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Office of the Auditor General

Performance Audit of

Medicaid Eligibility Determinations For Long-Term Care

September 1, 2022

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OFFICE OF THE AUDITOR GENERAL
FRANK J. MAUTINO

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

This is our performance audit of Medicaid eligibility determinations for long-term care.

The audit was conducted pursuant to the Illinois Public Aid Code at 305 ILCS 5/11-5.4 (enacted by Public Act 100-380 and amended by Public Act 100-665). This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

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

SIGNED ORIGINAL ON FILE

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September 2022

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OFFICE OF THE AUDITOR GENERAL

September 1, 2022
Performance Audit
Report Highlights

Frank J. Mautino *Auditor General*
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Performance Audit of

Medicaid Eligibility Determinations for Long-Term Care

Background:

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

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

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

Key Findings:

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

- For the 50 applications tested, we found that only 15 applications (**30%**) had an eligibility determination completed within the required timelines. On average, the 50 applications were **72 days overdue**. We found cases with an HFS Office of the Inspector General (OIG) referral were an average of **125 days overdue** while cases without an HFS OIG referral were **47 days overdue**.

- In addition, despite differences between the various reports produced by HFS, all three reports reviewed indicated applicants were not receiving their determinations of eligibility in a timely manner. Consequently, the status of the prior recommendation on the timeliness of eligibility determinations was determined to be **not implemented**.

- DHS and HFS noted that an IES system enhancement was established to address the processing delays related to OIG asset investigations. However, applications involving HFS OIG asset discovery investigations continued to be overdue during this audit period. The prior audit found that applications involving asset discovery investigations were an average of 114 days overdue. For this audit, we tested 16 cases referred to the HFS OIG in fiscal year 2020 to follow up on this recommendation. During this testing, we found that applications involving asset discovery referrals were an average of **125 days overdue**.

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

- DHS and HFS continued to not adequately track extensions in IES during this audit period. For the 13 extension cases reviewed, 10 cases **(77%)** contained issues such as inaccurate IES data, a lack of extension information in IES, or more than two extensions. According to HFS, a defect was discovered during the audit that affected the accuracy of the data in IES. As a result, the status of the recommendation on extension tracking was determined to be **not implemented**.

- The prior audit found the LTC monthly reports did not contain all elements as required by statute. We reviewed the LTC monthly reports for calendar years 2018 to 2020 and found HFS had added missing elements to the reports but

was not providing all the information as required. As a result, the status of this recommendation on the LTC monthly report completeness was determined to be **partially implemented**.

- During the prior audit, we found the LTC monthly reports were not accurate due to duplicate entries and other issues with the source data and a potential overstatement of the number of days applications are pending. During this audit, we reviewed the monthly reports for calendar years 2018 to 2020 and found similar issues with accuracy that were identified during the prior audit. We also found 11 of 50 applicants tested (**22%**) had a reported disability which would allow 60 days for processing those applications.
- We also requested LTC data on the total number of redeterminations completed during the audit and found the redeterminations data in the monthly reports contained multiple issues. Therefore, the status of the recommendation on the LTC monthly report accuracy was determined to be **not implemented**.
- Public Act 100-380 requests the Auditor General to review and evaluate the efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of DHS for LTC services. During this audit period, DHS made the decision to move away from the task-based system to a new facility-based system. According to DHS, there were significantly more pros and less cons for the facility-based approach. Although the decision to switch to the facility-based approach appeared to be reasonable, additional follow-up will need to be conducted during the next audit period. In addition, the agencies need to address the issue of IES not fully supporting the facility-based model before the required review of this during the next audit period.

Key Recommendations:

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

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

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

Report Digest

On August 25, 2017, the Governor signed into law Public Act 100-380 which amended the Illinois Public Aid Code. This amendment to the Illinois Public Aid Code requires that beginning July 1, 2017, the Auditor General is to report every three years to the General Assembly on the performance and compliance of the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), and the Department on Aging (DoA) in meeting the requirements placed upon them by Section 11-5.4 of the Illinois Public Aid Code and federal requirements concerning eligibility determinations for Medicaid long-term care services and supports (**see Appendix A**). This is the second audit (CY18-CY20) of their performance and compliance. Our assessment of the audit determinations is shown below in **Digest Exhibit 1**. (page 1)

Digest Exhibit 1
ASSESSMENT OF AUDIT DETERMINATIONS

Audit Determination	Auditor Assessment
Compliance with federal regulations on furnishing services as related to Medicaid long-term care services and supports as provided under 42 CFR 435.930. *Compliance with federal regulations on the timely determination of eligibility as provided under 42 CFR 435.912.*	• We determined calculating timeliness using the data provided would not provide accurate results. Therefore, a sample of 50 was selected. Only 15 applications (30%) had an eligibility determination within the required timelines. On average, the 50 applications were 72 days overdue. All three reports prepared by HFS indicated applicants were not receiving their determinations of eligibility in a timely manner. (pages 20-29)
The accuracy and completeness of the report required under paragraph (9) of subsection (e).	• Although some required elements were added to the reports, all elements were still not included. The monthly reports potentially overstated the number of days pending for applications and the data used in the redeterminations table contained duplicate entries. We were unable to determine the accuracy of the data in the reports, due to numbers not matching. (pages 43-47)
The efficacy and efficiency of the task-based process used for making eligibility determinations in the centralized offices of the Department of Human Services for long-term care services, including the role of the State's integrated eligibility system, as opposed to the traditional caseworker-specific process from which these central offices have converted.	• The implementation of the task-based approach was completed in October 2018. However, DHS decided to transition to a new facility-based approach during the audit period. We did not fully assess the efficacy and efficiency of the approaches since a decision was made to switch from the task-based process to the facility-based process during the audit period. (pages 50-52)
Any issues affecting eligibility determinations related to the Department of Human Services' staff completing Medicaid eligibility determinations instead of the designated single-state Medicaid agency in Illinois, the Department of Healthcare and Family Services.	• No apparent issues affecting eligibility determinations were identified related to DHS staff completing these determinations instead of HFS, the single State Medicaid agency. (pages 16-17)

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

Background

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

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

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

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

Issues Impacting the Audit

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

In addition, the COVID-19 Public Health Emergency allowed for significant changes to the Medicaid LTC eligibility determination process. These changes affected the approval of applications, referrals to the HFS Office of Inspector General (OIG), and redeterminations. Consequently, additional follow up should be completed related to the required review for this audit when the Public Health Emergency and related changes have ended. The changes suspended most of the previous eligibility determination requirements. (page 5)

Agencies Involved With LTC Eligibility Determinations

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

- **DHS** has the responsibility of determining an applicant's medical eligibility.

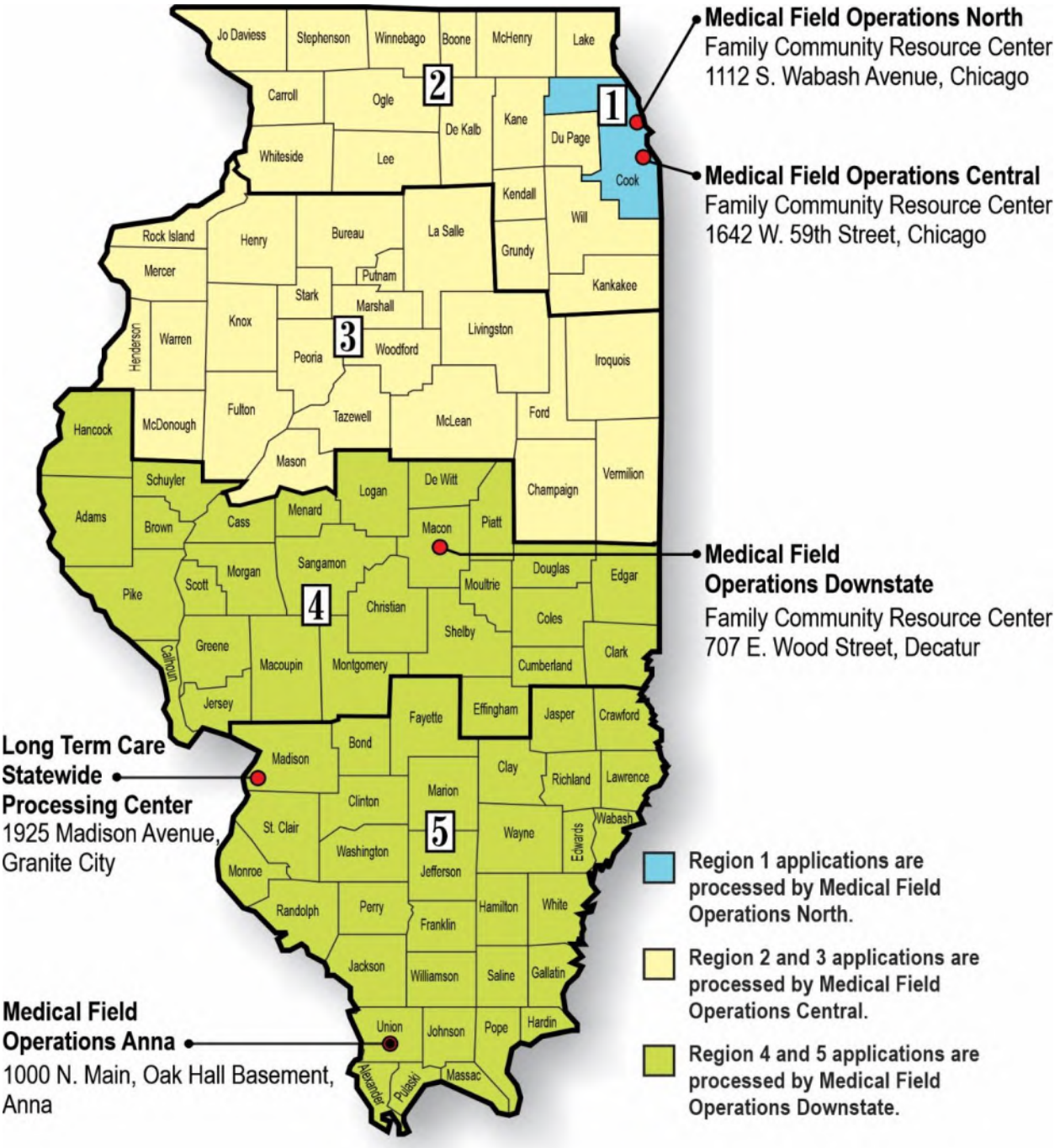
- **DoA** has the responsibility to conduct level of care determinations for nursing home facilities/institutional care (functional eligibility).
- **HFS** has the responsibility to develop policy related to LTC eligibility, investigate assets (if needed) to assist in determining an applicant's financial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

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

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

- **Medical Field Operations North** processes LTC applications for **Region 1**.
- **Medical Field Operations Central** processes LTC applications for **Regions 2 and 3.**
- **Medical Field Operations Downstate** processes LTC applications for **Regions 4** and **5**.
- **LTC Statewide Processing Center** is designed to handle specific work assigned from the other four Medical Field Operations offices. Assignments are based on priority or urgency needs, special projects, and backlog.
- **Medical Field Operations Anna** has been implemented to be a functional field office housing cases to alleviate the workload of the other three Medical Field Operations offices. This office was designed to handle cases for a specific area but has been unable to do so due to the current low head count of caseworkers. Once efficiently staffed, cases will be assigned and maintained by this office. (pages 5-7)

Digest Exhibit 2
DHS LONG-TERM CARE MEDICAL OPERATIONS OFFICES AND REGIONS
Calendar Year 2020



Note: The locations in Granite City and Anna began hiring staff in March 2020 and January 2021 respectively.

Source: OAG prepared based on DHS information.

LTC Eligibility Determination Process

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

Processing of LTC Applications

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

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

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

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

Delegated Authority to Determine Eligibility

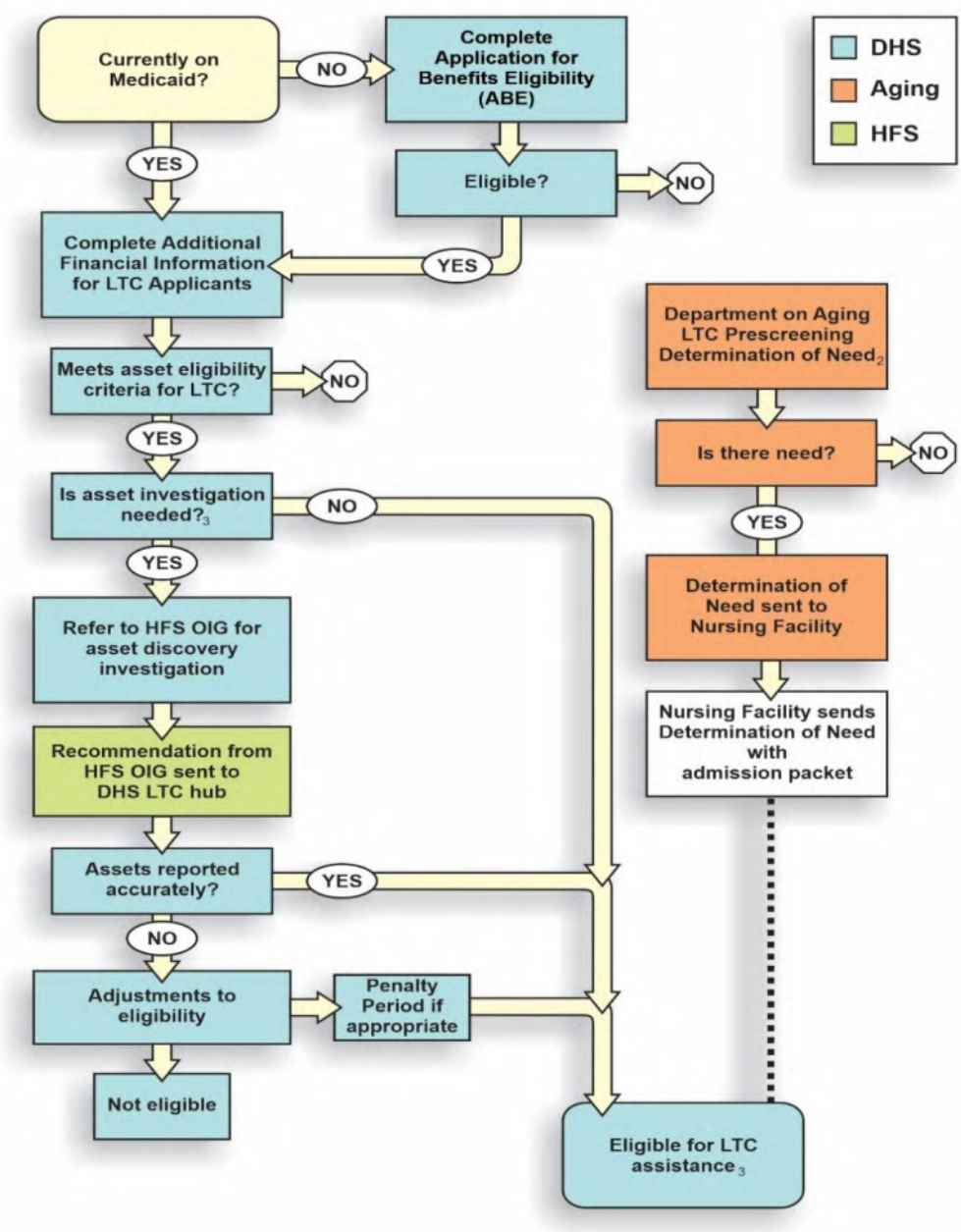
Public Act 100-380 requests the Auditor General to determine if there are any issues affecting eligibility determinations related to DHS' staff completing Medicaid eligibility determinations instead of HFS, the designated single State Medicaid agency in Illinois.

We determined that no apparent issues affecting eligibility determinations were identified related to DHS staff completing these determinations instead of HFS, the single State Medicaid agency. (pages 16-17)

Updates to LTC Policy Manual

During the prior audit, policy manual documents were discovered that needed updates and additional clarification to avoid confusion for caseworkers. Since HFS has the responsibility to develop and update the policy related to LTC eligibility, we recommended HFS update the policy manual as appropriate. During this audit, we found that HFS updated the policy manual in both areas addressed in the prior audit and this recommendation was determined to be **implemented**. (pages 18-19)

Digest Exhibit 3
LONG-TERM CARE ELIGIBILITY DETERMINATION PROCESS[1]
Calendar Year 2020



Notes:
[1] This exhibit presents the basic framework of the long-term care eligibility determination process and agency responsibilities and is not intended to cover all iterations of the process. As of 4/2/20, COVID-19 emergency rules affected the eligibility determination process by ensuring applications were reviewed quickly and certain requirements were not required to be reviewed by DHS caseworkers during this time.

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

[3] As of 1/30/20, HFS OIG referrals can occur during initial processing or after a case has been determined eligible.

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

Timeliness of Eligibility Determinations

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

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

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

Eligibility Determination Timelines

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

In order to analyze if applicants were receiving their determinations of eligibility within the required timelines, we reviewed the following three reports: LTC monthly reports, reports prepared for the federal Centers for Medicare and Medicaid Services, and internal weekly reports. Since the source data for all three reports was IES, there were multiple issues affecting the data for these reports. However, we still wanted to review whether the reports supported if applicants were receiving their determinations of eligibility in a timely manner. We found that all three reports indicated applicants were **not** receiving their determinations of eligibility in a timely manner.

Changes due to the COVID-19 Public Health Emergency

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

On April 2, 2020, DHS and HFS issued a policy memo (effective immediately) stating that self-attestation would be accepted for all new and pending medical applications for certain eligibility criteria factors including income and Illinois residency. Self-attestation means a person's written, verbal, or electronic declaration of his or her income in the application is considered to be truthful and correct. Additionally, there would be no resource tests for medical applications during the time period the COVID-19 emergency rules were effective. On April 7, 2020, DHS and HFS issued a policy memo (effective immediately) stating that

medical cases would no longer be closed due to failing to respond to a redetermination or due to a certification period ending.

In addition to the policy memos issued in April 2020, Public Act 101-649 (effective July 7, 2020) also amended the Illinois Public Aid Code and addressed the Public Health Emergency. Public Act 101-649 allowed the State to take necessary actions to address the emergency rules and those actions may continue for up to 12 months after the emergency rules end. Those actions included the following:

- accepting an applicant's or recipient's attestation of income, incurred medical expenses, residency, and insured status when electronic verification is not available;
- eliminating resource tests for some eligibility determinations; and
- suspending redeterminations.

Therefore, most of the previous eligibility requirements were suspended during the Public Health Emergency. According to HFS officials, the State was also unable to process any penalties or resource spenddowns during the time period the emergency rules were effective. However, the OIG continued to perform investigations on cases referred to them during the Public Health Emergency. Recommendations have been prepared for those investigations and the information will be sent to DHS for implementation at the end of the Public Health Emergency.

Issues Affecting the Data

We reviewed data consisting of **56,864** LTC applications received in calendar years 2018 through 2020. Upon review of the data, which was pulled from IES, we determined calculating timeliness for the population of applications using the data provided would not provide accurate results for the purposes of this audit. More specifically, we found:

- **6,300 of 56,864** applications (**11%**) did not have a decision date; and
- **28,026 of 56,864** applications (**49%**) had multiple entries based on the same name, date of birth, and application date. HFS pulled the data in such a manner that if an application had multiple assistance types, the application was listed more than once in the data.

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

After reviewing the query data pull for this audit, HFS officials became aware of some issues in the system and provided the following details:

- A defect was found with the extension tracker. The extension tracker was not consistently applying the number of extensions and the allowable number of extension days provided may be incorrect. A defect was logged for this issue.
- There may be duplicate applications because of how the data was pulled. HFS pulled the information by edge level not by case level. Cases can have multiple medical edges built which is why a case number may appear multiple times.
- The extension tracker was implemented in IES production on April 15, 2019. Any allowed requested extensions entered prior to that date were entered by caseworkers.

Timeliness Testing Results

According to the data, **18,019** LTC applications were submitted during fiscal year 2020. We selected a sample of 50 applications for testing due to the problems noted above.

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

Days Overdue	# of Applications
0	15
1-30	5
31-45	6
46-60	0
61-90	5
91-120	8
121+	11

Source: OAG analysis of LTC applications testing.

For the applications tested, we found that 15 applications (**30%**) had an eligibility determination within the required timelines. An additional 11 applications (**22%**) were completed within 45 days (between 4 and 45 days) beyond the required timeline. The remaining 24 applications **(48%**) were overdue by more than 45 days, ranging from 61 to 315 days. **Digest Exhibit 4** provides a detailed breakdown of the days overdue for the 50 applications sampled.

On average, the 50 applications were **72 days overdue**. The applications were evaluated against the State requirement of 60 days for an application on the basis of a disability and the federal/State requirement of 45 days for all other applications. For the cases without an OIG referral, the 34 applications were **47 days overdue**, on average.

For the 50 applications sampled, it took on average, **125 days** from receipt of application to disposition. In addition, of the 50 applications sampled, 16 applications were referred to the HFS OIG for an asset discovery investigation. LTC Medicaid eligibility was determined solely by a DHS LTC hub (without a referral to the HFS OIG) in 34 of the applications tested. The average days to determine eligibility (from receipt to final disposition) by Medical Field Operations was **98 days**, on average.

During testing, we found cases spent extended time at OIG for an average of 98 days. For cases with an OIG referral, they were an average of 125 days overdue. In comparison, cases without an OIG referral were 47 days overdue, on average. Additionally, when a case was referred to HFS OIG, it remained at the HFS OIG

for an average of **52 days** before the OIG made a decision to accept or reject the referral.

Due to these testing and reporting results, this recommendation on eligibility timeliness was determined to be **not implemented** during this audit period. (pages 20-29)

Applications with HFS OIG Asset Discovery Referrals

The HFS OIG reviews complex financial and legal documents as part of an asset discovery investigation; as a result, processing an application referred for an asset investigation requires additional time. Prior to August 2, 2018 (the effective date of Public Act 100-665), the Illinois Public Aid Code (305 ILCS 5/11-5.4(a)) allowed an extension of up to 90 days (i.e., a 135 day total processing time limit) when the HFS OIG determined there is a likelihood of non-allowable transfers of assets. However, the additional extensions for the HFS OIG application referrals were not applicable during the fieldwork testing for this audit because the sample was from FY19 or after the Act's effective date.

Testing Results

We reviewed a total of **16 cases** referred to the OIG for investigation during fieldwork testing. DHS worked on these applications from **0** days to **161** days before referring them to the HFS OIG. For the 16 HFS OIG applications in our sample, the average number of days from receipt of application to referral to HFS OIG was 60 days.

We found the 16 applications in the sample involving an asset discovery referral were overdue by **125 days**, on average, in fiscal year 2020. However, we found that the delay was not solely due to the time the application was being worked at the HFS OIG. In addition, multiple issues were identified for these HFS OIG cases during our review. These issues included timeliness issues, incorrect information in IES, issues related to COVID-19, and a lack of controls in IES. More specifically, we identified the following:

- All 16 of the HFS OIG cases reviewed (**100%**) were not completed in a timely manner, ranging from **37** to **260** days overdue. The time spent at the HFS OIG for these cases ranged from **47** to **182** days.
- In addition, the OIG referral date in IES was incorrect for 4 of the 16 cases (**25%**).
- For at least 5 of the 16 HFS OIG cases (**31%**), COVID-19 was referenced during the HFS OIG review – including referrals being withdrawn due to COVID-19.
- Finally, for the 15 HFS OIG cases where supporting screenshots were provided (screenshots were not provided for one case), all 15 (**100%**) indicated a lack of IES controls. More specifically, according to DHS officials, "*Note that the field for the 'Has the OIG Referral been Initiated' question states 'No' – which appears to be an error on IES's part, as IES should not accept dates for referral unless the question is marked 'Yes.*'"

However, these HFS OIG cases did not contain a "yes" answer for this question and yet referral dates were still allowed to be entered in IES.

The status of this recommendation was determined to be **partially implemented**. DHS and HFS noted that an IES system enhancement was established to address the processing delays related to OIG asset investigations. However, during the testing of FY20 cases, we found the cases with OIG investigations were still an average **of 125 days overdue**. In addition, multiple other issues were identified for these HFS OIG cases during our review. These issues included incorrect information in IES and a lack of controls in IES. (pages 30-34)

Extension Tracking

During the prior audit, DHS and HFS did not adequately track extensions. DHS and HFS did not track extensions in a manner that made it easy to identify the dates of the extensions or the number of extensions granted for each case.

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

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

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

Testing Results

We included a sample of 10 extension cases in our sample of 50 cases reviewed from IES during fieldwork. Three additional extension cases were included in the other sampled cases for **a total of 13 extension cases reviewed**. In total, 22 extensions were granted for the 13 applications reviewed.

For the extension cases reviewed, we found ten cases (**77%**) with inaccurate IES data, a lack of extension information in IES, or cases with more than two extensions. We also found that eight cases with extensions (**62%**) were not completed in a timely manner.

Extensions upon request by applicant:

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

Although the Statute only allow for two extensions per application and a maximum of 30 days per extension, we found exceptions to this during testing. For example, one case had extensions granted more than two times.

HFS noted that a system enhancement was implemented in IES to address this prior audit recommendation. However, the testing results showed the enhancement was not effective. In addition, during the audit, HFS discovered a defect that affected the accuracy of the data in IES. Therefore, the status of this recommendation on the status of extensions was determined to be **not implemented**. (pages 35-37)

LTC Monthly Reporting

Public Act 100-380 requested the Auditor General to evaluate the accuracy and completeness of the monthly report required by the Illinois Public Aid Code to be posted on both the DHS and HFS websites for the purpose of monitoring LTC eligibility processing (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)). These monthly reports are to specify the number of applications and redeterminations pending LTC Medicaid eligibility determination and admission, and the number of appeals and denials in the following categories:

- Length of time applications, redeterminations, and appeals are pending: 0 to 45 days, 46 days to 90 days, 91 days to 180 days, 181 days to 12 months, over 12 months to 18 months, over 18 months to 24 months, and over 24 months.
- Percentage of applications and redeterminations pending in DHS' Family Community Resource Centers, in DHS' LTC hubs, with HFS' Office of Inspector General, and those applications which are being tolled due to requests for extension of time for additional information.
- Status of pending applications, denials, appeals, and redeterminations.

Required Posting of LTC Monthly Report

HFS and DHS are posting the LTC reports on a monthly basis as required by the Illinois Public Aid Code. These reports are required to be posted on "each Department's website for the purposes of monitoring LTC eligibility processing" (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).

During the prior audit, HFS and DHS did not post all LTC reports as required by the Illinois Public Aid Code on a monthly basis. The prior audit found the LTC monthly reports were created by HFS and posted somewhat regularly to HFS' website; however, these reports were not posted to DHS' website as required by the Illinois Public Aid Code.

According to DHS, in August 2019, a link was added on its website linking to the HFS webpage where the LTC monthly report is posted. We confirmed this link on the DHS website was present and the link connected to the HFS webpage, as noted by DHS. We also confirmed the link was still active.

Review of CY20 LTC Monthly Reports

We requested documentation to support the posting of all monthly reports for calendar year 2020 (January to December 2020) from HFS. HFS provided both a web request confirmation email and a website posting approval form for 10 of the 12 months requested in CY20 (**83%**). The two months missing documentation were only missing a web request confirmation email (May 2020 and July 2020). Therefore, we determined HFS was in compliance with the Illinois Public Aid Code's monthly report posting requirement during this review of CY20.

DHS added a link to the HFS webpage and HFS provided support for all postings of LTC monthly reports in calendar year 2020, so this recommendation on LTC monthly reports was determined to be **implemented** during the audit period. (pages 38-39)

LTC Monthly Report Completeness

According to the prior audit, the LTC monthly reports did not contain all elements as required by statute. We followed up with HFS and reviewed the LTC monthly reports for these elements during this audit period. According to HFS, extensions began being tracked in IES during this audit period in April 2019. However, the monthly reports were still missing required elements during this audit period.

- The percentage of applications pending which are being tolled, or paused, due to requests for extension of time for additional information should be included. We reviewed the 36 monthly reports for calendar years 2018 to 2020, and all **36 (100%)** did not contain information on extensions.
- Information not only on the length of time applications are pending, but also the length of time redeterminations and appeals are pending should be included. The reports for calendar years 2018 through 2020 contained this information, with the exception of one month (September 2018).
- The monthly reports only provided the **number** of redeterminations pending by location, not the **percentages** as required by statute. Also, the reports did not contain this information for part of the audit period.

Although HFS was providing more information in the LTC monthly reports as required by 305 ILCS 5/11-5.4(f), there were some remaining issues with the completeness of the reports. Therefore, the status of this recommendation was determined to be **partially implemented**. (pages 40-41)

LTC Monthly Report Accuracy

The monthly reports posted on HFS' website pursuant to statute (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)) were not accurate. We reviewed the monthly reports for calendar years 2018 to 2020 and found the same issues with accuracy that were identified during the prior audit:

- the monthly reports potentially overstated the number of days pending for applications; and
- the data used to create tables in the reports contained duplicate entries.

Lack of Tracking Extensions and Disability Status

For this audit, we tested 50 applications and found evidence of a request for an extension by the applicant in 13 applications (**26%**). Eight of the applications had more than one extension.

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

basis of a disability, some of the applications in the 46 to 60 day category might not be overdue if the applicant applied on the basis of a disability.

Source Data Accuracy

The accuracy of the LTC monthly reports was previously reliant on the data in the tracking database, and the data in the tracking database was reliant on the caseworker accurately entering the data and identifying and removing duplicates. We were unable to make a determination regarding the accuracy of pending LTC applications data.

We requested LTC applications data for calendar years 2018 through 2020. Although both the data provided and monthly reports were from IES, we could not confirm the accuracy of the various reports during this audit. The data provided had multiple issues including applications with no decision dates and applications with multiple entries.

Testing Related to Source Data Accuracy

We compared the data provided by HFS to the monthly reports, internal weekly reports, and reports prepared for the federal Centers for Medicare and Medicaid Services. We were unable to determine the accuracy of the data for the various reports due to the numbers not matching between any of the reports. None of the reports or data matched for any of the months reviewed. Because the numbers presented in the LTC monthly report did not match the other two reports or the LTC applications data provided by HFS, we were unable to confirm the accuracy of the applications tables in the LTC monthly reports.

Redeterminations Data

We requested LTC data on the total number of redeterminations completed for calendar years 2018 through 2020 at the beginning of the audit. According to HFS, the following redeterminations were completed during the audit period:

- **59,070** redeterminations were completed during CY18.
- **49,303** redeterminations were completed during CY19.
- **38,160** redeterminations were completed during CY20.

Therefore, the number of redeterminations completed decreased from CY18 to CY20. In addition, the redeterminations data in the LTC monthly reports contained multiple issues. We reviewed the data and found case numbers and individual IDs with multiple entries. Of the 34 months reviewed, all **34** (**100%)** contained case numbers and individuals with multiple entries.

We reviewed the LTC application data in the LTC monthly reports and attempted to ensure the data matched the data in IES as indicated by the agencies. However, we could not determine the accuracy of the LTC monthly reports due to the numbers not matching between any of the reports. In addition, we reviewed the redetermination data and attempted to compare it to the redetermination data in the LTC monthly reports but identified multiple issues. The review found inaccuracies in the redetermination data used to create the LTC monthly reports

and the monthly reports did not match the provided redetermination data. Therefore, the status of this recommendation on LTC Report Accuracy was determined to be **not implemented**. (pages 42-47)

Consistency in LTC Pending Application Reporting

During the prior audit, discrepancies were identified in the LTC pending application numbers reported by HFS. More specifically, the reports used for the check-in calls for the federal Centers for Medicare and Medicaid Services usually reported a lower number of LTC applications pending greater than 45 days than HFS' LTC monthly reports. The two reports differed because the reports prepared for the check-in calls used application numbers from IES while the reports posted to the HFS website used numbers from the LTC application tracking database.

According to HFS officials, in October 2018, HFS started using IES as the source for both the LTC application data reported to the federal Centers for Medicare and Medicaid Services during bi-weekly check-in calls and the LTC monthly reports posted to the HFS website. Since both reports were pulled from IES source data, we attempted to compare them. Unfortunately, the data was unable to be fully confirmed between the reports due to reporting timing issues.

These reports were not required and were used for internal purposes only during the remainder of the audit because HFS was not sharing this data with the federal Centers for Medicare and Medicaid Services as was done during the prior audit. Therefore, the status of this recommendation was determined to be **not repeated**. (pages 48-49)

Application Processing Approaches

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

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

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

Application Processing Approaches

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

Decision to Switch Approaches

During this audit period, DHS completed the implementation of the task-based approach in October 2018. However, DHS officials stated that the task-based approach was not effective for processing. Therefore, DHS made the decision to move away from the task-based system to a new facility-based system. According to DHS, there were several reasons for this decision:

- Staff accountability was hard to track;

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

Comparison of Approaches

We did not fully assess the efficacy and efficiency of the facility-based approach since the process was implemented after the audit period. According to DHS, there were significantly more pros and less cons for the facility-based approach when compared to the other two approaches. The decision to switch to the facility-based approach appeared to be based upon reasonable assumptions. However, additional follow-up will need to be conducted on this decision to switch approaches during the next audit period when the facility-based approach was fully implemented. In addition, the agencies need to address the issue of IES not fully supporting the facility-based model before the required review of this during the next audit period. (pages 50-52)

Audit Recommendations

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

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

SIGNED ORIGINAL ON FILE

JOE BUTCHER
Division Director

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

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

FJM:SEC

Contents

Glossary and Acronyms

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

Glossary and Acronyms

TAN	Transaction Audit Number. After providers enter information into MEDI, a Transaction Audit Number is generated. The LTC tracking database then stores the information with the TAN.
WAG	Workers' Action Guide. A policy manual used by DHS caseworkers to guide decisions related to eligibility.

Introduction

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

- **Furnishing Medicaid Long-Term Care Services Promptly** – Compliance with federal regulations on furnishing services as related to Medicaid long-term care services and supports as provided under 42 CFR 435.930 - i.e., furnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures;
- **Timely Determination of Eligibility** – Compliance with federal regulations on the timely determination of eligibility as provided under 42 CFR 435.912 - i.e., the determination of eligibility for any applicant may not exceed: (i) ninety days for applicants who apply for Medicaid on the basis of disability; and (ii) forty-five days for all other applicants;
- **Monthly Report** – The accuracy and completeness of the monthly report required under paragraph (9) of subsection (e) of the Illinois Public Aid Code and for the purposes of monitoring long-term care eligibility processing - i.e., monthly reports posted to the DHS and HFS websites on the applications and

redeterminations pending long-term care eligibility determination and admission and the number of appeals of denials in given categories;

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

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

Exhibit 1
CURRENT STATUS OF PRIOR AUDIT RECOMMENDATIONS

Prior Audit	Current Audit	Recommendation	Status
1	N/A	Update LTC Policy Manual Guide	Implemented
2	1	Eligibility Determination Timeliness	Not Implemented
3	2	HFS OIG Application Referrals	Partially Implemented
4	3	Tracking of Extensions	Not Implemented
5	N/A	Required Monthly Report Website Postings	Implemented
6	4	LTC Monthly Report Completeness	Partially Implemented
7	5	LTC Monthly Report Accuracy	Not Implemented
8	N/A	Consistency in Pending Application Reporting	Not Repeated

Source: OAG prepared based on analysis of recommendations.

Background

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

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

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

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

Lawsuit

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

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

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

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

OAG Compliance Reviews

Throughout the audit period, HFS and DHS financial audits and compliance examinations contained findings related to the State's Integrated Eligibility System (IES) and inaccurate determination of eligibility. **Exhibit 2** shows examples of these relevant findings by agency. We also reviewed the FY18 through FY20 compliance examinations for DoA. None of the findings in these DoA compliance examinations pertained to long-term care Medicaid eligibility.

Exhibit 2
RELEVANT OAG FINDINGS BY AGENCY
Fiscal Year 2018 through Fiscal Year 2021

Finding	HFS				DHS			
	FY18	FY19	FY20	FY21	FY18	FY19	FY20	FY21
Failure to perform essential project management functions over IES	✓				✓			
Insufficient internal controls over changes to IES and recipient data	✓	✓	✓	✓	✓	✓	✓	✓
Inadequate controls over eligibility determinations and redeterminations	✓	✓	✓		✓	✓	✓	
Lack of security controls over IES	✓	✓			✓	✓		
Inadequate disaster recovery controls over IES		✓	✓	✓		✓	✓	✓
Untimely processing of applications for benefits and redeterminations of eligibility for benefits	✓	✓	✓		✓	✓	✓	
Insufficient review and documentation of provider enrollment determinations and failure to execute interagency agreements	✓	✓	✓	✓	✓	✓	✓	✓

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

Issues Impacting the Audit

As can be seen in Exhibit 2 and throughout this audit, issues related to IES continued to be identified. These issues surrounded the system's internal controls as well as the completeness of the data provided. Due to these issues, we determined reviewing the entire population of the applications data would not provide accurate results for the purposes of this audit and instead performed sample testing.

In addition, the COVID-19 Public Health Emergency allowed for significant changes to the Medicaid LTC eligibility determination process. These changes affected the approval of applications, referrals to the HFS Office of Inspector General (OIG), and redeterminations. Consequently, additional follow up should be completed related to the required review for this audit when the Public Health Emergency and related changes have ended. The changes suspended most of the previous eligibility determination requirements as discussed later in this report.

Agencies Involved With LTC Eligibility Determinations

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

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

Department of Human Services

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

The Aged, Blind, and Disabled program provides medical benefits to seniors, persons who are blind, and persons with disabilities with income of 100 percent or less of the federal poverty level and no more than $2,000 of non-exempt resources. A person with countable income and resources that are equal to or less than the Aged, Blind, and Disabled medical standards may qualify for Aged, Blind, and Disabled medical benefits without a spenddown obligation. If the individual's income and/or resources is over the specified limit, he or she may be enrolled in spenddown. A person is eligible for this program if he or she:

- Lives in Illinois;
- Is a U.S. citizen or meets certain requirements for noncitizens;

- Receives Supplemental Security Income or is ineligible for Supplemental Security Income due to income or due to expiration of the federal time limit on assistance to certain immigrants who have not yet become U.S. citizens;
- Is either blind, disabled, or 65 years or older; and
- Does not have any non-exempt resources in excess of $2,000.

When determining eligibility, DHS exempts certain assets up to a specific dollar amount, such as one automobile up to $4,500 and a place of residence up to $603,000 equity value in 2021 (this amount is to be increased annually based on the percentage increase in the Consumer Price Index). The Affordable Care Act Adult Program provides medical assistance to adults, specifically to those not eligible for other programs. The Affordable Care Act provides nursing home services for individuals who:

- Are age 19 through 64 years;
- Live in Illinois;
- Meet U.S. citizenship or immigration requirements;
- Are not eligible for other programs;
- Have income at or below 138% of the federal poverty level (adult cases are not eligible to be enrolled in spenddown); and
- Their resources are not counted, however, the five year look back for post eligibility determinations is completed reviewing resource transfers.

An individual can apply by going to a local DHS Family Community Resource Center or online, through the Application for Benefits Eligibility (ABE) online portal, or by mailing a paper application to the agency. According to DHS, most applications are submitted electronically through the ABE online portal. All providers who apply on behalf of an LTC resident are required to use the ABE online portal. DHS processes nearly all of its LTC applications through four (4) field operations offices (or LTC hubs) and one (1) LTC Statewide Processing Center created specifically for LTC eligibility determinations.

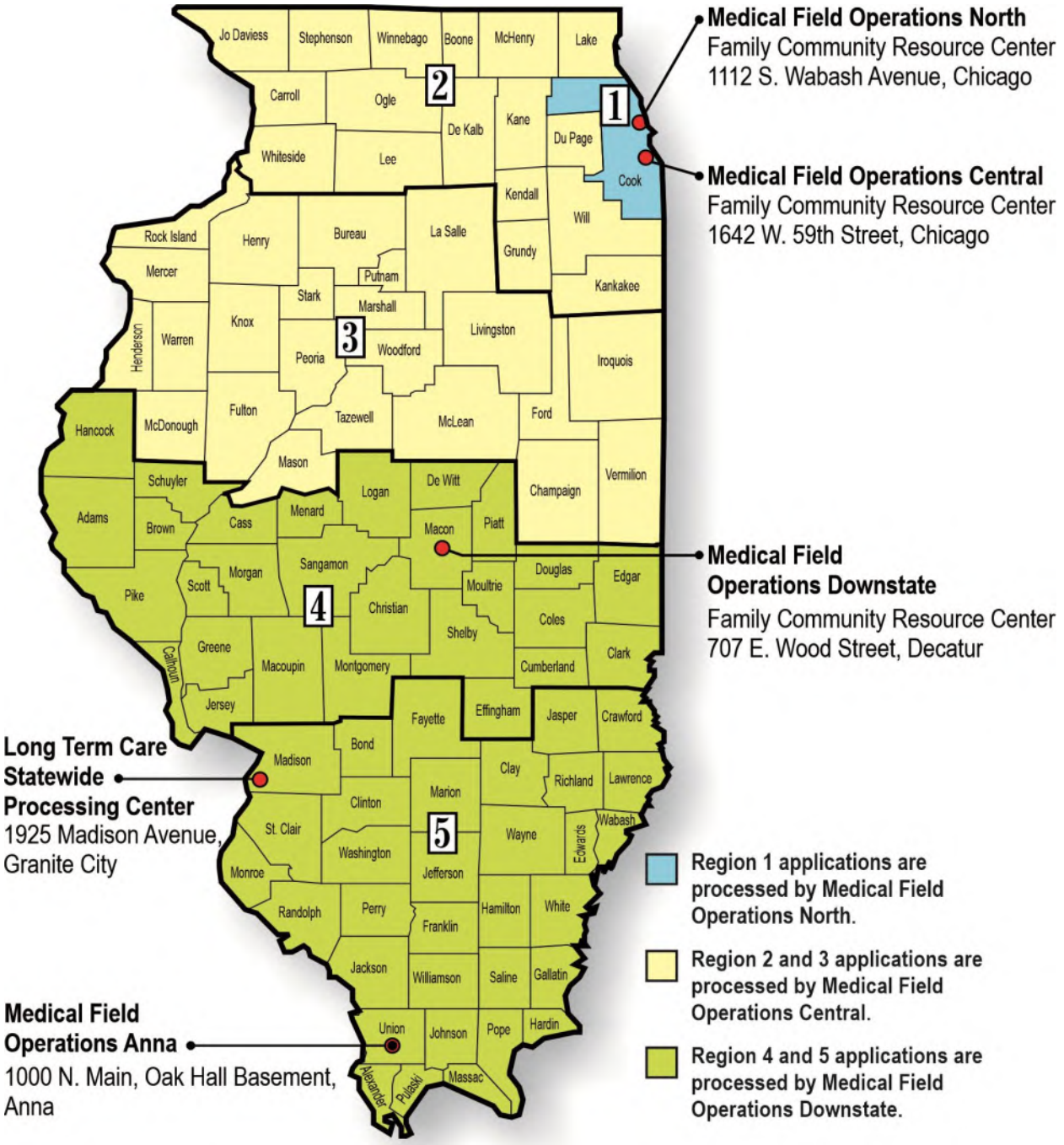
Applications submitted through the ABE online portal indicating the applicant is a resident of a nursing home or support living facility are auto directed in IES to the Medical Field Office that services the zip code entered. Once received in IES, the application is screened/registered and made available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

determinations for individuals applying on the basis of a disability, requiring these determinations to be completed within 60 days as opposed to 90 days.

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

- **Medical Field Operations North** processes LTC applications for **Region 1**.
- **Medical Field Operations Central** processes LTC applications for **Regions 2 and 3.**
- **Medical Field Operations Downstate** processes LTC applications for **Regions 4** and **5**.
- **LTC Statewide Processing Center** is designed to handle specific work assigned from the other four Medical Field Operations offices. Assignments are based on priority or urgency needs, special projects, and backlog. This center became operational in March 2020.
- **Medical Field Operations Anna** has been implemented to be a functional field office housing cases to alleviate the workload of the other three Medical Field Operations offices. This office was designed to handle cases for a specific area but has been unable to do so due to the current low head count of caseworkers. Once efficiently staffed, cases will be assigned and maintained by this office. This office was established in 2020 and became operational in January 2021.

Exhibit 3
DHS LONG-TERM CARE MEDICAL OPERATIONS OFFICES AND REGIONS
Calendar Year 2020



Note: The locations in Granite City and Anna began hiring staff in March 2020 and January 2021 respectively.

Source: OAG prepared based on DHS information.

Department on Aging

The Department on Aging's contracted entities conduct prescreening assessments to determine the need for LTC for individuals age 60 or older. Ideally, these prescreenings are conducted prior to placement in a nursing facility or supportive living program, but sometimes post-screenings must be conducted. According to DoA policy, prescreening should be viewed as an opportunity to prevent unnecessary institutionalization, all options for community-based services and supports must be explained in detail to the individual, and the individual must be afforded choice of available services.

Care Coordination Units are entities under contract with the DoA, which conduct prescreenings upon referral from hospitals, supportive living program providers, nursing facilities, or the community. Care Coordination Units serve as central access points for older adults who have intensive LTC needs. Care Coordination Units must have the capacity to complete face to face prescreenings seven days a week, at a minimum of seven business hours per day.

When a Care Coordination Unit receives a referral for a prescreening, a care coordinator from the Care Coordination Unit will conduct the eligibility determination and complete required forms. The Determination of Need (DON) is a standardized assessment to determine an individual's functional ability to perform basic and instrumental activities of daily living and identify unmet needs. Regardless of DON score, the care coordinator informs the individual of options for care. A total DON score of 29 or greater indicates a need for LTC, which meets the standard for functional eligibility for Medicaid.

DoA is responsible for completion of a component of the Preadmission Screening and Resident Reviews of LTC applicants, and if there is a suspicion of serious mental illness and/or developmental disability, refer applicants to the appropriate DHS contracted entity for further screening. These prescreenings are a federal requirement and are intended to help ensure individuals are not inappropriately placed in nursing facilities for LTC and ensure individuals are offered the most appropriate setting for their needs.

Department of Healthcare and Family Services

As the designated Medicaid single State agency, the Department of Healthcare and Family Services is responsible for the Medicaid LTC program for eligible residents in 1,088 facilities in Illinois. As of December, 2020, approximately 55,000 individuals were receiving Medicaid LTC services. HFS' mission is to ensure that LTC services are appropriate, meet the needs of recipients and standards of quality, and are in compliance with federal and State regulations.

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

HFS Office of the Inspector General

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

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

HFS Data and Systems

HFS explained the two sets of data and their associated systems: 1) admissions data from the Medicaid Management Information System (MMIS), and 2) applications data from IES. Officials noted there may be some overlap between the two sets of data. For example, the identifiers (such as name, date of birth, social security number, and provider identifier number) may be contained in both systems.

Regarding HFS OIG referral information, referrals to the OIG and corresponding decisions from the OIG are received through IES. According to HFS, in January 2019, fields were added in IES for OIG referrals. HFS officials also noted redetermination information is now available through IES, not MMIS. In addition, a new process regarding expedited cases was implemented in January 2020.

The IES data provided by HFS on December 17, 2021, included the following fields:

- applicant identifiers (first name, last name, date of birth, social security number);
- application number;
- application status;
- type of assistance;
- application date;

- decision date;
- extension information (number of extensions, number of extended days, extended due dates);
- OIG referral information (OIG referral and completion dates);
- case number/master index number;
- issue date;
- death date;
- verification checklist status, if requested;
- approved/denied/pending status; and
- office number/processing hub.

LTC Eligibility Determination Process

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

DHS Processing of LTC Applications

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

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

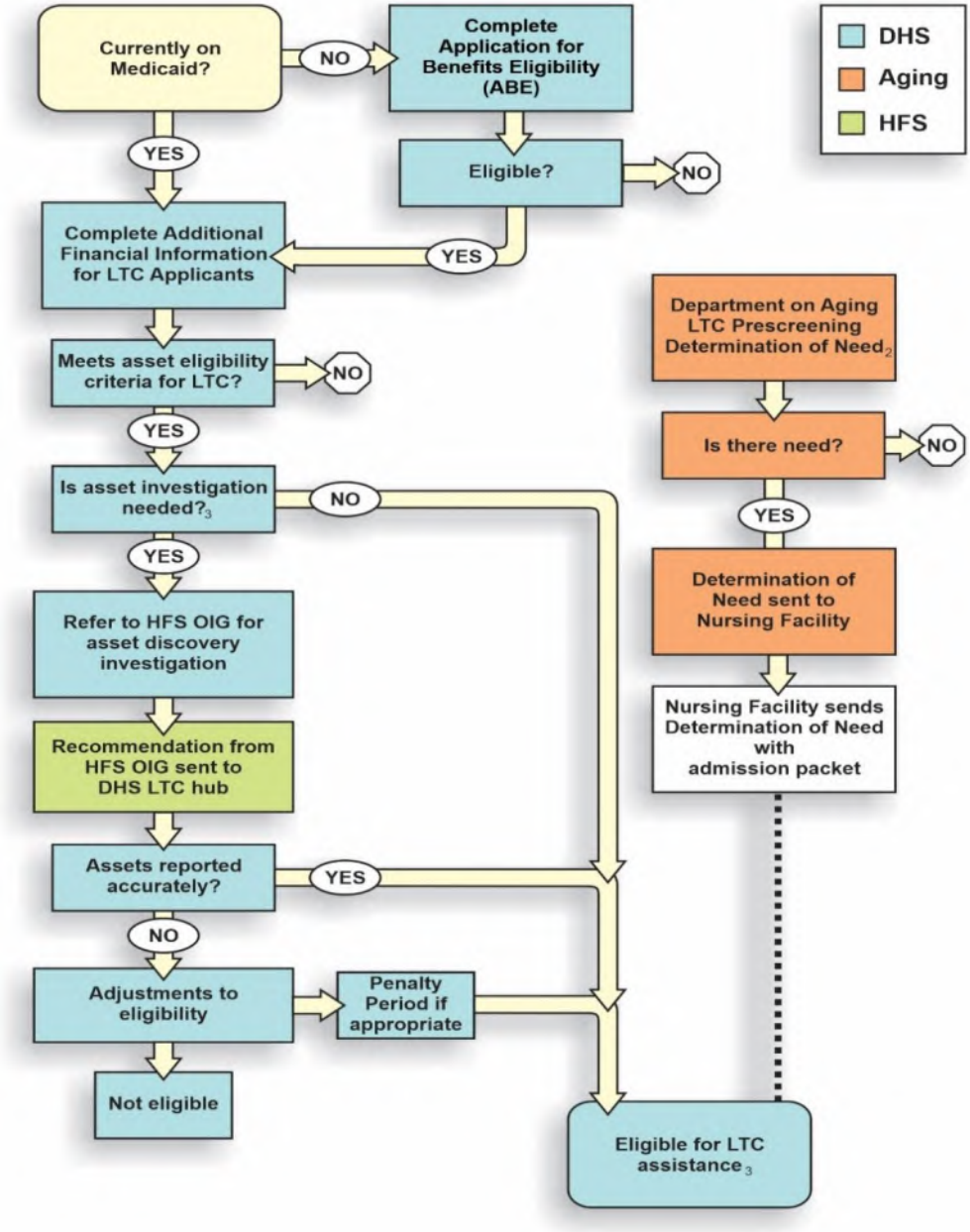
A Public Aid Eligibility Assistant initiates the application review process when an application is received. Public Aid Eligibility Assistants:

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

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

According to DHS officials, applications in these queues are assigned by a supervisor to a caseworker and worked on a first in, first out basis (meaning the oldest cases are worked first). A caseworker reviews the application to determine

Exhibit 4
LONG-TERM CARE ELIGIBILITY DETERMINATION PROCESS[1]
Calendar Year 2020



Notes:
[1] This exhibit presents the basic framework of the long-term care eligibility determination process and agency responsibilities and is not intended to cover all iterations of the process. As of 4/2/20, COVID-19 emergency rules affected the eligibility determination process by ensuring applications were reviewed quickly and certain requirements were not required to be reviewed by DHS caseworkers during this time.

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

[3] As of 1/30/20, HFS OIG referrals can occur during initial processing or after a case has been determined eligible.

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

if all necessary documentation was provided and attached to the IES case record to determine eligibility. If additional documentation is needed, a request is to be generated by IES and mailed to all applicable parties. After the request is generated, IES then routes the application from the Data Collection queue to the Ready to Certify queue. If extensions are requested, they are reviewed to either be granted or denied.

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

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

HFS OIG Asset Discovery Investigation Process

We communicated with officials from the HFS OIG's LTC Asset Discovery Investigation unit to discuss their role in the eligibility determination process. The unit receives referrals from the LTC hubs via email. After an initial prescreening, HFS OIG staff send an information request to the applicant (or an approved representative) for up to five years of financial records and legal documents, which may include bank statements, tax returns, annuity documentation, pension documents, trust documents, and information about land owned.

According to HFS OIG officials, cases will not be assigned to an analyst until all requested information has been received. If the information is not received, the case is denied. If information is received, staff enter the case in the HFS OIG tracking system, and the case is assigned to an analyst who reviews the information and makes a recommendation. After a supervisor reviews the case and recommendation, the resource directive is returned to the LTC hub. The case is then assigned to a DHS caseworker to implement the HFS OIG's resource directive. The HFS OIG follows up on the case about 60 to 90 days after the

directive is uploaded to IES to assess if the asset investigation portion of the case can be closed. According to HFS OIG officials, they choose to follow up in this time frame because clients have 60 days to appeal a decision.

During the COVID-19 Public Health Emergency and the low amount of referrals received, the OIG provided additional policy and review process training to staff. The resource test for LTC applicants was temporarily suspended due to the Public Health Emergency. A resource test is an established financial test of resources for the assessment of applicants. Accordingly, penalties and resource spenddowns were unable to be processed during the Public Health Emergency. However, the OIG continued to do the investigations on the cases referred to its office. Recommendations have been prepared and will be sent to DHS to implement at the end of the Public Health Emergency.

Department on Aging Prescreening Process

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

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

When the Care Coordination Unit has been notified of the name and location of the nursing facility or supportive living program, the appropriate forms are sent. The total DON score is included. This allows the nursing facility or supportive living program provider to enter admission information into the HFS Medical Electronic Data Interchange (MEDI) system to initiate the payment process.

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

Delegated Authority to Determine Eligibility

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

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

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

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

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

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

Although HFS develops the policies DHS uses, HFS is not directly involved in the determination of eligibility for Medicaid. DHS caseworkers review the application, request additional information from the applicant, if necessary, and determine eligibility. We followed up with both agencies regarding DHS staff completing these determinations instead of HFS, and neither agency noted any

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

Updates to LTC Policy Manual

In the prior audit, we recommended that HFS ensure policy manual guidance is updated as appropriate. HFS updated the policy manual in both areas addressed in the prior audit and this recommendation was determined to be **implemented**.

Updates to LTC Policy Manual

During the prior audit, policy manual documents were discovered that needed updates and additional clarification to avoid confusion for caseworkers. Since HFS has the responsibility to develop and update the policy related to LTC eligibility, we recommended HFS update the policy manual as appropriate. More specifically, HFS was required to make updates to the following areas in the policy manual:

- **Resource and Income Transfer Threshold** – Policy Manual 07-02-20, Workers' Action Guide 07-02-20, and any related links should be updated to reflect the resource and income transfer criteria change from $5,000 to $10,000 during the lookback period; and
- **Homestead Equity Limit** – Policy Manual 07-02-04-a should be updated to reflect the annual increase in the home equity interest limit in accordance with the Illinois Administrative Code and federal law (89 Ill. Adm. Code 120.385(c) and 42 USC 139p(f)(1)(C)).

Resource and Income Transfer Threshold

On August 10, 2016, HFS had revised the threshold for referral from $5,000 to $10,000 during the lookback period. However, during the prior audit, DHS policy manual and workers' action guide documents still provided instructions for transfers of resources and income to caseworkers reflecting the $5,000 transfer threshold. This missing update could have resulted in confusion for caseworkers as well as a waste of processing time and resources for applications unnecessarily referred to the HFS OIG.

We followed up during this audit and found the prior references in Policy Manual 07-02-20 to the $5,000 income transfer criteria during lookback had been updated to $10,000 on December 20, 2019. Therefore, the Workers' Action Guide (WAG) 07-02-20 was updated as required to include the new $10,000 total. In addition, WAG sections 07-02-20-a, b, and d were also updated in December 2019 and now link back to Policy Manual 07-02-20, which references the $10,000 total.

Home Equity Limit

When determining eligibility for Medicaid LTC services, a place of residence is exempt up to a specified dollar amount. According to the HFS Administrative Code, a person is not eligible if the equity interest in the residence exceeds the home equity allowed under federal law. Although this amount was required to be increased annually and listed as $572,000 in calendar year 2018, the relevant Policy Manual 07-02-04 was outdated and listed it as $536,000 during the prior

audit. This missing update could have resulted in confusion for caseworkers and an applicant being mistakenly found ineligible based on an incorrect amount in the policy manual.

We followed up during this audit and found the section previously listing the outdated home equity value (Policy Manual 07-02-04-a) now references WAG 25-03-02 (2). WAG 25-03-02 (2) was updated on February 22, 2018, and now contains a table listing the home equity limits for 2019-2021. Although the table did not contain the home equity limit for calendar year 2018 during the audit period, the table did contain calendar years 2019 and 2020 as well as 2021.

Status of Prior Audit Recommendation Number 1

Because HFS updated both missing updates in the policy manual, this recommendation was determined to be **implemented** during this audit period.

Timeliness of Eligibility Determinations

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

As discussed in more detail in the *Issues Affecting the Data* section, we determined calculating timeliness for the population of the applications using data provided would not provide accurate results for the purposes of this audit. As a result, we selected a sample of 50 applications for fieldwork testing. For the 50 applications tested, we found that only 15 applications (**30%**) had an eligibility determination completed within the required timelines. On average, the 50 applications were **72 days overdue**. We found cases with an OIG referral were an average of **125 days overdue** while cases without an OIG referral were **47 days overdue**. Finally, despite differences between the various reports produced by HFS, all three reports reviewed indicated applicants were not receiving their determinations of eligibility in a timely manner. Consequently, the status of the prior recommendation on the timeliness of eligibility determinations was determined to be **not implemented**.

LTC Medicaid Eligibility Determination Timeliness

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

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

Eligibility Determination Timelines

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

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

Certain extensions of the time limitations for determining eligibility are allowed. The applicant, his or her spouse, an approved representative, or the facility in which the applicant lives may request a 30-day extension to provide verification of current resources or resources transferred during the lookback period. Upon request, DHS or the HFS OIG may also allow a second 30-day extension, if needed. Additionally, prior to August 2, 2018, the effective date of Public Act 100-665, an extension of up to 90 days was also permissible when the HFS OIG

determined there was a likelihood of non-allowable transfers of assets. These extensions are authorized by the Illinois Public Aid Code (prior to Public Act 100-665, 305 ILCS 5/11-5.4(a) and 5.4(e)(8); following, 305 ILCS 5/11-5.4(a) and 5.4(e)).

In order to analyze if applicants were receiving their determinations of eligibility within the required timelines, we reviewed the following three reports: LTC monthly reports, reports prepared for the federal Centers for Medicare and Medicaid Services, and internal weekly reports. Since the source data for all three reports was IES, there were multiple issues affecting the data for these reports as discussed later in this report. However, we still wanted to review whether the reports supported if applicants were receiving their determinations of eligibility in a timely manner. Despite differences between the various reports produced by HFS, we found that all three reports indicated applicants were **not** receiving their determinations of eligibility in a timely manner.

LTC Monthly Reports

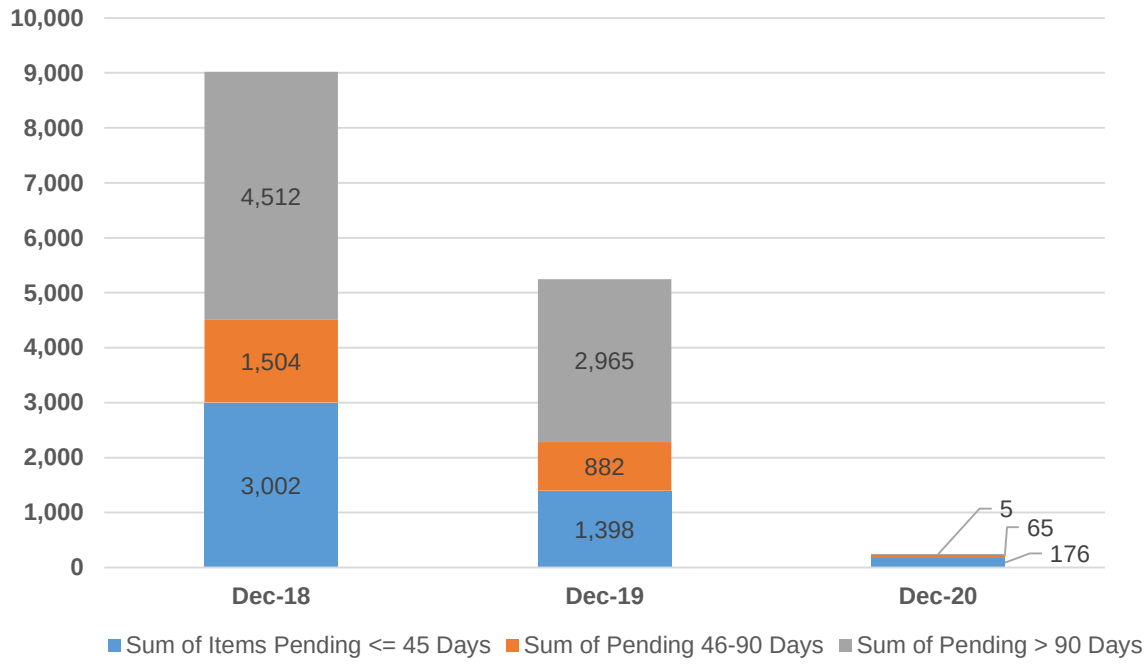
HFS' LTC monthly reports indicated that not all applicants were receiving their determinations of eligibility within the timelines established by the federal regulations and the Illinois Administrative Code (45 or 60 days on the basis of a disability). The Illinois Public Aid Code requires DHS and HFS to jointly compile data on pending applications, denials, appeals, and redeterminations into a monthly report and post that report on each Department's website for the purposes of monitoring LTC eligibility processing. We requested and received monthly reports for calendar years 2018 through 2020. The reports were reviewed to determine if all applicants were receiving their determinations of eligibility within the timelines established by federal regulations and the Illinois Administrative Code (42 CFR 435.912 and 89 Ill. Adm. Code 110.20 and 10.420) during the audit period.

Exhibit 5 summarizes HFS' reporting on LTC pending applications for 2018 through 2020.

- As of December 2018, **4,512** of **9,018** pending applications (**50%**) had been in the process for greater than 90 days. An additional 1,504 applications had been in the process for at least 46 days and up to 90 days. This means that **6,016** of the **9,018** pending applications (**67%**) were beyond the 45-day processing requirement at that point.
- As of December 2019**, 2,965** of the **5,245** pending applications (**57%**) had been in the process for greater than 90 days. An additional 882 applications had been in the process for at least 46 days and up to 90 days. This means that **3,847** of the **5,245** pending applications (**73%**) were beyond the 45-day processing requirement at that point.
- As of December 2020, **5** of the **246** pending applications (**2%**) had been in the process for greater than 90 days. An additional 65 applications had been in the process for at least 46 days and up to 90 days. This means that **70** of the

246 pending applications (**28%**) were beyond the 45-day processing requirement at that point.

Exhibit 5
LTC Pending Applications (Per LTC Monthly Reports)
End of Calendar Years 2018 through 2020 [1]



Note:
[1] Effective April 2, 2020, COVID-19 emergency rules affected pending applications by ensuring applications were reviewed quickly and certain requirements were no longer required to be reviewed by DHS caseworkers.
Source: OAG prepared based on HFS reports.

According to these monthly reports, a significant number of pending applications had been in the process for greater than 90 days as of December 2018 and 2019; however, the number of pending cases dropped drastically as of December 2020. Effective April 2, 2020, COVID-19 emergency rules affected pending applications by ensuring applications were reviewed quickly and prior requirements were no longer required to be reviewed by DHS caseworkers.

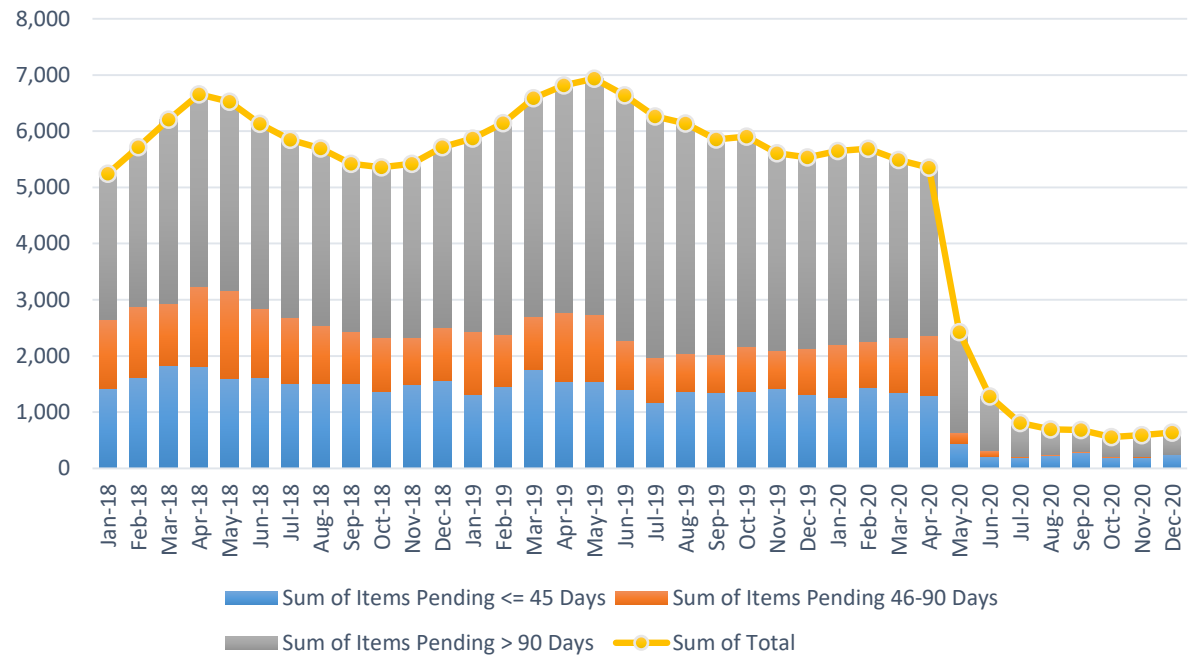
Reports Prepared for Federal Centers for Medicare and Medicaid Services

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

As shown in **Exhibit 6**, the number of pending applications remained above 5,000 until rapidly dropping during April 2020 (COVID-19 emergency rules became effective on April 2, 2020). The reports showed the following:

- As of April 1, 2020, there were 5,349 total pending applications. Of those total pending applications, 4,052 (**76%**) were pending for more than 45 days.
- As of May 1, 2020, there were a total of 2,426 total pending applications. Of those total pending applications, 1,977 (**81%**) were pending for more than 45 days.
- As of December 1, 2020, there were 634 pending applications. Of those total pending applications, 395 (**62%**) were pending for more than 45 days.

Exhibit 6
LTC Pending Applications (Per Reports for Federal Centers for Medicare and Medicaid Services)
Calendar Years 2018 through 2020



Source: OAG prepared based on HFS reports.

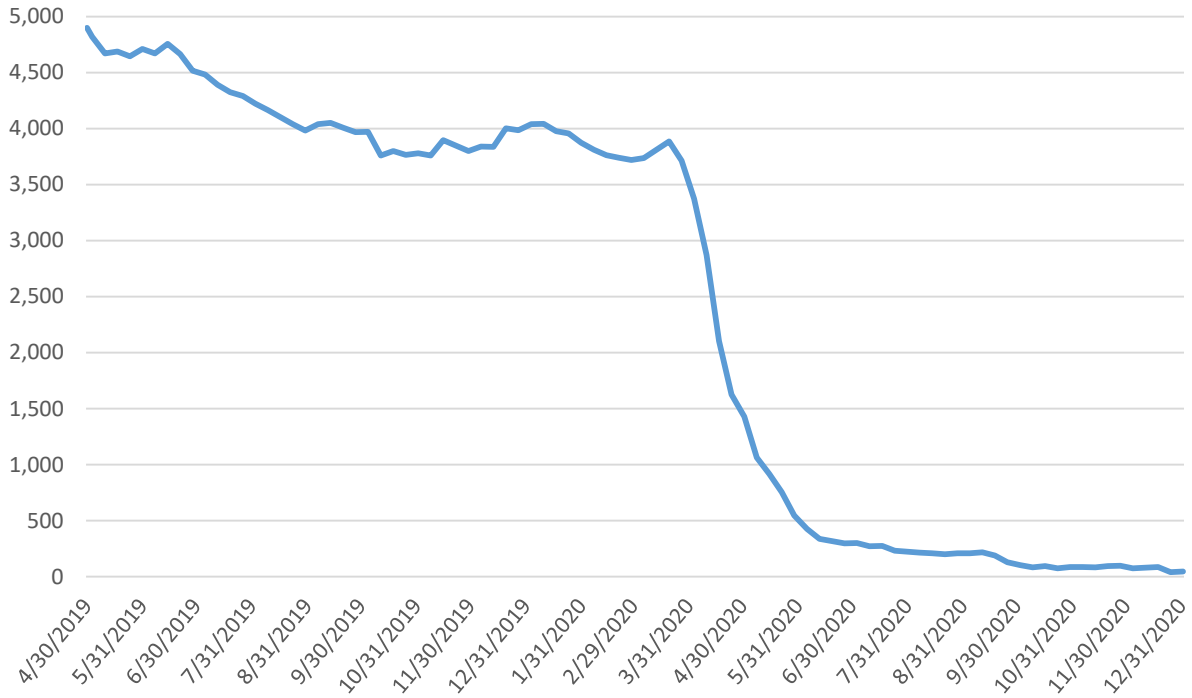
Therefore, although the total number of pending applications significantly decreased during April 2020, the percentage of pending applications over 45 days did not significantly decrease. The percentage ranged from 76 percent in April 2020 to 62 percent in December 2020.

Internal Weekly Reports

Finally, HFS' internal weekly reports also indicated that not all applicants were receiving their determinations of eligibility within the timelines established by the federal regulations and the Illinois Administrative Code. HFS created a new internal weekly report in April 2019. This internal report is used to track the volume of pending work in various categories and utilizes data from IES.

As shown in **Exhibit 7**, the number of applications pending for more than 45 days was 4,898 in April 2019 and remained above 3,500 until April 2020, when the number of pending applications started dropping. The number of applications pending for more than 45 days went from 3,373 in April 2020 to 40 as of December 2020. As discussed in the following section, the COVID-19 emergency policies impacted how applications were processed by DHS, which led to a significant decrease in applications pending for more than 45 days in April 2020.

Exhibit 7
LTC Pending Applications for More than 45 days (Per Weekly Reports)
April 2019 through December 2020



Source: OAG prepared based on HFS reports.

Changes due to the COVID-19 Public Health Emergency

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

On April 2, 2020, DHS and HFS issued a policy memo (effective immediately) stating that self-attestation would be accepted for all new and pending medical applications for certain eligibility criteria factors including income and Illinois residency. Self-attestation means a person's written, verbal, or electronic declaration of his or her income in the application is considered to be truthful and correct. Additionally, there would be no resource tests for medical applications during the time period the COVID-19 emergency rules were effective. On April 7, 2020, DHS and HFS issued a policy memo (effective immediately) stating that medical cases would no longer be closed due to failing to respond to a redetermination or due to a certification period ending.

In addition to the policy memos issued in April 2020, Public Act 101-649 (effective July 7, 2020) also amended the Illinois Public Aid Code and addressed the Public Health Emergency. Public Act 101-649 allowed the State to take necessary actions to address the emergency rules and those actions may continue for up to 12 months after the emergency rules end. Those actions included the following:

- accepting an applicant's or recipient's attestation of income, incurred medical expenses, residency, and insured status when electronic verification is not available;
- eliminating resource tests for some eligibility determinations; and
- suspending redeterminations.

Therefore, most of the previous eligibility requirements were suspended during the Public Health Emergency. According to HFS officials, the State was also unable to process any penalties or resource spenddowns during the time period the emergency rules were effective. However, the OIG continued to perform investigations on cases referred to them during the Public Health Emergency. Recommendations have been prepared for those investigations and the information will be sent to DHS for implementation at the end of the Public Health Emergency.

Exhibit 8
NUMBER OF PENDING APPLICATIONS BY OFFICE
Calendar Years 2018 through 2020 [1]

Location	As of Dec. 2018	As of Dec. 2019	As of Dec. 2020[1]
MFO **Downstate**	1,608	666	86
MFO **North**	1,780	904	19
MFO **Central**	5,630	3,664	141
DHS Offices **Other**	-	11	-
HFS OIG	565	562	307
Totals	**9,583**	**5,807**	**553**

Note:
[1] Effective April 2, 2020, COVID-19 emergency rules affected pending applications by ensuring applications were reviewed quickly and certain requirements were not required to be reviewed by DHS caseworkers.
Source: OAG prepared based on HFS reports.

Exhibit 8 provides a breakdown of the number of pending applications by Medical Field Operations (MFO) offices as of December 2018 through 2020. As can be seen in the exhibit, the number of pending applications decreased over the audit period. While most months reviewed during the audit period contained less than 2,000 applications reviewed, 4,771 applications were processed during April 2020 when the COVID-19 emergency rules became effective.

We asked HFS if there were any plans or estimated dates as to when the controls previously required for determining eligibility (resource tests, proof of income and residency, etc.) would be re-established. According to HFS, this is contingent on when the Public Health Emergency ends. Once the Public Health Emergency ends, most of the previous eligibility requirements will resume. The temporary changes due to the Public Health Emergency were applied to all pending applications including the resource reviews for backlogged cases as of March 18, 2020.

Follow up with HFS OIG

According to the HFS OIG, the OIG was in discussions with DHS regarding methods to improve the referral process prior to the Public Health Emergency. The OIG had just been given access to the IES queue to receive referrals systemically when the policy to approve cases without a resource test (due to the Public Health Emergency) was implemented.

In order for the caseworkers to be able to approve the cases, the IES referral system was bypassed and email referrals were once again used. In lieu of creating a desk aid, the decision was made to add information regarding identifying applications that meet the referral criteria to the already existing training that DHS provides to caseworkers.

Issues Affecting the Data

We reviewed data consisting of **56,864** LTC applications received in calendar years 2018 through 2020. Upon review of the data, which was pulled from IES, we determined calculating timeliness for the population of applications using the data provided would not provide accurate results for the purposes of this audit. More specifically, we found:

- **6,300 of 56,864** applications (**11%**) did not have a decision date; and
- **28,026 of 56,864** applications (**49%**) had multiple entries based on the same name, date of birth, and application date. HFS pulled the data in such a manner that if an application had multiple assistance types, the application was listed more than once in the data.

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

After reviewing the query data pull for this audit, HFS officials became aware of some issues in the system and provided the following details:

- A defect was found with the extension tracker. The extension tracker was not consistently applying the number of extensions and the allowable number of extension days provided may be incorrect. A defect was logged for this issue.
- There may be duplicate applications because of how the data was pulled. HFS pulled the information by edge level not by case level. Cases can have multiple medical edges built which is why a case number may appear multiple times.
- The extension tracker was implemented in IES production on April 15, 2019. Any allowed requested extensions entered prior to that date were entered by caseworkers.

Timeliness Testing Results

Exhibit 9
DAYS OVERDUE FOR APPLICATION TESTING
Sample of 50 Applications Tested

Days Overdue	# of Applications
0	15
1-30	5
31-45	6
46-60	0
61-90	5
91-120	8
121+	11

Source: OAG analysis of LTC applications testing.

According to the data, **18,019** LTC applications were submitted during fiscal year 2020. We selected a sample of 50 applications for testing due to the issues noted above. See **Appendix B** for additional sampling and testing information related to the audit's scope and methodology.

For the applications tested, we found that 15 applications (**30%**) had an eligibility determination within the required timelines. An additional 11 applications (**22%**) were completed within 45 days (between 4 and 45 days) beyond the required timeline. The remaining 24 applications **(48%**) were

Exhibit 10
APPLICATION PROCESSING DAYS OVERDUE
Sample of 50 Applications Tested

Applications processed by DHS only	Average days overdue
MFO Central	78
MFO Downstate	22
MFO North	49
DHS Only Application Average	47
Applications processed by DHS and OIG	**Average days overdue**
DHS and OIG	125
Overall Sample Average	72

Source: OAG analysis of LTC applications testing.

Exhibit 11
APPLICATION PROCESSING TIMELINESS
Sample of 50 Applications Tested

	Number Tested	Average days from receipt to final disposition	
		Days at DHS	Days at HFS OIG
DHS only applications	34	98	N/A
DHS & HFS OIG applications	16	86	98
Total	50	125	

Source: OAG analysis of LTC applications testing.

Exhibit 12
APPLICATION PROCESSING TIME BY HUB
Sample of 34 Non-OIG Applications Tested

Location	Number Tested	Average days from receipt to final disposition
MFO Central	10	120
MFO Downstate	13	73
MFO North	11	108
Total	34	98

Source: OAG analysis of LTC applications testing.

overdue by more than 45 days, ranging from 61 to 315 days. **Exhibit 9** provides a detailed breakdown of the days overdue for the 50 applications sampled.

Exhibit 10 provides a breakdown of the average days overdue by processing location. On average, the 50 applications were **72 days overdue**. The applications were evaluated against the State requirement of 60 days for an application on the basis of a disability and the federal/State requirement of 45 days for all other applications. For the cases without an OIG referral, the 34 applications were **47 days overdue**, on average.

Exhibit 11 presents the timeliness results of the application processing sample. For the 50 applications sampled, it took on average **125 days** from receipt of application to disposition. In addition, of the 50 applications sampled, 16 applications were referred to the HFS OIG for an asset discovery investigation. LTC Medicaid eligibility was determined solely by a DHS LTC hub (without a referral to the HFS OIG) in 34 of the applications tested. The average days to determine eligibility (from receipt to final disposition) by Medical Field Operations was **98 days**, on average. **Exhibit 12** presents the application processing sample by LTC hub.

During testing, we found cases spent extended time at OIG for an average of 98 days. For cases with an OIG referral, they were an average of 125 days overdue. In comparison, cases without an OIG referral were 47 days overdue, on average. Additionally, when a case was referred to HFS OIG, it remained at the HFS OIG for an average of **52 days** before the OIG made a decision to accept or reject the referral.

Federal regulations require Medicaid be furnished promptly to beneficiaries without any delay caused by the agency's administrative procedures. Federal regulations also require the timely determination of eligibility. If eligibility is

not determined timely, it could require LTC and other benefits to be paid for all applications pending beyond the deadlines for eligibility determinations (whether eligible or not).

Status of Prior Audit Recommendation Number 2

Although workshops were held in 2019 to help address timeliness issues, we found a significant number of applications were still pending past the required number of days during fieldwork testing. In addition, all three reports indicated applicants were not receiving their determinations of eligibility in a timely manner. Due to these testing and reporting results, this recommendation was determined to be **not implemented** during this audit period. Consequently, additional follow-up related to this recommendation should be completed again when the Public Health Emergency and related changes have ended. The changes suspended most of the previous eligibility determination requirements and were discussed in more detail in the *Changes due to the COVID-19 Public Health Emergency* section.

Eligibility Determination Timeliness

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

HFS Response:

The Department of Healthcare and Family Services accepts the recommendation. The Department will continue meetings with DHS to discuss processing timeliness and staffing.

DHS Response:

The Department accepts the recommendation. The Department of Human Services (DHS) will work cooperatively with the Department of Healthcare and Family Services (HFS) to review the process of long-term care eligibility determinations and create any needed controls necessary to comply with timeliness requirements.

Since the time period covered by the audit, long-term care application backlogs are minimal. DHS Office of Long-Term Care has increased head count in their three Medical Field Operation Offices (MFO) and continues to expand their fourth MFO. The Office of Long-Term Care has also provided extra emphasis on training in both policy and procedure skills and management review of worker resource allocation.

Applications with HFS OIG Asset Discovery Referrals

DHS and HFS noted that an IES system enhancement was established to address the processing delays related to OIG asset investigations. However, applications involving HFS OIG asset discovery investigations continued to be overdue during this audit period. The prior audit found that applications involving asset discovery investigations were an average of 114 days overdue. For this audit, we tested 16 cases referred to the HFS OIG in fiscal year 2020 to follow up on this recommendation. During this testing, we found that applications involving asset discovery referrals were an average of **125 days overdue**. In addition, multiple issues were identified for these HFS OIG cases during our review. These issues included incorrect information in IES and a lack of controls in IES. As a result, the status of the recommendation on processing delays related to HFS OIG asset discovery investigations was determined to be **partially implemented**.

HFS OIG Application Referrals

The HFS OIG reviews complex financial and legal documents as part of an asset discovery investigation; as a result, processing an application referred for an asset investigation requires additional time. Prior to August 2, 2018 (the effective date of Public Act 100-665), the Illinois Public Aid Code (305 ILCS 5/11-5.4(a)) allowed an extension of up to 90 days (i.e., a 135 day total processing time limit) when the HFS OIG determined there is a likelihood of non-allowable transfers of assets. However, the additional extensions for the HFS OIG application referrals were not applicable during the fieldwork testing for this audit because the sample was from FY19 or after the Act's effective date.

In addition, although the OIG continued to perform investigations on cases referred, recommendations prepared for these investigations were not allowed to be sent to DHS for implementation until the end of the COVID-19 Public Health Emergency. Therefore, the status of these investigations is pending and implementation is postponed at this time.

The prior audit found that applications involving asset discovery investigations were an average of 114 days overdue. According to DHS, a system enhancement was implemented on February 26, 2019, and designed to enable DHS caseworkers to notify the HFS OIG about referrals through IES. According to HFS, this allowed for better tracking of OIG referrals. This change simplified and streamlined the referral process for OIG and caseworkers. It ensured timely follow-up and allowed caseworkers to review tasks more easily. DHS further explained that this enhancement will be revisited once the Public Health Emergency waivers have been phased out.

Testing Results

As part of fieldwork, we selected 10 cases referred to the HFS OIG for asset discovery investigations during fiscal year 2020 (see **Appendix B** for additional sampling and testing information). We tested applications during fiscal year 2020 as a means to capture mainly those cases referred to the HFS OIG for asset discovery investigations after the enhancement was implemented (February 2019) but prior to the Public Health Emergency.

In addition to the 10 OIG cases sampled to follow up on the prior audit recommendation, other cases that were referred to the OIG were also in our sample. Therefore, we reviewed a total of **16 cases** referred to the OIG for investigation during fieldwork testing.

DHS worked on these applications from **0** days to **161** days before referring them to the HFS OIG. For the 16 HFS OIG applications in our sample, the average number of days from receipt of application to referral to HFS OIG was **60** days.

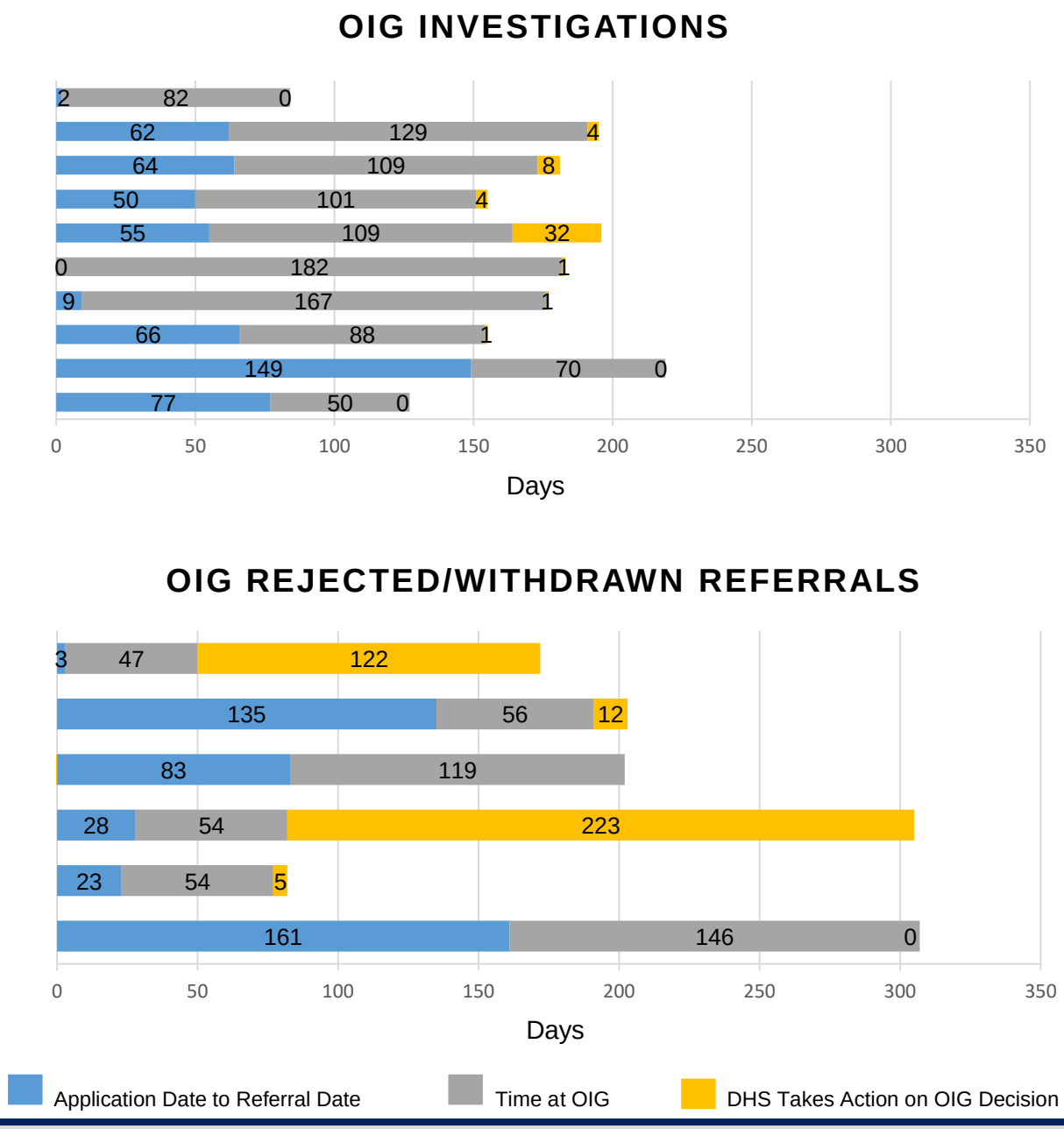
We found the 16 applications in the sample involving an asset discovery referral were **overdue by 125 days**, on average, in fiscal year 2020. However, as can be seen in **Exhibit 13**, we found that the delay was not solely due to the time the application was being worked at the HFS OIG. We found that once an investigation was concluded, or the referral was rejected/withdrawn, DHS implemented the recommendation between 0 and 223 days, with 10 of the 16 (**63%**) recommendations being implemented in 5 days or less.

We determined six cases reviewed were classified as "rejected." Of these six cases considered "rejected," three were canceled or withdrawn due to the Public Health Emergency. As a result, the status of "rejected" may be miscategorized for these cases.

In addition, multiple issues were identified for these HFS OIG cases during our review. These issues included timeliness issues, incorrect information in IES, issues related to COVID-19, and a lack of controls in IES. More specifically, we identified the following:

- All 16 of the HFS OIG cases reviewed (**100%**) were not completed in a timely manner, ranging from **37** to **260** days overdue. The time spent at the HFS OIG for these cases ranged from **47** to **182** days.
- In addition, the OIG referral date in IES was incorrect for 4 of the 16 cases (**25%**).
- For at least 5 of the 16 HFS OIG cases (**31%**), COVID-19 was referenced during the HFS OIG review – including referrals being withdrawn due to COVID-19.
- Finally, for the 15 HFS OIG cases where supporting screenshots were provided (screenshots were not provided for one case), all 15 (**100%**) indicated a lack of IES controls. More specifically, according to DHS officials, "*Note that the field for the 'Has the OIG Referral been initiated' question states 'No' – which appears to be an error on IES's part, as IES should not accept dates for referral unless the question is marked 'Yes.*'" However, these HFS OIG cases did not contain a "yes" answer for this question and yet referral dates were still allowed to be entered in IES.

Exhibit 13
OIG INVESTIGATIONS AND REJECTED REFERRALS SAMPLE TESTING RESULTS
Fiscal Year 2020



Source: OAG analysis of LTC applications testing

Testing Follow-up with the HFS OIG

We followed up with the HFS OIG regarding all of the HFS OIG cases sampled not being completed within a timely manner and/or the required 45 days. In addition, we also followed up regarding issues identified during testing related to IES for the HFS OIG cases. More specifically, we asked about the question "Has

the OIG Referral been initiated?" field in IES not being answered as "yes" or left blank but the following fields being allowed to be entered into IES. According to the HFS OIG, these issues have been raised with DHS but the issues have not been addressed. The HFS OIG elaborated about being unsure how DHS creates the tasks and what information entered triggers the task.

In addition, although the February 2019 system enhancement allowed the HFS OIG to receive notifications from DHS through IES, the documentation provided during testing also included emails for this communication. According to the HFS OIG, email notifications were requested from DHS caseworkers after referral transmission to ensure all referrals were received in a timely manner. Therefore, although referrals were provided and/or appeared as a task in IES, follow-up emails were also being sent during the COVID-19 Public Health Emergency. As a result of the Public Health Emergency, there was a procedure change to approve applications before an asset review referral. Therefore, it has been necessary to send notifications for cases for asset review via email until the Public Health Emergency ends.

Finally, for four of the HFS OIG investigation cases reviewed, we noticed that the date in IES did not always match the OIG recommendation date in the supporting documentation. These dates did not match by approximately two to seven days. According to the HFS OIG, there is often a delay between the recommendation date of the OIG's analyst and the submission date to DHS. Before the analyst's recommendation is final and sent to DHS, the recommendation is reviewed by a supervisor. This review can take a few days before the information is entered into IES. In 2020, when the HFS OIG used alternating schedules during COVID-19, the review time may have taken longer.

Status of Prior Audit Recommendation Number 3

The status of this recommendation was determined to be **partially implemented**. DHS and HFS noted that an IES system enhancement was established to address the processing delays related to OIG asset investigations. However, during the testing of FY20 cases, we found the cases with OIG investigations were still an average **of 125 days overdue**. Processing delays associated with applications referred to the HFS OIG could delay the determination of eligibility. In addition, multiple other issues were identified for these HFS OIG cases during our review. These issues included incorrect information in IES and a lack of controls in IES.

Although the OIG continued to perform investigations on the cases referred, recommendations prepared for these investigations were not to be sent to DHS for implementation until the end of the COVID-19 Public Health Emergency. Therefore, the status of these investigations is pending and implementation is postponed at this time. Several HFS OIG cases also referenced cases being withdrawn due to COVID-19 during this review. Therefore, additional follow up related to this recommendation and relevant testing should be completed again when the Public Health Emergency has ended.

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

HFS Response:

The Department of Healthcare and Family Services accepts the recommendation. OIG will continue to work in IES to ensure a proper and efficient case flow between DHS and OIG. OIG will continue to resolve any problems with the referral queue and IES and will report system problems if necessary.

DHS Response:

The Department accepts the recommendation. The Department of Human Services (DHS) will review and work cooperatively with the Department of Healthcare and Family Services (HFS) and the HFS OIG on changes to improve (i) the current referral process maintained between the Department of Healthcare and Family Services (HFS) and DHS to ensure completion of the process steps for referral and (ii) the current process for receiving and acting upon recommendations from the HFS OIG upon the HFS OIG's completion of its asset investigations.

Extension Tracking

DHS and HFS continued to not adequately track extensions in IES during this audit period. According to HFS, after the enhancement request in April 2019, IES was supposed to be able to systematically calculate the extended due date based on the verification type and display the extended details under the verification checklist due date extension history. However, for the 13 extension cases reviewed, 10 cases (**77%**) contained issues such as inaccurate IES data, a lack of extension information in IES, or more than two extensions. According to HFS, a defect was discovered during the audit that affected the accuracy of the data in IES. As a result, the status of the recommendation on extension tracking was determined to be **not implemented**.

Tracking of Extensions

During the prior audit, DHS and HFS did not adequately track extensions. DHS and HFS did not track extensions in a manner that made it easy to identify the dates of the extensions or the number of extensions granted for each case.

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

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

In addition, time limits for processing an application are required to be tolled, or paused, during the period of an applicant-requested extension, essentially subtracting time granted through these extensions from the application processing times. However, if extensions or extension dates are not easy to identify or not captured at all, then the extension processing times cannot be subtracted from the eligibility determination processing time as required.

During fieldwork, we followed up on cases with extensions, in order to follow up on the prior audit recommendation regarding extension tracking. In addition, by testing cases from fiscal year 2020, we included some cases with extensions granted after the related enhancement was implemented (April 2019) but prior to the COVID-19 Public Health Emergency to provide an update on the status of extensions granted during the audit period.

According to HFS, before the enhancement request, extensions were completed manually by the caseworker. After the enhancement request, IES systematically calculated the extended due date based on the verification type and displayed the extended details under the verification checklist due date extension history. In other words, when a user performs a verification extension, IES now systematically calculates the extended due date based on the verification type. DHS also provided IES support stating the total pending days for pending applications was supposed to be accurate as of April 8, 2019.

Testing Results

To follow up on the prior audit recommendation, we included a sample of 10 extension cases in our sample of 50 cases reviewed from IES during fieldwork. Three additional extension cases were included in the other sampled cases for **a total of 13 extension cases reviewed**. In total, 22 extensions were granted for the 13 applications reviewed.

Exhibit 14
EXTENSIONS TESTING RESULTS
Sample of Applications Tested

Category	Number
Extensions Summary	
Applications with Extensions	13
Total Number of Extensions	22
Number of Applications with Extensions not in IES	2
Incorrect Extensions	
Number of Applications Receiving More than 2 Extensions	1
Inaccurate IES Data	
Number of Applications with Inaccurate Count of Extensions in IES	8
Number of Applications with Inaccurate Length of Extended Days in IES	7

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

Source: OAG analysis of LTC applications testing.

We tested these cases to ensure only two extensions were granted for each case and that the extensions were only granted for 30 days each, as required. We also looked at the accuracy of the extension data provided by comparing the extension data from IES with the documentation and/or support provided by DHS. For the extension cases reviewed, we found ten cases (**77%**) with inaccurate IES data, a lack of extension information in IES, or cases with more than two extensions. We also found that eight cases with extensions (**62%**) were not completed in a timely manner.

Although the Statute only allows for two extensions per application and a maximum of 30 days per extension, we found exceptions to this during testing. For example, one case had extensions granted more than two times. **Exhibit 14** provides a summary of the results found during the review performed on extensions. This includes a summary of the cases with incorrect extensions and/or inaccurate IES data. The **text box** also provides the additional details regarding specific extension case examples. If caseworkers are allowed to enter a number and/or length of extensions greater than the required amount allowed, there is a lack of controls in IES.

Extension Case Examples** (with more than two extensions in IES)**:

Sample #26 - IES listed six extensions; however, according to DHS, *"This case only received 2 extensions, [sic] however, each extension had to be entered using three (entries)… to count for the 30 days."*

Sample #38 - IES listed five extensions granted while three were listed in the case notes. In addition, IES noted 50 days granted while the total extension time did not match this.

Sample #39 - IES listed one extension for 30 days and then three additional extensions for 10 days each. According to DHS, *"One extension had to be entered in IES as three 10 day extensions."*

According to HFS officials, HFS became aware that a defect was found with the extension tracker during the audit. The extension tracker was not consistently applying the number of extensions and allowable number of extension days provided may be incorrect. As a result, a defect was logged for this issue.

When extensions are not tracked adequately, it is difficult to ensure that DHS and HFS are limiting applications to two allowable extensions for 30 or 60 days.

Status of Prior Audit Recommendation Number 4

Although HFS noted that a system enhancement was implemented in IES to address this prior audit recommendation, the testing results showed the enhancement was not effective. There were still applications with more than two extensions and inaccurate data in IES.

In addition, during the audit, HFS discovered a defect that affected the accuracy of the data in IES. Therefore, the status of this recommendation was determined to be **not implemented**.

Tracking of Extensions	
RECOMMENDATION NUMBER 3	***The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should ensure extensions are tracked so processing times can be tolled, as required by the Illinois Public Aid Code, for extension days granted (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(8) & 305 ILCS 5/11-5.4(e)(9)(B); following, 305 ILCS 5/11-5.4(e) and 305 ILCS 5/11-5.4(f)(B)). Specifically, the Departments should ensure:*** • ***Extensions are captured in a usable manner;*** • ***Extensions are captured accurately; and*** • ***Only the allowable number of extensions are granted per application.***

HFS Response:

The Department of Healthcare and Family Services accepts the recommendation. OIG will continue to work in IES to ensure a proper and efficient tracking of extensions. OIG will continue to resolve any problems with the IES extension tracking and will report system problems if necessary.

DHS Response:

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

LTC Monthly Reporting

The prior audit found HFS and DHS did not post all LTC reports as required by the Illinois Public Aid Code on a monthly basis. For this audit, we requested documentation to support the posting of all monthly reports for calendar year 2020 (January to December 2020) from HFS. DHS added a link to the HFS webpage and HFS provided support for all postings of LTC monthly reports in calendar year 2020. Therefore the status of this recommendation was determined to be **implemented** during the audit period.

Public Act 100-380 requested the Auditor General to evaluate the accuracy and completeness of the monthly report required by the Illinois Public Aid Code to be posted on both the DHS and HFS websites for the purpose of monitoring LTC eligibility processing (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)). These monthly reports are to specify the number of applications and redeterminations pending LTC Medicaid eligibility determination and admission, and the number of appeals and denials in the following categories:

- Length of time applications, redeterminations, and appeals are pending: 0 to 45 days, 46 days to 90 days, 91 days to 180 days, 181 days to 12 months, over 12 months to 18 months, over 18 months to 24 months, and over 24 months.
- Percentage of applications and redeterminations pending in DHS' Family Community Resource Centers, in DHS' LTC hubs, with HFS' Office of Inspector General, and those applications which are being tolled due to requests for extension of time for additional information.
- Status of pending applications, denials, appeals, and redeterminations.

The LTC monthly reports were provided by HFS. The reports contain information on pending applications, admissions, redeterminations, and LTC appeals. Most of the tables in the report summarize pending LTC applications and admissions. According to the prior audit, the database was set up for reporting purposes so DHS and HFS could report on timeliness. Therefore, the tracking database previously facilitated HFS' ability to report on the timeliness of application data and the LTC monthly reports used numbers from this database prior to the utilization of IES. However, during this audit, the application source data for the LTC monthly reports provided was from IES.

Required Posting of LTC Monthly Report

HFS and DHS are posting the LTC reports on a monthly basis as required by the Illinois Public Aid Code. These reports are required to be posted on "each Department's website for the purposes of monitoring LTC eligibility processing" (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).

During the prior audit, HFS and DHS did not post all LTC reports as required by the Illinois Public Aid Code on a monthly basis. The prior audit found the LTC monthly reports were created by HFS and posted somewhat regularly to HFS'

website; however, these reports were not posted to DHS' website as required by the Illinois Public Aid Code.

According to DHS, in August 2019, a link was added on its website linking to the HFS webpage where the LTC monthly report is posted. We confirmed this link on the DHS website was present and the link connected to the HFS webpage, as noted by DHS. We also confirmed the link was still active.

Review of CY20 LTC Monthly Reports

We requested documentation to support the posting of all monthly reports for calendar year 2020 (January to December 2020) from HFS. HFS provided both a web request confirmation email and a website posting approval form for 10 of the 12 months requested in CY20 (**83%**). The two months missing documentation were only missing a web request confirmation email (May 2020 and July 2020).

According to HFS, the reason for the two missing documents was due to the retirement of the employee responsible for them. In addition, a website posting approval form was provided for 12 of the 12 months requested (**100%**). Therefore, we determined HFS was in compliance with the Illinois Public Aid Code's monthly report posting requirement during this review of CY20.

Status of Prior Audit Recommendation Number 5

DHS added a link to the HFS webpage and HFS provided support for all postings of LTC monthly reports in calendar year 2020. Therefore, this recommendation was determined to be **implemented** during the audit period.

LTC Monthly Report Completeness

The prior audit found the LTC monthly reports did not contain all elements as required by statute. We reviewed the LTC monthly reports for calendar years 2018 to 2020 and found HFS had added missing elements to the reports but was not providing all the information required by 305 ILCS 5/11-5.4(f). Specifically, there were some remaining elements not included in the reports including: the percent of pending and tolled due to extensions for applications and redeterminations as well as the associated percentages for the numbers of applications and redeterminations pending at the HFS OIG. As a result, the status of this recommendation on the LTC monthly report completeness was determined to be **partially implemented**.

According to the prior audit, the LTC monthly reports did not contain all elements as required by statute. We followed up with HFS and reviewed the LTC monthly reports for these elements during this audit period. According to HFS, extensions began being tracked in IES during this audit period in April 2019. During our review of the monthly reports, we found the reports did contain some additional required elements that were missing during the prior audit but other required elements were still not included.

LTC Monthly Report Requirements

The monthly reports are required to include the percentage of applications pending which are being tolled, or paused, due to requests for extension of time for additional information (305 ILCS 5/11-5.4(f)(B)). The previous audit found that the extensions information was not included in the reports because HFS reported issues with how extensions were tracked. We reviewed the 36 monthly reports for calendar years 2018 to 2020, and all **36 (100%)** did not contain information on extensions.

In addition, the monthly reports are required to include information not only on the length of time applications are pending, but also the length of time redeterminations and appeals are pending (305 ILCS 5/11-5.4(f)(A)). The previous audit found that some monthly reports did not include this information. The monthly reports are also required to include information on the status of pending applications, denials, appeals, and redeterminations (305 ILCS 5/11-5.4(f)(C)). The reports for calendar years 2018 through 2020 contained this information, with the exception of one month (September 2018).

Finally, the monthly reports are required to include the percentage of pending applications and redeterminations by location, i.e., DHS Family Community Resource Center, DHS LTC hub, or HFS OIG (305 ILCS 5/11-5.4(f)(B)). The previous audit found that the location breakdown was provided for the application data, but not for redeterminations. In March 2019 the monthly reports started to contain the location breakdown for redeterminations and the percentages for applications. However, the monthly reports only provide the **number** of redeterminations pending by location, not the **percentages** as required by statute. Also, the reports did not contain that information for part of the audit period.

Status of Prior Audit Recommendation Number 6

Although HFS was providing more information in the LTC monthly reports as required by 305 ILCS 5/11-5.4(f), there were some remaining issues with the completeness of the reports. Therefore, the status of this recommendation was determined to be **partially implemented.** If LTC monthly reports do not contain all required elements, the usefulness and transparency of the report continues to be diminished, which impacts the public's ability to monitor LTC eligibility processing.

LTC Monthly Report Completeness	
RECOMMENDATION NUMBER 4	***The Department of Healthcare and Family Services and the Department of Human Services should ensure monthly reports contain all elements required by Section 11-5.4(e)(9) of the Illinois Public Aid Code (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).***

HFS Response:

The Department of Healthcare and Family Services accepts the recommendation. Data fields that have not been captured and reported previously have been logged as change requests for IES.

DHS Response:

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

LTC Monthly Report Accuracy

During the prior audit, we found the LTC monthly reports were not accurate due to duplicate entries and other issues with the source data and a potential overstatement of the number of days applications are pending. During this audit, we reviewed the monthly reports for calendar years 2018 to 2020 and found similar issues with accuracy that were identified during the prior audit. The monthly reports potentially overstated the number of days pending for applications and the data used to create the redeterminations table contained duplicate entries. We also found 11 of 50 applicants tested (**22%**) had a reported disability which would allow 60 days for processing those applications.

We also compared the data provided by HFS to the monthly reports, internal weekly reports, and reports prepared for the federal Centers for Medicare and Medicaid Services. We were unable to determine the accuracy of the data or the various reports due to the numbers not matching between any of the reports. We also requested LTC data on the total number of redeterminations completed during the audit and found the redeterminations data in the monthly reports contained multiple issues. As a result, the status of the recommendation on the LTC monthly report accuracy was determined to be **not implemented**.

The monthly reports posted on HFS' website pursuant to statute (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)) were not accurate. We reviewed the monthly reports for calendar years 2018 to 2020 and found the same issues with accuracy that were identified during the prior audit:

- the monthly reports potentially overstated the number of days pending for applications; and
- the data used to create tables in the reports contained duplicate entries.

Potential for Overstating Number of Days Pending for Applications

The monthly reports in the prior audit overstated the number of days pending for applications. According to the Illinois Public Aid Code, **the time limits for processing an application are to be tolled during the period of any extension granted** (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(8); following, 305 ILCS 5/11-5.4(e)). HFS officials said the numbers in the monthly reports did not take into account days for which the time limits for processing applications are authorized to be tolled, or paused, due to extensions requested by applicants.

Extensions upon request by applicant:

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

Lack of Tracking Extensions and Disability Status

For this audit, we tested 50 applications and found evidence of a request for an extension by the applicant in 13 applications (**26%**). Eight of the applications had more than one extension. Therefore, we found these applications could have been tolled for between 28 and 60 days. This could change what "number of days pending" category an application is reported in and could also reduce the number of applications that are not in compliance with the processing time limits, as was also determined during the prior audit regarding extensions.

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

During fieldwork testing, DHS officials provided information from the Social Security Administration's State On-Line Query System, which allows authorized State agencies real-time online access to Social Security data. Although DHS does not track the disability status of applicants, we were able to identify this status through these records. Based on those records, 11 of 50 applicants tested (**22%**) had a reported disability. For one case in our sample, the disability status was unable to be provided because the social security number was not available.

Source Data Accuracy

We were unable to make a determination regarding the accuracy of pending LTC applications data. During the prior audit, testing identified various inaccuracies and omissions in the LTC application data provided to auditors, which was the source for 6 of 10 tables (summarizing pending items and timeliness) in the LTC monthly reports. The data from the LTC application tracking database contained various inaccuracies and missing dates, which impacted the accuracy of the LTC monthly report during the prior audit.

The accuracy of the LTC monthly reports was a previously reliant on the data in the tracking database, and the data in the tracking database was reliant on the caseworker accurately entering the data and identifying and removing duplicates. As of October 2018, the agencies noted that IES was used as the source of the LTC application data in the LTC monthly reports during this audit period. We requested LTC applications data for calendar years 2018 through 2020. Although both the data provided and monthly reports were from IES, we could not confirm the accuracy of the various reports during this audit. As discussed in more detail in the *Issues Affecting the Data* section of the audit, the data provided had multiple issues including applications with no decision dates and applications with multiple entries.

Testing Related to Source Data Accuracy

We compared the data provided by HFS to the monthly reports, internal weekly reports, and reports prepared for the federal Centers for Medicare and Medicaid Services. We were unable to determine the accuracy of the data for the various reports due to the numbers not matching between any of the reports.

Exhibit 15
APPLICATIONS APPROVED BY MONTH COMPARISON
Calendar Year 2020

Month	LTC Monthly Report	Report Prepared for federal CMS	Applications Data	Applications Data Unique Numbers Count
January 2020	362	723	533	363
February 2020	520	895	716	514
March 2020	512	932	709	493
April 2020	3,098	3,966	3,697	3,045
May 2020	1,601	2,176	1,845	1,550
June 2020	1,002	1,420	1,200	994
July 2020	896	1,206	1,069	861
August 2020	745	967	884	718
September 2020	828	1,004	1,030	803
October 2020	790	953	965	768
November 2020	650	762	766	626
December 2020	770	896	940	764

Source: OAG analysis of IES data and HFS reports.

As shown in **Exhibit 15**, the number of applications approved by month varied based on the report or the data provided by HFS. For example, in April 2020 the number of applications approved had a low of 3,045 and a high of 3,966. None of the reports or data matched for any of the months reviewed.

We also attempted to compare the number of pending applications in the monthly reports to the internal weekly reports. As with the number of applications approved by month, the numbers did not match between reports and the data provided. As shown in **Exhibit 16**, for the four dates where a comparison was able to be completed between the monthly and weekly reports, none of the report numbers match the applications data provided by HFS.

Exhibit 16
APPLICATIONS PENDING COMPARISON
Four Comparable Dates in 2019 and 2020

As of Date	LTC Monthly Report	Internal Weekly Report	Applications Data	Applications Data Unique Identification Count
April 30, 2019	6,260	6,333	9,543	6,285
May 31, 2019	5,944	6,065	9,325	6,110
January 31, 2020	5,307	5,288	8,551	5,798
July 31, 2020	491	491	1,421	908

Source: OAG analysis of IES data and HFS reports.

Because the numbers presented in the LTC monthly report did not match the other two reports or the LTC applications data provided by HFS, we were unable to confirm the accuracy of the applications tables in the LTC monthly reports.

Redeterminations Data

We requested LTC data on the total number of redeterminations completed for calendar years 2018 through 2020 at the beginning of the audit. According to HFS, the following redeterminations were completed during the audit period:

- **59,070** redeterminations were completed during CY18.
- **49,303** redeterminations were completed during CY19.
- **38,160** redeterminations were completed during CY20.

In addition, one table in the LTC monthly reports summarizes the timeliness of pending redeterminations. According to the monthly reports provided on the number of pending redeterminations at the end of each calendar year, there were **22,646** in **2018**, **23,400** in **2019**, and **2,192** in **2020**.

Therefore, the number of redeterminations completed decreased by **35 percent** from CY18 to CY20. In addition, the number of pending redeterminations decreased by **90 percent** from CY18 to CY20. However, redeterminations were affected by the COVID-19 emergency rules, which became effective April 2020. Additionally, Public Act 101-649 allowed the State to take necessary actions to address the COVID-19 Public Health Emergency and those actions included suspending redeterminations.

Redeterminations Data in LTC Monthly Reports

The redeterminations data in the LTC monthly reports contained multiple issues. **Exhibit 17** summarizes the issues with the redeterminations data. HFS provided the monthly data used to create the redeterminations table in the monthly reports

for 35 of the 36 reports during calendar years 2018 through 2020. HFS officials could not find the data for September 2018, so that month was not provided.

Exhibit 17
REDETERMINATIONS DATA SUMMARY (% With Issues)
Calendar Years 2018 through 2020

Issue	2018 [1]	2019	2020	Total
Future Pending Dates in Report Table	11 of 11 (100%)	1 of 12 (8%)	0 of 12 (0%)	12 of 35 (34%)
Category Breakdown Did Not Match	10 of 11 (91%)	0 of 12 (0%)	0 of 12 (0%)	10 of 35 (29%)
Overall Numbers Did Not Match	1 of 11 (9%)	1 of 12 (8%)	4 of 12 (33%)	6 of 35 (17%)
Case Numbers and Individuals with Multiple Entries[1]	10 of 10 (100%)	12 of 12 (100%)	12 of 12 (100%)	34 of 34 (100%)

Note: [1] The January 2018 data was not presented in the same format as the other months and a determination could not be made on any multiple case numbers or individuals. In addition, the September 2018 data was not provided by HFS.

Source: OAG analysis of HFS reports and supporting data.

We reviewed the data and found case numbers and individual IDs with multiple entries. The January 2018 data was not presented in the same format as the other months and a determination could not be made on any multiple case numbers or individuals. In addition, the September 2018 data was not provided by HFS.

Therefore, for the 34 months reviewed, all **34** (**100%)** contained case numbers and individuals with multiple entries. According to HFS officials, this may be due to two possible reasons. An individual may be receiving more than one type of medical assistance, and each medical assistance type may be listed separately. Also, spouses have the same case number and are in the data because a spouse is on one case and not requesting coverage but then the spouse has his/her own case where coverage is being received. These issues can lead to the number of reported pending redeterminations being higher than what is actually the case.

There were also **6 of 35** months (**17%**) where the total of pending redeterminations in the monthly reports did not match the total in the provided data. According to HFS officials, there was an issue with how the formula was counting the redeterminations on the linked spreadsheet that has since been resolved. Additionally, there were **10 of 35** months (**29%**) where even though the overall numbers matched, the categories did not match between the report and the provided data.

We found that the reports for **12 of 35** months (**34%** - all 11 months in 2018 and January 2019) contained redeterminations that should not have been included. These redeterminations had due dates after the end of the month and therefore

were not pending. This led to the number of redeterminations being overstated in the monthly reports.

Status of Prior Audit Recommendation Number 7

We reviewed the LTC application data in the LTC monthly reports and attempted to ensure the data matched the data in IES as indicated by the agencies. However, we could not determine the accuracy of the LTC monthly reports due to the numbers not matching between any of the reports. In addition, we reviewed the redetermination data and attempted to compare it to the redetermination data in the LTC monthly reports but identified multiple issues. The review found inaccuracies in the redetermination data used to create the LTC monthly reports and the monthly reports did not match the provided redetermination data. Therefore, the status of this recommendation was determined to be **not implemented**.

If LTC monthly reports are not accurate, the usefulness and transparency of the report is diminished, which impacts the public's ability to monitor long-term care eligibility processing.

LTC Monthly Report Accuracy	
RECOMMENDATION NUMBER 5	***The Department of Healthcare and Family Services and the Department of Human Services should develop controls to ensure monthly reports required by Section 11-5.4(e)(9) of the Illinois Public Aid Code are accurate (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).***

HFS Response:

The Department of Healthcare and Family Services accepts the recommendation. The Department started using the Integrated Eligibility System as the source for LTC application data in October 2018 to provide accurate application data on the LTC monthly report.

DHS Response:

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

Consistency in LTC Pending Application Reporting

During the prior audit, we found the LTC monthly reports were not consistent with another related report created by HFS. To follow up on the status of this recommendation, we requested HFS provide LTC monthly reports and updated federal reporting data. During the previous audit, the LTC monthly reports used numbers from the LTC tracking database while the federal reporting data used application numbers from IES. During this audit period, both reports contained source data from IES. However, due to changes with the updated federal reporting data, the reports were no longer comparable. In addition, according to HFS, the updated federal reporting data was used for internal purposes only during the remainder of this audit period. During the previous audit, there was a meeting in which staff met with federal partners during bi-weekly check-in calls. However, HFS has not been sharing this data with the federal Centers for Medicare and Medicaid Services during the remainder of this audit period. As a result, the status of this prior audit recommendation was determined to be **not repeated**.

During the prior audit, discrepancies were identified in the LTC pending application numbers reported by HFS. More specifically, the reports used for the check-in calls for the federal Centers for Medicare and Medicaid Services usually reported a lower number of LTC applications pending greater than 45 days than HFS' LTC monthly reports. The two reports differed because the reports prepared for the check-in calls used application numbers from the Integrated Eligibility System (IES) while the reports posted to the HFS website used numbers from the LTC application tracking database. The reports also differed because all data in IES was not entered into the tracking database. The prior audit recommended *"The Department of Healthcare and Family Services should ensure LTC pending application reporting is consistent among the reports required by the Public Aid Code and reports submitted to the federal government (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f))."* To follow up on the status of this recommendation, we requested HFS provide LTC monthly reports and updated federal reporting data. We attempted to compare the data for these reports since the source for both reports was noted as IES.

Updated Federal Reporting Data

According to HFS officials, in October 2018, HFS started using IES as the source for both the LTC application data reported to the federal Centers for Medicare and Medicaid Services during bi-weekly check-in calls and the LTC monthly reports posted to the HFS website. HFS confirmed that this change should have affected the previous discrepancies between the two reports being pulled from two different sources. In addition, HFS worked with the IES system vendor for additional updates regarding the reporting of this data used for federal check-in calls in 2019. HFS stated that these updates were utilized during their bi-weekly calls with the federal government until the COVID-19 Public Health Emergency began. During the Public Health Emergency, the federal Centers for Medicare and Medicaid Services cancelled all bi-weekly calls so no data was shared with the federal government for the remainder of the audit period.

Since both reports were pulled from IES source data, we attempted to compare them. Unfortunately, although both LTC monthly reports and updated federal reporting data were pulled from IES, the two reports could not be compared. More specifically, the data prepared for the federal Centers for Medicare and Medicaid Services was pulled as of the first of the month, while the data in the LTC monthly reports was pending as of the end of the month. As a result, the information in the reports could not be compared during this review. In addition, according to HFS, the federal reporting data was not being relayed to the federal Centers for Medicare and Medicaid Services for the remainder of the audit period.

Conclusion

HFS made improvements in the reporting of LTC applications data during this audit period. During the previous audit, the LTC monthly reports used numbers from the LTC tracking database while the federal reporting data used application numbers from IES. During this audit period, both reports contained source data from IES. Unfortunately, the data was unable to be fully confirmed between the reports due to reporting timing issues.

Status of Prior Audit Recommendation Number 8

The follow-up completed during this audit was unable to determine if controls had been developed to ensure reports were accurate due to the reports no longer being comparable. In addition, these reports were not required and were used for internal purposes only during the remainder of the audit because HFS was not sharing this data with the federal Centers for Medicare and Medicaid Services as was done during the prior audit. Therefore, the status of this recommendation was determined to be **not repeated**.

Application Processing Approaches

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

Application Processing Approaches

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

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

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

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

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

Decision to Switch Approaches

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

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

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

According to DHS officials, DHS made the decision to transition to a new facility-based approach in 2019 since the task-based approach was not working well. The facility-based approach is where a small team of caseworkers is assigned to a specific group of nursing homes. The team is responsible for processing all applications and ongoing case maintenance from those nursing homes. Since the volume of work is broken down by teams, there is less repetition related to assigning and tracking tasks. According to DHS, this also gives nursing homes a single point of contact for applications, ongoing case maintenance, and questions.

We were asked to evaluate the efficiency and efficacy of the task-based approach used for making eligibility determinations, including the role of IES, as opposed to the caseworker-based approach. However, the process to switch to the facility-based approach started during the audit period with the leadership discussions in July 2019 and the actual planning in August 2019. According to DHS, the transition was gradually completed between the various offices starting in February 2021 and ending with the MFO offices (excluding the MFO Anna) operating from a facility based approach by October 2021. Therefore, although the decision to switch to the facility-based approach was made during the audit period, the actual switch to this approach was not completed until after the audit period.

Comparison of Approaches

We did not fully assess the efficacy and efficiency of the facility-based approach since the process was implemented after the audit period. However, the pros and cons of the different processing approaches were reviewed with DHS. (See **Exhibit 19** for a list of the pros and cons for the different processing approaches.)

According to DHS, there were significantly more pros and less cons for the facility-based approach when compared to the other two approaches. The decision to switch to the facility-based approach appeared to be based upon reasonable assumptions. However, additional follow up will need to be conducted on this decision to switch approaches during the next audit period when the facility-based approach was fully implemented. In addition, the agencies need to address the issue of IES not fully supporting the facility-based model before the required review of this during the next audit period.

Exhibit 18
APPLICATIONS PROCESSING APPROACHES

	Caseworker-Based	Task-Based	Facility-Based
PROS	• Caseworker is the point of contact • Customer service friendly	• Assignments can be made based on caseworker strengths • Allows flexibility for assigning and completing assignments • Totally supported by IES • All work can be addressed when staff are absent	• Supervisor is the point of contact • Uses the best of caseworker-based and task-based processes • Units of staff are responsible for smaller groups of nursing homes • Allows for efficient customer service and for assignments to be easily tracked • Calls, inquiries, and emails are directed to the supervisor of the unit. • Allows flexibility for assigning and completing assignments • Works the case holistically • Nursing homes become familiar with team manager and staff • All work can be addressed when staff are absent • Mangers/caseworkers are involved with all aspects of the work and maintain their skills
CONS	• Several caseworkers are assigned to one nursing home • Not supported by IES	• Staff only work the task-assigned, they do not work holistically • Specific staff are not assigned to specific nursing homes • Not customer friendly, the client works with “whoever answers the phone” • Each time a case is touched by a new worker, they must re-familiarize themselves and/or become acquainted with the case	• IES does not fully support this hybrid model

Source: Illinois Department of Human Services.

Appendix A
Audit Authority

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

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

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

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

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

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

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

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

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

(Source: P.A. 100-380, eff. 8-25-17; 100-665, eff. 8-2-18; 101-101, eff. 1-1-20.)

(Effective Date: 8/25/2017)

Appendix B
Audit Scope and Methodology

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

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

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

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

We reviewed the previous financial audits and compliance examinations of HFS and DHS as well as the 2019 Performance Audit of Medicaid Eligibility Determinations for Long-Term Care. As part of this audit, we followed up on the status of the recommendations from the 2019 audit and the results are discussed in the body of the report. We also reviewed the FY18 through FY20 compliance examinations for DoA but none of the findings pertained to LTC Medicaid eligibility.

During the audit, we conducted teleconferences and phone interviews with officials from the three agencies. We also met with HFS officials to discuss the computer systems utilized for processing LTC applications and obtaining data downloads from HFS. In addition, we met with HFS to discuss legal litigation, flowchart updates, and COVID-19 rules. We met with DHS to clarify the information requested for fieldwork testing and continued to communicate with DHS throughout fieldwork testing. We also followed up with HFS in more detail regarding testing related to the HFS OIG cases and shared all final testing exceptions with DHS.

The requests for data from HFS had to be extended multiple times. Although the data was requested in the initial document request list, we did not obtain this data until over two months later. In addition, the requests for basic redetermination data from HFS had to be extended multiple times. We experienced other delays with obtaining responses from HFS and had to request additional documentation needed during testing while also identifying significant problems and missing information during testing. This follow up required additional time to work with the agencies and complete our review.

Testing and Sampling

We obtained a download of all Medicaid LTC applications for calendar years 2018-2020. We conducted a data validity and reliability review of the data and concluded that calculating the timeliness of eligibility determinations for the entire population would not provide accurate results for the purposes of this audit. More specifically, for this data pulled from the State's Integrated Eligibility System (IES), we found:

- **6,300 of 56,864** applications (**11.1%**) did not have a decision date; and
- **28,026 of 56,864** applications (**49.3%**) had multiple entries based on the same name, date of birth, and application date. HFS pulled the data in such a manner that if an application had multiple assistance types, the application was listed more than once in the data.

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

We selected a sample of 50 applications that were submitted during fiscal year 2020 (July 1, 2019 through June 30, 2020). Fiscal Year 2020 was selected because it started after changes were implemented for IES extensions and HFS OIG investigations but it also included applications prior to the start of the COVID-19 Public Health Emergency.

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

- We selected 10 cases referred to the HFS OIG for asset discovery investigations during fiscal year 2020. In addition, six other cases referred to the OIG were included in our sample for a total of 16 HFS OIG cases reviewed.
- We also selected 10 extension cases in our sample of cases reviewed during fiscal year 2020. Three additional extension cases were included in our sample for a total of 13 extension cases reviewed.

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

Exit Conferences

HFS, DHS, and DoA were provided with the confidential draft report and/or relevant sections of the confidential draft report. Exit conferences were held with DHS and HFS. DoA waived an exit conference in a correspondence from Michael Sartorius, Chief Internal Auditor, on August 5, 2022. The dates of the exit conferences, along with the principal attendees are noted below:

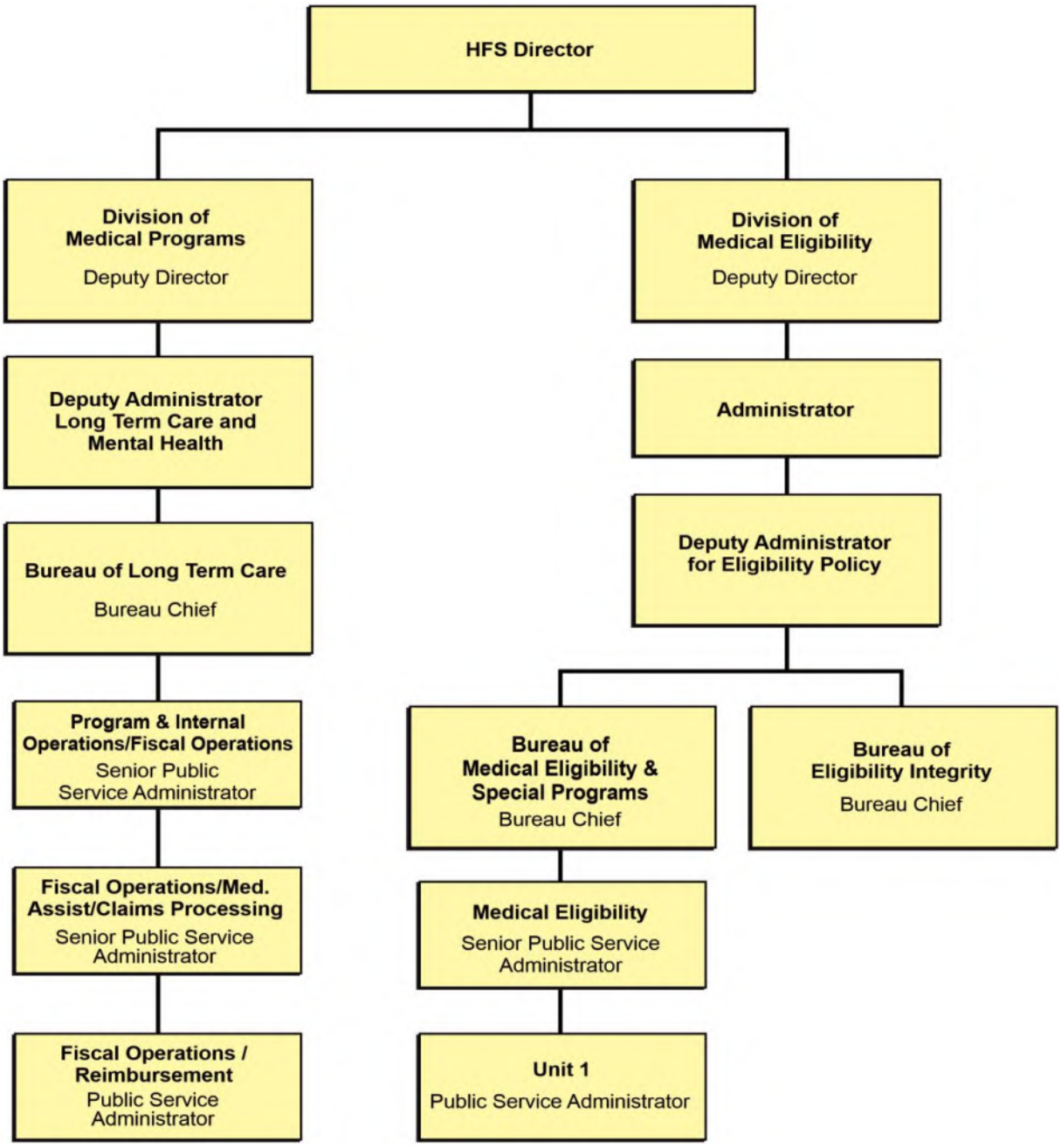
Exit Conference	**August 8, 2022**
Agency	**Name and Title**
Illinois Department of Human Services	• Ryan Croke, DHS Chief of Staff • Barrett Sheeley, Social Services Program Planner • Sharon Canty, Bureau Chief/Associate Director of the Office of LTC • Elizabeth Lusk, Social Services Program Planner • Jami Severino, Performance Management Bureau Chief • Tim Verry, Director of Family and Community Services • Amy Macklin, Chief Internal Auditor • Albert Okwuegbunam, Audit Liaison • Christopher Finley, Audit Liaison
Illinois Office of the Auditor General	• Sarah Cors, Senior Audit Manager • Paul Skonberg, Audit Supervisor • Abby Bailey, Audit Staff • James Kanter, Audit Staff

Exit Conference	**August 10, 2022**
Agency	**Name and Title**
Illinois Department of Healthcare and Family Services	• Tracy Keen, Acting Administrator for Division of Eligibility • Jamie Rutledge, LTC Medicaid Policy Writer • Elizabeth Lithila, Program Monitoring Manager, Bureau of LTC

	• Kathy Butcher, Manager of LTC Asset Discovery Investigations, OIG • Lisa Castillo, Bureau Chief, Bureau of Medicaid Integrity, OIG • Phronsie Spaulding, Assistant Bureau Chief, Bureau of Medicaid Integrity, OIG • Jamie Nardulli, Chief Internal Auditor • Amy Lyons, Audit Liaison
Illinois Office of the Auditor General	• Sarah Cors, Senior Audit Manager • Paul Skonberg, Audit Supervisor • Abby Bailey, Audit Staff • James Kanter, Audit Staff

Appendix C
HFS, DHS, and DoA Organizational Charts (as of 1/2022)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES ORGANIZATIONAL CHART [1]

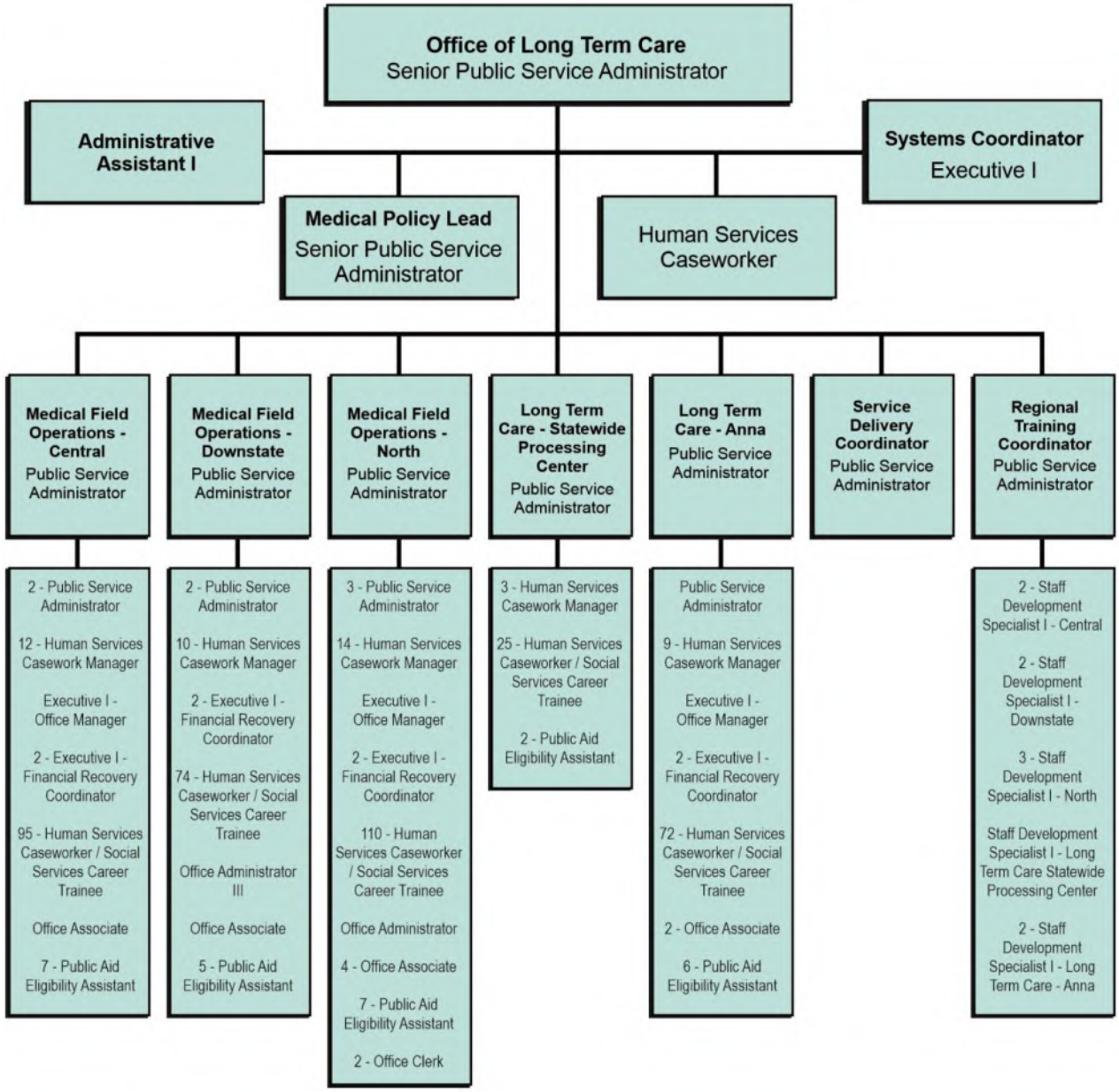


Note:
[1] The HFS Division of Medical Eligibility was created in March 2021 and the related bureaus were moved from the Division of Medical Programs to the Division of Medical Eligibility at that time.

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

Appendix C
HFS, DHS, and DoA Organizational Charts (as of 1/2022)

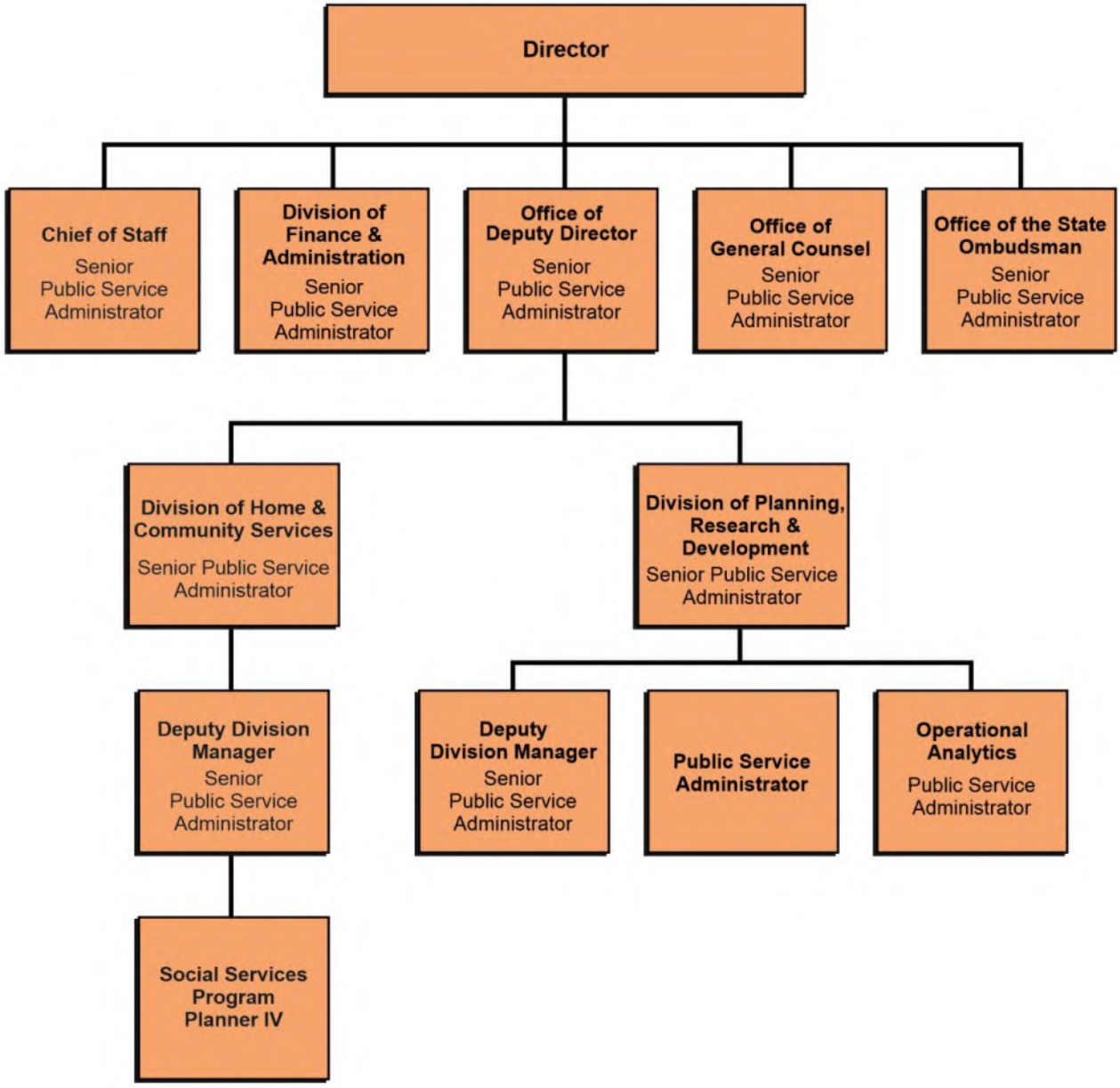
DEPARTMENT OF HUMAN SERVICES ORGANIZATIONAL CHART



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

Appendix C
HFS, DHS, and DoA Organizational Charts (as of 1/2022)

DEPARTMENT ON AGING ORGANIZATIONAL CHART



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

Appendix D
Agency Responses

ILLINOIS DEPARTMENT OF Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

August 18, 2022

Honorable Frank J. Mautino
Auditor General
740 East Ash
Springfield, IL 62703

Dear Auditor General Mautino:

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

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

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

Sincerely,

SIGNED ORIGINAL ON FILE

Theresa Eagleson
Director

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

Attachment Responses
Report: Medicaid Eligibility Determinations for Long-Term Care

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

Department Response: The Department of Healthcare and FamilyServices accepts the recommendation. The Department will continue meetings with DHS to discuss processing timeliness and staffing.

Recommendation Number 2: HFS OIG Application Referrals
The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should, in order to decrease the opportunity for application processing delays, work together to implement changes to improve the process of:

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

Department Response: The Department of Healthcare and Family Services accepts the recommendation. OIG will continue to work in IES to ensure a proper and efficient case flow between DHS and OIG. OIG will continue to resolve any problems with the referral queue and IES and will report system problems if necessary.

Recommendation Number 3: Tracking of Extensions
The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should ensure extensions are tracked so processing times can be tolled, as required by the Illinois Public Aid Code, for extension days granted (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(8) & 305 ILCS 5/11-5.4(e)(9)(B); following, 305 ILCS 5/11-5.4(e) and 305 ILCS 5/11-5.4(f)(B)). Specifically, the Departments should ensure:

- Extensions are captured in a usable manner.
- Extensions are captured accurately; and
- Only the allowable number of extensions are granted per application.

Department Response: The Department of Healthcare and Family Services accepts the recommendation. OIG will continue to work in IES to ensure a proper and efficient tracking of extensions OIG will continue to resolve any problems with the IES extension tracking and will report system problems if necessary.

Recommendation Number 4: LTC Monthly Report Completeness

The Department of Healthcare and Family Services and the Department of Human Services should ensure monthly reports contain all elements required by Section 11-5.4(e)(9) of the Illinois Public Aid Code (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).

Department Response: The Department of Healthcare and Family Services accepts the recommendation. Data fields that have not been captured and reported previously have been logged as change requests for IES.

Recommendation Number 5: LTC Monthly Report Accuracy

The Department of Healthcare and Family Services and the Department of Human Services should develop controls to ensure monthly reports required by Section 11-5.4(e)(9) of the Illinois Public Aid Code are accurate (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f))

Department Response: The Department of Healthcare and Family Services accepts the recommendation. The Department started using the Integrated Eligibility System as the source for LTC application data in October 2018 to provide accurate application data on the LTC monthly report.

JB Pritzker, *Governor*

Illinois Department of Human Services

Grace B. Hou, *Secretary*

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

August 16, 2022

Sarah Cors
Senior Audit Manager
Office of the Auditor General
Iles Park Plaza
740 East Ash
Springfield, IL 62703-3154

RE: DHS AUDIT RESPONSE - CY18-20 OAG LTC PERFORMANCE AUDIT

Dear Ms. Cors:

Attached is the Agency's response to CY18-20 OAG Long Term Care Performance audit.

If you require any additional information or have questions, please contact Amy Macklin, Chief Internal Auditor at (217) 720-9370.

Sincerely,

SIGNED ORIGINAL ON FILE

Amy Macklin, CPA
Chief Internal Auditor

Attachment: DHS AUDIT RESPONSE

cc: Grace B. Hou, Secretary
Tim Verry, Director, Division of Family and Community Services
Albert Okwuegbunam, DHS Internal Audit
Christopher Finley, DHS Internal Audit
Lisa McKinnie, DHS Internal Audit

AUDIT RESPONSE - CY18-20 OAG LTC PERFORMANCE AUDIT
Illinois Department of Human Services

Recommendation #1: Eligibility Determination Timeliness

Finding Synopsis:
DHS was not making LTC eligibility determinations in a timely manner as required by federal regulations and the Illinois Administrative Code.

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

DHS RESPONSE:

The Department accepts the recommendation. The Department of Human Services (DHS) will work cooperatively with the Department of Healthcare and Family Services (HFS) to review the process of long-term care eligibility determinations and create any needed controls necessary to comply with timeliness requirements.

Since the time period covered by the audit, long-term care application backlogs are minimal. DHS Office of Long-Term Care has increased head count in their three Medical Field Operation Offices (MFO) and continues to expand their fourth MFO. The Office of Long-Term Care has also provided extra emphasis on training in both policy and procedure skills and management review of worker resource allocation.

Recommendation #2: HFS OIG Application Referrals

Finding Synopsis:
During fiscal year 2020, we found that applications involving asset discovery referrals were an average of **125 days overdue**. While the agencies had noted the ability for DHS caseworkers to notify HFS about OIG referrals through IES, we found these notifications were not being provided through IES and the IES referral data was inaccurate during fieldwork testing.

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

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

DHS RESPONSE:

The Department accepts the recommendation. The Department of Human Services (DHS) will review and work cooperatively with the Department of Healthcare and Family Services (HFS) and the HFS OIG on changes to improve (i) the current referral process maintained between the Department of Healthcare and Family Services (HFS) and DHS to ensure completion of the process steps for referral and (ii) the current process for receiving and acting upon recommendations from the HFS OIG upon the HFS OIG's completion of its asset investigations.

Recommendation #3: Tracking of Extensions

Finding Synopsis:
DHS and HFS did not adequately track extensions. DHS and HFS did not track extensions in a manner that made it easy to identify the dates of the extensions or the number of extensions granted for each case. The extension tracker was not consistently applying the number of extensions and allowable number of extension days provided may be incorrect.

Recommendation:
The Department of Healthcare and Family Services, including the Office of the Inspector General, and the Department of Human Services should ensure extensions are tracked so processing times can be tolled, as required by the Illinois Public Aid Code, for extension days granted (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(8) & 305 ILCS 5/115.4(e)(9)(B); following, 305 ILCS 5/11-5.4(e) and 305 ILCS 5/11-5.4(f)(B)). Specifically, the Departments should ensure:

- Extensions are captured in a usable manner;
- Extensions are captured accurately; and
- Only the allowable number of extensions are granted per application.

DHS RESPONSE:

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

Recommendation #4: LTC Monthly Report Completeness

Finding Synopsis:
LTC monthly reports did not contain all elements as required by statute. Specifically, there were some remaining elements not included in the reports including: the percent of pending and tolled due to extensions for applications and redeterminations as well as the associated percentages for the numbers of applications and redeterminations pending at the HFS OIG.

Recommendation:
The Department of Healthcare and Family Services and the Department of Human Services should ensure monthly reports contain all elements required by Section 11-5.4(e)(9) of the Illinois Public Aid Code (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).

DHS RESPONSE:

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

Recommendation #5: LTC Monthly Report Accuracy

Finding Synopsis:
The review found inaccuracies in the redetermination data used to create the LTC monthly reports and the monthly reports did not match the provided redetermination data.

Recommendation:
The Department of Healthcare and Family Services and the Department of Human Services should develop controls to ensure monthly reports required by Section 115.4(e)(9) of the Illinois Public Aid Code are accurate (prior to Public Act 100-665, 305 ILCS 5/11-5.4(e)(9); following, 305 ILCS 5/11-5.4(f)).

DHS RESPONSE:

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

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