code of Federal Regulations (42 CFR 430 *et seq.*), the Illinois Public Aid Code (305 ILCS 5), and the Illinois Administrative Code (89 Ill. Adm. Code 120.1 through 120.550) guide the Illinois Medical Assistance or Medicaid program.

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The federal and State governments jointly fund and administer the Medicaid program. At the federal level, the Centers for Medicare and Medicaid Services are responsible for the program. Each State runs its Medicaid program in accordance with a Centers-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable federal requirements. HFS is responsible for the State’s Medicaid program in Illinois. According to the HFS website, its Bureau of Long Term Care administers the program that

reimburses more than 750 nursing facilities for care provided to approximately 57,000 Medicaid-eligible residents each month. In Fiscal Year 2007, Healthcare and Family Services paid \$1.5 billion for long term care out of a total spent for medical assistance of \$11.3 billion.

HFS and DHS entered into an Interagency Agreement in 2000 regarding the administration of the medical programs and the child support enforcement program. HFS has sole responsibility for developing and establishing policy with regard to eligibility for medical programs. HFS is to consult with DHS in the development, dissemination, and implementation of policy. The parties are to jointly incorporate policy and procedure in manuals and other publications. HFS shall have final approval of all policies regarding medical programs. DHS is to accept applications and make timely eligibility determinations and redeterminations, including spenddown requirements, for individuals applying for benefits under the medical programs.

According to officials at HFS, federal law does not generally distinguish eligibility based on services provided. There are certain provisions in federal law that are unique to long term care services, relating in particular to financial eligibility considerations. However, long term care is treated as a category of service, not a category of eligibility.

MEDICAID LONG TERM CARE PROBLEMS

Auditors identified significant and pervasive problems in the processes and data used by the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) which resulted in long term care clients, with spouses residing in the community (community spouse), being overcharged for their nursing home care. The eligibility determination process, specifically the processes used by both Departments related to determining how much income a client with a community spouse must pay to the long term care facility for his or her care, is complex, cumbersome, and confusing.

This audit was initiated based on a case where the State had data problems related to the nursing home group care credit of a client. The group care credit is the amount that the long term care client and the community spouse of the client have to pay monthly for nursing home care. The client had been in a nursing home since 2005. His wife was still living in the community and was making a monthly contribution to his care. The problem was identified when the amount the client's wife was required to pay toward the client's care tripled when her income had not changed significantly. The State has an income-based formula to determine how much of a co-payment Medicaid long term care patients are charged. When there is a spouse in the community, there are additional calculations that must be done.

Eventually DHS acknowledged the error. DHS recalculated the charge and said she owed nothing for 2008. According to DHS/HFS officials, the nursing home reimbursed the community spouse for amounts overcharged in 2006 and 2007. According to a newspaper article, when DHS was asked if other seniors had been overcharged, DHS officials said they had no way of knowing.

When auditors reviewed the case file, based on the Department's rules and procedures, the spouse should not have had to pay anything for the nursing home care from the very

beginning. Because there was a spouse still living in the community, the client's income and assets should all have been transferred to the community spouse.

Electronic Data Concerns

Auditors had significant concerns regarding the reliability and validity problems of the electronic data provided by the Departments. Both DHS and HFS operate their own data systems which process data related to long term care. The DHS system is largely a case management system, while the HFS MMIS system is used to process payments to providers.

Healthcare and Family Services Data

Because the case files did not allow us to find out what the HFS system showed as the amount the community spouse was actually supposed to pay, we requested electronic data from HFS. Because HFS pays the nursing homes, it needs to receive from DHS the correct amount the spouse should pay, so that HFS can know the portion the State should pay.

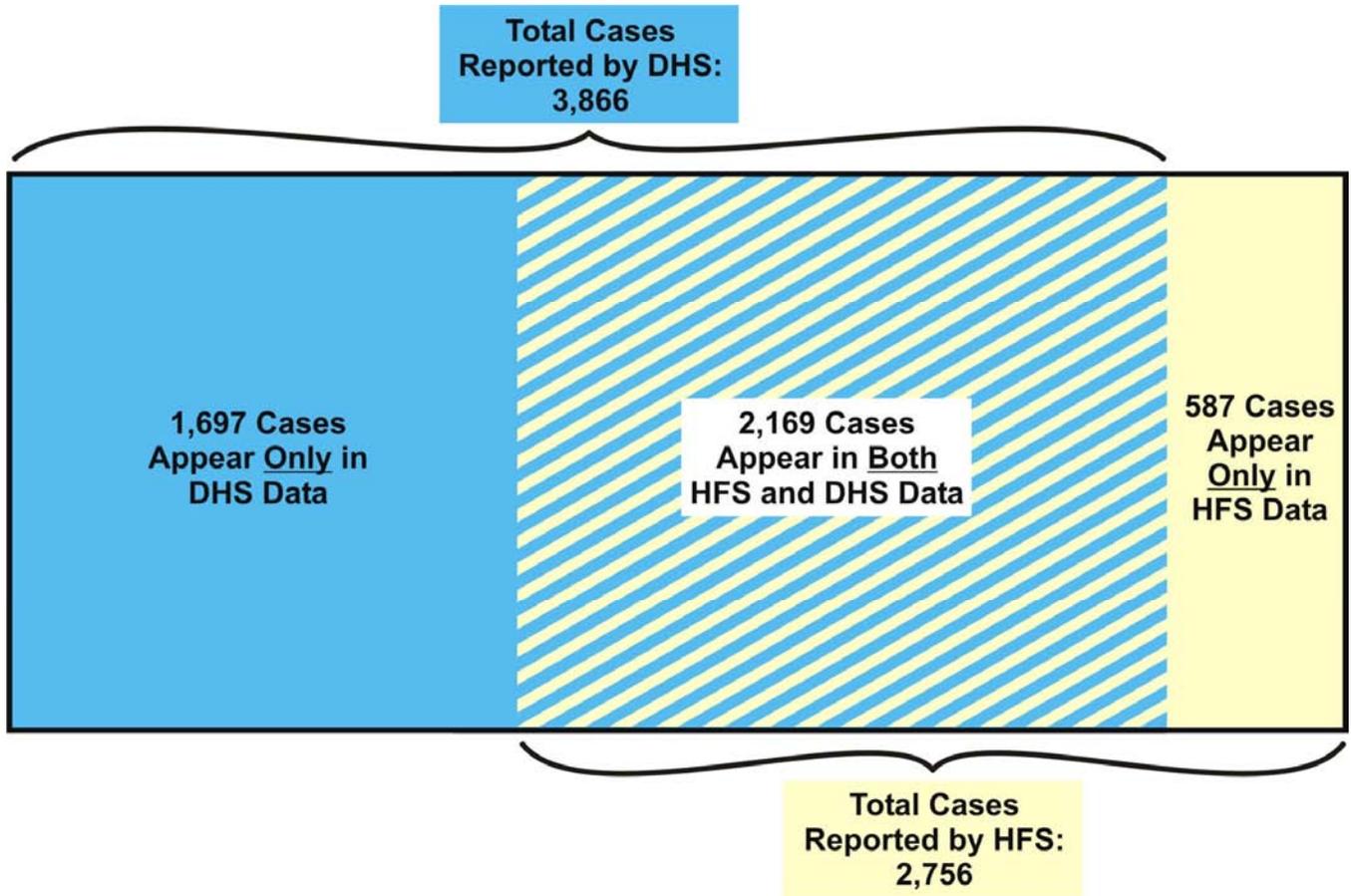
We requested data for all nursing home cases that had a community spouse. That data was to include what, if anything, the community spouse was supposed to pay. We received the requested data from HFS in December 2008. The data provided by HFS included 2,756 cases. We had previously requested from DHS a count of cases with a community spouse and it had reported that there were 3,552 in 2008.

Human Services Data

Because there was a discrepancy of 796 cases (29 percent) between the number of cases with community spouses reported by HFS (2,756) and DHS (3,552), we requested the same detailed data from DHS for the same time period (December 2008) to better understand the discrepancies in the data. We received the requested data from DHS in January 2009. The data provided by DHS included 3,866 cases. That meant that there was a discrepancy of 1,110 cases in numbers provided by HFS and DHS; DHS data included **40 percent more cases**. Exhibit 1-1 highlights the discrepancies between the data received from HFS and DHS. As shown in the Exhibit, there were 2,169 cases that appeared in both data sets. We also identified 13 cases which were duplicates within the HFS data set and one case that was duplicated within the DHS data.

To attempt to identify why there were such discrepancies, we analyzed the 2,169 cases that appeared in both data sets to see if the amount that the client or spouse was supposed to pay agreed. When we compared the group care credit for the 2,169 cases, there were **only 319 cases, or less than 15 percent**, where the dollar amount agreed. In over 85 percent of the cases (1,850) the amount that the client's spouse was supposed to pay **did not agree** between the two agencies.

Exhibit 1-1
**DIFFERENCES IN THE NUMBER OF COMMUNITY SPOUSE CASES
REPORTED BY DHS AND HFS
DECEMBER 2008**



Source: HFS and DHS data summarized graphically by OAG.

Revised Data from Agencies

After auditors analyzed the data and concluded there were significant problems, we shared our concerns regarding the data limitations with HFS and DHS. In a joint meeting with both agencies on April 22, 2009, HFS and DHS officials noted that they thought the differences in amounts and differences in populations were attributable to the criteria they used to select the data and to timing differences in the data. HFS and DHS officials stated that each agency would produce a new data set that would cover the same time period and use the same criteria, which would result in a better match of both the universe of cases and group care credits.

The next day, April 23, 2009, the agencies asked to meet again. At that meeting HFS and DHS officials said that they would not be able to each produce a data set because the two data sets would still not agree. A DHS official noted that their system was not updated automatically when the HFS system is updated. Officials stated the DHS caseworker uses the HFS MMIS system to update financial data, including updating the group care credit, and not the DHS system. Consequently, the data in the DHS system is outdated. HFS and DHS noted that they would need to collaborate and do one data set. Auditors noted that they did not have any confidence in the data being reliable, given the documented inconsistencies between DHS data, HFS data, and case files.

Agencies noted that automatic Social Security adjustments were the reason for many of the differences between the case files and the electronic data. They also noted several limitations and weaknesses in their systems but expressed confidence in the accuracy of the data. Among the weaknesses that the agencies noted were:

- When explaining their inability to produce a new data set, as promised in April 2009, the agencies stated, “. . . I believe we overemphasized the need to coordinate the timing of our data pulls without fully taking into account the **limitations of MMIS and CIS [Client Information System] in presenting directly comparable documentation of patient care credits** [emphasis added].”
- The agencies noted that DHS’ system is limited in the amount of data it maintains to document changes in eligibility and spousal diversion. Consequently, limited information is available to explain and document why certain changes in group care credits were made over the years. “**While some history is maintained, it is often overwritten when new information is used to update a client's status** [emphasis added].”
- The agencies noted that the CIS program was written in Autocoder **in the 1970's**. “Both the age and long since obsolete programming language of the CIS have prevented DHS from quickly pulling data in ways other than the on-going processes of determining eligibility.”
- Patient care credits, as represented in the HFS MMIS system, are the final result of a caseworker's calculations which are recorded on a 2500 form [LTC Resource Calculation Form] for each payment or patient credit modification. “**Entry of this patient credit data into the CIS system would be a duplication of effort for DHS staff** [emphasis added].” **Consequently, the DHS group care credit information is not reliable.**
- There are limitations on using automated data to replicate largely manual processes, where not all data elements are entered into both data systems. Officials noted, “**While the current system is inefficient and obviously difficult to audit**, we are still confident that the systems work [emphasis added].”

In June 2009, we offered the agencies one more opportunity to attempt to address the serious concerns we had regarding the accuracy and reliability of their data. Auditors requested a “...reconciliation of the total number of cases in the universes provided by DHFS in December 2008 and by DHS in January 2009...” DHS and HFS **did not provide the requested reconciliation**, but instead provided new data files that only included case identification numbers.

Both agencies used data as of June 4, 2009. In this comparison, DHS had 2,910 cases while HFS had 3,447 – an 18 percent difference. The agencies noted that 581 of the HFS cases included spousal diversion codes (referred to as “670” codes) that have been closed by DHS, but not reflected in HFS’ Data Warehouse. Agency officials noted that other discrepancies were due to up to a two day lag between DHS extracting the data and HFS loading the Data Warehouse.

Although the total universes, with explanations and adjustments, are closer than before, they still did not match. In addition, the new data runs did not include group care credit amounts, the most important information for this audit, so no assessment of their reliability could be attempted.

In addition, in preparing new data sets to reconcile, DHS and HFS discovered new weaknesses in coordination between the two agencies’ systems. They noted in their memo accompanying the reconciliation of the data that:

- “The HFS Recipient Case Income and Recipient Case Information segments are loaded from DHS's CDB [client data base] file. This was used to identify clients with income codes equal to “670” and a household arrangement code of 15. While these segments include Case Ids, they do not include RINs [Recipient Identification Numbers]. Previous data pulls did not take into account that when the Case ID from DHS is loaded into the Data Warehouse, their 13 character field (including 2 dashes) is converted into a 16 field, thus resulting in incorrect case Ids.”
- “In addition, we [DHS and HFS] **have recently discovered** that the Data Warehouse maintains “670” codes that may have been closed out by DHS. Again, while DHS is basically using a live, constantly updated system, our [HFS] Data Warehouse preserves the history [emphasis added].”

DATA ISSUES	
RECOMMENDATION NUMBER 1	<i>The Departments of Healthcare and Family Services and Human Services should review the Medical Assistance Program computer systems, specifically for long term care cases with a community spouse, and ensure the systems are working together and serving their intended purpose. The Departments should take the necessary actions to assure that the data contained in those systems is consistent, reliable, and timely updated.</i>
HFS AND DHS RESPONSE	Partially Agree. HFS and DHS agree that our data systems should be improved. Both departments are currently engaged in exhaustive planning efforts to replace our aging data systems with state of the art

	<p>technology that can operate efficiently and eliminate the kinds of data confusion experienced by the audit team. Over the next several years, the departments will be seeking legislative support for substantial financial investment to implement these new and improved systems.</p> <p>In the short term, the departments agree to consider whether aspects of the computer systems can and should be modified to enhance service to our long term care customers with community spouses. The departments also agree to review and clarify policy with an eye toward eliminating any requirement for updating irrelevant information.</p> <p>Nonetheless, the audit has shown no evidence of a lack of data integrity in the existing systems. The auditors found differences in the agencies' data but those differences were not indications of errors. The differences in data resulted from the timing of the data reports and the purpose for which the data was used.</p> <div style="border: 1px solid black; padding: 5px;"> <p>Auditor Comment #6</p> <p><i>The Departments are wrong in their assertion that there is no evidence of a lack of data integrity. The audit documents numerous data issues within the Departments' existing systems. In fact, during the course of the audit, the Departments identified significant limitations with their own systems. DHS and HFS officials noted in jointly provided written responses:</i></p> <ul style="list-style-type: none"> • <i>“I believe we overemphasized the need to coordinate the timing of our data pulls without fully taking into account the limitations of the Medicaid Management Information System and the Client Information System in presenting directly comparable documentation of patient care credit [emphasis added];”</i> • <i>“DHS data may not be correct because entry of patient credit data into the CIS system would be a duplication of effort for DHS staff [emphasis added];”</i> • <i>“While some history is maintained, it is often overwritten when new information is used to update a client's status;” and</i> • <i>We have recently discovered that the Data Warehouse [MMIS] maintains codes [spousal diversion case code] that may have been closed out by DHS. Department officials noted there were 581 HFS cases that had that code.</i> <p><i>Auditors also noted that:</i></p> <ul style="list-style-type: none"> • <i>There were corrections made to group care credits in hardcopy files that were not entered into the computerized MMIS system, thereby making the group care credit amounts in the MMIS system incorrect;</i> • <i>In 2 of 23 cases reviewed by auditors, DHS data still showed the cases as active spousal diversion cases even though in one case the client had died, and in the other case, the community spouse had died;</i> </div>
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- *In 7 of 23 cases auditors examined, there were 14 instances where the group care credits were wrong for four months or more. In three of those cases, the group care credit amount was wrong for two years or more. These incorrect amounts were in the Departments' computerized systems; and*
- *For nursing home cases with a community spouse, the central adjustment to Social Security **almost always results in the new group care credit being incorrect. These amounts are included in both DHS and HFS systems and are all issues of data integrity.***

All of these issues are specified and discussed in Chapter One of this report.

For example, HFS's Medicaid Management Information System (MMIS) is the only system used to document the amount of the group care credit. While policy states that DHS's Client Information System (CIS) is to be updated with the group care credit amount, the data reported in that system is used for informational purposes only, and has no impact on the patient's group care credit. The audit process included a comparison of the group care credit as held in MMIS in July 2008 to the group care credit held in CIS in December 2008. This comparison is flawed and led to the auditors' erroneous conclusion that the data held in each agency's system were negatively affecting our customers. The comparison is flawed because the data comes from two different time periods and is used for different purposes by the departments.

Auditor Comment #7

*The auditors did not reach an "erroneous conclusion." The auditors spent a significant amount of time trying to understand why a case's group care credit in the DHS system would be **substantially different** than the group care credit in the HFS system. The reasons for the differences in the 23 cases reviewed are detailed graphically and accurately in Exhibit 1-2.*

The Departments are wrong to assert that the data in their systems does not negatively affect their customers. When group care credit amounts are corrected by caseworkers but not corrected in the computer systems, clients are impacted.

*Furthermore, when their elderly and vulnerable clients **receive a notice telling them to pay an incorrect amount** – an amount that is contained in DHS/HFS data systems – directly to the nursing facility, their clients **are negatively affected.***

Electronic Data Compared to Case Files

In addition to significant differences in the universes of cases provided by both agencies, we also found significant differences between the group care credit amounts when we compared the case files with the electronic data we received from HFS and DHS. We reviewed 23 long term care cases with a community spouse. We checked whether the amount the community spouse was to pay for their spouse's care, or group care credit, agreed among the three sources. The three sources were from: the case file (the most recent LTC Resource Calculation Form); the computerized DHS data; and the computerized HFS data.

The following case illustrates a specific example found during our review of case files. While reviewing case files, we determined that we could not identify the group care credit amount which is in the HFS system and the amount that the client has to pay solely through documentation in the files.

Case Example #1: In one case that we reviewed, the client's case file showed that his group care credit amount should be \$0. However, the HFS database showed his group care credit amount as \$30 and the DHS database showed his group care credit amount as \$116.

Only one of the case files with a community spouse that we reviewed had the same group care credit amounts in the case file as both sets of electronic data from the two agencies. Exhibit 1-2 shows the differences in the group care credit amounts between case files we reviewed and the DHS and HFS data, along with an explanation as to why they differ.

To demonstrate that the data in both systems were accurate at the point in time they applied to, the agencies offered to create detailed timelines for each of the 23 cases which are included in Exhibit 1-2. The offer noted that explanations could describe the manual process for each case, at which point data was entered into either agency's data system (or why something may not have been entered) and how each case was communicated between agencies to implement the final payment adjustment. Those timelines were provided by the agencies in June 2009.

There were two primary reasons for the differences in group care credits among the three sources. Timing appears to be the first primary factor. Data was requested from agencies in November and December 2008, but the agencies pulled the data from different time periods. DHS' data was from December 2008. By the time DHS ran the auditors' data request, the 2009 COLA had already been added to their database. However, according to HFS, although they too did their data pull in December, their data reflected the group care credit as of July 2008. The second primary reason for differences between the data sources was that the DHS case files did not contain any documentation of the 2009 COLA increases.

**Exhibit 1-2
COMPARISON OF GROUP CARE CREDIT AMOUNTS FROM DHS ELECTRONIC DATA,
DHS CASE FILE, AND HFS ELECTRONIC DATA**

Case	Case File Amount	Electronic Data DHS	Electronic Data HFS	Explanations of Data Variation
1	\$0	\$63	\$0	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data.
2	\$191	\$191	No Data	No HFS data because CS had died 11-1-08. The DHS data still reported the case as having a CS.
3	\$680	\$725	\$680	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data.
4	\$0	No Data	No Data	There was no data because the client died on 10-3-08. Case file was reviewed before death occurred.
5	\$512	\$551	No Data	DHS data included the 2009 SS COLA increase which was not documented in the paper case file. HFS data was from before the client had been determined eligible.
6	\$0	\$116	\$30	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data. HFS data shows \$30 because SS COLA from 2008 had been wrong and not corrected for 12 months.
7	\$0	\$0	No Data	There was no HFS data because the client died on 10-16-08. Case file was reviewed before death occurred. DHS data was not yet adjusted to reflect the client's death.
8	\$0	\$67	\$0	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data.
9	\$0	\$104	\$0	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data.
10	\$299	\$427	\$382	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data. In March it was adjusted to \$299, the month after it was adjusted to \$329. HFS data of \$382 was from an earlier time and did not reflect any of the other changes.
11	\$1,158	\$1,252	\$1,175	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data. HFS data of \$1,175 reflects COLA & other changes.
12	\$993	\$17	\$0	DHS data included the 2009 SS COLA increase amount. The paper case file showed an amount that did not include a CS diversion.
13	\$0	\$61	\$0	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data.
14	\$0	\$79	\$0	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data.
15	\$0	\$64	\$0	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data.
16	\$0	\$26	\$0	DHS data included the 2009 SS COLA increase which was not documented in the paper case file. HFS data shows as \$0 but should have been \$10 according to the timeline.
17	\$0	\$86	\$0	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data.
18	\$0	\$28	\$0	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data.
19	\$1,113	\$1,164	\$1,113	DHS data included the 2009 SS COLA increase which was not yet reflected in HFS data. All three amounts do not reflect that there is a community spouse.
20	\$0	\$57	\$0	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data.
21	\$0	\$44	\$0	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data.
22	\$0	\$14	\$510	DHS data included the 2009 SS COLA increase which was not documented in the paper case file and not yet reflected in HFS data. HFS data shows \$510 because it was from an earlier time before the CS stopped working.
23	\$0	\$0	\$0	Excluded from central adjustment and amounts are all correct.

Notes: SS COLA = Social Security Cost Of Living Adjustment;
CS = Community Spouse; DHS = Department of Human Services;
HFS = Department of Healthcare and Family Services

Red indicates amount does not match
Green indicates amount matches
Black indicates there was no data

Source: DHS and HFS data summarized by OAG. DHS electronic data from January 2009 and HFS electronic data from December 2008.

Review of Sampled Cases

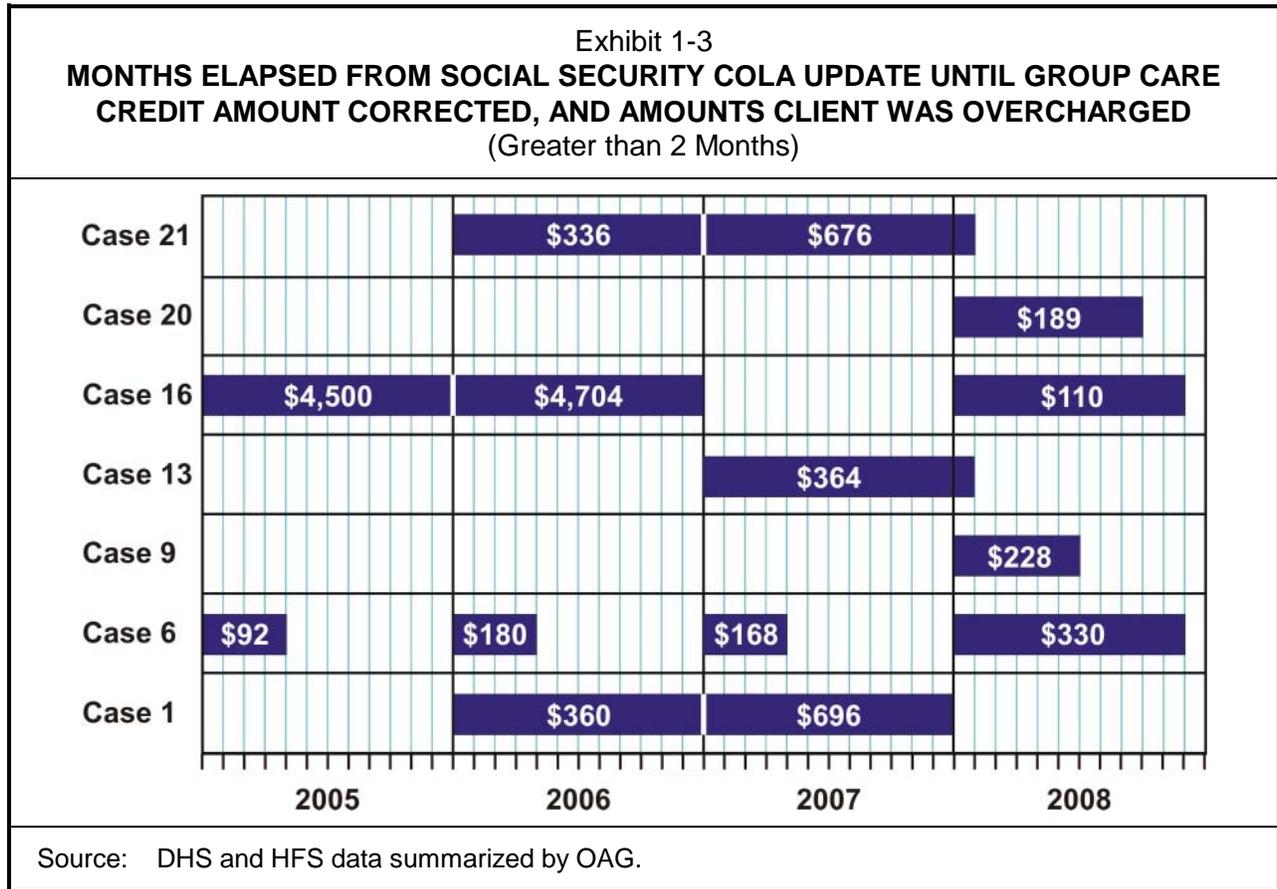
The agencies provided detailed timelines and additional information for each of the 23 cases sampled. The most significant problem auditors identified related to the Departments' handling of the annual Social Security cost of living increases received by clients with community spouses. Effective January of each year, most clients receive an annual Social Security cost of living increase. Rather than making a determination as to how much of the increase can be given to the community spouse at the time the amount of the Social Security increase is known, the Departments **automatically add** the cost of living increase to the client's group care credit (the amount of money the client is required to pay the long term care facility). To correct the amount that the client owes requires either a request from the long term care client and/or a review by a DHS caseworker. In either instance, the DHS caseworker must correct the group care credit information in the HFS MMIS system.

This automatic adjustment almost always results in the new group care credit being **incorrect**, since most or all of the income can be given to the community spouse. If not corrected in a timely manner, it results in the client being overcharged for their care. Although the auditors requested "Copies of any communications that were sent to the client or the family and, in particular, any notices informing them of the amount the client or community spouse was instructed to pay for nursing home services," DHS and HFS did not provide copies or include documentation of all such communications to auditors when providing support for the 23 cases sampled. Also, since the client makes payments directly to the long term care facility for his or her care, DHS and HFS did not have documentation showing how much the clients were paying the long term care facility. Consequently, auditors had to rely on the group care credit amounts shown in HFS' MMIS system as the amount the client was required to contribute to his or her care.

Our review of the detailed documentation provided by DHS and HFS for the 23 cases sample identified the following deficiencies:

- **Incorrect/Overstated Group Care Credits:** In many of the long term care cases we reviewed, the client was overcharged for months, and in some cases years, because either the client had not requested the additional income to go to the community spouse or because DHS had not conducted the necessary recalculation to correct the amount the client is required to pay. In most cases, at least one or two months passed before the automatic increase in the group care credit due to the Social Security cost of living increase was corrected. There were, however, **14 instances** in 7 of the 23 cases auditors examined where the clients' group care credits were incorrect **for more than a two month period** before the group care credit was manually corrected by the caseworker. In these cases, the State's payment to the long term care facility would have been reduced by the amount of the COLA and the client would be responsible to pay that amount to the facility. In the 14 instances where this occurred, the amount that the clients' group care credits were overstated **totaled \$12,933**. Exhibit 1-3 summarizes these 14 instances. In all but one of the instances, once the State retroactively corrected the group care credit amount, it paid the long term care facility the adjusted amount. As discussed below, the State does not then verify to ensure that

the long term care facility passed the reimbursement of the overpayment on to the client.



- Delays in Entering Changes into the HFS MMIS System:** In several cases, changes made by caseworkers to correct the client’s group care credit were not timely entered into the HFS MMIS system, which is the system used to pay the long term care facilities. For example:

The timeline provided for one case showed the caseworker conducted a redetermination in May 2008 and reduced the client’s group care credit to \$0. However, the timeline shows the group care credit was **not changed** to \$0 in the HFS MMIS system until October 2008, when it was made retroactive to January 2008. Consequently, for the period May through October 2008, the payments made by HFS to the long term care facility were incorrectly based on the client contributing income toward his care, which should have been going to the community spouse.

The timeline for another case showed a redetermination was completed in December 2006 and the group care credit was determined to be \$0. The client’s group care credit during 2006 had been \$28 per month. However, the timeline shows that the revised group care credit amount of \$0 was **never entered** into HFS’ MMIS system. Rather, the group care credit was further **increased** by the 2007 Social Security cost of living increase to \$52 per month. Finally, in February 2008, **13 months after** the

December 2006 redetermination had been completed that showed the group care credit was \$0, another redetermination was completed which again showed the group care credit should be \$0. That same month, the HFS MMIS system was updated to reflect the \$0 group care credit, and it was made retroactive to January 2007.

However, the group care credit was not made retroactive to 2006 during which the client also had an erroneous \$28 per month group care credit.

- **Medicare Premium:** In one case the Medicare premium was not netted out of the client's income in 2008, thereby overstating the amount the client had to pay toward his care.
- **Spouse Death:** In one case, a spouse died in November 2008, but the client was still in DHS' system as having a community spouse case in December.

In addition, there are instances where the information provided by the Department to the auditors did not contain adequate documentation to support the changes made to the group care credit amounts. As discussed earlier, after auditors noted the significant differences in the group care credit amounts in the DHS case files, the DHS electronic data, and the HFS electronic data, the Departments requested an opportunity to provide detailed timelines that would show why the amounts differed among the three sources. While in many instances the timelines and supporting documentation explained such differences, in others, questions remain why certain changes to the group care credits were made. For example:

- In one case, the client's group care credit was \$0 from the time of admission in 2007 until January 2009. In January 2009, the group care credit increased to \$64 as a result of the Social Security cost of living increase, but the DHS caseworker changed it back to \$0 in March 2009. The timeline provided by the Departments then shows the group care credit **increasing to \$329** on May 18, 2009, **but did not contain a report or other support** for this adjustment. As such, auditors could not examine the basis for or validity of this change. In the agencies' written response to the audit they noted: ". . . the \$329 was a typo in the submitted timelines."
- In another case, the client's group care credit was \$0 through October 2007. Beginning in November the group care credit began to increase significantly, up to \$1,164 as of January 2009. We inquired of DHS officials as to why the significant increase in the group care credit occurred. DHS officials stated that the community spouse entered a long term care facility in October 2007, thus there was no more diversion of the client's income to the community spouse, and the client's group care credit increased accordingly. However, the case file did not document this reason and, in fact, contained documentation to the contrary, including a March 2009 DHS "Authorization of Assistance Action" form with \$1,088 designated as income to be diverted to a community spouse. Also, the Departments sent the December "Notice to Long Term Care Residents Giving Income to Family," which is sent out to cases where income is diverted to a community spouse. This case again raises concerns regarding the validity and reliability of the data the agencies provided since the case was in the universe of cases with community spouses provided by both DHS and HFS, which it should not have been if the community spouse entered a nursing home.

- In another case a client's group care credit amount automatically increased in December 2007 (effective January 1, 2008) from \$0 to \$30 due to the annual COLA increase. The timeline and the case file both document that in February 2008 a caseworker completed a LTC Resource Calculation Form changing the group care credit amount back to \$0. Like the previous example, the timeline shows the revised group care credit amount of \$0 was never entered into HFS' MMIS system. Then a year later in December 2008 (effective January 1, 2009) the group care credit increased again from \$30 to \$116 due to the annual COLA increase. Later in December 2008, the group care credit was changed from \$116 back to \$0 for all of 2008.
- In another case, the client had a group care credit of \$382 in 2008, which increased to \$427 in January 2009 due to the 2009 Social Security increase. However, in February 2009, the timeline provided by the Departments showed that the DHS caseworker changed the group care credit to \$0. The change was made **retroactive to 2007**. Although the provided timeline contains a notation that information was received from the long term care facility, neither the case file nor other documentation provided support this adjustment. However, **one month later**, in March 2009, the DHS caseworker again changed the group care credit back to \$382 for 2008 and to \$299 for 2009. Finally, the 2009 group care credit was **changed again** to \$329 **one month later** in April 2009 by a DHS caseworker.
- In another case, the client had a group care credit of \$357 beginning in July 2003 which had increased to \$406 as of January 2007. In February 2007, a redetermination was completed for the period beginning June 2006, which concluded the client had a group care credit of \$0. The group care credit of \$0 was made retroactive to June 2006. However, based on the client's and community spouse's income documented in the case file, the auditors questioned whether the client should have been assessed any group care credit during the period July 2003 through May 2006.

The incorrect group care credits, many of which went uncorrected for extended periods of time, demonstrate the need for both Departments to undertake a review of all cases involving clients in long term care facilities with community spouses. Leaving group care credit amounts uncorrected results in community spouses not getting the income to which they are entitled and increases the risk of them becoming impoverished.

GROUP CARE CREDIT ISSUES	
<p>RECOMMENDATION NUMBER</p> <p style="font-size: 2em;">2</p>	<p><i>The Departments of Healthcare and Family Services and Human Services should work together to undertake a review of cases with group care credits to verify that the amounts are accurate. Furthermore, the Departments should take the steps necessary to ensure that group care credits revised as a result of the redetermination process are timely entered into the MMIS system and other systems.</i></p>
<p>HFS AND DHS RESPONSE</p>	<p>Partially Agree. The departments agree that a review of cases with group care credits would be a constructive task, however, we disagree with some of the audits conclusions.</p> <p>We agree that, in some instances, caseworker entry of updates into MMIS may not be timely but the timeliness is not always under state control. While some lateness may result from extremely large caseloads, timeliness is also affected by the lack of response from clients and their families, as well as the long term care facilities; and difficulties in obtaining information from spouses who are not our clients. The departments agree to explore efficient ways of performing a review of cases with group care credits to verify accuracy. In addition, we agree to explore enhancements to our procedures to ensure that the information gathered as part of redeterminations are used in timely calculations of the group care credits of long term care customers with community spouses.</p> <p>However, the departments disagree with the conclusion that the auditors identified significant and pervasive problems in the processes and data used by the two departments, which resulted in clients being overcharged for their care. The report alleges that in seven cases, there were instances in which the client or clients spouse was inconvenienced by an overcharge for their care, during the time that the Social Security Cost of Living Adjustment (COLA) resulted in a positive group care credit for the client. For six of the seven cases cited, that audit presents no evidence of any client or spouse incurring the hardship of paying the alleged overcharge amount. In contrast to the audit report, the alleged overcharge amount was never collected from the client or spouse in those six cases.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><i>Auditor Comment #8</i></p> <p><i>When 7 of 23 (30%) cases have incorrect group care credit amounts that were not corrected for 4 months or longer, there are significant and pervasive problems in the processes used by the Departments. Contrary to the Departments’ assertions, the audit report does not conclude that the clients were <u>overpaying</u> for their care based on incorrect group care credit amounts. As reported in the audit, the Departments could not provide documentation to show how much the client was actually paying the long term care facility. Consequently, the auditors had to rely on the group care credit amounts shown in HFS’ MMIS system as</i></p> </div>

	<p><i>the amount the client was required to contribute to his or her care.</i></p> <p><i>While the Departments assert that they contacted the nursing homes and determined that in 6 of 7 cases the clients did not overpay for their care, no documentation of such inquiries was shared with auditors. Also, this contact with nursing homes did not occur until after the auditors brought these cases to the Departments' attention. There are likely many other similar cases where elderly and vulnerable clients may have been overcharged for their care which have not been followed up by the Departments. However, the Departments have maintained that it is not their responsibility to determine whether its clients are being overcharged, and as noted in the Departments' response to Recommendation Number 6, "it is not a DHS role to oversee repayments."</i></p> <p>There are specific case citations in the report that require annotation:</p> <ul style="list-style-type: none"> • In the two cases described on page 17 (also described on page 2 and 3), there were no inaccurate group care credit payments made to the facility by the client or spouse. This has been confirmed by the facilities. • In the third dot point on page 18, the \$329 was a typo in the submitted timelines, and should be removed from the report. The client's group care credit has been \$0 since his admission in 2007. <div style="border: 1px solid black; padding: 5px;"> <p>Auditor Comment #9</p> <p><i>The Departments' error has been noted in the audit report.</i></p> </div>
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Conflicting Notices Sent to Clients and Community Spouses

In addition to the automatic adjustment made to the client's group care credit, the manner in which the Departments inform clients of the process they must follow to ensure the Social Security increase is not added to their group care credit contributes to the problem. The Departments send two letters within a two week period to long term care clients that provide conflicting, or at best confusing, information regarding the handling of the clients' Social Security increases. Copies of both notices are included in Appendix B of this report.

In early December, the agencies send a form letter only to long term care clients with community spouses which states that the client will be getting a Social Security cost of living increase in January, and if they want the increase to go to their community spouse, they need to contact their DHS caseworker. The second notice, which is mailed within two weeks of the first, tells the client the total amount of their new Social Security and the amount which is available each month to pay to the nursing home. The notice says: "**You must pay this money directly to the facility** [emphasis added]." Given that in most cases the client can transfer most or all of this income to the community spouse, this second letter is both misleading and confusing. There is

no mention in the second letter of the client’s ability to give the increase to his or her community spouse.

COST OF LIVING NOTIFICATIONS	
RECOMMENDATION NUMBER 3	<i>The Departments of Healthcare and Family Services and Human Services should revise and clarify Social Security cost of living notifications sent to clients with community spouses. Notices should tell clients what they should do and not tell them to pay amounts they do not owe.</i>
HFS AND DHS RESPONSE	<p>Agree. The departments agree to review the Social Security cost of living adjustment notifications and clarify them as needed. Most long term care residents receive only one notice. Two notices have been used in the case of a resident with a community spouse to ensure that each long-term care client is aware of the financial impact of the Social Security increase on their respective case.</p> <p>Although there is no erroneous information contained in the notices, the departments agree that we may be able to revise them to clarify the action that must be taken if the resident spouse is eligible to and wishes to divert all or a portion of the Social Security increase to their spouse in the community.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Auditor Comment #10</p> <p><i>Contrary to the Departments’ assertion, there is erroneous information in the notices. The statement in the second notice which, when referring to the Social Security cost of living increase, states “You must pay this money directly to the facility” is erroneous information when an assessment of the liability of a client with a community spouse has not been made.</i></p> </div>

Social Security Cost of Living Adjustments

As noted earlier in this Chapter, the primary cause of the group care credits we reviewed being inaccurate was the automatic addition of the client’s annual Social Security cost of living increase to his or her group care credit. During our interviews with DHS field office officials we discussed the central budgeting process and how overwhelming a responsibility it can be for some caseworkers. Central budgeting refers to the updates to client income information which are done through the HFS/DHS central office(s) based on information that they receive from the Social Security Administration (SSA).

According to DHS policy, the annual update of Social Security cost of living adjustment (COLA) is automated for some, but not all, long term care cases with a community spouse. When these SSA updates occur every year, the group care credit needs to be checked and recalculated by the caseworker. If there are changes, the caseworker is responsible for recalculating the group care credit, updating the LTC resource calculation form in the file, and

sending it to the client. Because this is a manual function, calculation or input errors due to the increase could affect the portion of income diverted to a spouse and the group care credit amount.

There was some misunderstanding among caseworkers that we met with as to how the adjustments related to the COLA increase are made. In one field office that we visited, two DHS caseworkers disagreed with one another about how the process for central budgeting works. One thought that LTC community spouse cases were not centrally adjusted and may need to be checked and recalculated manually by local office caseworkers. The second thought that the cases were centrally adjusted first and then were corrected and verified manually by the caseworker. For community spouse cases with spousal impoverishment protection, the process has to be adjusted or corrected manually and this is the responsibility of the local office caseworker. Caseworkers commented on the amount of time they spend annually when central budgeting is done for Social Security updates. They noted how much work is involved at the local level to manually correct the changes and prepare the notification letters. The following case example, which was relayed to us at a field office, illustrates the problem that can occur:

Case Example #2: A case with spousal impoverishment had a group care credit of \$0 but was affected by central budgeting of the Social Security cost of living adjustments. As a result, the group care credit went to \$13 dollars although it should have remained \$0. The caseworker needed to verify and obtain additional financial information from the client in order to update the amount correctly back to \$0.

All but one of the cases sampled had Social Security increases that were centrally budgeted (i.e., the cost of living was automatically added to the client’s group care credit). However, this central adjustment almost always results in a group care credit that is incorrect and that needs to be manually corrected by the caseworker. Given the problems caused by the central adjustments and since the DHS caseworkers need to compute them manually anyway, the Departments should consider discontinuing the central budgeting of Social Security cost of living increases for long term care clients who are diverting income to a community spouse.

CENTRAL COST OF LIVING ADJUSTMENT	
RECOMMENDATION NUMBER 4	<i>The Departments of Healthcare and Family Services and Human Services should stop centrally adjusting the group care credit amount for clients who are diverting income to a community spouse. Instead, caseworkers should adjust the group care credit manually based on current information.</i>
HFS AND DHS RESPONSE	Disagree. The departments agree to work together to review and make any appropriate changes to the centrally budgeted group care process for clients with community spouses. The departments, however, cannot agree to cease centrally adjusting increases in Social Security income received by the resident of a long term care facility. HFS’ as Illinois’ single state Medicaid agency, must establish policy that comports with federal requirements. On the other hand in the face of extremely limited resources, DHS must seek to use

the most efficient means to fulfill its responsibility for processing the eligibility determinations.

Auditor Comment #11

*Departments’ policies already exempt certain cases from central budgeting of the Social Security cost of living increase. One of the 23 cases auditors reviewed **was not** centrally budgeted. Because all long term care cases with community spouses need to be manually reviewed and adjusted by a caseworker anyway, **centrally adjusting them to a wrong amount** which the **caseworker then has to manually correct** does not appear to be an “efficient means” as stated by the Departments in their response.*

Medicaid eligibility is dependent on income and allowable diversions of that income. The state must presume that a resident’s income will be used to offset the cost of the resident’s long term care *unless* evidence is presented by the resident, spouse or other authorized party that the couple’s total current income makes them eligible for diversion of income from the resident to the community spouse.

The actual central updating of the increase in the clients Social Security benefit and the possible diversion of that income to a spouse are two independent actions. The central budgeting of the SSA COLA is not incorrect, as DHS receives the increase in income data directly from the Social Security Administration.

The state may not allow the increase in the client’s income to be diverted to the spouse without additional information. The departments must depend on the client, the client’s spouse, or the nursing home facility acting on behalf of the client to provide income verification from several different sources, such as the spouse’s SSA amount, private pensions, earned income, other government benefits, investment income, and any other source that may be used in the determination of the eligibility for the diversion.

Automatically allowing diversion of Social Security COLA increases to the community spouse without determining and documenting whether that individual’s total income has changed would not assure that the diversion was allowable. Establishing policy that ignores the increase would jeopardize federal Medicaid matching dollars.

Auditor Comment #12

*Auditors concur that federal Medicaid match should not be jeopardized. However, based on documentation provided by the Departments, federal regulations require the State must reduce its payment to a nursing home by the amount that remains **after** deducting the amount for the maintenance needs of a community spouse. The **correct** maintenance needs of the community spouse is determined **after** the caseworker conducts a review of information submitted by the client or the community spouse.*

	<p><i>Removing long term care cases with a community spouse from the central budgeting process could help to relieve the confusion and stress for this elderly and vulnerable population when they receive an erroneous joint Departmental notice telling them to pay an incorrect amount to the nursing facility.</i></p>
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Documentation of Client Contacts

The agencies note that in some cases the increase in the client’s group care credit may be due to the fact that the client or community spouse failed to contact the DHS field office as the first notice sent out in December requires. The notice says “. . . you are now giving some of your income to your spouse or children under age 21. You may be allowed to give the increase in your Social Security check to your spouse or children.” It continues that “If you want us to decide if you can do that, contact your local Department of Human Services office.” A copy of this notice is included in Appendix B.

Documentation of client contacts or client’s failure to contact DHS was not included in documentation for any of the cases auditors reviewed. DHS/HFS policy requires that the date and reason for all contacts, actions taken, and decisions made are to be documented in the DHS automated intake system as a case note. Recording the failure of a client or community spouse to contact DHS would provide a better documentation of why an action was taken to increase the client’s group care credit amount.

DOCUMENTING CLIENT’S RESPONSE OR FAILURE TO RESPOND	
<p>RECOMMENDATION NUMBER</p> <p>5</p>	<p><i>The Department of Human Services should take the necessary steps to ensure that the client’s response or failure of response is recorded in the case notes, which would result in more complete documentation of actions taken regarding the client’s group care credit.</i></p>
<p>HFS AND DHS RESPONSE</p>	<p>Disagree. Both departments take the position that it would be impractical to document lack of response to notices. Requiring staff to document lack of response in all cases would be an inefficient use of time, and given current staffing levels, would create further delay in eligibility processing and proper benefit calculations.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Auditor Comment #13</p> <p><i>The audit report states that “Documentation of client contacts or client’s failure to contact DHS was not included in documentation for any of the cases auditors reviewed.” The Departments stress the critical importance of receiving financial information from the client or community spouse in determining the proper group care credit amount. Given the importance of this interaction, or attempted interaction, it would be reasonable and logical to expect that such interactions be documented so that agency management and third parties would have assurance that appropriate steps were taken to obtain this critical information from the aging clients or community spouses.</i></p> </div>

Controls over Client Liability

Basic controls to ensure the amounts paid by clients are correct were ineffective in several cases we reviewed. The documentation that DHS and HFS provided did not allow auditors to determine if any overpayments made by the client to the long term care facility were repaid to the client and community spouse. Documentation did show HFS’ nursing home payment adjustments but no documentation showed any consideration of whether the client payments were checked, corrected, or adjusted.

DHS policy requires that caseworkers conduct an annual redetermination of the client’s eligibility, which includes, among other items, a review of the client’s income and group care credit. In one case, there was no documentation in the case file to show an annual redetermination had been conducted for a three year period. In other cases, redeterminations were conducted, but they were not timely. There may be several reasons for redeterminations not being completed in a timely manner, such as high caseworker caseloads, clients or community spouses not providing necessary information, etc. However, if redeterminations are completed, and completed in a timely manner, there is less likelihood that the client will overpay for his or her long term care, and a greater likelihood that income which legally can go to the community spouse is, in fact, going to the community spouse.

In the cases where DHS determined that clients had overpaid the long term care facility for their care, DHS retroactively reduced the amount that the client was required to pay to the facility and increased the State’s payment to the long term care facility to cover the amount overpaid by the client. Department officials stated that then the long term care facility may be responsible for refunding the money to the client.

When auditors asked Department officials whether they followed-up to ensure that the long term care facilities had reimbursed the clients for any overpayments that the client may have made, Department officials stated that a review of ongoing eligibility includes a review of each client's personal funds and room and board accounts. In the files we reviewed there was little evidence to suggest that room and board accounts are checked. Also, in other meetings DHS representatives had said that it is not their responsibility to do this and an HFS representative said they do not check client accounts.

CONTROLS ON CLIENT LIABILITY	
RECOMMENDATION NUMBER 6	<i>The Departments of Healthcare and Family Services and Human Services should implement a control to ensure that any overpayments made by a client as a result of the Departments’ eligibility determination process are repaid to the client by the long term care facility.</i>
HFS AND DHS RESPONSE	Partially agree. The departments agree to work toward eliminating situations in which long term care customers may be notified to make a payment to the facility that could result in an overpayment. The audit report states that DHS or HFS had no documentation that would allow the auditors to determine if any of the overpayments made

	<p>by the client to the facilities were repaid to the client and/or community spouse. The report erroneously assumes that the clients or community spouses made the overpayments, and contrary to the report, DHS has confirmed that in six of the seven cases cited in the audit, there were no overpayments made by clients to their respective facilities. Additionally, it is not a DHS role to oversee repayments. This is a nursing home accounting function. Any alternative that requires state oversight will require additional funding.</p>
	<p><i>Auditor Comment #14</i></p> <p><i>The audit report does not “erroneously assume” that in all cases where there was an incorrect group care credit for an extended period of time, that the client “overpaid” for their care. To the contrary, the report goes on to great length to disclose that the Departments did not have this information, so auditors could not determine how much, if any, the clients overpaid for their care. While the Departments assert that they contacted the nursing homes and determined that in 6 of 7 cases, the clients did not overpay for their care, no documentation of such inquiries was shared with auditors. Also, this contact with nursing homes did not occur until after the auditors brought these cases to the Departments’ attention. There are likely many other similar cases where elderly and vulnerable clients may have been overcharged for their care which have not been followed up by the Departments. However, as noted in the Departments’ response below to this Recommendation, “it is not a DHS role to oversee repayments.”</i></p> <p><i>Finally, if payments made by the State to long term care facilities are reduced for a long period of time because an amount has been erroneously charged to the client (for instance in case 16 profiled in Exhibit 1-3, payments by the State to the nursing facility were reduced by \$9,204 over two years to offset amounts that were to have been paid by the client), it would be logical to assume those nursing homes attempted to collect, or did in fact collect, that money from the client and/or the community spouse rather than simply be out that amount.</i></p>

AUDIT SCOPE AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We interviewed representatives of HFS and DHS. We also reviewed documentation maintained by the Departments. We visited three different DHS field office locations plus the Medical Field Operations office in Cook County. At those offices we interviewed officials and reviewed a total of 27 case files.

A detailed examination was conducted of 23 cases which DHS and HFS records indicated had a community spouse. Cases examined were selected by DHS staff at field offices that we visited. Case files were reviewed and data was obtained from both DHS and HFS computer systems. After auditors raised concerns regarding the reliability of the computerized data, the agencies prepared detailed timelines for each of the 23 cases. The timelines helped to show how the group care credit data from various agency data sources interrelated and how they were changed and updated. The timelines also documented, along with other documentation gathered through the course of the audit, the pervasiveness of the group care credit problems. However, even after these reviews, auditors had concerns about the reliability of data in DHS and HFS computer systems and case files. Because of these concerns, the audit includes recommendations that address the need for the agencies to work together to correct data weaknesses in their electronic data and case files.

In conducting the audit, we reviewed applicable State and federal statutes and rules. In addition, we reviewed DHS/HFS Policy Manual and Workers Action Guide sections that pertain to Medicaid long term care. These policies and guidance are written by HFS and administered by DHS. Compliance requirements were also tested and reviewed in relation to the objectives of the audit. Any instances of non-compliance we identified are noted in this report.

We reviewed risk and internal controls at the State agencies related to the audit's objectives. The audit objectives are contained in House Resolution 1295 (see Appendix A). This audit identified weaknesses in those controls, which are included as findings in this report.

We reviewed the previous financial audits and compliance attestation engagements released by the Office of the Auditor General for the State agencies. This included reviewing findings for the most recent compliance attestation engagements and the applicable findings from the most recent Statewide single audit.

REPORT ORGANIZATION

The remainder of this report is organized into the following chapters:

- Chapter Two – Policies and Procedures
- Chapter Three – Process for Determination and Redetermination

Chapter Two

POLICIES AND PROCEDURES

CHAPTER CONCLUSIONS

The Departments of Healthcare and Family Services (HFS) and Human Services (DHS) have policies that were not current or were not clear. Those problems may be negatively affecting the long term care eligibility determination process. In addition, some of DHS' local field offices were not operating according to the Policy Manual.

DHS had weaknesses in management oversight of the Medicaid long term care program. These weaknesses included Overdue for Redetermination reports not being used and a lack of supervisory review of caseworkers at DHS. In addition, there were computer system oversight issues and policy coordination issues that are the shared responsibility of HFS and DHS.

HFS had not implemented changes in the federal law that relate to Medicaid long term care services. The federal Deficit Reduction Act of 2005 made several changes concerning eligibility determinations for Medicaid long term care clients.

POLICY ISSUES

The Policy Manual used by field offices and caseworkers is written by HFS and administered by DHS. As a result of our audit work, we identified potential policy issues including those related to forms, annual facility visits, and responsible relative policy. We also identified two areas, the use of the Mail-In Application for Medical Benefits form and the annual facility visit policy, where requirements in the Policy Manual differed from practices occurring at some local field offices.

Mail-In Application for Medical Benefits Form

We reviewed a sample of 27 case files to determine if a completed Mail-In Application for Medical Benefits was in the case files. In our review, we found case files either contained a paper Mail-In Application for Medical Benefits form or the required signature page. Some files contained a computer print-out of a client's application information inputted by a caseworker via the computer intake system.

We visited four DHS field offices and found that two used face-to-face interviews and two used mail-in applications. When we asked DHS central office officials which offices used the mail-in-only process, they did not know and said it was at the discretion of the local office.

According to the Policy Manual, a completed paper application or electronic web application is required for an applicant to receive cash, medical assistance, or food stamps. More specifically, caseworkers are instructed to use the Mail-In Application for Medical Benefits, which includes long term care applicants. The application can also be used by the long term care facility to begin the application process. Caseworkers stated that some nursing homes are helpful in assisting with the application or verification process. A caseworker noted that the forms can be very confusing when received in the mail. The variation in how the current policy is implemented could cause inconsistency in the documentation that is included in the case file. Also, for elderly clients, the complex long term care application process may be difficult to deal with as a mail-in application.

We followed-up with HFS to determine if it was acceptable for a caseworker to input a client's application information versus obtaining a completed paper or web application. HFS officials stated it was acceptable to have a caseworker input data from a client electronically since the same information is collected; however, a caseworker must ensure a signed signature page is obtained from applicants or their representative and placed in the case file. An HFS official stated the intent of the policy was to be as flexible as possible for the applicant.

Annual Facility Visits

Some of DHS' local field office caseworkers are not completing or documenting annual facility visits as required by the Policy Manual. The Policy Manual requires the completion of a redetermination at least once a year for all long term care cases. As part of this process, the Policy Manual requires local office staff to visit the client's facility. We followed-up with local field offices and determined some are not completing these visits. In the 23 case files we reviewed where this requirement was applicable, **20 had not received the required facility visits**. Not conducting annual visits could miss errors in resident accounts or miss verification that the client is still a resident. One objective of a facility visit is to verify that the client is physically there.

We followed up with HFS to determine the intent of this requirement in the Policy Manual. HFS officials stated that caseworkers are supposed to complete these visits according to policy but noted that the practice could have changed and clarification may be necessary as this policy has not been reviewed for approximately 20 years. HFS and DHS should review this policy and determine whether it is still applicable or current as it relates to the LTC program.

Responsible Relative

The Policy Manual does not clearly explain the steps and procedures involved with handling long term care cases with responsible relatives. A responsible relative is a parent or spouse of a client who may be responsible for paying for a portion of the client's care. Caseworkers are instructed to complete and forward a Support Referral Form to the Bureau of Collections at intake for new applicants. However, the policy is not clear on how a caseworker determines which cases may involve a responsible relative.

This lack of clarity was shown when we met with the Bureau of Collections that receives the referrals. They reported that of approximately 60 spousal cases referred each month, only approximately 20 cases should have been referred. The remaining invalid referrals are cases where the community spouse does not have sufficient income to contribute as a responsible relative. These are cases where the community spouse is or could be receiving some of the client's income as spousal impoverishment protection. This large percentage of incorrect referrals could be an indication that caseworkers are not clear about the steps and procedures for handling cases with potential responsible relatives and may need additional guidance from the administering agencies. HFS and DHS should assure that the responsible relative policy is clear so that it can be properly implemented by caseworkers and the Bureau of Collections.

Outdated Forms

During our review of case files, we found some required forms may be outdated as they had not been updated for many years. We identified two potential problems: first, some forms had older revision dates dating back to 1998; and second, some field offices were using forms that had since been updated. When we followed-up with officials at HFS, they reported that most of the forms without a more current revision date were not their forms, but belonged to DHS. However, they were Medicaid forms and HFS is the single state Medicaid agency responsible for all Medicaid policy. This requires HFS and DHS to work together.

From our review, of the 40 forms that we checked, a little less than half of these forms were considered DHS forms. Although many of the HFS forms had a more current revision date, only one of the DHS forms had a more current revision date. We also found that one of the HFS forms that was discontinued in April 2007 still remained on the form retention list. According to DHS policy, caseworkers are to use the form retention list for all case records and destroy outdated forms and documents in the case records. In addition, they are to contact the Bureau of Policy Development about forms that are not included in the list.

We checked with HFS to determine if there had been any significant changes to the updated forms since some of the local offices were using forms with older revision dates and whether the use of outdated forms could negatively affect the eligibility determination process. From our review, we concluded that there were not significant changes made to the current revised forms.

One important form erroneously indicates that it should be distributed to Data Entry. It says this even though data has been entered directly by caseworkers for many years. This form is the Long Term Care Update Authorization form and includes an input version and an output version. This form is important because it is the link that allows DHS caseworkers to input the group care credit amount which is used in the HFS system. Although there are other forms and processes that electronically calculate and input the group care credit into DHS systems, they are not used to update the HFS system. Instead, this Long Term Care Update Authorization form, which does not include calculation or documentation of the source of the group care credit amount, is the form the caseworkers use to make the update to the HFS system.

DHS and HFS should work together and communicate any changes or revisions to forms between the two agencies and maintain the current changes on the Form Retention List so that local field offices can maintain their case files according to the list.

POLICY ISSUES	
<p>RECOMMENDATION NUMBER</p> <p style="font-size: 2em;">7</p>	<p><i>The Departments of Healthcare and Family Services and Human Services should work together to clarify policies. In particular, attention should be given to:</i></p> <ul style="list-style-type: none"> • <i>Assuring that using the <u>Mail-In Application for Medical Benefits Form</u> allows clients to get the assistance they need in applying for benefits;</i> • <i>Conducting <u>Annual Facility Visits</u> as is required by established policy;</i> • <i>Clarifying <u>Responsible Relative Policy</u>, so that only applicable long term care clients' spouses are referred for appropriate collection; and</i> • <i>Ensuring that <u>Outdated Forms</u> are not referenced in policy manuals or used by caseworkers.</i> <p><i>The Departments should also assure the established policies are followed by the local offices.</i></p>
<p>HFS AND DHS RESPONSE</p>	<p>Partially agree. The audit has not presented evidence of overall lack of clarity in policy. HFS and DHS will review the specific concerns raised as explained below. Some of the instances require annotations in the final report.</p> <ul style="list-style-type: none"> • Assuring that the Mail In Application for Medical Benefits Form allows clients to get the assistance they need in applying for benefits. <p>It is DHS policy to help applicants with the application process, as needed, including providing options on how the application can be submitted. DHS accepts walk-in applications, mail-ins and applications via the Internet. Applicants are able to obtain the assistance needed in order to apply for benefits.</p> <p>The audit presented no evidence of a family or client not being able to obtain the assistance necessary to complete the application process.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><i>Auditor Comment #15</i></p> <p><i>Given the complex nature of the application process and the vulnerable population served by this program, the auditors stand by their recommendation that the policy on mail-in applications should be clarified. In two large DHS field offices we were told that long term care applications were done through a mail-in only process. The long term care application process is very complex. Completing a mail-in application is very difficult. Clarifying</i></p> </div>

	<p><i>Department policy to local office officials, to help assure that applicants get the assistance they need from the Departments, is reasonable.</i></p> <ul style="list-style-type: none"> <p>Conducting Annual Site Visits as is required by established policy.</p> <p>DHS staff in Cook County conduct site visits as required. In other Regions with larger geographical areas and limited resources, staff complete this process by other means, including telephone and mail. As a result, HFS and DHS will review this policy and revise it as needed.</p> <p>Clarifying Responsible Relative Policy, so that only applicable long term care cases are referred for appropriate collections.</p> <p>The Responsible Relative Policy contained in PM 09-02-04-b is clear and adequately identifies when to and when not to refer cases to the Bureau of Collections. The audit report infers that most referrals to the Bureau of Collections are invalid. The departments disagree with this statement. A referral that does not result in a responsible relative paying for a client’s care does not equate to an invalid referral. In addition, to preserve and maximize the State’s revenues, it is good business practice to refer cases to the Bureau of Collections for a determination of financial responsibility. That is the only way to protect against inappropriate shifting of financial responsibility from a responsible relative to the taxpayers.</p> <p>Auditor Comment #16</p> <p><i>The auditors’ conclusion that the responsible relative policy either needs to be clarified or more effectively communicated to caseworkers is based largely on input provided by HFS’ own Bureau of Collections personnel. Collections personnel reported to auditors that of approximately 60 spousal cases referred each month, only approximately 20 cases should have been referred. As such, auditors concluded that if two-thirds of the cases being referred to Collections should not have been referred, there is either a problem with the Departments’ policies or there is a problem with the Departments’ implementation of such policies.</i></p> <ul style="list-style-type: none"> <p>Ensuring that outdated forms are not referenced in policy manuals or used by caseworkers.</p> <p>The Departments note that the audit did not find that any of the forms used resulted in an error or incorrect calculation of a benefit. HFS agrees to review forms to eliminate outdated forms in the Policy Manual and DHS agrees to work to assure that caseworkers do not use outdated forms.</p> <p>Ensuring the established policies are followed by local offices.</p> <p>The departments agree.</p>
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MANAGEMENT OVERSIGHT

There were weaknesses in management oversight that related to the Medicaid long term care program. These weaknesses included Overdue for Redetermination reports not being used effectively and supervisory review of caseworkers not performed at DHS. In addition, there were computer system oversight issues and policy coordination issues that are the shared responsibility of HFS and DHS.

Overdue for Redetermination Reports

A DHS management report that identifies cases that need redetermination has not been effectively used by management in local offices or by DHS central management. Utilizing a report like this could be a management control to assist in oversight of local field offices. Cases that are overdue for redetermination appear on this Overdue for Redetermination report. The report is sent from the central office to local offices each month. We identified cases that remained unresolved on the reports for local offices and a coding issue that made the reports less useful for central office management.

We reviewed an Overdue for Redetermination report from a field office. The report contained old cases for which eligibility had not been redetermined. Old cases included one dating back **four years** that remained overdue for redetermination as of September 2008. When we questioned field office staff, they did not provide an adequate reason why this case and other cases remained unresolved for long periods of time.

We then requested a subsequent Overdue for Redetermination report for this same field office. For the two different months reviewed (September and December), we found that nine old cases were repeated on the second report. This included the four year old case.

Because of the way cases were coded for identification on these standard reports it was not possible for central office management to know which cases were long term care. Based on information provided by a DHS official, different local offices used different codes to identify long term care cases. We requested and reviewed Overdue for

Redetermination reports for other field offices. We found that field offices used different identifiers for their caseloads and we could not identify which cases were overdue long term care cases on these reports. We asked DHS central office to identify the codes for long term care cases and they were not able to do so. DHS contacted each field office to be able to identify which codes indicated long term care cases which were overdue for redetermination. As illustrated in Exhibit 2-1, the long term care case identifiers vary significantly and it would be difficult for DHS to centrally monitor types of overdue cases under the current system.

Exhibit 2-1 OVERDUE FOR REDETERMINATION REPORTS LTC Case Identifier Examples	
<u>Field Office</u>	<u>LTC Identifiers</u>
#1	992, 993, 994, 995
#2	SL1, MU1, MU2
#3	006, NHC, NO6, LTC
#4	008
Source: DHS Information Summarized by OAG.	

Problems identified on management reports for local offices need to be resolved to make the reporting process meaningful. Reports for central management need to provide sufficient detail to allow management to know if there are problems for long term care redetermination cases or other specific types of cases.

Lack of Supervisory Review

Based on our interviews with field office staff, supervisors are not reviewing most DHS caseworker's eligibility determination results. This is true even though long term care eligibility determination can be a very complex process that is guided by layers of requirements including federal laws and rules, as well as State laws and administrative rules, and Departmental policies and procedures.

Long term care eligibility determinations are not routinely reviewed by a supervisor at the local offices. We met with staff at two smaller field offices where one caseworker in the office handles all long term care cases. Both of these caseworkers handle large caseloads with around 600 cases and there is no supervisory review of their work. We also met with staff at a larger field office. Similarly, caseworkers handled their own cases and there is no supervisory review of their work unless an appeal is filed for a case.

At the Medical Field Office in Cook County, an official explained that review is usually done with new hires or when there have been some identified proficiency problems. She said that due to the volume of work, there is no way to systematically have a supervisory review.

According to the Policy Manual, supervisory review and sign-off requirements are at the discretion of the Family Community Resource Center or field office. There is an applicable section on Form 552 (Authorization of Assistance Action), which is used to process information and update cases. This section allows the caseworker completing the action and the reviewer approving the action to enter their initials and date of approval. Of the 27 case files that we reviewed, none had documentation of a current supervisory review.

Supervisory review could help to identify and correct errors that are made in eligibility determination and entry of data. This could help to identify errors in determinations including entering the wrong group care credit or liability for a client's spouse.

HUMAN SERVICES MANAGEMENT OVERSIGHT	
RECOMMENDATION NUMBER 8	<i>The Department of Human Services should ensure that caseworkers are receiving proper guidance and supervisory review to carry out their required responsibilities. This should include developing and using applicable computerized management reports.</i>
HUMAN SERVICES RESPONSE	<p>Agree. DHS agrees to ensure casework staff receive proper training and guidance. Supervisory review is utilized for new staff, as well as staff that have exhibited performance deficiencies. Due to the increasingly large caseloads and limited number of supervisory personnel it is impossible to review every action taken by a caseworker on each case.</p> <p>Computerized management reports are necessary, and utilized by local, regional, and central office staff and management. Each Family Community Resource Center (FCRC) is sent a report, which lists the cases that are overdue for a redetermination. The report is separated by caseload, so each caseworker has a listing of his or her cases that require attention.</p> <p>Central and Regional office staff have the need for a larger picture view of overall redetermination currency. Several reports are available for their use. The Activity Reporting System reports give central office staff the ability to see the redetermination currency for different categories of cases, including long term care, for the State, a region, or a FCRC. In addition, reports can be run that allow central or regional staff to see this information at any given point in time.</p>

Computer Systems Management

Problems identified with data reliability are, at their roots, internal control problems over electronic data for HFS and DHS. These problems may be from weakness in management related to the utilization of various computer systems and caseworkers’ access to these systems. Long term care caseworkers use various computer programs to complete different steps in the initial and ongoing eligibility determination processes.

Through field office visits, we determined there are numerous computer programs used by LTC caseworkers. These caseworkers utilize different computer system programs to complete each of the following: initial intake process; case management; redeterminations; and verifications. In addition, it is not clear if or how these systems work together. For example, the Policy Manual states that a long term care address change is processed in one system, but it is not changed in another system unless a separate transaction is completed.

Furthermore, caseworkers use a Long Term Care Update Authorization form to input group care credit information into the Medicaid Management Information System (MMIS). They do this even though the group care credit amount is to be calculated and documented through the

systems discussed above (intake, case management, redeterminations, and verifications). According to officials in the Bureau of Long Term Care, MMIS is also the main system used by HFS. Although DHS caseworkers use the DHS intake and case management systems to calculate and input the group care credit, those systems do not automatically transfer the data to the HFS system; rather, it must be manually entered by the DHS caseworker.

As discussed in Chapter One, HFS and DHS have data reliability problems related to calculating and ensuring the correct group care credit amounts are being paid. Both Departments have their own databases containing group care credit amounts for clients served. We compared these two databases and determined that only 15 percent of the group care credit amounts matched. When we compared group care credit amounts from DHS and HFS electronic data, only one of the 23 community spouse cases that we reviewed had the same group care credit amounts documented in the case files as both sets of data and five cases had a different amount in each of the three different sources.

Policy Oversight

Two issues already discussed in this chapter point to a failure of management to control its processes related to Medicaid long term care. The issues are policies that are outdated or conflicting and policies that are unclear for workers to interpret and use. Both issues are indicators of management control weaknesses over the process.

FEDERAL DEFICIT REDUCTION ACT OF 2005

HFS has not implemented changes in the federal law that relate to Medicaid long term care services. The federal Deficit Reduction Act of 2005 made several changes related to eligibility determinations for Medicaid long term care clients. The law was signed in February 2006. The federal law made changes that make the look-back period for asset transfers longer; change when the penalty period is to be applied when a nonallowable asset transfer occurs; require that states use a provision called the income first rule; place a limit on the equity that an applicant can have in a home that is sheltered; and treat the purchase of annuities as an uncompensated and nonallowable transfer. These changes are discussed in more detail below. None of the required changes have been implemented by Illinois.

Look-Back Period

The federal law changed the look-back period for asset transfers from three years to five years. If an applicant transfers assets to someone but does not receive compensation or does not receive adequate compensation, they are to be penalized. Before the change in the law, an eligibility review would consider, or look back, for a period of three years for asset transfers. After the change, the look back covers a period of five years. The new five year period cannot go earlier than the date the new law was signed and effective.

Penalty Period

The federal law requires a change in when the penalty period is applied if there was a nonallowable asset transfer during the look-back period. If property has been transferred for less than it is worth, the applicant may be subject to a penalty period for nursing home services. The length of the penalty period is determined by dividing the dollar value of the nonallowable transfer by the monthly nursing home rate. If a \$10,000 uncompensated transfer was made and the monthly rate is \$5,000, there is a two month penalty period when the client would not be eligible for Medicaid assistance to pay for nursing home care.

Under the old law, and as Illinois applies it, the penalty period begins the month of the transfer. This means that in many cases the penalty period could be over before the client needs nursing home services. If the client is admitted to a nursing home six months after the nonallowable transfer and has a two month penalty, the penalty period would have elapsed before the client actually needs services.

Under the new law, the penalty period begins the month that the client is admitted to a nursing home and needs Medicaid assistance. If the client has no available assets to pay for the care during the penalty period, they may have to try to get the money from the recipient of the transfer, or other family members or friends. If the client had available assets, they would have to use the assets regardless of whether there was a penalty period or not. The new requirement pressures the recipient or family to pay even though it does not create a legal requirement to do so.

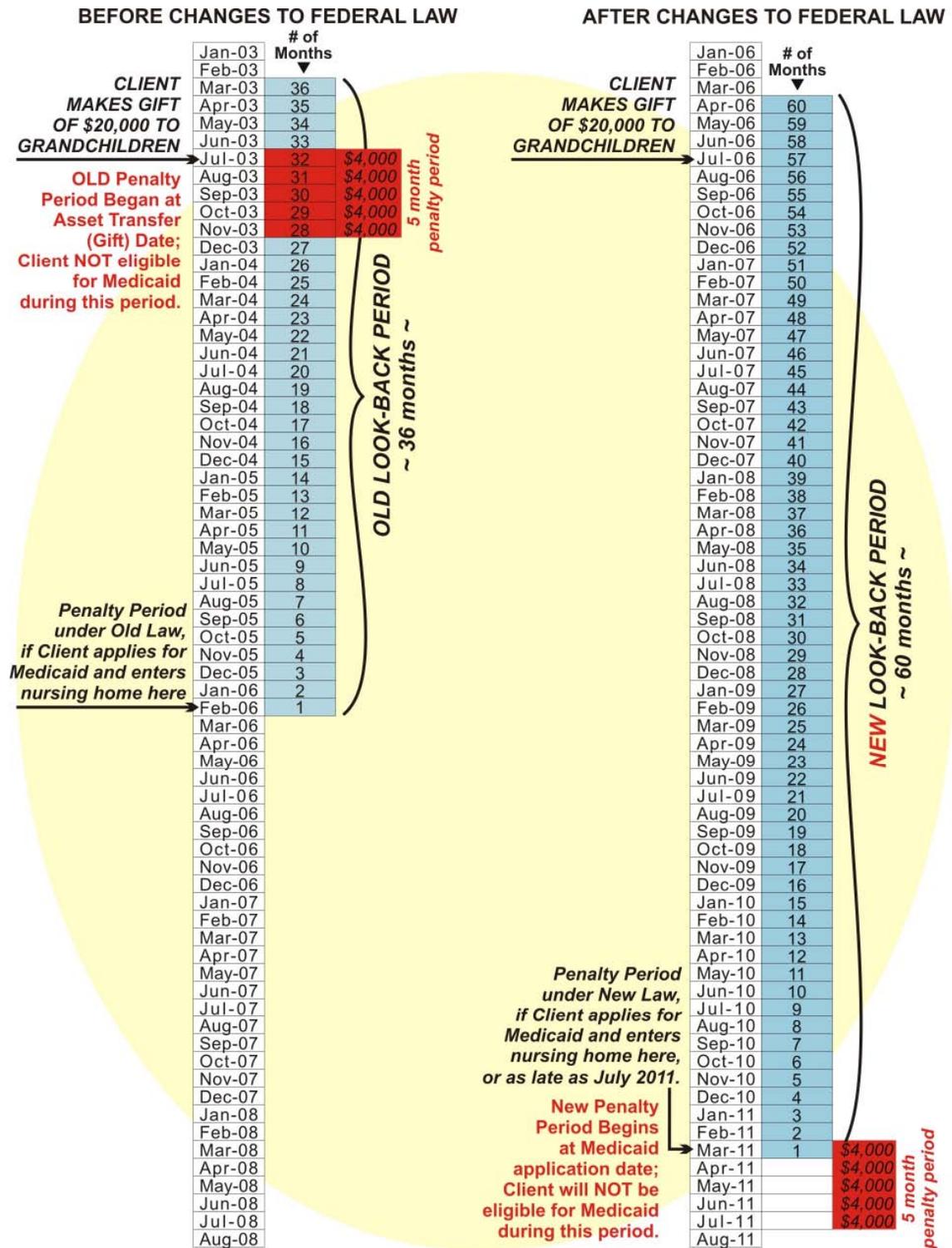
Case Example #3 - Old Law	Case Example #4 - New Law
<p><i>A client applies for Medicaid coverage of her long term nursing home care on February 1, 2006, and is otherwise qualified for coverage. The client discloses when she applies that she made \$20,000 in gifts, \$10,000 to each of two grandchildren, on July 1, 2003.</i></p> <p><i>The client's transfer was uncompensated and occurred during her 36-month look-back period. Thus, a penalty period calculation must be employed. Assume that the average monthly cost of nursing home care is \$4,000. Dividing the amount of the transfer by the average monthly cost of care results in 5 ($\\$20,000/\\$4,000 = 5$), which represents the number of months that the penalty period will last.</i></p> <p><i>Under the old law, the penalty period would begin on July 1, 2003 (the date of the transfer) and would run through November 2003 (five months). As a result, the client's penalty period would have already expired by the time she applied for Medicaid on February 1, 2006.</i></p>	<p><i>A client applies for Medicaid coverage of her long term nursing home care on March 1, 2011, and is otherwise qualified for coverage. The client discloses when she applies that she made \$20,000 in gifts, \$10,000 to each of two grandchildren, on July 1, 2006.</i></p> <p><i>The client's transfer was uncompensated and occurred during her 60-month look-back period. Thus, a penalty period calculation must be employed. Assume that the average monthly cost of nursing home care is \$4,000. Dividing the amount of the transfer by the average monthly cost of care results in 5 ($\\$20,000/\\$4,000 = 5$), which represents the number of months that the penalty period will last.</i></p> <p><i>Under the new law, the penalty period would begin on March 1, 2011 (the date of application) and would run through July 2011 (five months). As a result, the client would have to find some way to pay for those five months of care, possibly by recovering the money given to the grandchildren five years earlier.</i></p>

The combination changes to look-back and penalty periods could result in an asset transfer that was made up to five years earlier resulting in a penalty during which Medicaid assistance to pay for nursing home care would not be available. The preceding case examples show a nonallowable asset transfer and the result both before and after the change in federal law. Exhibit 2-2 also shows the same two examples graphically.

Income First Rule

Another change made by the federal Deficit Reduction Act requires states to implement a rule related to transferring income or assets to a community spouse to protect against spousal impoverishment. Before the Deficit Reduction Act, states had the option of using the income first method or the resource first method. After the Deficit Reduction Act, states are required to use the income first method. These rules come into play when a community spouse has less income than the maintenance needs allowance and the institutionalized spouse has resources (or assets) in excess of the resource transfer limit. The couple could appeal the resource transfer limits to raise the community spouse's income up to the maintenance needs allowance. The community spouse maintenance needs allowance is the amount that the spouse can receive to avoid spousal impoverishment. The 2008 maintenance needs allowance was \$2,610 per month.

**Exhibit 2-2
IMPACT OF CHANGES IN FEDERAL LAW RELATING TO LOOK-BACK AND PENALTY PERIODS FOR NURSING HOME ASSET TRANSFERS**



Source: Information from the Federal Deficit Reduction Act of 2005, summarized by OAG.

The **income first method** requires the couple to first transfer as much as possible of the institutionalized spouse’s income to the community spouse. After that transfer, if the community spouse’s income is not as high as the maintenance needs allowance, additional assets can be transferred to purchase an annuity that would increase the community spouse’s income up to the maintenance needs allowance. If the transfer of the institutionalized spouse’s income brings the community spouse’s income up to the maintenance needs allowance, no additional resource transfers would be allowed.

Income 1st	<i>First transfer institutionalized spouse’s income to the community spouse. If needed, additional assets may then be transferred to purchase an annuity to bring income up to the maintenance needs standard for the community spouse.</i>
Resource 1st	<i>First transfer institutionalized spouse’s resources or assets to purchase an annuity and increase the income up to the maintenance needs standard for the community spouse.</i>

Illinois has used the resource first method. Under the **resource first method** a couple would appeal to transfer additional assets (like money in a savings account) to purchase an annuity and increase the community spouse’s income up to the maintenance needs allowance. Under this method the additional resource transfer happens first, before considering income of the institutionalized spouse that could be transferred to the community spouse. After using the resource first method, if the institutionalized spouse has additional income, like Social Security, it could be used to pay for a portion of the care in the nursing home.

One negative impact of the income first method is if the institutionalized spouse dies before the community spouse, the community spouse is left with fewer assets to survive on. The spouse may also be left with less income because the surviving spouse could not receive Social Security for both members of the couple. Instead, they would receive the higher amount of the two, but the second income would be lost.

Other Changes

The federal law also requires that annuities purchased during the look-back period specify the state government as the primary beneficiary, after the community spouse’s death. So the annuity that could be purchased to raise the community spouse’s income and prevent spousal impoverishment would require the State to be the beneficiary when the community spouse dies.

The new law also places a cap on home equity on a home that is exempted from consideration as an asset in an initial eligibility determination. The limit on home equity would generally be \$500,000, but the state could elect to raise the amount to \$750,000.

Finally, the law changes two requirements that can be used by a client to avoid a penalty period, that should or could affect states:

1. States are barred from “rounding down” fractional periods of ineligibility when determining ineligibility periods resulting from asset transfers.
2. States are permitted to treat multiple transfers of assets as a single transfer and begin any penalty period on the earliest date that would apply to such transfers.

One case that we tested was referred to asset discovery because the client’s family had used the services of an attorney who advised them on financial planning. What happened in that example case was:

Case Example #5: The family gave a gift monthly of \$6,600 to the children. In the case, the parent had entered the nursing home as a private pay patient and was paying the monthly private rate of about \$3,600. When the asset discovery investigation was done, each of these multiple transfers was considered separately. So for a month the nonallowable payment was \$6,600 resulting in a penalty period of 1.8 months which was rounded down to 1. These transfers continued for over 6 months but were not combined as is allowed under the new law. In this case for example, a payment and a gift were made in March of 2007; the result was a one month penalty period for March of 2007. But the client was private pay and even though there were a number of one month penalty periods, it had no effect on the client’s eligibility.

Illinois’ Status

Illinois has not implemented provisions of the federal Deficit Reduction Act that deal with Medicaid nursing home care. HFS, in its 2008 Human Services Plan, notes that it has no plans to use the Deficit Reduction Act to reduce benefits or increase cost-sharing for any of its programs. However, it is noted that the Department is moving to implement the mandated provisions in a measured way. HFS officials reported to us that they are working to draft rules to implement the requirements of the Deficit Reduction Act.

IMPLEMENT THE FEDERAL DEFICIT REDUCTION ACT	
RECOMMENDATION NUMBER 9	<i>The Department of Healthcare and Family Services should implement the required provisions of the federal Deficit Reduction Act of 2005.</i>
HEALTHCARE AND FAMILY SERVICES RESPONSE	<p>Agree. HFS is drafting administrative rules to implement the DRA mandates.</p> <div style="border: 1px solid black; padding: 5px;"> <p>Auditor Comment #17 <i>The federal Deficit Reduction Act was passed in February 2006, and contains sweeping changes to the long term care program that will have a significant impact on clients and their community spouses. Three and a half years later, the Department states it is only now in the drafting stage of administrative rules to implement this federal mandate. The auditors do not find the Department’s actions to be timely.</i></p> </div>

Chapter Three

PROCESS FOR DETERMINATION AND REDETERMINATION

CHAPTER CONCLUSIONS

The responsibility for administering the long term care program is shared primarily by two agencies, the Departments of Healthcare and Family Services (HFS) and Human Services (DHS). DHS is responsible for eligibility determination for all Medicaid programs, including long term care. HFS pays for Medicaid long term care.

DHS is responsible for determining the initial eligibility of long term care applicants. DHS is also responsible for redetermination of clients' eligibility. The current Illinois Medicaid State Plan requires redetermination of eligibility for all recipients on an annual basis. This determination and redetermination process is handled by caseworkers at DHS' approximately 100 Family Community Resource Centers located throughout Illinois.

NURSING HOME INITIAL ELIGIBILITY DETERMINATION

Responsibility for administering the long term care program is shared by HFS and DHS. However, the federal Medicaid program requires that there be a single Medicaid agency designated for each state. In Illinois, HFS is the single state Medicaid agency. Because HFS is the single state Medicaid agency, it is crucial that these two agencies with major Medicaid responsibilities work together.

DHS is responsible for determining the initial eligibility of long term care applicants. This responsibility is handled by approximately 100 DHS Family Community Resource Centers located throughout Illinois, which are available to assist clients.

When a long term care client applies for medical assistance, caseworkers must verify specific asset amounts before the individual can be approved as eligible. According to the Policy Manual, the asset limit for long term care cases is \$2,000 for one person. Some assets are exempt from the asset limit, such as a home, motor vehicle, clothing, and household furnishings. Common nonexempt items include money in checking and savings accounts, stocks, bonds, and savings certificates. Nonexempt assets cannot exceed \$2,000 per person to be eligible for medical assistance. If the individual has more than \$2,000 in assets, they must first "spenddown" those assets before approval. Spenddown is discussed below.

The following example from the Policy Manual shows consideration of the assets of a client:

Case Example #6: Mr. J is a long term care applicant. He has a \$2,000 face value life insurance policy with a \$1,000 cash value. He has no other assets. The insurance policy does not affect Mr. Smith’s eligibility. The \$1,000 cash value life insurance is applied to his asset limit. Mr. J could have an additional \$1,000 in cash or other nonexempt assets and remain within the asset limit.

A client can enroll for medical assistance, but may not be eligible for payment of covered medical services until spenddown is met. Spenddown is the amount the client must spend (in assets), or verify in medical bills to get down to the \$2,000 limit.

For many individuals seeking medical assistance, the cost of private pay nursing homes exceeds their income in a short time. Clients can provide medical bills and/or receipts of payments for medical expenses that equal or exceed their spenddown amount.

Community Spouse Asset Allowance

If a long term care client has a spouse still living in the community, the client may utilize the Community Spouse Asset Allowance (CSAA). The CSAA is the amount of nonexempt **assets** that a client may transfer (without affecting eligibility) to their community spouse, or to another person for the sole benefit of the community spouse. The amount of the transfer is allowable and does not affect the client’s eligibility. The CSAA is the established maximum asset limit; for 2008 it was \$104,400. In addition to the CSAA amount, a client is allowed to transfer for the sole benefit of their spouse: personal effects, household goods, and one motor vehicle regardless of their dollar value.

Spenddown is the amount the client must spend (in assets or income), or verify in medical bills to begin eligibility for medical assistance.

Below are two examples from the Policy Manual regarding the Community Spouse Asset Allowance:

Case Example #7: Mr. G resides in a long term care facility. Mrs. G lives in their home in the community. Mr. G's assets are a \$35,000 certificate of deposit. Mrs. G's assets are a \$10,000 savings account. Since Mrs. G's assets are below the asset allowance standard of \$104,400, Mr. G can transfer his assets to her to bring her up to the CSAA. In this case, Mr. G can transfer all of his assets to Mrs. G without affecting eligibility. All of the couple's assets (\$35,000 + \$10,000 = \$45,000) are attributed to Mrs. G, so there are no available assets to affect Mr. G's eligibility. Mr. G must actually transfer the asset to Mrs. G.

Case Example #8: Using the same situation as above, Mr. G has an \$85,000 Certificate of Deposit. Mrs. G has a \$20,000 certificate. Subtracting Mrs. G's \$20,000 from the \$104,400 asset allowance standard leaves \$84,400. Mr. G can transfer \$84,400 of his \$85,000 certificate to Mrs. G without affecting his eligibility. If Mr. G makes the transfer, he will have \$600 in nonexempt assets that will need to be liquidated to pay for his care.

Consideration of Client Income

When a long term care client applies for medical assistance, caseworkers must also verify specific **income** amounts before the individual can be approved as eligible. Most long term care clients who are receiving medical assistance are over 65. For some, their only monthly income is Social Security. Others may also receive a monthly pension. This income is generally far less than the private pay cost at a nursing home. All income (excluding a \$30 per month personal needs allowance) is applied to nursing home costs unless a portion is diverted to a community spouse, which is discussed in the following section. Caseworkers must verify income at application, reapplication, redetermination, and whenever information indicates income has changed.

When countable monthly income plus excess assets are less than the HFS rate, Medicaid pays the difference. When countable monthly income and/or excess nonexempt assets are at least \$1 more than the cost of the long term care facility, the case is a spenddown case. Before medical assistance for the month can begin, medical expenses must equal the amount of the client's countable income and excess nonexempt assets. Persons whose countable monthly income and nonexempt assets are within the appropriate income and asset standards are eligible for medical assistance through Medicaid without having to meet a spenddown.

Spousal Impoverishment Protection

If a client has a spouse residing in the community, the spouse is covered by spousal impoverishment protection. The community spouse is allowed to retain enough of the couple's income to increase his or her income to the minimum maintenance needs standard and avoid impoverishment. Federal rules set a minimum and maximum standard and States can choose an amount between the two standards. For 2008, the maintenance needs standard (that may be diverted to a community spouse) was \$2,610 monthly in Illinois. As noted above, the institutionalized spouse may also transfer assets to a community spouse. For 2008, the spousal impoverishment asset allowance in Illinois was \$104,400. In June 2008, there were approximately 66,900 long term care cases in Illinois. Of those, DHS reported that approximately 3,552 (5 percent) had a community spouse. However, because of data issues, auditors are unsure whether the numbers or proportions of long term care and community spouse cases are accurate.

The client, spouse, or authorized representative completes a form at intake called the Request for Information – Assessment of Assets Form. This form asks the client and his or her spouse to provide information on assets. Caseworkers allow up to 14 calendar days from the date of request to get the information needed for the survey. Additional time is allowed if needed. Caseworkers complete the Assessment of Assets Form which indicates the total combined assets for the applicant and the spouse. This assessment of assets helps the couple plan for the use of their assets. A Determination of Asset Allowance Form is sent to the client, spouse, DHS, and Bureau of Collections identifying the amount of non-exempt assets that may be transferred to or for the full benefit of a spouse. Clients have 90 days to make the transfer and also have the right to appeal the decision.

Caseworkers confirmed the above process and noted that they are responsible for manually sending out these forms. None are mailed by the central office. One caseworker stated that many clients are overwhelmed with this process and caseworkers do their best to make it easier for them.

Group Care Credit – The focus of this audit is long term care clients who have a spouse living in the community. In these cases, the client can transfer monthly a portion of his or her income to the community spouse to provide spousal impoverishment protection. If that transfer results in income above the maintenance needs allowance, the community spouse may have to pay monthly a portion of the client's care. This is referred to as the group care credit. However, many cases have clients that do not have a living spouse. For these cases, all of the client's income, except a \$30 personal needs allowance, is paid for the client's care. This is also the group care credit and is paid by the client or the client's representative to the nursing home.

The case that prompted this audit involved a community spouse whose bill for the group care credit from the nursing home (for her husband) more than tripled from approximately \$60 to \$200 while her spouse's income had not changed significantly over the past two years. Based on our review of the case file, no group care credit should ever have been paid. The following example shows a scenario where no group care credit should be paid:

Case Example #9: At the time of application the institutionalized client's income was approximately \$1,000 per month, the community spouse's income was approximately \$500 a month. The institutionalized client diverted his income (minus \$30 personal needs allowance) to his community spouse. The institutionalized spouse could have diverted up to \$2,110 monthly to his community spouse. The maintenance needs standard (that may be diverted to a community spouse) was \$2,610 in 2008. However, since the institutionalized spouse's income was \$1,000 the first \$30 would be for the nursing home client's personal needs and the remaining \$970 could be diverted to the community spouse.

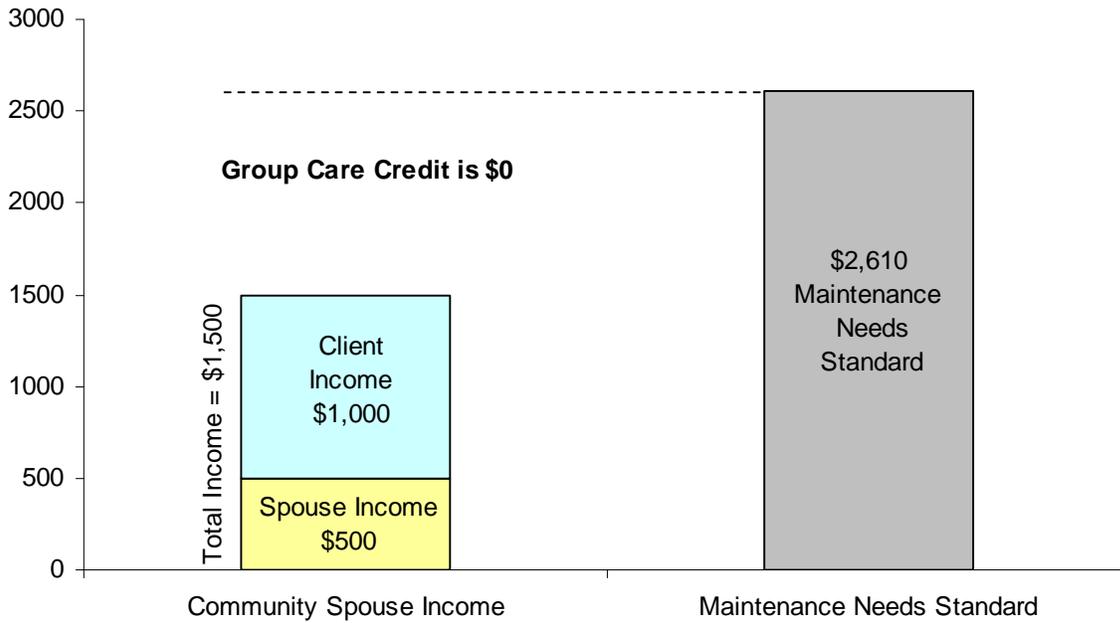
See Exhibit 3-1 for a summary of case example #9 and Exhibit 3-2 for graphic examples of cases with and without a group care credit.

Exhibit 3-1	
CASE EXAMPLE #9 - COMMUNITY SPOUSE MAINTENANCE NEEDS ALLOWANCE	
Maintenance Needs Standard	\$ 2,610
Spouse's Income from Social Security	- <u>\$ 500</u>
Community Spouse Maintenance Needs Allowance	= <u>\$2,110</u>
Client's Income from Social Security ((\$1,000 minus \$30 personal needs allowance)	\$970
Amount Available to Divert to Spouse	\$970
Group Care Credit Amount	\$-0-

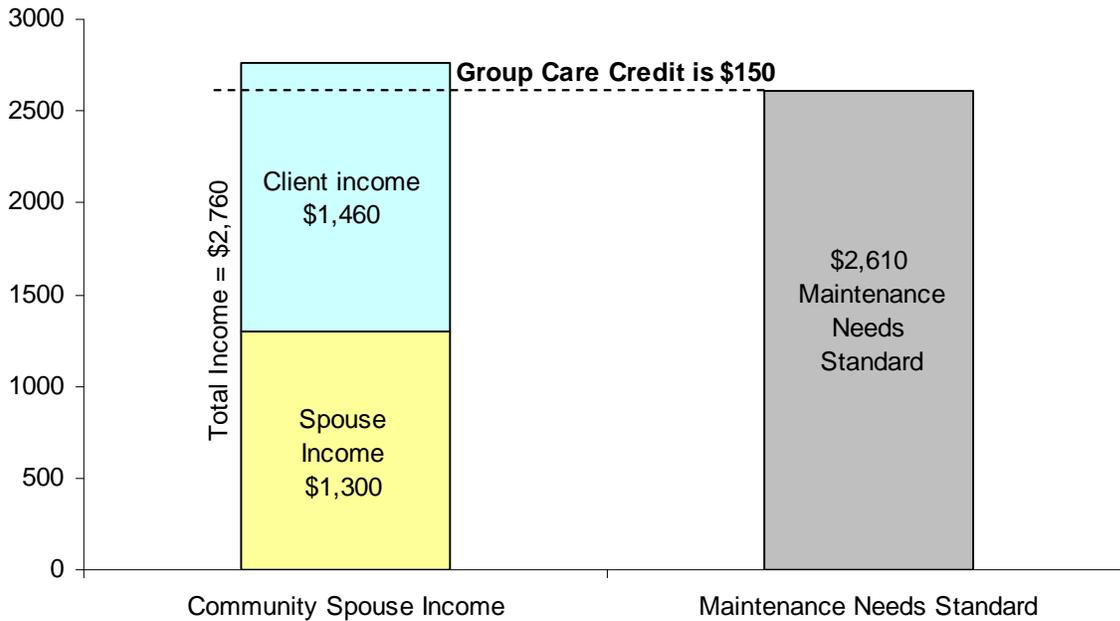
Source: OAG analysis of LTC maintenance needs allowance.

**Exhibit 3-2
COMMUNITY SPOUSE GROUP CARE CREDIT EXAMPLES
MONTHLY AMOUNTS**

Case with Income Diversion and No Group Care Credit (GCC):



Case with Income Diversion and a Group Care Credit (GCC):



Source: OAG summary example of Medicaid requirements.

Asset Discovery

All long term care applicants are required to complete an Additional Financial Information for LTC Applicants Form (Form 3654). According to a HFS/DHS Policy memo effective April 1, 2005, “At a minimum, Form 3654 must be signed...signing Form 3654 is a condition of eligibility.” This form was initially used for cases referred to the HFS Office of Inspector General (OIG) but is now required for all cases.

If any of the following criteria are met, the applicant is referred to the OIG for investigation:

- Applicant who does not have a community spouse and reports more than \$20,000 in assets at the time of application on a Mail-In Application for Medical Benefits; or
- Applicant who reports property transfers; or
- Applicant who has already transferred assets to a community spouse prior to application date; or
- Applicant who has consulted with a financial manager or planner; or
- Applicant who has not completed certain questions on the Additional Financial Information for LTC Applicants Form in regard to inheritance, jointly held assets, purchase of annuities, cashed in or closed assets, transferred or sold assets, and ownership of assets; or
- Any other reason the caseworker deems appropriate for an investigation.

In our review of case files, we noted that four cases from the same field office did not contain an Additional Financial Information for LTC Applicants Form. The caseworker at this field office thought this form was used for OIG referrals only. We reviewed two cases from other field offices that had been referred to the OIG for asset discovery investigations.

NURSING HOME ELIGIBILITY REDETERMINATION

DHS is required to determine client eligibility with criteria defined in the approved State Plan for the Medicaid program (42 USC 602(a)(1)(B)(iii), 42 CFR 431.10). The current Illinois State Plan requires redetermination of eligibility for all recipients on an annual basis. It is the Department of Human Service's responsibility to determine the continued eligibility of all recipients of medical assistance and it is the recipient's responsibility to cooperate in the redetermination of eligibility. A redetermination of eligibility is to be conducted at least every 12 months and at any time a recipient's circumstances that affect eligibility change.

Social Security Cost of Living Adjustments

In addition to the reconsideration of status that is required for cases on their annual redetermination anniversary, a partial reconsideration is also performed when a client's Social Security income is increased through a cost of living adjustment. Generally, these adjustments are done at the beginning of each calendar year. Most of these Social Security annual adjustments are calculated and applied by HFS centrally. However, for long term care cases that have a community spouse, these adjustments require special attention by the local caseworker. Because the increase could affect the portion of income diverted to a spouse and could affect the group care credit, these cases need to be **calculated manually** by the caseworker.

Case Example #10: In one case we reviewed the individual had been a client since 2005. The case included a community spouse and diversions of income were made to prevent spousal impoverishment. Annual Social Security adjustments would have been made and three annual redeterminations would have been required. The case file had none of the forms that indicate a redetermination had ever been performed and the group care credit amount had been wrong.

APPENDICES

APPENDIX A

House Resolution Number 1295



STATE OF ILLINOIS
NINETY-FIFTH GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

House Resolution No. 1295

Offered by Representative Lisa M. Dugan

WHEREAS, The Illinois Public Aid Code (305 ILCS 5/) sets out criteria, standards and procedures governing the Medical Assistance (Medicaid) Program that pays for the medical care for elderly and disabled persons whose needs may best be met by qualified long term care providers; and

WHEREAS, Eligibility for the Medical Assistance Program includes a determination of the financial resources available to the applicants to cover the cost of care, and a finding by the Department of Healthcare and Family Services together with the Department of Human Services regarding applicants' responsibility for payment for care; and

WHEREAS, The Medical Assistance Program pays for the care to the extent that an applicant's or recipient's financial resources are not sufficient to cover this cost; and

WHEREAS, There have been instances in which the Department of Healthcare and Family Services together with the Department of Human Services has committed errors in the eligibility determination process, including but limited to incorrect processing and evaluation of the applications and the financial information provided on behalf of the applicant or recipient, incorrect assessment of the applicant's or recipient's payment or spenddown responsibility, and failure to correct these errors on a timely basis; and

WHEREAS, Errors in the determinations of eligibility and the assessment of the financial resources of applicants or recipients who require long term care can incorrectly result in the qualification and disqualification of persons, or in excessive personal liability of the applicant or recipient; and

WHEREAS, It is critical that the eligibility determination process function effectively to ensure the proper expenditure of public funds, as well as coverage for those persons who are in need of and entitled to assistance; therefore, be it

RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE NINETY-FIFTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, that the Auditor General of the State of Illinois is directed to audit the Medical Assistance Program jointly administered by the Illinois Departments of Healthcare and Family Services and Human Services with respect to the accuracy and impact of eligibility determination standards and procedures regarding persons applying for or receiving assistance for long term care, with particular emphasis on the nature and scope of errors in the assessment of the financial resources and financial liability of the applicants and recipients; and be it further

RESOLVED, That the Department of Healthcare and Family Services, the Department of Human Services, and any other State agency, entity or person that may have information relevant to this audit cooperate fully and promptly with the Auditor General's Office in its conduct; and be it further

RESOLVED, That the Auditor General report the conclusions of this audit as soon as possible and make public the findings and recommendations upon completion in accordance with the provisions of Section 3-14 of the Illinois State Auditing Act; and be it further

RESOLVED, That copies of this resolution be delivered to the Auditor General, the Director of Healthcare and Family Services, and the Secretary of Human Services.

Adopted by the House of Representatives on May 28, 2008.

Michael J. Madigan

Michael J. Madigan, Speaker of the House

Mark Mahoney

Mark Mahoney, Clerk of the House

APPENDIX B

**Agency Notices on Social Security Cost of
Living Adjustments which are sent to
Long Term Care Clients with a
Community Spouse**

This is the first notice that is sent to long term care clients that have a spouse living in the community.





Notice to Long Term Care Residents Giving Income to Family

December 2008

This notice is for people who get Social Security benefits. If you do not get these benefits, this notice does not affect you.

If you get Social Security, you will get an increase starting in January 2009. Our files show that you are now giving some of your income to your spouse or children under age 21. You may be allowed to give the increase in your Social Security check to your spouse or children.

If you want us to decide if you can do that, contact your local Department of Human Services office. If you live in Chicago, contact Medical Field Operations at 312-793-8000.

If we decide you can give the extra amount to your spouse or children under age 21, they will start to get the increase depending on when you contacted us.

- If we hear from you by February 28, 2009, they can get the increase for January and February and the months following.
- If we hear from you on or after March 1, 2009, they will get the increase starting in the month you contact us.

If you do not contact us or if we decide you cannot give your increase to your spouse or children under age 21, you must use the extra amount of Social Security to help pay for the facility where you live.

If you do not understand this notice, please talk to your caseworker.

This notice applies only to Social Security. If you have changes in other income or your assets, you must tell your caseworker right away.

CN 08.28

This is the second notice that is sent to all long term care clients regardless of whether they have a spouse living in the community or not.





Department of Human Services



HUMAN DEPARTMENT OF
Healthcare and
Family Services

**Notice of Change in the
Amount Owed for Long Term Care**

DATE OF NOTICE

CAT. L.O. GRP. BASIC

LOCAL OFFICE / OFICINA

LOCAL

ADDRESS / DIRECCIÓN

*FECHA DEL AVISO

CAT. O.L. GRUPO BASICO

TO:

We have been told by the Social Security Administration that in January 2009 you will get \$ _____ in your Social Security check. This means that starting in January 2009 you have \$ _____ each month to pay the facility where you live. You must pay this money directly to the facility.

The amount you must pay is based on how much you get from Social Security. Healthcare and Family Services will pay for the rest of your care in the facility.

This change is separate from any other changes that may affect whether you can get medical benefits. If your income or assets change, you must tell your Department of Human Services Family Community Resource Center right away.

If you have questions about this notice, please call your caseworker. Family Community Resource Center telephone number: _____. For persons using a teletypewriter (TTY) call: _____.

CN 08.29

SEE OTHER SIDE FOR IMPORTANT INFORMATION

**Aviso Sobre Cambio En La
Cantidad Que Se Debe Por Cuidado de Largo Plazo**

La Administración del Seguro Social nos ha informado que en enero del 2009, usted recibirá \$ ____ en su cheque del seguro social. Esto significa que empezando en enero del 2009 tendrá \$ _____ cada mes para pagar a la institución donde usted vive. Usted debe pagar este dinero directamente a la institución.

La cantidad que debe pagar está basada en la cantidad que usted recibe del seguro social. Cuidado de Salud y Servicios Para Familias (Healthcare and Family Services) pagará el resto del costo de la institución.

Este cambio es separado de cualquier otro cambio que pueda afectar la asistencia médica que usted recibe. Si sus ingresos o bienes cambian, usted debe avisar a su Centro de Recursos Para Familias y Comunidad del Departamento de Servicios Humanos inmediatamente.

Si tiene alguna pregunta sobre este aviso, hable con su trabajador(a). El número de teléfono del Centro de Recursos Para Familias y Comunidad es: _____. Las personas que usan un teletipo (TTY), pueden llamar al: _____.

CN 08.29S

VEA AL REVERSO PARA INFORMACIÓN IMPORTANTE

This action will not be taken if you can show that it is wrong. You may meet with a representative from your Family Community Resource Center to question this action. This meeting would be informal and you may present information or evidence. The person or persons of your choice may represent you. Whether or not you have such a meeting you will still have the right to appeal the intended action.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

If you do not agree with our decision, you have the right to appeal and be given a fair hearing. You must file an appeal within 60 days following the Date of Notice on this form. You may represent yourself at this hearing or may be represented by anyone else, such as a lawyer, relative or friend. You can ask for an appeal fair hearing by calling 1-800-435-0774 (TTY: 1-800-734-7429) or by writing to the Illinois Department of Human Services, Bureau of Assistance Hearings, 401 South Clinton Street, 6th Floor, Chicago, IL 60607.

To apply for free legal help:

- In Cook County (including the City of Chicago) - Legal Assistance Foundation of Metropolitan Chicago: 312-341-1070
- In Will County - Will County Legal Assistance: 815-727-5123
- In other counties in Northern or Central Illinois with area codes (309), (630), (815) or (847) - Prairie State Legal Services: 800-531-7057 (toll free)
- In other counties in Central or Southern Illinois with area codes (217) or (618) - Land of Lincoln Legal assistance Foundation: 877-342-7891 (toll free)

No se tomará esta acción si usted puede demostrar que es errónea. Usted puede reunirse con un representante de su Centro de Recursos Para Familias y Comunidad (Family Community Resource Center) para cuestionar esta acción. Esta reunión será informal y podrá presentar información o evidencia. Puede ser representado por la(s) persona(s) que usted escoja. Aunque tenga o no tenga tal reunión, usted todavía tendrá el derecho de apelar la intentada acción.

USTED TIENE EL DERECHO DE APELAR ESTA DECISIÓN

Si no está de acuerdo con esta decisión, usted tiene el derecho de apelar y de que se le conceda una audiencia imparcial. Usted debe registrar la apelación dentro de 60 días de la "FECHA DEL AVISO" en este formulario. Usted puede representarse a sí mismo en esta audiencia o puede ser representado por cualquier otra persona tal como un abogado, pariente o amigo. Usted puede pedir una apelación y audiencia imparcial llamando gratis al 1-800-435-0774 (TTY: 1-800-734-7429) o escriba a Illinois Department of Human Services, Bureau of Assistance Hearings, 401 South Clinton Street, 6th Floor, Chicago, IL 60607.

Para solicitar asistencia legal gratis:

- En el condado de Cook (incluyendo la ciudad de Chicago) - Legal Assistance Foundation of Metropolitan Chicago: 312-341-1070
- En el condado de Will - Will County Legal Assistance: 815-727-5123
- En otras áreas del norte o centro de Illinois con códigos (309), (630), (815) o (847) - Prairie State Legal Services: 800-531-7057 (llamada gratis)
- En otros condados del centro y sur de Illinois con códigos (217) o (618) - Land of Lincoln Legal assistance Foundation: 877-342-7891 (llamada gratis)

APPENDIX C
Agency Responses

Auditor Comment #1 – Herein lies the problem as acknowledged by both agency directors: “The policies, procedures and systems reviewed are highly complex and confusing.”

As auditors, we are accustomed to dealing with complex and confusing processes. However, the real significance of, and difficulty with, this statement lies with the elderly and vulnerable population who ultimately must deal with these highly complex and confusing policies on a regular basis.



Barry S. Maram, Director

Pat Quinn, Governor

Carol L. Adams, Ph.D., Secretary

201 South Grand Avenue East
Springfield, Illinois 62763-0002

100 South Grand Avenue East
Springfield, Illinois 62762

August 21, 2009

Honorable William G. Holland
Auditor General
State of Illinois

Sir:

The Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) appreciate the work performed by the Illinois Office of the Auditor General auditors in conducting the "Long Term Care Performance Audit". The policies, procedures and systems reviewed are highly complex and confusing. This is especially true because two state agencies are accountable for conducting the program. The departments recognize that the audit team attempted to understand these complexities.

The departments agree with some of the auditors' recommendations and their report will assist us to better serve those clients for whom the state pays for long term care services and their spouses living in the community.

Attached to this letter are the detailed responses that address the recommendations.

Sincerely,

Barry S. Maram
Director

Carol L. Adams
Secretary

17
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Attachment Response Long Term Care Performance Audit

Below are our detailed responses to the audit recommendations. We found many conclusions in the report to be unfortunately misleading or inaccurate.

***Auditor Comment #2** - The auditors' conclusions are neither misleading nor inaccurate. We stand by the accuracy of our conclusions and have prepared detailed Auditor Comments addressing disagreements raised by the Departments in their response.*

Our primary concerns involve two fundamental issues that the audit team never fully recognized despite lengthy discussions with department staffs. First, per our policy, a nursing facility resident and his or her spouse bear principal responsibility for justifying the diversion of the resident's income to the community spouse rather than being used to offset what the state must pay for resident's long term care.

***Auditor Comment #3** - Auditors understand that the principal responsibility for diverting income rests with the client and/or community spouse. However, **the Departments also have the responsibility** to ensure that their processes related to spousal diversion of income are clear and not confusing, especially given the elderly and vulnerable population served by this program. The audit report documents that the communications sent to the client regarding the actions they need to take to divert annual social security increases to their community spouse are **contradictory and confusing**. The Departments agreed with the recommendation to review and clarify notices. The confusion and misunderstanding generated by these communications may well be a critical factor in the aging client population not requesting diversion of their income. Furthermore, in several cases reviewed in the audit, the client and/or nursing home **provided** the information needed to correct the group care credit, the caseworker **completed** the necessary paperwork to correct the group care credit, but the corrected group care credit **was not entered** into the MMIS system for an extended period of time. Auditors are simply recommending that the Departments carry out their responsibility to make the process less confusing and more timely for an elderly and vulnerable population.*

The second was a failure to fully recognize that the various data systems used by one or both of the agencies in conducting the long term care program may contain different data, especially at different points in time, yet still be entirely valid and sufficient to protect the integrity of the program.

***Auditor Comment #4** - The auditors agree that "lengthy discussions" were held with Department staff regarding data integrity issues. These "lengthy discussions" were necessary given:*

- 1) the significant differences in the number of long term care cases with a community spouse provided by DHS and HFS;*
- 2) the overwhelming differences in group care credits amounts provided for the same case by both Departments; and*
- 3) the Departments' unfamiliarity and misunderstandings as to how the DHS and HFS data systems interrelate.*

Data integrity issues identified in the audit are discussed in Auditor Comment #6.

As a result, many of the recommendations are flawed as they are based on invalid conclusions.

Auditor Comment #5 - The auditors' recommendations are not flawed. The recommendations are intended to make the process less "complex and confusing" for the elderly and vulnerable population served by this program. Auditor Comments have been prepared to address various assertions made by the Departments.

Recommendation Number 1 – Data Issues. The Departments of Healthcare and Family Services and Human Services should review the Medical Assistance Program computer systems, specifically for long term care cases with a community spouse, and ensure the systems are working together and serving their intended purpose. The Departments should take the necessary actions to assure that the data contained in those systems is consistent, reliable, and timely updated.

HFS and DHS Response:

Partially Agree. HFS and DHS agree that our data systems should be improved. Both departments are currently engaged in exhaustive planning efforts to replace our aging data systems with state of the art technology that can operate efficiently and eliminate the kinds of data confusion experienced by the audit team. Over the next several years, the departments will be seeking legislative support for substantial financial investment to implement these new and improved systems.

In the short term, the departments agree to consider whether aspects of the computer systems can and should be modified to enhance service to our long term care customers with community spouses. The departments also agree to review and clarify policy with an eye toward eliminating any requirement for updating irrelevant information.

Nonetheless, the audit has shown no evidence of a lack of data integrity in the existing systems. The auditors found differences in the agencies' data but those differences were not indications of errors. The differences in data resulted from the timing of the data reports and the purpose for which the data was used.

Auditor Comment #6 – The Departments are wrong in their assertion that there is no evidence of a lack of data integrity. The audit **documents numerous data issues** within the Departments' existing systems. In fact, during the course of the audit, **the Departments identified significant limitations with their own systems.** DHS and HFS officials noted in jointly provided written responses:

- "I believe we overemphasized the need to coordinate the timing of our data pulls **without fully taking into account the limitations** of the Medicaid Management Information System and the Client Information System **in presenting directly comparable documentation of patient care credit** [emphasis added];"
- "**DHS data may not be correct** because entry of patient credit data into the CIS system would be a duplication of effort for DHS staff [emphasis added];"
- "While some history is maintained, it is often overwritten when new information is used to update a client's status;" and
- We have recently discovered that the Data Warehouse [MMIS] maintains codes [spousal diversion case code] that may have been closed out by DHS. Department officials noted there were **581 HFS cases** that had that code.

Auditors also noted that:

- *There were corrections made to group care credits in hardcopy files that were not entered into the computerized MMIS system, thereby making the group care credit amounts in the MMIS system incorrect;*
- *In 2 of 23 cases reviewed by auditors, DHS data still showed the cases as active spousal diversion cases even though in one case the client had died, and in the other case, the community spouse had died;*
- *In 7 of 23 cases auditors examined, there were 14 instances where the group care credits were wrong for four months or more. In three of those cases, the group care credit amount was wrong for two years or more. These incorrect amounts were in the Departments' computerized systems; and*
- *For nursing home cases with a community spouse, the central adjustment to Social Security almost always results in the new group care credit being incorrect. These amounts are included in both DHS and HFS systems and are all issues of data integrity.*

All of these issues are specified and discussed in Chapter One of this report.

For example, HFS's Medicaid Management Information System (MMIS) is the only system used to document the amount of the group care credit. While policy states that DHS's Client Information System (CIS) is to be updated with the group care credit amount, the data reported in that system is used for informational purposes only, and has no impact on the patient's group care credit. The audit process included a comparison of the group care credit as held in MMIS in July 2008 to the group care credit held in CIS in December 2008. This comparison is flawed and led to the auditors' erroneous conclusion that the data held in each agency's system were negatively affecting our customers. The comparison is flawed because the data comes from two different time periods and is used for different purposes by the departments.

***Auditor Comment #7** - The auditors did not reach an "erroneous conclusion." The auditors spent a significant amount of time trying to understand why a case's group care credit in the DHS system would be **substantially different** than the group care credit in the HFS system. The reasons for the differences in the 23 cases reviewed are detailed graphically and accurately in Exhibit 1-2.*

*The Departments are wrong to assert that the data in their systems does not negatively affect their customers. When group care credit amounts are corrected by caseworkers but not corrected in the computer systems, clients are impacted. Furthermore, when their elderly and vulnerable clients **receive a notice telling them to pay an incorrect amount** – an amount that is contained in DHS/HFS data systems – directly to the nursing facility, their clients **are negatively affected**.*

Recommendation Number 2 – Group Care Credit Issues. The Departments of Healthcare and Family Services and Human Services should work together to undertake a review of cases with group care credits to verify that the amounts are accurate. Furthermore, the Departments should take the steps necessary to ensure that group care credits revised as a result of the redetermination process are timely entered into the MMIS system and other systems.

HFS and DHS Response:

Partially Agree. The departments agree that a review of cases with group care credits would be a constructive task, however, we disagree with some of the audits conclusions.

We agree that, in some instances, caseworker entry of updates into MMIS may not be timely but the timeliness is not always under state control. While some lateness may result from extremely large caseloads, timeliness is also affected by the lack of response from clients and their families, as well as the long term care facilities; and difficulties in obtaining information from spouses who are not our clients. The departments agree to explore efficient ways of performing a review of cases with group care credits to verify accuracy. In addition, we agree to explore enhancements to our procedures to ensure that the information gathered as part of redeterminations are used in timely calculations of the group care credits of long term care customers with community spouses.

However, the departments disagree with the conclusion that the auditors identified significant and pervasive problems in the processes and data used by the two departments, which resulted in clients being overcharged for their care. The report alleges that in seven cases, there were instances in which the client or clients spouse was inconvenienced by an overcharge for their care, during the time that the Social Security Cost of Living Adjustment (COLA) resulted in a positive group care credit for the client. For six of the seven cases cited, that audit presents no evidence of any client or spouse incurring the hardship of paying the alleged overcharge amount. In contrast to the audit report, the alleged overcharge amount was never collected from the client or spouse in those six cases.

***Auditor Comment #8** - When 7 of 23 (30%) cases have incorrect group care credit amounts that were not corrected for 4 months or longer, there are significant and pervasive problems in the processes used by the Departments. Contrary to the Departments' assertions, the audit report **does not** conclude that the clients were overpaying for their care based on incorrect group care credit amounts. As reported in the audit, the Departments **could not provide documentation** to show how much the client was actually paying the long term care facility. Consequently, the auditors had to rely on the group care credit amounts shown in HFS' MMIS system as the amount the client was required to contribute to his or her care.*

*While the Departments assert that they contacted the nursing homes and determined that in 6 of 7 cases the clients did not overpay for their care, **no documentation of such inquiries** was shared with auditors. Also, this contact with nursing homes did not occur until **after** the auditors brought these cases to the Departments' attention. There are likely many other similar cases where elderly and vulnerable clients may have been overcharged for their care which have not been followed up by the Departments. However, the Departments have maintained that it is not their responsibility to determine whether its clients are being overcharged, and as noted in the Departments' response to Recommendation Number 6, "it is not a DHS role to oversee repayments."*

There are specific case citations in the report that require annotation:

- In the two cases described on page 17 (also described on page 2 and 3), there were no inaccurate group care credit payments made to the facility by the client or spouse. This has been confirmed by the facilities.
- In the third dot point on page 18, the \$329 was a typo in the submitted timelines, and should be removed from the report. The client's group care credit has been \$0 since his admission in 2007.

***Auditor Comment #9** - The Departments' error has been noted in the audit report.*

Recommendation Number 3 – Cost of Living Notifications:

The Departments of Healthcare and Family Services and Human Services should revise and clarify Social Security cost of living notifications sent to clients with community spouses. Notices should tell clients what they should do and not tell them to pay amounts they do not owe.

HFS and DHS Response:

Agree. The departments agree to review the Social Security cost of living adjustment notifications and clarify them as needed. Most long term care residents receive only one notice. Two notices have been used in the case of a resident with a community spouse to ensure that each long-term care client is aware of the financial impact of the Social Security increase on their respective case.

Although there is no erroneous information contained in the notices, the departments agree that we may be able to revise them to clarify the action that must be taken if the resident spouse is eligible to and wishes to divert all or a portion of the Social Security increase to their spouse in the community.

Auditor Comment #10 – *Contrary to the Departments’ assertion, there is erroneous information in the notices. The statement in the second notice which, when referring to the Social Security cost of living increase, states “You must pay this money directly to the facility” is erroneous information when an assessment of the liability of a client with a community spouse has not been made.*

Recommendation Number 4 – Central Cost of Living Adjustment. The Departments of Healthcare and Family Services and Human Services should stop centrally adjusting the group care credit amount for clients who are diverting income to a community spouse. Instead, caseworkers should adjust the group care credit manually based on current information.

HFS and DHS Response:

Disagree. The departments agree to work together to review and make any appropriate changes to the centrally budgeted group care process for clients with community spouses.

The departments, however, cannot agree to cease centrally adjusting increases in Social Security income received by the resident of a long term care facility. HFS’ as Illinois’ single state Medicaid agency, must establish policy that comports with federal requirements. On the other hand in the face of extremely limited resources, DHS must seek to use the most efficient means to fulfill its responsibility for processing the eligibility determinations.

Auditor Comment #11 - *Departments’ policies already exempt certain cases from central budgeting of the Social Security cost of living increase. One of the 23 cases auditors reviewed was not centrally budgeted. Because all long term care cases with community spouses need to be manually reviewed and adjusted by a caseworker anyway, centrally adjusting them to a wrong amount which the caseworker then has to manually correct does not appear to be an “efficient means” as stated by the Departments in their response.*

Medicaid eligibility is dependent on income and allowable diversions of that income. The state must presume that a resident's income will be used to offset the cost of the resident's long term care *unless* evidence is presented by the resident, spouse or other authorized party that the couple's total current income makes them eligible for diversion of income from the resident to the community spouse.

The actual central updating of the increase in the clients Social Security benefit and the possible diversion of that income to a spouse are two independent actions. The central budgeting of the SSA COLA is not incorrect, as DHS receives the increase in income data directly from the Social Security Administration.

The state may not allow the increase in the client's income to be diverted to the spouse without additional information. The departments must depend on the client, the client's spouse, or the nursing home facility acting on behalf of the client to provide income verification from several different sources, such as the spouse's SSA amount, private pensions, earned income, other government benefits, investment income, and any other source that may be used in the determination of the eligibility for the diversion.

Automatically allowing diversion of Social Security COLA increases to the community spouse without determining and documenting whether that individual's total income has changed would not assure that the diversion was allowable. Establishing policy that ignores the increase would jeopardize federal Medicaid matching dollars.

***Auditor Comment #12** - Auditors concur that federal Medicaid match should not be jeopardized. However, based on documentation provided by the Departments, federal regulations require the State must reduce its payment to a nursing home by the amount that remains **after** deducting the amount for the maintenance needs of a community spouse. The **correct** maintenance needs of the community spouse is determined **after** the caseworker conducts a review of information submitted by the client or the community spouse. Removing long term care cases with a community spouse from the central budgeting process could help to relieve the confusion and stress for this elderly and vulnerable population when they receive an erroneous joint Departmental notice telling them to pay an incorrect amount to the nursing facility.*

Recommendation Number 5 – Documenting Client's Response of Failure to Respond.

The Department of Human Services should take the necessary steps to ensure that the client's response or failure of response is recorded in the case notes, which would result in more complete documentation of actions taken regarding the client's group care credit.

HFS and DHS Response:

Disagree. Both departments take the position that it would be impractical to document lack of response to notices. Requiring staff to document lack of response in all cases would be an inefficient use of time, and given current staffing levels, would create further delay in eligibility processing and proper benefit calculations.

***Auditor Comment #13** - The audit report states that "Documentation of client contacts or client's failure to contact DHS was not included in documentation for any of the cases auditors reviewed." The Departments stress the critical importance of receiving financial information from the client or*

community spouse in determining the proper group care credit amount. Given the importance of this interaction, or attempted interaction, it would be reasonable and logical to expect that such interactions be documented so that agency management and third parties would have assurance that appropriate steps were taken to obtain this critical information from the aging clients or community spouses.

Recommendation Number 6 – Controls on Client Liability. The Departments of Healthcare and Family Services and Human Services should implement a control to ensure that any overpayments made by a client as a result of the Departments’ eligibility determination process are repaid to the client by the long term care facility.

HFS and DHS Response:

Partially agree. The departments agree to work toward eliminating situations in which long term care customers may be notified to make a payment to the facility that could result in an overpayment.

The audit report states that DHS or HFS had no documentation that would allow the auditors to determine if any of the overpayments made by the client to the facilities were repaid to the client and/or community spouse. The report erroneously assumes that the clients or community spouses made the overpayments, and contrary to the report, DHS has confirmed that in six of the seven cases cited in the audit, there were no overpayments made by clients to their respective facilities. Additionally, it is not a DHS role to oversee repayments. This is a nursing home accounting function. Any alternative that requires state oversight will require additional funding.

***Auditor Comment #14 -** The audit report does not “erroneously assume” that in all cases where there was an incorrect group care credit for an extended period of time, that the client “overpaid” for their care. To the contrary, the report goes on to great length to disclose that the Departments did not have this information, so auditors could not determine how much, if any, the clients overpaid for their care. While the Departments assert that they contacted the nursing homes and determined that in 6 of 7 cases, the clients did not overpay for their care, no documentation of such inquiries was shared with auditors. Also, this contact with nursing homes did not occur until **after** the auditors brought these cases to the Departments’ attention. There are likely many other similar cases where elderly and vulnerable clients may have been overcharged for their care which have not been followed up by the Departments. However, as noted in the Departments’ response below to this Recommendation, “it is not a DHS role to oversee repayments.”*

Finally, if payments made by the State to long term care facilities are reduced for a long period of time because an amount has been erroneously charged to the client (for instance in case 16 profiled in Exhibit 1-3, payments by the State to the nursing facility were reduced by \$9,204 over two years to offset amounts that were to have been paid by the client), it would be logical to assume those nursing homes attempted to collect, or did in fact collect, that money from the client and/or the community spouse rather than simply be out that amount.

Recommendation Number 7 – Policy Issues. The Departments of Healthcare and Family Services and Human Services should work together to clarify policies. In particular, attention should be given to:

- Assuring that using the Mail-In Application for Medical Benefits Form allows clients to get the assistance they need in applying for benefits;

- Conducting Annual Facility Visits as is required by established policy;
- Clarifying Responsible Relative Policy, so that only applicable long term care clients' spouses are referred for appropriate collection; and
- Ensuring that Outdated Forms are not referenced in policy manuals or used by caseworkers.

The Departments should also assure the established policies are followed by the local offices.

HFS and DHS Response:

Partially agree. The audit has not presented evidence of overall lack of clarity in policy. HFS and DHS will review the specific concerns raised as explained below. Some of the instances require annotations in the final report.

- **Assuring that the Mail In Application for Medical Benefits Form allows clients to get the assistance they need in applying for benefits.**

It is DHS policy to help applicants with the application process, as needed, including providing options on how the application can be submitted. DHS accepts walk-in applications, mail-ins and applications via the Internet. Applicants are able to obtain the assistance needed in order to apply for benefits.

The audit presented no evidence of a family or client not being able to obtain the assistance necessary to complete the application process.

***Auditor Comment #15** – Given the complex nature of the application process and the vulnerable population served by this program, the auditors stand by their recommendation that the policy on mail-in applications should be clarified. In two large DHS field offices we were told that long term care applications were done through a mail-in only process. The long term care application process is very complex. Completing a mail-in application is very difficult. Clarifying Department policy to local office officials, to help assure that applicants get the assistance they need from the Departments, is reasonable.*

- **Conducting Annual Site Visits as is required by established policy.**

DHS staff in Cook County conduct site visits as required. In other Regions with larger geographical areas and limited resources, staff complete this process by other means, including telephone and mail. As a result, HFS and DHS will review this policy and revise it as needed.

- **Clarifying Responsible Relative Policy, so that only applicable long term care cases are referred for appropriate collections.**

The Responsible Relative Policy contained in PM 09-02-04-b is clear and adequately identifies when to and when not to refer cases to the Bureau of Collections. The audit report infers that most referrals to the Bureau of Collections are invalid. The departments disagree with this statement. A referral that does not result in a responsible relative paying for a client's care does not equate to an invalid referral. In addition, to preserve and maximize the

State's revenues, it is good business practice to refer cases to the Bureau of Collections for a determination of financial responsibility. That is the only way to protect against inappropriate shifting of financial responsibility from a responsible relative to the taxpayers.

Auditor Comment #16 - *The auditors' conclusion that the responsible relative policy either needs to be clarified or more effectively communicated to caseworkers is based largely on input provided by HFS' own Bureau of Collections personnel. Collections personnel reported to auditors that of approximately 60 spousal cases referred each month, only approximately 20 cases **should have been referred**. As such, auditors concluded that if two-thirds of the cases being referred to Collections should not have been referred, there is either a problem with the Departments' policies or there is a problem with the Departments' implementation of such policies.*

- **Ensuring that outdated forms are not referenced in policy manuals or used by caseworkers.**

The Departments note that the audit did not find that any of the forms used resulted in an error or incorrect calculation of a benefit. HFS agrees to review forms to eliminate outdated forms in the Policy Manual and DHS agrees to work to assure that caseworkers do not use outdated forms.

- **Ensuring the established policies are followed by local offices.**

The departments agree.

Recommendation Number 8 – Human Services Management Oversight. The Department of Human Services should ensure that caseworkers are receiving proper guidance and supervisory review to carry out their required responsibilities. This should include developing and using applicable computerized management reports.

DHS Response:

Agree. DHS agrees to ensure casework staff receive proper training and guidance. Supervisory review is utilized for new staff, as well as staff that have exhibited performance deficiencies. Due to the increasingly large caseloads and limited number of supervisory personnel it is impossible to review every action taken by a caseworker on each case.

Computerized management reports are necessary, and utilized by local, regional, and central office staff and management. Each Family Community Resource Center (FCRC) is sent a report, which lists the cases that are overdue for a redetermination. The report is separated by caseload, so each caseworker has a listing of his or her cases that require attention.

Central and Regional office staff have the need for a larger picture view of overall redetermination currency. Several reports are available for their use. The Activity Reporting System reports give central office staff the ability to see the redetermination currency for different categories of cases, including long term care, for the State, a region, or a FCRC. In addition, reports can be run that allow central or regional staff to see this information at any given point in time.

Recommendation Number 9 – Implement the Federal Deficit Reduction Act. The Department of Healthcare and Family Services should implement the required provisions of the federal Deficit Reduction Act of 2005.

HFS Response:

Agree. HFS is drafting administrative rules to implement the DRA mandates.

Auditor Comment #17 - The federal Deficit Reduction Act was passed in February 2006, and contains sweeping changes to the long term care program that will have a significant impact on clients and their community spouses. Three and a half years later, the Department states it is only now in the drafting stage of administrative rules to implement this federal mandate. The auditors do not find the Department's actions to be timely.

