STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
Frank J. Mautino, Auditor General

SUMMARY REPORT DIGEST

DEPARTMENT OF HUMAN SERVICES

Compliance Examination
For the Two Years Ended June 30, 2021

Release Date: September 29, 2022

FINDINGS THIS AUDIT: 33

	New	Repeat	Total
Category 1:	2	23	25
Category 2:	4	4	8
Category 3:	0	0	0
TOTAL	6	27	33

FINDINGS LAST AUDIT: 38

AGING SCHEDULE OF REPEATED FINDINGS

Repeated Since	Category 1	Category 2	Category 3
2020	4, 6		
2019	7, 8, 29	31	
2018	9, 10		
2017	1, 2, 5, 11, 13, 14, 15, 16, 19, 24	26	
2015	17		
2013	23	25	
2011	12		
2009	18		
2007	22		
2005	21	27	

INTRODUCTION

Because of the significance and pervasiveness of the findings described within the report, we expressed an **adverse opinion** on the Department's compliance with the assertions which comprise a State compliance examination. The Codification of Statements on Standards for Attestation Engagements (AT-C § 205.72) states a practitioner "should express an adverse opinion when the practitioner, having obtained sufficient appropriate evidence, concludes that misstatements, individually or in the aggregate, are both material and pervasive to the subject matter."

Further, the digest covers our Compliance Examination of the Department for the two years ended June 30, 2021. A separate Financial Audit as of and for the year ended June 30, 2021, was previously released on June 22, 2022. In total, this report contains 33 findings, 10 of which were reported in the Financial Audit.

SYNOPSIS

- (**21-11**) The Department was unable to provide adequate records substantiating the completeness of populations for one or more laws, regulations, or other requirements selected for testing. Therefore, we concluded the Department's population records were not sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36).
- (**21-22**) The Department is in violation of its policies and procedures, as well as, statutory requirements regarding the administration of accounts receivable at is State-Operated Developmental Disabilities and Mental Health Centers.
- (**21-24**) The Department failed to finalize and implement policies and rules for certain community-integrated living arrangements (CILA), and community-based residential settings.

Category 1: Findings that are **material weaknesses** in internal control and/or a **qualification** on compliance with State laws and regulations (material noncompliance).

Category 2: Findings that are **significant deficiencies** in internal control and **noncompliance** with State laws and regulations.

Category 3: Findings that have **no internal control issues but are in noncompliance** with State laws and regulations.

INTRODUCTION

This report presents our Department-wide compliance attestation examination for the two years ending June 30, 2021. At June 30, 2021 the Department operated 6 Developmental Centers, 7 Mental Health Centers, 1 combined Mental Health and Developmental Center, and 3 Rehabilitation Services Facilities. The findings are presented in the report beginning at page 43.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

COMPLETE POPULATIONS NOT PROVIDED

Auditors unable to make conclusions for populations provided

The Department of Human Services (Department) was unable to provide adequate records substantiating the completeness of populations for one or more laws, regulations, or other requirements selected for testing, as of the end of fieldwork. Due to these conditions, we concluded the Department's population records were not sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36) to test the Department's compliance with the following:

Specifically, some of the more important issues we noted were:

State-Operated Facilities' property and equipment unable to be verified

- The Department's State-Operated Facilities do not adequately track surplus or transferable property, do not include all property purchased with federal grant tags on its property listing, do not tag all property items, maintains property with tags that are not visible, does not maintain equipment listings that are complete and accurate representations of the equipment being held or where the equipment is being held. Due to these condition, we could not conclude the Department's State-Operated Facilities' population records were sufficiently precise and detailed to test the Department's property and equipment. Additional information on this matter can be found in Finding 2021-021.

Unable to verify population of Medicaid benefits terminated for incarcerated individuals

- While testing the Illinois Public Aid Code (305 ILCS 5/12-4.7b), we noted the Department was not able to provide adequate records substantiating the population of benefit terminations for incarcerated individuals. Additional information on this matter can be found in Finding 2021-017.
- While testing locally held funds at the Illinois Center for Rehabilitation and Education - Roosevelt, we noted the Facility did not maintain a cash receipts

journal to log cash received prior to entry into the Facility's general ledger. Further, while testing locally held funds at the Illinois Center for Rehabilitation and Education - Wood, we noted the Facility did not maintain an adequate general ledger for the Permanent Trust Fund. In addition, while testing petty cash funds at the Ludeman Developmental Center, we noted the Facility did not keep a cash receipts and disbursements journal for its petty cash box. Due to these condition, we could not conclude the Department's State-Operated Facilities' population records were sufficiently precise and detailed to test the Department's locally held funds and petty cash funds. Additional information on these matters can be found in Finding 2021-018.

Unable to verify the processing of the State-Operated Facilities' LHFs and Petty Cash Funds disbursements and receipts

- During the testing of non-pharmacy related commodities inventory, we noted the Department's year-end counts were conducted in early June 2021 due to a decision made by Department management to perform counts prior to a system conversion from the Department's Central Office Warehouse Control System (WCS) and the Department's State-Operated Facilities' Commodity Control System (CCS) to the inventory module within the Enterprise Resource Planning (ERP) System, which was to become effective on July 1, 2022. Because each of the three State-Operated facilities selected for testing did not perform reconciliations from the time of the inventory count in early June 2021 to an inventory count as of June 30, 2021, we were unable to conclude non-pharmaceutical commodities inventory was properly entered into the ERP System, or whether non-pharmacy inventory assets and the Department's corresponding net position were properly recorded in the Department's FY 2021 financial statements. Due to these condition, we could not conclude the Department's State-Operated Facilities' population records were sufficiently precise and detailed to test the Department's non-pharmacy related commodities inventory counts and processing during the examination period. Additional information on this matter can be found in Finding 2021-023.

Unable to conclude the Department's non-pharmacy commodities inventory was property entered into the ERP System

- While testing compliance with various Mental Health and Developmental Disabilities Administrative Acts at the State Operated Facilities, we noted the following:
  - Ludeman Developmental Center was unable to provide adequate records substantiating the population of restraints issued during the examination period. Additional information on this matter can be found in Finding 2021-012.

Ludeman could not substantiate population of restraints issued

  - Ludeman Developmental Center was unable to provide adequate records substantiating the population of employees qualified to order the use

Ludeman could not substantiate population of staff qualified to order the use of restraints

of restraints at the Facility during the examination period. Additional information on this matter can be found in Finding 2021-012.

Kiley could not substantiate population of restraints administered

- Kiley Developmental Center did not have a complete and accurate population of restraints administered. Additional information on this matter can be found in Finding 2021-012.

Multiple State-Operated Facilities could not substantiate population of visitors

- Kiley Developmental Center, the Ludeman Developmental Center, the Madden Mental Health Center, and the Murray Developmental Center were unable to provide adequate records substantiating the populations of visitor entry logs (for visitors who visited the facilities' residents) during the examination period. Additional information on this matter can be found in Finding 2021-013.
- Ludeman Developmental Center was unable to provide adequate records substantiating the population of interest receipts during the examination period. Additional information on this matter can be found in Finding 2021-018.

Multiple State-Operated Facilities could not substantiate population of incoming request for information

- Murray Developmental Center, the McFarland Mental Health Center, and the Ludeman Developmental Center were unable to provide adequate records substantiating the population of incoming requests for information. Additionally, the Jack Mabley Developmental Center does not have a policy requiring the maintenance of documentation in residents' files regarding requests for information that have been rejected. Additional information on this matter can be found in Finding 2021-014.

Even given the population limitations which hindered our ability to conclude whether the selected sample was representative of the population as a whole, we obtained the population provided by the Department for each of the areas above, selected a sample, and tested for compliance. For the samples tested, noncompliance was reported in the Findings referenced above. (Finding 11, page 43-46)

We recommended Department management and staff strengthen controls over records maintenance for each area in which a compliance requirement is present. Further, we recommended the Department strengthen its internal controls to ensure it maintains complete and accurate populations.

Department accepted the recommendation

The Department accepted the recommendation and stated each Division will work to strengthen controls to ensure adequate records are maintained and can be provided when requested.

INADEQUATE CONTROLS OVER ACCOUNTS RECEIVABLE

The Department is in violation of its policies and procedures, as well as, statutory requirements regarding the administration of accounts receivable at is State-Operated Developmental Disabilities (DD) and Mental Health (MH) Centers.

Inconsistencies noted within accounts receivable policies versus daily activities carried out by Department staff

During testing of the Department's billing and payment of services rendered at its State-Operated DD and MH Centers during the examination period, we noted multiple inconsistencies between the Department's Program Directive and the performance of daily activities undertaken by the DD and MH Centers' Recipient Resource Unit staff, the Department's Central Office Revenue Cash Management Unit staff, and the Department's Central Office Collections Unit staff.

DD and MH Centers utilizes a patient system to track accounts receivable which causes inaccuracies.

Further, because the Department's State-Operated DD and MH Centers' main accounts receivable tracking system is a patient system, we noted the system can lead to inaccuracies in the amounts due.

Due to these condition, we were unable to conclude the Department's population records were sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C §205.36) to fully test the Department's compliance with requirements governing accounts receivable collections procedures at the State-Operated DD and MH Centers.

Even given the population limitation noted above which hindered the ability of the accountants to conclude whether selected samples were representative of the population as a whole, we performed on-site testing of 60 residents' accounts receivable at three of the Department's State-Operated DD and MH Centers. Our testing resulted in the following exceptions:

Elgin Mental Health Center

Center staff failed to bill for services rendered

- For 2 of 45 (4%) residents tested who were Medicaid recipients, Center staff failed to bill the client after discharge.
- For 2 of 22 (9%) residents tested who had left the Facility, Center staff did not send a Notice of Determination (Notice) until years after discharge, instead of a month after discharge. The Notices were sent 118 and 132 months late.
- For 1 of 13 (8%) residents tested with a balance over 180 days old, Center staff failed to notify the Department's Central Office to write off the account after 180 days of it being outstanding. The

account, as of June 30, 2021, was outstanding for 96 months.

- In the prior examination, we noted $2,107,173 in payments from Medicare, Medicaid, and the Social Security Administration which were not applied to individual client accounts or refunded to the applicable program. In the current examination, Center staff could not provide an update on the unapplied amounts. (Finding 22, page 91-93)

$2,107,173 in unapplied payments unaccounted for

We recommended Department management update its policies and procedures governing accounts receivable and ensure staff comply with the updated policies and procedures. Additionally, we recommended Department management and staff maintain detailed records of all billings and the corresponding collections to facilitate proper reporting of accounts receivable activity. We also recommended Department management and staff consider writing off delinquent or uncollectible accounts to reflect only realizable amounts.

Department accepted the recommendation

The Department accepted the recommendation and stated its Office of Fiscal Services has updated and implemented accounts receivable procedures. The Department further stated its Division of Mental Health will continue to review policies and procedures over accounts receivable and ensure staff are adequately trained.

FAILURE TO IMPLEMENT POLICIES AND RULES OVER COMMUNITY-INTEGRATED LIVING ARRANGEMENTS AND COMMUNITY-BASED RESIDENTIAL SETTINGS AND ADEQUATELY MONITOR CILAS.

The Department failed to finalize and implement policies and rules for certain community-integrated living arrangements (CILA), and community-based residential settings.

Failure to Finalize and Implement Rules

During the previous examination period, we noted the Department had drafted but had not yet finalized and implemented rules related to the assignment and operations of monitors and receiverships for CILAs as required by the Act. During the current examination period, we noted the Department still had not finalized and implemented the rules, and as of June 30, 2021, the adoption of the rules was 9.5 years past the date required by statute.

Adoption of rules governing CILAs are 9.5 years past due dates required by statute.

Further, during the examination period, we noted the Department had not implemented rules regarding community-based residential settings. As of June 30, 2021, the adoption of the rules was 9.5 years past the date required by statute.

Failure to Finalize and Implement Policies, and Adequately Monitor the CILA Program

During testing, we noted the following:

BALC did not perform monitoring of residents' personal funds

- The Bureau of Accreditation Licensure and Certification (BALC) did not perform planned monitoring of CILA providers regarding residents' personal funds.

Various rules governing the CILA Program have not been updated

- As of June 30, 2021, the Department had drafted but not finalized rules and policies/procedures as follows:
  - Updates to Administrative Rule 115 (the CILA Rule, 59 Ill. Admin. Code 115), to comply with federal guidance. The CILA Rule is drafted and is undergoing the JCAR process as of the end of fieldwork.
  - The BALC Process and Procedure Manual was also being revised during the examination period and was not finalized until September 2021. The previous version of the Manual was last revised in August 2009.
  - The Division of Developmental Disabilities is in the process of developing and communicating a policy or procedure to formalize the look-back review process; however the policy/procedure was not finalized until September 2021. (Finding 24, page 97-99)

We recommended Department management comply with State law by completing and adopting rules related to the assignment and operations of monitors and receiverships for CILAs provider agencies. We also recommended the Department finalize and implement the CILA Rule, and its associated look-back reviews policies and procedures. Further, we recommended the Department perform the planned monitoring of CILA resident's personal funds.

Department accepted the recommendation

The Department accepted the recommendation and stated the requirements for Monitors and Receivership and Personal Funds Management have been incorporated into draft Rule 115, the IDHS Division of Developmental Disabilities has begun to review comment letters and will formulate responses as well as make necessary changes to the draft Rule based on the feedback received from the First Notice, the IDHS Division of Developmental Disabilities developed a policy for look-back reviews with the policy

being implemented in September 2021, and BALC has added questions to the Individual, Staff, and Guardian interview forms that are used when conducting a full survey to ensure planned monitoring of resident's personal funds.

OTHER FINDINGS

The remaining findings are reportedly being given attention by Department personnel. We will review the Department's progress towards the implementation of our recommendations in our next audit/examination.

AUDITOR'S OPINION

The financial audit report was previously released. The auditors stated the financial statements of the Department as of and for the year ended June 30, 2021, are fairly stated in all material respects.

ACCOUNTANT'S OPINION

The accountants conducted a compliance examination of the Department for the two years ended June 30, 2021, as required by the Illinois State Auditing Act. Because of the effect of the noncompliance described in Findings 2021-001 through Finding 2021-033, the accountants stated the Department did not materially comply with the requirements described in the report.

The financial audit and this compliance examination was performed by RSM US LLP.

SIGNED ORIGINAL ON FILE

JANE CLARK
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

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