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Office of the Auditor General

Performance Audit of

Medicaid Eligibility Determinations for Long-Term Care

July 16, 2025

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Auditor General

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OFFICE OF THE AUDITOR GENERAL
FRANK J. MAUTINO

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 Medicaid eligibility determinations for long-term care.

The audit was conducted pursuant to the Illinois Public Aid Code at 305 ILCS 5/11-5.4 (enacted by Public Act 100-380 and amended by Public Act 100-665). 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.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

Springfield, Illinois
July 2025

OFFICE OF THE AUDITOR GENERAL

July 16, 2025
Performance Audit
Report Highlights

Frank J. Mautino *Auditor General*
www.auditor.illinois.gov

Performance Audit of

Medicaid Eligibility Determinations for Long-Term Care

Background:

On August 25, 2017, the Governor signed into law Public Act 100-380 which amended the Illinois Public Aid Code.

This amendment to the Illinois Public Aid Code requires that beginning July 1, 2017, the Auditor General is to report every three years to the General Assembly on the performance and compliance of the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), and the Department on Aging (DoA) in meeting the requirements placed upon them by Section 11-5.4 of the Illinois Public Aid Code and federal requirements concerning eligibility determinations for Medicaid long-term care services and supports (see **Appendix A**).

This is the third audit (CY21-CY23) on their performance and compliance related to Medicaid eligibility determinations for long-term care. The first audit (CY15-CY17) was released in March 2019 and contained eight recommendations. The second audit (CY18-CY20) was released in September 2022 and contained five recommendations.

Key Findings:

- During this audit, issues related to the Integrated Eligibility System (IES) continued to be identified. These issues surrounded the system's internal controls as well as the completeness of the data provided. Due to these issues, we determined reviewing the entire population of the applications data would not provide accurate results for the purposes of this audit and instead performed sample testing.

- For the 50 applications tested, we found that 11 applications (**22%**) were pending past the required number of days. On average, it took **41 days** from receipt of application to decision. Three different reports produced by HFS (backlog reports, monthly reports, and weekly reports) all indicated applicants were not receiving their determinations of eligibility in a timely manner, particularly after the end of the Public Health Emergency. Consequently, the status of the prior recommendation on the timeliness of eligibility determinations was determined to be **partially implemented**.

- DHS and HFS noted that an IES system enhancement was established to address the processing delays related to OIG asset investigations. However, applications involving HFS OIG asset discovery investigations continued to be overdue during this audit period. The prior audit found that all 16 applications involving asset discovery investigations were not completed in a timely manner. For this audit, we tested 17 cases referred to the HFS OIG in calendar year 2023 to follow up on this recommendation. During this testing, we found that 8 of the 17 applications were not completed in a timely manner, ranging from **14 to 156 days overdue**.

- In addition, multiple issues were identified for these HFS OIG cases during our review. These issues included incorrect information in IES and a lack of controls in IES. As a result, the status of the recommendation on processing delays related to HFS OIG asset discovery investigations was determined to be **partially implemented**.

- Although HFS noted that a system enhancement was implemented in IES to address the prior audit recommendation regarding extension tracking, the testing results showed the enhancement was not fully effective. For the 10 extension cases reviewed, 5 applications (**50%**) had issues with inaccurate IES data, including granting one 60-day extension. While there continued to be cases with inaccurate IES data, there was improvement over the prior audit. Also, we found no examples of more than two extensions or extensions that were not in IES. As a result, the status of the recommendation on extension tracking was determined to be **partially implemented**.

- HFS is not posting the LTC reports on a monthly basis as required by the Illinois Public Aid Code. HFS completed reports for **28 of the 36 months (78%)** during the audit period. We also requested documentation to support the posting of the monthly reports completed during calendar years 2021 to 2023. HFS was only able to provide documentation for **5 of the 28 (18%)** reports.

- The prior audit found the LTC monthly reports did not contain all elements as required by statute. We reviewed the LTC monthly reports for calendar years 2021 to 2023 and found some required elements were still not included. As a result, the status of this recommendation on the LTC monthly report completeness was determined to be **partially implemented**.
- During the prior audit, we found the LTC monthly reports were not accurate due to duplicate entries and other issues with the source data. During this audit, we reviewed the monthly reports for calendar years 2021 to 2023 and found similar issues with accuracy that were identified during the prior audit. We also found 19 of 50 applicants tested (**38%**) had a reported disability, which would allow 60 days for processing those applications.
- We requested LTC data on the total number of redeterminations completed during the audit and found the redeterminations data in the monthly reports did not have any issues with the totals matching. The only remaining issue involved multiple entries, and no reports after February 2023 contained multiple entries. Therefore, the status of the recommendation on the LTC monthly report accuracy was determined to be **partially implemented**.
- Public Act 100-380 requested the Auditor General to review and evaluate the efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of DHS for LTC services. During this audit period, DHS moved away from the task-based system to a new facility-based system. During the current audit period, the IES reports used to identify work were designed to identify tasks. However, work is assigned to teams based on facilities rather than tasks. After the end of the audit period DHS began re-assessing the reports. Since the reports were not re-designed until after the end of the current audit period, we could not fully assess the efficacy and efficiency of the facility-based approach. Therefore, additional follow-up will need to be conducted during the next audit period.

Key Recommendations:

The audit report contains six recommendations directed to HFS and DHS, including:

- HFS, including the HFS OIG, and DHS should work together to implement controls to improve the timeliness of long-term care eligibility determinations to comply with timelines contained in federal regulations and the Illinois Administrative Code.
- HFS, including the HFS OIG, and DHS should, in order to decrease the opportunity for application processing delays, work together to implement changes to improve the process of: referring applications to the HFS OIG to ensure referrals are received by the HFS OIG, and receiving and acting upon recommendations from the HFS OIG upon completion of its asset investigations.
- HFS, including the HFS OIG, and DHS should ensure extensions are tracked so processing times can be tolled, as required by the Illinois Public Aid Code, for extension days granted. Specifically, the agencies should ensure: extensions are captured in a usable manner; extensions are captured accurately; and the length of extensions granted by IES are in accordance with statute.
- HFS and DHS should complete the monthly reports and post the reports to each Department's website as required by the Illinois Public Aid Code.
- HFS and DHS should ensure monthly reports contain all elements required by the Illinois Public Aid Code.
- HFS and DHS should develop controls to ensure monthly reports required by the Illinois Public Aid Code are accurate.

This performance audit was conducted by the staff of the Office of the Auditor General. HFS and DHS agreed with the recommendations.

Report Digest

On August 25, 2017, the Governor signed into law Public Act 100-380, which amended the Illinois Public Aid Code. This amendment to the Illinois Public Aid Code requires that beginning July 1, 2017, the Auditor General is to report every three years to the General Assembly on the performance and compliance of the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), and the Department on Aging (DoA) in meeting the requirements placed upon them by Section 11-5.4 of the Illinois Public Aid Code and federal requirements concerning eligibility determinations for Medicaid long-term care services and supports (**see Appendix A**). This is the third audit (CY21-CY23) of their performance and compliance. Our assessment of the audit determinations is shown below in **Digest Exhibit 1**. (pages 1-2)

Digest Exhibit 1
ASSESSMENT OF AUDIT DETERMINATIONS

Audit Determination	Auditor Assessment
Compliance with federal regulations on furnishing services as related to Medicaid long-term care services and supports as provided under 42 CFR 435.930. *Compliance with federal regulations on the timely determination of eligibility as provided under 42 CFR 435.912.*	• We determined calculating timeliness using the data provided would not provide accurate results. Therefore, a sample of 50 was selected. Eleven applications (22%) were pending past the required number of days. On average, it took 41 days from receipt of application to decision for the 50 applications. All three reports prepared by HFS indicated applicants were not receiving their determinations of eligibility in a timely manner, particularly after the end of the Public Health Emergency. (pages 19-26)
The accuracy and completeness of the report required under paragraph (9) of subsection (e).	• HFS completed reports for 28 of the 36 months (78%) during the audit period. Although HFS was providing most of the required elements in the LTC monthly reports, there were still some remaining issues with the completeness of the reports. The reports have an inaccurate representation of the number of potential overdue applications, and the data used to create the redeterminations table contained duplicate entries. We were unable to determine the accuracy of the data in the reports due to numbers not matching. (pages 35-44)
The efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of the Department of Human Services for long-term care services, including the role of the State's integrated eligibility system, as opposed to the traditional caseworker-specific process from which these central offices have converted.	• DHS gradually transitioned from the task-based approach to the facility-based approach during the audit period, starting in February 2021 and ending by October 2021. The IES reports used to identify work had to be re-assessed in order to assign work based on facilities versus tasks and that was completed after the end of the audit period. (pages 45-47)

Digest Exhibit 1
ASSESSMENT OF AUDIT DETERMINATIONS

Audit Determination	Auditor Assessment
Any issues affecting eligibility determinations related to the Department of Human Services' staff completing Medicaid eligibility determinations instead of the designated single-state Medicaid agency in Illinois, the Department of Healthcare and Family Services.	• No apparent issues affecting eligibility determinations were identified related to DHS staff completing these determinations instead of HFS, the single State Medicaid agency. (pages 17-18)

Source: OAG assessment of the audit determinations contained in Public Act 100-380.

Background

The U.S. Department of Health and Human Services defines long-term care services as services that include medical and non-medical care for people with a chronic illness or disability. Long-term care helps individuals meet health and personal needs. Long-term care can be provided at home, in the community, or in a facility. For purposes of Medicaid eligibility and payment, long-term care services are those provided to an individual who requires a level of care equivalent to that received in a nursing facility.

In order for Medicaid to pay for long-term care services, an applicant must meet general Medicaid eligibility requirements as well as financial and functional eligibility criteria. Eligibility requirements are established by federal regulations and state law.

- **Financial eligibility** requires an assessment of a person's available **income** and **assets**.
- **Functional eligibility** is defined as an assessment of a **person's care needs**, which may include a person's ability to perform activities of daily living (bathing, dressing, using the toilet, eating, etc.) or the need for skilled care.

If either financial or functional eligibility requirements are not met, Medicaid will not pay for long-term care services. However, over time, individuals may deplete their resources or income and become financially eligible, or their functioning may deteriorate to the point where they do meet functional eligibility criteria. (page 3)

Agencies Involved with LTC Eligibility Determinations

There are three State agencies involved in determining long-term care (LTC) eligibility: DHS, DoA, and HFS. Each of these agencies has responsibilities in the LTC eligibility process:

- **DHS** has the responsibility of determining an applicant's medical eligibility.
- **DoA** has the responsibility to conduct level of care determinations for nursing home facilities/institutional care (functional eligibility).

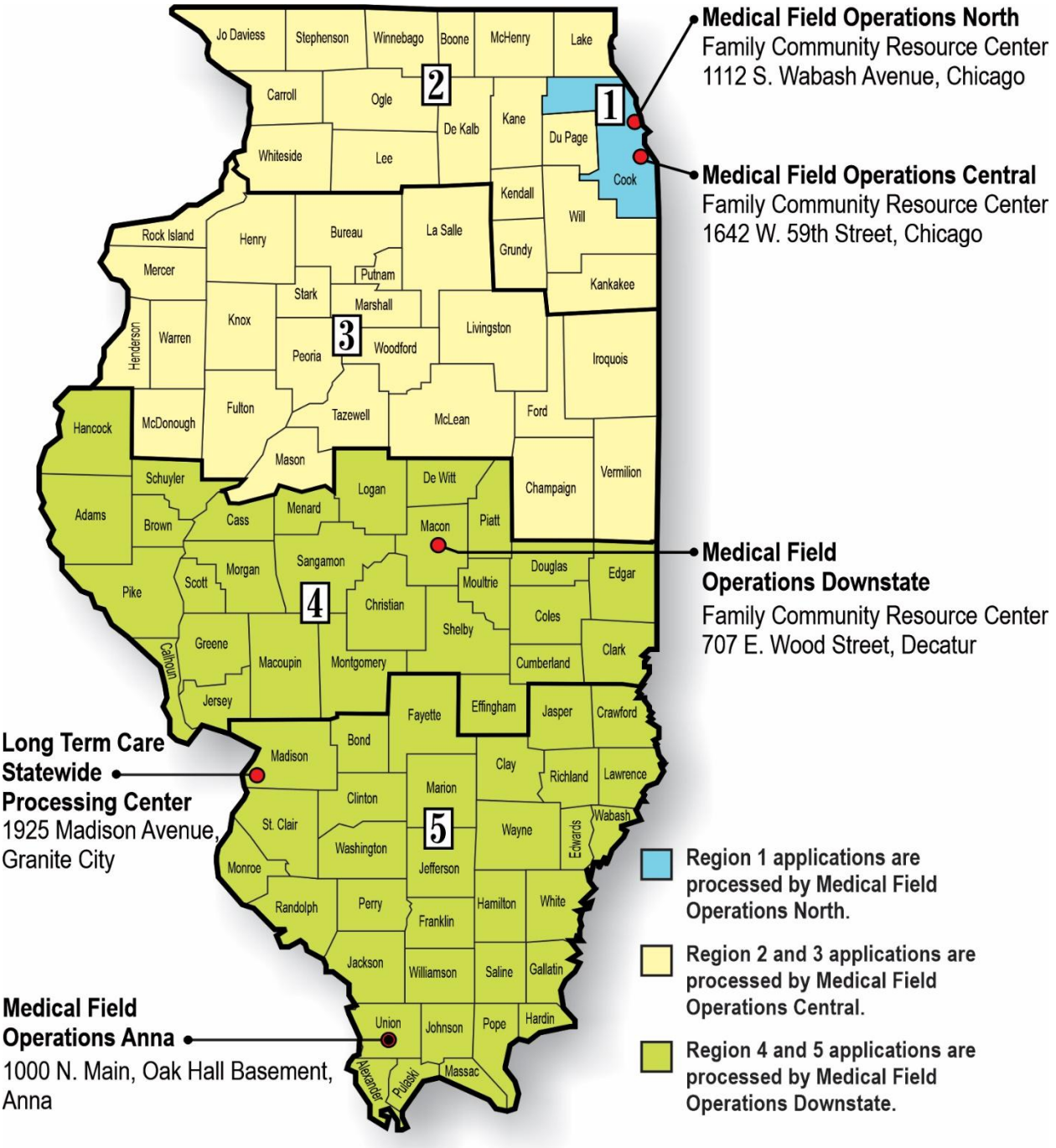
- **HFS** has the responsibility to develop policy related to LTC eligibility, investigate assets (if needed) to assist in determining an applicant's financial eligibility, and ensure payment is made to the LTC provider.

Digest Exhibit 2 shows the locations of the LTC hubs as well as the regions covered by each hub. Prior to March 2017, there were only two hubs: Medical Field Operations North and Medical Field Operations Downstate. Medical Field Operations Central opened in April 2017.

Medical Field Operations Anna was established in late 2020 becoming operational on January 16, 2021. A new LTC Statewide Processing Center was also established in 2020 becoming operational on March 16, 2020. Each LTC office processes applications. However, three Medical Field Operations offices process applications and maintain cases for a particular geographical area based on DHS Regions: Medical Field Operations North, Medical Field Operations Central, and Medical Field Operations Downstate.

- **Medical Field Operations North** processes LTC applications for **Region 1**.
- **Medical Field Operations Central** processes LTC applications for **Regions 2** and **3**.
- **Medical Field Operations Downstate** processes LTC applications for **Regions 4** and **5**.
- **LTC Statewide Processing Center** is designed to handle specific work assigned from the other four Medical Field Operations offices. Assignments are based on priority or urgency needs, special projects, and backlog. This center became operational in March 2020.
- **Medical Field Operations Anna** has been implemented to be a functional field office housing cases to alleviate the workload of the other three Medical Field Operations offices. This office was established in 2020 and became operational in January 2021. The agency currently is reviewing the process to redistribute cases to Medical Field Operations Anna and adjusting work at the other three Medical Field Operations offices to equalize the work. (pages 5-7)

Digest Exhibit 2
DHS LONG-TERM CARE MEDICAL OPERATIONS OFFICES AND REGIONS
Calendar Year 2023



Note: The Long Term Care (LTC) Statewide Processing Center and Medical Field Operations Anna offices process applications for the entire State.

Source: OAG prepared based on DHS information.

LTC Eligibility Determination Process

In Illinois, for Medicaid to pay for nursing facility care, an individual must: (1) apply for medical benefits through DHS, and (2) obtain a needs prescreening through DHS or DoA.

DHS Processing of LTC Applications

LTC eligibility is primarily determined by staff at one of the LTC offices in Illinois as discussed previously. An application moves through IES, a public benefits eligibility and case management system, which has been in various stages of implementation since October 2013.

Most LTC applications are received electronically through the Application for Benefits Eligibility (ABE) online portal, where new clients can apply for benefits. Nursing facility and supportive living facility providers submit applications on behalf of clients and are required to complete and submit the applications electronically through the ABE online portal. Once submitted through the ABE online portal, applications are entered into IES.

Additionally, some paper applications are received at either Family Community Resource Centers or LTC offices. When a paper application is received at a Family Community Resource Center, it is forwarded to the appropriate LTC office for processing. Since providers are required to submit applications through the ABE online portal, paper applications are usually received from the client or family members of the client.

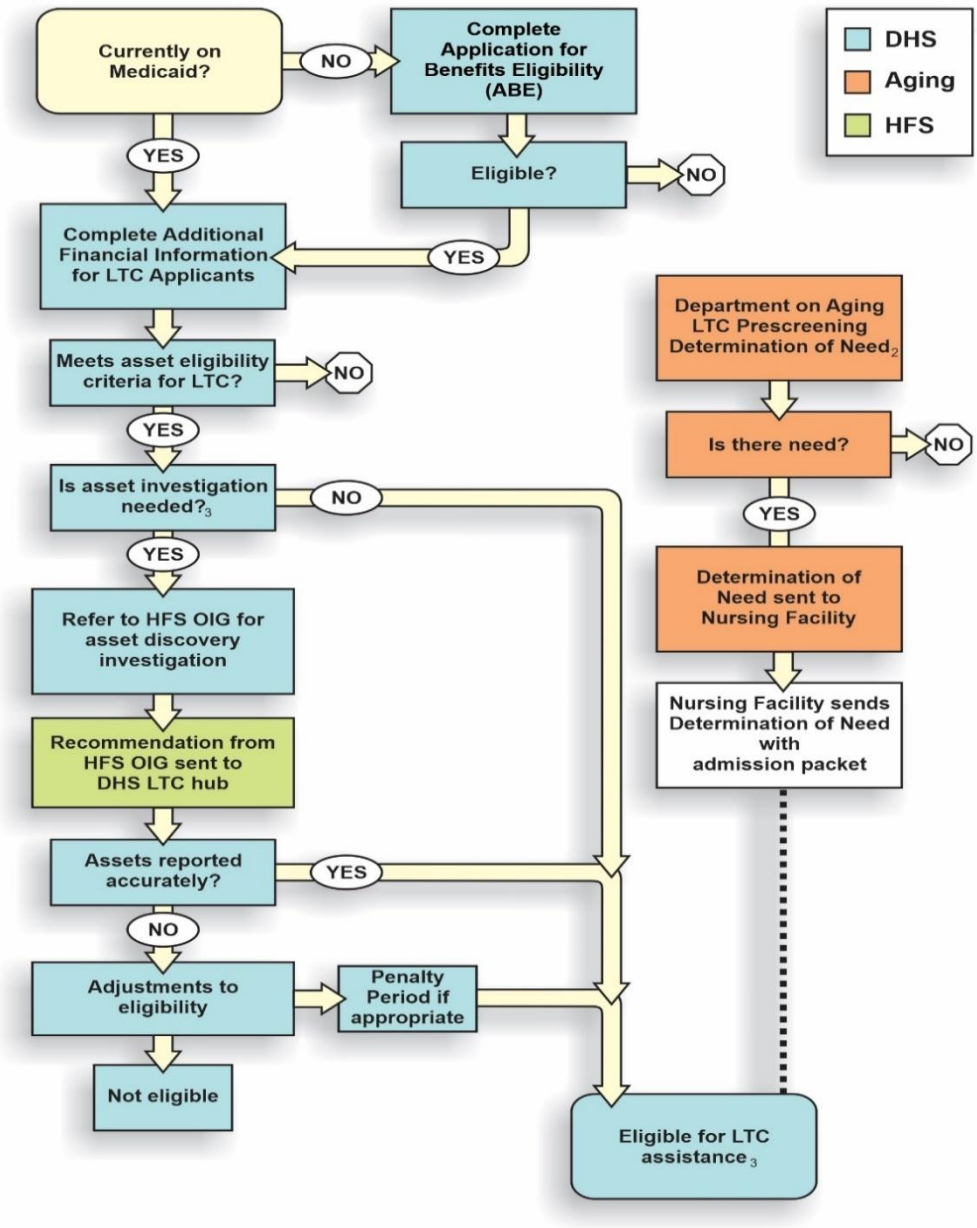
Digest Exhibit 3 is a general overview of the process of determining LTC eligibility, but is not intended to cover all iterations of the process. (pages 12-13)

Changes due to the COVID-19 Public Health Emergency

The COVID-19 Public Health Emergency (PHE) allowed for significant changes to the Medicaid LTC eligibility determination process. These changes affected the approval of applications, referrals to the HFS Office of Inspector General (OIG), and redeterminations. The changes to the eligibility determination process due to the PHE began in 2020.

The changes due to the PHE did not end until 2023, so they were in place for most of the current audit period. The Consolidated Appropriations Act, 2023 removed the connection between the PHE and the Medicaid continuous coverage requirement. Therefore, the continuous coverage requirement ended on March 31, 2023, and the redetermination process resumed in April 2023. The PHE ended on May 11, 2023, and the resource test for applications resumed on May 12, 2023. (page 16)

Digest Exhibit 3
LONG-TERM CARE ELIGIBILITY DETERMINATION PROCESS[1]
Calendar Year 2023



Notes:
[1] This exhibit presents the basic framework of the long-term care eligibility determination process and agency responsibilities and is not intended to cover all iterations of the process. COVID-19 emergency rules enacted in 2020 affected the eligibility determination process by ensuring applications were reviewed quickly and certain requirements were not required to be reviewed by DHS caseworkers during this time. The Public Health Emergency waivers began unwinding in April 2023.

[2] The Department on Aging does not complete a prescreening when a Determination of Need was completed within 90 days, a transition occurred from a psychiatric hospital, or a transition occurred from another nursing facility.

[3] HFS OIG referrals can occur during initial processing or after a case has been determined eligible.

Source: OAG prepared based on information provided on LTC eligibility determination process.

Delegated Authority to Determine Eligibility

Public Act 100-380 requested the Auditor General to determine if there are any issues affecting eligibility determinations related to DHS' staff completing Medicaid eligibility determinations instead of HFS, the designated single State Medicaid agency in Illinois.

We determined that no apparent issues affecting eligibility determinations were identified related to DHS staff completing these determinations instead of HFS, the single State Medicaid agency. (pages 17-18)

Timeliness of Eligibility Determinations

Public Act 100-380 requested the Auditor General determine if the agencies are in compliance with the following federal regulations:

- **42 CFR 435.930** – Was Medicaid (related to Medicaid LTC services) furnished promptly to beneficiaries without any delay caused by the agencies' administrative procedures; and
- **42 CFR 435.912** – Was the determination of eligibility for all applicants determined within 90 days for applicants who apply for Medicaid on the basis of disability or within 45 days for all other applicants.

Federal regulations require determinations of eligibility for any Medicaid applicant cannot exceed 90 days for applicants who apply for Medicaid on the basis of a disability and 45 days for all other applicants. Illinois imposes more strict timelines for Medicaid eligibility determinations for individuals applying on the basis of a disability. According to the Administrative Code sections for HFS and DHS, determination of eligibility for LTC must be completed within 60 days for all persons seeking to qualify on the basis of a disability and 45 days for all other applicants (89 Ill. Adm. Code 110.20 and 10.420).

Eligibility Determination Timelines

- ***Determination Based on Disability:***
  - 90 days – Federal Regulations
  - 60 days – Illinois Administrative Code
- ***Determination For All Others:***
  - 45 days – Federal Regulations and Illinois Administrative Code

In order to analyze if applicants were receiving their determinations of eligibility within the required timelines, we reviewed the following three reports: LTC monthly reports, medical application backlog reports, and internal weekly reports. We found that all three reports indicated applicants were not receiving their determinations of eligibility in a timely manner, particularly after the end of the Public Health Emergency.

Issues Affecting the Data

We reviewed data consisting of **44,661** LTC applications received in calendar years 2021 through 2023. Upon review of the data, which was pulled from IES, we determined calculating timeliness for the population of applications using the data provided would not provide accurate results for the purposes of this audit. More specifically, we found:

- **8,487 of 44,661** applications (**19%**) had multiple entries based on the same name, date of birth, and application date. The applications data was pulled by HFS in the same manner as the prior audit; if an application had multiple assistance types, then the application was listed multiple times in the data; and
- the data contained duplicate records and identifiers.

In addition, as discussed in the *Extension Tracking* section, the defect that was identified with the extension tracker during the previous audit was not corrected until June 2023. Therefore, for most of the audit period, there were potential issues with the number of extensions and the allowable number of extension days. Finally, there was no way to determine if the application should be based on a disability due to how the applications are accepted. DHS officials stated that they do not track the 60-day process because the goal is to process all medical applications within 45 days.

For these reasons, an accurate calculation of timeliness required testing individual applications as opposed to being able to test the timeliness of all applications in the population. We also focused on the timeliness of the eligibility determinations and did not assess if the eligibility was determined correctly.

Timeliness Testing Results

According to the IES data, **15,645** applications were submitted during calendar year 2023. We selected a sample of 50 applications for testing due to the issues noted above.

Digest Exhibit 4
DAYS OVERDUE FOR APPLICATION TESTING
Sample of 50 Applications Tested

Days Overdue	Number of Applications[1] PHE	Post PHE
0	18	21
1-30	0	4
31-45	0	2
46-60	0	0
61-90	0	1
91-120	0	2
121+	0	2

[1] PHE applications were submitted prior to the end of the Public Health Emergency on May 11, 2023.

Source: OAG analysis of LTC applications testing.

For the applications testing, we found that 11 applications (**22%**) were pending past the required number of days. Of those 11, 6 applications were completed within 45 days (between 5 and 38 days) beyond the required timeline. **Digest Exhibit 4** provides a detailed breakdown of the days overdue for the 50 applications sampled. For the 11 applications that were not completed within the required timelines, auditors determined that 5 were overdue because of an OIG investigation.

As discussed in the *Changes due to the COVID-19 Public Health Emergency* section, the COVID-19 Public Health Emergency ended on May 11, 2023, and the resource test for applications resumed on May 12, 2023. All the applications that were not completed in a timely manner occurred after the end of the PHE.

For the 50 applications sampled, it took on average **41 days** from receipt of application to decision. In addition, of the 50 applications sampled, 17

applications were referred to the HFS OIG for an asset discovery investigation. The applications that were referred to HFS OIG spent on average **58 days** at the OIG. For the 33 cases that did not have HFS OIG involvement, it took on average **22 days** for DHS to make a determination.

Due to these testing and reporting results, this recommendation on eligibility timeliness was determined to be **partially implemented** during this audit period. (pages 19, 23-26)

Applications with HFS OIG Asset Discovery Referrals

The HFS OIG reviews complex financial and legal documents as part of an asset discovery investigation; as a result, processing an application referred for an asset investigation requires additional time. However, Public Act 100-665 (effective August 2, 2018) removed the ability of HFS OIG to have an extension of up to 90 days (that is a 135-day total processing time limit). Even though the statutory extension for investigations was repealed, 90 days remains HFS OIG's target for completing the asset investigations. The targeted completion time was developed from time studies of working cases.

Testing Results

We reviewed a total of **17 cases** referred to the OIG for investigation during fieldwork testing. According to DHS officials, during the PHE, DHS was approving cases, then sending the cases to the OIG for post-eligibility determination. This was because assets were disregarded at that time. Because of this, 7 of the 17 cases with OIG referrals were referred to HFS OIG after the initial eligibility decision had already been made by DHS. Additionally, 4 of the 17 referrals were withdrawn or rejected by HFS OIG.

Eight of the 17 HFS OIG cases were not completed in a timely manner, ranging from **14** to **156** days overdue. The time spent at the OIG for these cases ranged from **34** to **154** days. **Eight** (**62%**) of the 13 investigations were completed in less than 90 days, which is the targeted completion time for OIG investigations.

In addition, multiple issues were identified for the HFS OIG cases. These issues included:

- The OIG referral date in IES was incorrect for **2** of **17** cases (**12%**).
- The OIG completed date in IES was incorrect for **1** of **17** cases (**6%**).
- All 17 OIG cases indicated a lack of IES controls. During the prior audit, DHS officials stated that IES should not accept dates for referral unless the "Has the OIG Referral been initiated" question is marked "Yes." However, the 17 HFS OIG cases tested did not contain a "yes" answer for this question and referral dates were still allowed to be entered in IES. Ten of the cases were marked with a "No," and 7 were blank. According to DHS officials, in July 2024, HFS OIG staff reported working with IES staff to fix the HFS OIG queue, and this field may have been the issue.

DHS worked on the 10 applications referred prior to the decision from **0** days to **77** days before referring them to the HFS OIG, and the average number of days from receipt of application to referral was **26** days.

Seven of the applications were referred to HFS OIG after DHS made an eligibility decision. DHS referred these applications to HFS OIG between **21** and **538** days after the initial decision was made. The time spent at HFS OIG for these cases ranged from **0** to **116** days.

During the previous audit, it was noted that even though the February 2019 system enhancement allowed the HFS OIG to receive notifications from DHS through IES, email notifications were requested from DHS caseworkers after the referral transmission. This was done to ensure that all referrals were received in a timely manner. DHS officials reported that this process has continued to be used during the current audit period due to the issues with the HFS OIG queue. While there were still some applications that were not completed in a timely manner, compared to the prior audit, there was improvement in the number of days overdue. Additionally, there was improvement in the average number of days between the application and when the application was referred to HFS OIG. However, there continued to be issues with incorrect data in IES and a lack of IES controls. Therefore, the status of this recommendation was determined to be **partially implemented**. (pages 27-31)

Extension Tracking

The Illinois Public Aid Code requires DHS and the HFS OIG to allow LTC applicants additional time to submit information and documents needed as part of the resources review (305 ILCS 5/11-5.4(e)). The agencies may grant a total of two extensions.

- The first extension shall not exceed 30 days; and
- A second extension of 30 days may be granted upon request for a maximum of 60 days.

During fieldwork, we followed up on cases with extensions in order to follow up on the prior audit recommendation regarding extension tracking.

Testing Results

We included 10 extension cases in our sample of 50 cases reviewed from IES during fieldwork. In total, 13 extensions were granted for the 10 applications reviewed.

Extensions upon request by applicant:

- ***1st Extension:*** Up to 30 days
- ***2nd Extension:*** 30 days

For the extension cases reviewed, we found 5 of 10 applications (**50%**) with inaccurate IES data. We also found that two cases with extensions (**20%**) were not completed in a timely manner.

Although the Statute only allows for a maximum of 30 days per extension, we found one case that was granted one 60-day extension. According to DHS officials, this occurred because IES automatically granted a 60-day extension.

Although HFS noted that a system enhancement was implemented in IES to address this prior audit recommendation, the testing results showed the enhancement was not fully effective. While there continued to be cases with inaccurate IES data, there was improvement over the prior audit. Also, auditors found no examples of more than two extensions or extensions that were not in IES. Therefore, the status of this recommendation was determined to be **partially implemented**. (pages 32-34)

LTC Monthly Reporting

Public Act 100-380 requested the Auditor General to evaluate the accuracy and completeness of the monthly report required by the Illinois Public Aid Code to be posted on both the DHS and HFS websites for the purpose of monitoring LTC eligibility processing (305 ILCS 5/11-5.4(f)).

Required Posting of LTC Monthly Report

HFS is not posting the LTC reports on a monthly basis as required by the Illinois Public Aid Code. These reports are required to be posted on "each Department's website for the purposes of monitoring LTC eligibility processing" (305 ILCS 5/11-5.4(f)). HFS completed reports for **28 of the 36 months (78%)** during the audit period.

During the prior audit, HFS and DHS posted all LTC reports as required by the Illinois Public Aid Code on a monthly basis. In August 2019, a link to the HFS website was added to the DHS website. During the current audit period, the link remained on the DHS website. However, the HFS website was updated, and the DHS website was not changed to reflect the new link.

Review of LTC Monthly Reports

Auditors requested documentation to support the posting of the monthly reports completed during calendar years 2021 to 2023. HFS was only able to provide documentation for **5 of the 28 (18%)** reports. If LTC monthly reports are not completed and posted to the websites as required, it is difficult for the public to monitor long-term care eligibility processing. (pages 35-36)

LTC Monthly Report Completeness

According to the prior audit, the LTC monthly reports did not contain all elements as required by statute. The reports did not contain information on extensions and the reports only provided the number of redeterminations pending by location, not the percentages as required. As a result, we reviewed monthly reports for this audit period of calendar years 2021 to 2023 and found some required elements were still not included.

- The monthly reports did not include the required percentages for applications and redeterminations that were pending and tolled due to extensions.
- Although the monthly reports provided the numbers for applications and redeterminations by location and pending with HFS OIG, the reports did not

start providing the associated redetermination percentages until the February 2023 report.

Although HFS was providing most information in the LTC monthly reports as required by 305 ILCS 5/11-5.4(f), there were still some remaining issues with the completeness of the reports. HFS stated that the reports will not be corrected until after the current audit period. Therefore, the status of this recommendation was determined to be **partially implemented**. (pages 37-38)

LTC Monthly Report Accuracy

The monthly reports posted on HFS' website pursuant to statute were not accurate (305 ILCS 5/11-5.4(f)). The monthly reports for calendar years 2021 to 2023 were reviewed, and the following issues with accuracy were found:

- the monthly reports did not present an accurate representation of the number of potentially overdue applications; and
- the data used to create the redetermination table in the reports contained duplicate entries.

Lack of Tracking Extensions and Disability Status

For the audit, we tested 50 applications and found evidence of a request for an extension by the applicant in 10 applications (**20%**). Two of the applications had more than one extension.

The reports also did not identify applications on the basis of disability. Because the Illinois Administrative Code allows 60 days for processing applications on the basis of a disability, some of the applications in the 46 to 60-day category might not be overdue if the applicant applied on the basis of a disability. We found that 19 of 50 applicants tested (**38%**) had a reported disability.

Source Data Accuracy

We were unable to make a determination regarding the accuracy of pending LTC applications data. During the prior audit, even though both the data provided and the monthly reports were from IES, auditors could not confirm the accuracy of the various reports. In addition to issues with the applications data, the numbers did not match between various reports. IES continued to be the source of the data in the LTC monthly reports during the current audit period.

Testing Related to Source Data Accuracy

We compared the data provided by HFS to the monthly reports, internal weekly reports, and medical application backlog reports. We were unable to determine the accuracy of the data for the various reports due to the numbers not matching between any of the reports. March 2022 was the only month where the numbers from any of the sources matched (monthly report and the applications data unique number count). The numbers presented in the LTC monthly report only matched the internal weekly reports. However, because the numbers in the LTC monthly report did not match the medical application backlog report nor the LTC

applications data provided by HFS, we were unable to fully confirm the accuracy of the applications tables in the LTC monthly reports.

Redeterminations Data

We requested LTC data on the total number of redeterminations completed for calendar years 2021 through 2023. Redeterminations were affected by the COVID-19 emergency rules, which became effective in April 2020 and suspended redeterminations. Therefore, according to HFS, no redeterminations were completed from January 2021 to May 2023 due to the PHE. Between June and December 2023, **38,038** redeterminations were completed.

HFS did not complete the monthly report for eight months during the audit period and provided the data used to create the redeterminations table in the monthly reports for **22 of the 28** reports during calendar years 2021 through 2023. We found that for the **22** months reviewed, **none** had issues with the totals matching. The only remaining issue with redeterminations data accuracy was with case numbers and Individual IDs with multiple entries. For the 22 months reviewed, **17** (**77%**) contained case numbers and individuals with multiple entries. However, none of the reports after February 2023 contained multiple entries.

We reviewed the LTC application data in the LTC monthly reports and attempted to ensure the data matched the data in IES. However, we could not determine the accuracy of the LTC monthly reports due to the numbers not matching between any of the reports. We also reviewed the redeterminations data and were able to compare it to the redeterminations data in the LTC monthly reports. There was improvement in the redeterminations data, and the only remaining issue with the redeterminations data was corrected for reports after February 2023. Therefore, the status of this recommendation was determined to be **partially implemented**. (pages 39-44)

Application Processing Approaches

Caseworker-based: A caseworker is assigned after intake and then serves as a primary contact for the client from that time forward. A single caseworker is seen for all aspects of a client's case.

Task-based: Clients no longer see a single caseworker for all aspects of their cases but instead work with different workers for different tasks. A supervisor assigns tasks to a worker based on what needs to be done in a given day or week, and the assignment can change each day given what the supervisor determines to be the most urgent tasks. When a worker picks up a case, the worker is to address all tasks appearing.

Facility-based: A team of caseworkers is assigned to a specific group of nursing homes. The team is responsible for processing all applications and ongoing case maintenance from those nursing homes.

Application Processing Approaches

Public Act 100-380 requested the Auditor General to review and evaluate the efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of DHS for LTC services, including the role of IES, as opposed to the traditional caseworker-specific process from which the central offices converted. See the **text box** for an overview of the approaches.

Decision to Switch Approaches

During the previous audit period, DHS completed the implementation of the task-based approach in October 2018. However, DHS officials stated that the task-based approach was not effective for processing. Therefore, in 2019, DHS made the decision to move away from the task-

based system to a new facility-based system. According to DHS, there were several reasons for this decision:

- staff accountability was hard to track;
- many staff were involved in correcting errors;
- barriers were created in looking at the case holistically and processing all work needing to be completed;
- staff would rotate throughout the year to different tasks and would need retraining. After a time of not processing certain work, staff lost the knowledge and skills needed; and
- nursing homes did not know who to contact when they had inquiries. Staff who had no knowledge of the case would have to research and recreate the case to provide answers to the nursing homes and families.

Comparison of Approaches

The efficacy and efficiency of the facility-based approach was not fully assessed during the prior audit since the process was implemented after the audit period. According to DHS, there were significantly more pros and less cons for the facility-based approach when compared to the other two approaches. The decision to switch to the facility-based approach appeared to be based upon reasonable assumptions. During the current audit period, the IES reports used to identify work were designed to identify tasks. However, work is assigned to teams based on facilities rather than tasks. After the end of the audit period DHS began re-assessing the reports. Since the reports were not re-designed until after the end of the current audit period, we could not fully assess the efficacy and efficiency of the facility-based approach. Therefore, additional follow up will need to be conducted during the next audit period. (pages 45-47)

Audit Recommendations

The audit report contains six recommendations directed to DHS and HFS. DHS and HFS agreed with the recommendations. The complete responses from DHS and HFS are included in this report as **Appendix D**.

This performance audit was conducted by the staff of the Office of the Auditor General.

SIGNED ORIGINAL ON FILE

JOE BUTCHER
Division Director

This report is transmitted in accordance with Section 3-14 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

FJM:PCS

Contents

Glossary and Acronyms

ABE	Application for Benefits Eligibility. Illinois' web-based portal for applying for, accessing, and managing health coverage, SNAP and cash benefits, and the Medicare Savings Program.
COVID-19	Coronavirus disease. An infectious disease caused by the SARS-CoV-2 virus.
DoA	Illinois Department on Aging. State agency responsible for long-term care prescreenings in Illinois.
DHS	Illinois Department of Human Services. State agency responsible for determining an applicant's medical eligibility for long-term care in Illinois.
DON	Determination of Need. Standardized assessment which specifies the factors that together determine an individual's need for long-term care.
HFS	Illinois Department of Healthcare and Family Services. Designated Medicaid single State agency responsible for the Medicaid long-term care program in Illinois.
IES	Integrated Eligibility System. Illinois' public benefits eligibility and case management system.
LTC	Long-Term Care. Services that include medical and non-medical care for people with a chronic illness or disability. For the purposes of Medicaid eligibility and payment, long-term care services are those provided to an individual who requires a level of care equivalent to that received in a nursing facility.
MEDI	Medical Electronic Data Interchange. HFS system used by Medicaid providers to enter admission information.
MFO	Medical Field Operations office. There are four of these DHS offices, which process LTC applications throughout the State.
MMIS	Medicaid Management Information System. A system that processes Medicaid claims submitted by medical providers for services rendered to Medicaid-eligible recipients and generates the related payments.

Glossary and Acronyms

OIG	Office of the Inspector General. For the purposes of this audit, an HFS office containing a specialized unit that conducts long-term care asset discovery investigations for long-term care applications referred by DHS caseworkers that meet specified criteria.
TAN	Transaction Audit Number. After providers enter information into MEDI, a Transaction Audit Number is generated. The LTC tracking database then stores the information with the TAN.

Introduction

On August 25, 2017, the Governor signed into law Public Act 100-380, which amended the Illinois Public Aid Code. This amendment to the Illinois Public Aid Code requires that beginning July 1, 2017, the Auditor General is to report every three years to the General Assembly on the performance and compliance of the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), and the Department on Aging (DoA) in meeting the requirements placed upon them by Section 11-5.4 of the Illinois Public Aid Code and federal requirements concerning eligibility determinations for Medicaid long-term care services and supports (**see Appendix A**). At a minimum the audit is to review, consider, and evaluate the following:

- **Furnishing Medicaid Long-Term Care Services Promptly** – Compliance with federal regulations on furnishing services as related to Medicaid long-term care services and supports as provided under 42 CFR 435.930 – that is furnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures;
- **Timely Determination of Eligibility** – Compliance with federal regulations on the timely determination of eligibility as provided under 42 CFR 435.912 – that is the determination of eligibility for any applicant may not exceed: (i) 90 days for applicants who apply for Medicaid on the basis of disability; and (ii) 45 days for all other applicants;
- **Monthly Report** – The accuracy and completeness of the monthly report required under paragraph (9) of subsection (e) of the Illinois Public Aid Code (following Public Act 100-665, 305 ILCS 5/11-5.4(f)) and for the purposes of

monitoring long-term care eligibility processing – that is monthly reports posted to the DHS and HFS websites on the applications and redeterminations pending long-term care eligibility determination and admission and the number of appeals of denials in given categories;

- **Process for Making Eligibility Determinations** – The efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of the Department of Human Services for long-term care services, including the role of the State's Integrated Eligibility System (IES), as opposed to the traditional caseworker-specific process from which these central offices have converted; and
- **Agency Issues** – Any issues affecting eligibility determinations related to the Department of Human Services' staff completing Medicaid eligibility determinations instead of the designated single State Medicaid agency in Illinois, the Department of Healthcare and Family Services (prior to Public Act 100-665, 305 ILCS 5/11-5.4(f); following 305 ILCS 5/11-5.4(g)).

This is the third audit (CY21-CY23) on the performance and compliance related to Medicaid eligibility determinations for long-term care. The first audit (CY15-CY17) was released in March 2019 and contained eight recommendations. The second audit (CY18-CY20) was released in September 2022 and contained five recommendations. **Exhibit 1** outlines the previous five recommendation areas and the current status of the recommendation. Each recommendation is also discussed in more detail later in the audit report.

Exhibit 1
CURRENT STATUS OF PRIOR AUDIT RECOMMENDATIONS

Prior Audit	Current Audit	Recommendation	Status
1	1	Eligibility Determination Timeliness	Partially Implemented
2	2	HFS OIG Application Referrals	Partially Implemented
3	3	Tracking of Extensions	Partially Implemented
4	5	LTC Monthly Report Completeness	Partially Implemented
5	6	LTC Monthly Report Accuracy	Partially Implemented

Source: OAG prepared based on analysis of recommendations.

Background

The U.S. Department of Health and Human Services defines long-term care services as services that include medical and non-medical care for people with a chronic illness or disability. Long-term care helps individuals meet health and personal needs. Long-term care can be provided at home, in the community (such as adult day services or transportation services), or in a facility. For purposes of Medicaid eligibility and payment, long-term care services are those provided to an individual who requires a level of care equivalent to that received in a nursing facility.

In order for Medicaid to pay for long-term care services, an applicant must meet general Medicaid eligibility requirements as well as financial and functional eligibility criteria. Eligibility requirements are established by federal regulations and state law.

- **Financial eligibility** requires an assessment of a person's available **income** and **assets**.
- **Functional eligibility** is defined as an assessment of a **person's care needs**, which may include a person's ability to perform activities of daily living (bathing, dressing, using the toilet, eating, etc.) or the need for skilled care.

If either financial or functional eligibility requirements are not met, Medicaid will not pay for long-term care services. However, over time, individuals may deplete their resources or income and become financially eligible, or their functioning may deteriorate to the point where they do meet functional eligibility criteria.

Lawsuit

In April 2017, a federal class action lawsuit (originally Koss, et al., v. Norwood & Dimas, now Koss, et al., v. Eagleson & Hou) was filed alleging DHS and HFS were delayed in processing and administering the plaintiffs' long-term care applications.

In March 2018, the court certified the class on behalf of "*all individuals who on or after February 1, 2015, have applied to be determined eligible for long-term care Medicaid benefits from the State of Illinois, and have not received a final eligibility determination or a notice of opportunity for a hearing within 45 days of the date of application in non-disability cases or 90 days in disability cases*." Additionally, a preliminary injunction order was entered requiring the State to:

- determine, on or before June 28, 2018, the eligibility of class members for long-term care benefits for which they have applied;
- implement policies and processes to ensure defendants prospectively comply with the federal Medicaid Act's deadlines for eligibility determinations; and
- beginning June 28, 2018, pay the long-term care and other benefits to (or for the benefit of) class members while their applications remain pending beyond the Medicaid Act's deadlines for eligibility determinations.

On November 2, 2021, the parties informed the court that the defendants were in compliance with the requirements for timely determination of eligibility on applications for long-term care Medicaid benefits and agreed to a process to: (1) decertify the class, (2) dismiss the appeal of the preliminary injunction, (3) vacate the preliminary injunction, and (4) dismiss the case. The court accepted these proposed steps to dispose the case, and the class was decertified on November 10, 2021. **After the appeal was dismissed by agreement, the district court dissolved the preliminary injunction and dismissed the case on December 17, 2021**.

OAG Compliance Reviews

Throughout the audit period, HFS and DHS financial audits and compliance examinations conducted by the Office of the Auditor General (OAG) contained findings related to the State's Integrated Eligibility System (IES) and inaccurate determinations of eligibility. **Exhibit 2** shows examples of these relevant findings by agency. Auditors also reviewed the FY22 compliance examination for DoA. None of the findings in the DoA compliance examination pertained to long-term care Medicaid eligibility.

Exhibit 2
RELEVANT OAG FINDINGS BY AGENCY
Fiscal Year 2021 through Fiscal Year 2023

Finding	HFS			DHS		
	FY21	FY22	FY23	FY21	FY22	FY23
Insufficient internal controls over changes to IES and recipient data	✓			✓		
Inadequate disaster recovery controls over IES	✓	✓	✓	✓	✓	✓
Insufficient review and documentation of provider enrollment determinations and failure to execute interagency agreements	✓	✓	✓	✓	✓	✓
Inadequate controls over eligibility determinations and redeterminations			✓			✓

Source: OAG prepared based on OAG financial and compliance findings.

Agencies Involved with LTC Eligibility Determinations

There are three State agencies involved in determining long-term care (LTC) eligibility: DHS, DoA, and HFS. **Appendix C** provides organizational charts for these three agencies. Each of these agencies has responsibilities in the LTC eligibility process:

- **DHS** has the responsibility of determining an applicant's medical eligibility.
- **DoA** has the responsibility to conduct level of care determinations for nursing home facilities/institutional care (functional eligibility).
- **HFS** has the responsibility to develop policy related to LTC eligibility, investigate assets (if needed) to assist in determining an applicant's financial eligibility, and ensure payment is made to the LTC provider.

Department of Human Services

Individuals who want Medicaid to cover LTC services apply for medical assistance. Individuals may be eligible under the Aged, Blind, and Disabled Medicaid program and the Affordable Care Act program.

The Aged, Blind, and Disabled Medicaid program provides medical benefits to seniors, persons who are blind, and persons with disabilities with income of 100 percent or less of the federal poverty level and no more than $17,500 of non-exempt resources. A person with countable income and resources that are equal to or less than the Aged, Blind, and Disabled medical standards may qualify for Aged, Blind, and Disabled medical benefits without a spenddown obligation. If the individual's income and/or resources are over the specified limit, he or she may be enrolled in spenddown. A person is eligible for this program if he or she:

- lives in Illinois;
- is a U.S. citizen or meets certain requirements for noncitizens;
- receives Supplemental Security Income or is ineligible for Supplemental Security Income due to income or due to expiration of the federal time limit on assistance to certain immigrants who have not yet become U.S. citizens;
- is either blind, disabled, or 65 years or older; and
- does not have any non-exempt resources in excess of $17,500.

When determining eligibility, DHS exempts certain assets up to a specific dollar amount, such as one automobile up to $4,500 and a place of residence up to $713,000 equity value in 2024 (this amount is to be increased annually based on the percentage increase in the Consumer Price Index). The Affordable Care Act Adult Program provides medical assistance to adults, specifically to those not eligible for other programs. The Affordable Care Act provides nursing home services for individuals who:

- are age 19 through 64 years;
- live in Illinois;

- meet U.S. citizenship or immigration requirements;
- are not eligible for other programs;
- have income at or below 138% of the federal poverty level (adult cases are not eligible to be enrolled in spenddown); and
- have resources that are not counted; however, the five-year look-back for post eligibility determinations is completed for reviewing resource transfers.

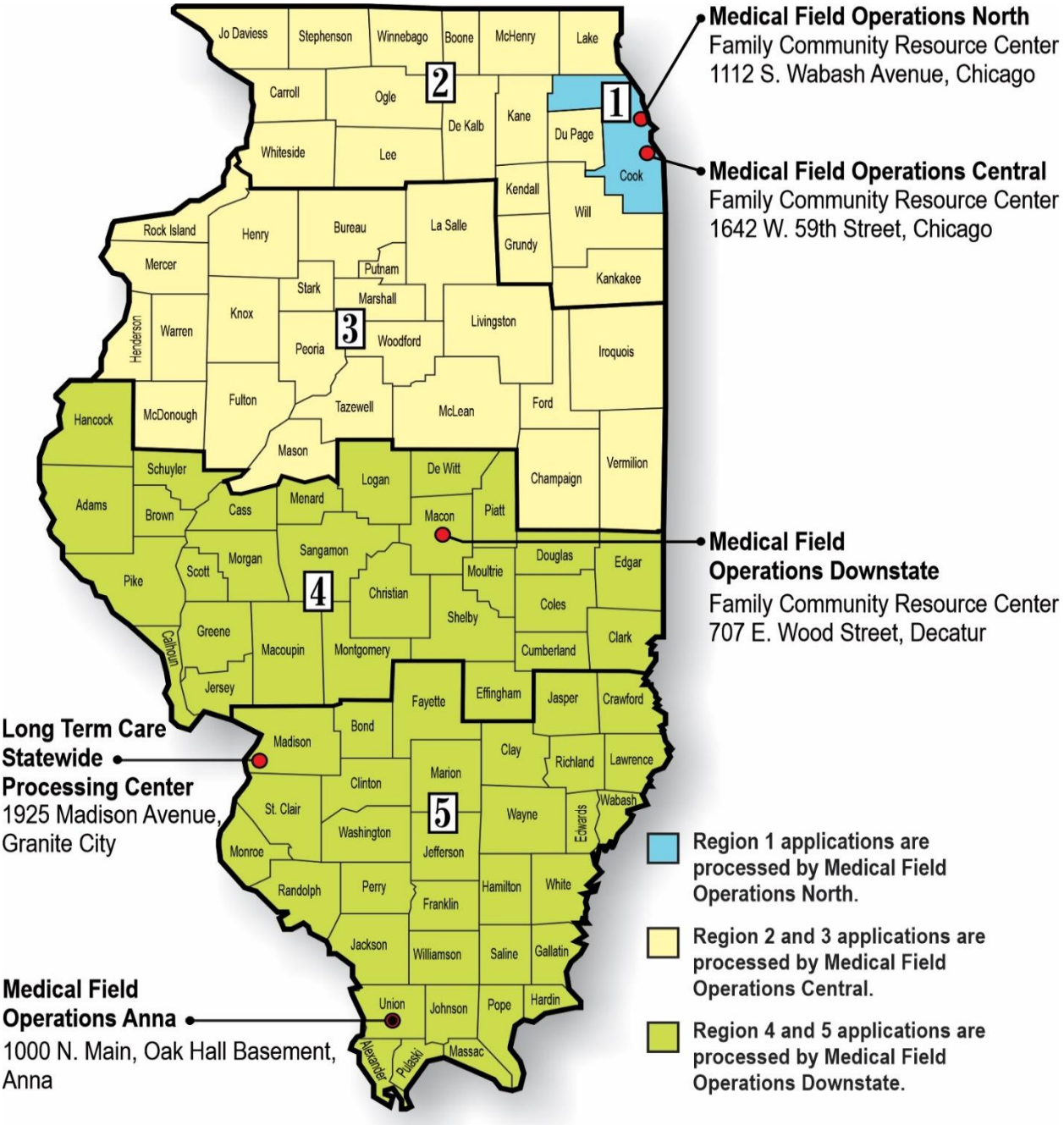
An individual can apply by going to a local DHS Family Community Resource Center or online through the Application for Benefits Eligibility (ABE) online portal, by mailing a paper application to the agency, or over the phone by calling the ABE Customer Call Center. According to DHS, most applications are submitted electronically through the ABE online portal. All providers who apply on behalf of an LTC resident are required to use the ABE online portal. DHS processes nearly all of its LTC applications through four field operations offices (or LTC hubs) and one LTC Statewide Processing Center created specifically for LTC eligibility determinations.

Applications submitted through the ABE online portal indicating the applicant is a resident of a nursing home or supportive living facility are auto directed in IES to the Medical Field Operations office that services the zip code entered. Once received in IES, the application is screened/registered and made available to the DHS caseworker. The DHS caseworker reviews the application, requests additional information if necessary, and determines eligibility. The length of time to process an application varies based upon several financial and non-financial factors, supporting documentation received, and if the client needed extensions for requested verifications. However, federal regulations and the Illinois Administrative Code establish timelines for eligibility determinations. Federal regulations require that determinations of eligibility for any Medicaid applicant cannot exceed 90 days for applicants who apply for Medicaid on the basis of a disability and 45 days for all other applicants. Illinois imposes more strict timelines for Medicaid eligibility determinations for individuals applying on the basis of a disability, requiring these determinations to be completed within 60 days as opposed to 90 days.

Exhibit 3 shows the locations of the LTC hubs as well as the regions covered by each hub. Prior to March 2017, there were only two hubs: Medical Field Operations North (1112 S. Wabash Ave. in Chicago) and Medical Field Operations Downstate (707 E. Wood St. in Decatur). Medical Field Operations Central opened in April 2017 (1642 W. 59th St. in Chicago). Medical Field Operations Anna (100 N. Main, Oak Hall Basement in Anna) was established in late 2020 becoming operational on January 16, 2021. A new LTC Statewide Processing Center (1925 Madison Ave., Granite City) was also established in 2020, becoming operational on March 16, 2020. Each LTC office processes applications. However, three Medical Field Operations offices process applications and maintain cases for a particular geographical area based on DHS Regions: Medical Field Operations North, Medical Field Operations Central, and Medical Field Operations Downstate.

- **Medical Field Operations North** processes LTC applications for **Region 1**.
- **Medical Field Operations Central** processes LTC applications for **Regions 2** and **3**.
- **Medical Field Operations Downstate** processes LTC applications for **Regions 4** and **5**.
- **LTC Statewide Processing Center** is designed to handle specific work assigned from the other four Medical Field Operations offices. Assignments are based on priority or urgency needs, special projects, and backlog. This center became operational in March 2020.
- **Medical Field Operations Anna** has been implemented to be a functional field office housing cases to alleviate the workload of the other three Medical Field Operations offices. This office was established in 2020 and became operational in January 2021. The agency currently is reviewing the process to redistribute cases to Medical Field Operations (MFO) Anna and adjusting work at the other three Medical Field Operations offices to equalize the work.

Exhibit 3
DHS LONG-TERM CARE MEDICAL OPERATIONS OFFICES AND REGIONS
Calendar Year 2023



Note: The Long Term Care (LTC) Statewide Processing Center and Medical Field Operations Anna offices process applications for the entire State.

Source: OAG prepared based on DHS information.

Department on Aging

The Illinois Department on Aging (DoA) contracted with Care Coordination Units (CCUs) to conduct Choices for Care consultations, known as prescreenings, to determine the need for long-term care for individuals age 60 or older. A prescreening is needed if an individual: 1) requires placement in a nursing facility or Supportive Living Program setting; 2) contemplates/requests placement in a nursing facility or supportive living program; or 3) may need home and community-based services.

According to DoA policy, prescreening should be viewed as an opportunity to prevent unnecessary institutionalization and provide an opportunity to share options for community-based services and supports. Options must be explained in detail to the individual, and the individual must be afforded a choice of available services.

Care Coordination Units utilize the AssessmentPro electronic platform, which is operated by Maximus, the HFS contracted consultant. Care Coordination Units receive requests to complete Choices for Care consultations primarily in AssessmentPro from either a hospital or nursing facility. CCUs receive requests for prescreenings directly from Supportive Living Program settings or other sources. CCUs are required to conduct prescreenings regardless of the method of referral. With the exception of federal holidays, CCUs must have the capacity to complete face-to-face prescreening in hospitals seven days a week, at a minimum of seven business hours per day.

The vast majority of prescreenings are conducted prior to placement in a nursing facility or Supportive Living Program setting. However, there may be instances where a postscreening must be conducted. In these instances, CCUs have two calendar days. Regardless of whether a prescreening or postscreening is conducted, once completed the appropriate forms are uploaded into AssessmentPro. The Determination of Need (DON) score (described below) is included. This allows the nursing facility or Supportive Living Program setting provider to enter admission information into the HFS Medical Electronic Data Interchange (MEDI) system to initiate the payment process.

As a key component of the screening process, CCU Care Coordinators conduct the eligibility determination and complete required forms. The DON is a standardized assessment to determine an individual's functional ability to perform basic and instrumental activities of daily living and identify unmet needs. Regardless of DON score, the Care Coordinator informs the individual of options for care. A total DON score of 29 or greater meets the standard for functional eligibility for LTC and/or home and community-based services.

Department of Healthcare and Family Services

As the designated Medicaid single State agency, the Department of Healthcare and Family Services (HFS) is responsible for the Medicaid LTC program for eligible residents in 960 facilities in Illinois. As of December 2023, approximately 64,000 individuals were receiving Medicaid LTC services. HFS'

mission is to ensure that LTC services are appropriate, meet the needs of recipients and standards of quality, and are in compliance with federal and State regulations.

HFS staff are responsible for developing policy in accordance with State and federal regulations and enrolling providers. HFS staff work with billing issues to ensure correct payment to providers is made by a system of ongoing pre- and post-payment review adjustments. In addition, HFS staff provide billing assistance and information to providers, resolve billing discrepancies, and coordinate billing with the DHS local offices.

HFS Office of the Inspector General

The HFS Office of the Inspector General (OIG) conducts LTC asset discovery investigations (asset investigations) for LTC applications referred by DHS caseworkers that meet specified criteria. A specialized unit within the HFS OIG, Long-Term Care Asset Discovery Investigation (LTC-ADI), is charged with ensuring the resource disclosure and transfer policies are appropriately enforced. This unit completes asset investigations and provides resource directives on LTC applications referred by DHS. A resource directive provides a DHS caseworker guidance on how to proceed with the referred applications. For example, a resource directive might recommend an application be approved with spenddown until the assets in excess of the allowed limits are expended.

The LTC-ADI unit's purpose is to prevent ineligible persons from receiving LTC benefits and to deter improper sheltering of assets and resources. The purpose of the asset investigations is to uncover undisclosed resources and unallowable resource transfers that occurred during the look-back period, which is five years prior to the date of the application. These asset investigations often include reviewing five years of financial records and legal documents, including, but not limited to, bank statements, tax returns, annuity documentation, pension documents, trust documents, and information about land owned.

HFS Data and Systems

According to HFS, admission information comes from the Medicaid Management Information System (MMIS) and applications data comes from IES. HFS provided applications data from IES.

Regarding HFS OIG referral information, referrals to the OIG and corresponding decisions from the OIG are received through IES. According to HFS, in January 2019, fields were added in IES for OIG referrals. In addition, a new process regarding expedited cases was implemented in January 2020.

HFS officials also noted redetermination information is now available through IES, not MMIS. Redetermination data is separate from application data. Also, as required by the Administrative Code, HFS officials explained facilities are required to complete pre-admission screenings on all residents that fit certain criteria. Once initial screenings are complete, providers can submit admission Transaction Audit Numbers (TANs) in the Medical Electronic Data Interchange (MEDI). All information related to the screening assessments would be

connected with this TAN information. According to HFS, this information would be separate from both MMIS and IES.

We confirmed the IES data provided by HFS on August 13, 2024, contained the following fields:

- applicant identifiers (first name, last name, date of birth, social security number);
- application number;
- application status;
- type of assistance;
- application date;
- decision date;
- extension information (number of extensions, number of extended days, extended due dates);
- OIG referral information (OIG referral and completion dates);
- case number;
- death date;
- verification checklist status, if requested;
- approved/denied/pending status; and
- office number/processing hub.

LTC Eligibility Determination Process

In Illinois, for Medicaid to pay for nursing facility care, an individual must: (1) apply for medical benefits through DHS, and (2) obtain a needs prescreening through DHS or DoA. **Exhibit 4** is a general overview of the process of determining LTC eligibility but is not intended to cover all iterations of the process.

DHS Processing of LTC Applications

LTC eligibility is primarily determined by staff at one of the LTC offices in Illinois as discussed previously. An application moves through IES, a public benefits eligibility and case management system, which has been in various stages of implementation since October 2013.

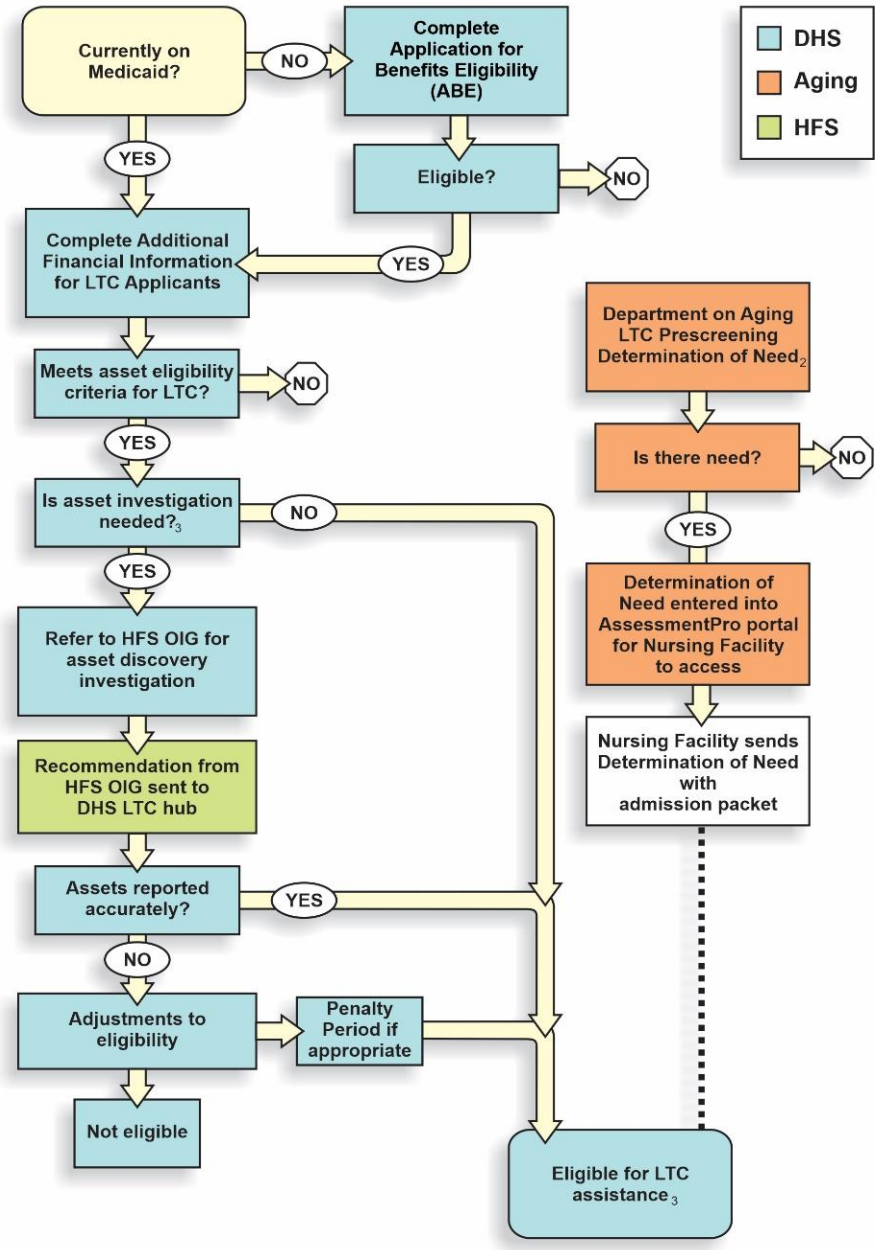
Most LTC applications are received electronically through the Application for Benefits Eligibility (ABE) online portal, where new clients can apply for benefits. Nursing facility and supportive living facility providers submit applications on behalf of clients and are required to complete and submit the applications electronically through the ABE online portal. Once submitted through the ABE online portal, applications are entered into IES. Additionally, some paper applications are received at either Family Community Resource Centers or LTC offices. When a paper application is received at a Family Community Resource Center, it is forwarded to the appropriate LTC office for processing. Since providers are required to submit applications through the ABE online portal, paper applications are usually received from the client or family members of the client.

A Public Aid Eligibility Assistant initiates the application review process when an application is received. Public Aid Eligibility Assistants:

- receive and review the application;
- conduct Social Security Number clearances;
- indicate whether the application was received electronically or is a paper application;
- ensure the application has the correct county;
- ensure the application is at the correct LTC hub; and
- complete other necessary preliminary checks (such as verifying if the applicant is already receiving benefits).

After these checks, the Public Aid Eligibility Assistant registers the application. The application then enters IES and is placed in the Interview Required-Initiate Data Collection queue or the No Interview Required-Initiate Data Collection queue.

Exhibit 4
LONG-TERM CARE ELIGIBILITY DETERMINATION PROCESS[1]
Calendar Year 2023



Notes:
[1] This exhibit presents the basic framework of the long-term care eligibility determination process and agency responsibilities and is not intended to cover all iterations of the process. COVID-19 emergency rules enacted in 2020 affected the eligibility determination process by ensuring applications were reviewed quickly and certain requirements were not required to be reviewed by DHS caseworkers during this time. The Public Health Emergency waivers began unwinding in April 2023.

[2] The Department on Aging does not complete a prescreening when a Determination of Need was completed within 90 days, a transition occurred from a psychiatric hospital, or a transition occurred from another nursing facility.

[3] HFS OIG referrals can occur during initial processing or after a case has been determined eligible.

Source: OAG prepared based on information provided on LTC eligibility determination process.

According to DHS officials, applications in these queues are assigned by a supervisor to a caseworker and worked on a first in, first out basis (meaning the oldest cases are worked first). A caseworker reviews the application to determine if all necessary documentation was provided and attached to the IES case record to determine eligibility. If additional documentation is needed, a request is to be generated by IES and mailed to all applicable parties. After the request is generated, IES then routes the application from the Data Collection queue to the Ready to Certify queue. If extensions are requested, they are reviewed to either be granted or denied.

If an applicant appears to have transfers of $10,000 or less, the caseworker will determine whether the transfers were allowable and, if not, calculate the length of the penalty period. However, if an application shows transfers greater than $10,000 in the five-year look-back period, evidence of estate planning, consultation with a financial planner for estate planning purposes, has unanswered questions requesting resource information or any other reason the caseworker deems appropriate, the DHS caseworkers are required to refer the application to the HFS OIG's LTC Asset Discovery Investigation unit. Once an asset investigation is complete, a resource directive is issued to the LTC hub. The resource directive might, for example, recommend an application be approved with spenddown until the applicant's assets in excess of the allowed limits are expended. HFS OIG cases are then assigned to a specific DHS caseworker to complete the eligibility determination.

Once in the Ready to Certify queue, applications are again worked on a first in, first out basis. A caseworker reviews the application and all documentation to determine if the case can be approved or denied. If additional information is needed, a request generated by IES is again to be issued and mailed to all applicable parties. This process may be repeated multiple times until a decision is made to approve or deny the application. Once a determination is made to approve or deny, IES generates and mails a Notice of Decision to all applicable parties.

HFS OIG Asset Discovery Investigation Process

The HFS OIG LTC Asset Discovery Investigation (LTC-ADI) unit receives referrals from the LTC hubs via email and IES. After an initial prescreening, LTC-ADI staff send an information request to the applicant (or an approved representative) for up to five years of financial records and legal documents, which may include bank statements, tax returns, annuity documentation, pension documents, trust documents, and information about land owned.

According to LTC-ADI procedures, cases will not be assigned to an analyst until all requested information has been received. If the information is not received, the case is denied. If information is received, staff enter the case in the HFS OIG tracking system, and the case is assigned to an analyst who reviews the information and makes a recommendation. After a supervisor reviews the case and recommendation, the resource directive is returned to the LTC hub. The case is then assigned to a DHS caseworker to implement the HFS OIG's resource

directive. LTC-ADI follows up on the case about 60 to 90 days after the directive is uploaded to IES to assess if the asset investigation portion of the case can be closed. According to LTC-ADI procedures, this timeframe allows for disposition of any client appeals.

During the COVID-19 Public Health Emergency (PHE), LTC-ADI received a low number of referrals. This allowed time for LTC-ADI to provide additional policy and review process training to staff. The resource test for LTC applicants was suspended during the PHE. This test assesses the available resources of an applicant. Accordingly, penalties and resource spenddowns were unable to be processed. However, LTC-ADI continued to do the investigations on the cases referred to its office. Recommendations were prepared and then sent to DHS to implement at the end of the PHE. The only penalties imposed were cases that had remaining penalties from the date of application prior to the PHE. On May 11, 2023, the PHE ended, and the resource test for applications resumed on May 12, 2023. Cases then resumed based upon the protocol prior to the PHE.

Department on Aging Prescreening Process

The Department on Aging (DoA) prescreening process begins when notification is given that an individual is either at risk of or contemplating entering a nursing facility or supportive living program. When a patient at a hospital is in need of a prescreening, the hospital contacts a Care Coordination Unit. A prescreening is needed if an individual: (1) requires placement in a nursing facility or supportive living program; (2) contemplates/requests placement in a nursing facility or supportive living program; or (3) may need home and community-based services.

The hospital must give the Care Coordination Unit at least 24-hour notice prior to discharge. The Care Coordination Unit receiving the referral checks various systems to determine if a prescreening has been completed by that or another Care Coordination Unit within the past 90 calendar days. If the individual has not been prescreened within the past 90 calendar days, the Care Coordination Unit proceeds with conducting a face-to-face prescreening. The date the request was received and the time the prescreening was completed must be documented by the Care Coordination Unit on the Case Record Recording Sheet.

Care Coordination Units receive requests to complete prescreenings primarily in their AssessmentPro queue from either a hospital or nursing facility. Once the prescreening has been completed, the appropriate forms are uploaded into AssessmentPro. The total DON score is included. This allows the nursing facility or supportive living program provider to enter admission information into the HFS Medical Electronic Data Interchange (MEDI) system to initiate the payment process.

DoA has a policy describing the prescreening procedures and required timeframes for completing the prescreening. Generally, the prescreening is completed within one calendar day from notification. If the individual has been screened within the past 90 calendar days, the Care Coordination Unit will not complete another screen. Instead, the Care Coordination Unit will complete a screening verification form, which notes the date the individual was last screened and the associated

form. These forms are sent to the nursing facility or supportive living program provider.

Changes Due to the COVID-19 Public Health Emergency

The COVID-19 Public Health Emergency (PHE) allowed for significant changes to the Medicaid LTC eligibility determination process. These changes affected the approval of applications, referrals to the HFS OIG, and redeterminations. The changes to the eligibility determination process due to the PHE began in 2020.

The changes due to the PHE did not end until 2023, so they were in place for most of the current audit period. The Consolidated Appropriations Act, 2023 removed the connection between the PHE and the Medicaid continuous coverage requirement. The continuous coverage requirement allowed individuals to remain enrolled in Medicaid through the course of the PHE. Therefore, the continuous coverage requirement ended on March 31, 2023, and the redetermination process resumed in April 2023. The PHE ended on May 11, 2023, and the resource test for applications resumed on May 12, 2023.

Delegated Authority to Determine Eligibility

No apparent issues affecting eligibility determinations were identified related to DHS staff completing these determinations instead of HFS, the single State Medicaid agency.

Public Act 100-380 requested the Auditor General to determine if there are any issues affecting eligibility determinations related to DHS' staff completing Medicaid eligibility determinations instead of HFS, the designated single State Medicaid agency in Illinois.

It is not unusual for the designated single State Medicaid agency to delegate authority to determine eligibility. Each state is required by federal regulations to submit a State Plan to the federal Centers for Medicare and Medicaid Services for review and approval. A State Plan is an agreement between the state and the federal government describing how the state administers its Medicaid program. Federal regulations (42 CFR 431.10) stipulate that a State Plan must "specify a single State agency established or designated to administer or supervise the administration of the plan" (emphasis added). The federal regulations also state the Medicaid agency:

> *(A) May, in the approved state plan, delegate authority to determine eligibility for all or a defined subset of individuals…*
>
> *(B) Must in the approved state plan specify to which agency, and the individuals for which, authority to determine eligibility is delegated.*

Illinois' State Plan for Medicaid delegated authority to DHS effective July 1, 1997. This delegation of authority was the result of the formation of DHS and the transfer of duties and eligibility determination staff from the designated single State Medicaid agency to the newly formed DHS. This delegation of authority was approved by the federal Centers for Medicare and Medicaid Services on August 30, 1999.

HFS and DHS have an interagency agreement in place, which discusses the roles of each agency. The primary interagency agreement, effective May 14, 2000, states that HFS will establish all eligibility policy, process DHS claims, and maintain, administer, and ensure compliance with State Medicaid plans. The interagency agreement states that it is DHS' responsibility to comply with all rules, regulations, and policies governing medical programs and provide information necessary for HFS to function effectively as the single State Medicaid agency. The interagency agreement also states that DHS will accept applications and make timely eligibility determinations for individuals applying for benefits under the medical programs.

Although HFS develops the policies DHS uses, HFS is not directly involved in the determination of eligibility for Medicaid. DHS caseworkers review the application, request additional information from the applicant, if necessary, and determine eligibility. We again followed up with both agencies regarding DHS staff completing these determinations instead of HFS, and neither agency noted any problems nor any changes since the prior audit. **Therefore, no apparent**

issues affecting eligibility determinations were identified related to DHS staff completing these determinations instead of HFS, the single State Medicaid agency.

Timeliness of Eligibility Determinations

During the prior audit, we found DHS was not making LTC eligibility determinations in a timely manner as required by federal regulations and the Illinois Administrative Code.

We determined that calculating timeliness for the population of the applications using data provided would not provide accurate results for the purposes of this audit. As a result, we selected a sample of 50 applications for fieldwork testing. For the 50 applications tested, we found that 39 applications (**78%**) had an eligibility determination completed within the required timelines compared to 15 of 50 applications (**30%**) tested in the previous audit. On average, it took **41** days to make a decision on the 50 applications compared to **125** days in the previous audit. Finally, despite differences between the various reports produced by HFS, all three reports reviewed indicated not all applicants were receiving their determinations of eligibility in a timely manner, particularly after the end of the Public Health Emergency (PHE). However, there was substantial improvement in the timeliness compared to the prior audit period. Consequently, the status of the prior recommendation on the timeliness of eligibility determinations was determined to be **partially implemented**.

LTC Medicaid Eligibility Determinations Timeliness

Public Act 100-380 requested the Auditor General determine if the agencies are in compliance with the following federal regulations:

- **42 CFR 435.930** – Was Medicaid (related to Medicaid LTC services) furnished promptly to beneficiaries without any delay caused by the agencies' administrative procedures; and
- **42 CFR 435.912** – Was the determination of eligibility for all applicants determined within 90 days for applicants who apply for Medicaid on the basis of disability or within 45 days for all other applicants.

Eligibility Determination Timelines

- ***Determination Based on Disability:***
  - 90 days – Federal Regulations
  - 60 days – Illinois Administrative Code
- ***Determination for All Others:***
  - 45 days – Federal Regulations and Illinois Administrative Code

Federal regulations require determinations of eligibility for any Medicaid applicant cannot exceed 90 days for applicants who apply for Medicaid on the basis of a disability and 45 days for all other applicants. Illinois imposes more strict timelines for Medicaid eligibility determinations for individuals applying on the basis of a disability. According to the Administrative Codes for HFS and DHS, determination of eligibility for LTC must be completed within 60 days for all persons seeking to qualify on the basis of a disability and 45 days for all other applicants (89 Ill. Adm. Code 110.20 and 10.420).

Certain extensions of the time limitations for determining eligibility are allowed. The applicant, his or her spouse, an approved representative, or the facility in which the applicant lives may request a 30-day extension to provide verification of current resources or resources transferred during the look-back period. Upon request, DHS or the HFS OIG may also allow a second 30-day extension, if

needed. These extensions are authorized by the Illinois Public Aid Code (305 ILCS 5/11-5.4(a) and 5.4(e)). Additionally, prior to Public Act 100-665 (effective August 2, 2018), HFS OIG had the ability to have an extension of up to 90 days (that is a 135-day total processing time limit).

In order to analyze if applicants were receiving their determinations of eligibility within the required timeframes, we reviewed three reports: LTC monthly reports, medical application backlog reports, and internal weekly reports. Since the source data for all three reports was IES, there were multiple issues affecting the data for these reports as discussed in the *LTC Monthly Report Accuracy* section. Despite differences between the various reports produced by HFS, we found that all three reports indicated not all applicants were receiving their determinations of eligibility in a timely manner, particularly after the end of the Public Health Emergency.

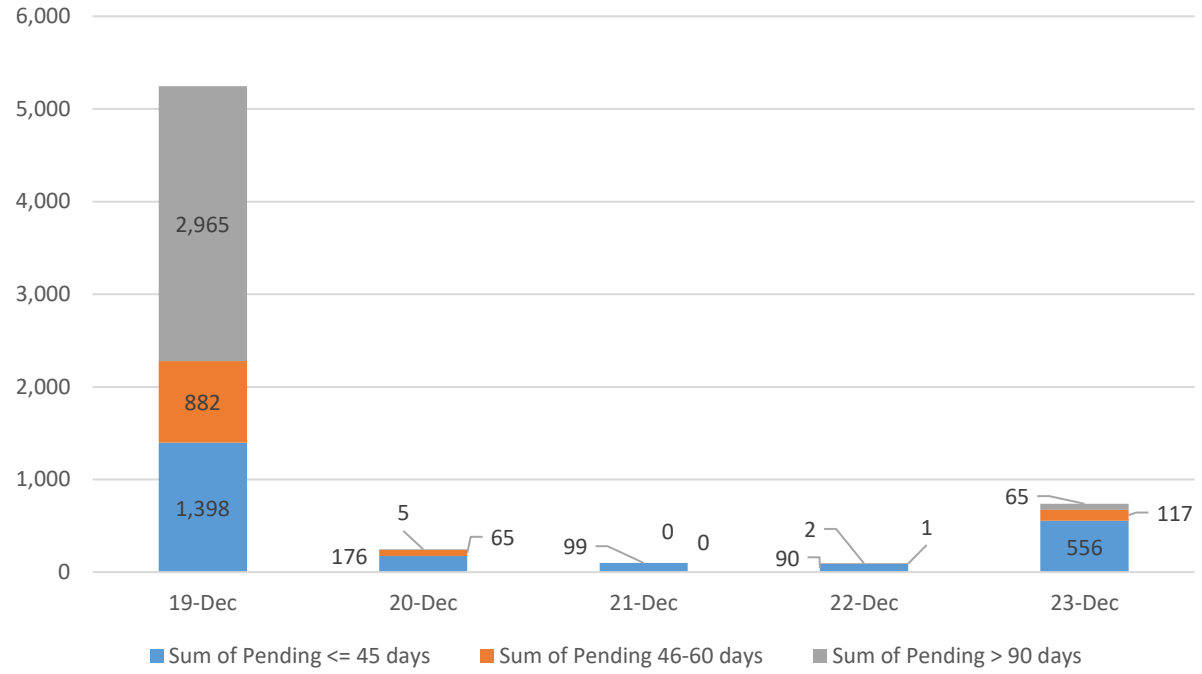
LTC Monthly Reports

We reviewed the monthly reports provided by HFS, for the audit period of calendar years 2021 through 2023, to determine if all applicants were receiving their determination of eligibility within the timelines established by federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 Ill. Adm. Code 110.20 and 10.420). The Illinois Public Aid Code requires DHS and HFS to jointly compile data on pending applications, denials, appeals, and redeterminations into a monthly report and post that report on each Department's website for the purposes of monitoring LTC eligibility processing (305 ILCS 5/11-5.4(f)).

HFS' LTC monthly reports indicate that while not all applicants were receiving their determination of eligibility within the timelines required by federal regulations and the Illinois Administrative Code, there was significant improvement compared to the prior audit period. As shown in **Exhibit 5**, the number of pending applications increased after the Public Health Emergency ended in May 2023. However, the number of pending applications still remained substantially below the number pending prior to the COVID-19 pandemic.

- The December 2021 report listed **99** applications, all pending less than 45 days.
- The December 2022 report listed **93** applications with 90 pending less than 45 days. One application was pending between 46 and 90 days, and two applications were pending over 90 days. In total, three applications (3%) were pending greater than the 45-day processing requirement.
- The December 2023 report listed **738** applications with 556 pending less than 45 days. There were 117 applications pending between 46 and 90 days and 65 applications pending over 90 days. In total, 182 applications (25%) were pending greater than the 45-day processing requirement. By comparison, the December 2019 report listed **5,245** pending applications with 3,847 (73%) pending greater than 45 days.

Exhibit 5
LTC PENDING APPLICATIONS (PER LTC MONTLY REPORTS)
End of Calendar Years 2019 through 2023



Source: OAG prepared based on HFS reports.

Medical Application Backlog Reports

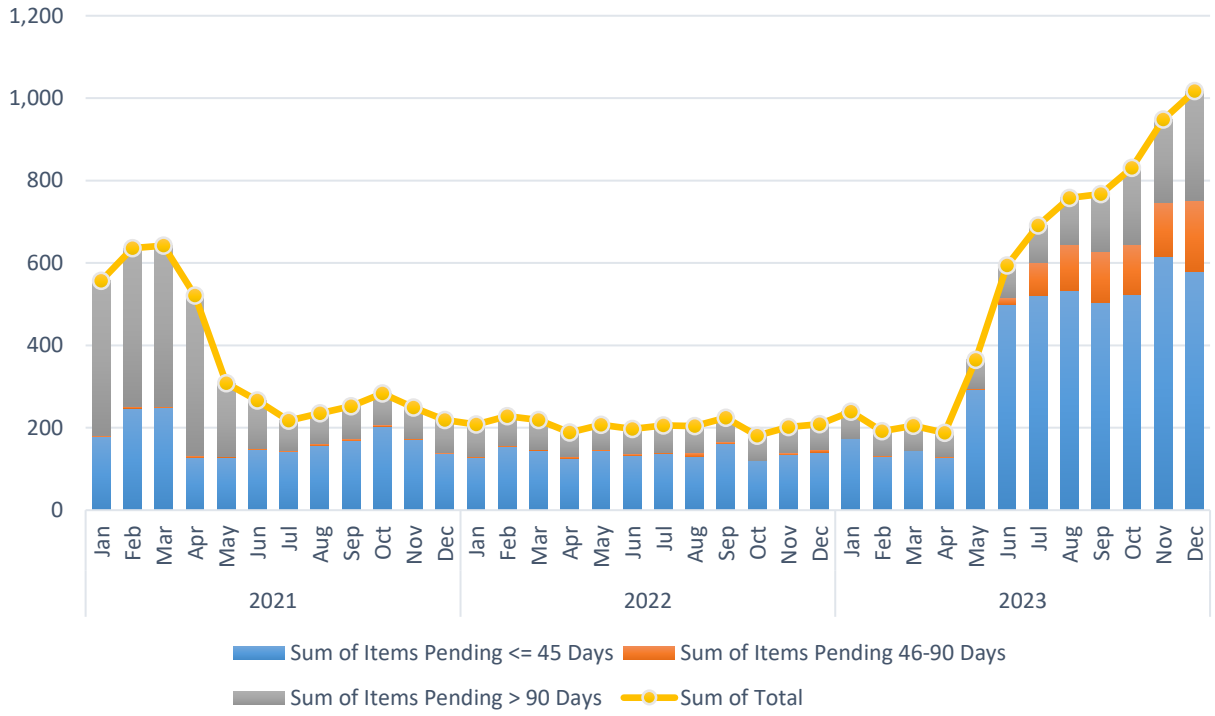
HFS' medical application backlog reports also indicated that not all applicants were receiving their determinations of eligibility within the timelines established by the federal regulations and the Illinois Administrative Code. Prior to the COVID-19 Public Health Emergency, HFS held bi-weekly calls with the federal Centers for Medicare and Medicaid Services (CMS). HFS prepared reports related to applications and redeterminations for those calls. The reports were created for external and internal reporting and were referenced if needed when updating federal CMS or other stakeholders. According to HFS officials, the meetings with federal CMS had not resumed during the current audit period. However, the medical application backlog reports that were referenced during the federal CMS meetings were still being prepared and were provided to auditors.

As shown in **Exhibit 6**, the number of pending applications remained low until rising again beginning in May 2023. The reports showed the following:

- As of January 31, 2021, there were 557 total pending applications. Of those total pending applications, 379 (**68%**) were pending for more than 45 days.

- As of April 30, 2023, there were 188 total pending applications. Of those total pending applications, 60 (**32%**) were pending for more than 45 days.
- As of December 31, 2023, there were 1,017 pending applications. Of those total pending applications, 437 (**43%**) were pending for more than 45 days.

Exhibit 6
LTC PENDING APPLICATIONS (PER MEDICAL APPLICATION BACKLOG REPORTS)
Calendar Years 2021 through 2023



Source: OAG prepared based on HFS reports.

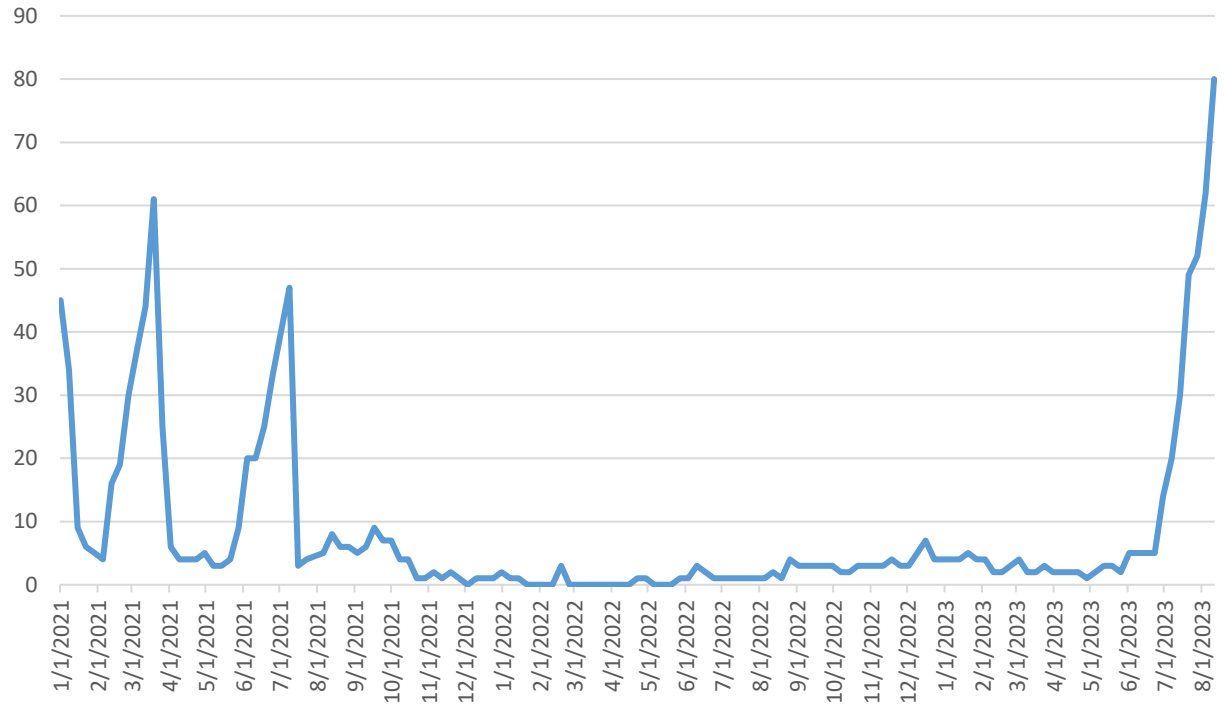
Internal Weekly Reports

Finally, HFS' internal weekly reports also indicated that not all applicants were receiving their determinations of eligibility within the timelines established by the federal regulations and the Illinois Administrative Code. HFS created an internal weekly report in April 2019. This internal report is used to track the volume of pending work in various categories and utilizes data from IES. HFS provided the weekly reports for the audit period through the week of August 11, 2023. According to HFS officials, there were no reports after August 2023 because the reports were not mandatory and were discontinued.

As shown in **Exhibit 7**, the number of applications pending for more than 45 days was 45 as of January 1, 2021. The number of pending applications varied between 0 and 61 until the end of July 2023, when it began increasing to 80 as of August 11,

2023. As discussed in the *Changes due to the COVID-19 Public Health Emergency* section, the COVID-19 Public Health Emergency ended in May 2023, resulting in the resumption of the normal application processing procedures, which led to a slight increase in the number of applications pending for more than 45 days. However, the number of applications pending for more than 45 days was still significantly lower than before the COVID-19 pandemic, when the number of pending applications was over 3,000 in April 2020.

Exhibit 7
LTC PENDING APPLICATIONS FOR MORE THAN 45 DAYS (PER WEEKLY REPORTS)
January 2021 through August 2023



Source: OAG prepared based on HFS reports.

Issues Affecting the Data

We reviewed data consisting of **44,661** LTC applications received in calendar years 2021 through 2023. The number of applications increased from 14,326 in 2021 to 15,645 in 2023. The total number of applications was down significantly from the 56,864 applications received during calendar years 2018 to 2020. Upon review of the data, which was pulled from IES, we determined calculating timeliness for the population of applications using the data provided would not provide accurate results for the purposes of this audit. More specifically, we found:

- **8,487 of 44,661** applications (**19%**) had multiple entries based on the same name, same date of birth, and same application date. The applications data was pulled by HFS in the same manner as the prior audit; if an application had

multiple assistance types, then the application was listed multiple times in the data; and

- the data contained duplicate records and identifiers.

In addition, as discussed in the *Extension Tracking* section, the defect that was identified with the extension tracker during the previous audit was not corrected until June 2023. Therefore, for most of the audit period, there were potential issues with the number of extensions and the allowable number of extension days. Finally, there was no way to determine if the application should be based on a disability due to how the applications are accepted. DHS officials stated that they do not track the 60-day process because the goal is to process all medical applications within 45 days.

For these reasons, an accurate calculation of timeliness required testing individual applications as opposed to being able to test the timeliness of all applications in the population. We also focused on the timeliness of the eligibility determinations and did not assess if the eligibility was determined correctly.

Timeliness Testing Results

According to the IES data, **15,645** applications were submitted during calendar year 2023. We selected a sample of 50 applications for testing due to the issues noted above. See **Appendix B** for additional sampling and testing information related to the audit's scope and methodology.

Exhibit 8
DAYS OVERDUE FOR APPLICATION TESTING
Sample of 50 Applications Tested

Days Overdue	Number of Applications[1] PHE	Post PHE
0	18	21
1-30	0	4
31-45	0	2
46-60	0	0
61-90	0	1
91-120	0	2
121+	0	2

[1] PHE applications were submitted prior to the end of the Public Health Emergency on May 11, 2023.

Source: OAG analysis of LTC applications testing.

For the applications testing, we found that 39 applications (**78%**) had an eligibility determination within the required timelines. An additional 6 applications (**12%**) were completed within 45 days (between 5 and 38 days) beyond the required timeline. **Exhibit 8** provides a detailed breakdown of the days overdue for the 50 applications sampled. For the 11 applications that were not completed within the required timelines, auditors determined that 5 were overdue because of an OIG investigation. Prior to August 2018, HFS OIG had the ability to have an extension of up to 90 days for investigations. According to HFS OIG officials, even though there is no additional time allowed for OIG investigations, HFS OIG has a targeted completion time of 90 days for investigations.

As discussed in the *Changes due to the COVID-19 Public Health Emergency* section, the COVID-19 Public Health Emergency ended on May 11, 2023, and the resource test for applications resumed on May 12, 2023. All the applications that were not completed in a timely manner occurred after the end of the PHE.

Exhibit 9 presents the timeliness results of the application processing sample.

For the 50 applications sampled, it took on average **41 days** from receipt of application to decision. In addition, of the 50 applications sampled, 17 applications were referred to the HFS OIG for asset discovery investigations. The applications that were referred to HFS OIG spent on average **58 days** at the OIG. For the 33 cases that did not have HFS OIG involvement, it took on average **22 days** for DHS to make a determination. **Exhibit 10** presents the application processing sample by LTC hub.

Exhibit 9
APPLICATION PROCESSING TIMELINESS
Sample of 50 Applications Tested

	Number Tested	Average days from receipt to initial decision	
		Days at DHS	Days at HFS OIG
DHS only applications	33	22	N/A
DHS & HFS OIG applications[1]	17	40	58
Total	50	41	

[1] Seven of the HFS OIG applications were referred to HFS OIG after DHS had made the initial decision.

Source: OAG analysis of LTC applications testing.

Exhibit 10
APPLICATION PROCESSING TIME BY HUB
Sample of 33 Non-OIG Applications Tested

Location	Number Tested	Average days from receipt to initial decision
MFO Central	10	10
MFO Downstate	12	24
MFO North	11	31
Total	33	22

Source: OAG analysis of LTC applications testing.

While there were still applications that were not completed in a timely manner, there was a substantial improvement in timeliness compared to the previous audit period. During the previous audit, only 15 of the 50 applications (**30%**) that were tested had an eligibility determination within the required timelines. For those 50 applications, it took on average **125 days** to make a determination. For the 34 applications that were not referred to HFS OIG, it took on average **98 days** to make a determination. Finally, for the previous audit, there were 16 applications that were referred to HFS OIG, and those applications spent on average **98 days** at the OIG.

Federal regulations require Medicaid to be furnished promptly to beneficiaries without any delay caused by the agencies' administrative procedures. Federal regulations also require the timely determination of eligibility. If eligibility is not determined timely, it could delay Medicaid benefits being provided to applicants and create hardships for the applicants.

Status of Prior Audit Recommendation Number 1

We found that **11 of 50** (**22%**) of applications were pending past the required number of days during fieldwork testing, all of which occurred after the end of the PHE. Additionally, while there was substantial improvement compared to the prior audit, all three reports indicated not all applicants were receiving their determinations of eligibility in a timely manner, particularly after the end of the PHE. Due to these testing and reporting results, this recommendation was determined to be **partially implemented** during this audit period. There was improvement in the timeliness of eligibility determinations. However, the number of untimely applications increased once the PHE ended.

Eligibility Determination Timeliness	
RECOMMENDATION NUMBER 1	***The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should work together to implement controls to improve the timeliness of long-term care eligibility determinations to comply with timelines contained in federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 Ill. Adm. Code 10.420).***

HFS Response:

The Department of Healthcare and Family Services (HFS) accepts the recommendation. As the report notes, the additional 90 days afforded for OIG's asset discovery investigations was removed from statute as of August 2018. Asset discovery investigations involve obtaining and reviewing up to five years of complex financial records, which takes time. OIG strives to complete all of its reviews within 90 days of referral, but without an allowance of additional time to complete these investigations, determinations in cases referred to OIG will continue to be untimely. So that applicants are not negatively impacted by these investigations, the State grants Provisional Eligibility until a decision on their application is reached.

DHS Response:

The Department of Human Services (DHS) accepts the recommendation. DHS will work cooperatively with the Department of Healthcare and Family Services (HFS) to review the process of long-term care eligibility determinations and create any needed controls necessary to comply with timeliness requirements. DHS has implemented the use of reports to improve the monitoring process for timeliness of processing applications. DHS will continue to monitor the effectiveness of the reports in monitoring pending work. DHS will also provide a yearly training session for applicable staff, which will include timely processing of applications.

Applications with HFS OIG Asset Discovery Referrals

DHS and HFS noted that an IES system enhancement was established to address the processing delays related to OIG asset investigations. However, applications involving HFS OIG asset discovery investigations continued to be overdue during this audit period. The prior audit found that all 16 sampled applications involving asset discovery investigations were not completed in a timely manner. For this audit, we tested 17 cases referred to the HFS OIG in calendar year 2023 to follow up on this recommendation. Seven of the applications were referred to HFS OIG after the initial eligibility decision had already been made by DHS. During this testing, we found that eight applications involving asset discovery referrals did not have a decision made in a timely manner. In addition, multiple issues continued to be identified for these HFS OIG cases during our review. These issues included incorrect information in IES and a lack of controls in IES. As a result, the status of the recommendation on processing delays related to HFS OIG asset discovery investigations was determined to be **partially implemented**.

HFS OIG Application Referral Process

The HFS OIG reviews complex financial and legal documents as part of an asset discovery investigation; as a result, processing an application referred for an asset investigation requires additional time. However, Public Act 100-665 (effective August 2, 2018) removed the ability of HFS OIG to have an extension of up to 90 days (that is a 135-day total processing time limit). Even though the statutory extension for investigations was repealed, 90 days remains HFS OIG's target for completing the asset investigations. The targeted completion time was developed from time studies of working cases.

Although the OIG continued to perform investigations on cases referred, recommendations prepared for these investigations were not allowed to be sent to DHS for implementation until the Public Health Emergency (PHE) ended on May 11, 2023. Therefore, resource tests resumed on May 12, 2023.

During the prior audit period, a system enhancement was implemented on February 26, 2019, and designed to enable DHS caseworkers to notify the HFS OIG about referrals through IES. According to HFS, this allowed for better tracking of OIG referrals. This change simplified and streamlined the referral process for OIG and caseworkers. It ensured timely follow-up and allowed caseworkers to review tasks more easily. DHS further explained that this enhancement will be revisited once the PHE waivers have been phased out.

Testing Results

As part of the testing of the 50 applications, we selected 10 cases referred to the HFS OIG for asset discovery investigations during calendar year 2023. In addition to the 10 OIG cases specifically sampled, seven other cases included referrals to the OIG and were also included in the analysis. Therefore, we reviewed a total of **17 cases** referred to the OIG for investigation during fieldwork testing. According to DHS officials, during the PHE, DHS was approving cases, then sending the cases to the OIG for post-eligibility determination. This was because assets were disregarded at that time. Also, DHS can approve cases and

then make referrals to the OIG after the decision was made based on when information from the applicant was received. Because of this, 7 of the 17 cases with OIG referrals were referred to HFS OIG after the initial eligibility decision had already been made by DHS, including two referrals that were withdrawn or rejected by HFS OIG. Additionally, two applications submitted after the end of the PHE had referrals that were withdrawn or rejected by HFS OIG. Therefore, 13 of the 17 OIG referrals resulted in investigations.

Eight of the 17 cases with referrals to HFS OIG were not completed in a timely manner, ranging from **14** to **156** days overdue. The time spent at the HFS OIG for these cases ranged from **34** to **154** days. **Eight** (**62%**) of the 13 investigations were completed in less than 90 days, which is the targeted completion time for HFS OIG investigations. According to HFS OIG officials, cases can take longer than the targeted completion time due to the scope and complexity of the financial review or there could be a delay related to working other more complex cases.

During the previous audit, all the HFS OIG applications were not completed in a timely manner, ranging from **37** to **260** days overdue. The time spent at HFS OIG for those applications ranged from **47** to **182** days. Additionally, the prior audit found that there were issues in IES with both incorrect information and a lack of controls.

In testing the 17 cases with referrals to the HFS OIG, multiple issues were identified for the HFS OIG cases. These issues included:

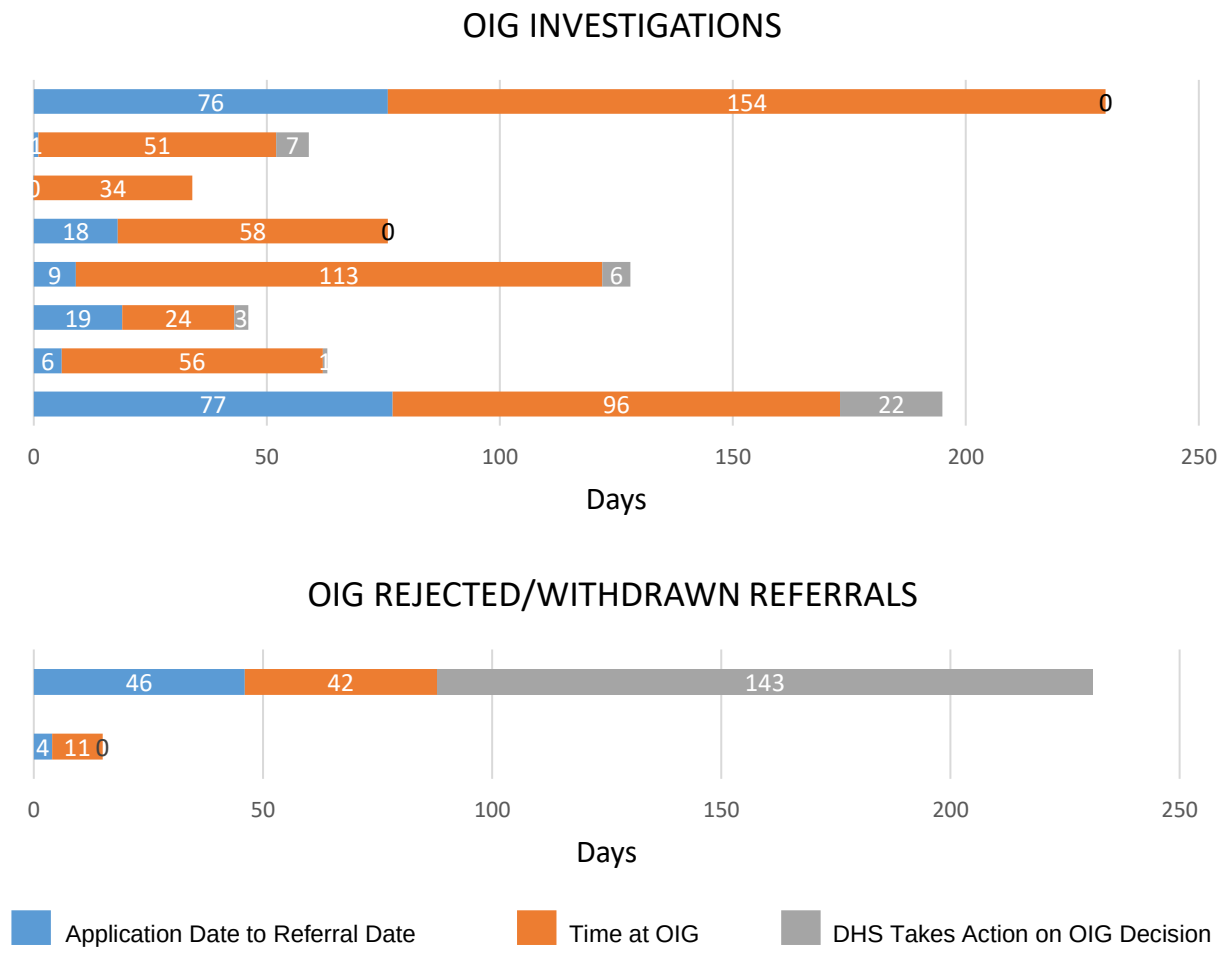
- The OIG referral date in IES was incorrect for **2** of **17** cases (**12%**).
- The OIG completed date in IES was incorrect for **1** of **17** cases (**6%**).
- All 17 OIG cases indicated a lack of IES controls. During the prior audit, DHS officials stated that IES should not accept dates for referral unless the "Has the OIG Referral been initiated" question is marked "Yes." However, the 17 HFS OIG cases tested did not contain a "yes" answer for this question and referral dates were still allowed to be entered in IES. Ten of the cases were marked with a "No," and 7 were blank. According to DHS officials, in July 2024, HFS OIG staff reported working with IES staff to fix the HFS OIG queue, and this field may have been the issue.

Referrals Prior to Eligibility Decision

Ten of the applications were referred to HFS OIG prior to DHS making a decision on eligibility. As shown in **Exhibit 11**, DHS worked on these applications from **0** to **77** days before referring them to HFS OIG, and the average number of days from receipt of application to referral to HFS OIG was **26** days. The time spent at HFS OIG for these cases ranged from **24** to **154** days. For these 10 applications, we found that once an investigation was concluded, or the referral was rejected/withdrawn, DHS implemented the recommendation between **0** and **143** days, with **5** of the **10** recommendations being implemented in 5 days or less. There was one application where DHS made a decision 34 days prior to HFS OIG closing the investigation due to the death of the applicant.

For the 16 applications sampled during the prior audit, DHS worked on the applications from **0** days to **161** days before they were referred to HFS OIG, and the average number of days from receipt of application to the referral to HFS OIG was **60** days. Also, the time spent at HFS OIG for those cases ranged from **47** to **182** days.

Exhibit 11
OIG INVESTIGATIONS AND REJECTED REFERRALS SAMPLE TESTING RESULTS
Calendar Year 2023

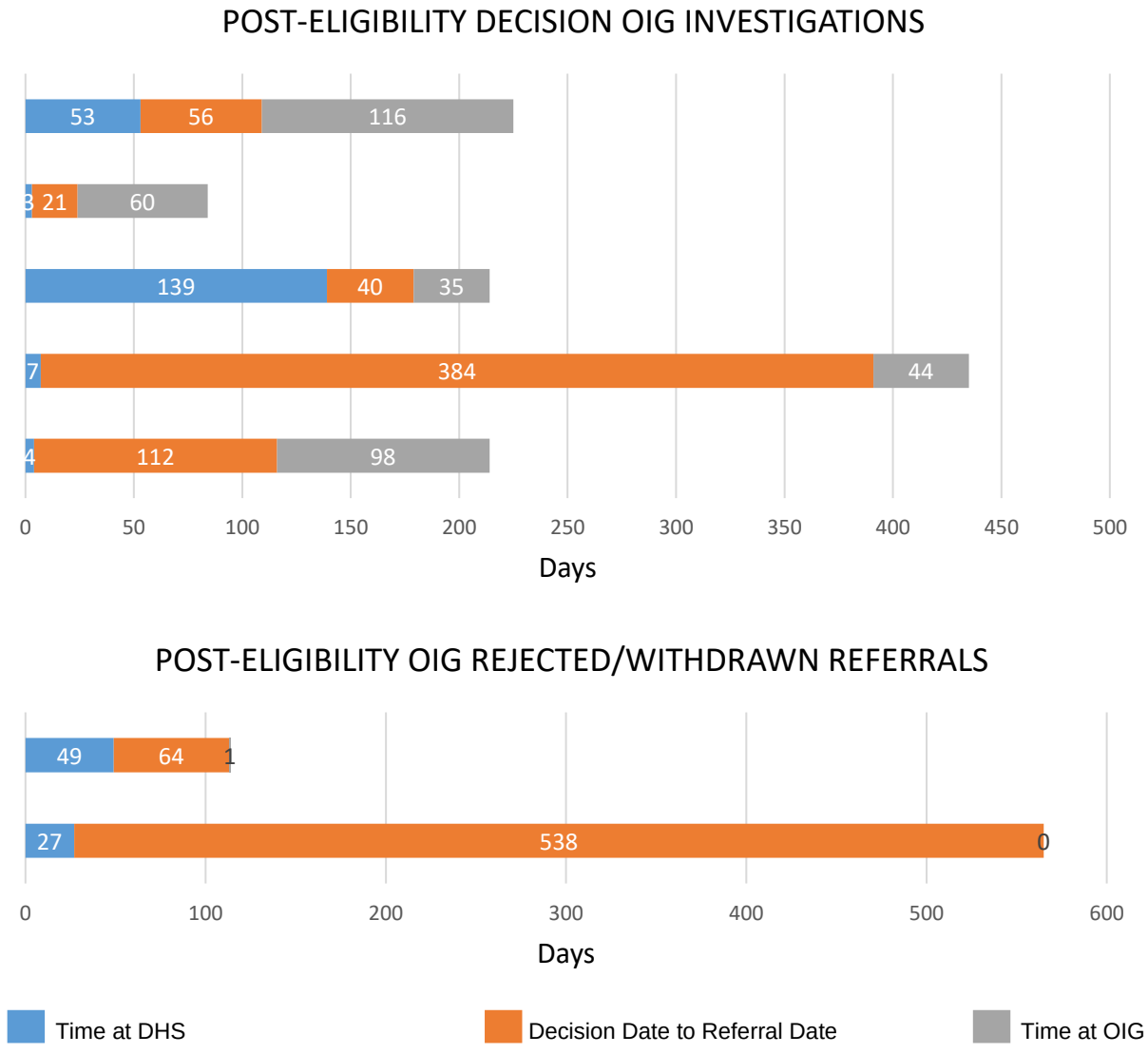


Source: OAG analysis of LTC applications testing.

Referrals After the Eligibility Decision

Seven of the applications were referred to HFS OIG after DHS made an eligibility decision. As shown in **Exhibit 12**, DHS referred these applications to HFS OIG between **21** and **538** days after the initial decision was made. The time spent at HFS OIG for these cases ranged from **0** to **116** days.

Exhibit 12
OIG POST-ELIGIBILITY DECISION INVESTIGATIONS AND REJECTED REFERRALS SAMPLE TESTING RESULTS
Calendar Year 2023



Source: OAG analysis of LTC applications testing.

Status of Prior Audit Recommendation Number 2

During the previous audit, it was noted that even though the February 2019 system enhancement allowed the HFS OIG to receive notifications from DHS through IES, email notifications were requested from DHS caseworkers after the referral transmission. This was done to ensure that all referrals were received in a timely manner. DHS officials reported that this process has continued to be used during the current audit period due to the issues with the HFS OIG queue. While there were still some applications that were not completed in a timely manner, compared to the prior audit, there was improvement in the number of days overdue. Additionally, there was improvement in the average number of days between the application and when the application was referred to HFS OIG. However, there continued to be issues with incorrect data in IES and a lack of IES controls. Therefore, the status of this recommendation was determined to be **partially implemented**.

	HFS OIG Application Referrals
RECOMMENDATION NUMBER 2	***The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should, in order to decrease the opportunity for application processing delays, work together to implement changes to improve the process of:*** • ***Referring applications to the HFS OIG to ensure referrals are received by the HFS OIG, and*** • ***Receiving and acting upon recommendations from the HFS OIG upon completion of its asset investigations.***

HFS Response:

The Department of Healthcare and Family Services (HFS) accepts the recommendation. HFS OIG (OIG) and DHS work together to ensure that referrals are received timely and that no cases are missed. OIG organizes and participates in quarterly meetings with DHS regarding the referral process and will continue. Also, OIG and DHS amended the referral criteria for asset discovery reviews as of April 2025 to better target high quality referrals and reduce unnecessary referrals. OIG cannot comment on any delays in the implementation of its recommendations.

DHS Response:

The Department of Human Services (DHS) accepts the recommendation. DHS will work cooperatively with the Department of Healthcare and Family Services (HFS) and the HFS OIG on changes to improve: (i) the current referral process maintained between HFS and DHS to ensure completion of the process steps for referral and (ii) the current process for receiving and acting upon recommendations from the HFS OIG upon the HFS OIG's completion of its asset investigations. DHS has implemented the use of reports to improve the monitoring process for timeliness of processing applications. DHS will continue to monitor the effectiveness of the reports in monitoring pending work. DHS will also provide a yearly training session for applicable staff, which will include the OIG referral process.

Extension Tracking

DHS and HFS continued to not adequately track extensions in IES during this audit period. After the enhancement request in April 2019, IES was supposed to be able to systematically calculate the extended due date based on the verification type and display the extended details under the verification checklist due date extension history. However, an IES defect with the extension tracker that was discovered during the prior audit that affected the accuracy of the data in IES was not corrected until June 2023. For the 10 extension cases reviewed, 5 cases (**50%**) contained issues, such as inaccurate IES data or granting a 60-day extension as opposed to the allowed 30-day extensions. While there continued to be issues with extensions in IES, there were improvements since the prior audit. As a result, the status of the recommendation on extension tracking was determined to be **partially implemented**.

Tracking of Extensions

The Illinois Public Aid Code requires DHS and the HFS OIG to allow LTC applicants additional time to submit information and documents needed as part of the resources review (305 ILCS 5/11-5.4(e)). The agencies may grant a total of two extensions. The first extension shall not exceed 30 days, and a second extension of 30 days may be granted upon request for a maximum of 60 days.

According to the Illinois Public Aid Code, time limits for processing an application are required to be tolled, or paused, during the period of an applicant-requested extension, essentially subtracting time granted through these extensions from the application processing times (305 ILCS 5/11-5.4(e)). However, if the number of extensions or extension dates are not easy to identify or not captured at all, then the extension processing times cannot be subtracted from the eligibility determination processing time as required.

During the prior audit, in April 2019, an enhancement was implemented that had IES systematically calculate the extended due date and display the extended details under the verification checklist due date extension history.

DHS provided IES support stating the total pending days for pending applications was supposed to be accurate as of April 8, 2019. However, the prior audit found that there was still inaccurate extension data in IES. In addition, although the Statute only allows for two extensions per application, the prior audit found a case where an extension was granted more than two times.

According to HFS officials, during the prior audit, HFS became aware that a defect was found with the extension tracker in IES. The extension tracker was not consistently applying the number of extensions, and the allowable number of extension days provided may be incorrect. A defect was logged for this issue. According to HFS, the issue with the tracker was resolved with the fix being implemented on June 12, 2023.

Testing Results

To follow up on the prior audit recommendation, we included 10 extension cases in our sample of 50 cases reviewed from IES during fieldwork. In total, 13 extensions were granted for the 10 applications reviewed. (See **Exhibit 13**.)

We tested these cases to ensure only two extensions were granted for each case and that the extensions were only granted for 30 days each as required. We also looked at the accuracy of the extension data provided by comparing the extension data from IES with the documentation and/or support provided by DHS. For the extension cases reviewed, we found 5 of 10 applications (**50%**) with inaccurate IES data. We also found that two cases with extensions (**20%**) were not completed in a timely manner.

Exhibit 13
EXTENSIONS TESTING RESULTS
Sample of Applications Tested

Category	Number
Extensions Summary	
Applications with Extensions	10
Total Number of Extensions	13
Inaccurate IES Data	
Number of Applications with Inaccurate Due Date in IES	3
Number of Applications with Inaccurate Length of Extended Days in IES	3
Number of Applications with Inaccurate Count of Extensions in IES	1
Number of Applications Receiving one 60-Day Extension	1

Note: Some applications with extensions may have more than one issue, so the total will not match.

Source: OAG analysis of LTC applications testing.

During the previous audit, 10 of the 13 applications (**77%**) with extensions had inaccurate IES data, a lack of extension information in IES, or cases with more than two extensions.

Although the Statute only allows for a maximum of 30 days per extension, we found one case that was granted one 60-day extension. According to DHS officials, this occurred because IES automatically granted a 60-day extension.

When extensions are not tracked adequately, it is difficult to ensure that DHS and HFS are limiting applications to up two allowable 30-day extensions.

Status of Prior Audit Recommendation Number 3

Although HFS noted that a system enhancement was implemented in IES to address this prior audit recommendation, the testing results showed the enhancement was not fully effective. While there continued to be cases with inaccurate IES data, there was improvement over the prior audit. Also, auditors found no examples of more than two extensions or extensions that were not in IES. Therefore, the status of this recommendation was determined to be **partially implemented**.

Tracking of Extensions	
RECOMMENDATION NUMBER 3	***The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should ensure extensions are tracked so processing times can be tolled, as required by the Illinois Public Aid Code, for extension days granted (305 ILCS 5/11-5.4(e) and 305 ILCS 5/11-5.4(f)(B)). Specifically, the Departments should ensure:*** • ***Extensions are captured in a usable manner;*** • ***Extensions are captured accurately; and*** • ***The length of extensions granted by IES are in accordance with statute.***

HFS Response:

The Department of Healthcare and Family Services (HFS) accepts the recommendation. A system enhancement request, #279747, was implemented on June 12, 2023, to capture the information and ensure extensions are in accordance with statute.

DHS Response:

The Department of Human Services (DHS) accepts the recommendation. DHS will work in cooperation with the Department of Healthcare and Family Services (HFS) in reviewing the current functionality of extension tracking in IES and implement any training needed based on both current and future functionality.

LTC Monthly Reporting

The prior audit found that HFS and DHS had posted all the reports on a monthly basis as required by the Illinois Public Aid Code. For this audit, HFS completed reports for **28 of the 36** (**78%**) months during the audit period. Additionally, HFS was only able to provide documentation for the posting of **5 of the 28** (**18%**) reports on the HFS website. DHS maintained a link on the DHS website. However, the HFS website was updated, but the DHS website was not changed to reflect the new link.

Public Act 100-380 requested the Auditor General to evaluate the accuracy and completeness of the monthly report required by the Illinois Public Aid Code to be posted on both the DHS and HFS websites for the purpose of monitoring LTC eligibility processing (305 ILCS 5/11-5.4(f)).

HFS provided **28 of the 36** (**78%**) LTC monthly reports for calendar years 2021 to 2023. According to HFS officials, the missing reports were not completed due to the transitioning of staff. The reports contain information on pending applications, admissions, redeterminations, and LTC appeals. Most of the tables in the reports summarize pending LTC applications and admissions. The application source data for the LTC monthly reports provided during this audit was IES.

Required Posting of LTC Monthly Report

HFS is not posting the LTC reports on a monthly basis as required by the Illinois Public Aid Code. These reports are required to be posted on "each Department's website for the purposes of monitoring LTC eligibility processing" (305 ILCS 5/11-5.4(f)).

During the prior audit, HFS and DHS posted all LTC reports as required by the Illinois Public Aid Code on a monthly basis. In August 2019, a link to the HFS website was added to the DHS website. During the current audit period, the link remained on the DHS website. However, the HFS website was updated, and the DHS website was not changed to reflect the new link.

Review of LTC Monthly Reports

Auditors requested documentation to support the posting of the monthly reports completed during calendar years 2021 to 2023. HFS was only able to provide documentation for **5 of the 28** (**18%**) reports. If LTC monthly reports are not completed and posted to the websites as required, it is difficult for the public to monitor LTC eligibility processing.

LTC Monthly Reporting	
RECOMMENDATION NUMBER 4	***The Department of Healthcare and Family Services and the Department of Human Services should complete the LTC reports and post the reports to each Department's website on a monthly basis as required by Section 11-5.4(f) of the Illinois Public Aid Code (305 ILCS 5/11-5.4(f)).***

HFS Response:

The Department of Healthcare and Family Services (HFS) accepts the recommendation. HFS had pended the posting of the monthly reports due to changes requested. HFS will begin posting these reports again immediately.

DHS Response:

The Department of Human Services (DHS) accepts the recommendation. DHS will work in cooperation with the Department of Healthcare and Family Services (HFS) to include the correct link to the HFS website.

LTC Monthly Report Completeness

The prior audit found the LTC monthly reports did not contain all elements as required by statute. We reviewed the LTC monthly reports for calendar years 2021 to 2023 and found HFS had added a missing element to the reports but was not providing all the information required by 305 ILCS 5/11-5.4(f). Specifically, monthly reports did not include the required percentages for applications and redeterminations that were pending and tolled due to extensions. Additionally, the associated percentages for the numbers of redeterminations pending at the HFS OIG were not included until the February 2023 reports. As a result, the status of this recommendation on the LTC monthly report completeness was determined to be **partially implemented**.

According to the prior audit, the LTC monthly reports did not contain all elements as required by statute. The reports did not contain information on extensions, and the reports only provided the number of redeterminations pending by location, not the percentages as required. As a result, we reviewed monthly reports for this audit period of calendar years 2021 to 2023 and found some required elements were still not included.

LTC Monthly Report Requirements

The monthly reports are required to provide the following:

- length of time applications, redeterminations, and appeals are pending: 0 to 45 days, 46 days to 90 days, 91 days to 180 days, 181 days to 12 months, over 12 months to 18 months, over 18 months to 24 months, and over 24 months;
- percentage of applications and redeterminations pending in DHS' Family Community Resource Centers, in DHS' LTC hubs, with HFS' Office of Inspector General, and those applications which are being tolled due to requests for extension of time for additional information; and
- status of pending applications, denials, appeals, and redeterminations (305 ILCS 5/11-5.4(f)).

After reviewing the monthly reports for calendar years 2021 to 2023, auditors found HFS was providing most of the information required by 305 ILCS 5/11-5.4(f). However, there were some remaining issues with the completeness of LTC monthly reports. More specifically, we found the following:

- The monthly reports did not include the required percentages for applications and redeterminations that were pending and tolled due to extensions.
- Although the monthly reports provided the numbers for applications and redeterminations by location and pending with HFS OIG, the reports did not start providing the associated redetermination percentages until the February 2023 report.

Status of Prior Audit Recommendation Number 4

Although HFS was providing most information in the LTC monthly reports as required by 305 ILCS 5/11-5.4(f), there were still some remaining issues with the completeness of the reports. HFS stated that the reports will not be corrected until

after the current audit period. Therefore, the status of this recommendation was determined to be **partially implemented**. If LTC monthly reports do not contain all required elements, the usefulness and transparency of the reports continue to be diminished, which impacts the public's ability to monitor LTC eligibility processing.

LTC Monthly Report Completeness

RECOMMENDATION NUMBER 5

The Department of Healthcare and Family Services and the Department of Human Services should ensure monthly reports contain all elements required by Section 11-5.4(f) of the Illinois Public Aid Code (305 ILCS 5/11-5.4(f)).

HFS Response:

The Department of Healthcare and Family Services (HFS) accepts the recommendation. Extensions are the only remaining data element to be included in the monthly reports. HFS estimates this information will be included by September 15, 2025. Per IL Administrative Code 89.120.308 3 (B), extensions are only applicable to initial determinations, not redeterminations.

DHS Response:

The Department of Human Services (DHS) accepts the recommendation. DHS will work cooperatively with the Department of Healthcare and Family Services (HFS) to ensure that all required items are contained in the long-term care monthly reports maintained by HFS.

LTC Monthly Report Accuracy

During the prior audit, we found the LTC monthly reports were not accurate due to duplicate entries and other issues with the source data and an inaccurate representation of the number of potential overdue applications. During this audit, we reviewed the monthly reports for calendar years 2021 to 2023 and found similar issues with accuracy that were identified during the prior audit. The monthly reports have an inaccurate representation of the number of potential overdue applications, and the data used to create the redeterminations table contained duplicate entries. We also found 19 of 50 applicants tested (**38%**) had a reported disability, which would allow 60 days for processing those applications.

We also compared the data provided by HFS to the monthly reports, internal weekly reports, and the medical application backlog report. We were unable to determine the accuracy of the data or the various reports due to the numbers not matching between the reports. We also requested LTC data on the total number of redeterminations completed during the audit and found the accuracy of the redeterminations data in the monthly reports improved since the prior audit. As a result, the status of the recommendation on the LTC monthly report accuracy was determined to be **partially implemented**.

The monthly reports posted on HFS' website pursuant to statute were not accurate (305 ILCS 5/11-5.4(f)). The monthly reports for calendar years 2021 to 2023 were reviewed, and the following issues with accuracy were found:

- the monthly reports did not present an accurate representation of the number of potentially overdue applications; and
- the data used to create the redetermination table in the reports contained duplicate entries.

Inaccurate Representation of the Number of Potential Overdue Applications

Extensions upon request by applicant:

- ***1st Extension:*** Up to 30 days
- ***2nd Extension:*** 30 days

According to the Illinois Public Aid Code, **the time limits for processing an application are to be tolled during the period of any extension granted** (305 ILCS 5/11-5.4(e)). HFS officials said that until July 2023, the numbers in the monthly reports did not take into account days for which the time limits for processing applications are authorized to be tolled, or paused, due to extensions requested by applicants.

Lack of Tracking Extensions and Disability Status

For the audit, we tested 50 applications and found evidence of a request for an extension by the applicant in 10 applications (**20%**). Two of the applications had more than one extension. Therefore, we found these applications could have been tolled for between 10 and 60 days. Applications that are granted extensions would not be considered overdue until having been pending for up to 105 days depending on the extensions granted.

The reports also did not identify applications on the basis of disability. Since the Illinois Administrative Code allows 60 days for processing applications on the

basis of a disability, some of the applications in the 46 to 60-day category might not be overdue if the applicant applied on the basis of a disability. According to HFS officials, there is no way to determine if the application should be based on a disability due to how the applications are accepted. Many individuals indicate they have a disability on the application. A disability status has to be verified by the Social Security Administration or the State's Client Assessment Unit. DHS officials stated that they do not track the 60-day process because the goal is to process all medical applications within 45 days.

During fieldwork testing, DHS officials provided information from the Social Security Administration's State On-Line Query System, which allows authorized state agencies real-time online access to Social Security data. Although DHS does not track the disability status of applicants, we were able to identify this status through these records. Based on those records, 19 of 50 applicants tested (**38%**) had a reported disability.

Source Data Accuracy

We were unable to make a determination regarding the accuracy of pending LTC applications data. During the prior audit, even though both the data provided and the monthly reports were from IES, auditors could not confirm the accuracy of the various reports. In addition to issues with the applications data, the numbers did not match between various reports. IES continued to be the source of the data in the LTC monthly reports during the current audit period.

Testing Related to Source Data Accuracy

We compared the data provided by HFS to the monthly reports, internal weekly reports, and medical application backlog reports. We were unable to determine the accuracy of the data for the various reports due to the numbers not matching between any of the reports.

Exhibit 14
APPLICATIONS APPROVED BY MONTH COMPARISON
Calendar Years 2022 through 2023

Month[1]	LTC Monthly Report	Medical Application Backlog Report	Applications Data	Applications Data Unique Numbers Count
January 2022	686	737	848	688
February 2022	677	722	821	672
March 2022	**803**	**850**	**973**	**803**
April 2022	700	727	858	695
May 2022	728	787	891	724
June 2022	673	767	935	735
September 2022	703	761	860	702
November 2022	668	707	804	667
December 2022	616	732	806	655
January 2023	673	719	867	674
February 2023	727	764	890	725
March 2023	704	842	957	776
April 2023	607	682	763	606
May 2023	545	601	651	542
June 2023	365	458	511	387
November 2023[2]	388	651	588	387

Notes:

[1] HFS did not complete all the required monthly reports during the audit period, and the months without reports during 2022 and 2023 are excluded from the analysis.

[2] HFS provided monthly reports for calendar years 2021 through 2023, and the December 2023 report presented data for November 2023.

Source: OAG analysis of IES data and HFS reports.

As shown in **Exhibit 14**, the number of applications approved by month varied based on the report or the data provided by HFS. For example, in March 2022 the number of applications approved had a low of 803 and a high of 973. March 2022 was the only month where the numbers from any of the four sources matched (monthly report and the applications data unique number count).

We also compared the number of pending applications in the monthly report to the internal weekly reports. As with the number of applications approved by month, the numbers did not match between reports and the data provided. As shown in **Exhibit 15**, for the five dates where a comparison was able to be completed between the monthly and the weekly reports, none of the report numbers match the applications data provided by HFS.

Exhibit 15
APPLICATIONS PENDING COMPARISON
Five Comparable Dates between 2021 and 2023

As of Date	LTC Monthly Report	Internal Weekly Report	Applications Data	Applications Data Unique Identification Count
April 30, 2021	173	173	474	301
December 31, 2021	138	138	612	378
September 30, 2022	82	82	1,069	592
March 31, 2023	119	119	1,263	627
June 30, 2023	414	414	1,937	1,014

Source: OAG analysis of IES data and HFS reports.

The numbers presented in the LTC monthly report only matched the internal weekly reports. In addition to the pending applications shown in **Exhibit 15**, the pending admissions also matched between the monthly and the weekly reports. However, because the numbers in the LTC monthly report did not match the medical application backlog report nor the LTC applications data provided by HFS, we were unable to fully confirm the accuracy of the applications tables in the LTC monthly reports.

Redeterminations Data

We requested LTC data on the total number of redeterminations completed for calendar years 2021 through 2023. Redeterminations were affected by the COVID-19 emergency rules, which became effective in April 2020 and suspended redeterminations. Therefore, according to HFS, no redeterminations were completed from January 2021 to May 2023 due to the PHE. Between June and December 2023, **38,038** redeterminations were completed.

In addition, one table in the LTC monthly reports summarizes the timeliness of pending redeterminations. According to the December monthly reports provided on the number of pending redeterminations there were **1,921** in **2021**, **1,373** in **2022**, and **1,981** in **2023**. According to HFS officials, this was due to that even though redeterminations were not being completed during the PHE, there were still pending redeterminations. Any redeterminations that were pending when the PHE began had the redetermination date extended.

Redeterminations Data in LTC Monthly Reports

HFS did not complete the monthly report for eight months during the audit period and provided the data used to create the redeterminations table in the monthly reports for **22 of the 28** reports during calendar years 2021 through 2023. According to HFS officials, the data for the missing six months could not be provided because the Department was in the middle of staff transitioning and reassigning responsibilities. Therefore, the supporting data was unable to be located. **Exhibit 16** shows the results of the analysis of the data used to create the redeterminations table in the monthly reports.

Exhibit 16
REDETERMINATIONS DATA SUMMARY (% With Issues)
Calendar Years 2021 through 2023

Issue	2021	2022	2023	Total[1]
Future Pending Dates in Report Table	0 of 8 (0%)	0 of 8 (0%)	0 of 6 (0%)	0 of 22 (0%)
Category Breakdown Did Not Match	0 of 8 (0%)	0 of 8 (0%)	0 of 6 (0%)	0 of 22 (0%)
Overall Numbers Did Not Match	0 of 8 (0%)	0 of 8 (0%)	0 of 6 (0%)	0 of 22 (0%)
Case Numbers and Individuals with Multiple Entries	8 of 8 (100%)	8 of 8 (100%)	1 of 6 (17%)	17 of 22 (77%)

[1] HFS did not complete the report for eight months during calendar years 2021 to 2023. Additionally, HFS was unable to provide the redeterminations data for six reports.

Source: OAG analysis of HFS reports and supporting data.

HFS has improved the accuracy of the redeterminations data in the monthly reports. During the prior audit there were issues with the total number of pending redeterminations not matching between the report and the data. We found that for the **22** months reviewed, **none** had issues with the totals matching. Additionally, during the prior audit there were reports where while the overall numbers matched, the categories did not match between the report and the provided data. Finally, while during the prior audit there were reports that included redeterminations that should not have been included, there were no reports with that issue during the current audit.

The only remaining issue with redeterminations data accuracy was with case numbers and individual IDs with multiple entries. For the 22 months reviewed, **17** (**77%**) contained case numbers and individuals with multiple entries. According to HFS officials, this may be because individuals might have multiple assistance types (for example, Medicare Savings Program and medical) and each type of assistance has to be redetermined. However, none of the reports after February 2023 contained multiple entries. According to HFS officials, the reports

were changed after the query was updated to only include medical assistance types.

Status of Prior Audit Recommendation Number 5

We reviewed the LTC application data in the LTC monthly reports and attempted to ensure the data matched the data in IES. However, we could not determine the accuracy of the LTC monthly reports due to the numbers not matching between any of the reports. According to HFS, the differences are due to how the IES data is analyzed for each of the reports. We also reviewed the redeterminations data and were able to compare it to the redeterminations data in the LTC monthly reports. There was improvement in the redeterminations data, and the only remaining issue with the redeterminations data was corrected for reports after February 2023. Therefore, the status of this recommendation was determined to be **partially implemented**. If LTC monthly reports are not accurate, the usefulness and transparency of the report is diminished, which impacts the public's ability to monitor long-term care eligibility processing.

LTC Monthly Report Accuracy	
RECOMMENDATION NUMBER 6	***The Department of Healthcare and Family Services and the Department of Human Services should develop controls to ensure monthly reports required by Section 11-5.4(f) of the Illinois Public Aid Code are accurate.***

HFS Response:

The Department of Healthcare and Family Services (HFS) accepts the recommendation. HFS is currently centralizing eligibility reporting to ensure that the same logic is applied to all eligibility reports. Centralizing the eligibility reports guarantees the completion of data validation and reconciliation. The estimated completion date for centralization is December 31, 2025.

DHS Response:

The Department of Human Services (DHS) accepts the recommendation. DHS will work cooperatively with the Department of Healthcare and Family Services (HFS) to ensure that all required items are accurate in the long-term care monthly reports maintained by HFS.

Application Processing Approaches

Application Processing Approaches

Caseworker-based: A caseworker is assigned after intake and then serves as a primary contact for the client from that time forward. A single caseworker is seen for all aspects of a client's case.

Task-based: Clients no longer see a single caseworker for all aspects of their cases but instead work with different workers for different tasks. A supervisor assigns tasks to a worker based on what needs to be done in a given day or week, and the assignment can change each day given what the supervisor determines to be the most urgent tasks. When a worker picks up a case, the worker is to address all tasks appearing.

Facility-based: A team of caseworkers is assigned to a specific group of nursing homes. The team is responsible for processing all applications and ongoing case maintenance from those nursing homes.

Public Act 100-380 requested the Auditor General to review and evaluate the efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of DHS for LTC services, including the role of IES, as opposed to the traditional caseworker-specific process from which the central offices converted. See the **text box** for an overview of the application processing approaches.

By November 2014, DHS moved from a caseworker-based approach to application processing to a statewide task-based approach. Prior to the switch to task-based processing, when a LTC application was received, it was assigned to a caseworker based on geographic area of the client's county or facility. In the task-based approach, caseworkers are assigned a specific function of case processing (such as accepting applications or collecting documentation) instead of all functions as with the traditional caseworker-based approach. Both the caseworker-based approach and the task-based approach had advantages and disadvantages.

IES had resulted in multiple reports of significant system slowness, which decreased caseworkers' ability to process applications in a timely manner. The concurrent changes made it difficult to attribute outcomes to either task-based processing or IES definitively. Although it was difficult to ascertain the efficiency and efficacy of the task-based approach compared to the caseworker-based approach, the decision to switch to the task-based approach appeared to be based upon business process research and reasonable assumptions.

Decision to Switch Approaches

During the previous audit period, DHS completed the implementation of the task-based approach in October 2018. DHS officials stated that after IES was fully implemented, there were improvements due to switching to the task-based approach. More specifically, the work became easier to locate after being uploaded to IES. However, DHS officials stated that the task-based approach was not effective for processing. Therefore, in 2019 DHS made the decision to move away from the task-based system to a new facility-based system. According to DHS, there were several reasons for this decision, including the following:

- staff accountability was hard to track;
- many staff were involved in correcting errors;

- barriers were created in looking at the case holistically and processing all work needing to be completed;
- staff would rotate throughout the year to different tasks and would need retraining. After a time of not processing certain work, staff lost the knowledge and skills needed; and
- nursing homes did not know who to contact when they had inquiries. Staff who had no knowledge of the case would have to research and recreate the case to provide answers to the nursing homes and families.

The facility-based approach is where a small team of caseworkers is assigned to a specific group of nursing homes. The team is responsible for processing all applications and ongoing case maintenance from those nursing homes. Since the volume of work is broken down by teams, there is less repetition related to assigning and tracking tasks. According to DHS, this also gives nursing homes a single point of contact for applications, ongoing case maintenance, and questions.

We were asked to evaluate the efficiency and efficacy of the task-based approach used for making eligibility determinations, including the role of IES, as opposed to the caseworker-based approach. The process to switch to the facility-based approach started during the leadership discussions in July 2019 and the actual planning in August 2019. According to DHS, the transition was gradually completed between the various offices starting in February 2021 and ending with the MFO offices (excluding the MFO Anna) operating from a facility-based approach by October 2021. Therefore, the switch to this approach was completed during the audit period. As shown in **Exhibit 3**, the Long Term Care Statewide Processing Center and MFO Anna do not follow the facility-based approach since those offices are not assigned specific nursing homes. Those offices utilize the One Touch Methodology to process cases. This methodology is when an assignment is given for a specific action, but when the caseworker begins to review the case there is other work that needs to be completed. The caseworker is to process all work needing to be addressed to the furthest point possible before stating they have completed the assignment.

Comparison of Approaches

The efficacy and efficiency of the facility-based approach was not fully assessed during the prior audit since the process was implemented after the audit period. However, the pros and cons of the different processing approaches were reviewed with DHS.

According to DHS, there were significantly more pros and less cons for the facility-based approach when compared to the other two approaches. The decision to switch to the facility-based approach appeared to be based upon reasonable assumptions. However, IES still does not fully support the facility-based model.

During the current audit period, the IES reports used to identify work were designed to identify tasks. However, work is assigned to teams based on facilities rather than tasks. Therefore, a DHS employee has to determine what facility the

case belongs to, so the case can be assigned to the correct team. After the end of the audit period DHS began re-assessing the reports. As of September 2024, an LTC staff representative was participating in the design meetings, so filters will be built in for the staff to find the work easier. In March 2025, DHS officials reported that the reports had been mostly completed with only small updates still being made. Since the reports were not re-designed until after the end of the current audit period, we could not fully assess the efficacy and efficiency of the facility-based approach. Therefore, additional follow-up will need to be conducted during the next audit period.

Appendix A
Audit Authority

Excerpt from the Illinois Public Aid Code 305 ILCS 5/11-5.4

Sec. 11-5.4. Expedited long-term care eligibility determination and enrollment.

(g) Beginning on July 1, 2017, the Auditor General shall report every 3 years to the General Assembly on the performance and compliance of the Department of Healthcare and Family Services, the Department of Human Services, and the Department on Aging in meeting the requirements of this Section and the federal requirements concerning eligibility determinations for Medicaid long-term care services and supports, and shall report any issues or deficiencies and make recommendations. The Auditor General shall, at a minimum, review, consider, and evaluate the following:

(1) compliance with federal regulations on furnishing services as related to Medicaid long-term care services and supports as provided under 42 CFR 435.930;

(2) compliance with federal regulations on the timely determination of eligibility as provided under 42 CFR 435.912;

(3) the accuracy and completeness of the report required under paragraph (9) of subsection (e);

(4) the efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of the Department of Human Services for long-term care services, including the role of the State's integrated eligibility system, as opposed to the traditional caseworker-specific process from which these central offices have converted; and

(5) any issues affecting eligibility determinations related to the Department of Human Services' staff completing Medicaid eligibility determinations instead of the designated single-state Medicaid agency in Illinois, the Department of Healthcare and Family Services.

The Auditor General's report shall include any and all other areas or issues which are identified through an annual review. Paragraphs (1) through (5) of this subsection shall not be construed to limit the scope of the annual review and the Auditor General's authority to thoroughly and completely evaluate any and all processes, policies, and procedures concerning compliance with federal and State law requirements on eligibility determinations for Medicaid long-term care services and supports.

(Source: P.A. 101-101, eff. 1-1-20; 101-209, eff. 8-5-19; 101-265, eff. 8-9-19; 101-559, eff. 8-23-19; 102-558, eff. 8-20-21.)

Appendix B
Audit Scope and Methodology

This audit was conducted in accordance with the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

We conducted this performance audit in accordance with generally accepted government auditing standards. 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.

The audit's objectives are stated in the Illinois Public Aid Code (305 ILCS 5/11-5.4(g)), originally enacted by Public Act 100-380 (see **Appendix A**). The Auditor General is required to report every three years to the General Assembly on the performance and compliance of the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), and the Department on Aging (DoA) in meeting the requirements placed upon them by Section 11-5.4 of the Illinois Public Aid Code and federal requirements concerning eligibility determinations for Medicaid long-term care (LTC) services and supports.

In conducting the audit, we reviewed statutes, administrative rules, and agency procedures for HFS, DHS, and DoA related to the audit objectives. Any instances of noncompliance are included in the audit report as recommendations. We requested and reviewed specific documents related to the Medicaid LTC program, including overviews and flowcharts for the program, budget and funding source information, organizational charts, as well as any applicable contracts, grants, and interagency agreements.

We reviewed management controls and assessed risk related to the audit's objectives. A risk assessment was conducted to identify areas that needed closer examination. We examined the five components of internal control – control environment, risk assessment, control activities, information and communication, and monitoring – along with the underlying principles. We considered all five components to be significant to the audit objectives. Any deficiencies in internal control that were significant within the context of the audit objectives are discussed in the body of the report. We assessed the risk of fraud occurring as related to the audit objectives and discussed these risks in an audit team meeting.

We reviewed the previous financial audits and compliance examinations of HFS and DHS as well as the 2022 Performance Audit of Medicaid Eligibility Determinations for Long-Term Care. As part of this audit, we followed up on the status of the recommendations from the 2022 audit and the results are discussed in the body of the report. We also reviewed the FY22 compliance examination for DoA but none of the findings pertained to LTC Medicaid eligibility.

During the audit, we held meetings and teleconferences with officials from the three agencies. We continued to communicate with DHS throughout fieldwork testing. We also followed up with HFS in more detail regarding testing related to the HFS OIG cases and shared all final testing exceptions with DHS.

The requests for data from HFS had to be extended multiple times. Although the data was requested in the initial document request list, we did not obtain this data until over one month past the original due date. We had to request additional documentation needed during testing while also identifying significant problems and missing information during testing. This follow-up required additional time to work with the agencies and complete our review.

Testing and Sampling

We obtained a download of all Medicaid LTC applications for calendar years 2021 to 2023. We conducted a data validity and reliability review of the data and concluded that calculating the timeliness of eligibility determinations for the entire population would not provide accurate results for the purposes of this audit. More specifically, for this data pulled from the State's Integrated Eligibility System (IES), we found:

- **8,847 of 44,661** applications (**20%**) had multiple entries based on the same name, date of birth, and application date. HFS pulled the data in such a manner that if an application had multiple assistance types, the application was listed more than once in the data.

In addition, the data contained duplicate records and identifiers. For these reasons, an accurate calculation of timeliness required testing individual applications as opposed to being able to test the timeliness of all applications in the population. We also focused on the timeliness of the eligibility determinations and did not assess if the eligibility was determined correctly.

We selected a sample of 50 applications that were submitted during calendar year 2023. Calendar year 2023 was selected because it was the last calendar year in the audit period, and the COVID-19 Public Health Emergency (PHE) ended during the year. Therefore, the sample included applications from both during the PHE and after the PHE had ended.

For the 50 applications selected for testing, we randomly selected 30 applications to cover all three field offices and judgmentally selected 20 applications to cover cases with extensions and cases with HFS OIG referrals.

- We selected 10 cases referred to the HFS OIG for asset discovery investigations during calendar year 2023. In addition, seven other cases referred to the OIG were included in our sample for a total of 17 HFS OIG cases reviewed.
- We also selected 10 extension cases in our sample of cases reviewed during calendar year 2023.

The applications were not selected using a statistically valid method utilizing confidence intervals and confidence levels; therefore, results in this audit have not been, and should not be, projected to the population.

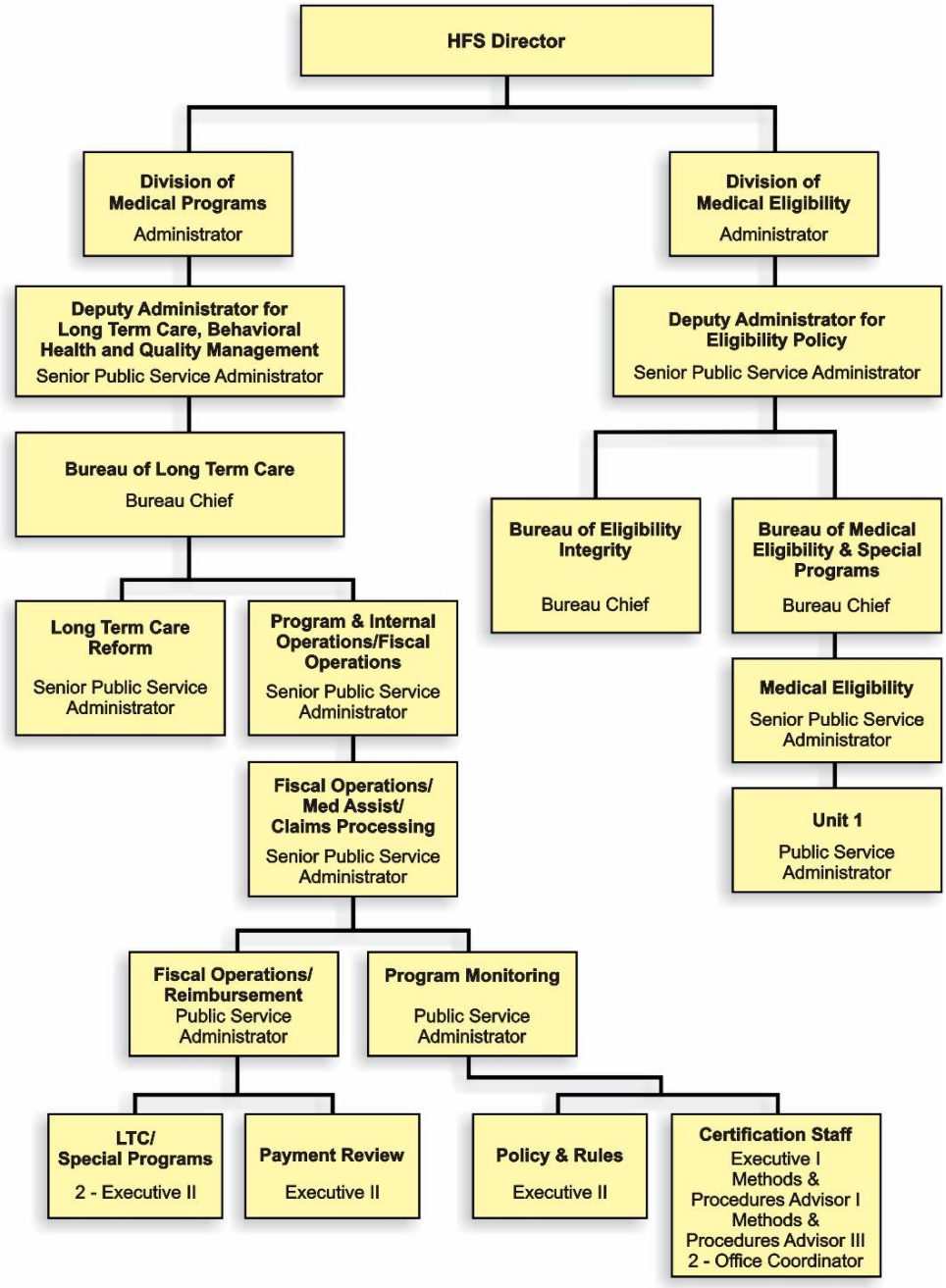
Exit Conferences

HFS, DHS, and DoA were provided with the confidential draft report and/or relevant sections of the confidential draft report. HFS waived an exit conference in a correspondence from Jamie Nardulli, Chief Internal Auditor, on June 3, 2025. An exit conference was scheduled with DHS but was not held due to technical difficulties. DHS then declined to re-schedule the exit conference. DoA waived an exit conference in a correspondence from Ellen Jennings-Fairfield, Chief Internal Auditor, on May 21, 2025. The date of the scheduled exit conference, along with the principal invitees are noted below:

Exit Conference	**May 27, 2025**
Agency	**Name and Title**
Illinois Department of Human Services	• Dulce Quintero, Secretary • Tiffany Blair, Chief of Staff • Joseph Wellbaum, Chief Financial Officer • Amy Crawford, General Counsel • John Schomberg, Assistant Secretary of Programs • Ryan Thomas, Assistant Secretary of Operations • Amy Macklin, Chief Internal Auditor • Christopher Finley, Audit Liaison • Leslie Cully, Interim Director, Division of Family & Community Services • Katie Fromme, FCS Bureau of Performance Management, Audit Liaison • Elizabeth Lusk, FCS Bureau of Performance Management, Audit Liaison • Sharon Canty, Regional Office Administrator, Office of Long Term Care • Yolanda Lampkin-Diming, Assistant Regional Administrator, Region 1 Central FCRC • Cassie Laird, Associate Director, Office of Program Support and Program Evaluation • Angela Imhoff, Acting Associate Director, Office of Family & Community Resource Centers
Illinois Office of the Auditor General	• Paul Skonberg, Audit Manager • Amanda Temir-Young, Audit Staff • Will Londrigan, Audit Staff

Appendix C
HFS, DHS, and DoA Organizational Charts (as of 7/2024)

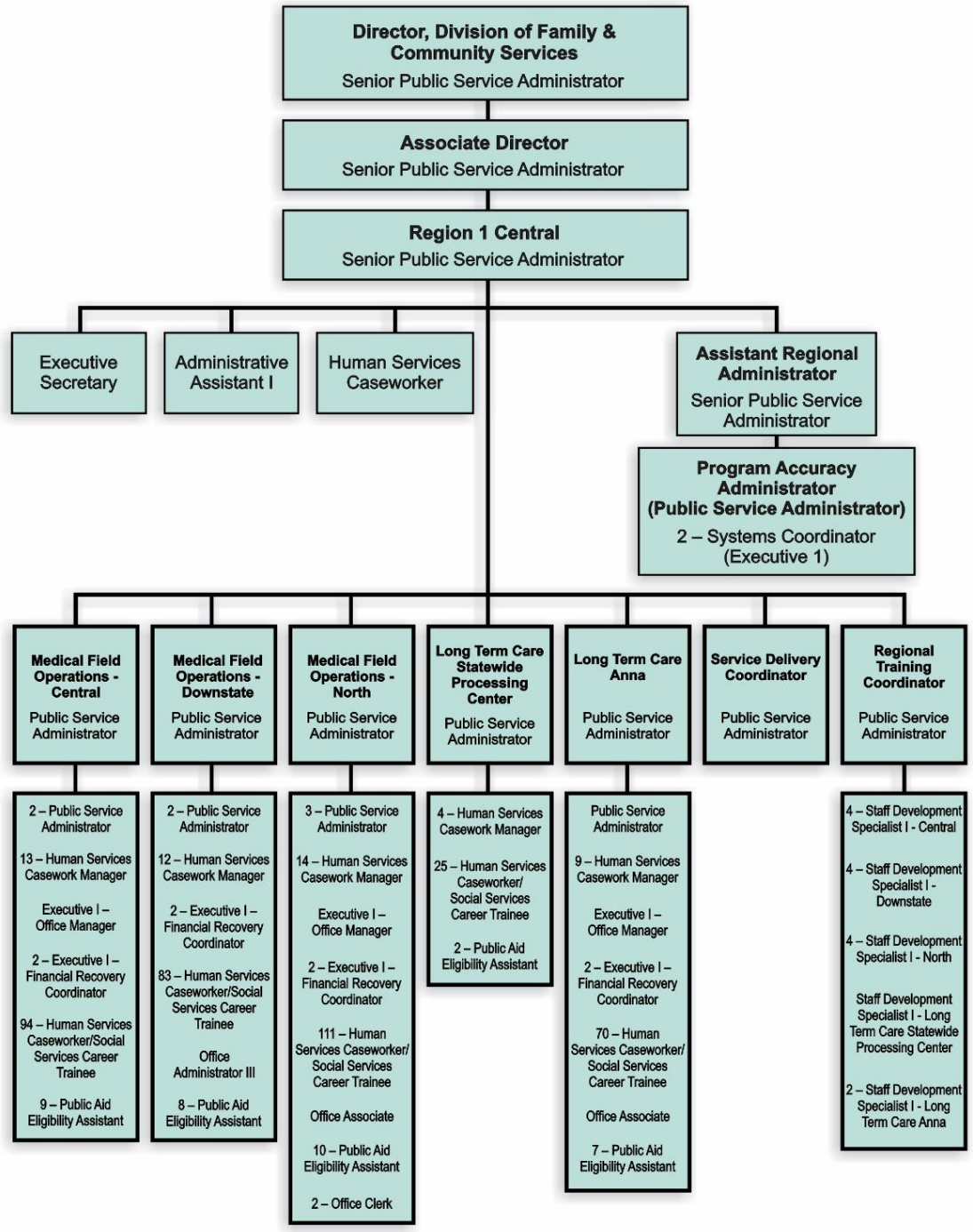
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES ORGANIZATIONAL CHART



Source: OAG prepared from HFS, DHS, and DoA information.

Appendix C
HFS, DHS, and DoA Organizational Charts (as of 7/2024)

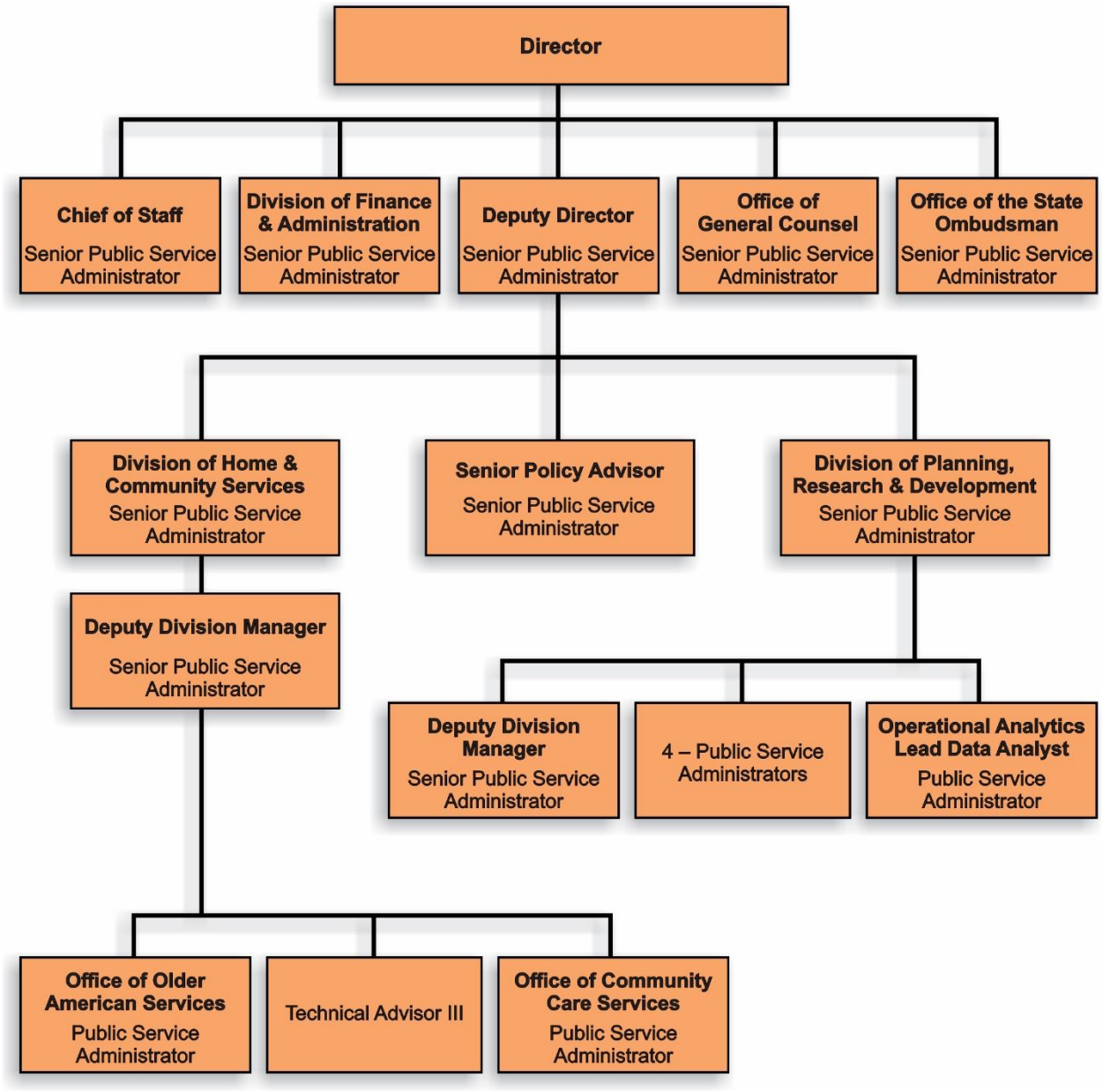
DEPARTMENT OF HUMAN SERVICES ORGANIZATIONAL CHART



Source: OAG prepared from HFS, DHS, and DoA information.

Appendix C
HFS, DHS, and DoA Organizational Charts (as of 7/2024)

DEPARTMENT ON AGING ORGANIZATIONAL CHART



Source: OAG prepared from HFS, DHS, and DoA information.

Appendix D
Agency Responses

May 29, 2025

Honorable Frank J. Mautino
Illinois Office of the Auditor General
400 W. Monroe, Suite 306
Springfield, Illinois 62704

Re: Public Act 100-380
Performance Audit of Medicaid Eligibility Determinations for Long-Term Care
IDHS Response to Recommendations

Dear Auditor General Mautino:

This letter is in response to the Office of the Auditor General (OAG) Performance Audit of Medicaid Eligibility Determinations for Long-Term Care. The Illinois Department of Human Services (IDHS) appreciates the work performed and professionalism of your team in conducting the audit.

Enclosed are detailed responses that address each of the OAG recommendations.

Should you have any questions or comments regarding the IDHS responses to the recommendations, you may contact Chris Finley, Office of Internal Audit, at (217) 720-7173 or by e-mail at Christopher.E.Finley@illinois.gov.

Sincerely,

SIGNED ORIGINAL ON FILE
Dulce M. Quintero
Secretary

Cc:
John Schomberg, Assistant Secretary of Programs
Amy Macklin, Chief Internal Auditor

ILLINOIS DEPARTMENT OF HUMAN SERVICES
MANAGEMENT RESPONSES

Performance Audit of Medicaid Eligibility Determinations for Long-Term Care

Recommendation 1 – Eligibility Determination Timeliness

Recommendation: The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should work together to implement controls to improve the timeliness of long-term care eligibility determinations to comply with timelines contained in federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 Ill. Adm. Code 10.420).

Department Response: The Department of Human Services (DHS) accepts the recommendation. DHS will work cooperatively with the Department of Healthcare and Family Services (HFS) to review the process of long-term care eligibility determinations and create any needed controls necessary to comply with timeliness requirements. DHS has implemented the use of reports to improve the monitoring process for timeliness of processing applications. DHS will continue to monitor the effectiveness of the reports in monitoring pending work. DHS will also provide a yearly training session for applicable staff, which will include timely processing of applications.

ILLINOIS DEPARTMENT OF HUMAN SERVICES
MANAGEMENT RESPONSES

Performance Audit of Medicaid Eligibility Determinations for Long-Term Care

Recommendation 2 – HFS OIG Application Referrals

Recommendation: The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should, in order to decrease the opportunity for application processing delays, work together to implement changes to improve the process of:

- Referring applications to the HFS OIG to ensure referrals are received by the HFS OIG; and
- Receiving and acting upon recommendations from the HFS OIG upon completion of its asset investigations.

Department Response: The Department of Human Services (DHS) accepts the recommendation. DHS will work cooperatively with the Department of Healthcare and Family Services (HFS) and the HFS OIG on changes to improve: (i) the current referral process maintained between HFS and DHS to ensure completion of the process steps for referral and (ii) the current process for receiving and acting upon recommendations from the HFS OIG upon the HFS OIG's completion of its asset investigations. DHS has implemented the use of reports to improve the monitoring process for timeliness of processing applications. DHS will continue to monitor the effectiveness of the reports in monitoring pending work. DHS will also provide a yearly training session for applicable staff, which will include the OIG referral process.

ILLINOIS DEPARTMENT OF HUMAN SERVICES
MANAGEMENT RESPONSES

Performance Audit of Medicaid Eligibility Determinations for Long-Term Care

Recommendation 3 – Tracking of Extensions

Recommendation: The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should ensure extensions are tracked so processing times can be tolled, as required by the Illinois Public Aid Code, for extension days granted (305 ILCS 5/11-5.4(e) and 305 ILCS 5/11-5.4(f)(B)). Specifically, the Departments should ensure:

- Extensions are captured in a usable manner;
- Extensions are captured accurately; and
- The length of extensions granted by IES are in accordance with statute.

Department Response: The Department of Human Services (DHS) accepts the recommendation. DHS will work in cooperation with the Department of Healthcare and Family Services (HFS) in reviewing the current functionality of extension tracking in IES and implement any training needed based on both current and future functionality.

ILLINOIS DEPARTMENT OF HUMAN SERVICES
MANAGEMENT RESPONSES

Performance Audit of Medicaid Eligibility Determinations for Long-Term Care

Recommendation 4 – LTC Monthly Reporting

Recommendation: The Department of Healthcare and Family Services and the Department of Human Services should complete the LTC reports and post the reports to each Department's website on a monthly basis as required by Section 11-5.4(f) of the Illinois Public Aid Code (305 ILCS 5/11-5.4(f)).

Department Response: The Department of Human Services (DHS) accepts the recommendation. DHS will work in cooperation with the Department of Healthcare and Family Services (HFS) to include the correct link to the HFS website.

ILLINOIS DEPARTMENT OF HUMAN SERVICES
MANAGEMENT RESPONSES

Performance Audit of Medicaid Eligibility Determinations for Long-Term Care

Recommendation 5 – LTC Monthly Report Completeness

Recommendation: The Department of Healthcare and Family Services and the Department of Human Services should ensure monthly reports contain all elements required by Section 11-5.4(f) of the Illinois Public Aid Code (305 ILCS 5/11-5.4(f)).

Department Response: The Department of Human Services (DHS) accepts the recommendation. DHS will work cooperatively with the Department of Healthcare and Family Services (HFS) to ensure that all required items are contained in the long-term care monthly reports maintained by HFS.

ILLINOIS DEPARTMENT OF HUMAN SERVICES
MANAGEMENT RESPONSES

Performance Audit of Medicaid Eligibility Determinations for Long-Term Care

Recommendation 6 – LTC Monthly Report Accuracy

Recommendation: The Department of Healthcare and Family Services and the Department of Human Services should develop controls to ensure monthly reports required by Section 11-5.4(f) of the Illinois Public Aid Code are accurate.

Department Response: The Department of Human Services (DHS) accepts the recommendation. DHS will work cooperatively with the Department of Healthcare and Family Services (HFS) to ensure that all required items are accurate in the long-term care monthly reports maintained by HFS.

HFS
Illinois Department of
Healthcare and Family Services

JB Pritzker, Governor
Elizabeth M. Whitehorn, Director

401 South Clinton Street
Chicago, Illinois 60607

Telephone: +1-312-793-4792
TTY: +1-800-526-5812

June 13, 2025

Honorable Frank J. Mautino
Auditor General
State of Illinois

Dear Auditor General Mautino:

The Department of Healthcare and Family Services (HFS) appreciates the work performed by your office in conducting the audit for Long-Term Care Medicaid Eligibility.

Enclosed with this letter are detailed responses that address each of the recommendations.

If you have any questions or comments about our responses to the recommendations, please contact Amy Lyons, External Audit Liaison, at (217) 558-4347 or through email at amy.lyons@illinois.gov.

Sincerely,

SIGNED ORIGINAL ON FILE

Elizabeth M. Whitehorn
Director

Enclosures

E-mail: hfs.webmaster@illinois.gov **Internet:** http://www.hfs.illinois.gov/

RECOMMENDAITON #1 – ELIGIBIITY DETERMINATION TIMELINESS

RECOMMENDATION

The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should work together to implement controls to improve the timeliness of long-term care eligibility determinations to comply with timelines contained in federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 Ill. Adm. Code 10.420).

DEPARTMENT RESPONSE

The Department of Healthcare and Family Services (HFS) accepts the recommendation. As the report notes, the additional 90 days afforded for OIG's asset discovery investigations was removed from statute as of August 2018. Asset discovery investigations involve obtaining and reviewing up to five years of complex financial records, which takes time. OIG strives to complete all of its reviews within 90 days of referral, but without an allowance of additional time to complete these investigations, determinations in cases referred to OIG will continue to be untimely. So that applicants are not negatively impacted by these investigations, the State grants Provisional Eligibility until a decision on their application is reached.

RECOMMENDATION #2 – HFS OIG APPLICATION REFERRALS

RECOMMENDATION

The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should, in order to decrease the opportunity for application processing delays, work together to implement changes to improve the process of:

- Referring applications to the HFS OIG to ensure referrals are received by the HFS OIG, and
- Receiving and acting upon recommendations from the HFS OIG upon completion of its asset investigations.

DEPARTMENT RESPONSE

The Department of Healthcare and Family Services (HFS) accepts the recommendation. HFS OIG (OIG) and DHS work together to ensure that referrals are received timely and that no cases are missed. OIG organizes and participates in quarterly meetings with DHS regarding the referral process and will continue. Also, OIG and DHS amended the referral criteria for asset discovery reviews as of April 2025 to better target high quality referrals and reduce unnecessary referrals. OIG cannot comment on any delays in the implementation of its recommendations.

RECOMMENDATION #3 – TRACKING OF EXTENSIONS

RECOMMENDATION

The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should ensure extensions are tracked so processing times can be tolled, as required by the Illinois Public Aid Code, for extension days granted (305 ILCS 5/11-5.4(e) and 305 ILCS 5/11-5.4(f)(B)). Specifically, the Departments should ensure:

- Extensions are captured in a usable manner;
- Extensions are captured accurately; and
- The length of extensions granted by IES are in accordance with statute.

DEPARTMENT RESPONSE
The Department of Healthcare and Family Services (HFS) accepts the recommendation. A system enhancement request, #279747, was implemented on June 12, 2023, to capture the information and ensure extensions are in accordance with statute.

RECOMMENDATION #4 – LTC MONTHLY REPORTING

RECOMMENDATION
The Department of Healthcare and Family Services and the Department of Human Services should complete the LTC reports and post the reports to each Department's website on a monthly basis as required by Section 11-5.4(f) of the Illinois Public Aid Code (305 ILCS 5/11-5.4(f)).

DEPARTMENT RESPONSE
The Department of Healthcare and Family Services (HFS) accepts the recommendation. HFS had pended the posting of the monthly reports due to changes requested. HFS will begin posting these reports again immediately.

RECOMMENDATION #5 – LTC MONTHLY REPORTING COMPLETENESS

RECOMMENDATION
The Department of Healthcare and Family Services and the Department of Human Services should ensure monthly reports contain all elements required by Section 11-5.4(f) of the Illinois Public Aid Code (305 ILCS 5/11-5.4(f)).

DEPARTMENT RESPONSE
The Department of Healthcare and Family Services (HFS) accepts the recommendation. Extensions are the only remaining data element to be included in the monthly reports. HFS estimates this information will be included by September 15, 2025. Per IL Administrative Code 89.120.308 3 (B), extensions are only applicable to initial determinations, not redeterminations.

RECOMMENDATION #6 – LTC MONTHLY REPORTING ACCURACY

RECOMMENDATION

The Department of Healthcare and Family Services and the Department of Human Services should develop controls to ensure monthly reports required by Section 11-5.4(f) of the Illinois Public Aid Code are accurate.

DEPARTMENT RESPONSE

The Department of Healthcare and Family Services (HFS) accepts the recommendation. HFS is currently centralizing eligibility reporting to ensure that the same logic is applied to all eligibility reports. Centralizing the eligibility reports guarantees the completion of data validation and reconciliation. The estimated completion date for centralization is December 31, 2025.

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