STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES

STATE COMPLIANCE EXAMINATION
FOR THE TWO YEARS ENDED JUNE 30, 2023

Performed as Special Assistant Auditors for
the Auditor General, State of Illinois

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
STATE COMPLIANCE EXAMINATION
For the Two Years Ended June 30, 2023

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STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES

AGENCY OFFICIALS

Secretary	Dulce Quintero (10/9/2023 – Present) Grace B. Hou (through 10/8/2023)
Assistant Secretary (Operations)	Ryan Thomas (10/9/2023 – Present) Dulce Quintero (through 10/8/2023)
Assistant Secretary (Programs)	John Schomberg, Designate (1/21/2025 – Present) Vacant (9/14/2024 – 1/20/2025) Kirstin Chernawsky (5/1/2024 – 9/13/2024) Vacant (through 4/30/2024)
Budget Director	Adam Morrow (9/16/2024 – Present) Tiffany Blair (through 9/15/2024)
Business Services Director	Paul Hartman
Chief of Staff	Tiffany Blair (9/16/2024 – Present) Amanda Elliott (12/24/2022 – 9/15/2024) Ryan Croke (through 12/31/2022)
Chief Financial Officer	Joseph Wellbaum (1/01/2025 – Present) Robert Brock (through 12/31/24)
Chief Operating Officer	Stacy Howlett (2/1/2024 – Present) Vacant (1/1/2024 – 1/31/2024) Francisco DuPrey (through 12/31/2023)
Chief Internal Auditor	Amy Macklin
General Counsel	Amy Crawford (4/1/2025 – Present) Rob Grindle, Interim (1/21/2025 – 6/30/2025) John F. Schomberg (through 1/20/2025)
Inspector General	Charles Wright (8/17/2023 – Present) Peter Neumer (through 8/16/2023)

Agency main offices are located at:

100 South Grand Avenue, East Springfield, Illinois 62762	401 South Clinton Street Chicago, Illinois 60607

IDHS
ILLINOIS DEPARTMENT OF HUMAN SERVICES

JB Pritzker, *Governor*

Dulce M. Quintero, *Secretary*

100 South Grand Avenue, East • Springfield, Illinois 62762
401 South Clinton Street • Chicago, Illinois 60607

MANAGEMENT ASSERTION LETTER

May 1, 2025

RSM US LLP
1450 American Lane, Suite 1400
Schaumburg, IL 60173

All:

We are responsible for the identification of, and compliance with, all aspects of laws, regulations, contracts, or grant agreements that could have a material effect on the operations of the State of Illinois, Department of Human Services (Department). We are responsible for and we have established and maintained an effective system of internal controls over compliance requirements. We have performed an evaluation of the Department's compliance with the following specified requirements during the two-year period ended June 30, 2023. Based on this evaluation, we assert that during the years ended June 30, 2022, and June 30, 2023, the Department has materially complied with the specified requirements listed below.

A. Other than what has been previously disclosed and reported in the Schedule of Findings, the Department has obligated, expended, received, and used public funds of the State in accordance with the purpose for which such funds have been appropriated or otherwise authorized by law.

B. Other than what has been previously disclosed and reported in the Schedule of Findings, the Department has obligated, expended, received, and used public funds of the State in accordance with any limitations, restrictions, conditions, or mandatory directions imposed by law upon such obligation, expenditure, receipt, or use.

C. Other than what has been previously disclosed and reported in the Schedule of Findings, the Department has complied, in all material respects, with applicable laws and regulations, including the State uniform accounting system, in its financial and fiscal operations.

D. Other than what has been previously disclosed and reported in the Schedule of Findings, State revenues and receipts collected by the Department are in accordance with applicable laws and regulations and the accounting and recordkeeping of such revenues and receipts is fair, accurate, and in accordance with law.

E. Other than what has been previously disclosed and reported in the Schedule of Findings, money or negotiable securities or similar assets handled by the Department on behalf of the State or held in trust by the Department have been properly and legally administered, and the accounting and recordkeeping relating thereto is proper, accurate, and in accordance with law.

Yours truly,

State of Illinois, Department of Human Services

SIGNED ORIGINAL ON FILE

Dulce Quintero, Secretary

SIGNED ORIGINAL ON FILE

Joseph Wellbaum, Chief Financial Officer

SIGNED ORIGINAL ON FILE

Amy Crawford, General Counsel

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
STATE COMPLIANCE EXAMINATION
For the Two Years Ended June 30, 2023

STATE COMPLIANCE REPORT

SUMMARY

The State compliance testing performed during this examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants; the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States; the Illinois State Auditing Act (Act); and the *Audit Guide.*

ACCOUNTANT'S REPORT

The Independent Accountant's Report on State Compliance and on Internal Control Over Compliance does not contain scope limitations or disclaimers, but does contain an adverse opinion on compliance and identifies material weaknesses over internal control over compliance.

SUMMARY OF FINDINGS

	Current Report	2022 Report	2021 Report
GAS Findings	9	8	10
State Compliance Findings	23	N/A	23
Total Findings	32	8	33
GAS New Findings	3	2	1
GAS Repeated Findings	6	6*	9
GAS Not Repeated Findings	2	5*	4

*Prior GAS findings 2021-005 and 2021-006 have been combined into finding 2022-005

State Compliance New Findings	4	N/A	5
State Compliance Repeated Findings	19	N/A	18
State Compliance Not Repeated Findings	4	N/A	8

SCHEDULE OF FINDINGS

Item No.	Page	Last/First Reported	Description	Finding Type
Current Findings				
2023-001	12	2022/2022	Inadequate Internal Controls over Accounting for Federal Awards	Material Weakness and Material Noncompliance
2023-002	16	2022/2017	Medical Assistance Program Financial Information	Material Weakness and Material Noncompliance
2023-003	19	New	Intergovernmental Expenses	Material Weakness and Material Noncompliance

STATE COMPLIANCE REPORT (Continued)

Item No.	Page	Last/First Reported	Description	Finding Type
Current Findings (Continued)				
2023-004	20	New	Classification of Fund Balance	Material Weakness and Material Noncompliance
2023-005	21	2022/2019	Inadequate Disaster Recovery Controls over the Integrated Eligibility System (IES)	Material Weakness and Material Noncompliance
2023-006	23	2022/2017	Inadequate General Information Technology Controls over IES	Material Weakness and Material Noncompliance
2023-007	26	New	Inadequate Controls over Eligibility Determinations and Redeterminations	Material Weakness and Material Noncompliance
2023-008	28	2022/2018	Insufficient Review and Documentation of Provider Enrollment	Material Weakness and Material Noncompliance
2023-009	30	2022/2018	Inadequate General Information Technology Controls over IMPACT	Material Weakness and Material Noncompliance
2023-010	32	2021/2017	Complete Populations Not Provided	Material Weakness and Material Noncompliance
2023-011	34	2021/2011	Noncompliance with Statutory Requirements Regarding the Use of Restraints and Seclusion	Material Weakness and Material Noncompliance
2023-012	37	2021/2017	Noncompliance with Statutory Requirements Regarding the Monitoring of Facility Visitors	Material Weakness and Material Noncompliance
2023-013	40	2021/2017	Noncompliance with Statutory Requirements Regarding Residents' Admission, Discharges, Annual Evaluations, and Requests for Information	Material Weakness and Material Noncompliance
2023-014	46	2021/2017	Noncompliance with Statutory Requirements Regarding Residents' Dental, Mental, and Physical Examinations	Material Weakness and Material Noncompliance
2023-015	49	2021/2017	Noncompliance with Statutory Requirements Regarding Pregnancy Policies, Administering Pregnancy Tests and Recording Residents' Menstrual Cycles	Material Weakness and Material Noncompliance
2023-016	51	2021/2015	Inadequate Execution and Monitoring of Interagency Agreements	Material Weakness and Material Noncompliance

STATE COMPLIANCE REPORT (Continued)

Item No.	Page	Last/First Reported	Description	Finding Type
Current Findings (Continued)				
2023-017	53	2021/2009	Inadequate Administration of Locally Held Funds and Petty Cash	Material Weakness and Material Noncompliance
2023-018	58	2021/2017	Inadequate Controls over Personal Services	Material Weakness and Material Noncompliance
2023-019	64	2021/2005	Inadequate Controls over State Property and Equipment	Material Weakness and Material Noncompliance
2023-020	67	New	Inadequate Controls over Monthly Revenue Status (SB04) Reconciliations	Material Weakness and Material Noncompliance
2023-021	68	2021/2013	Inadequate Controls over Commodities	Material Weakness and Material Noncompliance
2023-022	72	2021/2017	Failure to Implement Policies and Rules over Community Integrated Living Arrangements and Community-Based Residential Settings and Adequately Monitor CILAs	Material Weakness and Material Noncompliance
2023-023	74	2021/2021	Inadequate Controls over Forensic Patient Transport	Material Weakness and Material Noncompliance
2023-024	76	2021/2021	Untimely Receipt of Facility and Community Agency Responses to the Department OIG	Material Weakness and Material Noncompliance
2023-025	78	New	Inadequate Controls over the Monitoring and Implementation of State Statutes	Material Weakness and Material Noncompliance
2023-026	81	2021/2013	Late Submission of Required Reports	Significant Deficiency and Noncompliance
2023-027	84	2021/2017	Lack of Compliance with Policies for Vehicles	Significant Deficiency and Noncompliance
2023-028	87	2021/2005	Weaknesses in Contingency Planning	Significant Deficiency and Noncompliance
2023-029	88	2021/2019	Access to Systems not Controlled	Material Weakness and Material Noncompliance
2023-030	90	2021/2019	Weaknesses in Cybersecurity Programs and Practices	Significant Deficiency and Noncompliance
2023-031	92	New	Inadequate Controls over the Protection of Confidential Information	Significant Deficiency and Noncompliance
2023-032	93	New	Inadequate Controls over Employee Travel	Significant Deficiency and Noncompliance

STATE COMPLIANCE REPORT (Continued)

Prior Findings Not Repeated

Item No.	Page	Last/First Reported	Description	
A	95	2022/2022	Other Accounts Receivable Misstatement	
B	95	2022/2019	Detailed Agreement Between the Department of Human Services, the Department of Healthcare and Family Services and the Department of Innovation and Technology	
C	95	2021/2021	Inadequate Controls over Contractual Agreements and Emergency Purchases	
D	96	2021/2009	Inadequate Controls over Accounts Receivable	
E	96	2021/2021	Inadequate Agreement to Ensure Compliance with IT Security Requirements	
F	96	2021/2021	Inadequate Controls over Cellular Phones	

EXIT CONFERENCE

Findings 2023-001 through 2023-009 and their associated recommendations appearing in this report were discussed with Department personnel at an exit conference on November 20, 2024.

Attending were:

Department of Human Services:

Dulce Quintero	Secretary
Ryan Thomas	Assistant Secretary of Operations
Tiffany Blair	Chief of Staff
John Schomberg	General Counsel
Robert Brock	Chief Financial Officer
Mark Bartolozzi	Director of Fiscal Services
Amy Macklin	Chief Internal Auditor
Sarah Eves	Bureau Chief of General Accounting
Joseph Wellbaum	Senior Public Service Administrator
Victoria Pyles	Senior Public Service Administrator
Celeste Johnson	Senior Public Service Administrator
Brian Bond	Senior Public Service Administrator
Albert Okwuegbunam	Public Service Administrator
Matthew Sporlein	Public Service Administrator
Christopher Finley	Public Service Administrator

Office of the Auditor General:

Courtney Dzierwa	Statewide Single Audit Manager
Megan Green	Senior Audit Manager

STATE COMPLIANCE REPORT (Continued)

RSM US LLP:

Jen Katz	Partner
Ryan Caldwell	Partner
Kelly Kirkman	Partner
Melissa Quinn	Senior Manager
Adam Lanter	Manager
Crystal Bruns	Supervisor

The responses to the recommendations 2023-001 through 2023-004 were provided by Christopher Finley, Public Service Administrator, in a correspondence dated November 13, 2024, the responses to the recommendations in findings 2023-005 through 2023-007 were provided in a correspondence dated August 13, 2024, and the responses to the recommendations in findings 2023-008 and 2023-009 were provided in a correspondence dated July 24, 2023.

The Department of Healthcare and Family Services (HFS) responses to the recommendations were provided by Elizabeth Whitehorn, Director, in a correspondence dated July 23, 2024 and August 14, 2024.

The remaining findings and recommendations appearing in this report were discussed with Department personnel at an exit conference on April 16, 2025. Attending were:

Department of Human Services:

Dulce Quintero	Secretary
Ryan Thomas	Assistant Secretary
John Schomberg	Assistant Secretary for Programs
Amy Crawford	General Counsel
Joseph Wellbaum	Chief Financial Officer
Amy Macklin	Chief Internal Auditor
Christopher Finley	Public Service Administrator

Office of the Auditor General:

Megan Green	Statewide Single Audit Manager

RSM US LLP:

Jen Katz	Partner
Kelly Kirkman	Partner
Paige Morgano	Manager
Crystal Bruns	Supervisor

The responses to these recommendations were provided by Christopher Finley, Public Service Administrator, in a correspondence dated April 24, 2025.

RSM

RSM US LLP

Independent Accountant's Report

Honorable Frank J. Mautino
Auditor General
State of Illinois

and

State of Illinois, Department of Human Services

Report on State Compliance

As Special Assistant Auditors for the Auditor General, we have examined the State of Illinois, Department of Human Services' (Department) compliance with the specified requirements listed below, as more fully described in the *Audit Guide for Financial Audits and Compliance Attestation Engagements of Illinois State Agencies* (*Audit Guide*) as adopted by the Auditor General, during the two years ended June 30, 2023. Management of the Department is responsible for the Department's compliance with the specified requirements. Our responsibility is to express an opinion on the Department's compliance with the specified requirements based on our examination.

The specified requirements are:

A. The Department has obligated, expended, received, and used public funds of the State in accordance with the purpose for which such funds have been appropriated or otherwise authorized by law.

B. The Department has obligated, expended, received, and used public funds of the State in accordance with any limitations, restrictions, conditions, or mandatory directions imposed by law upon such obligation, expenditure, receipt, or use.

C. The Department has complied, in all material respects, with applicable laws and regulations, including the State uniform accounting system, in its financial and fiscal operations.

D. State revenues and receipts collected by the Department are in accordance with applicable laws and regulations and the accounting and recordkeeping of such revenues and receipts is fair, accurate, and in accordance with law.

E. Money or negotiable securities or similar assets handled by the Department on behalf of the State or held in trust by the Department have been properly and legally administered and the accounting and recordkeeping relating thereto is proper, accurate, and in accordance with law.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants, the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the Illinois State Auditing Act (Act), and the *Audit Guide*. Those standards, the Act, and the *Audit Guide* require that we plan and perform the examination to obtain reasonable assurance about whether the Department complied, in all material respects, with the specified requirements referenced above. An examination involves performing procedures to obtain evidence about whether the Department complied with the specified requirements. The nature, timing, and extent of the procedures selected depend on our judgement, including an assessment of the risks of material noncompliance, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our modified opinion.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements relating to the engagement.

Our examination does not provide a legal determination on the Department's compliance with the specified requirements.

Our examination disclosed material noncompliance with the specified requirements during the two years ended June 30, 2023. As described in items 2023-001 through 2023-032 in the accompanying Schedule of Findings, the Department did not comply with the following specified requirements. Items 2023-001 through 2023-025 and 2023-029 are each considered to represent material noncompliance with the specified requirements.

Specified Requirement A

As described in the accompanying Schedule of Findings as items 2023-001 through 2023-003, 2023-007, 2023-008, 2023-017, 2023-018, 2023-019, 2023-021, and 2023-032, the Department had not obligated, expended, received, and used public funds of the State in accordance with the purpose for which such funds have been appropriated or otherwise authorized by law.

Specified Requirement B

As described in the accompanying Schedule of Findings as items 2023-001 through 2023-003, 2023-007, 2023-008, 2023-017, 2023-018, 2023-019, 2023-021, and 2023-032, the Department had not obligated, expended, received, and used public funds of the State in accordance with any limitations, restrictions, conditions, or mandatory directions imposed by law upon such obligation, expenditure, receipt, or use.

Specified Requirement C

As described in the accompanying Schedule of Findings as items 2023-001 through 2023-032, the Department had not complied, in all material respects, with applicable laws and regulations, including the State uniform accounting system, in its financial and fiscal operations.

Specified Requirement D

As described in the accompanying Schedule of Findings as item 2023-017, the Department had not ensured the State revenues and receipts collected by the Department were in accordance with applicable laws and regulations and the accounting and recordkeeping of such revenues and receipts was fair, accurate, and in accordance with law.

Specified Requirement E

As described in the accompanying Schedule of Findings as item 2023-017, money or negotiable securities or similar assets handled by the Department on behalf of the State or held in trust by the Department had not been properly and legally administered and the accounting and recordkeeping relating thereto is proper, accurate, and in accordance with law.

Items 2023-026 through 2023-028 and items 2023-030 through 2023-032 individually would have been regarded as significant noncompliance with the specified requirements; however, when aggregated, we determined these items constitute material noncompliance with the specified requirements.

In our opinion, because of the effect of the noncompliance described in the preceding paragraphs, the Department has not complied with the aforementioned requirements for the two years ended June 30, 2023.

The State of Illinois, Department of Human Services' Responses to Findings
The Department's responses to the compliance findings identified in our examination are described in the accompanying Schedule of Findings. The Department's responses were not subjected to the procedures applied in the examination and, accordingly, we express no opinion on the responses.

The State of Illinois, Department of Healthcare and Family Services' Responses to Findings
The State of Illinois, Department of Healthcare and Family Services' responses to the compliance findings 2023-005 through 2023-009 identified in our examination are described in the accompanying Schedule of Findings. The State of Illinois, Department of Healthcare and Family Services' responses were not subjected to the procedures applied in the examination and, accordingly, we express no opinion on the responses.

The purpose of this report is solely to describe the scope of our testing and the results of that testing in accordance with the requirements of the *Audit Guide*. Accordingly, this report is not suitable for any other purpose.

Report on Internal Control Over Compliance
Management of the Department is responsible for establishing and maintaining effective internal control over compliance with the specified requirements (internal control). In planning and performing our examination, we considered the Department's internal control as a basis for designing examination procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the Department's compliance with the specified requirements and to test and report on the Department's internal control in accordance with the *Audit Guide*, but not for the purpose of expressing an opinion on the effectiveness of the Department's internal control. Accordingly, we do not express an opinion on the effectiveness of the Department's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that were not identified. However, as described in the accompanying Schedule of Findings, we identified certain deficiencies in internal control that we consider to be material weaknesses and significant deficiencies.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with the specified requirements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material noncompliance with the specified requirements will not be prevented, or detected and corrected, on a timely basis. We consider the deficiencies described in the accompanying Schedule of Findings as items 2023-001 through 2023-025 and 2023-029 to be material weaknesses.

A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiencies described in the accompanying Schedule of Findings as items 2023-026 through 2023-028, and 2023-030 through 2023-032, to be significant deficiencies.

As required by the *Audit Guide*, immaterial findings excluded from this report have been reported in a separate letter.

The State of Illinois, Department of Human Services' Responses to Findings
The Department's responses to the internal control findings identified in our examination are described in the accompanying Schedule of Findings. The Department's responses were not subjected to the procedures applied in the examination and, accordingly, we express no opinion on the responses.

The State of Illinois, Department of Healthcare and Family Services' Responses to Findings
The State of Illinois, Department of Healthcare and Family Services' responses to the internal control findings 2023-005 through 2023-009 identified in our examination are described in the accompanying Schedule of Findings. The State of Illinois, Department of Healthcare and Family Services' responses were not subjected to the procedures applied in the examination and, accordingly, we express no opinion on the responses.

The purpose of this report is solely to describe the scope of our testing of internal control and the results of that testing based on the requirements of the *Audit Guide*. Accordingly, this report is not suitable for any other purpose.

SIGNED ORIGINAL ON FILE

Schaumburg, Illinois
May 1, 2025

Finding 2023-001 Inadequate Internal Controls over Accounting for Federal Awards

The Department of Human Services (Department) does not have sufficient internal control over accounting for grant transactions resulting in material misstatements to the draft financial statements.

The individuals at the Department responsible for drawing federal award monies did not track expenditures paid by fund and report this information to the Department's Office of Fiscal Services (Fiscal Services) which is responsible for recording grant transactions. In addition, the individuals depositing federal award draws did not always deposit the money into the same funds in which the program expenditures were paid. This is more frequently an issue for Department programs funded by more than one fund, such as the Childcare and the Temporary Assistance for Needy Families (TANF) programs, or programs which receive cost allocations.

For financial reporting purposes, the Department (Fiscal Services) tracks grant data for purposes of accruing grant receivables, unearned revenue, unavailable revenue and payable balances, all of which impact Federal Operating Grant Revenue, using Office of Comptroller required SCO forms including SCO-563 *Grant /Contract Analysis*, SCO-567, *Interfund Transfers – Grantee Agency,* and SCO-568 *Interfund Transactions – Grantor Agency*.

In preparing the SCO Forms, the Department made errors in reporting expenditure amounts, including expenditure adjustments, and cash receipts, including lapse period receipts, for its federal award programs, resulting in errors in the financial statements for grant transactions. Additionally, based on audit procedures performed, the SCO Forms required multiple revisions throughout calendar year 2024.

Corrected Misstatements:

1) In the General Revenue Fund (0001), expenditures were overstated by $476 thousand and grant receipts were understated by $2.7 million in the SCO-563 form. This resulted in an understatement of unearned revenue and overstatement of Federal Operating Grant Revenue by $3.2 million. Further, certain opening balances in the SCO-563 form were not accurate, which resulted in an understatement of unearned revenue and overstatement of Federal Operating Grant Revenue of $1.1 million.

2) In the General Revenue Fund (0001), assistance listing number (ALN) 10.561 included COVID-related funding with the non-COVID related funding. When working with the Department to split the activity between COVID-related funding and non-COVID related funding, an overstatement of Unearned Revenue and understatement of Federal Operating Grant Revenue of $2.7 million was identified.

3) In the General Revenue Fund (0001), expenditures in the SCO-563 were understated by $7.8 million for ALN 10.561C. This resulted in an understatement of Due from Other Governments – Federal and Unavailable Revenue by $7.8 million.

4) In the General Revenue Fund (0001), a transfer in the amount of $16.3 million was incorrectly recorded, resulting in an overstatement of Federal Operating Grant Revenue.

Finding 2023-001 Inadequate Internal Controls over Accounting for Federal Awards (Continued)

5) In the Employment and Training Fund (0347), expenditures in the SCO-563 form were overstated by $94.5 million resulting in an overstatement of Federal Operating Grant Revenue, Unavailable Revenue and Due from Other Governments - Federal.

6) In the Employment and Training Fund (0347), certain opening balances in the SCO-563 form were not accurate, which resulted in an overstatement of Due from Other Governments – Federal and Unavailable Revenue in the amount of $47.1 million.

7) A transfer was captured incorrectly between the Employment and Training Fund (0347) and the Special Purpose Trust Fund (Fund 0408), in the amount of $5.2 million. Further, a transfer was captured incorrectly in the amount of $16.3 million, resulting in an understatement of Federal Operating Grant Revenue.

8) In the Employment and Training Fund (0347), expenditures in the SCO-563 form were overstated by $68.8 million due to inclusion of expenditures and grant receipts to be reported by the Department of Child and Family Services in Fund 0220. This resulted in an overstatement of Due from Other Governments – Federal by $7.4 million and Federal Operating Grant Revenue by $68.8 million, and an understatement of Unearned Revenue by $61.4 million.

9) In the Food Stamp and Commodity Fund (1245), the SNAP major program expenditure report for ALNs 10.551 and 10.542 did not include June activity. This resulted in an understatement of Federal Operating Grants Revenue and Health and Social Services Expenses of $376.8 million. Further, the activity recorded for fiscal year 2024 did not include emergency allotment funding. This resulted in an understatement of Federal Operating Grant Revenue and Health and Social Services expenditures of $91 million.

10) In the Special Purpose Trust Fund (0408), certain opening balances in the SCO-563 form were not accurate, which resulted in an overstatement of Federal Operating Grant Revenue of $357 thousand, overstatement of Due from Other Governments – Federal of $461 thousand, overstatement of Unavailable Revenue of $1.2 million, and an understatement of Unearned Revenue of $1 million.

11) In the DHS Federal Projects Fund (0592), certain opening balances in the SCO-563 form were not accurate, which resulted in an understatement of Unearned Revenue and Due To by $10.3 million.

12) In the Vocational Rehabilitation Fund (0081), certain opening balances in the SCO-563 form were not accurate, which resulted in an overstatement of Federal Operating Grant Revenue of $7 million.

The errors reflected above were corrected in the final financial statements.

Finding 2023-001 Inadequate Internal Controls over Accounting for Federal Awards (Continued)

Uncorrected Misstatements:

Uncorrected misstatements were identified as follows:

1) In the Vocational Rehabilitation Fund (0081), Federal Operating Grant Revenue was recognized in excess of eligible expenditures incurred which resulted in an uncorrected misstatement for an overstatement of Federal Operating Grant Revenue in the amount of $6.3 million.

2) In the USDA Women, Infants and Children Fund (0700), the ending unearned revenue balance per the SCO-563 form did not agree to the trial balance. As a result, Federal Operating Grant Revenue was overstated and unearned revenue was understated by $2.7 million.

3) In the DHS Special Purposes Trust Fund (0408), DHS Technology Initiative Fund (0211) and the Employment and Training Fund (0347), certain costs that were incurred in FY22 were included in total reimbursable costs in the SCO-563 in FY23 instead of in FY22, resulting in an understatement of prior year Federal Operating Grant Revenue and an overstatement of current year Federal Operating Grants Revenue of $6 million, $1 million, and $1.7 million, respectively.

GASB Codification Section N50 provides the authoritative guidance for reporting nonexchange transactions. The majority of the Department's Federal awards are voluntary nonexchange transactions which are considered expenditure-driven or reimbursement-type grants. For these award types, the provider (Federal agency) stipulates that a recipient (the Department) cannot qualify for resources without first incurring allowable costs under the provider's program (eligibility requirement). Recipients of voluntary nonexchange transactions should recognize receivables (or a decrease in liabilities) and revenues (net of estimated uncollectible amounts), when all applicable eligibility requirements, including time requirements, are met.

Under a good system of internal control, detailed records of monthly grant transactions should be maintained for each Federal award, by fund, and reconciled to the general ledger by fund, to ensure amounts used to calculate receivables, unearned amounts, unavailable amounts and revenue are accurate in each Fund's SCO forms.

Department management indicated that several federal grant programs operated through more than one fund. For these programs, expenditures for each Federal award are tracked in total and provided to Fiscal Services in a report called a "bucket report." The bucket report does not indicate which funds the expenditures were paid from resulting in misallocations on the SCO-563 forms. Additionally, other errors resulted from additional COVID-19 related grant funding in FY23 which then had to be separated from ongoing programs. The June 2023 expenditure data was not made available in time to be included in the FY23 GAAP reporting.

As a result of errors in the SCO forms used as a basis for recording financial statement transactions, the draft financial statements were materially misstated as noted in the discussion above. (Finding Code No. 2023-001, 2022-001)

Finding 2023-001 Inadequate Internal Controls over Accounting for Federal Awards (Continued)

Recommendation

We recommend the Department strengthen its internal control over preparing the SCO Forms by including a reconciliation of Federal grant receipts and expenditures by ALN included in each SCO Form to the general ledger for each fund (the ERP System). Deposits of federal draws should be recorded in the fund(s) that incurred the associated expenditures. Once prepared, balances reported in the SCO forms should be compared to the draft financial statements, by fund, to conclude if amounts are reasonable. Additionally, large balances in Due from Other Governments – Federal, Unearned Revenue and Unavailable Revenue should be investigated as they are unusual for reimbursement type grant awards in which the Department can generally draw funds monthly upon the incurrence of qualifying expenditures.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. The expenditure and receipts data used to prepare the draft financial statements comes from the general ledger module in ERP. The Department prepared a reconciliation of ERP federal grant expenditures by ALN versus the buckets provided by the Federal Reporting area. Moving forward, the Department will also include ERP draw/receipt data. Additionally, the Department will compare expenditures against receipts by both fund and ALN to conclude whether the amounts are reasonable. Finally, the Department will investigate large balances shown as “Due from Other Governments” for those grants that are drawn on a reimbursement basis.

Finding 2023-002 Medical Assistance Program Financial Information

The Department of Human Services (Department) does not have an adequate understanding of the suitability of the design of internal control or the operating effectiveness of internal control in place over all data recorded in its financial statements for transactions initiated by other State agencies and recorded in the Department's financial statements.

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

- The Department could not provide documentation of the preparation or the Department's review of expenditure reconciliations for Federal Medical Assistance Program (MAP) funds or the State Children's Health Insurance Program (CHIP) (Funds 0120, 0142, 0211, 0365, 0502, 0509, 0718) between amounts reported in the Department's general ledger system (ERP) and amounts reported in the Grant/Contract Analysis Forms (Form SCO-563s) provided to the Office of Comptroller (IOC) which support the receivable and revenue calculation for financial reporting. The amount per the Form SCO-563s (totaling approximately $424 million for total reimbursable costs "TRC" for Assistance Listing Numbers (ALN) 93.767 and 93.778), is a computed amount (a formula), essentially the amount needed to achieve the reported receivable balance provided by the Department of Healthcare and Family Services (HFS), a separate State agency, or a maximum amount for funds which have a statutory deposit limit. The Department does not retain a reconciliation between what is reported on the Form SCO-563s (claimable expenditures) and within ERP (all expenditures) for each fund which identifies which expenditures were used for claiming the federal award. Additionally, there is no documentation maintained by the Department to support the calculation and methodology used by HFS in preparing the net federal receivable amount (approximately $16.1 million for the two ALNs).

- During testing of expenditures and liabilities, we determined that the Department is not monitoring or reviewing the payments submitted by HFS, or the liabilities calculated by HFS, on behalf of the Department and reported in the Department's financial statements. When HFS submits a request for payment to the IOC, a summary file is also sent to the Department which goes through an interface and is recorded into ERP. An employee in the Department's Office of Fiscal Services reconciles the payments between ERP and the IOC before accepting them into ERP. Although the Department has documented their understanding of how transactions for DHS programs are processed within HFS, the Department was unable to provide auditors with documentation of their monitoring performed over the amounts reported in the Department's financial statements.

- Additionally, the Department is placing reliance on the internal control over the applicable HFS system without recent independent verification of the system. Currently, the Department receives summarized information from HFS and records the transactions into ERP and the SCO-563 forms without performing sufficient procedures to determine the accuracy of the information.

A good system of internal control requires that management review all significant accounts and balances recorded in the financial statements for accuracy, which includes transactions initiated by other State agencies.

Finding 2023-002 Medical Assistance Program Financial Information (Continued)

Internal controls over financial reporting for governmental entities should be designed to provide reasonable assurance of achieving effective and efficient operations, reliability of reporting for internal and external use, and/or compliance with provisions of applicable laws and regulations.

The Governmental Accounting Standards Board's *Codification of Governmental Financial and Reporting Standards*, Section 1100.101, provides that a governmental accounting system must make it possible both: (a) to present fairly and with full disclosure the funds and activities of the governmental unit in conformity with generally accepted accounting principles, and (b) to determine and demonstrate compliance with finance-related legal and contractual provisions. This requires the financial statements to agree with and to be supported by the Department's underlying records to enable accurate financial statements to be prepared.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

This finding was first noted during the Department's financial audit of the year ended June 30, 2017. In subsequent years, the Department has been unable to fully implement its corrective action plan.

Department management indicated they rely on the HFS Bureau of Claims Processing and the controls in the Medicaid Management Information System (MMIS). Although management has outlined a corrective action plan to address the findings, Department management stated, the plan was not executed prior to June 30, 2023.

Lack of sufficient internal controls over transactions and balances recorded in the Department's financial statements increases the likelihood of misstatements. (Finding Code No. 2023-002, 2022-002, 2021-001, 2020-001, 2019-001, 2018-001, 2017-002)

Recommendation

We recommend the Department assume more responsibility for the transactions and balances reported in its financial statements that are initiated/estimated by other State agencies, including the following:

- The Department should enter into an interagency agreement (IA) with HFS that details the responsibilities of each agency with regards to initiating, processing and recording transactions, and how the sufficiency of internal control over Department transactions will be monitored (i.e. annual internal audit, SOC 1 Type 2 audit, or other).

- Once an IA is executed, on a regular basis, the Department should determine if the control system and related monitoring agreed to through the IA is sufficient to prevent and detect significant financial statement errors. The sufficiency of internal control should be monitored each time there is a major change to Federal MAP/CHIP programs or IT systems used for those programs.

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

Finding 2023-002 Medical Assistance Program Financial Information (Continued)

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. The Department has begun drafting an interagency agreement with the Department of Healthcare and Family Services (HFS), which will outline the responsibilities of each agency regarding the reliability of HFS' MMIS data. The Department will also work with HFS to outline how the federal MAP receivables are supported by reports and source data compiled by HFS. Lastly, the Department will monitor the interagency agreement and make necessary modifications as needed.

Finding 2023-003 Intergovernmental Expenses

The Department of Human Services (Department) does not have sufficient internal control over accounting for intergovernmental expense transactions.

In contractual services expenditures for the General Revenue Fund (0001), three transactions totaling $9 million out of 46 transactions totaling $97.3 million tested that were recognized during the year ended June 30, 2023, were expenditures incurred in the year ended June 30, 2022 and should have been recognized for the year ended June 30, 2022. Of the three transactions, two were intergovernmental charges from the Department of Innovation and Technology (DoIT).

In equipment expenditures for the General Revenue Fund (0001), two transactions totaling $6.2 million out of 12 transactions totaling $13.6 million tested that were recognized during the year ended June 30, 2023, were expenditures incurred in the year ended June 30, 2022 and should have been recognized for the year ended June 30, 2022. Both transactions were intergovernmental charges from the DoIT.

Upon further investigation, it was determined there were approximately $53.5 million of contractual services and other expenditures incurred by DoIT to be billed out to the Department, of which only approximately $37.5 million had been recognized in accounts payable during fiscal year 2022. The Department reported nearly $15.9 million in expenditures for the year ended June 30, 2023, that were incurred for data center charges, supplemental IT charges and communication charges in the year ended June 30, 2022.

GASB Codification Section 1600 provides the authoritative guidance for reporting expenditure transactions. Paragraph 119 states “In the absence of an explicit requirement to do otherwise, a government should accrue a governmental fund liability and expenditure in the period in which the government incurs the liability. Governmental fund liabilities and expenditures that should be accrued include liabilities that, once incurred, normally are paid in a timely manner and in full from current financial resources—for example, salaries, professional services, supplies, utilities, and travel. To the extent not paid, such liabilities generally represent claims against current financial resources and should be reported as governmental fund liabilities.”

Department management indicated they used the amount of expenditures paid to the revolving fund during FY23 lapse period to identify the $37.5 million that was owed to DoIT at June 30, 2022.

As a result of the errors noted above, expenditures in the prior year financial statements were understated and expenditures in the current year financial statements were overstated by $15.9 million. (Finding Code No. 2023-003)

Recommendation

We recommend the Department utilize information provided by the Illinois Office of Comptroller (IOC) SCO-565 Inter-Fund Payable/Receivable form in preparing and reviewing its final inter-fund balances.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. The Department will utilize the data on the SCO-565 provided by the Illinois Office of the Comptroller in preparing and reviewing inter-fund balances included in GAAP reports and financial statements.

Finding 2023-004 Classification of Fund Balance

The Department of Human Services (Department) did not properly classify fund balance in the General Revenue Fund.

During our testing of fund balance classifications, we noted that the Department inappropriately classified $57,470,000 of fund balance in the General Revenue Fund. The $57,470,000 of fund balance was reported as restricted fund balance but should have been reported as unassigned fund balance.

GASB Codification Section 1800 provides the authoritative guidance for reporting fund balance in governmental funds. Paragraph 179 states "Fund balance classifications should depict the nature of the net resources that are reported in a governmental fund. An individual governmental fund could include nonspendable resources and amounts that are restricted, committed, or assigned, or any combination of those classifications." Further, paragraph 178 states "Unassigned fund balance is the residual classification for the general fund. This classification represents fund balance that has not been assigned to other funds and that has not been restricted, committed, or assigned to specific purposes within the general fund. The general fund should be the only fund that reports a positive unassigned fund balance amount.

Department management indicated the General Revenue fund balance included a nonspendable portion relating to the balance of inventory, which led the Department to report the fund balance as restricted.

The improper classification of fund balance in the General Revenue Fund represents a failure in internal controls over financial reporting to identify an error with GASB reporting requirements. (Finding Code No. 2023-004)

Recommendation

We recommend the Department evaluate the policies and procedures in place related to fund balance review to ensure that categories are properly calculated, reviewed and reported.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. The Department will continue to work with the Illinois Office of the Comptroller (IOC) on reviewing and updating the classification of Departmental fund balances.

Finding 2023-005 Inadequate Disaster Recovery Controls over the Integrated Eligibility System (IES)

The Department of Human Services and the Department of Healthcare and Family Services (collectively, the "Departments") lacked adequate disaster recovery controls over the Integrated Eligibility System (IES).

Management of the Departments have a shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Departments' IES is the automated system used by the Departments to intake, process (with the assistance of caseworkers), and approve assistance applications, maintenance items, Mid-Point Reports, and redeterminations of eligibility as well as to make payments for the State's human service programs. Additionally, the Departments work with the Department of Innovation and Technology (DoIT) for information technology management and support over IES.

The Departments' Disaster Recovery Plan for its IES application did not include the following:

- Detailed recovery scripts over the application and its data,
- Detailed environment diagrams,
- IES support staff and vendor contact information,
- Documentation on the backup and responsibilities for recovery of IES, and
- Documentation of the current environment.

Additionally, we noted the Departments did not conduct recovery testing of critical systems and components in fiscal year 2023.

This finding was first noted during the Departments' financial audits of the year ended June 30, 2019. In subsequent years, the Departments have been unable to fully implement its corrective action plan.

The Code of Federal Regulations (Code) (45 C.F.R. § 95.621(f)(2)(ii)(F), *ADP System Security Requirements and Review Process*, requires the Departments' automated data processing (ADP) security plan, policies and procedures to include contingency plans to meet critical processing needs in the event of short or long-term interruption of service.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology, Contingency Planning section requires entities to develop contingency plans for systems to achieve continuity of operations for organizational missions and business functions along with addressing system restoration and implementation of alternative missions or business processes when systems are compromised or breached.

The *Control Objectives for Information and Related Technologies* published by Information Systems Audit and Control Association (ISACA), Managed I&T-Related Risk Area, promotes controls for analyzing risks and maintaining a risk profile of risks and their potential impact and responses.

The Departments' management indicated the delayed completion of the Information System Contingency Plan (ISCP) for the IES application was due to the time required for IES technical teams to formulate and vet a complete, detailed failover playbook that would meet the Department's expectations for recovery time objectives.

Finding 2023-005 Inadequate Disaster Recovery Controls over the Integrated Eligibility System (IES) (Continued)

The lack of an adequate Disaster Recovery Plan and testing could result in the Departments' inability to recover IES data in the event of disaster, which would be detrimental to recipients of benefits, and the Departments' and State's operations. (Finding Code No. 2023-005, 2022-004, 2021-007, 2020-009, 2019-009)

Recommendation

We recommend the Departments work with DoIT to allocate sufficient resources to enable a full recovery of IES in the event of a disaster and implement adequate disaster recovery controls over IES. Additionally, in the interim, we recommend the Departments work with DoIT to develop a prioritization plan and emergency operating procedures to allow IES to operate under reduced capacity in the event of a disaster.

We further recommend management of the Departments enhance the Disaster Recovery Plan to include:

- Detailed recovery scripts over the application and its data,
- Detailed environment diagrams,
- IES support staff and vendor contact information,
- Documentation on the backup and responsibilities for recovery of IES, and
- Documentation of the current environment.

Finally, we recommend the Departments perform disaster recovery testing on a regular basis as defined in the plan.

Department of Human Services' Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. The Department has worked with IES application stakeholders, including DoIT, to complete the Information System Contingency Plan in FY24. The plan documents the recovery control requirements of the finding. A comprehensive tabletop test exercise of the IES contingency plan and playbook was completed on December 1, 2023. The Department will work toward testing and updating the IES contingency plan annually.

Department of Healthcare and Family Services' Response

The Department of Healthcare and Family Services accepts the recommendation. The IES application and data reside on the Department of Innovation and Technology (DoIT) infrastructure and as our service provider they are responsible for ensuring disaster recovery controls are in place and tested. The Department of Human Services has worked with IES application stakeholders to complete the Information System Contingency Plan in FY24. The plan documents the recovery control requirements noted. A comprehensive tabletop test exercise of the IES contingency plan and playbook was completed on December 1, 2023. The Departments will work with DoIT to test and update the IES contingency plan annually.

Finding 2023-006 Inadequate General Information Technology Controls over IES

The Department of Healthcare and Family Services and the Department of Human Services (collectively, the "Departments") had weaknesses in the general information technology (IT) and security controls over the Integrated Eligibility System (IES).

Management of the Departments has a shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Departments' IES is the automated system used by the Departments to intake, process (with the assistance of caseworkers), and approve assistance applications, maintenance items, Mid-Point Reports, and redeterminations of eligibility as well as to make payments for the State's human service programs.

In addition to the conditions noted below, related IES issues over disaster recovery controls are noted in Finding Code No. 2023-005.

Environment
The IES application and data reside on the Department of Innovation and Technology (DoIT) environment. In this regard, DoIT is a service provider to the Departments.

During the Departments' internal security review, completed as part of its Plan of Actions and Milestones (2023) report to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (Federal CMS), significant threats over DoIT's general IT environment, which hosts IES, were identified.

Further, during our fieldwork it was noted the Departments experienced three security breaches related to the IES system; the first breach occurred in August 2022, the second breach was discovered in March 2023, and the third breach occurred in August 2023.

The Code of Federal Regulations (Code) (45 C.F.R. § 95.621(f)(1)), *ADP System Security Requirement*, requires the Departments to be responsible for the security of all automated data processing (ADP) system projects under development and operational systems involved in the administration of the U.S. Department of Health and Human Services programs. The Departments are required to determine the appropriate security requirements based on recognized industry standards or standards governing the security of federal ADP systems and information processing.

Federal CMS' *MARS-E Document Suite* (minimum acceptable risk standards for exchanges), states that protecting and ensuring the confidentially, integrity, and availability of state Marketplace information, common enrollment information, and associated information is the responsibility of the states.

The internal control requirements of the Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance) within the Code (2 C.F.R. § 200.303) requires the Departments to establish and maintain effective internal control over the Medicaid Program to provide reasonable assurance the Departments are managing the Medicaid Program in compliance with federal statutes, regulations, and the terms and conditions and comply with federal statutes, regulations and terms and conditions of the Medicaid Program.

Finding 2023-006 Inadequate General Information Technology Controls over IES (Continued)

These internal controls should be in compliance with guidance in Standards for Internal Control in the Federal Government (otherwise commonly referred to as the Green Book) issued by the Comptroller General of the United States or the Internal Control Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

The Departments' management indicated multi-year IES technology refresh projects are still in progress. The Departments continue working through project delays and challenges to resolve security weaknesses and close out aged Plan of Action and Milestone findings.

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

Change Control
IES Application Changes - Policies and Procedures
Based on our review of sampled infrastructure changes, we noted backout plans to return the system to a previous functional version in the event a change moved into production caused undesired results had not been prepared for individual infrastructure changes for 5 out of 5 (100%) changes reviewed.

The National Institute of Standards and Technology (NIST), Special Publication 800-53, Fifth Revision, *Security and Privacy Controls for Information Systems and Organizations*, Configuration Management section, backout plans should be retained to support rollback of changes made to systems.

Additionally, DoIT's Change Management Policy requires that each change have a backout plan documented.

The Departments' management indicated the Departments have made improvements to the current change management process and are working with DoIT to provide additional infrastructure change required documentation.

Findings over the IES Environment and Change Control were first noted during the Departments' financial audits of the year ended June 30, 2017. In subsequent years, the Departments have been unsuccessful in fully implementing corrective action plans.

Failure to establish and document backout plans for changes to IES infrastructure diminishes the Departments' ability to recover the application if an error were to occur during the change process. (Finding Code No. 2023-006, 2022-005, 2021-005, 2021-006, 2020-007, 2020-008, 2019-008, 2018-010, 2017-010)

Finding 2023-006 Inadequate General Information Technology Controls over IES (Continued)

Recommendation

We recommend management of both Departments work together to strengthen controls over the IES environment by addressing all significant threats identified in the Plan of Actions and Milestones (2023) report to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

We also recommend management of both Departments ensure backout plans are developed and documented for infrastructure changes.

Department of Human Services' Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. The Departments will work to implement the IES Technical Refresh (TR) and Okta MFA projects, as planned in FY25, to resolve security weaknesses and close out aged Plan of Action and Milestone findings. The Department will also work with the Department of Innovation and Technology on documented backout plans with all IES infrastructure changes.

Department of Healthcare and Family Services' Response

The Department of Healthcare and Family Services accepts the recommendation. The IES application and data reside on the Department of Innovation and Technology (DoIT) infrastructure and as our service provider they are responsible for ensuring a secure environment, significant threats are identified and backout plans for changes are developed. The Departments will work with DoIT to implement the IES Technical Refresh (TR) and Okta MFA projects as planned in FY25 to resolve security weaknesses and close out aged Plan of Action and Milestone findings. The Departments will also require DoIT provide documented backout plans with all IES infrastructure changes.

Finding 2023-007 Inadequate Controls over Eligibility Determinations and Redeterminations

The Department of Healthcare and Family Services and the Department of Human Services (collectively, the "Departments") lacked controls over eligibility determinations and redeterminations for Federal programs where such determination is documented using the Integrated Eligibility System (IES).

Management of the Departments have shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Departments' IES is the automated system used by the Departments to intake, process (with the assistance of caseworkers), and approve assistance applications, maintenance items, Mid-Point Reports and redeterminations of eligibility as well as to make payments for the State's human service programs.

In order to conclude if the determination of eligibility was proper, we selected a sample of 60 cases (30 new applications and 30 redeterminations) and tested whether the cases were properly certified (approved or denied) based on non-financial, financial and timeliness criteria. Our testing considered all the documentation contained within the case file, including the scanned documentation supporting caseworker overrides required prior to certification. In 12 of the 60 cases tested (20%), we noted exceptions. Specifically, we noted:

- Two new applications (7%) tested did not have the certification completed timely. Certifications were 12 and 162 days late.
- One new application (3%) tested did not have residency and citizenship verified.
- One redetermination (3%) did not have the required documentation maintained.
- Five redeterminations (17%) tested did not have the certification completed timely. Certifications were 35 to 101 days late.
- Two redeterminations (7%) used the net pay instead of the gross pay for the benefit calculation with no impact to the benefit provided.
- One redetermination (3%) had unearned income incorrectly calculated.

The Code of Federal Regulations (Code) (42 C.F.R. § 435.403), *Eligibility in the States, District of Columbia, the Norther Mariana Islands, and American Samoa*, requires recipients of Medicaid to provide documentary evidence of their citizenship, residency, SSNs, and income. Further, the Code (42 C.F.R. § 431.17), *Maintenance of Records* requires the Departments to maintain records of each applicant and beneficiary, including records which support the determination of eligibility.

The Code (7 C.F.R. § 273.10), *Determining Household Eligibility and Benefit Levels*, requires the household's eligibility be determined for the month of application by considering the household's circumstances for the entire calendar month in which the household filed its application. Eligibility for recertification shall be determined based on circumstances anticipated for the certification period starting the month following the expiration of the current certification period.

Finding 2023-007 Inadequate Controls over Eligibility Determinations and Redeterminations (Continued)

The Code (7 C.F.R. § 274.1 and §274.2), *Issuance System Approval Standards* and *Providing Benefits to Participants*, indicates DHS is responsible for the timely and accurate issuance of SNAP benefits to certified eligible households, and that all newly certified households (except those given expedited service) shall be given the opportunity to participate no later than 30 calendar days following the date the application was filed.

The Departments' management indicated contributing factors for the exceptions noted include worker errors in manual processes, the high volume of work and the complexity of the programs involved.

Inadequate controls over eligibility determinations resulted in determinations of eligibility that were not demonstrated or documented prior to recipient certification, and the State expending Federal and State funds for recipients that may not have been eligible to receive benefits. Noncompliance with federal laws and regulations could lead to sanctions and/or loss of future Federal funding, disallowance of costs, and the requirement to return Federal funds previously received. (Finding Code No. 2023-007)

Recommendation

We recommend management of both Departments work together to implement additional controls to ensure appropriate documentation of eligibility is obtained at the time of certification and retained in IES, and to complete certifications of applications and redeterminations timely.

Department of Human Services' Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS, in conjunction with HFS and our IES Vendor, is in the process of implementing additional controls to ensure appropriate documentation of eligibility is obtained at the time of certification and retained in IES, and that certifications are made timely.

Department of Healthcare and Family Services' Response

The Department of Healthcare and Family Services accepts the recommendation. The two cases related to medical were due to caseworker error. The Department has an ongoing monitoring program of caseworkers. The Bureau of Eligibility Integrity is working on a refresher training that is focused on errors caseworkers make.

Finding 2023-008 Insufficient Review and Documentation of Provider Enrollment

The Department of Healthcare and Family Services (HFS) and the Department of Human of Services (DHS) (collectively, the "Departments") failed to sufficiently review and document provider enrollment requirements during the required monthly screenings for enrolled providers.

Management of the Departments have shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system is a multi-agency effort to implement a web-based system to give providers a more convenient and consistent user experience and to ensure beneficiaries receive timely and high-quality Medicaid Services. IMPACT is an automated system used by the Departments to accommodate provider enrollment approvals and all Medicaid claim payments to such providers.

During fiscal year 2023, the IMPACT system had 304,070 active providers. Monthly batch screenings are utilized by the Departments to support providers continued to meet the enrollment criteria. In order to determine the Departments monitored the monthly batch screenings, we selected a sample of 60 providers for testing. Our testing results noted HFS was unable to provide support for one or more monthly batch screenings performed for 22 (37%) providers tested.

Finally, this finding was first noted during the Departments' fiscal year 2018 financial audit, five years ago. While the Departments did successfully execute an interagency agreement as recommended in prior engagements, the Departments' management has been unsuccessful in implementing a corrective action plan to remedy the provider enrollment deficiency.

The Code of Federal Regulations (Code) (42 C.F.R. § 455.436 (c)(1)) requires the Departments to consult appropriate databases to confirm identity upon enrollment and reenrollment. In addition, the Code (42 C.F.R § 455.450 (a)(3)) requires the Departments to conduct database checks on a pre-and post-enrollment basis to ensure providers continue to meet the enrollment criteria for their provider type, in accordance with § 455.436.

The Code (2 C.F.R § 200.303), Internal Controls, requires the Departments to: (1) establish and maintain effective internal control over the Medicaid Program to provide reasonable assurance the Departments are managing the Medicaid Program in compliance with federal statutes, regulations, and the terms and conditions; and (2) comply with federal statues, regulations and terms and conditions of the Medicaid Program. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" (otherwise commonly referred to as the Green Book) issued by the Comptroller General of the United States or the "Internal Control Integrated Framework" issued by the Committee of Sponsoring Organization of the Treadway Commission (COSO).

Additionally, the Code (42 C.F.R. § 431.17) requires the Departments to maintain records necessary for the proper and efficient operations of the State's Medicaid Plan.

Finally, the Departments' management teams are responsible for implementing timely corrective action on all of the findings identified during a financial audit.

Finding 2023-008 Insufficient Review and Documentation of Provider Enrollment (Continued)

The Departments' management indicated issues with provider monthly batch screenings was due to a system error which was corrected in June 2023.

Inadequate controls over the operation of IMPACT, such as insufficient review and monitoring of monthly batch screenings, could result in expenditures to providers who are were no longer eligible and represents noncompliance with the Code. (Finding Code No. 2023-008, 2022-007, 2021-009, 2020-011, 2019-011, 2018-006)

Recommendation

We recommend the Departments strengthen internal controls to ensure providers continue to meet criteria in accordance with the Code.

Department of Human Services' Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work with HFS and the service provider to ensure controls over IMPACT are adequate.

Department of Healthcare and Family Services' Response

The Department of Healthcare and Family Services (HFS) accepts the recommendation. A system error caused issues with the provider month batch screenings and was corrected as part of the IL -1.6 System Release in June 2023. Screenings have been occurring on a regular basis since then.

Finding 2023-009 Inadequate General Information Technology Controls over IMPACT

The Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) (collectively, the "Departments") had inadequate general information technology controls over the State of Illinois' Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system.

Management of the Departments have shared responsibility for various human service programs in the State and for internal controls over the manual and automated processes relating to eligibility for these programs. The Departments' IMPACT system is a multi-agency effort to implement a web-based system to give providers a more convenient and consistent user experience and to ensure beneficiaries receive timely and high-quality Medicaid Services. IMPACT is an automated system used by the Departments to accommodate provider enrollment approvals and all Medicaid claim payments to such providers.

The Departments did not have adequate user access controls for the IMPACT system. During testing auditors noted:

- Four of 17 (24%) terminated users from HFS had not been deleted from the system. As of June 30, 2023, the deletion of users was 15 to 336 days late.
- One of 17 (6%) terminated users from HFS did not have access timely deleted. The user was deleted from the system 148 days after the user's termination date.
- One of one (100%) terminated users from DHS had not been deleted from the system. As of June 30, 2023, the deletion of the user was 346 days late.
- One of seven (14%) active users from DHS no longer required the use of IMPACT and did not have access timely deleted. As of June 30, 2023, the deletion of the user was 45 days late.

Although an automated process prevents access after 60 days from the user's last login to the program, the users noted in the exceptions were not deleted. The automated process is for non-use only, after 60 days. However, if the individuals were to continue to utilize their accounts they would remain active until deleted.

This finding was first noted during the Departments' fiscal year 2018 financial audit, five years ago. As such, the Departments' management has been unsuccessful in implementing a corrective action plan to remedy this deficiency.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, (Fifth Revision)) published by the National Institute of Standards and Technology (NIST), Access Control section, requires entities to develop and comply with control over the timely termination of access rights and the periodic review of access rights.

Furthermore, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires all State agencies to establish and maintain a system, or systems, of internal fiscal and administrative controls, to provide assurance that revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability of the State's resources.

Finally, the Departments' management teams are responsible for implementing timely corrective action on all of the findings identified during a financial audit**.**

Finding 2023-009 Inadequate General Information Technology Controls over IMPACT (Continued)

HFS management stated user access was not timely terminated due to limitations in communication between the departments. DHS management stated user access was not timely terminated due to changes in staffing levels that led to difficulties in executing the offboarding process.

Inadequate internal controls over user access could result in unauthorized use and/or inappropriate access to the IMPACT system, which could go undetected by the Departments for an extended period of time and could lead to confidential information being compromised. (Finding Code No. 2023-009, 2022-008, 2021-010, 2020-012, 2019-012, 2018-005)

Recommendation

We recommend the Departments strengthen their internal controls over the timely removal of access to the IMPACT system for terminated employees or employees no longer requiring access.

Department of Human Services' Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review the onboarding and offboarding procedures. Administration will create a process to review User access. Monthly reminders will be sent to all managers reminding them of the requirements for terminating user access upon separation or transfer of employees.

Department of Healthcare and Family Services' Response

The Department of Healthcare and Family Services (HFS) accepts the recommendation. The Division of Personnel has implemented an exit process for employees leaving the Department. Part of this process is to ensure system access is communicated and removed promptly.

Finding 2023-010 Complete Populations Not 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:

- Reporting functions within the Department's accounting information system did not generate accurate populations used for leases and asset additions and deletions reported on the Department's Agency Report of State Property (C-15 Form).
- While testing compliance with various Mental Health and Developmental Disabilities Administrative Acts and other State laws governing the State-Operated Mental Health and Developmental Disabilities facilities, we noted the following:
    - For Mental Health and Developmental Disabilities Code (MH Code) (405 ILCS 5/2-108(a-e)), the Fox Developmental Center was not able to provide adequate records substantiating the population of restraints issued during the examination period. Additional information can be found in Finding 2023-011.
    - For MH Code (405 ILCS 5/2-108(g-h)), the Ludeman Developmental Center was not able to provide adequate records substantiating the population of employees qualified to order the use of restraints at the Facility during the examination period. Additional information can be found in Finding 2023-011.
    - For the Mental Health and Developmental Disabilities Administrative Act (MH Administrative Act) (20 ILCS 1705/47), the Jack Mabley Developmental Center was 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 can be found in Finding 2023-012.
    - For MH Code (405 ILCS 5/2-113) Fox Developmental Center, Chester Mental Health, Ludeman Developmental Center, and Shapiro Developmental Center were unable to provide adequate records substantiating the populations provided for testing. Additional information on these populations by location can be found in finding 2023-013.
    - For the MH Administrative Act (20 ILCS 1705/10.1), Shapiro Developmental Center was unable to provide adequate records substantiating the population of women of child-bearing age residing at the facility during the examination period. Additional information can be found in Finding 2023-015.

Even given the population limitations noted above 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, where applicable.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

According to the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36), when using information produced by the entity, the practitioner should evaluate whether the information is sufficiently reliable for the practitioner's purposes, including, as necessary, obtaining evidence about the accuracy and completeness of the information, and evaluating whether the information is sufficiently precise and detailed for the practitioner's purposes.

Finding 2023-010 Complete Populations Not Provided (Continued)

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the essential transactions of the Department to protect both the legal and financial rights of the State and of persons directly affected by the Department's activities.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable law.

Department personnel indicated that with the transition to the Enterprise Resource Planning accounting system, the Department discovered some of the reporting functions were generating incomplete and inaccurate lease, asset addition, and asset deletion populations which required consultation with the Department of Innovation and Technology and the vendor to address. Substantiation of the population of the other areas noted above was difficult based on the nature of the population.

Without the Department provided complete and adequate documentation to enable testing, we were impeded in completing our procedures and providing useful and relevant feedback to the General Assembly regarding the Department's compliance for the above areas. Further, the Department is unable to demonstrate it has met each compliance requirement it is subject to when sufficient records are not maintained. (Finding Code No. 2023-010, 2021-011, 2019-013, 2017-013).

Recommendation

We recommend Department management and staff strengthen controls over records maintenance for each area in which a compliance requirement is present. To every extent possible, population records should be sequentially numbered. Further, we recommend the Department strengthen its internal controls to ensure it maintains complete and accurate populations.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. Each Division will work to strengthen controls to ensure adequate records are maintained and can be provided when requested.

Finding 2023-011 Noncompliance with Statutory Requirements Regarding the Use of Restraints and Seclusion

The Department of Human Services (Department) did not comply with statutory requirements regarding the use of restraints.

During fieldwork, we performed on-site testing regarding the use of restraints at five of the Department's State-Operated facilities. As noted in Finding 2023-010, Fox Developmental Center was unable to provide adequate records substantiating the population of restraints issued and Ludeman Developmental was unable to provide adequate records substantiating the population of employees qualified to order the use of restraints on residents during the examination period.

Although we were unable to obtain the above complete populations across all five facilities, we performed testing on information provided which resulted in the following exceptions at three Department facilities:

Chester Mental Health Center

- For 1 of 12 (8%) residents tested, the Center was unable to provide support that prior written authorization was given by the Facility Director prior to the application of the restraint.
- For 1 of 12 (8%) residents tested, we were unable to determine whether the Facility Director was informed of the restraint in writing within 24 hours.
- For 2 of 12 (17%) residents tested, prior authorization was not obtained before applying the same restraint within a 48 – hour period.
- For 5 of 12 (42%) residents tested, we were unable to determine if the Facility Director reviewed the ordered restraints.
- For 13 of 59 (22%) restraints tested, employee restraint certifications were not valid upon application of restraint date.
- For 5 of 59 (8%) restraints tested, the Facility was unable to provide documentation to support the certifications for the employees who applied the restraints were up to date on the date of restraint application.

Elgin Mental Health Facility

- For 2 of 12 (17%) restraints tested, the Facility was unable to provide documentation to support the certifications for the employees who applied the restraints were up to date on the date of restraint application.

Ludeman Developmental Center

- For 1 of 12 (8%) residents tested, the resident was not examined by a physician or supervisory nurse within two hours after the initial employment of the emergency restraint.
- For 4 of 12 (33%) residents tested, we were unable to determine the person applying the restraint had completed the proper training.
- For 1 of 12 (8%) residents tested, we were unable to determine if prior authorization was obtained before the restraints were applied.
- For 1 of 12 (8%) residents tested, we were unable to determine whether the Facility Director was informed of the restraint in writing within 24 hours.
- For 11 of 12 (92%) resident restraints tested, the Facility was unable to provide documentation to support the certifications for the employees who applied the restraints were up to date on the date of restraint application.

Finding 2023-011 Noncompliance with Statutory Requirements Regarding the Use of Restraints and Seclusion (Continued)

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2011. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Mental Health and Developmental Disabilities Code (MH Code) (405 ILCS 5/2-108) requires the following:

- a written order of a physician, clinical psychologist, clinical social worker, clinical professional counselor, advanced practice psychiatric nurse, or registered nurse with supervisory responsibilities to employ the use of restraint;
- in the event of a temporary emergency restraint order, a physician or supervisory nurse shall examine the recipient within two hours after the initial employment of the emergency restraint;
- the person who ordered the restraint to inform the Facility Director or his designee in writing of the use of the restraint within 24 hours;
- the Facility Director to review all restraint orders daily and inquire into reasons for the orders for restraint by any person who routinely orders them;
- once a restraint has been employed during one 24-hour period, it shall not be used again on the same resident during the next 48 hours without the prior written authorization of the Facility director; and,
- all employees authorized to employ restraints on patients receive training in the safe and human application of restraints and maintenance of records detailing which employees have been trained and are authorized to apply restraint, the date of training and the type of restraint that the employee was trained to use.

According to the Facility Procedural Guide # MD460 Use of Restraints & Seclusion (Containment) in Mental Health Facilities, all staff involved in the use of mechanical restraint and seclusion are to receive training and to demonstrate (ongoing and annual) competence. Only staff who demonstrated competency may implement, monitor, or supervise the use of restraint and seclusion in a mental health facility.

Further, the Department's Mental Health Program Directive (02.03.03.010) requires authorized staff to write an order for restraint on the IL462-0044 RD after personally observing and examining the resident.

Additionally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department personnel stated the issues were a result of inadequate oversight of processes and errors resulting from manual processes.

Failure to have adequate internal controls over the use and application of restraints and the training of persons administering restraints is noncompliance with the MH Code and could adversely affect the care and treatment of residents and could subject the State to unnecessary legal risks. Furthermore, failure to re-train personnel within 12-month periods represents noncompliance with the Department's Mental Health Program Directive. Failure to retain complete and accurate records represents noncompliance with the State Records Act. (Finding Code No. 2023-011, 2021-012, 2019-014, 2017-015, 2015-010, 2013-032, 11-17)

Finding 2023-011 Noncompliance with Statutory Requirements Regarding the Use of Restraints and Seclusion (Continued)

Recommendation

We recommend Department management re-train staff on compliance with statutory requirements regarding the use of restraints. This training should include documentation requirements when restraints are ordered. We also recommend Department management establish a process to monitor compliance with annual training requirements.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will re-train staff on compliance with statutory requirements regarding the use of restraints. This training will include documentation requirements when restraints are ordered. Furthermore, procedures to monitor compliance will be developed.

Finding 2023-012 Noncompliance with Statutory Requirements Regarding the Monitoring of Facility Visitors

The Department of Human Services (Department) did not comply with statutory requirements regarding the monitoring of Facility visitors.

As part of our testing at eight of the Department's State-operated facilities, we reviewed facility visitor logs and tested facility procedures regarding the monitoring of visitors. We were unable to obtain a complete population of visitor entry logs for Jack Mabley Development Center as noted in Finding 2023-010. Our testing resulted in the following exceptions:

Elgin Mental Health Center

- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- The Facility failed to adequately document if visitors provided Security staff with State-issued identification in lieu of providing them a temporary badge.

Shapiro Developmental Center

- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.

Chester Mental Health Center

- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- The Facility's policy for visitors did not include procedures for resident visitors.
- The Facility's policy for visitors is not being adequately followed.

Murray Developmental Center

- The Facility does not follow a consistent procedure for all business/non-employee visitors to the Facility.
- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- The Center did not maintain adequate physical safeguards regarding building access and monitoring.

Fox Developmental Center

- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.

Jack Mabley Developmental Center

- The Facility's visitor log appeared to be incomplete. Missing information included visitor's name, address, phone, email, purpose of visit, time in, time out, badge out and badge in.
- The Business Office at Jack Mabley Developmental Center concurrently utilized two types of visitor logs, resulting in some non-residential visitors signing on both logs.
- Inconsistencies were noted between different copies of the same visitor logs provided.

Finding 2023-012 Noncompliance with Statutory Requirements Regarding the Monitoring of Facility Visitors (Continued)

Jack Mabley Developmental Center (Continued)

- Copies of the visitor logs for the Maintenance Garage could not be provided for the period of July 1, 2021 through December 20, 2021.
- Business visitors were not always required to show identification on arrival.
- Visitors are not consistently provided visitor badges.

Illinois Center for Rehabilitation and Education – Wood

- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- Visiting hours posted were not in agreement with the Facility's polices.

Ludeman Development Center

- The population of visitor logs maintained by the facility was incomplete.
- For 6 of 8 (75%) months selected, the Facility was unable to provide copies of the completed visitor logs.
- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.
- For 3 of 15 (20%) of employees selected, we noted the employees were not displaying proper employee identification while at the Facility, as required.
- For 2 of 15 (13%) of employees selected, we noted the employees were unable to produce proper photo identification while at the Facility.
- The Center did not maintain adequate physical safeguards regarding building access and monitoring.

Treatment and Detention Facility

- The Facility's visitor log appeared to be incomplete. Missing information included time-in, time-out, organization or address of the individual, purpose, and area of visit.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities. Additionally, the State Records Act (5 ILCS 160/17a) states that regardless of other authorization to the contrary, no record shall be disposed of by the Department, unless approval of the State Records Commission is first obtained.

The Illinois Administrative Code (59 Ill. Admin Code 102.10(e)) states only persons on official business, such as employees, authorized visitors, and persons providing required foods and services shall have access to center/program campus property.

The Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/47) states the Facility Director shall develop and implement written policies and procedures to insure that employees and visitors are properly identified at all times they are on the grounds of the Facility.

Finding 2023-012 Noncompliance with Statutory Requirements Regarding the Monitoring of Facility Visitors (Continued)

Department Directive 01.01.02.210 states "Building security or a designated Employee must maintain a log of temporary badges issued. At certain locations, building security or a designated Employee will hold the Visitor's State-Issued identification (ID) card. The ID card will be returned upon receipt of the temporary badge".

Department personnel stated that staff turnover, error due to manual processes, and lack of oversight resulted in the issues noted.

Failure to enforce policies and procedures to ensure compliance with the MH Act governing the identification of all visitors to a facility could result in unauthorized individuals' access to facility grounds, posing an increased risk to the safety of the residents and facility staff. Additionally, failure to provide adequate physical safeguards regarding building access and monitoring could also result in unauthorized access to the facility campus and residents. (Finding Code No. 2023-012, 2021-013, 2019-015, 2017-016)

Recommendation

We recommend Department management enforce policies and procedures to ensure compliance with the MH Act regarding visitors to facilities and employees. The policies and procedures should include training personnel on compliance requirements and implementing management oversight over compliance requirements. We also recommend each Facility retain visitor entry logs as required. Further, we recommend the Department improve controls over building access and monitoring.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work to ensure compliance with statutory requirements regarding monitoring of facility visitors and employees. Staff will be trained regarding the requirements when processing visitors signing in at the facilities and procedures will be developed to monitor compliance.

Finding 2023-013 Noncompliance with Statutory Requirements Regarding Residents' Admissions, Discharges, Annual Evaluations, and Requests for Information

The Department of Human Services (Department) did not comply with statutory requirements regarding residents' admissions, discharges, annual evaluations, and requests for information.

During fieldwork, we performed on-site testing at seven of the Department's State-Operated facilities regarding resident admissions, discharges, and requests for information. Although we were unable to obtain complete populations in relation to testing for four facilities during the examination period (Fox Developmental Center, Chester Mental Health, Ludeman Developmental Center, and Shapiro Developmental Center), we sampled and tested 60 residents/students which resulted in the following exceptions:

Chester Mental Health Center

During the performance of testing admissions:

- For 2 of 10 (20%) residents tested, the Facility was unable to provide support that attempts were made to immediately make contact with at least two designated persons or agencies, or that notification concerning the admission was mailed within 24 hours.

During the performance of testing requests for information:

- The Facility was unable to provide a complete and accurate population of individuals requesting information relating to admission.
- For 4 of 10 (40%) residents tested, an authorization to disclose/obtain information form (Form IL462-0146) could not be located in the resident's file.
- For 1 of 10 (10%) residents tested, the resident's progress notes note an authorization to disclose/obtain information form (IL462-0146) was signed on the date of admission. However, the date of the signature on form IL462-0146 differs.
- For 2 of 10 (20%) residents tested, the authorization to disclose/obtain information form (Form IL462-0146) located in the patient's file was blank.
- For 3 of 3 (100%) external requests, required information of the requesting party was missing. Specifically, the missing information was the requesting party's address, phone number, and relationship to the resident.
- The Facility did not follow its policy to ensure compliance with the Mental Health and Developmental Disabilities Code. We noted the facility staff did not consistently complete DHS Form 179 - External Correspondence Log, and external calls of this nature were not routed through a centralized location (Forensic Coordinator's Office).
- The Facility does not have a detailed policy that reflects current practice regarding admissions and the use of the Authorization to Disclose/Obtain Information Form, Form 146. The policy does not indicate how or where to document when a patient does not wish anyone to be notified, when a patient refuses to sign the form, or when contact was made/attempted to be made in order to substantiate compliance with the Mental Health and Developmental Disabilities Code.

Finding 2023-013 Noncompliance with Statutory Requirements Regarding Residents' Admissions, Discharges, Annual Evaluations, and Requests for Information (Continued)

Chester Mental Health Center (Continued)

During the performance of testing discharges:

- For 10 of 30 (33%) discharged patients tested, the written notice of discharge was given to the recipient between 4 and 7 days late. Further, none of the Notice of Discharge/Transfer Forms indicated the reason for transfer/discharge and why the statutorily required number of days' notice was not/could not be met.
- For 1 of 30 (3%) discharged patients tested, the Notice of Transfer could not be located in the patient's files.

Elgin Mental Health Facility

During the performance of testing discharges:

- For 9 out of 30 (30%) discharged patients, the Facility failed to give more than 7 days of advanced written notice for residents' discharges. Notice was provided on the day of discharge.

Fox Developmental Center

During the performance of testing admissions:

- The Center was unable to provide a complete and accurate population of newly admitted individuals.
- The Center was unable to provide a complete and accurate population of Dually Diagnosed persons for the period under examination. Additionally, the reports provided by the Center did not contain the residents' legal admission status, the date and Facility and unit of transfer or discharge, whether or not there is a public or private guardian, whether or not the Facility Director has certified that appropriate treatment and habilitation are available for and being provided to such person, and whether or not the patient or a guardian has requested review, and, if so, the outcome of the review.
- For 1 out of 8 (13%) residents tested, the Notice of Admission was not sent to the resident's guardian within the required 24 hours. Additionally, the wrong date of admissions was written on the form.
- For 1 out of 8 (13%) residents tested, the Notice of Admission could not be provided by the Center.

Jack Mabley Developmental Center

During the performance of testing admissions:

- For 12 of 12 (100%) admissions tested, the facility did not maintain documentation that, upon admission, recipients were inquired if a spouse, family member, friend or agency is to be notified of their admission to the facility. As such, we were unable to test compliance with the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-113(a)).

Ludeman Development Center

During the performance of testing admissions:

- The Center was unable to provide a complete and accurate population of Dually Diagnosed persons for the period under examination. Additionally, the reports provided by the Center did not contain the residents' diagnosis, whether the Facility Director has certified that appropriate treatment and habilitation are available for and being provided to such person, and whether or not the patient or a guardian has requested review, and, if so, the outcome of the review.

Finding 2023-013 Noncompliance with Statutory Requirements Regarding Residents' Admissions, Discharges, Annual Evaluations, and Requests for Information (Continued)

Ludeman Development Center (Continued)
During the performance of testing admissions:

- For 3 of 20 (15%) residents tested, the facility was unable to provide adequate supporting documentation to complete testing.
- For 8 out of 8 (100%) residents tested, the Notice of Admission was not sent to the resident's guardian within the required 24 hours.

During the performance of testing requests for information:
The Facility disclosed that it has no internal controls or formal policy in place to document that requests for information were responded to within two working days.

- For 8 of 8 (100%) residents tested, the authorization to disclose/obtain information form (Form IL462-0146) was completed improperly.

During the performance of testing discharges:

- For 6 of 20 (30%) discharged patients tested, the Facility Director did not give a written notice of the discharge to the resident at least 14 days prior to the discharge of the patient.
- For 4 of 20 (20%) discharged patients tested, the Facility Director did not give a written notice of the discharge to the resident's guardians at least 14 days prior to the discharge of the patient.
- For 3 of 20 (15%) discharged patients tested, the notice of discharge to the resident did not have the date the resident received the notice. Therefore, we could not determine if notice of discharge was provided 14 days prior to discharge.
- For 4 of 20 (20%) discharged patients tested, the notice of discharge to the guardian did not have the date that the guardian received the notice. Therefore, we could not determine if the guardian received a notice of discharge 14 days prior to discharging.

Shapiro Developmental Center
During the performance of testing admissions:

- The Center was unable to provide a complete and accurate population of Dually Diagnosed persons for the period under examination. Additionally, the reports provided by the Center did not contain the residents' legal admission status, the date and Facility and unit of transfer or discharge, whether or not there is a public or private guardian, whether or not the Facility Director has certified that appropriate treatment and habilitation are available for and being provided to such person, and whether or not the patient or a guardian has requested review, and, if so, the outcome of the review.

During the performance of testing discharges:

- For 5 of 20 (25%) discharged patients tested, the written notice of discharge was not given to the recipient prior to date of discharge. Further, the Center documented the guardian waived the 14-day notice requirement, however, did not document on what date the guardian waived the 14-day requirement. As such, we were unable to determine whether the guardian was informed of the discharge prior to the discharge occurring.
- The Facility was unable to provide a complete and accurate population of discharges for the period under examination. Discrepancies were identified between the population provided by the Facility in comparison to the listing provided by the Central Office.

Finding 2023-013 Noncompliance with Statutory Requirements Regarding Residents' Admissions, Discharges, Annual Evaluations, and Requests for Information (Continued)

Treatment and Detention Facility

During the performance of testing annual evaluations:

- For 1 out of 4 (25%) residents selected for testing, the Facility did not complete the noted recipient's annual evaluation within 12 months of their commitment.
- For 1 out of 4 (25%) residents selected for testing, the Facility did not prepare the written report for the noted recipient within 30 days of their evaluation.

During the performance of testing discharges:

- For 3 out of 7 (43%) residents selected for testing, the facility did not file with the committing court of their intention to file, or not file, a petition for conditional release on behalf of the residents.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Mental Health and Developmental Disabilities Code (MH Code) (405 ILCS 5/2-113(a)) requires that upon admission, the Facility inquire of the resident if a spouse, family member, friend or an agency is to be notified of their admission. Good internal controls require employees to complete an admission form and maintain a copy of the admission form in the resident's file. The form should be signed by the employee making the inquiry of the resident.

Additionally, the MH Code (405 ILCS 5/2-113(b)-(f)) indicates that any person may request information from a developmental disability or mental health facility relating to whether an adult resident or minor resident admitted pursuant to Section 3-502 has been admitted to the facility. Any parties requesting information must submit proof of identification and list their name, address, phone number, relationship to the resident and reason for the request. The facility shall respond to the inquirer within 2 working days. If the resident is located at the facility, the facility director shall inform the resident of the request and shall advise the resident that disclosure of their presence at the facility will not obligate the resident to have contact with the inquirer. No information shall be disclosed unless the resident consents in writing to the disclosure. If the resident has consented to the release of information the facility shall inform the requesting party that the resident is located at the facility. The facility shall, with the resident's consent, tell the requesting party how to contact the resident. When the resident is not located at the facility or when the resident does not consent in writing to release such information, the facility shall inform the consenting party that no information is available regarding that person. Transactions pursuant to this section shall be noted in the resident's record.

Further, Section (405 ILCS 5/4-201) of the MH Code indicates that a person with an intellectual disability shall not reside in a Department mental health facility unless the person is evaluated and is determined to be a person with mental illness and the facility director determines that appropriate treatment and habilitation are available and will be provided to such person on the unit. In all such cases, the Department of Mental Health facility director shall certify in writing within 30 days of the completion of the evaluation and every 30 days thereafter, that the person has been appropriately evaluated, that services specified in the treatment and habilitation plan are being provided, that the setting in which services are being provided is appropriate to the person's needs, and that provision of such services full complies with all applicable federal statutes and regulations concerning the provision of services to persons with a developmental disability.

Finding 2023-013 Noncompliance with Statutory Requirements Regarding Residents' Admissions, Discharges, Annual Evaluations, and Requests for Information (Continued)

Additionally, any person admitted to a Department mental health facility who is reasonably suspected of having a mild or moderate intellectual disability, including those who also have a mental illness, shall be evaluated by a multidisciplinary team which includes a qualified intellectual disabilities professional designated by the Department facility director. Section (405 ILCS 5/4-203(b)) of the MH Code requires the Department to ensure that a monthly report is maintained for each Department mental health facility, and each unit of a Department development disability facility for a dually diagnosed persons, which lists (1) initial of persons admitted to, residing at, or discharged from a Department mental health facility or unit for dually diagnosed persons of Department developmental disability facility during that month with a primary or secondary diagnosis of intellectual disability, (2) the date and facility and unit of admission or continuing care, (3) the legal admission status, (4) the recipient's diagnosis, (5) the date and facility and unit of transfer or discharge, (6) whether or not there is a public or private guardian, (7) whether the facility director has certified that appropriate treatment and habilitations are available for and being provided to such person, and (8) whether the person or guardian has requested review, and if so, the outcome of the review.

The MH Code (405 ILCS 5/4-704(a)) states that at least 14 days prior to the discharge of a client from a department developmental disabilities facility under Section 4-701 or 4-702, the facility director shall give written notice of the discharge to the client, if he is 12 years of age or older, to his attorney and guardian, if any, to the person who executed the application for admission and to the resident school district when appropriate.

The MH Code (405 ILCS 5/3-903) requires the Facility Director to give written notice of discharge from a Department mental health facility to the recipient, his attorney, and guardian, if any, at least 7 days prior to the date of intended discharge.

The Sexually Violent Persons Commitment Act (725 ILCS 207/55(a)) requires the Department to submit a written report to the court on their mental condition at least once every 12 months after an initial commitment.

The Sexually Violent Persons Commitment Act (725 ILCS 207/55(c)) requires any examiner conducting an examination under this Section to be prepare a written report of the examination no later than 30 days after the date of the examination.

The Sexually Violent Persons Commitment Act (725 ILCS 207/60(a)) states that if the evaluator on behalf of the Department recommends conditional release, then the director or their designee shall, within 30 days of the receipt of the evaluator's report, file with the committing court notice of their intention whether or not to petition for conditional release on the committed person's behalf.

Chester Mental Health Center policy (RI.03.05.03.02, Request for Patient Information, IV "Income Calls requesting Patient information on admission status") requires that when a call is an inquiry about a patient's admission status, the Clinical Staff employee that responds to the request will then send an email to the Forensic Coordinator's office with the date/time that the response was given to the requestor. The Forensic Coordinator's office will then log the date/time the request was completed on the CMHC-179.

Additionally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by Department's activities.

Finding 2023-013 Noncompliance with Statutory Requirements Regarding Residents' Admissions, Discharges, Annual Evaluations, and Requests for Information (Continued)

Department personnel stated that lack of oversight, error due to manual processes, and need for training and policy revisions resulted in the issues noted.

Failure to ensure conformity with statutory requirements regarding each resident's admission to and discharge from Department facilities could adversely impact the care and treatment of each resident, could hinder a resident's interaction with parties external to the facility, may result in intellectually disabled persons not residing in a facility appropriate to their needs, and represents non-compliance with State Law. (Finding Code No. 2023-013, 2021-014, 2019-016, 2017-017)

Recommendation

We recommend Department management review its systems of internal control over compliance to ensure:

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

2. Facility-level and Department-wide training on the Department's policies and procedures for areas with recurrent noncompliance or complexity are performed; and,

3. A monitoring process is functioning to timely identify areas of noncompliance with State laws and Department policies at the facilities and implement corrective action.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review and retrain staff on internal policies to ensure compliance with laws and regulations. Additionally, IDHS will pursue an automated solution to meet reporting requirements.

Finding 2023-014 Noncompliance with Statutory Requirements Regarding Residents' Dental, Mental, and Physical Examinations

The Department of Human Services (Department) did not comply with statutory requirements regarding residents' dental, mental, and physical examinations.

During fieldwork, we performed on-site testing at five of the Department's State-Operated facilities regarding resident dental, mental, and physical examinations. We sampled and tested 60 residents prescribed medications, which resulted in the following exceptions:

Chester Mental Health Center

- For 5 out of 48 (10%) medication administrations tested, the nurse administering the medication did not sign the Medication Administration Record (MAR).

Fox Developmental Center

- For 1 out of 12 (8%) residents tested, the Center administered medication to the resident before the completion of a physical or mental exam. Further, the physical or mental exam was not completed timely after admission. The Center did not report this to the Director or retain such a report in the resident's file.
- For 4 out of 48 (8%) medication administrations tested, the nurse administering the medication did not sign the MAR.
- For 1 out of 48 (2%) medication administrations tested, the Center could not identify the nurse administering the medication. Therefore, we were unable to determine if medications were properly administered by persons legally qualified under the law.
- For 2 out of 48 (4%) medication administrations tested, the name of the nurse administering the medication on the MAR did not match the name on the license number provided, so we were unable to determine if the nurse who signed the MAR was licensed by the State.
- For 2 out of 48 (4%) medication administrations tested, the physician's order's effective date was before the date the doctor signed the order.
- For 1 out of 12 (8%) residents tested, the physical exam was completed before the resident was admitted to the Center.
- For 1 out of 12 (8%) residents tested, the Center did not provide the requested information. Therefore, we were unable to determine if medication was administered prior to a mental or physical exam. Furthermore, it appears the psychological exam was not completed upon admission as required.

Ludeman Developmental Center

- For 2 out of 12 (17%) residents tested, the Center could not provide the completed physical exam.
- For 7 out of 12 (58%) residents tested, the Center did not provide the requested information. Therefore, we were unable to determine if medication was administered prior to a mental or physical exam.
- For 2 out of 12 (17%) medication administrations tested, the nurse administering the medication could not be identified on the MAR. As a result, we were unable to determine if medication was administered only by a person legally qualified under the State.
- For 1 out of 12 (8%) medication administrations tested, the nurse administering the medication did not sign the MAR.
- For 1 of 12 (8%) residents tested, the Center failed to provide dental examinations at least once every 18 months. The dental examinations were provided 616 days late.

Finding 2023-014 Noncompliance with Statutory Requirements Regarding Residents' Dental, Mental, and Physical Examinations (Continued)

Ludeman Developmental Center (Continued)

- During testing, we identified an instance of a patient who was improperly included in the population. The patient was discharged in fiscal year 2021 and should not have been included in the population provided.

Mabley Developmental Center

- Two support workers selected for testing were providing 1:1 care without meeting the minimum qualifications. We were unable to determine if the individuals met the qualifications for a Mental Health Technician 1.

Shapiro Developmental Center

- For 3 out of 48 (6%) medication administrations tested, the nurses did not properly complete the MAR.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/7) states medication shall not be prescribed until a physical and mental examination of the recipient has been completed. The Act requires all medications administered to recipients shall be administered only by those persons who are legally qualified to do so by the laws of the State of Illinois. Additionally, it requires the Department to adopt a model protocol and forms for recording all patient diagnosis, care, and treatment at each State-operated facility for the mentally ill and for persons with developmental disabilities under the jurisdiction of the Department. The model protocol and forms shall be used by each facility unless the Department determines that equivalent alternatives justify an exemption. Good internal controls should ensure that the forms are properly completed.

The Mental Health and Development Disabilities Administrative Act (MH Act) (20 ILCS 1705/7) states that all recipients in a Department facility shall be given a dental examination by a licensed dentist or registered dental hygienist at least once every 18 months and shall be assigned to a dentist for such dental care and treatment as is necessary.

The Facility's Dental Procedures (Policy Number 12-02) state all individuals will be referred for a dental examination within 30 days of admission.

The Department of Central Management Services' position description for a Mental Health Technician I at Mabley Developmental Center requires a Mental Health Technician I to have successfully completed a comprehensive training program at the Mental Health Technical Trainee level.

Additionally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department personnel stated that inadequate oversight, error due to manual processes and temporary staff to cover vacancies resulted in the issues noted.

Finding 2023-014 Noncompliance with Statutory Requirements Regarding Residents' Dental, Mental, and Physical Examinations (Continued)

Failure to properly administer and prescribe drugs could result in harm to the residents. Failure to retain supporting documentation supporting resident care impedes the ability to monitor the provision of necessary care to residents. Failure to provide residents timely dental examinations could adversely affect the care and treatment of the resident as well as impact the operations of the facilities. Furthermore, it represents noncompliance with State law. (Finding Code No. 2023-014, 2021-015, 2019-017, 2017-018)

Recommendation

We recommend the Department provide dental services, and physical and mental health examinations to residents as required. We recommend the Department improve internal control over the completion and retention of information pertaining to facility residents such as examination records and medication records.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. Staff will be retrained, and policy and procedures will be reviewed to ensure medication is administered, examinations are completed, and medication records are maintained in accordance with statutory requirements.

Finding 2023-015 Noncompliance with Statutory Requirements Regarding Pregnancy Policies, Administering Pregnancy Tests and Recording Residents' Menstrual Cycles

The Department of Human Services (Department) did not comply with statutory requirements regarding prenatal care for residents, administering pregnancy tests and recording resident's menstrual cycles.

During fieldwork, we performed on-site testing at twelve of the Department's State-Operated facilities. We sampled and tested 60 residents across four facilities, which resulted in the following exceptions:

Elgin Mental Health Center

- For 1 of 20 (5%) residents selected for testing, the Center did not have consent forms or emergency room (ER) documentation to support testing of pregnancy prior to admission.

Fox Developmental Center

- For 3 of 6 (50%) residents selected for testing, we were unable to determine if a pregnancy plan was required as the Center was unable to provide documentation of pregnancy tests performed subsequent to a resident being noted as not menstruating.
- For 3 of 6 (50%) residents selected for testing, the Center did not properly complete the monthly menstrual tracking sheet.
- The Center does not have a policy that indicates when a subsequent pregnancy test to the initial admission test should be performed. During testing, several residents were noted to have no menstruation for multiple months. However, subsequent pregnancy tests subsequent to those missed menstruations were not performed and/or documented.
- We were unable to place reliance on the population of pregnancies provided by the Center.

Ludeman Developmental Center

- For 16 of 19 (84%) residents selected, the Center did not properly complete or retain the monthly menstrual tracking sheet.
- For 13 of 19 (68%) residents selected, the consent for pregnancy testing signed by the recipient or guardian was not present in the recipients' medical records.

Shapiro Developmental Center

- The Center was unable to provide adequate records substantiating the population of women of child-bearing age residing at the facility during the period. Further, a resident who was pregnant during the examination period was improperly excluded from the listing.
- For 4 of 15 (27%) residents selected, the Center failed to document the tracking of the resident's menstruation in the Menstrual Tracking Records.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Mental Health and Developmental Disabilities Administrative Act (MH Act) (20 ILCS 1705/10.1) requires every woman of child-bearing age who is admitted to the facility under the jurisdiction of the Department, with her consent or the consent of her guardian, be tested for pregnancy upon admission and thereafter as indicated. Additionally, it requires records of menstrual cycles to be maintained for a resident who is admitted to and remains in a facility for more than 60 days.

Finding 2023-015 Noncompliance with Statutory Requirements Regarding Pregnancy Policies, Administering Pregnancy Tests and Recording Residents' Menstrual Cycles (Continued)

Additionally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Facility designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department personnel stated that error due to manual processes and employee oversight resulted in the issues noted.

Failure to obtain or retain a record of a signed consent form prior to administering a pregnancy test to a resident could result in a resident receiving unauthorized medical care and/or subject the State to unnecessary legal risks. Failure to perform or retain a record of a resident's pregnancy testing and menstrual cycle could adversely affect the care and treatment of the resident as well as impact the operations of the facilities. Further, it represents noncompliance with State law. (Finding Code No. 2023-015, 2021-016, 2019-018, 2017-019)

Recommendation

We recommend the Department establish comprehensive Department-wide internal controls over compliance with the MH Act regarding pregnancy testing and residents' menstrual cycles, which should include training personnel on compliance requirements and outline management oversight over compliance requirements.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review and revise related policies and establish comprehensive Department-wide internal controls regarding pregnancy testing and residents' menstrual cycles, including training personnel, compliance monitoring, and improved management oversight to ensure compliance with the Mental Health Act.

Finding 2023-016 Inadequate Execution and Monitoring of Interagency Agreements

The Department of Human Services (Department) failed to adequately execute and monitor interagency agreements.

During testing, we noted the following:

During the examination period, the Illinois Public Aid Code (Code) (305 ILCS 5/12-4.7b) required the Department to enter into intergovernmental agreements to conduct monthly exchanges of information with the Illinois Department of Corrections, the Cook County Department of Corrections, and the office of the sheriff of every other county to determine whether any individual included in an assistance unit receiving public aid under any Article of this Code is an inmate in a facility operated by the Illinois Department of Corrections, the Cook County Department of Corrections, or a county sheriff. During our testing of these agreements, we noted:

- For 27 of 102 (26%) counties of the State, the Department had not established a data sharing agreement with the respective sheriff offices.
- For 3 of 60 (5%) of individuals with terminated benefits tested, the Department was not able to provide the underlying support.

  The data used for testing of benefit termination for incarcerated individuals is based on current integrated eligibility system data. As a result, the population provided as of the date of the request may not properly represent the population for the period under examination. Due to this limitation, we were unable to determine if there were additional individuals which should have been included in the population provided by the Department and subjected to our testing.

Additionally, we selected a sample of other intergovernmental agreements and noted the following:

- 3 of 46 (7%) intergovernmental agreements tested were signed between 173 and 602 after the effective date of the agreement.

  Good internal controls require the approval of agreements prior to the effective date. The Statewide Accounting Management System (SAMS) Manual (Procedure 15.20.30) indicates a contract is reduced to writing when the contract is signed by the vendor and then by more than one authorized agency representative at the earliest date of signature.

- For 1 of 46 (2%) intergovernmental agreements tested, documentation was not provided by the Department to substantiate compliance with the duties outlined.

  The Fiscal Control and Internal Audit Act (FCIAA) (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable laws.

  The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate proper documentation of the essential transactions of the Department to protect both the legal and financial rights of the State and of person directly affected by the Department's activities.

Finding 2023-016 Inadequate Execution and Monitoring of Interagency Agreements (Continued)

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2015. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

Department personnel indicated they reached out to all Sheriff's Offices in the State of Illinois in an attempt to establish a data sharing agreement. The Sheriffs who agreed have had data sharing agreements executed. Additionally, interagency agreements were signed late for various reasons including competing priorities and necessary revisions and updates to the documents. Furthermore, for the one intergovernmental agreement for which documentation was not provided, Department personnel indicated that the program transitioned to another Agency which resulted in the oversight in maintaining proper documentation.

The Department enters into multiple agreements with other State agencies and other units of government. The purpose of the agreements is to assist the Department in fulfilling its mandated mission. In order to assess whether the agreement is reasonable, appropriate, and sufficiently documents the responsibilities of the appropriate parties, the agreement needs to be approved prior to the effective date. Additionally, failure to execute agreements that are mandated by law is noncompliance with the applicable law and noncompliance could negatively impact those affected by the law. (Finding Code No. 2023-016, 2021-017, 2019-022, 2017-021, 2015-009)

Recommendation

We recommend Department management execute all interagency agreements as required by law. In addition, we recommend all parties to the interagency agreements sign the agreement prior to the effective date of the agreement.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work to ensure all future interagency agreements are signed prior to the effective date and any required statutory deadlines. Additionally, IDHS has sent data sharing agreements to all county sheriff offices of which seventy-seven have signed agreements and clarifications were received noting five do not house inmates. Additionally, a change to the statute effective January 1, 2025 allows IDHS to obtain the needed information by other means and as a result, IDHS has worked with the Department of Innovation and Technology in the development of a reporting process for each sheriff's office.

Finding 2023-017 Inadequate Administration of Locally Held Funds and Petty Cash

The Department of Human Services (Department) inadequately administered locally held funds (bank accounts) and petty cash during the examination period. Exceptions were noted regarding the administration, accounting, reconciliation, reporting, receipt, and disbursement of these funds.

During fieldwork, we tested quarterly reporting of receipts and disbursements of locally held funds at five of the Department's State-Operated facilities. We also performed on-site testing of the Department's petty cash funds at five of the Department's State-Operated facilities. We noted the following exceptions:

Illinois Center for Rehabilitation and Education - Roosevelt

Locally Held Funds

- The Center had insufficient segregation of duties over the cash receipts process for the locally held funds (Fund 1150 (Permanent Trust) and 1149 (Special Revenue)). One employee had the authority to perform significant portions of the transaction cycle.
- 1 of 6 (17%) of receipts tested, totaling $930, was deposited 10 days late.
- 6 of 16 (38%) quarterly *Report of Receipts and Disbursements for Locally Held Funds* (C-17 Reports) did not reconcile to the Center's general ledger.

Petty Cash

- For 1 of 2 (50%) of replenishments tested, the Facility did not follow the Department's policy when replenishing the Petty Cash Fund. At the time of replenishment, the Petty Cash Fund was not below 50%, they did not have a large number of invoices on hand, the fund was not dissolving, they were not changing custodians, nor was the replenishment representing the final reimbursement for the current fiscal year end.
- 1 of 2 (50%) *Petty Cash Fund Usage Reports* (Form C-18) was submitted 9 days late.

Illinois Center for Rehabilitation and Education – Wood

Locally Held Funds

- The Facility did not maintain a complete general ledger for funds 1149 and 1150.
- The Facility did not perform bank reconciliations during the examination period for funds 1149 and 1150.

Ludeman Developmental Center

Locally Held Funds

- During the testing of the Other Special Trust Fund (Fund 1139), we noted the following:
    - For 2 of 2 (100%) bank accounts tested, the bank statement did not reconcile to the general ledger. The net difference identified was $2,737.
    - 2 of 8 (25%) C-17 Reports did not reconcile to the receipts recorded in the facility's general ledger. Variances ranged from ($145) to ($979).
    - 1 of 8 (13%) C-17 Reports did not reconcile to the disbursements recorded in the facility's general ledger. Variances ranged from ($100) to $2.
    - For 1 of 5 (20%) receipts selected for testing, totaling $300, the Facility was unable to provide supporting documentation.

Finding 2023-017 Inadequate Administration of Locally Held Funds and Petty Cash (Continued)

Ludeman Developmental Center (continued)

- During testing of the Resident's Trust Fund (Fund 1143), we noted the following:
  - For 1 of 1 (100%) bank accounts tested, the bank statement did not reconcile to the general ledger or the C-17 Report. The difference identified between the general ledger and bank account was $148,252. The difference identified between the C-17 Report and the bank account was $148,256.
  - 10 checks totaling $25,259 were outstanding between 168 and 826 days, as of June 30, 2023.
  - 4 deposits totaling $10,143, were not recorded to the general ledger in a timely manner. The deposits were recorded to the ledger between 91 and 704 days after the original deposit.
  - 4 services fees totaling $14,148, were not timely submitted to the Department within 30 days of being received by the Facility.
  - An unreconciled variance of $576,705 as of June 30, 2023 was identified during review of the bank reconciliation for the fund.

Petty Cash

- The Facility's General Revenue petty cash fund turnover rates on its Form C-18 submitted in Calendar Years 2022 and 2023, were 0 and not provided, respectively. The Facility did not provide explanations on the Form C-18 stating why the current level of the fund is needed.
- 1 of 2 (50%) of petty cash disbursements tested, totaling $60, was for costs to renew a commercial driver's license. This license did not appear to have any connection to the employee's job description. The Facility was unable to provide documentation that the disbursement was approved by the Office of Comptroller.
- Per review of the check register, we identified four checks from the Facility's General Revenue petty cash fund were issued out of sequence.
- For 2 of 2 (100%) of reimbursements tested, totaling $175, the Facility did not document the source or the reason the receipt was received by the Facility.

Shapiro Developmental Center

Locally Held Funds

- During the testing of the Other Special Trust Fund (Fund 1139), we noted the following:
  - 1 of 2 (50%) C-17 Reports tested could not be reconciled to the related bank statement. The unreconciled variance identified was $169.
  - For 1 of 1 (100%) bank accounts tested, the bank statement did not reconcile to the general ledger or C-17 Report. The difference identified was ($169).

- During the testing of the Resident's Trust Fund (Fund 1143), we noted the following:
  - 2 of 2 (100%) C-17 Reports tested could not be reconciled to the related bank statement. The unreconciled variances identified were $145 and ($2,002), respectively.
  - For 1 of 1 (100%) bank accounts tested, the bank statement did not reconcile to the general ledger. The difference identified was ($2,002).

Finding 2023-017 Inadequate Administration of Locally Held Funds and Petty Cash (Continued)

Shapiro Developmental Center (continued)

- During the testing of the Rehabilitation Fund (Fund 1144), we noted the following:
  - For 2 of 30 (7%) disbursements selected for testing, the amount per the disbursement journal was not in agreement with the amount per the bank statement.
  - For 1 of 1 (100%) bank accounts tested, the bank statement did not reconcile to the general ledger. The difference identified was $270.
  - 2 of 2 (100%) C-17 Reports tested could not be reconciled to the related bank statements. The unreconciled variances identified were $133 and $270, respectively.

Treatment and Detention Facility

Locally Held Funds

- For 1 of 7 (14%) disbursements tested, the Facility did not maintain a copy of the release receipt. As a result, we were unable to determine if the disbursement was properly approved.

Central Office

Petty Cash

- 1 of 59 (2%) petty cash funds tested did not have any money for two years and was not in use.
- For 2 of 15 (13%) petty cash funds tested, funds were below the approved amount for at least two years. Additionally, no log information could be provided to support the funds' activity.
- For 1 of 15 (7%) petty cash funds tested, the fund was below the approved funded amount since 2014.
- For 1 of 24 (4%) petty cash receipts and disbursements tested, notation of payment from petty cash was not documented on either the internal petty cash vouchers, vendor invoice, or statement.
- For 18 of 18 (100%) petty cash funds tested, Form C-18s were not timely filed with the Illinois Office of Comptroller. 6 (33%) were not filed and 12 (67%) were filed between 8 and 56 days late.
- For 7 of 18 (39%) petty cash funds tested, the Department was not able to provide copies of Form C-18.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2009. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Public Funds Deposit Act (30 ILCS 225/1) states when such deposits become collected funds and are not needed for immediate disbursement, they shall be invested within two working days at prevailing rates or better. Receipts between $500 and $10,000 should be deposited within 48 hours.

The Department of Human Services' Program Directive (Directive) (02.08.01.010) states that the Business Administrator is responsible for ensuring that adequate accounting controls exist over locally held funds. This includes responsibility for: a) establishing and maintaining adequate and effective controls over cash; and c) posting transactions onto the Locally Held Fund System timely and accurately to the proper accounts; d) reconciling bank accounts for locally held funds; f) ensuring that disbursement are properly authorized; h) providing Central Office with all information necessary to meet the Department's reporting requirements for locally held funds.

Finding 2023-017 Inadequate Administration of Locally Held Funds and Petty Cash (Continued)

Directive (01.09.01.020) states that replenishment of Petty Cash Funds should only be made when one of the following occurred: 1) When 50% of the fund has been exhausted; 2) When a large number of invoices are on hand; 3) Before dissolving the fund; 4) When changing custodians; or 5) When the amount represents the final reimbursement for the current fiscal year.

The Statewide Accounting Management System (SAMS) Manual (Procedure 33.13.20) requires the Facility to submit accurate C-17 Reports reflecting the receipts and disbursements occurring in each locally held fund each quarter.

The SAMS (Procedure 09.10.40) requires:

- Form C-18 to be completed for all petty cash funds exceeding $100 and to be filed with the Comptroller's Office no later than January 31 for the preceding calendar year.
- The petty cash fund to turn over approximately six times annually to ensure the proper dollar level of the fund and reduce the dollar level of the fund if the Form C-18 shows insufficient activity.
- Notation of payment to be made on the face of the internal petty cash vouchers (or attached thereto) or vendor's invoices or statements after payment by the custodian to the individual.

Good business practices prescribe checks be voided and reissued if they have been outstanding for 60 days.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and maintain accountability over the State's resources.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Facility's activities.

Department personnel stated that oversight and insufficient staff to ensure adequate separation of duties resulted in the issues noted.

It is important to properly administer locally held funds as they are not subject to appropriations, are often in a fiduciary capacity, and are held outside the State Treasury. In addition, failure to adequately administer locally held funds could lead to fraud, theft, or overdraft charges. Inadequate administration of locally held funds and petty represents noncompliance with State statutes. Inadequate controls over the locally held funds and petty cash funds results in noncompliance with the Department's Administrative Directive, SAMS procedures, and other requirements and could result in errors or irregularities not being detected in the normal course of business. (Finding Code No. 2023-017, 2021-018, 2019-023, 2017-024, 2015-027, 2013-016, 11-23, 09-26)

Finding 2023-017 Inadequate Administration of Locally Held Funds and Petty Cash (Continued)

Recommendation

We recommend Department management and staff comply with current laws, regulations, and policies and procedures regarding locally held funds and petty cash. We also recommend management develop and maintain a system to support the segregation of duties.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work to strengthen controls over the administration of locally held funds, petty cash, and postage. The Department will re-train staff on proper procedures, ensure segregation of duties where feasible, and implement a process to monitor compliance.

Finding 2023-018 Inadequate Controls over Personal Services

The Department of Human Services (Department) did not maintain adequate controls over its personal services function.

During the performance of testing at the Central office, we noted the following:

Employee File Testing

We selected 60 employee files for examination testing procedures. Of the 60 selections, 9 selections were new hires during the period under examination. During the performance of testing, we noted the following:

- For 12 of 60 (20%) personnel files tested, a completed employment application form was missing from the employee's personnel folder and could not be located by the Department**.**
- For 1 of 9 (11%) personnel files tested for new hires, a completed U.S. Citizenship and Immigration Services (USCIS) I-9 Employment Eligibility Verification Form (Form I-9) was missing from the employee's personnel folder and could not be located by the Department.
- For 3 of 9 (33%) personnel files tested for new hires, we were unable to determine the employer's authorized representative completed and signed Section 2 of the Form I-9 no later than three business days after the employee's first day of employment.
- For 9 of 58 (16%) employees subject to a performance evaluation, the Department was unable to provide documentation to support the completion of the employees' performance evaluation.
- For 45 of 58 (78%) employees subject to a performance evaluation, the performance evaluation was not completed in a timely manner.
- For 1 of 12 (8%) terminated employees tested, the employee was overpaid by $64.15 in their final gross pay.
- For 3 of 60 (5%) personnel files tested, variances were identified between the salary amount paid out and salary amount identified in the personnel file.

USCIS instructions for Form I-9s require Section 1 to be completed no later than the first day of employment. After completing Section 1, the employee is to sign their name and document the date signed. Additionally, Section 1 of the Form I-9 requires the employee to indicate whether a preparer, translator, or other individual provided assistance in completing the Form I-9. The employer is to complete and sign Section 2 of the Form I-9 within 3 days of the employees' first day of employment.

Further, the Illinois Administrative Code (80 Ill. Admin. Code 302.270) requires the Department to prepare an evaluation of employee performance not less often than annually to support administrative personnel decisions by documenting regular performance measures.

Timesheet Testing

During testing of timesheets, we noted the following exceptions:

- For 14 of 60 (23%) employees tested, the Daily Summary Attendance Reports (IL444-4141) were not signed by the employees' supervisor.
- For 5 of 60 (8%) employees tested, the IL444-4141 could not be provided for the pay period requested for examination.
- For 3 of 60 (5%) employees tested, the IL444-4141 was not properly completed by the timekeeper.
- For 2 of 60 (3%) employees tested, documentation was not provided to support the approval of time off.

Finding 2023-018 Inadequate Controls over Personal Services (Continued)

The State Officials and Employees Ethics Act (Act) (5 ILCS 430/5-5(c)) requires State employees to periodically submit time sheets documenting the time spent each day on official State business to the nearest quarter hour either on paper, electronically, or both. Time sheets are to be maintained in either paper or electronic format by the applicable fiscal office for a period of at least two years.

The Department's Administrative Directive (01.02.02.170) requires timekeepers to be responsible for keeping the time and attendance of all staff in the assigned area. Each timekeeper is to complete the IL444-4141 for every calendar day (including weekends and holidays), or is to ensure that another timekeeper completes it. Supervisors, or the supervisor's designee, are responsible for approving the IL444-4141.

Overtime Testing

During testing of timesheets, there were 10 employees who worked overtime during the pay periods selected for examination. For 1 of 10 (10%) of employees, documentation could not be provided by the Department to support the approval of the 31.50 hours of overtime worked by the employee.

The Department's Administrative Directive (01.02.02.230) states supervisors are responsible for determining the need for overtime and approving the time worked.

Statement of Economic Interest Testing

Of the 60 employees selected for testing, 10 were required to file statement of economic interest (statement). During the testing of statements filed, we noted the following exceptions:

- 1 of 10 (10%) of employees did not file a statement with the Office of the Secretary of State.

The Illinois Governmental Ethics Act (5 ILCS 420/4A-105) except as provided in section 4A-106.1, by May 1 of each year a statement must be filed by each person whose position at that time subjects him to the filing requirements of Section 4A-101 or 4A-101.5 unless he has already filed a statement in relation to the same unit of government in that calendar year.

Leave of Absence Testing

During testing of employees who took leave of absence (LOA), we noted the following exceptions:

- For 1 of 60 (2%) employees tested, authorized CMS2 forms identifying and approving the beginning leave of absence date could not be located by the Department.

The Department's Administrative Directive (01.02.02.140) states that written requests are required to be submitted for LOA approval.

Employee Trainings

During testing of employee trainings, we noted the following exception:

- For 2 of 60 (3%) employees, 7 required trainings were completed between 9 and 136 days late.

Finding 2023-018 Inadequate Controls over Personal Services (Continued)

During fieldwork, we performed on-site testing at four of the Department's State-operated facilities over employee timesheet records. Our testing resulted in the following exceptions:

Elgin Mental Health Center

- While testing Monthly Attendance Records (MARs), we noted the following:
  - For 5 out of 60 (8%) MARs selected for testing, the MARs were not signed and dated by the timekeeper within 10 working days of the employee's receipt of the MAR.
  - For 5 out of 60 (8%) MARs selected for testing, the MARs did not contain the required signatures and/or dates from the employee, supervisor, and/or timekeeper.
  - For 7 of 60 (12%) MARs selected for testing, the MAR could not be located within the employees' personnel file and therefore no testing could be performed.

- While testing Staff Request for Time Off (IL444-4140), we noted the following:
  - For 9 out of 218 (4%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the IL444-4141 did not trace to the employees' monthly MAR.
  - For 61 out of 218 (28%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the Center was unable to provide the completed form.

Kiley Developmental Center

- While testing MARs, we noted the following:
  - For 1 of 60 (2%) MARs tested were not signed by the employee.
  - For 6 of 60 (10%) MARs tested, the employees did not timely sign the MAR. The MARs were signed between 24 and 130 days late.
  - For 10 of 60 (17%) MARs tested, the MARs did not contain signatures of the supervisor and/or the timekeeper.

- While testing Daily Staff Attendance Reports (IL444-4141), we noted the following:
  - For 19 of 214 (9%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the reports were not completed by the employee.
  - For 4 of 214 (2%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the Center was unable to provide the completed form.
  - For 19 of 214 (9%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the reports did not contain proper evidence of the supervisor's signature.
  - For 1 of 214 (0.5%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the report was not completed within two working days of returning to work.
  - For 2 of 214 (1%) Daily Staff Attendance Reports (IL444-4141) selected for testing, the employee did not fill out the attendance sheet while present at the Center.

- While testing Staff Request for Time Off forms (IL444-4140) we noted the following:
  - For 2 of 214 (1%) Staff Request for Time Off forms (IL444-4140) selected for testing, the employee was on their regularly scheduled day off but marked as unexcused.

- While testing Payroll Timekeeping System (PTS) User Access we noted the following:
  - For 1 of 18 (6%) of PTS users tested, the user did not have their access removed in a timely manner.

Finding 2023-018 Inadequate Controls over Personal Services (Continued)

Shapiro Developmental Center

- A poster was not conspicuously displayed providing notice of state employee protection under the Whistle Blower Protection Article of the State Officials Employees Ethics Act (Act).

- While testing MARs, we noted the following:
  - For 1 of 53 (2%) MARs selected for testing, the MARs did not contain all required signatures from the employee, supervisor, and/or timekeeper.
  - For 3 of 53 (6%) MARs selected for testing, the MARs did not reflect the accurate time codes for employee attendance following the completion of the Employee Time Correction Report (IL444-4090).
  - For 4 of 273 (1.5%) dates tested, the IL444-4090 for one of the employee's selected was not properly signed and dated.

- While testing documentation related to staff time off and timekeeping, we noted the following:
  - For 2 of 273 (1%) dates tested, the IL444-4140 was not properly completed as the signature and date from the employee were missing.
  - For 1 of 273 (.4%) Work Away Record (IL444-4604) was not properly approved as the signature and date from the timekeeping Department were missing.
  - For 5 of 297 (2%) dates tested, the IL444-4141 did not trace to the MAR.
  - For 2 of 273 (1%) dates tested, the Facility could not provide a copy of the completed IL444-4140 for testing.
  - For 2 of 297 (1%) dates tested, the IL444-4141 did not contain all the proper initials.
  - For 9 of 273 (3%) dates tested, the IL444-4140 did not trace to the Daily Staff Attendance Record (IL444-4141).

Ludeman Developmental Center

While testing MARs, we noted the following:

- For 44 of 60 (73%) months tested where the MAR could be provided, the MARs did not contain all required signatures from the employee, supervisor, and/or timekeeper.
- For 44 of 60 (73%) months tested where the MAR could be provided, the MARs were not signed and completed within 10 working days of employee receipt.
- For 7 of 60 (12%) MARs tested, the MAR could not be located within the employee's personnel file.

While testing documentation related to staff time off and timekeeping, we noted the following:

- For 15 of 96 (16%) dates tested, the Daily Staff Attendance Record (IL444-4141) did not trace to the employees' MAR.
- For 64 of 70 (91%) dates tested, the Facility was unable to provide the Staff Request for Time Off (IL444-4140).
- For 24 of 96 (25%) dates tested, the Facility was unable to provide the Daily Staff Attendance Report (IL444-4141).
- For 1 of 15 (7%) employees tested, the Facility was unable to provide the Staff Request for Time Off (IL444-4140) and the Daily Staff Attendance Report (IL444-4141).

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

Finding 2023-018 Inadequate Controls over Personal Services (Continued)

The Department's Administrative Directive (Directive) (01.02.02.170) requires a report, which documents that the employee time was spent on official State business, and which should be reviewed and signed by the employee, timekeeper, and supervisor within 10 working days.

The Department's Directive (01.02.02.170(G)) states employees are to promptly review the MAR and determine whether it accurately reflects time spent on official State business and authorized leave. If the MAR is accurate, the employee shall sign and date it then submit it to his/her supervisor or supervisor's designee for signature and date. Once the supervisor has signed and dated it, it shall be submitted to the timekeeper for signature and date. The entire signature process, from employee to timekeeper, must be completed within ten (10) working days of the employee's receipt of the MAR.

The Department's Directive (01.02.02.170 (Procedure I.A)) states supervisors are responsible for appointing a timekeeper to keep accurate and timely attendance records for each employee within the assigned area. Both the employee and the appointed timekeeper are responsible for maintaining accurate records of the employee's use of time. Supervisors, or the supervisor's designee, are also responsible for approving time off for all employees under their direct supervision. Employees are responsible for submitting the Staff Request for Time Off form (IL444-4140) to request time off. Also, the Directive 01.02.02.170(Procedure I.I) states that supervisors are responsible for ensuring that time and attendance records are retained for a 3 year period on-site and 2 years archived off-site for a total of 5 years.

The Department's Directive (01.02.03.015(B)) states employees and supervisors are responsible for ensuring that all time off requests are completed properly and that the increments of time requested are accurate. Documentation for approved time off must be documented by the submission of the Staff Request for Time Off form (IL444-4140) to the employee's supervisor or designated timekeeper. Also, the Directive (01.02.02.170(I.A)) states the supervisor has responsibility for verifying that an employee has available benefit time. If an employee takes time off and has no benefit time available, loss of pay or administrative action might occur.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and to maintain accountability over the State's resources.

Additionally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department personnel stated that lack of oversight and inefficiencies in manual processes resulted in the issues noted.

Failure to maintain complete Form I-9s is a violation of USCIS requirements and could expose the Department to penalties. Annual performance evaluations are important to ensure all employees understand the duties and responsibilities assigned to them and that they are adequately performing the duties for which they are being compensated. Without performance evaluations there is no documented basis for promotion, demotion, discharge, layoff, recall, or reinstatement and current employment status. Finally, by not maintaining appropriate time records, the Department is not in compliance with the Act and its Directives which could result in improper payments to employees and inaccurate accrual of benefit time. (Finding Code No. 2023-018, 2021-019, 2019-024, 2017-036).

Finding 2023-018 Inadequate Controls over Personal Services (Continued)

Recommendation

We recommend the Department comply with current processes and procedures regarding maintenance of personnel files, completion of Form I-9s, and completion of employee performance evaluations. Additionally, we recommend the Department ensure overtime and leaves of absence are properly approved, employees file required Statements of Economic Interest, and employees timely complete required trainings. Finally, we recommend Department management provide additional training to supervisors pertaining to its Directive and the Act and hold staff accountable for maintaining appropriate time records.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will develop tools and training to address the retention requirements and timeliness to ensure adherence to various rules, regulations, and compliance requirements. IDHS will develop a plan that will incorporate a quality assurance review process.

Finding 2023-019 Inadequate Controls over State Property and Equipment

The Department of Human Services (Department) did not have adequate internal control over State property inventories and record keeping.

During fieldwork, we performed on-site property and equipment testing at five of the Department's State-operated facilities. Our testing resulted in the following exceptions:

Ann Kiley Developmental Center

- 10 of 12 (83%) equipment items selected for backwards testing were not properly recorded in the Department's *Physical Asset Balance Report* as of June 30, 2023.
- 1 out of 12 (8%) equipment items tested was not located in the area indicated on the inventory listing.

Elgin Mental Health Center

- 4 out of 12 (33%) equipment items selected for backwards testing were not properly recorded in the Department's *Physical Asset Balance Report* as of June 30, 2023.
- The Facility's grounds were not properly maintained. During a tour of the Facility, we identified several areas/rooms/buildings that required repair work.
- The Facility does not maintain a tracking mechanism for its obsolete or unused property. Due to this condition, we could not conclude that the Facility's population records for obsolete or unused property were complete and accurate.
- The Facility improperly removed obsolete property still in its custody from property records.

Illinois Center for Rehabilitation and Education – Wood

- 1 of 12 (8%) items selected for forwards testing did not contain a property tag.
- 12 of 12 (100%) items selected for backwards testing did not trace to the facility's property records.
- 1 out of 12 (8%) equipment items, totaling $743, was not in the location noted on the Facility's records.

Ludeman Developmental Center

- The Facility's grounds were not properly maintained. Several instances of property deterioration, including damaged sidewalks and roads, were noted while touring the facility's grounds.
- 6 of 12 (50%) equipment items tested were not in the location noted on the Facility's records.
- 8 of 12 (67%) property items selected for testing could not be located on the facility's property records.

Shapiro Development Center

- The Facility's grounds were not properly maintained. During a tour of the Facility, several instances of property deterioration were observed, including ceilings that were falling in and several areas/rooms/buildings that required repair work.
- A large amount of equipment items were observed which appeared to be transferable and were not identified by the Facility as such. Furthermore, the Facility does not appear to have controls in place to safeguard against the accumulation of obsolete or unused equipment. Further, 4 of 7 (57%) obsolete items could not be located.
- 3 of 12 (25%) equipment items were not located in the area indicated on the inventory listing.
- 3 of 12 (25%) equipment items could not be located on premises on the date of our site visit. The Department was subsequently able to locate the property.

Finding 2023-019 Inadequate Controls over State Property and Equipment (Continued)

- 1 of 12 (8%) equipment items tested could not be traced to the *Physical Asset Balance Report*.
- 3 of 6 (50%) transferable equipment items were not identified as transferable.
- 19 of 19 (100%) equipment items could not be located on the facility's *Physical Asset Balance Report*.
- 1 of 12 (8%) of equipment items selected during backwards testing was coded with the incorrect plant code.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2005. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The State Property Control Act (30 ILCS 605/4) requires the Department to be accountable for the supervision, control, and inventory of all items under its jurisdiction.

The Statewide Accounting Management System (SAMS) (Procedure 29.10.10) requires the Department to maintain detailed records of all property which includes the correct descriptions of asset and correct information of its location. Additionally, the Department is required to identify assets that are obsolete, damaged, or no longer used in operations and, if necessary, remove them from asset records. The asset records should be reconciled with the results of inventory and updated accordingly.

The Illinois Administrative Code Section (44 Ill. Admin. Code 5010.400) requires agencies to adjust property records within 90 days after acquisition, change, or deletion of equipment items.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation; and revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

Finally, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Facility's activities.

Department personnel stated that lack of employee and management oversight. Additionally, multiple ongoing capital development projects have caused significant declines in ground and property maintenance. These projects have taken the focus from regular operational needs.

Failure to properly control and record State property represent noncompliance with State law and increases the potential for possible loss or theft of State property. Failure to transfer or find a use for excess property does not allow the State to manage State assets in the most economical manner and could lead to unnecessary purchases by other State agencies. Failure to properly record State property can lead to inaccurate financial information being reported. In addition, failure to properly maintain property could lead to further damage and/or usage conditions. (Finding Code No. 2023-019, 2021-021, 2019-025, 2017-037, 2015-024, 2013-024, 11-30, 09-36, 07-14, 05-20)

Finding 2023-019 Inadequate Controls over State Property and Equipment (Continued)

Recommendation

We recommend Department management and staff comply with current policies and procedures regarding property and equipment and follow the control system in place. Additionally, we recommend the Department adequately maintain buildings and facilities to prevent further deterioration.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS Office of Business Services is working to review property policies and procedures and communicate the importance of strict adherence to documented policy. In addition, requests for maintenance and repair projects for buildings and facilities have been submitted, as required, to the Capital Development Board for review and funding.

Finding 2023-020 Inadequate Controls over Monthly Revenue Status (SB04) Reconciliations

The Department of Human Services (Department) had inadequate controls over the reconciliation of its internal receipt records to the Office of Comptroller's (Comptroller) *Monthly Revenue Status Reports* (SB04).

We noted the following:

- 1 of 55 (2%) reconciliations contained a discrepancy of $30,000,000 that was not identified and resolved.
- 3 of 12 (25%) reconciliations of internal receipts records to the SB04 tested were prepared between 1-2 days late.

The Statewide Accounting Management System (SAMS) Manual (Procedure 07.30.20) states agency reconciliations are the primary control that ensures certain requirements are being satisfied. Agencies must reconcile to the SAMS on a monthly basis and notify the Comptroller of any irreconcilable differences so that necessary corrective action can be taken to locate the differences and correct the accounting records. These reconciliations must be completed within 60 days of the month end. SAMS Procedure 25.40.20 required the Department to reconcile on a monthly basis and notify Comptroller of any unreconcilable differences so necessary corrective action can be taken to locate the differences and correct the accounting records.

Department personnel stated that the discrepancy noted on the reconciliation was a keying error due to this being a manual process. Oversight resulted in the late submissions.

Failure to timely and properly reconcile the Monthly Revenue Status (SB04) can result in errors not being identified and resolved in a timely manner. (Finding Code No. 2023-020)

Recommendation

We recommend Department management monitor controls over the monthly reconciliations in accordance with the SAMS to identify and correct errors in a timely manner.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work to improve oversight and revise internal operating procedures to ensure reconciliations are accurate and submitted timely.

Finding 2023-021 Inadequate Controls over Commodities

The Department of Human Services (Department) did not maintain adequate internal control and oversight over annual inventory procedures.

Central Office Location Testing

During fiscal year 2022, the Department converted from the Department's Warehouse Control System (WCS) to the inventory module within the Enterprise Resource Planning (ERP) system. During observation of inventory counts for fiscal year 2023, we noted the following:

- The Department's Administrative Directive (01.05.07.010) provided to the Department's staff performing inventory counts was not updated to reflect the conversion from WCS to ERP.
- The Department was not able to generate reports from the ERP which reflect the average cost of inventory.
- For 1 of 12 (8%) of inventory items tested, there was a discrepancy between auditor counts and the Department's final inventory adjustment.
- The Department did not track and calculate the annual percentage of local farm or food products purchased during fiscal years 2022 and 2023.

State-Operated Facility Testing

During fieldwork, we performed on-site pharmacy and non-pharmacy commodities inventory tests at three of the Department's State-Operated facilities:

Elgin Mental Health Center

- For 8 of 20 (40%) pharmacy inventory items counted during the annual inventory, the Facility's counts did not agree with auditor test counts. The discrepancy between counts ranged from -1 to 3.
- For 5 of 20 (25%) non-pharmacy inventory items counted during the annual inventory, the Facility's counts did not agree with auditor test counts. The discrepancy between counts ranged from 3 to 144.
- For 4 of 20 (20%) additions to inventory selected for cutoff procedures, data input into the Facility's system did not agree with purchase orders, facility requisition reports, receiving reports, invoices, or inventory stock card reports.
- There is a lack of segregation of duties over the inventory cycle. Employees responsible for ordering, receiving, recording, and maintaining custody are also performing inventory counts. Additionally, these employees are responsible for reconciling, reviewing reconciliations, approving, and posting adjustments.

Ludeman Developmental Center

- For 4 of 20 (20%) non-pharmacy inventory items counted during the annual inventory, the Facility's counts did not agree with auditor test counts. The discrepancy between counts ranged from -12 to 100.
- For 4 of 40 (10%) inventory items selected for addition cutoff procedures, data input into the Facility's system did not agree with the related purchase orders.

Finding 2023-021 Inadequate Controls over Commodities (Continued)

Shapiro Developmental Center

- During testing, one individual on the user listing did not appear to be an employee of the Department.
- There is a lack of segregation of duties over the inventory cycle. Employees responsible for ordering, receiving, recording, and maintaining custody, are also performing inventory counts. Additionally, these employees are responsible for reconciling, reviewing reconciliations, approving, and posting adjustments.
- During inventory procedures, teams performing counts were instructed to not count specific inventory items that should have been included in the final inventory count.
- For 3 of 34 (9%) inventory items selected for testing, the Facility was unable to provide the related vouchers.
- For 4 of 80 (5%) non-pharmacy inventory items counted during the annual inventory, the Facility's counts did not agree with auditor test counts. The discrepancy between counts ranged from -4 to 15.
- For 1 of 40 (3%) non-pharmacy inventory items counted during the annual inventory, the description of the item within ERP was not in agreement with the item's physical marker.
- For 1 of 40 (3%) non-pharmacy inventory items counted during the annual inventory, the items were counted under the improper unit type.
- 1 of 20 (5%) non-pharmacy additions tested was excluded from inventory adjustments. While reviewing commodities inventory procedures, the directions provided require employees to set aside items received the inventory process and to exclude these items from their counts. Such instructions contradict the Administrative Directive.
- 7 of 466 (1%) total non-pharmacy inventory items appeared on the facility's final valuation report but were not counted by the facility during inventory procedures.
- 94 inventory adjustments made by the facility for the 466 non-pharmacy items were recorded inaccurately.
- 83 of 658 (13%) medications tested that were used on June 29th and June 30th, were not properly removed from the system.
- Several instances were identified of inventory not being maintained in sanitary conditions.
- For 1 of 11 (9%) inventory items tested for turnover, the item had a turnover rate of less than one. The Facility was not able to provide a reasonable explanation to support the quantity maintained.
- For 2 of 11 (18%) inventory items tested for turnover, we were unable to determine the turnover ratio. As a result, we were unable to assess compliance with State statute.
- For 2 of 10 (20%) non-pharmacy inventory additions tested, receipts of inventory did not appear to be entered into the ERP system.
- For 1 of 15 (7%) items tested, the Facility stated the inventory entered in the system was incorrect.
- 3 of 20 (15%) inventory requisitions tested were not properly authorized.
- 9 of 20 (45%) inventory requisitions tested received prior to fiscal year end were not entered into the system until the following fiscal year.
- The Facility was unable to provide documentation to support the ending balances of the fiscal year 2021 and fiscal year 2022 inventory. As a result, we were unable to perform testing for inventory balance fluctuations through fiscal year 2023.
- During the performance of inventory procedures, 68 items were identified as having inventory on hand but having no assigned value.

Finding 2023-021 Inadequate Controls over Commodities (Continued)

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2013. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

The Statewide Accounting Management System (SAMS) Manual (Procedure 03.60.20) requires the Department to perform an annual physical count of inventory on hand and to reconcile the results to inventory records to ensure the completeness and accuracy of those records. In addition, inventory held by governmental funds should be valued at cost.

In addition, generally accepted accounting principles require the proper valuation of inventory for financial reporting purposes. This would require verifying detailed transactions agree to the recorded inventory balances.

The Local Food, Farms and Jobs Act (Act) (30 ILCS 595/10(a)) states in order to create, strengthen, and expand local farm and food economies through Illinois, it shall be the goal of this State that 20% of all and food products purchased by State agencies and State-owned facilities, including, without limitation, facilities for persons with mental health and development disabilities, be local farm or food products. Furthermore, the Act (30 ILCS 595/10(d)) states all State agencies and State-owned facilities that purchase food and food products shall develop a system for (i) identifying the percentage of local farm or food products purchased for fiscal year 2021 as the baseline; and (ii) tracking and reporting local farm or food products purchases on an annual basis.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable law; that funds property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation; and that revenues, expenditures, and transfers of assets, resources, or fund applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over State's resources.

The Illinois Procurement Code (30 ILCS 500/50-55) requires every State agency to stock no more than a 12-month supply of inventory. An inventory turnover ratio of less than one indicates a greater than 12-month supply of inventory.

Department personnel stated the exceptions noted were due to oversight and revisions to Administrative Directives to reflect the new process in ERP not yet being finalized. Further, Department personnel stated, although the Department is able to calculate the annual percentage of local farm or food products after purchases are made, the Department was not tracking the percentage on an ongoing basis due to oversight.

Failure to develop and maintain strong controls over commodities could lead to fraud, waste, and abuse of commodity items. (Finding Code No. 2023-021, 2021-023, 2019-028, 2017-040, 2015-026, 2013-023)

Finding 2023-021 Inadequate Controls over Commodities (Continued)

Recommendation

We recommend the Department improve its centralized oversight function related to inventory to allow for adequate controls, compliance with procedures and rules, as well as provision of guidance, reminders, and assistance to facility staff. We also recommend the Department update policies and procedures to reflect the conversion to the ERP system and ensure staff are adequately trained on inventory policies and procedures.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review policies and procedures and continue to train staff on job functions and the importance of proper segregation of duties to ensure compliance.

Finding 2023-022 Failure to Implement Policies and Rules over Community Integrated Living Arrangements and Community-Based Residential Settings and Adequately Monitor CILAs

The Department of Human Services (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 examination period, we noted the Department had not finalized and implemented rules regarding community-based residential settings. As of June 30, 2023, the adoption of the rules was 11.5 years past the due date required by statute.

The Mental Health & Developmental Disabilities Act (Act) (20 ILCS 1705/73(b)) requires the Department to draft and promulgate rules governing community-based residential settings. The rules for community-based residential settings shall include settings that offer to persons with serious mental illness (i) community-based residential recovery-oriented mental health care, treatment, and services; and (ii) community-based residential mental health and co-occurring substance use disorder care, treatment, and services. The rule was required to be drafted by January 1, 2012.

Department personnel stated although they are not finalized, the Division of Mental Health has developed draft rules. This work began in fiscal year 2011, but when it appeared close to completion, pushback from community providers and legislators caused the administration at the time to pause the work on this task.

During the prior examination, we noted the Department had not 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 that the rules had been finalized and implemented.

Failure to Adequately Monitor the CILA Program

During the performance of testing, we determined 63 of 230 (27%) developmental services agencies did not certify with the Department that mandated wage increases to benefits are passed through in accordance with the legislative or administrative mandate.

Under the Act (210 ILCS 135/4(c-5)), each developmental services agency licensed under this Act shall submit an annual report to the Department, as a contractual requirement between the Department and the developmental services agency, certifying that all legislatively or administratively mandated wage increases to benefit workers are passed through in accordance with the legislative or administrative mandate. The Department shall determine the manner and form of the annual report.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

Department management stated that although they reached out multiple times through their networks to explain the requirement and remind providers, some providers did not complete the requirement.

Finding 2023-022 Failure to Implement Policies and Rules over Community Integrated Living Arrangements and Community-Based Residential Settings and Adequately Monitor CILAs (Continued)

Failure to adopt and implement rules governing community-based residential settings could adversely impact the care and treatment of individuals and represents noncompliance with the Act. Failure to receive the annual report from service agencies represents noncompliance with Act and limits the Department's oversight of wage increases. (Finding Code No. 2023-022, 2021-024, 2019-031, 2017-014)

Recommendation

We recommend Department management comply with State law by completing and adopting rules related to community-based residential settings and enforcing the requirement for developmental agencies to certify regarding wage increases to benefits.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. Rule 115, which oversees the Community Integrated Living Arrangements (CILA), was officially updated in 2023 and Rule 120, which governs all three developmental disabilities waivers, was updated in 2024. IDHS has recorded a training regarding the updates to the Rules and provided updated resources regarding the changes. Furthermore, IDHS publishes Information Bulletins about updated rules. Regarding the monitoring of the implementation of direct support professional wage increase, IDHS has strengthened the process to ensure attestations are completed by CILA and Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) providers, which has included email and phone call follow up to improve the response rate of providers.

Finding 2023-023 Inadequate Controls over Forensic Patient Transport

The Department of Human Services (Department) did not implement adequate corrective actions related to its Elgin Mental Health Center (Elgin MHC) Forensic Patient Transport Procedures.

In August 2016, the Office of the Auditor General (OAG) released a Performance Audit of the Department's Forensic Patient Transport Procedures pursuant to Illinois House of Representatives Resolution Number 199 and amended by Legislative Audit Commission Resolution Number 147. The OAG's Forensic Patient Transport Performance Audit contained 5 recommendations in which the Department was to take corrective actions necessary to ensure responsible parties at the Elgin MHC had adequate policies and procedures to ensure material compliance with all relevant governing laws, rules, and regulations. During the previous examination, we reported the Department had implemented 2 of the 5 recommendations, and partially implemented 3 of the 5 recommendations.

As required by *Governmental Auditing Standards*, we were required to follow-up on the Department's implementation of the corrective actions for the three partially implemented recommendations during the examination period.

Based on our follow-up testing procedures, we noted the Department still had not fully implemented two of the five recommendations. Specifically, we identified the following:

- Ensuring Trip Information packets are filled out completely and appropriately for all trips:
  During fieldwork, we selected 60 trips during the examination period and identified 4 of 60 (7%) trip packets did not include vehicle safety and security checklists and 4 of 60 (7%) trip packets did not have required signatures.

- Ensuring Elgin MHC staff receive annual training on current transportation policy and application of security devices:
  During fieldwork, we selected 70 security personnel at the Elgin MHC by trips completed during the examination period. We noted the following:
  - 8 of 70 (11%) security personnel tested did not have documentation on file to support completed trainings.
  - 35 of 70 (50%) employees tested did not properly complete training prior to the patient transport.

Elgin MHC Forensic Treatment Program Policy 730 (FTP 730), Transportation Outside the Secure Setting for Court/ Medical/ Other - issued 4/29/15 and revised 8/29/17, requires pre-trip documentation to have a vehicle safety & security checklist and a trip information packet, among other documentation. The trip information packet includes details such as date, route, and staffing level. After the trip, the trip information packet is required to be reviewed by the Sallyport Officer to insure it is complete and noted on the Sallyport Officer checklist. If approved, the trip information packet is then to be signed by the senior security office assigned to the trip. The reviewing supervisor is then required to note any additional instructions for the transportation team.

FTP 730 requires all transportation staff to complete training in current transportation procedure at least annually.

Department personnel stated the exceptions noted were the result of staff error.

Finding 2023-023 Inadequate Controls over Forensic Patient Transport (Continued)

Failure to complete and maintain accurate documentation over forensic transport procedures represents noncompliance with State regulations. Further, failure to follow internal controls governing the transportation of patients increases the risk of potential harm to the patient, Elgin MHC staff, or unassuming third parties. (Finding Code No. 2023-023, 2021-032, OAG Forensic Patient Transport Procedures Performance Audit (August 2016))

Recommendation

We recommend Department management maintain and develop internal controls that adequately provide transportation trainings to staff and enhance management oversight to ensure trip information packets are filled completely.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS has implemented additional oversight to the trip packet process to improve reviews and ensure completion. Additionally, the completed trips are reviewed by the security department and results are reported to the Quality Department. Also, Staff Development has implemented a training tracker accessible to all managers to monitor for timely completion of trainings and to address failure to timely complete trainings within employee evaluations.

Finding 2023-024 Untimely Receipt of Facility and Community Agency Responses to the Department OIG

The Department of Human Services (Department) did not ensure mental health facilities, developmental disabilities facilities, and community agencies under its operational authority timely filed written responses with the Department's Office of the Inspector General (OIG).

During the examination period, we tested 26 OIG investigative reports to determine if the respective facilities or community agency timely filed their written response. The results of our testing indicated 6 of 26 (23%) investigative report responses from facilities and community agencies were not timely filed within 30 calendar days of receiving the report from the Department's OIG. Responses to the report were submitted between 1 and 585 days late by the facilities and community agencies. The Secretary was not notified reports were not submitted within the required 30-day period and therefore did not determine corrective action to be taken.

The Department's OIG Services was created by the Department of Human Services Act (Act) (20 ILCS 1305/1-17) to investigate and report upon allegations of abuse, neglect, or financial exploitation of individuals receiving services within mental health facilities, developmental disabilities facilities, and community agencies operated, licensed, funded, or certified by the Department, but not licensed or certified by any other State agency.

Further, the Act (20 ILCS 1305/1-17(n)(1)) requires within 30 calendar days from receipt of a substantiated investigative report or an investigative report which contains recommendations, absent a reconsideration request, the facility or community agency shall file a written response with the OIG that addresses, in a concise and reasoned manner, the actions taken to: (i) protect the individual; (ii) prevent recurrences; and (iii) eliminate the problems identified. The written response is required to include the implementation and completion dates of such actions. If the written response is not filed within the allotted 30 calendar day period, the Act then requires the Department's Secretary to determine the appropriate corrective action to be taken.

Department personnel stated, for various reasons, the applicable facilities were unable to complete the responses within the 30 calendar days. For 2 out of the 6, the responses were a day late due to failing to count a holiday in the 30 calendar days. Department management further stated the unfiled responses were not brought to the Secretary's attention because Department management knew the responses were being worked on and would ultimately be completed and submitted by the facilities.

Failure to properly file and respond to investigative reports could result in matters not being addressed or remedied in a timely manner, affecting those individuals utilizing the response facilities and community agencies. (Finding Code No. 2023-024, 2021-030)

Recommendation

We recommend Department management enhance its policies and procedures to ensure facilities and community agencies timely submit written responses to the OIG. We further recommend that if responses are not received within the 30 calendar days outlined by statute, the Secretary determines the appropriate corrective action to be taken as required by law.

Finding 2023-024 Untimely Receipt of Facility and Community Agency Responses to the Department OIG (Continued)

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS has developed and implemented a process to ensure facilities timely submit written responses to the OIG. This process is being formalized in a standard operating procedure and will be circulated upon completion. Additionally, the Secretary has appointed designees within the Divisions of Mental Health and Developmental Disabilities to determine appropriate corrective action if a response to the OIG's report is not filed within the allotted 30 calendar day period.

Finding 2023-025 Inadequate Controls over the Monitoring and Implementation of State Statutes

The Department of Human Services (Department) did not comply with various statutory mandates.

During testing, we noted the following:

- The Department developed and made publicly available a strategic plan regarding improving access to inpatient psychiatric beds 110 days late.

  The Mental Health Inpatient Facility Access Act (405 ILCS 140/15) requires the strategic plan to be finalized and made publicly available one year after the effective date of the Act.

  Department personnel stated the report was delayed due to extensive research, stakeholder input, and a lengthy legal review process involved in producing an effective strategic plan.

  Failure to timely provide a strategic plan could adversely impact the care and treatment of individuals and represents noncompliance with the Mental Health Inpatient Facility Access Act.

- The Department failed to collaborate with the Department of Healthcare and Family Services (HFS) to develop a standard format for information collection.

  Per the Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/63.5), no later than January 1, 2023, the Department shall collaborate to develop a standardized format for: 1) collecting de-identified aggregate data from all member assessment tools; 2) collecting other de-identified aggregate data that behavioral health providers are required to submit to the State pertaining to the administration of mental health and behavioral health services, including, but not limited to, substance use disorder at the Department of Human Services or the Department of Healthcare and Family Services; and 3) registration for Value Options through Beacon Health Options Provider Connect portal. The Department must comply with the new standardized format within 6 months after its date of completion.

  Department personnel stated the Department had been in contact with HFS regarding developing the standardized format as specified in the Act. However, the project could not be completed by January 1, 2023.

  Failure to create a standardized format for data collection could lead to information not being properly captured and make it more difficult to perform data analysis.

- Surplus funds in the Mental Health Reporting Fund (Fund) were not used to award grants that promote the National School Mental Health Curriculum model for school-based mental health support, integration, and services. Additionally, the Department had not created a National School Mental Health curriculum model for school-based mental health support, integration, and services.

Finding 2023-025 Inadequate Controls over the Monitoring and Implementation of State Statutes (Continued)

The State Finance Act (Act) (30 ILCS 105/6z-99(b)) requires the Illinois State Police and Department to coordinate to use moneys in the Fund to finance their respective duties of collecting and reporting data on mental health records and ensuring that mental health firearm possession prohibitors are enforced as set forth under the Firearms Concealed Carry Act and the Firearm Owners Identification Card Act. Any surplus in the Fund beyond what is necessary to ensure compliance with mental health reporting under these Acts shall be used by the Department for mental health treatment programs, as follows: (1) 50% shall be used to fund community-based mental health programs aimed at reducing gun violence, community integration and education, or mental health awareness and prevention, including administrative costs; and (2) 50% shall be used to award grants that use and promote the National School Mental Health Curriculum model for school-based mental health support, integration, and services.

Department personnel stated that while the Department was aware of the requirement, the Division of Mental Health was not aware these funds were available to spend on this program.

Failing to use excess funds to provide mental health treatment programs represents noncompliance with the Act and impedes the Department's ability to provide mental health programs aimed at reducing gun violence.

- The Department had not publicly posted information regarding patient rights about pregnancy and childbirth to its website.

  The Medical Patient Rights Act (410 ILCS 50/3.4(b)) requires the Department to post, either by physical or electronic means, information about rights regarding pregnancy and childbirth on its publicly available website.

  Department management stated the required information was not publicly posted to the Department's website due to oversight. It has since been posted as of February 20, 2024.

  Failure to post information related to medical patient rights could impact patients and their treatments.

- The Child Care Assistance Program Eligibility Calculator on the Department's website was updated 619 days after the effective date of Section 9A-11 of the Public Aid Code (Code).

- Policies identifying eligibility for the Child Care Assistance Program did not identify the following categories of families as being eligible:
  - Families transitioning from TANF to work;
  - Families at risk of becoming recipients of TANF; and,
  - Families with special needs as defined by rule.

  The Code (305 ILCS 5/9A-11) requires the Department to update the Child Care Assistance Program Eligibility Calculator posted on its website to include a question on whether a family is applying for childcare assistance for the first time or is applying for a redetermination of eligibility.

Finding 2023-025 Inadequate Controls over the Monitoring and Implementation of State Statutes (Continued)

Further, the Code (305 ILCS 5/9A-11) enumerates the categories of families to be covered, including families transitioning from TANF to work, families at risk of becoming recipients of TANF, and families with special needs as defined by rule.

Department personnel stated changes in staffing and assigned duties within the Division of Early Childhood caused delays in updating the eligibility calculator. Furthermore, some of the mandate language relates to defunct programs that were in place prior to the current Child Care Assistance Program (CCAP).

Failure to timely post updates to the Child Care Assistance Program Eligibility Calculator and develop policies to identify all categories of eligible families represents noncompliance with the Code and could result in eligible families not receiving available child care assistance. (Finding Code No. 2023-025)

Recommendation

We recommend the Department comply with the respective statutory requirements or seek legislative remedy as appropriate.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will review the requirements of the statutes identified and the need for any related policy and procedure changes to remedy the issues. Additionally, IDHS will assess the need for additional staff or the need to fill staff vacancies to improve compliance.

Finding 2023-026 Late Submission of Required Reports

The Department of Human Services (Department) did not submit required reports to the Governor, the General Assembly, or other officials in a timely manner.

During the examination period, the Department was required to submit various reports to the Governor, the General Assembly, and other officials. The following reports were not submitted timely:

- The Department did not submit an annual report by January 1, 2022 and 2023, to the General Assembly as required by the Children and Family Services Act.

- Furthermore, the related interagency agreement with the Department of Children and Family Services (DCFS) expired on January 21, 2023, and was not subsequently renewed.

  The Children and Family Services Act (Act) (20 ILCS 505/43(c)) requires the Department on each January 1, to submit a report to the General Assembly on: 1) the number of youth in care and young adults who were intercepted during the reporting period and the supportive services and treatment programs they were connected with to prevent homelessness, incarnation, or other negative outcomes; and 2) the duration of the services the youth in care and young adults received in order to stabilize them during their transition out of State care. Additionally, the Act (20 ILCS 505/43(a)) requires the Department, DCFS, and other agencies to enter into an interagency agreement for the purpose of providing preventive services to youth in care and young adults who are aging out of or have recently aged out of the custody or guardianship of DCFS.

  Department management indicated that due to confidentiality laws, the Department does not have access to the information needed to write the report. Furthermore, due to competing priorities and employee oversight, communication was not made regarding renewal of this interagency agreement.

- The Department submitted 1 of 2 (50%) annual reports required under the Reimagine Public Safety Act during the examination period 123 days late.

  The Reimagine Public Safety Act (430 ILCS 69/35-20(e)), requires the Office of Firearm Prevention within the Department to issue a report to the General Assembly no later than January 1 of each year that identifies communities within Illinois municipalities of 1,000,000 or more residents and municipalities with less than 1,000,000 residents and more than 35,000 residents that are experiencing concentrated firearm violence, explaining the investments that are being made to reduce concentrated firearm violence, and making further recommendations on how to end Illinois' firearm violence epidemic.

  Department personnel stated the report was submitted past the deadline due to the need to ensure the accuracy and completeness of the data included in the report.

- The Department did not timely submit annual reports required to the General Assembly regarding homeless minors older than 16 years of age but less than 18 referred to a youth transitional housing program for whom parental consent to enter the program is not obtained. The reports for calendar years 2021 and 2022 were submitted 479 and 114 days late, respectively.

Finding 2023-026 Late Submission of Required Reports (Continued)

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

Department personnel stated delays in submitting the reports were due to the need to obtain required information from a partner agency and delays resulting from compiling, reviewing, and approving the information contained in the report.

- 5 of 10 (50%) quarterly report filings required under the Illinois Public Aid Code (Code) were filed between 13 and 109 days after the end of the next fiscal quarter.

  The Code (305 ILCS 5/12-5), requires the Department to report to the General Assembly at the end of each fiscal quarter the amount of all funds received and paid into the Social Services Block Grant Fund and the Local Initiative Fund and the expenditures and transfers of such funds for services, programs and other purposes authorized by law. The Code does not identify a due date for the quarterly reports.

  Department personnel stated the Code does not include a due date and believed they were in compliance with filing of the reports.

- 6 of 8 (75%) monthly reports required to be filed under the Accountability for the Investment of Public Funds Act (Act) were filed between 1 and 44 days late.

  The Act (30 ILCS 237/10) requires the Department to make "sufficient information concerning the investment of any public funds" available on the Internet and updated by the 15th of each month. Furthermore, the reports are to identify the amount of funds held by the Department on the last day of the month or the average daily balance of the preceding month, total monthly investment income, the asset allocation of the investments made by the agency and a complete listing of institutions approved to do business with the Department.

  Department personnel stated that during the period, there was a vacancy in the position that performs these duties, resulting in the reports not posting timely.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2013. In subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

Failure to prepare, submit, or publish required reports to the Governor, General Assembly, and other officials in a timely manner is noncompliance with State law and could impact decisions made by the Governor, General Assembly, and other officials. (Finding Code No. 2023-026, 2021-025, 2019-032, 2017-031, 2015-019, 2013-033)

Finding 2023-026 Late Submission of Required Reports (Continued)

Recommendation

We recommend Department management submit all reports on or before the due date as specified in the applicable State law or seek legislative relief from the reporting requirement.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS is developing a centralized process to ensure mandated reports are filed timely. Additionally, IDHS will work with partner agencies to obtain information needed to ensure compliance with reporting requirements.

Finding 2023-027 Lack of Compliance with Policies for Vehicles

The Department of Human Services (Department) did not fully comply with the requirements applicable to its operation of automotive equipment.

Reporting Requirements for Individually Assigned Vehicles

During testing, we noted the following:

- For 1 of 9 (11%) individuals tested who were personally assigned a vehicle, the Department was not able to provide documentation of proper insurance coverages.
- For 4 of 9 (44%) individuals tested who were personally assigned a vehicle, the Department was unable to provide documentation to support the assignment was communicated to the Department of Central Management Services (DCMS) within 30 days of assignment.
- 2 of 2 (100%) Individually Assigned Vehicle (IAV) Annual Reports tested were submitted 38 days late.

The Illinois Vehicle Code (625 ILCS 5/10-101(b)) requires every employee of the State, who operates for purposes of State business a vehicle, not owned, leased, or controlled by the State to procure insurance in the limits of the amounts liability not less than the amounts required in Section 7-23 of the Illinois Vehicle Code. The Department's procedure regarding certification is to have employees complete the Insurance Verification Card (Form IL444-4042).

The Illinois Administrative Code (44 Ill. Admin. Code 5040.340) requires agencies to report to DCMS annually and when changes occur, including the name of each employee assigned a vehicle, the equipment number and license plate of the assigned vehicle, employee's headquarters and residence, and any additional information requested by DCMS.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001(3)) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation. Management has the ultimate responsibility for the Department's internal control over reporting of information. This responsibility should include adequate systems of reviewing the completeness, accuracy, and maintenance of all Department records.

Department management stated the exceptions noted regarding Individually Assigned Vehicles were due to the need for additional time to make necessary changes and oversight of requirements.

Failure to obtain documentation of employee licensure and insurance is noncompliance with the Illinois Vehicle Code and potentially subjects the State to unnecessary liability costs. Failure to submit individually assigned vehicle assignments and annual reports in a timely manner represents noncompliance with the Administrative Code and limits DCMS' oversight of State vehicles.

Reporting Requirements for Vehicle Accidents

During testing, we noted the following:

- For 2 of 9 (22%) accidents involving State owned vehicles used by Department employees, a Motorist's Report of Illinois Vehicle Accident Form (Form SR-1) was not submitted to DCMS.
- For 2 of 9 (22%) accidents involving State owned vehicles, the Department could not provide documentation to the support the timely submission of the Form SR-1 to DCMS.

Finding 2023-027 Lack of Compliance with Policies for Vehicles (Continued)

The Department's Administrative Directive 01.05.05.030, regarding reporting of motor vehicle accidents and insurance coverage, requires that as a condition of coverage, employees involved in a motor vehicle accident are required to have a legible written report of the accident in the DCMS Division of Risk Management no later than 7 calendar days following the accident.

The Illinois Administrative Code (44 Ill. Admin. Code 5040.520(i)) requires agencies to submit a Motorist's Report of Illinois Motor Vehicle Accident form (Form SR-1) to DCMS within 7 calendar days following an accident.

Department management stated delays occurred for various reasons including the need to obtain information from employees that were unavailable due to being on leave of absence or injuries resulting from the accident. Furthermore, for one "accident", there was no known accident identified but rather damage identified upon inspection of the vehicle for regular maintenance.

Failure to report accidents to DCMS in a timely manner may impact the State's ability to investigate and defend itself against resulting claims.

Maintenance and Utilization of State Vehicles

During testing of maintenance and utilization records for Department vehicles, we noted the following:

- For 11 of 60 (18%) vehicles tested, the Department was unable to provide documentation to support the performance of required maintenance.
- For 38 of 60 (63%) vehicles tested, oil changes were not performed as required.
- For 18 of 60 (30%) vehicles tested, tire rotations were not performed as required.
- For 11 of 60 (18%) vehicles tested, there was no documentation to support an annual inspection was performed.
- For 6 of 60 (10%) vehicles tested, there was no documentation to support the performance of the 6-month safety inspection.
- For 21 of 60 (35%) vehicles tested, we were unable to confirm the last service performed in fiscal year 2021. As a result, we were unable to conclude on compliance with vehicle maintenance during the period under examination.
- For 8 of 60 (13%) vehicles tested, breakeven mileage requirements were not met.
- For 3 of 60 (5%) vehicles tested, we identified variances between the odometer readings and support provided by the Department. As a result, we are unable to rely on the calculation for vehicle utilization.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2017. In the subsequent years, the Department has been unsuccessful in implementing an adequate corrective action plan.

DCMS issued a Memorandum to agency vehicle coordinators on September 24, 2018, which outlines maintenance, lube, oil and filter change interval policies for passenger vehicles. Per this Memorandum, the standard lube, oil and filter change interval requirement for passenger fleet vehicles 10 years and older is 3,000 miles or 12 months, whichever comes first. For passenger vehicles 9 years and newer, the policy is 5,000 miles or 12 months, whichever comes first. Tire rotation on all passenger vehicles is required every other oil change.

Finding 2023-027 Lack of Compliance with Policies for Vehicles (Continued)

Further, the Illinois Administrative Code (44 Ill. Admin. Code 5040.410(a)) requires agencies to have vehicles inspected by DCMS or an authorized vendor at least once per year or as required by law and shall maintain vehicles in accordance with the schedules provided by DCMS or with other schedules acceptable to DCMS that provide for proper care and maintenance of special use vehicles.

DCMS Vehicle Usage Policy states vehicles that are used for transporting passengers are required to have both the annual and safety inspection. The 6-month safety test includes the testing and inspection of brakes, lights, horns, reflections, rear vision mirrors, mufflers, safety chains, windshield wipers, warning flags and flares, frame, axle, cab and body, or cab or body, wheels, steering apparatus, and other safety devices and appliances.

DCMS Vehicle Usage Policy states underutilized vehicles that are not able to be redeployed due to age, mileage, and/or condition will be turned-in to DCMS' Surplus Property to be disposed through a sale on Ibid, the State's online auction site, or offered to another agency at DCMS's discretion.

Finally, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001(3)) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation. Management has the ultimate responsibility for the Department's internal control over reporting of information. This responsibility should include adequate systems of reviewing the completeness, accuracy, and maintenance of all Department records.

Department management stated that the discrepancies noted occurred during and were a direct result of the COVID-19 pandemic. Travel was severely restricted, if not prohibited, and as a result vehicles were largely underutilized or not used at all. Employees were not at headquarters and were working remotely which resulted in maintenance requirements being missed as no one was available to schedule and/or take vehicles to maintenance facilities.

Failure to maintain and utilize vehicles in accordance with DCMS policy could result in the vehicle not being operable through its estimated useful life and could result in costly repairs. (Finding Code No. 2023-027, 2021-026, 2019-034, 2017-041)

Recommendation

We recommend Department management enhance its processes and internal controls to ensure compliance with insurance and reporting requirements for individually assigned vehicles, accident reporting requirements, and vehicle maintenance and usage requirements.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. The IDHS Office of Business Services will continue to work with Executive Leadership and Division Directors regarding the timely submission of vehicle maintenance reports and accident reports and implement process changes to ensure insurance verification certifications are provided timely and verified prior to approval of vehicle use.

Finding 2023-028 Weaknesses in Contingency Planning

The Department of Human Services (Department) had not conducted a business impact analysis (BIA) during the examination period.

During the examination of the Department's security and control of confidential information, we noted the Department had not conducted a BIA in conjunction with the Department of Innovation & Technology (DoIT) in 2023.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation.

The *Control Objectives for Information and Related Technologies* published by *Information Systems Audit and Control Association* (ISACA), Managed I&T-Related Risk Area, promotes controls for analyzing risks and maintaining a risk profile of risks and their potential impact and responses.

The Department stated that due to DoIT temporarily overhauling their BIA template, a BIA was not performed during the examination period.

Failure to conduct BIA hinders the ability for the Department to identify and prioritize critical IT systems and components. Without performing BIA, the Department could have trouble aligning business processes and systems, determining maximum tolerable downtime, and set objectives for recovery times. (Finding Code No. 2023-028, 2021-027, 2019-035, 2017-033, 2015-031, 2013-027, 11-35, 09-30, 07-28, 05-24)

Recommendation

We recommend the Department conduct a BIA to identify and prioritize critical IT systems and components.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will conduct a Business Impact Analysis (BIA) to identify and prioritize critical IT systems and components, with assistance from the Department of Innovation and Technology (DoIT).

Finding 2023-029 Access to Systems Not Controlled

The Department of Human Services (Department) did not adequately control access to certain systems.

During our testing of system access, we noted the Department did not adequately monitor user access to the Recipient Reimbursements (RE2), Electronic Visit Visitation (EVV) and the Payroll and Timekeeping System (PTS). We noted:

- 5 of 25 (20%) users who were interviewed about their job duties appeared to have access across EVV and RE2 applications that did not align with their job duties.
- The Department does not have an adequate review process in place to ensure all users with access to EVV are reviewed in a calendar year.
- The Department does not timely remove user access to EVV after the user's termination date. We noted 35 of 495 (7%) EVV users were still assigned to districts after their termination date and at the time of testing, in which access had remained ranging up to approximately 4 years after their termination date.
- The Department did not properly follow procedures to deactivate terminated users' access within 5 business days for 2 of 25 (8%) samples we tested for the PTS application as access was removed 2 weeks and 1 month later.
- For 5 of 60 (8%) active individuals tested, Form IL444-4056 was not completed in accordance with policy.
- For 5 of 60 (8%) active individuals tested, the Department was unable to provide Form IL444-4056.
- For 4 of 67 (6%) terminated individuals tested, access was not timely deactivated.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology (NIST), Account Management section promotes controls for ensuring access to system resources are appropriately authorized, monitored, and disabled.

Department policy requires that access must be removed at the end of the user's last day, or at a minimum, within 5 business days for transfers and other voluntary separations.

The Department's policy requires a completed and signed Form IL444-4056 for access to the system.

The Department stated the primary access termination occurs at the network level, and then at the RACF layer used to restrict access to mainframe-based application systems, preventing employees from accessing state resources. This led to incorrect reliance on network and RACF access removal rather than removing application specific access.

Failure to transparently review user access and timely deactivate terminated users' access could result in unauthorized access to the Department's systems and confidential data. (Finding Code No. 2023-029, 2021-029, 2019-036)

Finding 2023-029 Access to Systems Not Controlled (Continued)

Recommendation

We recommend the Department:

- Enhance user access review procedures to ensure that application users' access rights align with their job responsibilities for RE2, EVV, and PTS applications;
- Implement a review process to ensure all EVV users are reviewed for appropriateness on an annual basis; and,
- Implement processes to ensure user access is removed timely for the EVV application.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will enhance user access review procedures to ensure application users' access aligns with their job responsibilities for RE2, EVV, and PTS applications. IDHS will implement a formalized process for the annual review of EVV users to verify appropriateness and compliance with access control policies. The Department will also establish procedures to ensure user access is removed promptly following employee offboarding or role changes. IDHS will collaborate with Human Resources and stakeholders to strengthen access monitoring, ensuring that only authorized personnel retain system access. Furthermore, the Department will reinforce staff awareness and compliance efforts regarding secure system access management.

Finding 2023-030 Weaknesses in Cybersecurity Programs and Practices

The Department of Human Services (Department) had not implemented adequate internal controls related to cybersecurity programs and practices.

The Department is responsible for the protection of sensitive information collected, including Social Security Numbers, personally identifiable information, protected health information, and financial information associated with fulfilling its overall mission. The Illinois State Auditing Act (30 ILCS 5/3-2.4) requires the Auditor General to review State agencies and their cybersecurity programs and practices. During the examination of the Department's cybersecurity program, practices, and control of confidential information, we noted the Department had not:

- developed a risk management framework or performed a comprehensive risk assessment to identify confidential information susceptible to attacks or evaluate and implement risk-reducing controls.
- have an Acceptable Use Policy in place for the period.
- conducted regular reviews of policies including policies relied on from the Department of Innovation and Technology (DoIT) for the period.
- required staff to acknowledge policies and procedures on an annual basis.
- have a formal cybersecurity plan in place for the period.

Additionally, the Department did not provide a complete and accurate listing of service providers and thus, all relevant SOC reports may not have been reviewed as required. As such, we were unable to conclude the Department's population records were sufficiently precise and detailed under the Professional Standards promulgated by the American Institute of Certified Public Accounts (AT-C § 205.36).

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and to maintain accountability over the State's resources.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by National Institute of Standards and Technology (NIST), requires entities to consider risk management practices, threat environments, legal and regulatory requirements, mission objectives and constraints in order to ensure the security of their applications, data, and continued business mission.

The Department indicated management believed the reliance on DoIT's policies and procedures was appropriate and its risk assessment was comprehensive.

The lack of adequate cybersecurity programs and practices could result in unidentified risk and vulnerabilities, which could ultimately lead to the Department's volumes of personally identifiable information being susceptible to cyber-attacks and unauthorized disclosure. (Finding Code 2023-030, 2021-031, 2019-029).

Finding 2023-030 Weaknesses in Cybersecurity Programs and Practices (Continued)

Recommendation

We recommend the Department:

- Develop a risk management framework and perform a comprehensive risk assessment;
- Develop an Acceptable Use Policy;
- Review policies/procedures on a defined frequency;
- Require staff/contractors to acknowledge policies and procedures on an annual basis;
- Develop a formal cybersecurity plan; and,
- Develop a complete and accurate listing of service providers.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will work with the Department of Innovation and Technology (DoIT) to develop a risk management framework and conduct a comprehensive risk assessment to identify and mitigate cybersecurity risks. IDHS will implement an Acceptable Use Policy and establish a process to review policies and procedures on a defined frequency. Additionally, IDHS will require staff and contractors to acknowledge policies and procedures annually to ensure compliance and awareness. IDHS will also develop a process to track and manage service providers.

Finding 2023-031 Inadequate Controls over the Protection of Confidential Information

The Department of Human Services (Department) had not followed all of their policies and procedures related to the protection of certain confidential information.

During the performance of facility visits, we noted the following:

- One instance of improper protection of protected health information (PHI) (McFarland).
- One unlocked shred bin identified (Ludeman).
- Once instance of improper disposal of sensitive employee information (Shapiro).

The Personal Information Protection Act (Act) (815 ILCS 530/30) requires the safe disposal of information. The Act requires any State agency that collects personal data that is no longer needed or stored at the agency shall dispose of the personal data or written material it has collected in such a manner as to ensure the security and confidentiality of the material.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires all State agencies to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and to maintain accountability over the State's resources.

Department personnel stated that lack of employee and management oversight resulted in the issues noted.

The lack of adequate controls could result in unidentified risk and vulnerabilities and ultimately lead to the Department's volumes of personally identifiable information and protected health information being susceptible to unauthorized disclosure. (Finding Code No. 2023-031)

Recommendation

We recommend the Department implement controls and follow policies regarding the protection of confidential/personal information.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. IDHS will retrain staff on the processes and policies regarding the protection of confidential information. Furthermore, additional oversight and monitoring procedures will be implemented to ensure compliance.

Finding 2023-032 Inadequate Controls over Employee Travel

The Illinois Department of Human Services (Department) did not have adequate controls over employee travel.

Travel Voucher Testing

During testing, we noted the following:

- 5 of 60 (8%) travel vouchers tested, totaling $7,501, contained travel outside the State of Illinois and were not approved by the Governor's Office of Management and Budget (GOMB) 30 days prior to travel.

The Illinois Administrative Code (Code) (80 Ill. Admin Code 2800.700) requires travel outside of Illinois to be submitted to GOMB for approval at least 30 days in advance of the departure date.

Department personnel stated the travel was not preapproved by GOMB due to error.

Insurance Verification

During testing, we noted the following:

- 8 of 40 (20%) employees tested received reimbursement for mileage prior to having completed and certifying to proper insurance coverage. Forms were signed between 56 and 627 days after expense reimbursement.
- 3 of 40 (8%) employees tested received reimbursement for mileage without having certifications of proper insurance coverage on file with the Department.

The Illinois Vehicle Code (625 ILCS 5/10-101(b)) requires every employee of the State, who operates for purposes of State business a vehicle, not owned, leased, or controlled by the State to procure insurance in the limits of the amounts liability not less than the amounts required in Section 7-23 of the Illinois Vehicle Code. The Department's procedure regarding certification is to require employees to complete the Insurance Verification Card (Form IL444-4042).

Department personnel stated when the agency transitioned to the Enterprise Resource Planning (ERP) accounting system and the old system was decommissioned, functionality was not replicated within ERP to provide an "indicator" that flags when an employee had a current insurance verification on file. Since ERP does not have this indicator, there is no current automated process that prevents reimbursement when an employee does not have a current insurance verification on file.

Travel Headquarters Report (Form TA-2)

During the performance of testing, we noted the following:

- 2 of 4 (50%) Form TA-2s filed excluded employees from several divisions. The Form TA-2 due July 15, 2022, excluded 6 divisions and the Form TA-2 due January 15, 2023, excluded 1 division.
- 3 of 4 (75%) Form TA-2s filed did not agree to supporting documentation. Variances were noted between 1 and 8 employees.

The State Finance Act (30 ILCS 105/12-3) requires the Department to file reports of all its officers and employees for whom official headquarters have been designated at any location other than that at which their official duties require them to spend the largest part of their working time.

Finding 2023-032 Inadequate Controls over Employee Travel (Continued)

Department personnel stated the discrepancies identified were the result of manual processes subject to human error.

Failure to obtain proper approvals can result in travel which is disallowed. Failure to obtain documentation of employer licensure and insurance represents noncompliance with the Illinois Vehicle Code and potentially subjects the State to unnecessary liability costs. Failure to file accurate Form TA-2 reports with the LAC reduces governmental oversight and represents noncompliance with the State Finance Act. (Finding Code No. 2023-032)

Recommendation

We recommend the Department establish and maintain controls over employee travel to ensure compliance with State statutes, the Illinois Administrative Code, and internal policies.

Department Response

The Illinois Department of Human Services (IDHS) accepts the recommendation. The IDHS Office of Business Services (OBS) will recommend process changes to ensure Insurance Verification Cards are submitted timely and verified prior to approval of vehicle use. OBS will continue work to improve oversight, notifications, and review of TA-2 filings to ensure timely and accurate submissions.

Prior Findings Not Repeated

A. FINDING (Other Accounts Receivable Misstatement)

During the previous engagement, the Department of Human Services did not have sufficient internal controls over accounting for accounts receivable balances for recipient services overpayments in the Department's draft financial statements. The Other Receivables balance in the DHS Recoveries Trust Fund (Fund 0921) contained receivables tracked in both the Accounts Receivable System (ARS) and the Enterprise Resource Planning (ERP) system. In preparing the June 30, 2022, financial statements, the Department only recorded the receivable balance tracked in the ARS system in Fund 0921 and failed to record the receivable balance tracked in the ERP in Fund 0921. The error resulted in understatement of gross other receivables, the allowance for uncollectible other receivables and unavailable revenue in the amounts of $35 million, $21 million, and $14 million, respectively, in the June 30, 2022, governmental funds balance sheet. In addition, there was an understatement of gross other receivables and the allowance for uncollectible other receivables in the amounts of $35 million and $21 million, respectively, in the June 30, 2022, statement of net position and an understatement of other charges for services in the amount of $14 million in the June 30, 2022, statement of activities.

During the current engagement, we noted the Department of Human Services included the balances from both the ARS system and the ERP. (Finding Code No. 2022-003)

B. FINDING (Detailed Agreement Between the Department of Human Services, the Department of Healthcare and Family Services and the Department of Innovation and Technology (DoIT) over IES not Finalized)

During the previous engagement, the Department of Healthcare and Family Services (HFS) and the Department of Human Services (DHS) (collectively, the "Departments") did not finalize an interagency agreement (IA) during fiscal year 2022 with the Department of Innovation and Technology (DoIT) to define each agency's roles and responsibilities with respect to the Integrated Eligibility System (IES). The Departments had drafted an interagency agreement with DoIT defining the specific roles and responsibilities for each agency; however, it was not executed during fiscal year 2022.

During the current engagement, we noted the Departments executed the IA with DoIT. (Finding Code No. 2022-006, 2021-008, 2020-010, 2019-010)

C. FINDING (Inadequate Controls over Contractual Agreements and Emergency Purchases)

During the previous engagement, the Department had not properly filed emergency purchases, incorrectly completed Contract Obligation Documents, filed contracts with the Illinois Office of Comptroller late, and did not obtain a surety bond for construction contracts.

During the current engagement, we noted the Department had remedied these matters during the performance of testing. As a result, this finding is not repeated. (Finding Code No. 2021-020)

Prior Findings Not Repeated (Continued)

D. FINDING (Inadequate Controls over Accounts Receivable)

During the previous engagement, the Department was 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 Centers (MH) Centers.

During the current year engagement, accounts receivables were examined for the Department as a whole and our sample tested indicated the Department had adequate controls over accounts receivable in respects to their policies and procedures. As a result, this finding is not repeated. (Finding Code No. 2021-022, 2019-026, 2017-038, 2015-025, 2013-013, 11-22, 09-23, 07-15)

E. FINDING (Inadequate Agreement to Ensure Compliance with IT Security Requirements)

During the previous engagement, the Department had not entered into a sufficiently detailed, comprehensive Department-wide agreement with the Department of Innovation and Technology (DoIT) to ensure prescribed requirements and available security mechanisms were in place in order to protect the security, processing, integrity, and availability of confidentiality of its systems and data.

During the current engagement, we noted an agreement was properly executed which prescribed requirements and available security mechanisms to protect the security, processing, integrity, and availability of confidentiality of its systems and data. As a result, this finding is not repeated. (Finding Code No. 2021-028)

F. FINDING (Inadequate Controls over Cellular Phones)

During the previous engagement, the Department did not maintain adequate internal controls over the tracking or cancelation of assigned cellular phones.

During the current engagement, we noted the Department had remedied these matters during the performance of testing. As a result, this finding is not repeated. (Finding Code No. 2021-033)

Status of Performance Audits

As part of the Fiscal Year 2022 and 2023 compliance examination of the Illinois Department of Human Services, we followed up on the status of the following performance audits performed by the Office of the Auditor General:

- **Performance Audit of the Illinois Prescription Monitoring Program** (released September 2021)
  - This is the first time follow-up has been conducted on this audit. The audit contained 11 recommendations directed to the Department of Human Services, **4** of which have been implemented or not repeated.
- **Management Audit of the Department's ISC Selection Process** (released April 2020)
  - This is the second time follow-up has been conducted on this audit. The audit contained 13 recommendations directed to the Department of Human Services, **12** of which have been implemented or not repeated.

The exhibit below summarizes the current status of the recommendations. Recommendations that were followed up on during this audit are detailed in the following pages.

STATUS OF PAST PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

Audit	Total Number of Recommendations	Status		
		Implemented/ Not Repeated	Partially Implemented	Not Implemented
Prescription Monitoring Program	11	**4**	**6**	**1**
ISC Selection Process	13	**12**	**0**	**1**

Source: Summary of the current status of past performance audits.

Status of Performance Audits

ILLINOIS DEPARTMENT OF HUMAN SERVICES PRESCRIPTION MONITORING PROGRAM

The Illinois Office of the Auditor General conducted a performance audit of the Prescription Monitoring Program operated by the Illinois Department of Human Services Department pursuant to Legislative Audit Commission Resolution Number 154. The audit was released in September 2021 and contained ten recommendations to the Department of Human Services and one recommendation directed at the Department of Human Services and the Department of Public Health.

STATUS OF PAST PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

			Status		
Audit	**Rec. No.**	**Recommendation Description**	**Implemented/ Not Repeated**	**Partially Implemented**	**Not Implemented**
Prescript. Monitoring	1	Administrative Rules and Interfacing EHRs	X		
Prescript. Monitoring	2	Imposing Fines		X	
Prescript. Monitoring	3	Data Accuracy		X	
Prescript. Monitoring	4	Accurate Licensing Data		X	
Prescript. Monitoring	5	Sports and Accident Injury Data Reviews	X		
Prescript. Monitoring	6	Update the Policies and Procedures Manual		X	
Prescript. Monitoring	7	Ensure Dispenser Requirements are Completed as Required			X
Prescript. Monitoring	8	Ensure Prescribers are Registered with the Illinois Prescription Monitoring Program		X	
Prescript. Monitoring	9	Program Assessment Issues	X		
Prescript. Monitoring	10	Monitoring Issues		X	
Prescript. Monitoring	11	Committee Weaknesses	X		

Source: Summary of current performance audit follow-up.

Recommendation 1 – Fully Implemented Administrative Rules and Interfacing EHRs

The Department should fully implement an ILPMP in accordance with State requirements by ensuring all EHRs are fully interfaced with the ILPMP, as required.

Current status: Not Repeated

The Illinois Controlled Substances Act (Act) required all Electronic Health Record (EHR) systems to interface with the ILPMP by January 1, 2021. In the original performance audit, auditors found all EHRs were not fully implemented and able to interface with the ILPMP by January 1, 2021, as required.

As of June 30, 2023, all EHRs were not fully implemented and able to interface with the ILPMP. However, the Department was in the process of pursing legislative remedy from this requirement. As of June 30, 2023, Senate Bill 0285 had passed both houses in the General Assembly and had been sent to the Governor for approval. Senate Bill 0285 would amend the Act to state, "*It is the responsibility of any new, ceased, or unconnected healthcare facility and its selected Electronic Health Record system or Pharmacy Management System to make contact with and ensure integration with the Prescription Monitoring Program.*" Senate Bill 0285 would reassign the responsibility for ensuring integration of patient information from the ILPMP and/or the Department to the healthcare facilities and software vendors. Although as of June 30, 2023, the recommendation was not implemented, because Senate Bill 0285 was signed by the Governor and became effective as Public Act 103-0477 on August 3, 2023, the status of this recommendation is not repeated and does not need to be followed up on during the next compliance examination.

Recommendation 2 – Imposing Fines

The Department should update the Administrative Code to align with the Illinois Controlled Substances Act related to imposing fines, and develop a formal plan to help ensure dispensing reporting requirements are being implemented as required.

Current status: Partially Implemented

During the original audit period, the Illinois Controlled Substances Act and the Illinois Administrative Code did not agree on imposing fines for willful failure to report the dispensing of a controlled substance. According to the Act, DHS may impose a fine; however, the Administrative Code stated DHS shall impose a fine. In addition, there was no formal plan in place to ensure compliance with dispensing reporting requirements.

The Illinois Administrative Code was updated to align with the Act, and both the Administrative Code and the Act state the Department **may impose** a civil fine of $100 per day for willful failure to comply with statutory reporting requirements. However, the Department did not have a formal plan in place to ensure compliance with dispensing reporting requirements by the end of the compliance examination period (or June 30, 2023). Therefore, the status of this recommendation was **partially implemented.**

Recommendation 3 – Data Accuracy

The Department should establish general information technology controls over the data and correct the significant deficiencies related to contractual services, business processes, change control, disaster recovery, and security. Until these deficiencies are corrected, the ILPMP data and processes, change control, disaster recovery, and security reporting with respect to that data cannot be relied upon.

Current status: Partially Implemented

In February 2019, the ILPMP implemented a new feature called *MyPMP* The ILPMP implemented the *MyPMP* service into the website and planned to eventually integrate this service with EHR systems (*PMPnow). MyPMP* is a dashboard display containing summarized patient information for a prescriber. To follow up on the status of this recommendation, IS auditors reviewed documents related to contractual services, business processes, security, change control, and disaster recovery.

Contractual Services

In order to develop and implement the website, *PMPnow*, and Prescription Information Library (PIL) database, DHS contracted with three entities to provide various services: LogiCoy, Eastern Illinois University, and Hanson Information Systems, Inc. Review of the contracts found:

- **LogiCoy** – Our review of the contract and amendments noted DHS did not provide for auditing or reviewing of LogiCoy's internal controls over the security and development of the connections or Prescription Monitoring Program website.
  - DHS provided a System and Organizational Controls *(*SOC) 2, type 2 report for the period of August 1, 2021 through July 31, 2022. However, DHS did not provide an analysis of the LogiCoy SOC 2 report deviations or Complementary User Entity Controls. In addition, DHS provided a SOC 2, type 2 report for the period August 1, 2022 through July 31, 2023.
- **Hanson Information Systems, Inc**. – The contract is for providing hosting services for the PIL database and website. Although the contract required Hanson to undergo a SOC examination, Hanson had not.

Business Processes

It was noted that DHS receives data from various sources. When reviewing Business Processes, IS auditors identified the following:

- In the event of errors, DHS was not aware if anyone followed up with the dispenser on noted errors.
- According DHS staff, not all dispensers were providing data. Additionally, they were not conducting follow-up with these dispensers to determine why they were not complying with the Act.

DHS developed the *Illinois Prescription Monitoring Program Policies and Procedures Manual 2023* (Manual) to provide guidance related to several areas. The Manual included updated policies and business process information. However, the IS review of the Manual noted that it did not document:

- The controls for internal users to request access.
- The controls for terminating users.
- The requirement for user access reviews.
- The controls (change controls) for correcting the data (updated policy provided after examination period; see Change Control section below).

Security
In order to determine if a user's information was being properly validated, we obtained the population of users. Our analysis of the users' information noted 90,017 users, of which 23,736 were active prescribers, dispensers, or designees. Our review of the active users noted the following:

- **9,621 of 23,736 (41%)** active accounts did not have a DEA license number as required by 77 Ill. Admin. Code 2080.205(n).

We also found five other categories of exceptions during our review of the 23,736 active prescribers, dispensers, or designees, which indicates a possible internal control weakness over account authorization. We found that:

- **57** accounts did not have an address as required by 77 Ill. Admin. Code 2080.205(n).
- There were **6** accounts shown as active that did not have an authorization date, 5 of which were denied or pending.
- There were **10** accounts that had never logged in.
- **694** accounts had not changed their password in one year or more.
- **89** accounts with a last login date of more than 12 months old.

According to the ILPMP Policies and Procedures Manual, if an account had been inactive for a period of more than 12 months, the ILPMP administrator system shall automatically de-activate the account. According to DHS officials, when a user tries to login to the PMP website, the system checks the last login date, and if it is more than 12 months the user will not be able to access any patient prescription data. The Manual also requires a password change every 180 days. According to DHS officials, if a user logs in and is prompted by the system to change the account password but does not complete the required password change, the user cannot access patient prescription data.

Change Control
DHS did not have a formalized internal control process to control changes to the PIL. Because there were no policies or procedures in place, we were unable to design suitable audit procedures to determine if changes to the PIL were properly controlled. DHS stated there was an ad-hoc process, but nothing was formalized. DHS was able to provide a spreadsheet, which tracked change requests and contained fields to show the details of the request, as well as the status of implementing the change. However, this process was not documented in the ILPMP Policies and Procedures Manual during the compliance examination period. DHS was able to provide an updated policy dated April 22, 2024, which does appear to formalize this process.

In addition, we noted both developers have access to the production environment, thus creating a separation of duties weakness. However, DHS officials noted that there are two developers for the program website, which allows for vacations, sick time coverage, and peer review. DHS officials also stated that there are internal controls in place that act as safeguards against unauthorized changes, such as restrictions on available commands and monitoring functions.

Disaster Recovery
The *IT Incident and Recovery Plan* (Plan) for the ILPMP, dated September 2023, stated, "This document delineates our policies and procedures for technical disaster recovery, as well as our process level plans for recovering critical technology infrastructure." The Plan documented the contact information for the Emergency Response Team and Disaster Recovery Team.

The Recovery Plan Practice and Exercising section stated, "Practice and exercise should be practiced monthly with IT Staff members on how to diagnose, troubleshoot and resolve issues." The section also stated the key services were to be restored within four hours of the incident and business as usual recovery would be within 8-24 hours. Auditors found the Department had a detailed disaster recovery plan for the ILPMP, and the finding related to disaster recovery was **not repeated**.

In conclusion, IS auditors found improvements to the ILPMP Policies and Procedures Manual and the disaster recovery plan; however, IS auditors found issues with the data and IT controls. More specifically, IS auditors' follow-up found the following:

- ***9,621 of 23,736 (41%)*** *active accounts did not have a verified DEA number as required by administrative code.* ***Additionally, we noted five other areas in which internal control weaknesses allowed accounts to have an active status when they should not have been authorized, or should have been automatically unauthorized or de-activated.***
- *DHS did not provide an analysis of LogiCoy's SOC 2 report deviations or Complimentary User Entity Controls for the time period August 1, 2021 through July 31, 2022. In addition, DHS provided a SOC 2, type 2 report for the period August 1, 2022 through July 31, 2023. Hanson Information Systems, Inc. did not undergo a SOC examination, which was a requirement of the contract.*
- *DHS stated that not all dispensers were providing data as required, and DHS was unaware if follow up was being conducted on dispenser errors.*
- *The ILPMP Policies and Procedures Manual lacked specific controls and requirements needed for user access and change controls.*

Because of the internal control weaknesses found when reviewing the ILPMP data, we are not able to rely on the data with respect to our testing of the Illinois Prescription Monitoring Program. The status of this recommendation was **partially implemented.**

Recommendation 4 – Accurate Licensing Data

The Department should establish a process to ensure the licensing data utilized by the ILPMP does not contain invalid or outdated information. The Department of Human Services should consider establishing an interagency agreement with the Department of Financial and Professional Regulation outlining each agency's responsibilities related to licensing data.

Current status: Partially Implemented

In the original audit period, DHS and DFPR had not established an interagency agreement outlining each agency's responsibilities related to prescriber and dispenser licensing data. Periodic reviews of valid licenses were not being conducted after licenses were added to the ILPMP. In addition, there was not a process in place to check licensing data utilized by the ILPMP for invalid or outdated information.

DHS established a *Data Sharing Agreement* with IDFPR. According to DHS, the agreement outlined each agency's responsibilities related to the licensing data, and the licensing data was to be provided to DHS on a weekly basis. Due to time constraints encountered during this follow-up period, auditors were unable to perform the testing needed against the PIL data. Therefore, the follow up on Recommendation 4 will be conducted during the next follow-up period, and the status of this recommendation is **partially implemented**.

Recommendation 5 – Sports and Accident Injury Data Reviews

The Department and the Department of Public Health should establish a process to conduct data reviews of sports and accident injuries as required by the Act. In addition, the Department should alert prescribers whose discharged patients were dispensed a controlled substance about the risk of addiction and applicable guidelines.

Current status: Not Repeated

The Controlled Substances Act required the Department and the Illinois Department of Public Health (DPH) to coordinate continuous reviews of ILPMP and DPH data to determine if a patient may be at risk of opioid addiction. In addition, the ILPMP was required to alert the patient's prescriber as to the addiction risk and urge each to follow the Centers for Disease Control and Prevention guidelines related to the patient's injury. According to DHS, "this portion of the statute will sunset on January 1, 2024."

According to the Department, DPH provided the Department with sports injury data on June 13, 2023. In addition, the Department and DPH were meeting to ensure the Department could link the data to the ILPMP. The ILPMP had not sent any alerts to prescribers whose discharged patients were dispensed a controlled substance about the risk of addiction and applicable guidelines by the end of the compliance examination period (or June 30, 2023). However, the related statutory requirement ceased to be effective on January 1, 2024. Therefore, even though the recommendation was not implemented as of June 30, 2023, the status of this recommendation is considered not repeated for purposes of this report and does not need to be followed up on during the next compliance examination period.

Recommendation 6 – Update the Policies and Procedures Manual

The Department should update the ILPMP Policies and Procedures Manual as it is currently outdated. The updates should include current policies related to law enforcement requests.

Current status: Partially Implemented

During the original audit period, the Illinois Prescription Monitoring Program Policies and Procedures Manual (Manual) was outdated and did not include current practices. For example, the Manual did not include current information about law enforcement requests. In addition, the Manual referenced previous employees and old information.

To follow up on this recommendation, auditors reviewed the previous version of the Manual and compared it with an updated Manual provided by DHS. Auditors found that DHS had updated the Manual and had developed a system to periodically review and update the Manual. Auditors found the Manual contained updated information on law enforcement requests, and DHS corrected the other basic issues identified in the performance audit.

The review of the Manual as part of the follow-up related to the *Review of General IT Controls* was discussed under Recommendation 3. DHS developed the Manual to provide guidance related to several IT areas. Our IS review of the Manual noted the Manual did not document:

- the controls for internal users to request access;
- the controls for terminating users;

- the requirement for user access reviews; and
- the controls (change controls) for correcting the data (updated policy provided after examination period; see Change Control section).

Due to the Manual being outdated related to these IT issues, the status of this recommendation was **partially implemented.**

Recommendation 7 – Ensure Dispenser Requirements are Completed as Required

The Department should ensure dispensers are submitting specific information as required by the Illinois Controlled Substances Act and the Illinois Administrative Code. This includes addressing the following discrepancies with meeting these requirements:

- *Ensuring dispensers are submitting specific information to the ILPMP by the end of the next business day after a controlled substance is dispensed;*
- *Ensuring the following required information is submitted by dispensers: Patient ID, Patient Location Code, Patient Name, Birthdate, Date Sold, and Prescriber's Full Name;*
- *Beginning to collect and ensure the following additional required information is submitted by dispensers: Date Dispensed, Dispenser's DEA Number, Dispenser's Full Name, and Dispenser's Address;*
- *Following-up on problematic information submitted by dispensers so such information does not end up in the active PIL data including: records with patients over 110 years old, records with an animal species code, and/or records with an invalid patient name; and*
- *Ensuring the following required information for LTC cases is submitted by dispensers on a weekly basis and the fields needed for their submission are created including: Diagnosis Code, Name of Medication, Date Discharged, Changes to Medicine, Reason for Admission, Date Admitted, Pre-existing Conditions, Patient Ethnicity, Patient Height, and Patient Weight.*

Current status: Not Implemented

In the performance audit of the Illinois Prescription Monitoring Program, auditors found the Department did not monitor whether pharmacies were submitting the information timely, and the Department did not ensure dispensers were submitting all required information. Effective August 20, 2021, the Controlled Substances Act required DHS to collect various patient, dispenser, and prescriber information by the end of the business day on which a controlled substance was dispensed, rather than the end of the next business day as was previously required.

According to the Department, as of June 30, 2023, the Department had not developed a process to monitor timeliness.

Additionally, DHS stated that they do not require the following fields to be submitted by dispensers (even though these fields are still currently required by the Administrative Code):

- prescriber's full name;
- dispenser's full name; and
- dispenser's address.

The Department noted that the removal of these fields from the Administrative Code would require an Administrative Rule change, which had not been made. Finally, the Department noted that they are still in the process of determining the scope for ensuring the required information for LTC cases was submitted on a weekly basis. Therefore, the status of this recommendation was **not implemented.**

Recommendation 8 – Ensure Prescribers are Registered with the Illinois Prescription Monitoring Program

The Department should ensure all prescribers possessing an Illinois Controlled Substance license are registered with the ILPMP as required by the Illinois Controlled Substances Act.

Current status: Partially Implemented

The Illinois Controlled Substances Act (Act) required all prescribers register with the Illinois Prescription Monitoring Program (ILPMP). However, during the original audit period, auditors found all prescribers were not registered with the ILPMP, and in December 2020, 68% of licensed prescribers were registered with the ILPMP.

According to DHS, the ILPMP had taken steps to increase awareness of the registration requirement and had sent a notification email in September 2022. According to DHS, the Department had seen a large increase in registrations. DHS stated, "…the numbers used internally to determine compliance come directly from IDFPR. The total number of IL CS license holders as of July 2023 was 73,916 and the total number of IL CS license holders registered is 54,919 and non-registered is 18,997 for a 74.2% compliance rate and 25.8% non-compliance rate with the Act." Therefore, the status of this recommendation was **partially implemented**.

Recommendation 9 – Program Assessment Issues

The Department should address the identified program assessment issues and related deficiencies by:

- *Ensuring reports used for program assessment contain complete and accurate information and following-up when such reports show significant changes, incorrect calculations, and/or missing information; and*
- *Establishing an interagency agreement with the Department of Public Health to reinstate the process of exchanging data in more depth through the Opioid Data Dashboard and providing additional program assessment information to cover significant drug-related issues such as deaths, abuse, and overprescribing.*

Current status: Implemented

DHS updated the grant monitoring and reporting information in the ILPMP Policies and Procedures Manual to ensure reporting was complete and accurate. DHS and DPH also entered into an intergovernmental agreement for a term of September 1, 2021, through August 31, 2023, for data sharing purposes. According to DHS, DHS and DPH were sharing data for the Opioid Data Dashboard during the compliance examination period. Auditors reviewed information provided documenting data transmitted for the Opioid Data Dashboard, and the status of this recommendation was noted as **implemented** for the purposes of this review and does not need to be followed up on during the next examination period.

Recommendation 10 – Monitoring Issues

The Department should address the identified monitoring issues and related deficiencies by:

- *Performing sufficient tracking of monitoring reports required by the Illinois Administrative Code including error reports, zero reports, and personal information reports;*
- *Ensuring all monitoring reports required by intergovernmental agreements are completed as outlined in the agreements; and*
- *Sufficiently monitoring ILPMP contractors through System and Organization Controls reports or internal control reviews.*

Current status: Partially Implemented

During the original audit period, auditors found the Department had not performed sufficient tracking of monitoring reports required by the Illinois Administrative Code including for error reports, zero reports, and personal information reports. The Department had also not ensured all monitoring reports required by intergovernmental agreements were completed as outlined in the agreements. Finally, the Department had not sufficiently monitored ILPMP contractors through System and Organization Controls reports or internal control reviews.

To follow up on this recommendation, the Department provided the following reports for this compliance examination period: zero, error, and information on personal information requests. According to the Department, the ILPMP followed up with pharmacies to correct errors detected. The pharmacy submission timeliness report was not fully implemented during the compliance examination period, and the report was under continuing development and implementation.

The ILPMP updated the Policies and Procedures Manual to include a process for interagency agreements and grant management. The interagency agreement for the grant noted in the prior audit report ended in August 2019, which was not within the current compliance examination period.

According to the Department, the ILPMP was working with the Department contract division to determine how to monitor contractors through System and Organization Controls (SOC) reports. However, such SOC reports and analysis could not be provided for support when requested during the IS review for this audit follow-up. Therefore, the status of this recommendation was **partially implemented.**

Recommendation 11 – Illinois Prescription Monitoring Program Committee Weaknesses

The Department should address the identified ILPMP Committee weaknesses by:

- *Ensuring the Illinois Controlled Substances Act and the Illinois Administrative Code have the same Prescription Monitoring Program Advisory Committee (PMPAC) members listed for the PMPAC. In addition, the PMPAC charges outlined by the Act should be completed, as required.*
- *Ensuring Peer Review Committee (PRC) members with the same profession as the prescribers or dispensers being reviewed are preparing preliminary reports and/or making recommendations, as required by the Act. In addition, PRC meetings should be held quarterly and fulfill annual reporting requirements with the required information, as required by the Illinois Administrative Code. Finally, the lists of at-risk prescribers should not be cleared and should be followed-up on.*
- *Establishing an LTC Advisory Committee as required by the Illinois Administrative Code. This committee should be composed of healthcare professionals associated with the care of geriatric populations and include university partners performing research and longitudinal outcome evaluations.*

Current status: Implemented

To follow up on this recommendation, auditors reviewed the Illinois Administrative Code updated effective **September 8, 2023**, and found the PMPAC members listed are the same as those in the Act. Auditors reviewed the Peer Review Committee at-risk dispenser and prescriber review and recommendation process. The Peer Review Committee members were reviewing at-risk prescribers and making recommendations. The Department was also maintaining the lists of at-risk providers identified and following up with the prescribers. Finally, the Illinois Administrative Code was updated effective **July 7, 2023**, and all references to the LTC Advisory Committee were removed.

Therefore, the recommendation was partially implemented as of **June 30, 2023**, with the anticipated completion as of **September 8, 2023**. Although the recommendation was only partially implemented at the end of the compliance examination period (as of June 30, 2023), the recommendation was **implemented** shortly after the compliance examination period ended (on July 7, 2023, and September 8, 2023). Therefore, the status of this recommendation was noted as **implemented** for the purposes of this review and does not need to be followed up on during the next compliance examination period.

Status of Performance Audits

INDEPENDENT SERVICE COORDINATION (ISC) SELECTION PROCESS

The Office of the Auditor General conducted a management audit of the Department's ISC Selection Process. The Management Audit of the ISC Selection Process was conducted pursuant to House Resolution 214. The audit was released in April 2020 and contained a total of 13 recommendations to the Department. As part of the Fiscal Year 2020 and 2021 compliance examination of the Department, follow up determined the Department had implemented 3 recommendations, partially implemented 8 recommendations, and not implemented 2 recommendations. The current status of the recommendations is shown in the table below.

STATUS OF PAST PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2023

Audit	Rec. No.	Recommendation Description	Status		
			Implemented/ Not Repeated	Partially Implemented	Not Implemented
ISC Selection Process	1	Information Sharing with the General Assembly	X		
ISC Selection Process	2	Planning – Necessity of NOFO	X		
ISC Selection Process	3	Planning – Scoring Parameters	X		
ISC Selection Process	4	Planning – Development of Administrative Rules	X		
ISC Selection Process	5	Planning – Policies and Procedures	X		
ISC Selection Process	6	Planning – Evaluation Team	X		
ISC Selection Process	7	Planning – NOFO Issues	X		
ISC Selection Process	8	Planning – Transition			X
ISC Selection Process	9	Compliance Process Issues	X		
ISC Selection Process	10	Evaluation – Outlier Scoring	X		
ISC Selection Process	11	Evaluation – Inconsistent Selection Criteria	X		
ISC Selection Process	12	Evaluation – Scoring Irregularities	X		
ISC Selection Process	13	Evaluation – Appeal Review Process	X		

Source: Summary of current performance audit follow-up.

Recommendation 2 – Planning – Necessity of NOFO

The Department should verify and document the necessity for conducting competitive grant NOFOs prior to issuing the NOFO.

Current Status – IMPLEMENTED/NOT REPEATED

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, DHS did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 3 – Planning – Scoring Parameters

The Department should conduct adequate planning in developing scoring parameters for evaluators to follow when conducting competitive grant procedures.

Current Status – IMPLEMENTED/NOT REPEATED

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 6 – Planning – Evaluation Team

The Department should take steps during the process for selecting evaluation team members to ensure that the members have sufficient time to conduct the evaluations.

Current Status – IMPLEMENTED/NOT REPEATED

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 7 – Planning – NOFO Issues

The Department should ensure that all applicable procedural manuals and rules are complete and up to date before conducting competitive grant procedures.

Current Status – IMPLEMENTED/NOT REPEATED

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 8 – Planning – Transition

The Department should better follow its own transition plan, both in time and activities, for changes or transition in any system it maintains. The Department should ensure that it has and maintains all applicable data needed for any transition. Additionally, when the Department seeks outside resources to assist with change, it should allow enough time to receive and consider any feedback it receives.

Current Status – NOT IMPLEMENTED

During the current audit, we found that the Department had not conducted any system transitions. The Department acknowledged the need for planning; however, we were unable to conduct any testing to ensure such a plan was followed.

Recommendation 9 – Compliance Process Issues

The Department should follow all requirements in the administrative rules when conducting a competitive grant procurement process.

Current Status – IMPLEMENTED/NOT REPEATED

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 10 – Evaluation – Outlier Scoring

The Department should determine what constitutes a significant difference in scoring and maintain documentation of discussion of scoring differences among evaluators to provide evidence that the scoring process detailed in the Notice of Funding Opportunity was followed.

Current Status – IMPLEMENTED/NOT REPEATED

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 11 – Evaluation – Inconsistent Selection Criteria

The Department should comply with administrative rules and only award competitive grants based on the criteria presented in the Notices of Funding Opportunity. The Department should also consider implementing consistent selection processes across all Department units that are utilizing competitive grant procurements.

Current Status – IMPLEMENTED/NOT REPEATED

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 12 – Evaluation – Scoring Irregularities

The Department should develop controls for the competitive procurement of grants that include a verification that evaluators followed guidance provided in scoring parameters.

Current Status – IMPLEMENTED/NOT REPEATED

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.

Recommendation 13 – Evaluation – Appeal Review Process

The Department should develop policies and procedures for conducting the competitive grant appeal process. These procedures should include maintaining documentation to support how appeal decisions were determined. Additionally, the Department should consider whether a review of evaluations scores should be a part of determining the integrity of the process.

Current Status – IMPLEMENTED/NOT REPEATED

During the current audit, Department officials said they requested and received an approval for a deviation from the Grant Accountability and Transparency Act (GATA) requirements allowing the Department to extend the ISC grant program cycle for another two (2) one-year periods, which made the total grant cycle five years. Therefore, the Department did not issue any NOFOs during Fiscal Years 2022 and 2023. As of June 30, 2023, the Department was pursuing approval from GOMB to exempt the ISC grant program from GATA requirements regarding NOFOs.