STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT
OF THE

COVERING ALL KIDS HEALTH INSURANCE PROGRAM

DECEMBER 2013

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OFFICE OF THE AUDITOR GENERAL
WILLIAM G. HOLLAND

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

This is our report of the program audit of the Covering ALL KIDS Health Insurance program.

The audit was conducted pursuant to Section 170/63 of the Covering ALL KIDS Health Insurance Act. 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.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
December 2013

STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
William G. Holland, Auditor General

SUMMARY REPORT DIGEST

COVERING ALL KIDS HEALTH INSURANCE PROGRAM

PROGRAM AUDIT
For the Year Ended: June 30, 2012

Release Date: December 2013

SYNOPSIS

Public Act 95-985 amended the Covering ALL KIDS Health Insurance Act [215 ILCS 170/63] and directed the Auditor General to annually audit the ALL KIDS program. This is the **fourth annual audit** and covers FY12. The focus of this audit is on "EXPANDED ALL KIDS," which is the portion of the ALL KIDS program that serves uninsured children not previously covered by KidCare (children whose family income was greater than 200 percent of the federal poverty level or who were undocumented immigrants).

This FY12 audit follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. Our audit found:

- In FY12, 92,879 children were enrolled in the EXPANDED ALL KIDS program.
- Total claims paid in FY12 for the EXPANDED ALL KIDS enrollees were $77.2 million.
- FY12 ALL KIDS claim data included 193 recipients who received 1,802 services totaling $80,752 after the month of their 19th birthday, when their eligibility ended. Additionally, the data included 246 individuals who appeared to be enrolled with more than one identification number.
- Our FY12 review indicated a continued problem with HFS incorrectly categorizing documented immigrants as undocumented in its data. However, HFS noted that manual reviews were being completed and as of February 1, 2013, $1.2 million in federal match for the individuals identified by our previous audit had been received.
- While HFS and DHS took action to address the previous recommendations, many of these actions did not occur within this audit period (FY12). We determined that one recommendation was implemented and 10 were repeated.

Future audit populations will be decreased due to the passage of PA 96-1501, which made children whose families' household income is above 300 percent of the federal poverty level (FPL) ineligible for EXPANDED ALL KIDS.

In June 2013, Illinois was retroactively approved back to July 1, 2008, to receive federal reimbursement under Title XXI of the Social Security Act for citizens and documented immigrant children in EXPANDED ALL KIDS Premium Level 2.

Due to the limited time for HFS and DHS to implement prior audit recommendations, the General Assembly may wish to consider reducing the frequency of the EXPANDED ALL KIDS audit period from annually to at least once every three years or on a more frequent basis if determined necessary by the Auditor General.

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FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

BACKGROUND

The expansion added children whose family income was greater than 200 percent of the federal poverty level and all undocumented immigrant children.

Effective July 1, 2006, Illinois' KidCare program, which included Medicaid and Children's Health Insurance Program (SCHIP) populations, **was expanded** by the Covering ALL KIDS Health Insurance Act (Act) to include all uninsured children not previously covered. The expansion added children whose family income was greater than 200 percent of the federal poverty level and all undocumented immigrant children. At that time, the KidCare program was renamed ALL KIDS. Since the EXPANDED ALL KIDS program is a subset of a much larger ALL KIDS program, **many of the recommendations in this report may be relevant to the program as a whole.**

The children who were added as a part of the expansion were not eligible for federal reimbursement and thus are funded entirely by the State.

Throughout this audit, we will refer to the portion of the ALL KIDS program that serves the uninsured children not previously covered by KidCare as "EXPANDED ALL KIDS." The children who were added as a part of the expansion were not eligible for federal reimbursement and thus are funded entirely by the State.

Public Act 95-985 amended the Covering ALL KIDS Health Insurance Act [215 ILCS 170/63] directing the Auditor General to annually audit the EXPANDED ALL KIDS program beginning June 30, 2008, and each June 30th thereafter. The Public Act was effective June 1, 2009. This is the fourth audit (FY12). The first audit (FY09) was released in May 2010 and contained 13 recommendations. The second audit (FY10) was released in April 2011 and contained 14 recommendations. The third annual audit (FY11) was released in October 2012 and contained 11 recommendations.

This FY12 audit of the EXPANDED ALL KIDS program follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. Many of the previous audit recommendations that were addressed by HFS and DHS were not addressed until FY13. Since this annual audit's time period is FY12, we will review these changes in future audits. (pages 2-5)

Recent Changes to the Covering ALL KIDS Health Insurance Program

Two events in recent years will have a significant impact on the EXPANDED ALL KIDS program and our audits.

Effective July 1, 2011, children whose families' household income is above 300 percent of the federal poverty level (FPL) are no longer eligible.

Illinois was approved to receive reimbursement for children in a family with income up to 300 percent of the FPL (Premium Level 2) under Title XXI of the Social Security Act.

Two events in recent years will have a significant impact on the EXPANDED ALL KIDS program and our audits. The first was the passage of Public Act 96-1501, which added an income limit for determining eligibility for the EXPANDED ALL KIDS program. Effective July 1, 2011, children whose families' household income is above 300 percent of the federal poverty level (FPL) are no longer eligible. Children enrolled as of July 1, 2011, were able to remain enrolled in the program until June 30, 2012. Eliminating eligibility for children in families with household income above 300 percent of the FPL will reduce the number of Program participants and expenditures to be audited.

The second occurred on June 4, 2013. HFS received a notification from the federal Department of Health and Human Services (HHS) that Illinois was approved to receive federal reimbursement for citizens and documented immigrant children in a family with income up to 300 percent of the FPL under Title XXI of the Social Security Act, as reauthorized under the Children's Health Insurance Program Reauthorization Act of 2008 (CHIPRA). CHIPRA was formerly titled the State Children's Health Insurance Program (SCHIP). HFS applied for this reimbursement on March 31, 2009. HFS officials noted that the only State law that provides coverage to children in families with income between 200 and 300 percent of the FPL is the Covering ALL KIDS Health Insurance Act (All Kids Premium Level 2).

Our prior EXPANDED ALL KIDS audits have only included children whose medical care was totally State-funded. The federal government granted the State retroactive reimbursement for this population (children from families with income between 200 and 300 percent of FPL) dating back to July 1, 2008. As of September 2013, HFS officials indicated they are in the exploratory phase as to their approach for recovering these federal matching funds. We will follow up on HFS's efforts to obtain retroactive reimbursement as part of the FY13 audit. (page 12)

Matter for Consideration by the Illinois General Assembly

HFS and DHS accepted all recommendations from our past ALL KIDS audit and have been working to implement them. The Covering ALL KIDS Health Insurance Act requires the Auditor General to conduct an **annual** audit of the EXPANDED ALL KIDS program. However, with an annual audit, HFS and DHS have had limited time to implement the recommendations before the next audit period began.

The General Assembly may wish to consider reducing the frequency of the EXPANDED ALL KIDS audit period from annually to at least once every three years or on a more frequent basis if determined necessary by the Auditor General.

Due to the limited time for HFS and DHS to implement prior audit recommendations before the next audit begins, and the decline in EXPANDED ALL KIDS participants (discussed above), the General Assembly may wish to consider reducing the frequency of the EXPANDED ALL KIDS audit period from annually to at least once every three years or on a more frequent basis if determined necessary by the Auditor General. (pages 13-14)

ALL KIDS Program

In FY12, Illinois' ALL KIDS program as a whole had almost 1.9 million enrollees and HFS paid $2.6 billion in claims. In FY12, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion totaled 92,879. As seen in Digest Exhibit 1, on June 30, 2012, there were 67,616 enrollees as a result of the expansion of which 47,282 (70%) were classified as undocumented immigrants in the HFS data. (pages 6-7)

Digest Exhibit 1
EXPANDED ALL KIDS ENROLLMENT BY PLAN [2, 3]
As of June 30

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants	
	FY11	FY12	FY11	FY12
Assist <134% FPL/$30,656.50[1]	n/a	n/a	48,481	44,623
Share 134%-150% FPL/$34,575[1]	n/a	n/a	1,472	1,323
Premium Level 1 151%-200% FPL/$46,100[1]	n/a	n/a	1,253	1,006
Premium Level 2 201%-300% FPL/$69,150[1]	18,318	18,402	382	301
Premium Level 3 301%-400% FPL/$92,200[1]	4,028	1,469	59	20
Premium Level 4 401%-500% FPL/$115,250[1]	765	366	14	5
Premium Level 5 501%-600% FPL/$138,300[1]	134	82	6	4
Premium Level 6 601%-700% FPL/$161,350[1]	35	8	2	0
Premium Level 7 701%-800% FPL/$184,400[1]	13	2	0	0
Premium Level 8 >800% FPL/No limit[1]	13	5	0	0
Totals	**23,306**	**20,334**	**51,669**	**47,282**

Notes:

[1] Denotes the applicable federal poverty level income guidelines for the plan level and the maximum income for a family of four for that plan during FY12.

[2] Enrollment is the total number of enrollees that were eligible on June 30 of 2011 and 2012. There were 97,030 enrollees eligible at some point during FY11 and 92,879 enrollees eligible at some point during FY12.

[3] Due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the enrollment for FY12 undocumented immigrants is overstated, while the enrollment for documented immigrants is understated.

Source: ALL KIDS enrollment data provided by HFS.

Payments for ALL KIDS Services

Payments for services increased to $84,199,508 in FY10 and to $96,556,069 in FY11. In FY12, the total payments for services dropped to $77,174,711. We questioned HFS about the large decrease in payments. HFS indicated that the decrease in payments was due to the payment cycle and not a decrease in services.

According to data provided by HFS, in FY09 the payments for services that were added as a result of the July 1, 2006 expansion totaled $79,068,335. The payments for services increased to $84,199,508 in FY10 and to $96,556,069 in FY11. In FY12, the total payments for services dropped to $77,174,711. **We questioned HFS about the large decrease in payments. HFS indicated that the decrease in payments was due to the payment cycle and not a decrease in services.** The majority of the payments for services were for undocumented immigrants. Payments for undocumented immigrants totaled $54.9 million in FY09, $59.2 million in FY10, $58.8 million in FY11, and $48.3 million in FY12.

Digest Exhibit 2 breaks out the payments for services by whether the child had documentation for citizenship/immigration status or whether the child was undocumented for both FY11 and FY12. However, due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the payments for undocumented immigrants are overstated, while the payments for documented immigrants are understated. (pages 7-8)

Digest Exhibit 2
PAYMENTS FOR EXPANDED ALL KIDS SERVICES BY ALL KIDS PLAN [1, 3]
Fiscal Years 2011 and 2012

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals	
	FY11	FY12[4]	FY11	FY12[4]	FY11	FY12 [4]
Assist <134% FPL/$30,656.50[2]	n/a	n/a	$55,291,285	$45,768,372	$55,291,285	$45,768,372
Share 134%-150% FPL/$34,575[2]	n/a	n/a	$1,514,515	$1,123,934	$1,514,515	$1,123,934
Premium Level 1 151%-200% FPL/$46,100[2]	n/a	n/a	$1,465,795	$1,015,019	$1,465,795	$1,015,019
Premium Level 2[5] 201%-300% FPL/$69,150[2]	$26,632,165 [5]	$21,752,687 [5]	$328,189	$315,323	$26,960,354	$22,068,010
Premium Level 3 301%-400% FPL/$92,200[2]	$6,343,863	$3,653,924	$110,717	$82,692	$6,454,580	$3,736,616
Premium Level 4 401%-500% FPL/$115,250[2]	$2,722,244	$1,976,315	$12,001	$9,662	$2,734,246	$1,985,977
Premium Level 5 501%-600% FPL/$138,300[2]	$1,088,856	$1,155,549	$41,848	$26,368	$1,130,704	$1,181,917
Premium Level 6 601%-700% FPL/$161,350[2]	$776,095	$214,265	$1,439	$1,067	$777,535	$215,333
Premium Level 7 701%-800% FPL/$184,400[2]	$63,510	$13,722	$0	$0	$63,510	$13,722
Premium Level 8 >800% FPL/No limit[2]	$163,543	$65,811	$2	$0	$163,545	$65,811
Totals	**$37,790,277**	**$28,832,273**	**$58,765,792**	**$48,342,438**	**$96,556,069**	**$77,174,711**

Notes:

[1] Due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the costs for undocumented immigrants are overstated, while the costs for documented immigrants are understated.

[2] Denotes the applicable federal poverty level income guidelines for the plan level and the maximum income for a family of four for that plan during FY12.

[3] Totals may not add due to rounding.

[4] According to HFS the decrease in FY12 payments was due to the payment cycle and not a decrease in services.

[5] HFS was notified on June 4, 2013, by the Centers for Medicare & Medicaid Services, that Illinois children up to 300% of the federal poverty level were approved to be covered by Title XXI of the Social Security Act (Medicaid). This has a retroactive effective date of July 1, 2008.

Source: ALL KIDS claim data provided by HFS.

Cost for Services Provided in FY12

As noted above, the decrease in payments from $96.6 million in FY11 to $77.2 million in FY12 was due to the payment cycle and not a decrease in services. This means that the services may have been provided in FY12, but were not paid until FY13.

To determine the actual cost for services occurring during the fiscal year for the ALL KIDS program, we requested the cost for services that were provided in each of the last three fiscal years from HFS. We determined that the cost for services provided during the fiscal year increased from $89 million in FY10, to $89.3 million in FY11, and decreased slightly to $87.8 million in FY12. (page 9)

Payments vs. Premiums Collected

In FY11, HFS received approximately $10.8 million in premiums from enrollees, thus making the net cost of the ALL KIDS expansion approximately $85.8 million. In FY12, based on a report provided by HFS, HFS received almost $10.5 million in premiums, thereby decreasing the net cost of the ALL KIDS expansion to almost $66.7 million. We requested the amount of unpaid premiums for EXPANDED ALL KIDS in FY12 from HFS. HFS officials indicated the accounts receivable system tracks unpaid premiums by family and not by individual. As a result, since families could have family members in various medical programs, outstanding premium payments for a specific program such as EXPANDED ALL KIDS could not be provided. Digest Exhibit 3 shows both FY11 and FY12 payments and premiums collected from the EXPANDED ALL KIDS program. (page 11)

Digest Exhibit 3
EXPANDED ALL KIDS PAYMENTS VS. PREMIUMS[1]
Fiscal Years 2011 and 2012

EXPANDED ALL KIDS Plan	FY11 Payments	FY12 Payments [3]	FY11 Premiums Collected	FY12 Premiums Collected	FY11 Net Cost	FY12 Net Cost
Assist <134% FPL/$30,656.50[2]	$55,291,285	$45,768,372	n/a	n/a	**$55,291,285**	**$45,768,372**
Share 134%-150% FPL/$34,575[2]	$1,514,515	$1,123,934	$835	$75	**$1,513,680**	**$1,123,859**
Premium Level 1 151%-200% FPL/$46,100[2]	$1,465,795	$1,015,019	$206,970	$157,163	**$1,258,825**	**$857,856**
Premium Level 2[4] 201%-300% FPL/$69,150[2]	$26,960,354	$22,068,010	$7,402,166	$8,109,776	**$19,558,188**	**$13,958,234**
Premium Level 3 301%-400% FPL/$92,200[2]	$6,454,580	$3,736,616	$2,175,092	$1,447,912	**$4,279,488**	**$2,288,704**
Premium Level 4 401%-500% FPL/$115,250[2]	$2,734,246	$1,985,977	$674,995	$517,210	**$2,059,251**	**$1,468,767**
Premium Level 5 501%-600% FPL/$138,300[2]	$1,130,704	$1,181,917	$245,505	$197,661	**$885,200**	**$984,256**
Premium Level 6 601%-700% FPL/$161,350[2]	$777,535	$215,333	$52,715	$29,280	**$724,820**	**$186,053**
Premium Level 7 701%-800% FPL/$184,400[2]	$63,510	$13,722	$16,210	$11,180	**$47,300**	**$2,542**
Premium Level 8 >800% FPL/No limit[2]	$163,545	$65,811	$30,755	$11,440	**$132,790**	**$54,371**
Totals	**$96,556,069**	**$77,174,711**	**$10,805,242**	**$10,481,697**	**$85,750,827**	**$66,693,014**

Notes:

[1] Totals may not add due to rounding.

[2] Denotes the applicable federal poverty level income guidelines for the plan level and the maximum income for a family of four for that plan during FY12.

[3] According to HFS the decrease in FY12 payments was due to the payment cycle and not a decrease in services.

[4] HFS was notified on June 4, 2013, by the Centers for Medicare & Medicaid Services, that Illinois citizen and documented immigrant children up to 300% of the federal poverty level were approved to be covered by Title XXI of the Social Security Act (Medicaid). This has a retroactive effective date of July 1, 2008.

Source: ALL KIDS claim and premium collection data provided by HFS.

Follow up on FY11 Recommendations

While HFS and DHS took some action to address the previous recommendations, many of these actions did not occur within this audit period (FY12).

While HFS and DHS took some action to address the previous recommendations, many of these actions did not occur within this audit period (FY12). As a result, many recommendations are repeated in this audit. We determined that one recommendation was implemented and 10 were repeated. We will continue to follow up on the actions taken after our period during our FY13 annual audit. (pages 2-3)

Redetermination of Eligibility

In the FY09 audit, auditors concluded that the annual reviews of ALL KIDS eligibility – also called redeterminations – required by the Illinois Administrative Code [89 Ill. Adm. Code 123.260] were not being adequately implemented by HFS. For ALL KIDS enrollees that fall in the Assist, Share, and Premium Level 1 categories (e.g., at or below 200 percent of the federal poverty level), an annual "passive" redetermination was used by HFS. Prior to the end of the eligibility period, HFS sent each family an annual renewal

notice. The renewal notice listed the eligibility information for the family and instructed the family to return the form **only if** any of the information had changed. If there were no changes, the family was instructed to do nothing. In contrast, to continue coverage, enrollees in Premium Levels 2 through 8 were required to send in the annual redetermination form, which included updated eligibility information.

This recommendation to adequately implement eligibility redeterminations was repeated in our FY10 and FY11 audits. Effective October 1, 2011, Public Act 96-1501 required verification of one month's income for determining continued eligibility (instead of passive redetermination). According to HFS officials, the passive renewal process ended in July 2012, but corrective action did not begin until January 2013. Actions taken to implement this recommendation were included in the contract with a third party vendor, which began performing electronic eligibility verifications after this audit period. Since corrective action was not taken during FY12, this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2012, to June 30, 2013. (pages 15-16)

Income of Stepparent

During the review of HFS and DHS policies during the FY09 audit, auditors determined that DHS did not calculate family income for EXPANDED ALL KIDS eligibility as required by the Administrative Code. The Administrative Code [89 Ill. Adm. Code 123.110] defines family as the child applying for the program and individuals who live with the child, which includes "the spouse of the child's parent" (i.e., the child's stepparent). Therefore, the income calculation for any child receiving services under the Covering ALL KIDS Health Insurance Act (i.e., those children whose services are totally State funded) should include the income of the stepparent.

HFS and DHS officials indicated that the policy has been updated and now requires stepparent income to be included when determining eligibility. In this FY12 audit, we reviewed 16 eligibility files and determined that in all 8 of the cases with a stepparent in the household, the income of the step-parent was included when determining eligibility. Therefore, this recommendation is **implemented**. (pages 16-17)

Non-Payment of Premiums

During the FY09 and FY10 audits, auditors found that HFS did not terminate ALL KIDS coverage when the enrollee failed to pay premiums timely as required by 89 Ill. Adm. Code 123.340(a). Auditors also found that HFS and DHS did not have controls in place to ensure that families who were previously terminated from coverage met re-enrollment requirements found in the Administrative Code. The

Administrative Code [89 Ill. Adm. Code 123.210(c)(2)] requires full payment of premiums due, for periods in which a premium was owed and not paid, before the child can be re-enrolled. Additionally, the Administrative Code [89 Ill. Adm. Code 123.210(c)(4)] requires the first month's premium be paid if there was an unpaid premium on the date the child's previous coverage was cancelled.

During the FY11 audit, HFS noted that it was in discussion with DHS regarding system enhancements that could be made to the Automated Intake System so the proper coding would be automatically applied to these cases to prevent re-enrollment of children with outstanding premium debt. According to HFS officials, DHS has been providing reports to HFS for individuals that did not pay premiums since October 2012. Consequently, corrective action taken by HFS and DHS staff did not occur until FY13 and the effects of corrective action would not be reflected in the FY12 eligibility data. Therefore, this recommendation is **repeated** and testing will be performed during the next audit cycle. (pages 17-18)

ALL KIDS Data Reliability

Auditors identified five specific issues associated with the FY09, FY10, and FY11 data provided by HFS. These five areas were: 1) eligibility data included individuals that were older than 18 years of age; 2) eligibility data included duplicate enrollees with two different recipient identification numbers, and/or different birth dates or addresses; 3) eligibility data included end dates that were not accurate; 4) irregularities between claims and eligibility data; and 5) some documented immigrants were categorized as undocumented immigrants. The number of undocumented immigrants as well as the cost associated with them in the EXPANDED ALL KIDS program were overstated due to the incorrect categorizing of documented immigrants.

In the FY12 data, we identified 246 individuals who appeared to be enrolled with more than one identification number. We also identified 193 recipients that received 1,802 services totaling $80,752 after the month of their 19th birthday.

We continued to find that eligibility data contained individuals who were enrolled in ALL KIDS more than once. In the FY12 data, we identified 246 individuals who appeared to be enrolled with more than one identification number. We also identified 193 recipients that received 1,802 services totaling $80,752 after the month of their 19th birthday. Therefore, the status of this part of the recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2012, to June 30, 2013. (pages 18-19)

Classification of Documented Immigrants

During the FY09 audit, auditors determined that HFS did not accurately classify documented immigrants who receive ALL KIDS services. According to HFS officials, to ensure that federal matching funds were not requested for documented immigrants who were ineligible for matching funds (i.e., those

documented immigrants who had not been in the country for five years), those documented immigrants were classified as undocumented immigrants.

HFS noted that manual reviews were being completed and as of February 1, 2013, $1.2 million in federal match for the individuals identified by the audit had been received.

In an updated response to the FY11 audit, HFS noted that the recommendation was partially implemented and new coding now more accurately records immigration status. HFS noted that manual reviews were being completed and as of February 1, 2013, $1.2 million in federal match for the individuals identified by the audit had been received.

HFS also indicated that the incorrect classification of immigrants was due to a matching problem with the Social Security Administration. According to HFS, the matching process is done monthly to continuously improve its data. HFS officials noted changes are made when they identify an undocumented recipient with a social security number that is matched incorrectly. Since this process is on-going, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle. (pages 19-20)

Duplicate Claims

As part of our review of EXPANDED ALL KIDS payments, auditors analyzed FY10 claim data and identified potential duplicate payments. A sample of 20 pairs of potential duplicate claims was chosen because the claims had the same recipient, same service date, same procedure, and both providers were paid the State maximum rate for the procedure. The judgmental sample of 20 possible duplicate claims was provided to HFS for explanation.

HFS reviewed the 20 potential duplicate pairs of claims and determined that 7 were duplicates. Examples of the seven duplicates included: claims submitted by the physician and by the hospital or clinic; and claims submitted by two different physicians. The seven duplicate claims totaled $1,428.

HFS officials indicated that implementation of this recommendation is still in progress. Since implementation of corrective action was not taken during the FY12 audit period, this recommendation is **repeated**. Detailed testing will be performed in the next audit cycle. (pages 20-21)

Eligibility Documentation

All three of the previous ALL KIDS audits found that, due to the way HFS implemented the Covering ALL KIDS Health Insurance Act, HFS and DHS did not obtain documentation to support eligibility in some instances. This included documentation for residency, birth, and income. As a result, auditors could not determine whether eligibility was determined correctly by HFS and DHS.

On January 25, 2011, Public Act 96-1501 was adopted, which addressed some of this recommendation. The Public Act mandated two changes to eligibility documentation requirements. These changes required one month's worth of income verification for determining eligibility and required verification of Illinois residency. These changes were effective on July 1, 2011.

According to both HFS and DHS officials, effective March 14, 2012, an automated Secretary of State clearance was completed to verify residency. We tested whether HFS and DHS were verifying Illinois residency after March 14, 2012. We selected 50 cases identified by DHS that had eligibility beginning in June 2012. Both DHS and HFS pulled electronic and paper files for our review. HFS and DHS could not locate three of the recipient files, and an additional recipient file sampled had an application date prior to March 2012. Of the remaining 46 files reviewed, we found that residency was verified in 44 of the 46 files. Of the 44 recipients verified, 20 had eligibility verified by the Secretary of State clearance and 24 were verified by various forms of documentation. Documentation of residency verification included a social security number match with the Illinois Secretary of State's Office or hard copy documentation such as addresses on bills, Mexican Consular identification cards, driver's licenses, or pay stubs. Each of these documents contained the applicant's Illinois address. Although progress was made, in the 49 applicable files tested, proof of residency verification was not found in two files and three additional files were not able to be located by HFS and DHS; therefore, this part of the recommendation is **repeated** and will be followed up on in future audits.

In addition, HFS and DHS indicated that the new income requirement was not addressed in FY12. As a result, since HFS and DHS have not implemented the required one month's worth of income requirement, the status of this part of the recommendation is **repeated**. This recommendation will be followed up on during the next audit cycle. Also, according to both HFS and DHS, neither agency has addressed the portion of the recommendation related to applicants who are self-employed; therefore, the status of this part of the recommendation is **repeated**. (pages 21-23)

Transportation Claims

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over transportation claims. As a result, transportation providers were able to bill multiple trips in a single day for the same recipient. Additionally, controls in the billing system do not contain edits for pickup or drop off times or locations. In its updated responses, HFS indicated that corrective action

was taken to address this recommendation prior to the current audit period. This includes implementing system edits to allow only one round trip per day and sending notices to providers reminding them to submit accurate claim details.

We reviewed FY12 transportation claims and continued to find duplicate transportation claims and claims with inaccurate details. Our review identified seven providers that billed 202 duplicate services totaling $1,524 in FY12. We also identified 141 services totaling $2,925 that did not have the necessary information to make any determinations about the services that were provided. For example, there were several instances where all the origin and destination times for a given day for a recipient were all the same. Likewise, there were several instances where the origin and destination locations were all the same. Since it was not possible to determine where and when these recipients were picked up and where and when they were dropped off, it is unclear how the claims were approved for payment.

Since we continue to find issues with transportation claim documentation, the status of this recommendation is **repeated**. This recommendation will be followed up on during the next audit cycle. (pages 23-24)

Optical Edits

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over optical claims. HFS allows children to receive as many eyeglasses as needed through the Department of Corrections – Illinois Correctional Industries (ICI) without prior approval. As a result, optical providers were able to bill for multiple frames and fittings for same recipient during the year. Specifically, auditors identified one provider with a large number of recipients receiving multiple frames and fittings during FY10. Additionally, auditors also determined that HFS did not have effective controls in place over the number of eye exams billed for each recipient.

Due to this provider's high correlation of customers with multiple pairs of frames received during FY10, auditors reported this provider to HFS and to the HFS-OIG for further investigation. The HFS Office of the Inspector General (OIG) noted it was aware of this provider's billing patterns and was in the early stages of auditing this provider. We followed up with the OIG in the FY11 audit; the OIG failed to act on our referral and noted it could not find a case on this provider.

In an updated response to this recommendation, the HFS OIG stated that it was in the process of developing predictive modeling routines related to optical care. The OIG also noted it ran data mining routines to determine children with multiple

eyeglass expenditures, and requested charts to determine whether the multiple eyeglasses were medically necessary or if there was evidence of fraud, waste, or abuse. During our FY12 review, the OIG had not completed a review, but indicated it was currently auditing the provider that was identified in the FY10 audit.

Since the steps taken by the OIG occurred after our FY12 audit period, the status of this recommendation is **repeated**. Therefore, this recommendation will be followed up on during the next audit cycle. (pages 24-25)

Guidance Over Preventive Medicine Service Claims

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over the billing of preventive medicine service claims. The claims are for preventive medicine services for healthy children who are established patients. According to an HFS official, preventive medicine services are used for annual doctor visits and are not to be used numerous times per year. These services generally bill at a higher rate than a problem focused visit. In the FY10 EXPANDED ALL KIDS claim data, we identified 1,013 recipients that received three or more preventive medicine services for healthy children.

During our review of the FY12 data, auditors continued to identify EXPANDED ALL KIDS recipients that received preventive medicine services for healthy children during FY12 that exceeded the benefit limitation. The Handbook for Providers of Healthy Kids Services establishes the number of preventive medicine services allowed per year by age of the recipient. We identified 2,255 recipients that received 2,732 preventive medicine services in excess of the limit. According to HFS, controls were not set up to address this until December 2012. As a result, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2012, to June 30, 2013. (pages 25-26)

We identified 2,255 recipients that received 2,732 preventive medicine services in excess of the limit.

Inconsistent Dental Policies

During our review of FY10 EXPANDED ALL KIDS dental claims, we found deficiencies in controls related to dental billings. Auditors found instances in FY10 data where dental services were paid for in excess of the allowed benefit schedule. Auditors also found instances where the allowed benefit schedule differed from what officials said was allowed and from what was posted on HFS' ALL KIDS Dental Services webpage. Additionally, we identified billing outliers within the dental claims. These irregularities were reported to the Department of Healthcare and Family Services for follow-up and/or investigation.

We found in our FY12 review, the ALL KIDS Dental Services webpage still states that children are limited to a periodic oral exam once every 12 months per dentist, whereas the Dental Office Reference Manual schedule of Benefits still states that children can receive an oral exam once every 6 months in an office setting and once every 12 months in a school setting.

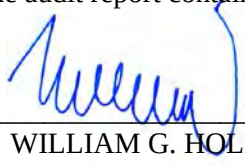
In this FY12 audit, we analyzed the data and did not find instances of payments beyond the established frequency limits for periodic oral examinations, sealants, and prophylaxes (cleanings).

Additionally, in the FY10 and FY11 audits, we recommended that HFS ensure that dental policies or other information available to the public accurately states frequency of benefits. We found in our FY12 review, the ALL KIDS Dental Services webpage still states that children are limited to a periodic oral exam once every 12 months per dentist, whereas the Dental Office Reference Manual schedule of Benefits still states that children can receive an oral exam once every 6 months in an office setting and once every 12 months in a school setting. HFS indicated that it was in the process of revising the Dental Office Manual and Administrative Rules to accurately state frequency and benefits. As a result, the status of this part of the recommendation is **repeated** and will be followed up on during the next audit.

During this audit, we followed up on providers that we referred to the HFS OIG during our FY10 audit. In response to our inquiry, the OIG noted one provider was audited and the provider repaid $9,471. The OIG performed Quality of Care Reviews which found no issues for two of the other providers referred in FY10. For the last provider, the OIG initiated a Special Project Audit in FY10 which was never completed. During our review of top ten providers in FY12, we found this provider continued to have a high average cost per client or other outliers, and again referred this provider to the OIG. According to the OIG, it is currently auditing this provider. (page 27)

RECOMMENDATIONS

The audit report contains 10 recommendations. Eight recommendations were specifically for the Department of Healthcare and Family Services. Two recommendations were for both the Department of Healthcare and Family Services and the Department of Human Services. The Department of Healthcare and Family Services and the Department of Human Services agreed with all 10 recommendations. Appendix H to the audit report contains the agency responses.



WILLIAM G. HOLLAND
Auditor General

WGH:SAW

AUDITORS ASSIGNED: This Program Audit was performed by the Office of the Auditor General's staff.

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COVERING ALL KIDS HEALTH INSURANCE PROGRAM

REPORT CONCLUSIONS

Public Act 95-985 amended the Covering ALL KIDS Health Insurance Act [215 ILCS 170/63] directing the Auditor General to annually audit the EXPANDED ALL KIDS program beginning June 30, 2008, and each June 30th thereafter. The Public Act was effective June 1, 2009. This is the fourth audit (FY12). The first audit (FY09) was released in May 2010 and contained 13 recommendations. The second audit (FY10) was released in April 2011 and contained 14 recommendations. The third annual audit (FY11) was released in October 2012 and contained 11 recommendations.

This FY12 audit of the EXPANDED ALL KIDS program follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. Many of the previous audit recommendations that were addressed by HFS and DHS were not addressed until FY13. Since this annual audit's time period is FY12, we will review these changes in future audits.

ALL KIDS Program

In FY12, Illinois' ALL KIDS program as a whole had almost 1.9 million enrollees and HFS paid $2.6 billion in claims. In FY12, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion totaled 92,879. On June 30, 2012, there were 67,616 enrollees as a result of the expansion of which 47,282 (70%) were classified as undocumented immigrants in the HFS data.

According to data provided by HFS, in FY09 the payments for services that were added as a result of the July 1, 2006 expansion totaled $79,068,335. The payments for services increased to $84,199,508 in FY10 and to $96,556,069 in FY11. In FY12, the total payments for services dropped to $77,174,711. We questioned HFS about the large decrease in payments. HFS indicated that the decrease in payments was due to the payment cycle and not a decrease in services.

We analyzed claim data and determined that the cost for EXPANDED ALL KIDS services provided in FY12 was $87,796,066. The cost for services provided in FY10 was $88,977,725 and in FY11 the cost was $89,340,554. Therefore, even though payments for services decreased by almost $19.4 million in FY12, the actual decrease in the cost for services provided during the fiscal year was only $1.5 million.

Payments for undocumented immigrants totaled $54.9 million in FY09, $59.2 million in FY10, $58.8 million in FY11, and $48.3 million in FY12. Therefore, in FY11 and FY12, undocumented immigrants made up approximately 63 percent of the total payments for the EXPANDED ALL KIDS program over the last two fiscal years. However, due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the

payments for undocumented immigrants are overstated, while the payments for documented immigrants are understated.

In FY11, HFS received approximately $10.8 million in premiums from enrollees, thus making the net payment for the ALL KIDS expansion approximately $85.8 million, an increase of approximately $11.3 million from FY10. In FY12, based on a report provided by HFS, HFS received almost $10.5 million in premiums, thereby decreasing the net cost of the ALL KIDS expansion to almost $66.7 million. We requested the amount of unpaid premiums for EXPANDED ALL KIDS in FY12 from HFS. HFS officials indicated the accounts receivable system tracks unpaid premiums by family and not by individual. As a result, since families could have family members in various medical programs, outstanding premium payments for a specific program such as EXPANDED ALL KIDS could not be provided.

Follow-up on Previous Recommendations

While HFS and DHS took some action to address the previous recommendations, many of these actions did not occur within this audit period (FY12). As a result, many recommendations are repeated in this audit. We determined that one recommendation was implemented and 10 were repeated. The following 10 issues were repeated during the FY12 audit period:

- HFS and DHS did not implement adequate eligibility redeterminations for EXPANDED ALL KIDS recipients. According to HFS officials, the passive renewal process ended in July 2012, but corrective action did not begin until January 2013;

- HFS did not implement corrective action during FY12, which would terminate ALL KIDS coverage when the enrollee failed to pay premiums. Additionally, HFS and DHS did not have controls in place to ensure that families who were previously terminated from coverage met re-enrollment requirements;

- Eligibility data contained individuals who were enrolled in ALL KIDS more than once. In the FY12 data, we identified 246 individuals who appeared to be enrolled with more than one identification number. We also identified 193 recipients that received 1,802 services totaling $80,752 after the month of their 19th birthday when they were no longer eligible;

- HFS did not accurately classify documented immigrants who receive ALL KIDS services. HFS noted that manual reviews were being completed and as of February 1, 2013, $1.2 million in federal match for the individuals identified by prior OAG audits had been received. The process is on-going and will be followed up on during the next audit;

- In FY10, we reviewed claim data and identified potential duplicate payments. HFS officials indicated that implementation of this recommendation is still in progress;

- Residency was verified in 44 of the 46 enrollee case files reviewed. Also, HFS and DHS were not verifying one month's worth of income for eligibility as required by

Public Act 96-1501, which was effective on July 1, 2011. HFS and DHS also have not implemented controls over eligibility requirements for individuals who are self-employed. HFS and DHS were unable to locate 3 of the 50 files we requested for testing;

- HFS continued to have issues with controls over transportation, preventive medicine, and dental claims:

  - ✓ **Transportation** -Our review identified seven providers that billed 202 duplicate services totaling $1,524 in FY12. We also identified 141 services totaling $2,925 that did not have the necessary information to make any determinations about the services that were provided;

  - ✓ **Preventive Medicine** – We continued to find recipients that received preventive medicine services for healthy children during FY12 that exceeded the benefit limitation;

  - ✓ **Dental** - A provider with a high average cost per client that we had previously reported to the HFS-OIG continued to have a high average. We referred this provider to the OIG again during this audit. We also found that HFS was still in the process of revising the Dental Office Manual and Administrative Rules to accurately state frequency and benefit limits; and

- HFS did not have electronic billing edits for optical claims for ordering frames and billing exams and fittings. The HFS Office of the Inspector General (OIG) stated that it was in the process of developing predictive modeling routines related to optical care. During our FY12 review, OIG indicated that it was currently auditing the optical provider that was identified in the FY10 audit.

BACKGROUND

Public Act 95-985 amended the Covering ALL KIDS Health Insurance Act [215 ILCS 170/63] directing the Auditor General to annually audit the EXPANDED ALL KIDS program beginning June 30, 2008, and each June 30th thereafter (see Appendix A). The Public Act was effective June 1, 2009. This is the fourth annual audit (FY12). The first audit (FY09) was released in May 2010 and contained 13 recommendations. The second audit (FY10) was released in April 2011 and contained 14 recommendations. There were five new recommendations and three new areas added to previous recommendations. The third annual audit (FY11) was released in October 2012 and contained 11 recommendations. The Act requires that the audit include:

- payments for health services covered by the program; and

- contracts entered into by HFS in relation to the program.

STATE STATUTES RELATED TO ALL KIDS

Effective July 1, 2006, Illinois' KidCare program, which included Medicaid and Children's Health Insurance Program (SCHIP) populations, **was expanded** by the Covering ALL KIDS Health Insurance Act (Act) to include all uninsured children not previously covered. The expansion added children whose family income was greater than 200 percent of the federal poverty level and all undocumented immigrant children. At that time, the KidCare program was renamed ALL KIDS. Since the EXPANDED ALL KIDS program is a subset of a much larger ALL KIDS program, **many of the recommendations in this report may be relevant to the program as a whole.**

The provisions in the Act prior to the passage of Public Act 96-1501 defined a child as a person under the age of 19. The Act had specific eligibility requirements for the program. In order to be eligible under this Act, a person:

1) must be a resident of the State of Illinois;

2) must be ineligible for medical assistance under the Illinois Public Aid Code or benefits under the Children's Health Insurance Program Act; and

3) must have been uninsured for an extended period of time as set forth by Department rule or meet certain exceptions such as losing insurance due to job loss.

Children who became eligible for ALL KIDS after the expansion include: (1) children whose family income exceeded 200 percent of the federal poverty level (e.g., exceed the income requirements of Medicaid and the Children's Health Insurance Program), and (2) all other children that were not covered prior to July 1, 2006. These other children consist of undocumented immigrants who did not receive KidCare prior to the expansion. **The children who were added as a part of the expansion were not eligible for federal reimbursement and thus are funded entirely by the State.** Throughout this audit, we will refer to this newly expanded population as "EXPANDED ALL KIDS."

The term "ALL KIDS" is an umbrella term that is used by HFS to include all health care provided to children whether it is through Medicaid, the Children's Health Insurance Program, or from the expansion as mandated by the Covering ALL KIDS Health Insurance Act.

Recent Changes to the Covering ALL KIDS Health Insurance Act

Public Act 96-1501 was signed into law by the Governor on January 25, 2011. The Public Act amended the Covering ALL KIDS Health Insurance Act and addressed several matters raised in both our initial and second audits of the EXPANDED ALL KIDS program. These changes to the Covering ALL KIDS Health Insurance Act included:

- effective July 1, 2011, requiring verification of one month's income for determining eligibility (instead of one pay stub which typically covered less than one month) ;
- effective October 1, 2011, requiring verification of one month's income for determining continued eligibility (instead of using passive redetermination); and

- effective July 1, 2011, requiring verification of Illinois residency.

During the audit, as seen in Recommendation Number 6, we found that none of these changes were implemented in FY12. Public Act 96-1501 also added an income limit for determining eligibility for the EXPANDED ALL KIDS program. Effective July 1, 2011, children whose families' household income is above 300 percent of the federal poverty level are no longer eligible. Children enrolled as of July 1, 2011, were able to remain enrolled in the program until June 30, 2012.

Impact on Fiscal Year 2012 Audit

This FY12 audit of the EXPANDED ALL KIDS program follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. Many of the previous audit recommendations that were addressed by HFS and DHS were not addressed until FY13. Since this annual audit's time period is FY12, we will review these changes in future audits.

ILLINOIS ADMINISTRATIVE CODE FOR ALL KIDS

The Illinois Administrative Code [89 Ill. Adm. Code 123] implements the Covering ALL KIDS Health Insurance Act that authorizes HFS to administer an insurance program that offers access to health insurance to all uninsured children in Illinois.

The rules reiterate some of the eligibility criteria set forth by the Act and expand on some of the eligibility exclusions and reasons for termination of coverage. The rules note that covered services are those that are covered by the Children's Health Insurance Program, minus service exclusions that include non-emergency medical transportation and over-the-counter drugs. The rules also have several important provisions that specifically relate to this audit. These include:

- eligibility shall be reviewed annually;

- premiums will not increase during the eligibility period, unless the family adds children to the coverage or there is a regulatory change in cost sharing;

- family is defined as the child applying for the program and the following individuals who live with the child: the child's parents, the spouse of the child's parent, children under 19 years of age of the parents or the parent's spouse, the spouse of the child, the children of the child, and if any of the previously mentioned are pregnant, the unborn children;

- the family at any time may request a downward modification of the premium for any reason including a change in income or change in family size; and

- there is a grace period through the end of the month of coverage to pay premiums, and failure to pay the full monthly premium by the last day of the grace period will result in termination of coverage.

As noted earlier in this report, in 2011, Public Act 96-1501 added an income limit for determining eligibility for the EXPANDED ALL KIDS program. Effective July 1, 2011, children whose families' household income is above 300 percent of the federal poverty level are no longer eligible.

ALL KIDS PROGRAM

In FY12, Illinois' ALL KIDS program as a whole had almost 1.9 million enrollees and HFS paid $2.6 billion in claims. In FY12, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion totaled 92,879. On June 30, 2012, there were 67,616 enrollees as a result of the expansion of which 47,282 (70%) were classified as undocumented immigrants in the HFS data. Exhibit 1 breaks out enrollment by fiscal year, by plan, and by whether the child was classified as a citizen or documented immigrant or whether the child was classified as undocumented in HFS's system. Appendix B shows the ALL KIDS premium and co-pay requirements by plan.

ALL KIDS Enrollment

Families interested in enrolling their children in the ALL KIDS program must fill out an application. See Appendix C for a copy of the ALL KIDS application. This can be done online, through the mail, by visiting a DHS local office, or by working with an ALL KIDS Application Agent. ALL KIDS Application Agents are paid $50 for each completed application that results in new coverage. Appendix D includes a list of Application Agents, the number of approved applications, and the amount each Application Agent was paid in FY12. ALL KIDS applications are processed by HFS or DHS, depending on which agency receives the application. If the family qualifies by meeting the eligibility requirements, the family is sent an ALL KIDS member handbook explaining the ALL KIDS program and an ALL KIDS member card.

Exhibit 1
EXPANDED ALL KIDS ENROLLMENT BY PLAN [2, 3]
As of June 30

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants	
	FY11	FY12	FY11	FY12
Assist <134% FPL/$30,656.50[1]	n/a	n/a	48,481	44,623
Share 134%-150% FPL/$34,575[1]	n/a	n/a	1,472	1,323
Premium Level 1 151%-200% FPL/$46,100[1]	n/a	n/a	1,253	1,006
Premium Level 2 201%-300% FPL/$69,150[1]	18,318	18,402	382	301
Premium Level 3 301%-400% FPL/$92,200[1]	4,028	1,469	59	20
Premium Level 4 401%-500% FPL/$115,250[1]	765	366	14	5
Premium Level 5 501%-600% FPL/$138,300[1]	134	82	6	4
Premium Level 6 601%-700% FPL/$161,350[1]	35	8	2	0
Premium Level 7 701%-800% FPL/$184,400[1]	13	2	0	0
Premium Level 8 >800% FPL/No limit[1]	13	5	0	0
Totals	**23,306**	**20,334**	**51,669**	**47,282**

Notes:

[1] Denotes the applicable federal poverty level income guidelines for the plan level and the maximum income for a family of four for that plan during FY12.

[2] Enrollment is the total number of enrollees that were eligible on June 30 of 2011 and 2012. There were 97,030 enrollees eligible at some point during FY11 and 92,879 enrollees eligible at some point during FY12.

[3] Due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the enrollment for FY12 undocumented immigrants is overstated, while the enrollment for documented immigrants is understated.

Source: ALL KIDS enrollment data provided by HFS.

PAYMENTS FOR ALL KIDS SERVICES

According to data provided by HFS, in FY09 the payments for services that were added as a result of the July 1, 2006 expansion totaled $79,068,335. The payments for services increased to $84,199,508 in FY10 and to $96,556,069 in FY11. In FY12, the total payments for services dropped to $77,174,711. **We questioned HFS about the large decrease in payments. HFS indicated that the decrease in payments was due to the payment cycle and not a decrease in services, which is discussed in the following section.** The majority of the payments for services were for undocumented immigrants. Payments for undocumented immigrants totaled $54.9 million in FY09, $59.2 million in FY10, $58.8 million in FY11, and $48.3 million in FY12. Therefore, in FY11 and FY12, undocumented immigrants make up approximately 62 percent of the total payments for the EXPANDED ALL KIDS program.

Exhibit 2 breaks out the payments for services by whether the child had documentation for citizenship/immigration status or whether the child was undocumented for both FY11 and FY12. However, due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the payments for undocumented immigrants are overstated, while the payments for documented immigrants are understated.

Exhibit 2
PAYMENTS FOR EXPANDED ALL KIDS SERVICES BY ALL KIDS PLAN [1, 3]
Fiscal Years 2011 and 2012

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals	
	FY11	FY12	FY11	FY12	FY11	FY12 [4]
Assist <134% FPL/$30,656.50[2]	n/a	n/a	$55,291,285	$45,768,372	$55,291,285	$45,768,372
Share 134%-150% FPL/$34,575[2]	n/a	n/a	$1,514,515	$1,123,934	$1,514,515	$1,123,934
Premium Level 1 151%-200% FPL/$46,100[2]	n/a	n/a	$1,465,795	$1,015,019	$1,465,795	$1,015,019
Premium Level 2[5] 201%-300% FPL/$69,150[2]	$26,632,165 [5]	$21,752,687 [5]	$328,189	$315,323	$26,960,354	$22,068,010
Premium Level 3 301%-400% FPL/$92,200[2]	$6,343,863	$3,653,924	$110,717	$82,692	$6,454,580	$3,736,616
Premium Level 4 401%-500% FPL/$115,250[2]	$2,722,244	$1,976,315	$12,001	$9,662	$2,734,246	$1,985,977
Premium Level 5 501%-600% FPL/$138,300[2]	$1,088,856	$1,155,549	$41,848	$26,368	$1,130,704	$1,181,917
Premium Level 6 601%-700% FPL/$161,350[2]	$776,095	$214,265	$1,439	$1,067	$777,535	$215,333
Premium Level 7 701%-800% FPL/$184,400[2]	$63,510	$13,722	$0	$0	$63,510	$13,722
Premium Level 8 >800% FPL/No limit[2]	$163,543	$65,811	$2	$0	$163,545	$65,811
Totals	**$37,790,277**	**$28,832,273**	**$58,765,792**	**$48,342,438**	**$96,556,069**	**$77,174,711**

Notes:

[1] Due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the costs for undocumented immigrants are overstated, while the costs for documented immigrants are understated.

[2] Denotes the applicable federal poverty level income guidelines for the plan level and the maximum income for a family of four for that plan during FY12.

[3] Totals may not add due to rounding.

[4] According to HFS the decrease in FY12 payments was due to the payment cycle and not a decrease in services.

[5] HFS was notified on June 4, 2013, by the Centers for Medicare & Medicaid Services, that Illinois children up to 300% of the federal poverty level were approved to be covered by Title XXI of the Social Security Act (Medicaid). This has a retroactive effective date of July 1, 2008.

Source: ALL KIDS claim data provided by HFS.

Cost for Services Provided in FY12

As shown in Exhibit 2, payments decreased from $96.6 million in FY11 to $77.2 million in FY12. We questioned such a large decrease and inquired with HFS. HFS indicated that the decrease was due to the payment cycle and not a decrease in services. This means that the services may have been provided in FY12, but were not paid until FY13.

To determine the actual cost for services occurring during the fiscal year for the ALL KIDS program, we requested the cost for services that were provided in each of the last three fiscal years from HFS. As seen in Exhibit 3, we determined that the cost for services provided during the fiscal year increased from $89 million in FY10, to $89.3 million in FY11, and decreased slightly to $87.8 million in FY12. The decrease in cost is consistent with the decrease in enrollment as seen in Exhibit 1.

Exhibit 3
COST OF SERVICES PROVIDED DURING FISCAL YEAR
Regardless of fiscal year paid

	FY10	FY11	FY12
Assist Undocumented	$56,553,841	$51,748,700	$52,880,356
Share Undocumented	1,664,957	1,334,339	1,243,020
Premium Level 1 Undocumented	1,431,973	1,352,497	1,080,426
Premium Level 2	22,017,851	23,430,626	24,968,912
Premium Level 2 Undocumented	383,239	310,814	332,303
Premium Level 3	4,677,979	5,961,107	3,813,686
Premium Level 3 Undocumented	42,416	120,568	78,809
Premium Level 4	1,294,824	2,530,880	2,245,898
Premium Level 4 Undocumented	13,642	9,513	11,994
Premium Level 5	442,450	1,525,657	812,399
Premium Level 5 Undocumented	115,692	41,309	31,685
Premium Level 6	136,185	778,299	205,256
Premium Level 6 Undocumented	1,075	1,445	1,099
Premium Level 7	29,331	57,851	10,200
Premium Level 8	172,262	136,949	80,023
Premium Level 8 Undocumented	8	2	0
Totals	**$88,977,725**	**$89,340,554**	**$87,796,066**

Note: Totals may not add due to rounding.
Source: ALL KIDS claim data provided by HFS.

PAYMENTS BY CATEGORY OF SERVICE

According to data provided by HFS, 92 percent of the payments during FY12 for EXPANDED ALL KIDS services were paid for 13 categories of services. Exhibit 4 shows that $70.8 million of the $77.2 million in total EXPANDED ALL KIDS payments were for the following services: Pharmacy; Dental Services; Physician Services; Inpatient Hospital Services (General); General Clinic Services; Outpatient Services (General); Capitation Services; Healthy

Kids Services; Inpatient Hospital Services (Psychiatric); Mental Health Rehab Option Services; Alcohol and Substance Abuse Rehab Services; Home Health Services; and Medical Supplies.

Exhibit 4
TOTAL PAYMENTS BY CATEGORY OF SERVICE FOR EXPANDED ALL KIDS PROGRAM
Totaling more than $1 million during FY12

Category of Service	Total FY12 Payments	Percent of Total FY12 Payments
Pharmacy	$12,859,538	17%
Dental Services	$12,176,338	16%
Physician Services	$11,800,806	15%
Inpatient Hospital Services (General)	$8,207,232	11%
General Clinic Services	$6,238,724	8%
Outpatient Services (General)	$4,615,828	6%
Capitation Services	$3,820,898	5%
Healthy Kids Services	$3,417,928	4%
Inpatient Hospital Services (Psychiatric)	$2,133,624	3%
Mental Health Rehab Option Services	$1,918,629	2%
Alcohol and Substance Abuse Rehab. Services	$1,486,545	2%
Home Health Services	$1,062,273	1%
Medical Supplies	$1,032,743	1%
Total for categories with payments > than $1 million	**$70,771,105**	**92%**
Other categories totaling < than $1 million	$ 6,403,607	8%
Total Payments for All Service Categories	**$77,174,711**	**100%**

Note: Totals may not add due to rounding.

Source: FY12 ALL KIDS data provided by HFS.

The category with the highest percentage of payments was Pharmacy at 17 percent. **Pharmacy increased from $10.7 million in FY10 to $20.8 million in FY11 and decreased to $12.9 million in FY12.** In the last audit, we asked HFS why there was such a large increase in FY11. HFS indicated it was due to vouchering more claims in FY11. In FY12, Dental Services accounted for 16 percent of the overall total. Appendix E shows the total FY12 payments by category of service. Appendix F shows the FY12 EXPANDED ALL KIDS payments by plan and by category of service. Appendix G shows FY12 Providers that received more than $50,000 from EXPANDED ALL KIDS.

PAYMENTS VS. PREMIUMS COLLECTED

In FY11, HFS received approximately $10.8 million in premiums from enrollees, thus making the net cost of the ALL KIDS expansion approximately $85.8 million, an increase of approximately $11.3 million from FY10. In FY12, based on a report provided by HFS, HFS received almost $10.5 million in premiums, thereby decreasing the net cost of the ALL KIDS expansion to almost $66.7 million. We requested the amount of unpaid premiums for EXPANDED ALL KIDS in FY12 from HFS. HFS officials indicated the accounts receivable system tracks unpaid premiums by family and not by individual. As a result, since families could have family members in various medical programs, outstanding premium payments for a specific program such as EXPANDED ALL KIDS could not be provided. Exhibit 5 shows both FY11 and FY12 payments and premiums collected from the EXPANDED ALL KIDS program.

Exhibit 5
EXPANDED ALL KIDS PAYMENTS VS. PREMIUMS [1]
Fiscal Years 2011 and 2012

EXPANDED ALL KIDS Plan	FY11 Payments	FY12 Payments[3]	FY11 Premiums Collected	FY12 Premiums Collected	FY11 Net Cost	FY12 Net Cost
Assist <134% FPL/$30,656.50[2]	$55,291,285	$45,768,372	n/a	n/a	**$55,291,285**	**$45,768,372**
Share 134%-150% FPL/$34,575[2]	$1,514,515	$1,123,934	$835	$75	**$1,513,680**	**$1,123,859**
Premium Level 1 151%-200% FPL/$46,100[2]	$1,465,795	$1,015,019	$206,970	$157,163	**$1,258,825**	**$857,856**
Premium Level 2 [4] 201%-300% FPL/$69,150[2]	$26,960,354	$22,068,010	$7,402,166	$8,109,776	**$19,558,188**	**$13,958,234**
Premium Level 3 301%-400% FPL/$92,200[2]	$6,454,580	$3,736,616	$2,175,092	$1,447,912	**$4,279,488**	**$2,288,704**
Premium Level 4 401%-500% FPL/$115,250[2]	$2,734,246	$1,985,977	$674,995	$517,210	**$2,059,251**	**$1,468,767**
Premium Level 5 501%-600% FPL/$138,300[2]	$1,130,704	$1,181,917	$245,505	$197,661	**$885,200**	**$984,256**
Premium Level 6 601%-700% FPL/$161,350[2]	$777,535	$215,333	$52,715	$29,280	**$724,820**	**$186,053**
Premium Level 7 701%-800% FPL/$184,400[2]	$63,510	$13,722	$16,210	$11,180	**$47,300**	**$2,542**
Premium Level 8 >800% FPL/No limit[2]	$163,545	$65,811	$30,755	$11,440	**$132,790**	**$54,371**
Totals	**$96,556,069**	**$77,174,711**	**$10,805,242**	**$10,481,697**	**$85,750,827**	**$66,693,014**

Notes:

[1] Totals may not add due to rounding.

[2] Denotes the applicable federal poverty level income guidelines for the plan level and the maximum income for a family of four for that plan during FY12.

[3] According to HFS the decrease in FY12 payments was due to the payment cycle and not a decrease in services.

[4] HFS was notified on June 4, 2013, by the Centers for Medicare & Medicaid Services, that Illinois citizen and documented immigrant children up to 300% of the federal poverty level were approved to be covered by Title XXI of the Social Security Act (Medicaid). This has a retroactive effective date of July 1, 2008.

Source: ALL KIDS claim and premium collection data provided by HFS.

RECENT CHANGES AFFECTING THE COVERING ALL KIDS HEALTH INSURANCE PROGRAM

Two events in recent years will have a significant impact on the EXPANDED ALL KIDS program and our audits. The first was the passage of Public Act 96-1501, which added an income limit for determining eligibility for the EXPANDED ALL KIDS program. Effective July 1, 2011, children whose families' household income is above 300 percent of the federal poverty level (FPL) are no longer eligible. Children enrolled as of July 1, 2011, were able to remain enrolled in the program until June 30, 2012.

The second occurred on June 4, 2013. HFS received a notification from the federal Department of Health and Human Services (HHS) that Illinois was approved to receive federal reimbursement for citizens and documented immigrant children in a family with income up to 300 percent of the FPL under Title XXI of the Social Security Act, as reauthorized under the Children's Health Insurance Program Reauthorization Act of 2008 (CHIPRA). CHIPRA was formerly titled the State Children's Health Insurance Program (SCHIP). HFS applied for this reimbursement on March 31, 2009. While HFS's State Plan amendment for CHIPRA to provide coverage for children in families with income up to 300 percent of the FPL was approved by HHS, HFS officials noted that the only State law that provides coverage to children in families with income between 200 and 300 percent of the FPL is the Covering ALL KIDS Health Insurance Act (All Kids Premium Level 2).

These two changes have implications for future OAG audits of the EXPANDED ALL KIDS Program. As shown in Exhibit 6, beginning July 1, 2012, there should be no children enrolled in Premium Levels 3 through 8, due to the passage of Public Act 96-1501 (the Public Act allowed children already enrolled in the program to have eligibility during the period July 1, 2011, through June 30, 2012). This will reduce the number of EXPANDED ALL KIDS participants and expenditures to be audited.

As also shown in Exhibit 6, there are a significant number of citizens/documented immigrants that are included in Premium Level 2. The State has been approved to receive federal reimbursement for their medical care. Our prior EXPANDED ALL KIDS audits have only included children whose medical care was totally State-funded. The federal government granted the State retroactive reimbursement for this population (children from families with income between 200 and 300 percent of FPL) dating back to July 1, 2008. As of September 2013, HFS officials indicated they are in the exploratory phase as to their approach for recovering these federal matching funds. We will follow up on HFS's efforts to obtain retroactive reimbursement as part of the FY13 audit.

Exhibit 6
RECENT CHANGES IMPACTING THE EXPANDED ALL KIDS POPULATION
Comparison between FY12 and FY13

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants	
	FY12	FY13	FY12	FY13
Assist <134% FPL/$30,656.50[2]	n/a	n/a	44,623	TBD[1]
Share 134%-150% FPL/$34,575[2]	n/a	n/a	1,323	TBD[1]
Premium Level 1 151%-200% FPL/$46,100[2]	n/a	n/a	1,006	TBD[1]
Premium Level 2 201%-300% FPL/$69,150[2]	18,402	TBD[1]	301	TBD[1]
Premium Level 3 301%-400% FPL/$92,200[2]	1,469		20	
Premium Level 4 401%-500% FPL/$115,250[2]	366		5	
Premium Level 5 501%-600% FPL/$138,300[2]	82		4	
Premium Level 6 601%-700% FPL/$161,350[2]	8		0	
Premium Level 7 701%-800% FPL/$184,400[2]	2		0	
Premium Level 8 >800% FPL/No limit[2]	5		0	
Totals	**20,334**	**0**	**47,282**	**TBD[1]**

Eliminated from EXPANDED ALL KIDS per PA 96-1501, as of June 30, 2012.

HFS was notified on June 4, 2013, by the Centers for Medicare & Medicaid Services, that Illinois children up to 300% of the federal poverty level were approved to be covered by Title XXI of the Social Security Act (CHIPRA). This has a retroactive effective date of July 1, 2008.

Note:

[1] To be determined during our FY13 audit.

[2] Denotes the applicable federal poverty level income guidelines for the plan level and the maximum income for a family of four for that plan during FY12.

Source: OAG analysis of PA 96-1501 and notification from the Centers for Medicare & Medicaid Services.

MATTER FOR CONSIDERATION BY THE ILLINOIS GENERAL ASSEMBLY

HFS and DHS accepted all recommendations from our past ALL KIDS audit and have been working to implement them. The Covering ALL KIDS Health Insurance Act requires the Auditor General to conduct an annual audit of the EXPANDED ALL KIDS program. However, with an annual audit, HFS and DHS have had limited time to implement the recommendations before the next audit period began. The FY10 audit was released in April 2011 and the FY11 audit was released in October 2012. HFS and DHS were unable to address many of the recommendations prior to the beginning of this audit period, which began July 1, 2011.

Consequently, these findings are repeated in this FY12 audit, which covers the period July 1, 2011, to June 30, 2012.

Due to the limited time for HFS and DHS to implement prior audit recommendations before the next audit begins, and the decline in EXPANDED ALL KIDS participants (as discussed in the previous section), the General Assembly may wish to consider reducing the frequency of the EXPANDED ALL KIDS audit period from annually to at least once every three years or on a more frequent basis if determined necessary by the Auditor General.

MATTER FOR CONSIDERATION BY THE GENERAL ASSEMBLY EXPANDED ALL KIDS Audit Frequency
The General Assembly may wish to consider reducing the frequency of the audit requirement found at 215 ILCS 170/63 from annually to at least once every three years or on a more frequent basis if determined necessary by the Auditor General. This would provide the Department of Human Services and the Department of Healthcare and Family Services with additional time to take corrective action, which would then be reviewed by the Auditor General's subsequent audit.

FOLLOW-UP ON FY11 RECOMMENDATIONS

While HFS and DHS took some action to address the previous recommendations, many of these actions did not occur within this audit period (FY12). As a result, many recommendations are repeated in this audit because the annual audit cycle did not allow implementation of the steps necessary to address the recommendation before the end of the audit period. We determined that one recommendation was implemented and 10 were repeated. We will continue to follow up on the actions taken after our period during our FY13 annual audit. Exhibit 7 shows the status of the recommendations from the FY11 audit.

Exhibit 7
STATUS OF PREVIOUS AUDIT RECOMMENDATIONS

Recommendation Area	FY11 Recommendation Number	Status of FY12 Recommendations Reported in FY11 Audit
Redetermination of ALL KIDS eligibility	3	Repeated
Stepparent income	4	Implemented
Non-payment of premiums	5	Repeated
ALL KIDS data reliability	6	Repeated
Classification of documented immigrants	7	Repeated
Duplicate Claims	9	Repeated
Eligibility documentation	10	Repeated
Transportation Claims	11	Repeated
Optical Edits	12	Repeated
Guidance Over Preventive Medicine Service Claims	13	Repeated
Inconsistent Dental Policies	14	Repeated

Note: Recommendations numbers 1, 2, and 8 were implemented during the FY11 audit.

Redetermination of Eligibility

In the FY09 audit, auditors concluded that the annual reviews of ALL KIDS eligibility – also called redeterminations – required by the Illinois Administrative Code [89 Ill. Adm. Code 123.260] were not being adequately implemented by HFS. For ALL KIDS enrollees that fall in the Assist, Share, and Premium level 1 categories (e.g., at or below 200 percent of the FPL), an annual "passive" redetermination was used by HFS. Prior to the end of the eligibility period, HFS sent each family an annual renewal notice. The renewal notice listed the eligibility information for the family and instructed the family to return the form only if any of the information had changed. If there were no changes, the family was instructed to do nothing. Therefore, a "passive" redetermination only required families to return the annual renewal form if there was a change in their information. In contrast, to continue coverage, enrollees in Premium levels 2 through 8 were required to send in the annual redetermination form, which included updated eligibility information.

This recommendation to adequately implement eligibility redeterminations was repeated in our FY10 and FY11 audits. Effective October 1, 2011, Public Act 96-1501 required verification of one month's income for determining continued eligibility (instead of passive redetermination). According to HFS officials, the passive renewal process ended in July 2012, but corrective action did not begin until January 2013. Actions taken to implement this recommendation were included in the contract with a third party vendor, which began performing electronic eligibility verifications after this audit period. Since corrective action was not taken during FY12, detailed testing will be performed in the next audit cycle.

The status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2012, to June 30, 2013.

REDETERMINATION OF ELIGIBILITY	
RECOMMENDATION NUMBER **1**	***The Department of Healthcare and Family Services and the Department of Human Services should review one month's income for determining continued eligibility as required by Public Act 96-1501.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department is using the 'Work Number' and AWVS, which provides employment earnings and unemployment insurance benefit information as available on the lllinois Department of Employment Security files, to obtain income information for a full 30 day period. One month of income data is requested from the recipient if the information is not available electronically.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department agrees with the recommendation. In July 2012, the State of Illinois ceased generating administrative renewal notices, which advised families that they did not have to respond if nothing relevant to their child's eligibility, including income, had changed. Instead, eligibility is now reviewed by a third party vendor using electronic data matches when the Social Security numbers of the responsible relatives to the children are known and verified. Those eligibility reviews are used in making recommendations to the State of Illinois Department of Human Service (IDHS) and the Department of Healthcare and Family Services (HFS) employees, who then carry out the recommendation by either continuing eligibility, modifying eligibility, or canceling eligibility. Effective with medical applications on or after 10/1/13, and to coincide with the implementation of the first phase of the Integrated Eligibility System (IES), policy has now been changed to clarify that as required under the Affordable Care Act, electronic data matches are the preferred means of verifying income in order to determine proper eligibility for medical programs, and that verification of 30 days of income is now required for all medical programs.

Income of Stepparent

During the review of HFS and DHS policies during the FY09 audit, auditors determined that DHS did not calculate family income for EXPANDED ALL KIDS eligibility as required by the Administrative Code. The Administrative Code [89 Ill. Adm. Code 123.110] defines family as the child applying for the program and individuals who live with the child, which includes "the spouse of the child's parent" (i.e., the child's stepparent). Therefore, the income calculation

for any child receiving services under the Covering ALL KIDS Health Insurance Act (i.e., those children whose services are totally State funded) should include the income of the stepparent.

HFS and DHS officials indicated that the policy has been updated and now requires stepparent income to be included when determining eligibility. HFS and DHS provided the July 29, 2011 Manual Release that incorporates the new policy on counting stepparent income when determining eligibility for undocumented children covered under the EXPANDED ALL KIDS program into the Policy Manual. We reviewed this policy during the FY11 audit and determined that HFS and DHS did incorporate the necessary changes into their policies. However, since the policy changes did not occur during the FY11 audit period and would not have been reflected in the FY11 claim and eligibility data, we could not determine whether the stepparent income was actually included as part of the income calculation for all EXPANDED ALL KIDS recipients during the FY11 audit period.

In this FY12 audit, we reviewed 16 eligibility files and determined that 8 of the cases had a stepparent in the household. In all 8 cases, the income of the stepparent was included when determining eligibility. Therefore, the status of this recommendation is **implemented**.

Non-Payment of Premiums

During the FY09 and FY10 audits, auditors found that HFS did not terminate ALL KIDS coverage when the enrollee failed to pay premiums timely as required by 89 Ill. Adm. Code 123.340(a). Auditors also found that HFS and DHS did not have controls in place to ensure that families who were previously terminated from coverage met re-enrollment requirements found in the Administrative Code. The Administrative Code [89 Ill. Adm. Code 123.210(c)(2)] requires full payment of premiums due, for periods in which a premium was owed and not paid, before the child can be re-enrolled. Additionally, the Administrative Code [89 Ill. Adm. Code 123.210(c)(4)] requires the first month's premium be paid if there was an unpaid premium on the date the child's previous coverage was cancelled.

During the FY11 audit, HFS noted that it was in discussion with DHS regarding system enhancements that could be made to the Automated Intake System so the proper coding would be automatically applied to these cases to prevent re-enrollment of children with outstanding premium debt. According to HFS officials, DHS has been providing reports to HFS for individuals that did not pay premiums since October 2012. Consequently, corrective action taken by HFS and DHS staff did not occur until FY13 and the effects of corrective action would not be reflected in the FY12 eligibility data. Therefore, this recommendation is **repeated** and detailed testing will be performed during the next audit cycle.

NON-PAYMENT OF PREMIUMS	
RECOMMENDATION NUMBER **2**	***The Department of Healthcare and Family Services should:*** • ***terminate ALL KIDS coverage to families that do not pay monthly premiums as required by 89 Ill. Adm. Code 123.340;*** • ***ensure that prior to re-enrollment in ALL KIDS, families pay all premiums due, for periods in which a premium was owed and not paid, as required by 89 Ill. Adm. Code 123.210(c)(2); and*** • ***ensure that before being re-enrolled, the first month's premium was paid if there was an unpaid premium on the date the child's previous coverage was cancelled as required by 89 Ill. Adm. Code 123.210(c)(4).***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. Administrative rules have been revised and a report was developed to identify cases that are approved in error.

ALL KIDS Data Reliability

Auditors identified five specific issues associated with the FY09, FY10, and FY11 data provided by HFS. These five areas were: 1) eligibility data included individuals that were older than 18 years of age; 2) eligibility data included duplicate enrollees with two different recipient identification numbers, and/or different birth dates or addresses; 3) eligibility data included end dates that were not accurate; 4) irregularities between claims and eligibility data; and 5) some documented immigrants were categorized as undocumented immigrants. The number of undocumented immigrants as well as the cost associated with them in the EXPANDED ALL KIDS program were overstated due to the incorrect categorizing of documented immigrants.

During our review of the FY12 EXPANDED ALL KIDS eligibility data, we continued to find that eligibility data contained individuals who were enrolled in ALL KIDS more than once. In the FY12 data, we identified 246 individuals who appeared to be enrolled with more than one identification number. We also identified 193 recipients that received 1,802 services totaling $80,752 after the month of their 19th birthday. Therefore, the status of this part of the recommendation is also **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2012, to June 30, 2013.

ALL KIDS DATA RELIABILITY	
RECOMMENDATION NUMBER **3**	***The Department of Healthcare and Family Services should have controls in place to ensure that its ALL KIDS eligibility and claim data is accurate and reliable. This includes ensuring that enrollees over 18 years of age are identified as no longer eligible, ensuring that enrollees are not enrolled in ALL KIDS more than once, and ensuring that enrollees are no longer eligible for services after their end date.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. A programming error that allowed a one day of eligibility the month following a child's 19th birthday has been corrected. A process to identify individuals assigned more than one identification number is in development.

Classification of Documented Immigrants

During the FY09 audit, auditors determined that HFS did not accurately classify documented immigrants who receive ALL KIDS services. According to HFS officials, to ensure that federal matching funds were not requested for documented immigrants who were ineligible for matching funds (i.e., those documented immigrants who had not been in the country for five years), those documented immigrants were classified as undocumented immigrants.

During the FY10 audit, HFS officials stated they researched the cases from the FY09 audit and found that a system error was causing the misclassifications. HFS noted the error was corrected on October 29, 2010.

In an updated response to the FY11 audit, HFS noted that the recommendation was partially implemented and new coding now more accurately records immigration status. HFS noted that manual reviews were being completed and as of February 1, 2013, $1.2 million in federal match for the individuals identified by the audit had been received.

In a response to the previous audit, HFS indicated that the incorrect classification of immigrants was due to a matching problem with the Social Security Administration. We met with HFS to review the matching process. According to HFS, the matching process is done monthly to continuously improve its data. HFS officials noted that HFS continues to try to clean up problems with social security numbers as they are identified; however, it is hard to do without additional staff. HFS officials noted changes are made when they identify an undocumented recipient with a social security number that is matched incorrectly. Since this process is on-going, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2012, to June 30, 2013. Due to the incorrect classification of documented and undocumented immigrants, the enrollee and payment figures in this report are overstated for undocumented immigrants and are understated for documented immigrants.

CLASSIFICATION OF DOCUMENTED IMMIGRANTS	
RECOMMENDATION NUMBER **4**	***The Department of Healthcare and Family Services should:*** • ***ensure that documented immigrants are classified correctly in its database;*** • ***maintain the necessary information needed to identify documented immigrants such as social security numbers, alien registration numbers, and dates of entry; and*** • ***ensure that the State receives federal matching funds for all eligible claims.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. New coding to more accurately record immigration status has been implemented. HFS received Federal approval to claim Federal matching funds for lawfully residing children under Section 214 of CHIPRA.

Duplicate Claims

As part of our review of EXPANDED ALL KIDS payments, auditors analyzed FY10 claim data and identified potential duplicate payments. A sample of 20 pairs of potential duplicate claims was chosen because the claims had the same recipient, same service date, same procedure, and both providers were paid the State maximum rate for the procedure. The judgmental sample of 20 possible duplicate claims was provided to HFS for explanation.

HFS reviewed each of the 20 potential duplicate pairs of claims and determined that 7 were duplicates. Examples of the seven duplicates included: claims submitted by the physician and by the hospital or clinic; and claims submitted by two different physicians. The seven duplicate claims totaled $1,428.

HFS officials indicated that implementation of this recommendation is still in progress. Since implementation of corrective action was not taken during the FY12 audit period, this recommendation is **repeated**. Detailed testing will be performed in the next audit cycle.

DUPLICATE CLAIMS	
RECOMMENDATION NUMBER **5**	***The Department of Healthcare and Family Services should review the manual review process for rejected claims and strengthen the controls to prevent duplicate claims from being paid.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department continues to enhance the data warehouse query to identify duplicates and reviews the data monthly.

Eligibility Documentation

All three of the previous ALL KIDS audits found that, due to the way HFS implemented the Covering ALL KIDS Health Insurance Act, HFS and the Department of Human Services (DHS) did not obtain documentation to support eligibility in some instances. This included documentation for residency, birth, and income. As a result, auditors could not determine whether eligibility was determined correctly by HFS and DHS.

On January 25, 2011, Public Act 96-1501 was adopted, which addressed some of this recommendation. The Public Act mandated two changes to eligibility documentation requirements. These changes required one month's worth of income verification for determining eligibility and required verification of Illinois residency. These changes were effective on July 1, 2011.

According to both HFS and DHS officials, effective March 14, 2012, an automated Secretary of State clearance was completed to verify residency. We tested whether HFS and DHS were verifying Illinois residency after March 14, 2012. We selected 50 cases identified by DHS that had eligibility beginning in June 2012. Both DHS and HFS pulled electronic and paper files for our review. HFS and DHS could not locate three of the recipient files, and an additional recipient file sampled had an application date prior to March 2012. Of the remaining 46 files reviewed, we found that residency was verified in 44 of the 46 files. Of the 44 recipients verified, 20 had eligibility verified by the Secretary of State clearance and 24 were verified by various forms of documentation. Documentation of residency verification included a social security number match with the Illinois Secretary of State's Office or hard copy documentation such as addresses on bills, Mexican Consular identification cards, driver's licenses, or pay stubs. Each of these documents contained the applicant's Illinois address. Although progress was made, in the 49 applicable files tested, proof of residency verification was not found in two files and three additional files were not able to be located by HFS and DHS; therefore, this part of the recommendation is **repeated** and will be followed up on in future audits.

In addition, HFS and DHS indicated that the new income requirement was not addressed in FY12. As a result, since HFS and DHS have not implemented the required one month's worth of income requirement, the status of this part of the recommendation is **repeated**. This recommendation will be followed up on during the next audit cycle.

During our FY10 review, auditors found that HFS and DHS did not properly determine whether individuals actually were or were not self-employed. Errors and inconsistencies in determining the income of self-employed individuals could again result in a family paying a higher premium or co-pay, or could result in the State paying for a greater portion of a child's medical services than necessary. According to both HFS and DHS, neither agency has addressed the portion of the recommendation related to applicants who are self-employed; therefore, the status of this part of the recommendation is **repeated**.

ELIGIBILITY DOCUMENTATION	
RECOMMENDATION NUMBER **6**	***The Department of Healthcare and Family Services and the Department of Human Services should:*** • ***ensure that all necessary eligibility documentation to support birth, identity, and residency is received in order to ensure that eligibility is determined accurately;*** • ***require one month's worth of income verification for determining eligibility; and*** • ***implement better controls to verify whether individuals are self-employed and to ensure that adequate information is provided and eligibility is determined correctly.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department has implemented electronic verification of citizenship, identity, residency, and income. Paper verification is requested when these items cannot be verified electronically. These procedural changes assure HFS is fully compliant with both State and Federal law.
DEPARTMENT OF HUMAN SERVICES' RESPONSE Continued on following page	The Department of Human Services (DHS) agrees with the recommendation. 1. DHS follows policy set forth by the Illinois Department of Healthcare and Family Services (HFS), the single state Medicaid agency. In March 2012, an automated Secretary of State residency clearance is generated for new medical applicants and requestors over the age of 16 registered in the Automated Intake System (AIS) or the Integrated Eligibility System (IES) in the All Kids unit, and in all DHS Family and Community Resource Centers (FCRCs). That clearance is to be filed in the case record. The Department currently follows policy created by HFS regarding eligibility documentation supporting birth and identity.

	2. Effective with medical applications submitted on or after 10/1/13, and to coincide with the implementation of the first phase of the Integrated Eligibility System, policy has now changed to clarify that as required under the Affordable Care Act, electronic data matches are the preferred means of verifying income in order to determine proper eligibility for medical programs, and that verification of 30 days of income is now required for all medical programs. 3. DHS has not identified an alternative source to verify self employment income other than current policy of requiring business records of income and expenses. The Illinois Medicaid Redetermination Project contract with Maximus utilizes electronic income verification that may assist in identifying income that has not been disclosed by the recipient. DHS will request clarification from the federal Center for Medicare and Medicaid Services on the existence of any federal regulation on self-employment income verification, and whether we are currently in compliance.

Transportation Claims

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over transportation claims. As a result, transportation providers were able to bill multiple trips in a single day for the same recipient. Additionally, controls in the billing system do not contain edits for pickup or drop off times or locations.

In its updated responses, HFS officials indicated that corrective action was taken to address this recommendation prior to the current audit period. This includes implementing system edits to allow only one round trip per day and sending notices to providers reminding them to submit accurate claim details.

We reviewed FY12 transportation claims and continued to find duplicate transportation claims and claims with inaccurate details. Our review identified seven providers that billed 202 duplicate services totaling $1,524 in FY12. We also identified 141 services totaling $2,925 that did not have the necessary information to make any determinations about the services that were provided. For example, there were several instances where all the origin and destination times for a given day for a recipient were all the same. Likewise, there were several instances where the origin and destination locations were all the same. Since it was not possible to determine where and when these recipients were picked up and where and when they were dropped off, it is unclear how the claims were approved for payment.

Since we continue to find issues with transportation claim documentation, the status of this recommendation is **repeated**. This recommendation will be followed up on during the next audit cycle.

TRANSPORTATION CLAIMS	
RECOMMENDATION NUMBER **7**	***The Department of Healthcare and Family Services should:*** • ***ensure that proper electronic billing edits are in place to prevent payment of duplicate transportation claims. In addition, HFS should identify and recoup past duplicate payments made to providers; and*** • ***ensure that transportation providers submit accurate claim detail with their request for payment to ensure HFS has the information necessary for monitoring.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. A Project Initialization Request was prepared to program a system edit that will only allow one round-trip per prior approval number per day. The Department is also working to place some restrictions on origin and destination times and require the input of address and city information by providers to help ensure more accurate claim detail.

Optical Edits

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over optical claims. HFS allows children to receive as many eyeglasses as needed through the Department of Corrections – Illinois Correctional Industries (ICI) without prior approval. As a result, optical providers were able to bill for multiple frames and fittings for same recipient during the year. Specifically, auditors identified one provider with a large number of recipients receiving multiple frames and fittings during FY10. Additionally, auditors also determined that HFS did not have effective controls in place over the number of eye exams billed for each recipient.

Due to this provider's high correlation of customers with multiple pairs of frames received during FY10, auditors reported this provider to HFS and to the HFS-OIG for further investigation. The HFS-OIG noted it was aware of this provider's billing patterns and was in the early stages of auditing this provider. We followed up with the OIG in the FY11 audit; the OIG failed to act on our referral and noted it could not find a case on this provider.

In an updated response to this recommendation, the HFS Office of the Inspector General (OIG) stated that it was in the process of developing predictive modeling routines related to optical care. The OIG also noted it ran data mining routines to determine children with multiple eyeglass expenditures, and requested charts to determine whether the multiple eyeglasses were medically necessary or if there was evidence of fraud, waste, or abuse. During our FY12 review, the OIG had not completed a review, but indicated it was currently auditing the provider that was identified in the FY10 audit.

Since the steps taken by the OIG occurred after our FY12 audit period, the status of this recommendation is **repeated**. Therefore, this recommendation will be followed up on during the next audit cycle.

OPTICAL EDITS	
RECOMMENDATION NUMBER **8**	***The Department of Healthcare and Family Services should ensure that electronic billing edits exist to identify potential abuse related to the ordering of eyeglass frames and for the billing of exams and fittings. Additionally, HFS should identify and recoup unallowable past optical payments made to providers.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. OIG has specifically run data mining routines to determine the top 7 children with multiple eyeglass expenditures and they are limited to 3 practitioners tied to one alternate payee. OIG is requesting these charts to determine whether the provision of multiple eyeglasses to these children is medically necessary or evidence of fraud, waste or abuse for this alternate payee. A provider notice will be sent reminding providers to retain documentation that exams or glasses exceeding the benefit limitation are either medically necessary, due to a change in prescription, or the glasses were lost, stolen or broken beyond repair. It should be noted that for Title XIX and XXI over 99% of the exam claims were for two exams or less and over 99% of the claims for glasses were for one to two pairs in FY13.

Guidance Over Preventive Medicine Service Claims

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over the billing of preventive medicine service claims. The claims are for preventive medicine services for healthy children who are established patients. According to an HFS official, preventive medicine services are used for annual doctor visits and are not to be used numerous times per year. These services generally bill at a higher rate than a problem focused visit. In the FY10 EXPANDED ALL KIDS claim data, we identified 1,013 recipients that received three or more preventive medicine services for healthy children.

As a result, we recommended HFS more clearly define how providers should bill preventive medicine services and should ensure that electronic billing edits exist to identify potential abuse related to the billing of preventive medicine services. HFS accepted this recommendation and provided the following updated response in May 2012: "*A provider notice was sent in May 2011 to remind providers of the proper use and frequency limits of preventative CPT codes. As of April 2011, the Bureau of Claims Processing has also initiated a manual review of applicable preventative CPT codes.*"

During our review of the FY12 data, auditors identified numerous EXPANDED ALL KIDS recipients that received preventive medicine services for healthy children during FY12 that

exceeded the benefit limitation. The Handbook for Providers of Healthy Kids Services establishes the number of preventive medicine services allowed per year by age of the recipient. Exhibit 8 shows the number of recipients exceeding the benefit limit and the total number of claims exceeding the limit for FY12. We identified 2,255 recipients that received 2,732 preventive medicine services in excess of the limit. According to HFS, controls were not set up to address this until December 2012. As a result, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2012, to June 30, 2013.

Exhibit 8
PREVENTIVE MEDICINE SERVICES EXCEEDING BENEFIT LIMITS
Fiscal Year 2012

Age at Time of Service	No. of Preventive Medicine Services Allowed	Number of Recipients Exceeding Benefit Limit	No. of Preventive Medicine Services Exceeding Benefit Limit
Less than 1 year	6	5	12
1 to 3 years	4	4	4
3 to 6 years	1	268	318
6 to 19 years	Every other year or more if medically necessary	1,978	2,398
Totals		**2,255**	**2,732**

Source: FY12 ALL KIDS data provided by HFS.

GUIDANCE OVER PREVENTIVE MEDICINE SERVICE CLAIMS	
RECOMMENDATION NUMBER **9**	***The Department of Healthcare and Family Services should more clearly define how providers should bill preventive medicine services and should distinguish between preventive services and office visits for established patients. The Department should also ensure that electronic billing edits exist to identify potential abuse related to the billing of preventive medicine services.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department has issued a Provider Notice reminding providers of the proper use and frequency limits of preventive services codes. The Department is working to institute systematic edits to limit the number of preventive service billings.

Inconsistent Dental Policies

During our review of FY10 EXPANDED ALL KIDS dental claims, we found deficiencies in controls related to dental billings. Auditors found instances in FY10 data where dental services were paid for in excess of the allowed benefit schedule. Auditors also found instances where the allowed benefit schedule differed from what officials said was allowed and from what was posted on HFS' ALL KIDS Dental Services webpage. Additionally, we identified billing outliers within the dental claims. These irregularities were reported to the Department of Healthcare and Family Services for follow-up and/or investigation.

In this FY12 audit, we analyzed the data and did not find instances of payments beyond the established frequency limits for periodic oral examinations, sealants, and prophylaxes (cleanings).

Additionally, in the FY10 and FY11 audits, we recommended that HFS ensure that dental policies or other information available to the public accurately states frequency of benefits. We found in our FY12 review, the ALL KIDS Dental Services webpage still states that children are limited to a periodic oral exam once every 12 months per dentist, whereas the Dental Office Reference Manual schedule of Benefits still states that children can receive an oral exam once every 6 months in an office setting and once every 12 months in a school setting. HFS indicated that it was in the process of revising the Dental Office Manual and Administrative Rules to accurately state frequency and benefits. As a result, the status of this part of the recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2012, to June 30, 2013.

During this audit, we followed up on providers that we referred to the HFS OIG during our FY10 audit. In response to our inquiry, the OIG noted one provider was audited and the provider repaid $9,471. The OIG performed Quality of Care Reviews which found no issues for two of the other providers referred in FY10. For the last provider, the OIG initiated a Special Project Audit in FY10 which was never completed. During our review of top ten providers in FY12, we found this provider continued to have a high average cost per client or other outliers, and again referred this provider to the OIG. According to the OIG, it is currently auditing this provider.

INCONSISTENT DENTAL POLICIES	
RECOMMENDATION NUMBER **10**	***The Department of Healthcare and Family Services should ensure that dental policies and other information available to the public accurately state frequency of benefits.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department will revise Administrative Rules to accurately state frequency of benefits. In addition, HFS will update the Dental Office Reference Manual as well as the website to be consistent with the Administrative Rules.

SCOPE AND METHODOLOGY

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

The audit's objectives are contained in the Covering ALL KIDS Health Insurance Act [215 ILCS 170/63] (see Appendix A). The Act directs the Office of the Auditor General to annually conduct an audit of the program that includes payments for health services covered by the program and contracts entered into by the Department in relation to the program. This is the fourth annual audit directed by the Covering ALL KIDS Health Insurance Act.

During this audit, we mainly focused on following up on previous audits' recommendations. However, we did review two additional areas. Based on FY12 payments, we reviewed pharmacy claims for the top 20 recipients, and we reviewed the top 10 individual providers. We identified two pharmacy payments for one recipient that were more than $71,000, and followed up on them with HFS. According to HFS, the expense was allowable due to the high dosage for this recipient and high cost of this type of drug. During our review of providers, we identified one dentist that had billing outliers. This was a provider that we had identified in the past and had previously reported to the HFS OIG. We again reported our findings to the OIG. Since many of the changes were made by HFS and DHS after FY12 ended, the follow-up on these recommendations will be conducted during the FY13 audit. Like in fiscal years 2010 and 2011, HFS officials reported that there were no contracts specific to the ALL KIDS Expansion for FY12.

To follow up on two areas, we tested two new eligibility procedures that were implemented during FY12. We tested to see whether residency was being verified and whether DHS was including stepparent income in its eligibility calculations. To test residency, we randomly selected 50 of the 293 recipient files that were identified by DHS as being enrolled in June 2012. DHS local offices could not provide three of the recipient files, and an additional recipient file sampled had an application date prior to March 2012 and was excluded from our review. To test stepparent income, we randomly selected 20 of 975 cases that DHS identified as potentially having a stepparent or other caretaker relative. Neither of these samples should be projected to the population.

Since the data system was reviewed during a previous audit, we did not review the data system during FY12. However, we did review the data for completeness by conducting limit tests and range tests. Any weaknesses in internal controls that have not been addressed from the previous audits are included as findings in this report.

APPENDICES

APPENDIX A

Covering ALL KIDS Health Insurance Act [215 ILCS 170]

Notes:

The requirement to audit the Covering ALL KIDS Health Insurance Program is found at 215 ILCS 170/63 of this appendix.

The version of the Covering ALL KIDS Health Insurance Act presented in this appendix is not current; it is current for the FY12 audit period.

Appendix A

THE COVERING ALL KIDS HEALTH INSURANCE ACT [215 ILCS 170]

(215 ILCS 170/1)

(Section scheduled to be repealed on July 1, 2016)

Sec. 1. Short title. This Act may be cited as the Covering ALL KIDS Health Insurance Act.

(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/5)

(Section scheduled to be repealed on July 1, 2016)

Sec. 5. Legislative intent. The General Assembly finds that, for the economic and social benefit of all residents of the State, it is important to enable all children of this State to access affordable health insurance that offers comprehensive coverage and emphasizes preventive healthcare. Many children in working families, including many families whose family income ranges between $40,000 and $80,000, are uninsured. Numerous studies, including the Institute of Medicine's report, "Health Insurance Matters", demonstrate that lack of insurance negatively affects health status. The General Assembly further finds that access to healthcare is a key component for children's healthy development and successful education. The effects of lack of insurance also negatively impact those who are insured because the cost of paying for care to the uninsured is often shifted to those who have insurance in the form of higher health insurance premiums. A Families USA 2005 report indicates that family premiums in Illinois are increased by $1,059 due to cost-shifting from the uninsured. It is, therefore, the intent of this legislation to provide access to affordable health insurance to all uninsured children in Illinois.

(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/7)

(Section scheduled to be repealed on July 1, 2016)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial

from the federal government, this Section shall be implemented:

(a) The Department of Healthcare and Family Services or its designees shall:

(1) By July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants to the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section.

(2) By October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility under the Program. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice, a notice of cancellation shall be issued to the recipient and coverage shall end on the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the month following the last date of coverage. Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By July 1, 2011, require verification of Illinois residency.

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for

benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data will be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another individual's eligibility.

(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility verification.

(Source: P.A. 96-1501, eff. 1-25-11.)

(215 ILCS 170/10)

(Section scheduled to be repealed on July 1, 2016)

Sec. 10. Definitions. In this Act:

"Application agent" means an organization or individual, such as a licensed health care provider, school, youth service agency, employer, labor union, local chamber of commerce, community-based organization, or other organization, approved by the Department to assist in enrolling children in the Program.

"Child" means a person under the age of 19.

"Department" means the Department of Healthcare and Family Services.

"Medical assistance" means health care benefits provided under Article V of the Illinois Public Aid Code.

"Program" means the Covering ALL KIDS Health Insurance Program.

"Resident" means an individual (i) who is in the State for other than a temporary or transitory purpose during the taxable year or (ii) who is domiciled in this State but is absent from the State for a temporary or transitory purpose during the taxable year.

(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/15)

(Section scheduled to be repealed on July 1, 2016)

Sec. 15. Operation of Program. The Covering ALL KIDS Health Insurance Program is created. The Program shall be administered by the Department of Healthcare and Family Services. The Department shall have the same powers and authority to administer the Program as are provided to the Department in connection with the Department's administration of the Illinois Public Aid Code, including, but

not limited to, the provisions under Section 11-5.1 of the Code, and the Children's Health Insurance Program Act. The Department shall coordinate the Program with the existing children's health programs operated by the Department and other State agencies.
(Source: P.A. 96-1501, eff. 1-25-11.)

(215 ILCS 170/20)
(Section scheduled to be repealed on July 1, 2016)
Sec. 20. Eligibility.
(a) To be eligible for the Program, a person must be a child:
(1) who is a resident of the State of Illinois;
(2) who is ineligible for medical assistance under the Illinois Public Aid Code or benefits under the Children's Health Insurance Program Act;
(3) either (i) who has been without health insurance coverage for 12 months, (ii) whose parent has lost employment that made available affordable dependent health insurance coverage, until such time as affordable employer-sponsored dependent health insurance coverage is again available for the child as set forth by the Department in rules, (iii) who is a newborn whose responsible relative does not have available affordable private or employer-sponsored health insurance, or (iv) who, within one year of applying for coverage under this Act, lost medical benefits under the Illinois Public Aid Code or the Children's Health Insurance Program Act; and
(3.5) whose household income, as determined by the Department, is at or below 300% of the federal poverty level. This item (3.5) is effective July 1, 2011.
An entity that provides health insurance coverage (as defined in Section 2 of the Comprehensive Health Insurance Plan Act) to Illinois residents shall provide health insurance data match to the Department of Healthcare and Family Services as provided by and subject to Section 5.5 of the Illinois Insurance Code.
The Department of Healthcare and Family Services, in collaboration with the Department of Insurance, shall adopt rules governing the exchange of information under this Section. The rules shall be consistent with all laws relating to the confidentiality or privacy of personal information or medical records, including provisions under the Federal Health Insurance Portability and Accountability Act (HIPAA).
(b) The Department shall monitor the availability and retention of employer-sponsored dependent health insurance

coverage and shall modify the period described in subdivision (a)(3) if necessary to promote retention of private or employer-sponsored health insurance and timely access to healthcare services, but at no time shall the period described in subdivision (a)(3) be less than 6 months.

(c) The Department, at its discretion, may take into account the affordability of dependent health insurance when determining whether employer-sponsored dependent health insurance coverage is available upon reemployment of a child's parent as provided in subdivision (a)(3).

(d) A child who is determined to be eligible for the Program shall remain eligible for 12 months, provided that the child maintains his or her residence in this State, has not yet attained 19 years of age, and is not excluded under subsection (e).

(e) A child is not eligible for coverage under the Program if:

(1) the premium required under Section 40 has not been timely paid; if the required premiums are not paid, the liability of the Program shall be limited to benefits incurred under the Program for the time period for which premiums have been paid; re-enrollment shall be completed before the next covered medical visit, and the first month's required premium shall be paid in advance of the next covered medical visit; or

(2) the child is an inmate of a public institution or an institution for mental diseases.

(f) The Department may adopt rules, including, but not limited to: rules regarding annual renewals of eligibility for the Program in conformance with Section 7 of this Act; rules providing for re-enrollment, grace periods, notice requirements, and hearing procedures under subdivision (e)(1) of this Section; and rules regarding what constitutes availability and affordability of private or employer-sponsored health insurance, with consideration of such factors as the percentage of income needed to purchase children or family health insurance, the availability of employer subsidies, and other relevant factors.

(g) Each child enrolled in the Program as of July 1, 2011 whose family income, as established by the Department, exceeds 300% of the federal poverty level may remain enrolled in the Program for 12 additional months commencing July 1, 2011. Continued enrollment pursuant to this subsection shall be available only if the child continues to meet all eligibility criteria established under the Program as of the effective date of this amendatory Act of the 96th General

Assembly without a break in coverage. Nothing contained in this subsection shall prevent a child from qualifying for any other health benefits program operated by the Department.
(Source: P.A. 96-1272, eff. 1-1-11; 96-1501, eff. 1-25-11.)

(215 ILCS 170/21)
(Section scheduled to be repealed on July 1, 2016)
Sec. 21. Presumptive eligibility. Beginning on the effective date of this amendatory Act of the 96th General Assembly and except where federal law or regulation requires presumptive eligibility, no adult may be presumed eligible for health care coverage under the Program and the Department may not cover any service rendered to an adult unless the adult has completed an application for benefits, all required verifications have been received, and the Department or its designee has found the adult eligible for the date on which that service was provided. Nothing in this Section shall apply to pregnant women.
(Source: P.A. 96-1501, eff. 1-25-11.)

(215 ILCS 170/25)
(Section scheduled to be repealed on July 1, 2016)
Sec. 25. Enrollment in Program. The Department shall develop procedures to allow application agents to assist in enrolling children in the Program or other children's health programs operated by the Department. At the Department's discretion, technical assistance payments may be made available for approved applications facilitated by an application agent. The Department shall permit day and temporary labor service agencies, as defined in the Day and Temporary Labor Services Act and doing business in Illinois, to enroll as unpaid application agents. As established in the Free Healthcare Benefits Application Assistance Act, it shall be unlawful for any person to charge another person or family for assisting in completing and submitting an application for enrollment in this Program.
(Source: P.A. 96-326, eff. 8-11-09.)

(215 ILCS 170/30)
(Section scheduled to be repealed on July 1, 2016)
Sec. 30. Program outreach and marketing. The Department may provide grants to application agents and other community-based organizations to educate the public about the availability of the Program. The Department shall adopt rules regarding performance standards and outcomes measures expected of organizations that are awarded grants

under this Section, including penalties for nonperformance of contract standards.

The Department shall annually publish electronically on a State website and in no less than 2 newspapers in the State the premiums or other cost sharing requirements of the Program. (Source: P.A. 94-693, eff. 7-1-06; 95-985, eff. 6-1-09.)

(215 ILCS 170/35)

(Section scheduled to be repealed on July 1, 2016)

Sec. 35. Health care benefits for children.

(a) The Department shall purchase or provide health care benefits for eligible children that are identical to the benefits provided for children under the Illinois Children's Health Insurance Program Act, except for non-emergency transportation.

(b) As an alternative to the benefits set forth in subsection (a), and when cost-effective, the Department may offer families subsidies toward the cost of privately sponsored health insurance, including employer-sponsored health insurance.

(c) Notwithstanding clause (i) of subdivision (a)(3) of Section 20, the Department may consider offering, as an alternative to the benefits set forth in subsection (a), partial coverage to children who are enrolled in a high-deductible private health insurance plan.

(d) Notwithstanding clause (i) of subdivision (a)(3) of Section 20, the Department may consider offering, as an alternative to the benefits set forth in subsection (a), a limited package of benefits to children in families who have private or employer-sponsored health insurance that does not cover certain benefits such as dental or vision benefits.

(e) The content and availability of benefits described in subsections (b), (c), and (d), and the terms of eligibility for those benefits, shall be at the Department's discretion and the Department's determination of efficacy and cost-effectiveness as a means of promoting retention of private or employer-sponsored health insurance.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/36)

(Section scheduled to be repealed on July 1, 2016)

Sec. 36. Moratorium on eligibility expansions. Beginning on the effective date of this amendatory Act of the 96th General Assembly, there shall be a 2-year moratorium on the expansion of eligibility through increasing financial eligibility standards, or through increasing income disregards, or

through the creation of new programs that would add new categories of eligible individuals under the medical assistance program under the Illinois Public Aid Code in addition to those categories covered on January 1, 2011. This moratorium shall not apply to expansions required as a federal condition of State participation in the medical assistance program.
(Source: P.A. 96-1501, eff. 1-25-11.)

(215 ILCS 170/40)
(Section scheduled to be repealed on July 1, 2016)
Sec. 40. Cost-sharing.
(a) Children enrolled in the Program under subsection (a) of Section 35 are subject to the following cost-sharing requirements:
(1) The Department, by rule, shall set forth requirements concerning co-payments and coinsurance for health care services and monthly premiums. This cost-sharing shall be on a sliding scale based on family income. The Department may periodically modify such cost-sharing.
(2) Notwithstanding paragraph (1), there shall be no co-payment required for well-baby or well-child health care, including, but not limited to, age-appropriate immunizations as required under State or federal law.
(b) Children enrolled in a privately sponsored health insurance plan under subsection (b) of Section 35 are subject to the cost-sharing provisions stated in the privately sponsored health insurance plan.
(c) Notwithstanding any other provision of law, rates paid by the Department shall not be used in any way to determine the usual and customary or reasonable charge, which is the charge for health care that is consistent with the average rate or charge for similar services furnished by similar providers in a certain geographic area.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/41)
(Section scheduled to be repealed on July 1, 2016)
Sec. 41. Health care provider participation in State Employees Deferred Compensation Plan. Notwithstanding any other provision of law, a health care provider who participates under the Program may elect, in lieu of receiving direct payment for services provided under the Program, to participate in the State Employees Deferred Compensation Plan adopted under Article 24 of the Illinois Pension Code. A health care provider who elects to participate in the plan does

not have a cause of action against the State for any damages allegedly suffered by the provider as a result of any delay by the State in crediting the amount of any contribution to the provider's plan account.
(Source: P.A. 96-806, eff. 7-1-10.)

(215 ILCS 170/45)
(Section scheduled to be repealed on July 1, 2016)
Sec. 45. Study; contracts.
(a) The Department shall conduct a study that includes, but is not limited to, the following:
(1) Establishing estimates, broken down by regions of the State, of the number of children with and without health insurance coverage; the number of children who are eligible for Medicaid or the Children's Health Insurance Program, and, of that number, the number who are enrolled in Medicaid or the Children's Health Insurance Program; and the number of children with access to dependent coverage through an employer, and, of that number, the number who are enrolled in dependent coverage through an employer.
(2) Surveying those families whose children have access to employer-sponsored dependent coverage but who decline such coverage as to the reasons for declining coverage.
(3) Ascertaining, for the population of children accessing employer-sponsored dependent coverage or who have access to such coverage, the comprehensiveness of dependent coverage available, the amount of cost-sharing currently paid by the employees, and the cost-sharing associated with such coverage.
(4) Measuring the health outcomes or other benefits for children utilizing the Covering ALL KIDS Health Insurance Program and analyzing the effects on utilization of healthcare services for children after enrollment in the Program compared to the preceding period of uninsured status.
(b) The studies described in subsection (a) shall be conducted in a manner that compares a time period preceding or at the initiation of the program with a later period.
(c) The Department shall submit the preliminary results of the study to the Governor and the General Assembly no later than July 1, 2008 and shall submit the final results to the Governor and the General Assembly no later than July 1, 2010.
(d) The Department shall submit copies of all contracts

awarded for the administration of the Program to the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate.
(Source: P.A. 94-693, eff. 7-1-06; 95-985, eff. 6-1-09.)

(215 ILCS 170/47)
(Section scheduled to be repealed on July 1, 2016)
Sec. 47. Program Information. The Department shall report to the General Assembly no later than September 1 of each year beginning in 2007, all of the following information:
(a) The number of professionals serving in the primary care case management program, by licensed profession and by county, and, for counties with a population of 100,000 or greater, by geo zip code.
(b) The number of non-primary care providers accepting referrals, by specialty designation, by licensed profession and by county, and, for counties with a population of 100,000 or greater, by geo zip code.
(c) The number of individuals enrolled in the Covering ALL KIDS Health Insurance Program by income or premium level and by county, and, for counties with a population of 100,000 or greater, by geo zip code.
(Source: P.A. 95-650, eff. 6-1-08.)

(215 ILCS 170/50)
(Section scheduled to be repealed on July 1, 2016)
Sec. 50. Consultation with stakeholders. The Department shall present details regarding implementation of the Program to the Medicaid Advisory Committee, and the Committee shall serve as the forum for healthcare providers, advocates, consumers, and other interested parties to advise the Department with respect to the Program. The Department shall consult with stakeholders on the rules for healthcare professional participation in the Program pursuant to Sections 52 and 53 of this Act.
(Source: P.A. 94-693, eff. 7-1-06; 95-650, eff. 6-1-08.)

(215 ILCS 170/52)
(Section scheduled to be repealed on July 1, 2016)
Sec. 52. Adequate access to specialty care.
(a) The Department shall ensure adequate access to specialty physician care for Program participants by allowing referrals to be accomplished without undue delay.
(b) The Department shall allow a primary care provider to make appropriate referrals to specialist physicians or other

healthcare providers for an enrollee who has a condition that requires care from a specialist physician or other healthcare provider. The Department may specify the necessary criteria and conditions that must be met in order for an enrollee to obtain a standing referral. A referral shall be effective for the period necessary to provide the referred services or one year, whichever is less. A primary care provider may renew and re-renew a referral.

(c) The enrollee's primary care provider shall remain responsible for coordinating the care of an enrollee who has received a standing referral to a specialist physician or other healthcare provider. If a secondary referral is necessary, the specialist physician or other healthcare provider shall advise the primary care physician. The primary care physician or specialist physician shall be responsible for making the secondary referral. In addition, the Department shall require the specialist physician or other healthcare provider to provide regular updates to the enrollee's primary care provider.
(Source: P.A. 95-650, eff. 6-1-08.)

(215 ILCS 170/53)
(Section scheduled to be repealed on July 1, 2016)
Sec. 53. Program standards.

(a) Any disease management program implemented by the Department must be or must have been developed in consultation with physician organizations, such as State, national, and specialty medical societies, and any available standards or guidelines of these organizations. These programs must be based on evidence-based, scientifically sound principles that are accepted by the medical community. An enrollee must be excused from participation in a disease management program if the enrollee's physician licensed to practice medicine in all its branches, in his or her professional judgment, determines that participation is not beneficial to the enrollee.

(b) Any performance measures, such as primary care provider monitoring, implemented by the Department must be or must have been developed on consultation with physician organizations, such as State, national, and specialty medical societies, and any available standards or guidelines of these organizations. These measures must be based on evidence-based, scientifically sound principles that are accepted by the medical community.

(c) The Department shall adopt variance procedures for the application of any disease management program or any performance measures to an individual enrollee.

(Source: P.A. 95-650, eff. 6-1-08.)

(215 ILCS 170/54)

Sec. 54. Dental home initiative. The Department, in cooperation with the dental community and other affected organizations such as Head Start, shall work to develop and promote the concept of a dental home for children covered under this Act. Included in this dental home outreach should be an effort to ensure an ongoing relationship between the patient and the dentist with an effort to provide comprehensive, coordinated, oral health care so that all children covered under this Act have access to preventative and restorative oral health care.
(Source: P.A. 97-283, eff. 8-9-11.)

(215 ILCS 170/55)

(Section scheduled to be repealed on July 1, 2016)

Sec. 55. Charge upon claims and causes of action; right of subrogation; recoveries. Sections 11-22, 11-22a, 11-22b, and 11-22c of the Illinois Public Aid Code apply to health care benefits provided to children under this Act, as provided in those Sections.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/56)

(Section scheduled to be repealed on July 1, 2016)

Sec. 56. Care coordination.

(a) At least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs or other health benefit programs administered by the Department, including the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a

culturally and linguistically appropriate manner; and (iii) to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.

(b) Payment for such coordinated care shall be based on arrangements where the State pays for performance related to health care outcomes, the use of evidence-based practices, the use of primary care delivered through comprehensive medical homes, the use of electronic medical records, and the appropriate exchange of health information electronically made either on a capitated basis in which a fixed monthly premium per recipient is paid and full financial risk is assumed for the delivery of services, or through other risk-based payment arrangements.

(c) To qualify for compliance with this Section, the 50% goal shall be achieved by enrolling medical assistance enrollees from each medical assistance enrollment category, including parents, children, seniors, and people with disabilities to the extent that current State Medicaid payment laws would not limit federal matching funds for recipients in care coordination programs. In addition, services must be more comprehensively defined and more risk shall be assumed than in the Department's primary care case management program as of the effective date of this amendatory Act of the 96th General Assembly.

(d) The Department shall report to the General Assembly in a separate part of its annual medical assistance program report, beginning April, 2012 until April, 2016, on the progress and implementation of the care coordination program initiatives established by the provisions of this amendatory Act of the 96th General Assembly. The Department shall include in its April 2011 report a full analysis of federal laws or regulations regarding upper payment limitations to providers and the necessary revisions or adjustments in rate methodologies and payments to providers under this Code that would be necessary to implement coordinated care with full financial risk by a party other than the Department.

(Source: P.A. 96-1501, eff. 1-25-11.)

(215 ILCS 170/60)

(Section scheduled to be repealed on July 1, 2016)

Sec. 60. Federal financial participation. The Department shall request any necessary state plan amendments or waivers of federal requirements in order to allow receipt of federal funds for implementing any or all of the provisions of the

Program. The failure of the responsible federal agency to approve a waiver or other State plan amendment shall not prevent the implementation of any provision of this Act.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/63)
(Section scheduled to be repealed on July 1, 2016)
Sec. 63. Audits by the Auditor General. The Auditor General shall annually cause an audit to be made of the Program, beginning June 30, 2008 and each June 30th thereafter. The audit shall include payments for health services covered by the Program and contracts entered into by the Department in relation to the Program.
(Source: P.A. 95-985, eff. 6-1-09.)

(215 ILCS 170/65)
Sec. 65. (Repealed).
(Source: P.A. 94-693, eff. 7-1-06. Repealed internally, eff. 7-1-08.)

(215 ILCS 170/90)
(Section scheduled to be repealed on July 1, 2016)
Sec. 90. (Amendatory provisions; text omitted).
(Source: P.A. 94-693, eff. 7-1-06; text omitted.)

(215 ILCS 170/97)
(Section scheduled to be repealed on July 1, 2016)
Sec. 97. Severability. If any provision of this Act or its application to any person or circumstance is held invalid, the invalidity of that provision or application does not affect other provisions or applications of this Act that can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/98)
(Section scheduled to be repealed on July 1, 2016)
Sec. 98. Repealer. This Act is repealed on July 1, 2016.
(Source: P.A. 96-1501, eff. 1-25-11.)

(215 ILCS 170/99)
(Section scheduled to be repealed on July 1, 2016)
Sec. 99. Effective date. This Act takes effect July 1, 2006.
(Source: P.A. 94-693, eff. 7-1-06.)

APPENDIX B

Covering ALL KIDS Health Insurance Act Plans

Appendix B

COVERING ALL KIDS HEALTH INSURANCE ACT PLANS

	Premium	Max Monthly Premium	Physician Visit	Emergency Room Visit	Generic/ Brand Name Drug	Inpatient Admission	Outpatient Service	Annual Out-of-Pocket Max.
Assist	None	n/a	None	None	None	None	None	None
Share	None	n/a	$2	$2	$2	$2	$2	$100 per family
Premium Level 1	$15 (1) [1] $25 (2) $30 (3) $35 (4) $40 (5+)	$40	$5	$25 [2]	$3/$5	$5	$5	$100 per family
Premium Level 2	$40 per child	$80	$10	$30	$3/$7	$100	5% of ALL KIDS payment rate	$500 per child
Premium Level 3	$70 per child	$140	$15	$50	$6/$14	$150	10% of ALL KIDS payment rate	$750 per child
Premium Level 4	$100 per child	$200	$20	$75	$9/$21	$200	15% of ALL KIDS payment rate	$1,000 per child
Premium Level 5	$150 per child	None	$25	$100	$12/$28	10% of ALL KIDS payment rate	20% of ALL KIDS payment rate	$5,000 per child
Premium Level 6	$200 per child	None	$25	$100	$12/$28	10% of ALL KIDS payment rate	20% of ALL KIDS payment rate	$5,000 per child
Premium Level 7	$250 per child	None	$25	$100	$12/$28	10% of ALL KIDS payment rate	20% of ALL KIDS payment rate	$5,000 per child
Premium Level 8	$300 per child	None	$25	$100	$12/$28	25% of ALL KIDS payment rate	25% of ALL KIDS payment rate	None

Source: ALL KIDS Final Report –July 2010.

[1] The number in parentheses denotes the number of family members

[2] Co-pay for non-emergency visits only

APPENDIX C
ALL KIDS Application

Note: The application presented is the application used during the audit period. A new application dated 4-13 is currently being used.

State of Illinois
Illinois Department of Healthcare and Family Services

All Kids Healthcare for All Kids
FamilyCare
Moms & Babies

Application

for All Kids, FamilyCare, and Moms & Babies Health Insurance

Nothing is more important than making sure your family has access to healthcare. Programs like these make that possible. Thank you for taking the time to complete this application. You can also apply online at www.allkids.com.

- **All Kids** covers children who need health insurance. Some families who pay for private health insurance for their children may qualify for help to pay their premiums.
- **FamilyCare** covers parents living with their children age 18 or younger. FamilyCare also covers grandparents or other relatives who are raising children in place of their parents. Some families who pay for private health insurance may qualify for help to pay their premiums.
- **Moms & Babies** covers pregnant women and their babies.

Apply now! Print in ink. Answer all the questions. If you need more space use an extra sheet of paper. If someone in your family already gets All Kids, FamilyCare or Moms & Babies, you do not need to file a new application. Call your customer service representative or caseworker.

Tell us about the applicant.

The applicant is usually the person filling out this form. The applicant should be the parent, guardian, or relative a child lives with, or a pregnant woman.

Applicant's name _____ (Last) _____ (First)

Birth date __ __ / __ __ / __ __ __ __ (m m / d d / y y y y) **Social Security Number** __ __ __ - __ __ - __ __ __ __ (Optional)

Address _____ **Apt. #** _____

City _____ **State** _____ **Zip** _____ **County** _____

Phone (_____) _____ (Home), (_____) _____ (Work)

If you do not have a phone and we can reach you by calling someone else, tell us who.

Name _____, Phone ( ) _____

How many people live with you? _____ **How many of them want health insurance or help paying premiums?** _____

What language do you use the most? ☐ English ☐ Spanish ☐ Other _____

You can help us by answering the next two questions, but you do not have to tell us.

Are you of Hispanic or Latino origin? ☐ Yes ☐ No

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown (Mark **all** that apply.)

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

Tell us about the people who want health insurance or want help to pay premiums.

Be sure to list yourself if you want health insurance or want help to pay premiums.

	Person #1	Person #2	Person #3
1. Name	(Last, First)	(Last, First)	(Last, First)
2. Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
3. Birth date	__ __/__ __/__ __ __ __ (mm/dd/yyyy)	__ __/__ __/__ __ __ __ (mm/dd/yyyy)	__ __/__ __/__ __ __ __ (mm/dd/yyyy)
4. Tell us the Social Security Number, if the person has one. If they applied for one, tell us the date. ✔ Send proof they applied. **For anyone else, write N/A.**	__ __ __-__ __-__ __ __ __ ☐ This person applied for a number on _____. (mm/dd/yyyy)	__ __ __-__ __-__ __ __ __ ☐ This person applied for a number on _____. (mm/dd/yyyy)	__ __ __-__ __-__ __ __ __ ☐ This person applied for a number on _____. (mm/dd/yyyy)
5. How is this person related to the applicant?	☐ Son ☐ Daughter ☐ Self ☐ Spouse ☐ Other: _____	☐ Son ☐ Daughter ☐ Self ☐ Spouse ☐ Other: _____	☐ Son ☐ Daughter ☐ Self ☐ Spouse ☐ Other: _____
6. Is this person an American Indian or Alaska Native?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Has this person received medical care in the past 3 months that you want us to pay for? If yes, tell us which months. ✔ Send proof of income for each month, if different from your current income.	☐ Yes ☐ No 1. _____ 2. _____ 3. _____	☐ Yes ☐ No 1. _____ 2. _____ 3. _____	☐ Yes ☐ No 1. _____ 2. _____ 3. _____
8. Is this person pregnant or has this person been pregnant in the last 3 months? ✔ If yes, send a signed statement from a doctor or health clinic with the expected date of delivery and the number of the babies expected.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

Person #1	Person #2	Person #3

9. Is this person a U.S. citizen? If yes, tell us where they were born.

Person #1	Person #2	Person #3
☐ Yes City:_____ State:_____	☐ Yes City:_____ State:_____	☐ Yes City:_____ State:_____
☐ No	☐ No	☐ No

✔ If yes, provide one of the following documents: U.S. Passport, Certificate of Naturalization (N-550 or N-570) or Certificate of Citizenship (N-560 or N-561).
If these are not available, provide one item from each column:

Place of birth –

- Certified copy of a birth certificate from the state or county where the person was born;
- Final Adoption Decree;
- Official military record that shows a place of birth;
- Papers showing the person was employed by the U.S. government before 1976.

Identity –

- Driver's license;
- State issued ID card;
- School ID;
- U.S. military ID;
- U.S. military dependent card; or
- Other government ID (city, county or U.S. state issued).
- For children under age 16:
  - School or day care records or a report card, OR
  - A parent or guardian's signature on page 7 of this application

Read page 9 for more information on how to get your birth certificate.

10. If this person has a valid Alien Registration Number, write it below and provide proof. Pregnant women and children who do not have an Alien Registration Number may still get health insurance.

✔ Send a copy of one of the items listed below as proof for each Alien Registration Number you list on this form.

- Alien Registration Receipt Card, Permanent Resident Card or Green Card
- Passport with the following stamps or attachments: Arrival-Departure Record (I-94) including the stamp showing status, Resident Alien Form (I-551) or Temporary Resident Card (I-688)
- A court-ordered notice for asylees
- Other proof of lawful immigration status

Receiving most public health benefits should not affect a person's immigration status. The U.S. Citizenship and Immigration Service may consider someone to be a public charge if they live in long-term care, like a nursing home or mental health facility that the government pays for.

Person #1	Person #2	Person #3
11. Has this person had health insurance or Medicare any time in the last 12 months? If yes, complete all of the following.		
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Month, Day and Year Coverage Began __ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __
If the insurance ended, tell us the month, day and year it ended and why. __ __ / __ __ / __ __ __ __ ☐ Someone's job ended ☐ Met lifetime limit ☐ Other: _____	__ __ / __ __ / __ __ __ __ ☐ Someone's job ended ☐ Met lifetime limit ☐ Other: _____	__ __ / __ __ / __ __ __ __ ☐ Someone's job ended ☐ Met lifetime limit ☐ Other: _____
Insurance Company		
Name of Policyholder		
Policyholder's SSN (optional) __ __ __ - __ __ - __ __ __ __	__ __ __ - __ __ - __ __ __ __	__ __ __ - __ __ - __ __ __ __
Employer Name		
Phone Number ( )	( )	( )
Policy Number		
Group Number		
Are both physician and hospital services covered? ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is this COBRA insurance? COBRA is group insurance you buy from a former job. ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Relationship to policyholder		
If this person cannot use the insurance, tell us why.		
12. For anyone 18 or younger, we need their parents' names. You can help us by answering the other questions, but you do not have to tell us. **For anyone without this information, write N/A.**		
Mother's full name: SSN: __ __ __ - __ __ - __ __ __ __ Employer: ☐ Full-time ☐ Part-time	**Mother's** full name: SSN: __ __ __ - __ __ - __ __ __ __ Employer: ☐ Full-time ☐ Part-time	**Mother's** full name: SSN: __ __ __ - __ __ - __ __ __ __ Employer: ☐ Full-time ☐ Part-time
Father's full name: SSN: __ __ __ - __ __ - __ __ __ __ Employer: ☐ Full-time ☐ Part-time	**Father's** full name: SSN: __ __ __ - __ __ - __ __ __ __ Employer: ☐ Full-time ☐ Part-time	**Father's** full name: SSN: __ __ __ - __ __ - __ __ __ __ Employer: ☐ Full-time ☐ Part-time

Person #1	Person #2	Person #3

13. For anyone who is married, tell us about their spouse. You can help us by answering these questions, but you do not have to tell us. **For anyone without this information, write N/A.**

Spouse's full name:	**Spouse's** full name:	**Spouse's** full name:
SSN: __ __ __-__ __-__ __ __ __	SSN: __ __ __-__ __-__ __ __ __	SSN: __ __ __-__ __-__ __ __ __
Employer:	Employer:	Employer:
☐ Full-time ☐ Part-time	☐ Full-time ☐ Part-time	☐ Full-time ☐ Part-time

Tell us about other people in your family and your income.

14. We need to know about your family group to decide if you can get health insurance.
Family group means people in your family who live with you. You, your spouse, any children 18 or younger and their parents, if they also live with you, make up your family group.

Tell us about anyone in your family group who is NOT asking for health insurance.

Name _____ SSN (optional) __ __ __-__ __-__ __ __ __

Birth date __ __/__ __/__ __ __ __ Relationship to applicant _____

Name _____ SSN (optional) __ __ __-__ __-__ __ __ __

Birth date __ __/__ __/__ __ __ __ Relationship to applicant _____

Name _____ SSN (optional) __ __ __-__ __-__ __ __ __

Birth date __ __/__ __/__ __ __ __ Relationship to applicant _____

15. Is any adult, parent, stepparent, spouse or pregnant woman named on this form currently employed? ☐ Yes ☐ No

Is anyone named on this form self-employed or own their own business? ☐ Yes ☐ No

If yes, complete the following. If you own your own business or are self-employed, enter "self" for employer.

✔ Send a copy of one pay stub (including tips) received in the last 30 days from each job. If anyone is self-employed, provide 30 days of detailed business records that include income and expenses. For a sample form, visit www.allkids.com.

Name _____ Employer _____

Employer address _____ Phone (____) _____

Number of hours worked weekly _____ Amount paid before taxes (include tips, bonuses, commissions) _____ How often paid _____

Name _____ Employer _____

Employer address _____ Phone (____) _____

Number of hours worked weekly _____ Amount paid before taxes (include tips, bonuses, commissions) _____ How often paid _____

Name _____ Employer _____

Employer address _____ Phone (____) _____

Number of hours worked weekly _____ Amount paid before taxes (include tips, bonuses, commissions) _____ How often paid _____

16. Is anyone named on this form GETTING money from any source other than employment (such as Social Security, child support, spousal support, rental property, unemployment benefits, pensions, trusts)? ☐ Yes ☐ No **If yes, tell us about them.**

✔ Send proof of one payment received in the last 30 days for each source of income you list.

Name _____ Source _____

Payment amount _____ How often paid _____

If this is rental property income, does the person receiving the income manage the property? ☐ Yes ☐ No

Name _____ Source _____

Payment amount _____ How often paid _____

If this is rental property income, does the person receiving the income manage the property? ☐ Yes ☐ No

Name _____ Source _____

Payment amount: _____ How often paid _____

If this is rental property income, does the person receiving the income manage the property? ☐ Yes ☐ No

17. Is anyone named on this form PAYING child support or spousal support? ☐ Yes ☐ No **If yes, tell us how much they paid in the last month.**

✔ Send proof of one payment made to each person in the last 30 days.

Name _____ Amount _____ How often paid _____

Name _____ Amount _____ How often paid _____

18. Is anyone named on this form PAYING for child care so they can work? ☐ Yes ☐ No **If yes, tell us how much they paid in the last month for each child.**

Name of child in child care _____ **Name** of care giver _____

Person paying for care _____ Payment amount _____

Relationship of care giver to child (if any) _____ How often paid _____

Name of child in child care _____ **Name** of care giver _____

Person paying for care _____ Payment amount _____

Relationship of care giver to child (if any) _____ How often paid _____

Name of child in child care _____ **Name** of care giver _____

Person paying for care _____ Payment amount _____

Relationship of care giver to child (if any) _____ How often paid _____

19. Please tell us how you heard about All Kids.

Check all the boxes that apply.

- ☐ Radio ad
- ☐ TV ad
- ☐ Billboard
- ☐ Newspaper ad or story
- ☐ Mail sent to my home
- ☐ Internet or Website
- ☐ Doctor's office
- ☐ Clinic
- ☐ Hospital
- ☐ Friend or relative
- ☐ Employer
- ☐ School
- ☐ Government office or agency
- ☐ W.I.C. site
- ☐ Labor union
- ☐ Other: _____

Read and sign.

Read carefully, then sign and date the application below.

1. We will keep what you tell us private as required by law.
2. Some families have to make a payment each month for this health insurance. This payment is called a premium. The amount of the premium depends on the family's income.
3. Some families have to pay part of the bill when they visit the doctor, go into the hospital or get a prescription filled. These payments are called co-payments. The amount of co-payment depends on the family's income.
4. You agree the state may seek reimbursement for services the state covered for your family if those services should have been paid for by any other health coverage your family may have.
5. Be sure to answer the questions correctly. We may check all information on this form. You must help us if we ask you to prove that your information is right.
6. We will **not** share any information about immigration of any person who does not have an Alien Registration Number. We **will** verify the immigration status of any person if you gave us their Alien Registration Number. To do that, we will check the number with the U.S. Citizenship and Immigration Service (USCIS). We may send other information to USCIS, such as copies of proof you sent of an Alien Registration Number and the person's Social Security Number, if they have one.
7. You must tell your All Kids or FamilyCare representative within 10 days if any of the following happens:
   - Your income changes.
   - The number of people in your family who live with you changes.
   - Your address or phone number changes.
   - Someone who gets health benefits moves out of Illinois, dies, or goes to jail or prison.
8. If we pay medical bills for you, you give your right to collect medical support payments to the State of Illinois. You must help us if we ask you to establish paternity or obtain medical support payments for members of your family. You may not have to do this if you have a good reason not to. Your children can get health insurance even if you do not help us when we ask you to help.
9. Anyone who misuses our health insurance card may be committing a crime.

I declare under penalty of perjury that I have read all statements on this form and the information I give is true, correct and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information.

Applicant's signature _____ Date _____
(Make a mark and have another adult sign next to your mark if you cannot sign your name.)

If you completed this application on behalf of the Applicant, sign and complete the following.

Signature _____ Date _____ Phone (____) _____

Name (print) _____ Relationship to applicant _____

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

Final checklist

- Did you answer all the questions on the application?
- Did you sign and date the application?
- Do you have copies of all the proofs we said you would need? All the information that needs proof is marked with a ✔ .
- If you want to apply for rebates, did you get both sides of the Rebate Form completed and signed?

Mail your application along with copies of any proof to:

All Kids Unit
P. O. Box 19122
Springfield, IL 62794-9122

If you use the envelope that came with this application, you do not need to use a stamp.

Next steps

- If any information changes after you send the application, call toll-free 1-866-All-Kids (1-866-255-5437) to tell us what changed. If you use a TTY, call 1-877-204-1012.
- We will review your application as quickly as possible.
- If we find something is missing, we will send you a letter telling you what else to send.
- Please allow 45 days for us to make a decision.
- We will send you a notice to tell you if you can get All Kids, FamilyCare or Moms & Babies. If you do not qualify, we will also send a notice and tell you why.

Other important information

- If your children already have an All Kids card, do not apply again. If you want to add someone to your All Kids, FamilyCare or Moms & Babies health plan, you do not have to send a new application. Call your caseworker at the Illinois Department of Human Services (DHS) or call your All Kids customer service representative to add another family member.

- If your family has child support or Social Security income, a stepparent in the home, high medical bills, or you are applying for a disabled family member or one who is 65 or older, it may be better for you to apply at your DHS Family Community Resource Center. For more information, call toll-free 1-866-All-Kids (1-866-255-5437). If you use a TTY, call 1-877-204-1012.

- If you are not satisfied with the actions taken on your application, you have the right to a fair hearing. You can ask for a fair hearing by writing your local office, or by writing the Department at Bureau of Administrative Hearings, 401 South Clinton Street, Sixth Floor, Chicago, Illinois 60607 or by calling 1-800-435-0774. If you use a TTY, call 1-877-734-7429. **Use these numbers only to file an appeal.** All other calls and inquiries should be directed to 1-866-All-Kids (1-866-255-5437). If you use a TTY, call 1-877-204-1012.

- All Kids, FamilyCare and Moms & Babies are open and accessible without regard to sex, race, disability, national origin, religion or age. The State of Illinois is an equal opportunity employer that practices affirmative action. The State of Illinois provides reasonable accommodations according to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

U.S. citizenship documents

Because of a new federal law, we must ask people who are United States citizens to send us documents that prove they are citizens. This new law affects all children and adults who apply for medical benefits if they are U.S. citizens.

If you do not have these documents for anyone in your family who is a U.S. citizen, you must try to get them.

You can get birth certificates from the state or county where the person was born. You may have to pay for official copies of birth certificates. Usually, you need to know the person's name, date of birth and parents' names to order their birth certificate.

- Persons who were born in Illinois can get their birth certificate from the county where they were born. Here are a few county phone numbers and websites:

County	Phone	Website
Champaign	1-217-384-3720	www.champaigncountyclerk.com/vitals
Cook	1-312-603-7799	www.cookctyclerk.com
DuPage	1-630-682-7035	www.co.dupage.il.us
Jackson	1-618-687-7360	www.co.jackson.il.us/elected/co_clerk.htm
Kane	1-630-232-5950	www.co.kane.il.us/coc
Lake	1-847-377-2411	www.co.lake.il.us/cntyclk/vital
Peoria	1-309-672-6059	www.co.peoria.il.us (Select "Get Vital Records")
Rock Island	1-309-786-4451	www.co.rock-island.il.us
St. Clair	1-618-277-6600	www.co.st-clair.il.us (Select "B")
Will	1-815-740-4615	www.willclrk.com/vitalrecords.htm

You can get a complete list of where to go for a birth certificate for any county in Illinois on the Internet at **www.idph.state.il.us/vitalrecords/countylisting.htm**. The Illinois Department of Public Health can help you find a county office if you call **1-217-782-6553**. If you use a TTY, call 1-800-547-0466. The call is free.

- Persons who were born in Illinois can also get birth certificates from the Illinois Department of Public Health by calling **1-217-782-6553**. You can order your birth certificate over the Internet at **www.idph.state.il.us/vitalrecords** if you use a credit card.
- The National Center for Health Statistics can help you find out where to get birth certificates for people who were born in a state other than Illinois. Call **1-866-441-6247**. The call is free. If you can use a computer, visit **www.cdc.gov/nchs**.

If you cannot get these documents, call 1-866-All-Kids to tell us why. If you use a TTY, call 1-877-204-1012. The call is free. There may be other documents that you can use to show that you or your family member is a U.S. citizen.

Other benefit programs offered by the State of Illinois

Veterans Care offers access to affordable, comprehensive healthcare to veterans across Illinois. Veterans pay an affordable monthly premium of $40 or $70 and receive medical, dental and vision coverage. For additional information, please visit www.illinoisveteranscare.com or call 1-877-4VETS-RX. If you use a TTY, call 1-877-204-1012.

Illinois Cares Rx provides a safety net for seniors and persons with disabilities so they won't have to pay more out of pocket under the Medicare drug plan. To find out more, visit www.illinoiscaresrx.com or call the Illinois Health Benefits hotline at 1-800-226-0768. If you use a TTY, call 1-877-204-1012.

The **Illinois Rx Buying Club** provides an average discount of 24% at many Illinois pharmacies. To get more information or to enroll visit www.illinoisrxbuyingclub.com or call 1-866-215-3462. If you use a TTY, call 1-866-215-3479.

Health Benefits for Workers with Disabilities is a comprehensive healthcare program for employed persons with disabilities. Working individuals between the ages of 16 and 64 may be eligible. To download an application, visit www.hbwdillinois.com or call 1-800-226-0768. If you use a TTY, call 1-866-675-8440.

HFS Medical Benefits provides comprehensive healthcare for low-income seniors and persons of any age with disabilities. To apply, visit a local Department of Human Services office. To find an office nearby, call 1-800-843-6154. If you use a TTY, call 1-800-447-6404. You can download a mail-in application by visiting www.health.illinois.gov.

The **Low Income Home Energy Assistance Program (LIHEAP)** helps qualified households pay for winter energy services. The amount of the benefit depends on income, household size, fuel type and geographic location. Visit www.liheapillinois.com/community.html.

The **Illinois Department of Human Services' Child Care Program** provides low-income, working families with access to quality, affordable child care. Parents can learn about child care in their community and see if they qualify for a subsidy by contacting their local Child Care Resource and Referral agency (CCR&R). Visit www.ilchildcare.org or call 1-800-649-1884 to find your local CCR&R.

The **HFS Division of Child Support Enforcement (DCSE)** will help anyone who needs support for a child. DCSE helps parents and caretakers locate the parent who does not live with the child, legally establish the child's father, get child support or medical coverage and change the amount a parent has to pay for child support. Services are free. You can apply for services by visiting www.ilchildsupport.com, by calling 1-800-447-4278 or by visiting a DCSE office. If you use a TTY, call 1-800-526-5812. The call is free.

If you are interested in registering to vote, please go to www.elections.il.gov/ or call the Department of Human Services Helpline at 1-800-843-6154 or 1-800-447-6404 (for TTY). If you would like assistance or need translation services, please contact your DHS Family Community Resource Center.

Rebate Form for All Kids and FamilyCare

Use this form if you want All Kids or FamilyCare Rebate.

A rebate is a monthly amount we will pay you if you already pay for health insurance for yourself, your spouse or your children. If you choose to get rebates, you will use your current insurance card to get healthcare.

Only families who have health insurance can get rebate payments. Also, only families with a certain amount of income can get rebates. You may be able to get rebates for your children if your family is like one in the list below. The income amounts for adults are lower.

☐ You are the **only** person in your family	→	You may qualify for rebates if the income you get each month is between $1,201 and $1,805.
☐ You have **two** people in your family	→	You may qualify for rebates if the income you get each month is between $1,616 and $2,428.
☐ You have **three** people in your family	→	You may qualify for rebates if the income you get each month is between $2,030 and $3,052.
☐ You have **four** people in your family	→	You may qualify for rebates if the income you get each month is between $2,445 and $3,675.

Add $623.00 for each additional person.

To ask for rebates, you must send this form **with** the rest of your application.

Part A

The main person whose name is on the insurance must sign this part of the form. Often this person is called the policyholder. This person may get the health insurance from a job.

Policyholder's name _____
Last First

Home Address _____ **Apt. #** _____

City _____ **State** _____ **Zip** _____

SSN __ __ __ - __ __ - __ __ __ __ **Phone** (_____) _____

We must have the SSN (Social Security Number) so we can pay the rebate to this person.

Policy Number _____ **Group Number** _____

Tell us the names of the family members you want rebates for.

_____

_____

I agree to call All Kids/FamilyCare right away if this health insurance ends, someone is added or taken off the health insurance, the amount paid for the insurance changes, covered benefits change or someone else becomes the policyholder.

I authorize my employer, plan administrator and insurance company to provide the information requested in Part B on the next page for the purpose of determining whether I qualify for All Kids/FamilyCare. I also authorize my employer, plan administrator and insurance company to verify my coverage and any of the information below for any time when I get All Kids/ FamilyCare Rebate.

Signature of Employee/Policyholder _____

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

Part B

This part of the form must be completed by the employer providing the health insurance or the insurance agent.

Note to Employer/Insurance Agent: The employee/policyholder named on the front of this form is applying for help to cover the cost of their family's health insurance premiums. Please assist them by completing the information below and returning the form to the employee/policyholder as soon as possible. (As used below, "employee" applies to an employee or private policyholder.) For help in completing this form, call toll-free 1-877-805-5312.

Employer (if employer policy) _____

Employer address _____

City _____ **State** _____ **Zip** _____

Person completing this form _____

Phone (_____) _____ **Fax** (_____) _____

Insurance company _____ **Policy Number** _____ **Group Number** _____

What benefits are covered? ☐ Physician Services ☐ Hospital Inpatient Services
Check all that apply.

Amount of premium paid by employee $_____
Include amounts paid for dental, vision and prescription coverage.

Premiums are paid ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ monthly
☐ every 2 months ☐ quarterly ☐ semi-annually ☐ annually

Persons covered by the employee premium contribution:

_____

_____

Does the employer pay 100% of the cost of the employee's coverage? ☐ Yes ☐ No
If no, how much of the amount listed above is for coverage of the employee only (single rate)?

$_____ Include amounts for dental, vision and prescription coverage.

Enrollment period for policy _____

Date the premium listed above began or begins _____

Date of next scheduled change in premium _____

Authorized signature of employer/agent _____ **Date** _____

Return the completed rebate form to the employee for submission with the All Kids / FamilyCare application.

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

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APPENDIX D

Application Agents, Number of Approved Applications, and the Amount Paid

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2012

Name	City	Approved Applications	Total Amount Paid
LAKE CO H D WAUKEGAN CLINIC	WAUKEGAN	969	$48,450.00
VNA HEALTH CENTER	AURORA	691	34,550.00
GREATER ELGIN FAMILY CARE CTR	ELGIN	567	28,350.00
WCHD WIC PROGRAM	JOLIET	540	27,000.00
ALIVIO MEDICAL CENTER	CHICAGO	501	25,050.00
ERIE FAMILY HEALTH CENTER	CHICAGO	459	22,950.00
CHAMPAIGN URBANA PUBLIC HLTH	CHAMPAIGN	450	22,500.00
AUNT MARTHAS YOUTH SRVC CENTER	CHICAGO HEIGHTS	436	21,800.00
UPTOWN NEIGHBORHOOD H CENTER	CHICAGO	366	18,300.00
DUPAGE MENTAL HLTH NORTH PHC	ADDISON	321	16,050.00
INFANT WELFARE SOCIETY OF CHGO	CHICAGO	303	15,150.00
WINNEBAGO HLTH DEPT MILLENNIUM	ROCKFORD	303	15,150.00
MIDLAKES CLINIC	ROUND LAKE BEACH	291	14,550.00
ROCK ISLAND COUNTY HLTH DEPT	ROCK ISLAND	287	14,350.00
BHS FANTUS HEALTH CENTER	CHICAGO	253	12,650.00
DUPAGE CTY HEALTH DEPT	WHEATON	236	11,800.00
MCLEAN COUNTY HEALTH DEPT	BLOOMINGTON	232	11,600.00
MCHENRY COUNTY DEPT OF HEALTH	WOODSTOCK	223	11,150.00
PREGNANCY TESTING CENTER	BERWYN	220	11,000.00
DUPAGE MENTAL HEALTH EAST PHC	LOMBARD	211	10,550.00
MELROSE PARK FAMILY HEALTH CTR	MELROSE PARK	203	10,150.00
HENRY BOOTH HOUSE	CHICAGO	186	9,300.00
KANKAKEE COUNTY HEALTH DEPT	KANKAKEE	184	9,200.00
THE GENESIS CENTER	DES PLAINES	178	8,900.00
ARAB AMERICAN FAMILY SERVICES	BRIDGEVIEW	172	8,600.00
DEKALB COUNTY HLTH DEPT	DEKALB	149	7,450.00
DUPAGE MNTL HLTH WESTMONT PHC	WESTMONT	142	7,100.00
WHITESIDE COUNTY HEALTH DEPT	MORRISON	142	7,100.00
JACKSON COUNTY HEALTH DEPT	MURPHYSBORO	141	7,050.00
KNOX COUNTY HEALTH DEPT	GALESBURG	137	6,850.00
CHINESE AMERICAN SERV LEAGUE	CHICAGO	134	6,700.00
AUNT MARTHAS CARPENTERSVILLE	CARPENTERSVILLE	133	6,650.00
SIHF MOTHER AND CHILD CTR	CENTREVILLE	133	6,650.00
RESURRECTION MEDICAL CENTER	DES PLAINES	126	6,300.00
CHICAGO FAM HLTH CTR SO CHI	CHICAGO	122	6,100.00
MACON COUNTY HEALTH DEPT	DECATUR	121	6,050.00
SUWADA MARIA	ELK GROVE VLG	121	6,050.00
WEST TOWN NEIGHBORHOOD H CTR	CHICAGO	119	5,950.00
ACCESS NORTHWEST FMLY HLTH CTR	ARLINGTON HTS	117	5,850.00
ST CLAIR COUNTY HEALTH DEPT	BELLEVILLE	116	5,800.00
DUPAGE COUNTY HEALTH DEPT	WEST CHICAGO	115	5,750.00
MILE SQUARE HEALTH CENTER	CHICAGO	114	$5,700.00

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2012

Name	City	Approved Applications	Total Amount Paid
PRIMECARE WEST TOWN	CHICAGO	113	$5,650.00
ASIAN HUMAN SERVICES FAMILY	CHICAGO	108	5,400.00
KOREAN AMERICAN COMM SERVICES	CHICAGO	105	5,250.00
NORWEGIAN AMERICAN HOSP	CHICAGO	104	5,200.00
ERIE HELPING HANDS HEALTH CTR	CHICAGO	101	5,050.00
SERVICIOS MEDICOS LA VILLITA	CHICAGO	98	4,900.00
LAWNDALE CHRISTIAN HLTH	CHICAGO	97	4,850.00
AUNT MARTHAS YOUTH SERVICE CTR	HAZEL CREST	96	4,800.00
LOWER WEST SIDE HEALTH CENTER	CHICAGO	96	4,800.00
SO CHICAGO MCH HEALTH CLINIC	CHICAGO	91	4,550.00
COMMUNITY HEALTH CARE INC	DAVENPORT	82	4,100.00
DR JORGE PRIETO HEALTH CENTER	CHICAGO	82	4,100.00
ROGERS PARK HIHC	CHICAGO	82	4,100.00
SIHF W BELLEVILLE HEALTH CTR	BELLEVILLE	81	4,050.00
FRIEND FAMILY HEALTH CENTER	CHICAGO	79	3,950.00
KID CARE MEDICAL	ELGIN	79	3,950.00
FAMILY HEALTH SOCIETY	CHICAGO HEIGHTS	72	3,600.00
ST JOSEPH HOSP LAKEVIEW CLINIC	CHICAGO	71	3,550.00
NORTH SHORE HEALTH CENTER	HIGHLAND PARK	70	3,500.00
LOGAN SQUARE NEIGHBORHOOD ASSN	CHICAGO	69	3,450.00
PANTIRU MIHAELA	CHICAGO	69	3,450.00
HAWTHORNE FAMILY HEALTH CENTER	CICERO	68	3,400.00
MACOUPIN COUNTY HEALTH DEPT	CARLINVILLE	68	3,400.00
SWEDISH COVENANT HOSPITAL	CHICAGO	68	3,400.00
LINCOLN SQUARE	CHICAGO	67	3,350.00
GRUDZINSKI ANNA	CHICAGO	65	3,250.00
MERCY DIAGNOSTIC TREATMENT CTR	CHICAGO	65	3,250.00
COORDINATED YOUTH WIC PROGRAM	WOOD RIVER	64	3,200.00
CHINESE MUTUAL AID ASSOCIATION	CHICAGO	63	3,150.00
CRUSADER CLINIC	ROCKFORD	63	3,150.00
CHRISTIAN COUNTY HEALTH DEPT	TAYLORVILLE	60	3,000.00
HANUL FAMILY ALLIANCE SUBURBAN	MOUNT PROSPECT	60	3,000.00
CENTRO DE SALUD ESPERANZA	CHICAGO	59	2,950.00
SOUTH LAWNDALE MCH CENTER	CHICAGO	59	2,950.00
FRANCES NELSON HEALTH CENTER	CHAMPAIGN	57	2,850.00
CIRCLE FAMILY HEALTHCARE NETWK	CHICAGO	56	2,800.00
UNIVERSITY OF IL AT CHIC HOSP	CHICAGO	55	2,750.00
KEDZIE FAMILY HEALTH CENTER	CHICAGO	54	2,700.00
WES HEALTH SYSTEM	NORTH RIVERSIDE	54	2,700.00
AUNT MARTHA YTH SERV HLTHY KID	AURORA	52	2,600.00
WOMENS HEALTH SERVICES	OAK LAWN	52	2,600.00
LEE COUNTY HEALTH DEPT	DIXON	51	$2,550.00

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2012

Name	City	Approved Applications	Total Amount Paid
MANO A MANO FAMILY RESOURCE	ROUND LAKE BEACH	50	$2,500.00
RUSH ADOLESCENT FAMILY CENTER	CHICAGO	50	2,500.00
PETERSON FAMILY HEALTH CENTER	CHICAGO	49	2,450.00
JERSEY COUNTY HEALTH DEPT	JERSEYVILLE	48	2,400.00
NEAR NORTH HEALTH SERV KOMED	CHICAGO	47	2,350.00
PCC COMMUNITY WELLNESS CENTER	OAK PARK	47	2,350.00
JOSEPH J FURLIN	MELROSE PARK	46	2,300.00
KLING PROFESSIONAL CENTER	CHICAGO	45	2,250.00
STICKNEY PUBLIC HEALTH DIST	BURBANK	44	2,200.00
ADVOCATE NORTHSIDE	CHICAGO	43	2,150.00
CICERO HEALTH CENTER	CICERO	43	2,150.00
CLAY COUNTY HEALTH DEPT	FLORA	43	2,150.00
FAYETTE COUNTY HLTH DEPT	VANDALIA	43	2,150.00
PCC AUSTIN FAMILY HEALTH CNT	CHICAGO	43	2,150.00
SALUD FAMILY HEALTH CENTER	CHICAGO	43	2,150.00
EVANSTON HEALTH DEPT	EVANSTON	42	2,100.00
GRUNDY COUNTY HEALTH DEPT	MORRIS	42	2,100.00
KID CARE MEDICAL	HANOVER PARK	39	1,950.00
DES PLAINES VALLEY HEALTH CTR	SUMMIT	38	1,900.00
MUSLIM WOMEN RESOURCE CTR	CHICAGO	38	1,900.00
LIVINGSTON CO PUBLIC HLTH DEPT	PONTIAC	36	1,800.00
ROSELAND COMMUNITY HOSPITAL	CHICAGO	36	1,800.00
AUNT MARTHA YTH SERV CTR INC	HARVEY	35	1,750.00
CENTRO DE INFORMACION	ELGIN	35	1,750.00
CLARIDAD LETICIA	CHICAGO	35	1,750.00
HANCOCK COUNTY HEALTH DEPT	CARTHAGE	35	1,750.00
ACCESS CABRINI HEALTH CENTER	CHICAGO	34	1,700.00
ALIA SIDDIQI MD	CHICAGO	34	1,700.00
BLUE ISLAND MEDICAL CENTER	BLUE ISLAND	34	1,700.00
OGLE COUNTY HEALTH DEPT	OREGON	34	1,700.00
TAZEWELL COUNTY HLTH DEPT	TREMONT	34	1,700.00
ACCESS AT ST FRANCIS HLTH CTR	CHICAGO	33	1,650.00
COMMUNITY ALTERNATIVES UNLTD	CHICAGO	33	1,650.00
KID CARE MEDICAL	ARLINGTON HTS	33	1,650.00
HEARTLAND HEALTH CENTER WILSON	CHICAGO	32	1,600.00
WILL CO HEALTH DEPT NORTHERN B	BOLINGBROOK	32	1,600.00
FORD IROQUOIS PUB HLTH DEPT	WATSEKA	31	1,550.00
BOND CO HEALTH DEPT	GREENVILLE	30	1,500.00
DROZD BEATA	NILES	29	1,450.00
SIHF STATE STREET CTR	EAST ST LOUIS	29	1,450.00
EDGAR COUNTY HEALTH DEPT	PARIS	27	1,350.00
ADVANCED MEDICAL GROUP	WHEELING	26	$1,300.00

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2012

Name	City	Approved Applications	Total Amount Paid
CLINTON COUNTY HEALTH DEPT	CARLYLE	26	$1,300.00
EGYPTIAN HEALTH DEPT	ELDORADO	26	1,300.00
SIHF BELLEVILLE FP HEALTH CTR	BELLEVILLE	26	1,300.00
FAMILY FOCUS AURORA	AURORA	25	1,250.00
KID CARE MEDICAL	MOUNT PROSPECT	25	1,250.00
SHELBY COUNTY HEALTH DEPT	SHELBYVILLE	25	1,250.00
SOUTH EAST ASIA CENTER	CHICAGO	25	1,250.00
BHS JOHN SENGSTACKE PROF BLDG	CHICAGO	24	1,200.00
ENGLEWOOD NEIGHBORHOOD H CTR	CHICAGO	24	1,200.00
ALMA MEDICAL CENTER	MAYWOOD	23	1,150.00
HOWARD AREA COMMUNITY CENTER	CHICAGO	23	1,150.00
LOGAN SQUARE HLTH CTR COOK CO	CHICAGO	23	1,150.00
PIKE COUNTY HEALTH DEPT	PITTSFIELD	23	1,150.00
TKACZ JOANNA	CHICAGO	23	1,150.00
GREENE COUNTY HEALTH DEPT	CARROLLTON	22	1,100.00
RIVEREDGE HOSPITAL	FOREST PARK	22	1,100.00
COORDINATED YOUTH SERVICES	GRANITE CITY	21	1,050.00
PRIMECARE FULLERTON	CHICAGO	21	1,050.00
SIHF KOCH HEALTH CTR	GRANITE CITY	20	1,000.00
WINFIELD MOODY HEALTH CENTER	CHICAGO	20	1,000.00
EVANSTON SCHOOL BASED HLTH CTR	EVANSTON	19	950
VISTA MEDICAL CENTER EAST	WAUKEGAN	19	950
HAMILTON COUNTY HEALTH DEPT	MCLEANSBORO	18	900
HOLY CROSS HOSPITAL	CHICAGO	18	900
MACNEAL HEALTH NETWORK	BERWYN	18	900
PRIMECARE NORTHWEST	CHICAGO	18	900
PUI TAK CENTER	CHICAGO	18	900
SIHF FAIRMONT CITY HEALTH CTR	FAIRMONT CITY	18	900
CHILD AND FAMILY CONNECTION 1	LOVES PARK	17	850
SIHF WASHINGTON PARK CTR	WASHINGTON PARK	17	850
ST ANTHONY HOSPITAL COMMUNITY	CHICAGO	17	850
HENRY COUNTY HEALTH DEPT	KEWANEE	16	800
SIHF ALTON WOMENS HEALTH CTR	ALTON	16	800
WAYNE COUNTY HEALTH DEPT	FAIRFIELD	16	800
KID CARE MEDICAL	ADDISON	15	750
SOUTH SUBURBAN HOSPITAL	HAZEL CREST	15	750
ZABIEROWSKI URSULA	HOFFMAN ESTATES	15	750
CENTRAL COUNTIES HEALTH CTR	SPRINGFIELD	14	700
CHICAGO CTR FOR TORAH AND CHES	CHICAGO	14	700
CHILD AND FAMILY CONNECTIONS	LISLE	14	700
FRANKLIN WILLIAMSON HLTH DEPT	MARION	14	700
INFANT WELFARE CLINIC	OAK PARK	14	$700

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2012

Name	City	Approved Applications	Total Amount Paid
MENARD CO HEALTH DEPT	PETERSBURG	14	$700
CHRISTIAN COMMUNITY HLTH CTR	CALUMET CITY	13	650
INSTITUTO DEL PROGRESO LATINO	CHICAGO	13	650
JO DAVIESS CO HEALTH DEPT	GALENA	13	650
NORTH CHICAGO COMM HEALTH CTR	NORTH CHICAGO	13	650
PLAZA MEDICAL CENTER	CHICAGO	13	650
ASHLAND FAMILY HEALTH CENTER	CHICAGO	12	600
BRANDON FAMILY HEALTH CENTER	CHICAGO	12	600
CHICAGO DEPARTMENT OF HEALTH	CHICAGO	12	600
COLES COUNTY PUBLIC HLTH DEPT	CHARLESTON	12	600
RONALD MCDONALD CARE MOBILE	ROCKFORD	12	600
SIHF WINDSOR HEALTH CTR	EAST ST LOUIS	12	600
SINAI HEALTH SYSTEM	CHICAGO	12	600
ONE THOUSAND ONE INS AND FINAN	CHICAGO	11	550
KID CARE MEDICAL	EAST DUNDEE	10	500
SAN RAFAEL	CHICAGO	10	500
A G FAMILY CARE LTD	BUFFALO GROVE	9	450
BIRUTE PAULAUSKAITE	MUNDELEIN	9	450
CHILD AND FAMILY CONNECTIONS	CRYSTAL LAKE	9	450
LAKE CO H D ZION CLINIC	ZION	9	450
CARROLL COUNTY HEALTH DEPT	MT CARROLL	8	400
COM HLTH PARTNERSHIP HOOPESTON	HOOPESTON	8	400
DOCTORS MEDICAL CENTER	CHICAGO	8	400
JASPER CO HEALTH DEPT	NEWTON	8	400
KASZOWSKA ELZBIETA	NAPERVILLE	8	400
KID CARE MEDICAL	WEST CHICAGO	8	400
OZDROVSKA NADIA	HARWOOD HEIGHTS	8	400
PADOWSKI BOGUMILA	DES PLAINES	8	400
RANDOLPH COUNTY HEALTH DEPT	CHESTER	8	400
SIHF CAHOKIA HEALTH CTR	CAHOKIA	8	400
SPANISH CTR LYRP OUTREACH PROJ	JOLIET	8	400
STREAMWOOD BEHAVIORAL HLTH CTR	STREAMWOOD	8	400
THE CLINIC IN ALTGELD INC	CHICAGO	8	400
WEST CHICAGO FAMILY HEALTH CTR	WEST CHICAGO	8	400
ALEXIAN CENTER FOR MENTAL HLTH	ARLINGTON HTS	7	350
AVON TOWNSHIP	ROUND LAKE PARK	7	350
CENTRO MEDICO	CHICAGO	7	350
EASTER SEALS CHILD FAM CONN 12	TINLEY PARK	7	350
GRADZIK BARBARA	FRANKLIN PARK	7	350
KULPA ANNA	LK IN THE HLS	7	350
MARTIN T RUSSO FAMILY HLTH CTR	BLOOMINGDALE	7	350
MONTGOMERY CO HLTH DEPT	HILLSBORO	7	$350

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2012

Name	City	Approved Applications	Total Amount Paid
TRINITY HOSPITAL	CHICAGO	7	$350
ADOLESCENT HEALTH CENTER	CARBONDALE	6	300
ART OF INSURANCE	ARLINGTON HTS	6	300
BOBROWSKA IZABELLA	CHICAGO	6	300
BRIDGEPORT CHILD DEVELOPMENT	CHICAGO	6	300
COMMUNITY NURSE HEALTH ASSN	LAGRANGE	6	300
EFFINGHAM COUNTY HEALTH DEPT	EFFINGHAM	6	300
EGYPTIAN HEALTH DEPT	CARMI	6	300
MASON COUNTY HEALTH DEPARTMENT	HAVANA	6	300
WEST DIVISION FAMILY HLTH CTR	CHICAGO	6	300
AUSTIN COOK COUNTY COMM HC	CHICAGO	5	250
BERWYN PUBLIC HEALTH DIST	BERWYN	5	250
CASS CO HEALTH DEPT VIRGINIA	VIRGINIA	5	250
CHICAGO HLTH OUTREACH HOMELESS	CHICAGO	5	250
CHRISTIAN COMMUNITY HLTH CTR	CHICAGO	5	250
CZERWOSZ AGATA	OAK LAWN	5	250
KARWINSKI MALGORZATA	CHICAGO	5	250
KENDALL CO HLTH AND HUMAN SERV	YORKVILLE	5	250
LINCOLN PRAIRIE BEHAVIORAL HC	SPRINGFIELD	5	250
MERCER COUNTY HEALTH DEPT	ALEDO	5	250
PERRY CO HLTH DEPT	PINCKNEYVILLE	5	250
VIETNAMESE ASSOC OF ILLINOIS	CHICAGO	5	250
CHURCH OF THE HOLY SPIRIT	SCHAUMBURG	4	200
DISTRICT 62 SPARK	DES PLAINES	4	200
ERIE HENSON HEALTH CENTER	CHICAGO	4	200
KOZIOL MARIUSZ	ELK GROVE VLGE	4	200
MADISON MEDICAL CENTER	CHICAGO	4	200
OMNI YOUTH SERVICES WHEELING	WHEELING	4	200
PEDIATRICS CLINIC	DES PLAINES	4	200
SERVICE OF WILL GRUNDY KANKAKE	JOLIET	4	200
SOUTHERN IL CASE COORDINATION	CENTRALIA	4	200
STAR DENTAL CENTER	WHEELING	4	200
TRICITY FAMILY SERVICES	GENEVA	4	200
BELOVED COMM FMLY WELLNESS CTR	CHICAGO	3	150
CDHP SOUTHWEST DISTRICT OFFICE	BRIDGEVIEW	3	150
HEALTHCARE CONSORTIUM OF IL	DOLTON	3	150
JEWISH CHILD AND FAMILY SRVS	CHICAGO	3	150
KID CARE MEDICAL	ELK GROVE VLGE	3	150
LAKE COUNTY KIDCARE APP	WAUKEGAN	3	150
OMNI YOUTH SERVICES PROS HGHTS	PROSPECT HTS	3	150
PROGRAMA CIELO	CHICAGO	3	150
SOUTH STATE MEDICAL CENTER	CHICAGO	3	$150

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2012

Name	City	Approved Applications	Total Amount Paid
SOUTHERN SEVEN HEALTH DEPT	VIENNA	3	$150
ST ANTHONY HOSPITAL	CHICAGO	3	150
TRIPLE CARE	CHICAGO	3	150
VILLAGE OF HOFFMAN ESTATES	HOFFMAN ESTATES	3	150
AUSTIN FAMILY HEALTH CENTER	CHICAGO	2	100
BETHANY CHRISTIAN SRVCS OF MO	COLUMBIA	2	100
BOOKER FAMILY HEALTH CENTER	CHICAGO	2	100
CITY OF DES PLAINES	DES PLAINES	2	100
COM HLTH PARTNERSHIP AURORA	AURORA	2	100
COMM HEALTH PARTNERSHIP OF IL	KANKAKEE	2	100
CUMBERLAND COUNTY HEALTH DEPT	TOLEDO	2	100
DD SERVICES OF METRO EAST	BELLEVILLE	2	100
ERIE TEEN HEALTH CENTER	CHICAGO	2	100
HEARTLAND HEALTH OUTREACH	CHICAGO	2	100
HUMBOLT PARK FAM HLTH CENTER	CHICAGO	2	100
MALISZEWSKI MARZENA	ALGONQUIN	2	100
MEDICAL REIMBURSEMENT AND MGMT	PEORIA	2	100
MOULTRIE COUNTY HEALTH DEPT	SULLIVAN	2	100
NEMETZ RONNIE	LOMBARD	2	100
PILSEN FAMILY HEALTH CENTER	CHICAGO	2	100
SIHF BETHALTO HEALTH CTR	EAST ALTON	2	100
SOUTHWEST FAMILY HEALTH CENTER	CHICAGO	2	100
ST SABINA EMERGENCY SRVCS CTR	CHICAGO	2	100
SUBURBAN ACCESS INC	HILLSIDE	2	100
THE SUCCESS CENTER	LANSING	2	100
WCHD EASTERN BRANCH OFFICE	UNIVERSITY PARK	2	100
YOUTH SVCS GLENVIEW NORTHBROOK	GLENVIEW	2	100
ACCESS AT EYE INSTITUTE	CHICAGO	1	50
ARMITAGE FAMILY HEALTH CENTER	CHICAGO	1	50
ASSOCIATION HOUSE OF CHICAGO	CHICAGO	1	50
BONDAROWICZ RENATA	SCHAUMBURG	1	50
CATHOLIC CHARITIES AURORA	AURORA	1	50
CCDPH NORTH DISTRICT OFFICE	ROLLING MEADOWS	1	50
CFC 19	DECATUR	1	50
CHILD AND FAMILY CONNECTIONS	FREEPORT	1	50
CHILDBIRTH THE WAY NATURE INTE	LIBERTYVILLE	1	50
COTTAGE GROVE HEALTH CENTER	FORD HEIGHTS	1	50
DECATUR OB GYN ASSOCIATES	DECATUR	1	50
DEWITT PIATT BI CO HLTH DEPT	CLINTON	1	50
DUPAGE COUNTY HUMAN RESOURCES	WHEATON	1	50
DUPAGE MNTL HLTH CRISIS UNIT	LOMBARD	1	50
DUPAGE TRANS SERVICES CENTER	WHEATON	1	$50

Appendix D
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2012

Name	City	Approved Applications	Total Amount Paid
EVANSTON ROGERS PARK FAM HLTH	CHICAGO	1	$50
GREAT RIVERS SC	JACKSONVILLE	1	50
HANOVER TOWNSHIP	HANOVER PARK	1	50
HENDERSON CO HEALTH DEPT	GLADSTONE	1	50
KRZYMINSKI HALINA	LEMONT	1	50
LEE JUNG	ARLINGTON HTS	1	50
LONG TIM	WOODRIDGE	1	50
MYERS STEPHEN	HOFFMAN ESTATES	1	50
OAK PARK HEALTH DEPT	OAK PARK	1	50
PEORIA CITY COUNTY HLTH DEPT	PEORIA	1	50
PEORIA CNTY BRD CARE DEV DISBL	PEORIA	1	50
PINKNEY HARVEY	ALSIP	1	50
PUCHALSKI ALINA	LAKE FOREST	1	50
SANGAMON CO DEPT PUBLIC HEALTH	SPRINGFIELD	1	50
SEIU LOCAL 4 HEALTH FUND	CHICAGO	1	50
SENN HIGH SCHOOL HEALTH CENTER	CHICAGO	1	50
SIHF ALTON HEALTH CTR	ALTON	1	50
SIHF QUICK CARE I CTR	EAST ST LOUIS	1	50
SOUTHERN SEVEN HD	ULLIN	1	50
SOUTHERN SEVEN HEALTH DEPT	ROSICLARE	1	50
SOUTHERN SEVEN HEALTH DEPT	JONESBORO	1	50
STEPHENSON CO HEALTH DEPT	FREEPORT	1	50
SUBURBAN ACCESS CFC 7	HOMEWOOD	1	50
TOWN OF CICERO	CICERO	1	50
TRINITY MEDICAL CENTER	ROCK ISLAND	1	50
WASHINGTON SEADRA	RICHTON PARK	1	50
WESTSIDE FAMILY HEALTH CENTER	CHICAGO	1	50
ZIELINSKI ADOLPHE	GLENVIEW	1	50
ZULEWSKI LUKASZ	CHICAGO	1	50
	Totals	**17,188**	**$859,400**

Source: HFS data.

APPENDIX E

FY12 Total Payments by Category of Service

Appendix E
TOTAL PAYMENTS BY CATEGORY OF SERVICE
During FY12

Category of Service	FY12 Payment Amount	Percent of Total Payments
Pharmacy Services	$12,859,538	17%
Dental Services	12,176,338	16%
Physician Services	11,800,806	15%
Inpatient Hospital Services (General)	8,207,232	11%
General Clinic Services	6,238,724	8%
Outpatient Services (General)	4,615,828	6%
Capitation Services	3,820,898	5%
Healthy Kids Services	3,417,928	4%
Inpatient Hospital Services (Psychiatric)	2,133,624	3%
Mental Health Rehab Option Services	1,918,629	2%
Alcohol and Substance Abuse Rehab. Services	1,486,545	2%
Home Health Services	1,062,273	1%
Medical Supplies	1,032,743	1%
Medical equipment/prosthetic devices	962,326	1%
Optical Supplies	810,417	1%
Clinical Laboratory Services	650,274	1%
Anesthesia Services	505,757	1%
Speech Therapy/Pathology Services	401,029	1%
Targeted case management service (mental health)	303,010	<1%
Psychiatric Clinic Services (Type 'A')	302,054	<1%
Physical Therapy Services	248,699	<1%
Optometric Services	213,238	<1%
Emergency Ambulance Transportation	212,856	<1%
Inpatient Hospital Services (Physical Rehabilitation)	212,490	<1%
Occupational Therapy Services	203,001	<1%
Nurse Practitioners Services	193,961	<1%
Development Therapy, Orientation and Mobility Services (Waivers)	166,285	<1%
Targeted case management service (early intervention)	146,190	<1%
Clinic Services (Physical Rehabilitation)	143,242	<1%
Podiatric Services	141,504	<1%
Outpatient Services (ESRD)	94,453	<1%
LTC--ICF/MR	73,755	<1%
Psychiatric Clinic Services (Type 'B')	61,815	<1%
All Kids application agent (valid on provider file only)	53,850	<1%
Service Car	$52,481	<1%

Appendix E
TOTAL PAYMENTS BY CATEGORY OF SERVICE
During FY12

Category of Service	FY12 Payment Amount	Percent of Total Payments
Nursing service	$46,606	<1%
Non-Emergency Ambulance Transportation	43,986	<1%
Social work service	31,421	<1%
Early Intervention Services	31,374	<1%
Audiology Services	27,387	<1%
Midwife Services	25,785	<1%
Licensed Clinical Professional Counselor	11,561	<1%
Chiropractic Services	10,913	<1%
Psychologist service	8,092	<1%
Fluoride varnish	6,603	<1%
Taxicab Services	6,000	<1%
Medicar Transportation	966	<1%
Portable X-Ray Services	121	<1%
Waiver service (depends on HCPCS code)	108	<1%
Total FY12 Payments	**$77,174,711**	**100%**

Note: Totals may not add due to rounding.

Source: Summary of FY12 ALL KIDS data provided by HFS.

APPENDIX F

FY12 EXPANDED ALL KIDS Payments

Appendix F

FY12 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Alcohol and Substance Abuse Rehab Services	All Kids Application Agent (Valid on Provider File Only)	Anesthesia Services	Audiology Services	Capitation Services	Chiropractic Services	Clinic Services (Physical Rehabilitation)	Clinical Laboratory Services	Dental Services
Assist Undocumented	$896,820.34	$31,900.00	$295,049.85	$10,013.47	$3,705,193.63	$10,303.22	$85,357.00	$500,191.10	$8,677,591.83
Share Undocumented	38,754.10	1,000.00	7,436.10	263.10	54,600.00	42.68	390.00	13,211.72	253,102.22
Level 1 Undocumented	9,644.04	2,650.00	7,935.95	52.60	36,118.46	10.67	5,720.00	9,337.61	245,801.58
Level 2	415,522.77	15,850.00	155,510.70	13,376.25	22,919.77	556.77	34,623.00	104,924.10	2,468,794.58
Level 2 Undocumented	0	900.00	1,442.90	0	1,231.20	0	0	2,399.59	78,714.36
Level 3	89,704.67	1,400.00	27,375.75	3,096.82	835.10	0	9,216.00	15,602.76	359,075.96
Level 3 Undocumented	0	0	322.35	0	0	0	0	191.67	7,308.87
Level 4	4,341.00	0	7,382.25	547.11	0	0	3,516.00	2,998.69	70,600.14
Level 4 Undocumented	0	0	337.70	0	0	0	0	118.29	2,867.38
Level 5	31,757.79	150.00	1,089.85	22.15	0	0	780.00	1,040.75	9,428.06
Level 5 Undocumented	0	0	0	15.20	0	0	3,640.00	17.60	1,128.49
Level 6	0	0	1,873.15	0	0	0	0	239.63	819.85
Level 6 Undocumented	0	0	0	0	0	0	0	0	412.42
Level 7	0	0	0	0	0	0	0	0	358.05
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	0	0	0	0	0	0	0	0	333.80
Level 8 Undocumented	0	0	0	0	0	0	0	0	0
Totals by Category	**$1,486,544.71**	**$53,850.00**	**$505,756.55**	**$27,386.70**	**$3,820,898.16**	**$10,913.34**	**$143,242.00**	**$650,273.51**	**$12,176,337.59**

Source: Summary of FY12 ALL KIDS data provided by HFS.

Appendix F

FY12 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Development Therapy, Orientation and Mobility Services (Waivers)	Early Intervention Services	Emergency Ambulance Transportation	Fluoride Varnish	General Clinic Services	Healthy Kids Services	Home Health Services	Inpatient Hospital Services (General)
Assist Undocumented	$13,007.09	$4,764.32	$127,923.30	$1,274.00	$4,830,582.76	$1,816,378.90	$39,093.14	$5,095,977.57
Share Undocumented	208.65	0	3,746.58	0	98,772.51	62,126.99	797.42	80,170.10
Level 1 Undocumented	389.48	0	2,092.63	0	91,079.05	76,134.83	0	33,993.66
Level 2	117,762.26	21,864.49	66,870.70	4,159.00	1,032,317.41	1,157,106.68	434,985.37	1,990,801.25
Level 2 Undocumented	0	0	803.24	0	19,862.32	25,512.73	0	6,994.40
Level 3	17,929.08	1,950.79	8,213.74	728.00	136,483.66	218,433.59	101,349.88	339,703.98
Level 3 Undocumented	0	0	202.72	0	589.77	2,796.42	0	0
Level 4	12,848.95	2,584.30	2,579.65	182.00	23,751.94	47,032.06	198,287.96	83,539.60
Level 4 Undocumented	0	0	0	0	357.22	934.03	0	0
Level 5	503.15	0	423.11	234.00	2,917.79	7,973.49	126,757.10	511,573.91
Level 5 Undocumented	0	0	0	0	4.00	664.18	0	0
Level 6	2,207.34	210.16	0	0	1,995.23	1,626.62	111,106.00	64,477.92
Level 6 Undocumented	0	0	0	0	0	165.54	0	0
Level 7	1,429.36	0	0	26.00	0	484.90	0	0
Level 7 Undocumented	0	0	0	0	0	0	0	0
Level 8	0	0	0	0	10.00	557.00	49,896.00	0
Level 8 Undocumented	0	0	0	0	0	0	0	0
Totals by Category	**$166,285.36**	**$31,374.06**	**$212,855.67**	**$6,603.00**	**$6,238,723.66**	**$3,417,927.96**	**$1,062,272.87**	**$8,207,232.39**

Source: Summary of FY12 ALL KIDS data provided by HFS.

Appendix F

FY12 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Inpatient Hospital Services (Physical Rehabilitation)	Inpatient Hospital Services (Psychiatric)	Licensed Clinical Professional Counselor	LTC--ICF/MR	Medical Equipment/Prosthetic Devices	Medical Supplies	Medicar Transportation	Mental Health Rehab Option Services	Midwife Services
Assist Undocumented	$206,525.12	$1,296,276.26	$7,498.28	43,124.70	$477,001.80	$459,985.98	$966.28	$1,051,087.88	$24,109.05
Share Undocumented	0	35,924.86	0	0	10,934.06	2,513.86	0	35,856.81	395.20
Level 1 Undocumented	0	39,424.22	75.46	0	9,069.86	4,844.75	0	18,190.58	0
Level 2	5,965.04	669,758.51	3,986.99	0	375,740.34	430,950.83	0	673,215.10	1,177.63
Level 2 Undocumented	0	4,572.32	0	30,630.60	2,606.22	960.42	0	7,458.29	0
Level 3	0	37,713.39	0	0	33,890.09	86,308.12	0	97,834.40	0
Level 3 Undocumented	0	15,273.91	0	0	12,556.87	1,768.96	0	851.69	0
Level 4	0	9,804.28	0	0	27,089.42	29,299.50	0	25,263.42	102.62
Level 4 Undocumented	0	0	0	0	0	0	0	0	0
Level 5	0	23,633.69	0	0	2,249.07	8,647.88	0	7,694.16	0
Level 5 Undocumented	0	0	0	0	5,855.81	0	0	0	0
Level 6	0	1,242.96	0	0	1,909.29	1763.17	0	1,176.25	0
Level 6 Undocumented	0	0	0	0	0	0	0	0	0
Level 7	0	0	0	0	887.6	22.42	0	0	0
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	0	0	0	0	2,535.89	5,676.94	0	0	0
Level 8 Undocumented	0	0	0	0	0	0	0	0	0
Totals by Category	**$212,490.16**	**$2,133,624.40**	**$11,560.73**	**$73,755.30**	**$962,326.32**	**$1,032,742.83**	**$966.28**	**$1,918,628.58**	**$25,784.50**

Source: Summary of FY12 ALL KIDS data provided by HFS.

Appendix F

FY12 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Non-Emergency Ambulance Transportation	Nurse Practitioners Services	Nursing Service	Occupational Therapy Services	Optical Supplies	Optometric Services	Outpatient Services (ESRD)	Outpatient Services (General)	Pharmacy Services (Drug and OTC)
Assist Undocumented	$31,321.22	$94,281.06	$46,606.00	$50,419.05	$597,259.14	$140,534.66	$94,452.52	$2,837,720.26	$4,603,081.20
Share Undocumented	890.86	4,695.14	0	814.35	16,913.52	4,181.73	0	71,230.32	91,689.37
Level 1 Undocumented	632.85	2,138.17	0	1,174.80	14,608.67	4,408.23	0	72,248.77	114,208.43
Level 2	9,579.72	81,016.35	0	112,990.86	149,717.77	52,018.25	0	1,219,892.66	5,497,185.68
Level 2 Undocumented	182.07	293.16	0	1,388.40	5,568.72	1,570.00	0	10,505.76	47,812.04
Level 3	652.90	9,455.70	0	16,873.98	20,790.13	8,223.12	0	265,057.07	989,277.81
Level 3 Undocumented	0	24.20	0	0	510.71	147.60	0	1,979.00	31,722.93
Level 4	489.51	1,568.18	0	11,773.05	4,243.13	1,729.72	0	63,749.89	1,145,282.21
Level 4 Undocumented	0	0	0	1,068.00	186.63	110.70	0	502.00	666.58
Level 5	117.27	364.91	0	440.55	354.54	222.50	0	70,598.11	314,375.74
Level 5 Undocumented	0	0	0	1,628.70	67.56	18.45	0	0	11,483.71
Level 6	119.97	123.72	0	1,168.54	131.85	54.90	0	2,114.00	6,817.83
Level 6 Undocumented	0	0	0	0	0	0	0	230.00	0
Level 7	0	0	0	3,260.24	64.29	18.45	0	0	37.10
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	0	0	0	0	0	0	0	0	5,897.06
Level 8 Undocumented	0	0	0	0	0	0	0	0	0
Totals by Category	**$43,986.37**	**$193,960.59**	**$46,606.00**	**$203,000.52**	**$810,416.66**	**$213,238.31**	**$94,452.52**	**$4,615,827.84**	**$12,859,537.69**

Source: Summary of FY12 ALL KIDS data provided by HFS.

Appendix F

FY12 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Physical Therapy Services	Physician Services	Podiatric Services	Portable X-Ray Services	Psychiatric Clinic Services (Type 'A')	Psychiatric Clinic Services (Type 'B')	Psychologist Service	Service Car	Social Work Service
Assist Undocumented	$48,497.14	$6,954,480.23	$96,817.01	$120.6	$180,091.00	$41,208.00	$6,006.22	$49,590.24	$18,534.91
Share Undocumented	2,563.20	212,052.80	3,725.08	0	7,514.00	1,818.00	0	16.46	716.56
Level 1 Undocumented	5,909.94	196,243.64	2,868.28	0	3,162.00	0	49.23	201.84	50.70
Level 2	150,165.05	3,580,924.38	31,133.49	0	84,260.67	12,830.00	1,908.46	2,464.31	11,274.29
Level 2 Undocumented	787.65	59,848.57	1,592.90	0	884.00	0	0	0	0
Level 3	19,212.90	618,855.82	4,780.15	0	18,816.00	5,959.00	128.23	207.71	844.72
Level 3 Undocumented	0	6,155.82	203.05	0	0	0	0	0	0
Level 4	14,453.40	134,332.72	367.31	0	5,116.00	0	0	0	0
Level 4 Undocumented	0	1,548.11	0	0	0	0	0	0	0
Level 5	669.85	27,097.83	16.60	0	2,210.00	0	0	0	0
Level 5 Undocumented	0	775.89	0	0	0	0	0	0	0
Level 6	2,429.92	6,847.32	0	0	0	0	0	0	0
Level 6 Undocumented	0	259.47	0	0	0	0	0	0	0
Level 7	4,009.72	479.09	0	0	0	0	0	0	0
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	0	904.48	0	0	0	0	0	0	0
Level 8 Undocumented	0	0	0	0	0	0	0	0	0
Totals by Category	**$248,698.77**	**$11,800,806.17**	**$141,503.87**	**$120.60**	**$302.053.67**	**$61,815.00**	**$8,092.14**	**$52,480.56**	**$31,421.18**

Source: Summary of FY12 ALL KIDS data provided by HFS.

Appendix F

FY12 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Speech Therapy/Pathology Services	Targeted Case Management Service (Early Intervention)	Targeted Case Management Service (Mental Health)	Taxicab Services	Waiver Service (Depends on HCPCS Code)	Total Payments
Assist Undocumented	$34,818.49	$9,778.69	$118,650.33	$5,999.61	$108.00	$45,768,372.45
Share Undocumented	1,512.07	0	3,353.89	0	0	1,123,934.31
Level 1 Undocumented	1,669.37	647.32	2,231.10	0	0	1,015,018.77
Level 2	267,453.50	103,939.35	165,192.52	0	0	21,752,686.85
Level 2 Undocumented	120.15	0	681.41	0	0	315,323.42
Level 3	58,150.20	19,470.96	10,321.41	0	0	3,653,923.59
Level 3 Undocumented	0	0	85.91	0	0	82,692.45
Level 4	28,767.63	10,975.14	1,716.31	0	0	1,976,315.09
Level 4 Undocumented	965.20	0	0	0	0	9,661.84
Level 5	1,428.45	0	777.04	0	0	1,155,549.34
Level 5 Undocumented	1,068.00	0	0	0	0	26,367.59
Level 6	3,124.05	685.43	0	0	0	214,265.10
Level 6 Undocumented	0	0	0	0	0	1,067.43
Level 7	1,951.99	692.8	0	0	0	13,722.01
Level 7 Undocumented	0	0	0	0	0	0
Level 8	0	0	0	0	0	65,811.17
Level 8 Undocumented	0	0	0	0	0	0
Totals by Category	**$401,029.10**	**$146,189.69**	**$303,009.92**	**$5,999.61**	**$108.00**	**$77,174,711.41**

Source: Summary of FY12 ALL KIDS data provided by HFS.

APPENDIX G

Providers that Received more than $50,000 from the ALL KIDS Expansion During FY12

Note:

The list of providers was summarized by the Provider ID number provided by the Department of Healthcare and Family Services. As a result, some providers with more than one location may have more than one Provider ID number. Therefore, there are some providers that appear more than once in this Appendix.

Source: FY12 paid claim data provided by HFS.

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2012

Provider Name	City	State	Total Amount Paid
CHILDRENS MEMORIAL HOSPITAL	CHICAGO	IL	$2,747,125.47
UNIVERSITY OF ILLINOIS HOSP	CHICAGO	IL	1,138,619.89
ACCREDO HEALTH GROUP	WARRENDALE	PA	1,102,993.73
COMER CHILDRENS HOSPITAL	DARIEN	IL	1,028,630.87
J H STROGER HOSP OF COOK CTY	CHICAGO	IL	617,438.85
BHC STREAMWOOD HOSPITAL INC	STREAMWOOD	IL	486,891.91
ACCREDO HEALTH GROUP INC	MEMPHIS	TN	451,739.36
RONALD MCDONALDS CHILDRENS HSP	MAYWOOD	IL	445,189.20
ST MARY OF NAZARETH HOSPITAL	CHICAGO	IL	412,165.12
ILL CORRECTIONAL INDUSTRIES	SPRINGFIELD	IL	409,683.14
HOPE CHILDRENS HOSPITAL	OAK LAWN	IL	400,772.30
LUTHERAN GENERAL CHILDRENS HOS	PARK RIDGE	IL	384,230.99
INFANT WELFARE SOCIETY OF CHGO	CHICAGO	IL	376,281.22
ST ANTHONY HOSPITAL	CHICAGO	IL	374,800.21
CARLE HOME INFUSION	CHAMPAIGN	IL	359,069.46
LAKE VILLA GATEWAY FOUNDATION	LAKE VILLA	IL	356,122.17
HARTGROVE HOSPITAL	CHICAGO	IL	347,709.33
VISITING NURSE ASSN FOX VALLEY	AURORA	IL	346,274.87
CHILDRENS HOS MED CTR CH	CINCINNATI	OH	344,389.28
LAWNDALE CHRISTIAN HLTH CTR	CHICAGO	IL	342,910.77
FANTUS HEALTH CENTER	CHICAGO	IL	339,693.50
MAXIM HEALTHCARE SERVICES INC	OAK PARK	IL	319,787.85
MARYVILLE SCOTT NOLAN CENTER	DES PLAINES	IL	318,856.76
KEDZIE FAMILY HEALTH CENTER	CHICAGO	IL	313,206.38
GREATER ELGIN FAMILY CARE CTR	ELGIN	IL	312,263.17
SERVICIOS MEDICOS LA VILLITA	CHICAGO	IL	306,617.45
BOND DRUG COMPANY OF ILLINOIS	CHICAGO	IL	297,258.99
MT SINAI HOSP MED CTR CHICAGO	CHICAGO	IL	292,719.17
NASREEN TAIBA	ADDISON	IL	287,233.85
AQEL FADI	CHICAGO	IL	280,649.78
ROCKFORD MEMORIAL HOSPITAL	ROCKFORD	IL	277,552.72
AMERICAN HOMECARE FEDERATION	ENFIELD	CT	273,010.37
ROSECRANCE CENTER	ROCKFORD	IL	267,586.13
SINAI CHILDRENS HOSPITAL	CHICAGO	IL	253,053.42
RUSH CHILDRENS SERVICES	CHICAGO	IL	243,412.01
RIVEREDGE HOSPITAL	FOREST PARK	IL	$242,464.73

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2012

Provider Name	City	State	Total Amount Paid
ALIVIO MEDICAL CENTER	CHICAGO	IL	$240,665.01
AMBER PHARMACY	CHICAGO	IL	223,335.78
PRIVATE HOME CARE UNLIMITED	CHICAGO	IL	216,882.00
CHILDRENS HOSPITAL OF ILLINOIS	PEORIA	IL	213,709.41
ST ALEXIUS MEDICAL CENTER	HOFFMAN ESTATES	IL	208,807.25
THE KENNETH W YOUNG CENTERS	ELK GROVE VLGE	IL	207,922.85
LA RABIDA CHILDRENS HOSP	CHICAGO	IL	194,494.06
CAREMARK INC	MT PROSPECT	IL	186,542.75
CORNELL INTERVENTION WOODRIDGE	WOODRIDGE	IL	183,736.32
COMM COUNSEL CTRS C4 NORTH	CHICAGO	IL	182,115.42
CICERO HEALTH CENTER	CICERO	IL	181,507.45
ADVOCATE CONDELL MEDICAL CTR	LIBERTYVILLE	IL	176,669.28
NORTHWEST COMMUNITY HOSPITAL	ARLINGTON HGTS	IL	174,154.16
VISTA CLINIC OF COOK COUNTY	PALATINE	IL	173,527.09
CENTRAL DUPAGE HOSPITAL	WINFIELD	IL	172,457.90
UPTOWN INTERNATIONAL CENTER	CHICAGO	IL	168,151.92
THE GENESIS CENTER	DES PLAINES	IL	166,340.95
CENTRO DE SALUD ESPERANZA	CHICAGO	IL	164,051.12
HUMBOLDT PARK FAMILY HLTH CTR	CHICAGO	IL	161,362.41
CENTURY PHO INC	CHICAGO	IL	161,035.73
APOGEE HEALTH PARTNERS INC	CHICAGO	IL	159,879.52
OSTOMY CENTER	CHICAGO	IL	158,981.08
ST LOUIS CHILDRENS HOSPITAL	SAINT LOUIS	MO	156,169.42
WALGREENS SPECIALTY INFUSION	LOMBARD	IL	152,050.35
LAKE CO H D WAUKEGAN CLINIC	WAUKEGAN	IL	151,484.58
NORWEGIAN AMERICAN HOSP GROUP	CHICAGO	IL	150,235.82
ALEXIAN BROS BEHAVIORAL HLTH	HOFFMAN ESTATES	IL	149,987.36
ADVOCATE NORTHSIDE	CHICAGO	IL	148,235.72
C AND M PHARMACY LLC	GLENVIEW	IL	146,653.26
WHITESMAN LOUIS	CHICAGO	IL	144,804.75
LAWNDALE CHRISTIAN HLTH	CHICAGO	IL	143,240.70
BIOPARTNERS IN CARE	LENEXA	KS	142,580.50
COPLEY MEMORIAL HOSPITAL	AURORA	IL	140,259.96
CLARK DAVID	CHICAGO	IL	137,631.69
WINE PAUL	CHICAGO	IL	133,270.50
IPA OF KANE COUNTY	MOKENA	IL	$132,629.53

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2012

Provider Name	City	State	Total Amount Paid
AUNT MARTHAS HEALTH CENTER	AURORA	IL	$128,639.30
HAWTHORNE FAMILY HEALTH CENTER	CHICAGO	IL	128,389.26
PCC COMM WELLNESS CENTER	OAK PARK	IL	127,571.70
SWEDISH COVENANT HOSPITAL	CHICAGO	IL	124,679.14
DOUBEK MEDICAL SUPPLY INC	ALSIP	IL	124,578.06
QUEST DIAGNOSTICS LLC IL	WOOD DALE	IL	121,939.46
REHABILITATION INSTITUTE	CHICAGO	IL	121,511.16
PROVENA MERCY CENTER	AURORA	IL	120,224.56
NDO	CHICAGO	IL	118,284.72
GATEWAY FOUNDATION L STAR	CHICAGO	IL	117,276.30
ALEXIAN BROTHERS MED CTR	ELK GROVE VLGE	IL	115,870.82
AUNT MARTHAS CARPENTERSVILLE	CARPENTERSVILLE	IL	111,516.52
MEDSTAR LABORATORY INC	HILLSIDE	IL	110,236.00
ERIE DENTAL HEALTH CENTER	CHICAGO	IL	110,183.08
LABORATORY CORPORATION AMERICA	DUBLIN	OH	110,169.99
CARLE FOUNDATION HOSPITAL	URBANA	IL	108,215.54
UNITED SEATING AND MOBILITY	EARTH CITY	MO	106,729.80
EVANSTON HOSPITAL	EVANSTON	IL	105,542.51
LEYDEN FAMILY SERVICE AND MHC	FRANKLIN PARK	IL	105,530.30
PLAZA MEDICAL CENTER	CHICAGO	IL	105,296.43
CORNELL INTERVENTIONS DUPAGE	HINSDALE	IL	101,880.89
AURORA CHICAGO LAKESHORE HOSP	CHICAGO	IL	101,127.34
ERIE FAMILY HEALTH CENTER	CHICAGO	IL	101,073.73
OPTION CARE ENTERPRISES INC	WOOD DALE	IL	100,397.96
CRUSADER CLINIC BROADWAY	ROCKFORD	IL	99,150.39
MACNEAL HOSPITAL	BERWYN	IL	98,839.90
TAHIR EJAZ	BERWYN	IL	98,083.95
SHIELD DENVER HLT CARE CTR INC	ELMHURST	IL	97,966.82
ST JOHNS CHILDRENS HOSPITAL	SPRINGFIELD	IL	97,096.13
SHERMAN HOSPITAL	ELGIN	IL	96,359.75
MARIANJOY REHABILITATION HOSP	WHEATON	IL	94,850.93
NORWEGIAN AMERICAN HOSP	CHICAGO	IL	94,497.67
MIDLAKES CLINIC	ROUND LAKE BEACH	IL	94,364.40
TSALIAGOS CHRISTOS	CHICAGO	IL	93,951.39
GREATER CHICAGO MEDICAL ASSOC	CHICAGO	IL	91,995.84
CHICAGO FAM HLTH CTR SO CHI	CHICAGO	IL	$91,096.23

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2012

Provider Name	City	State	Total Amount Paid
ADA S MCKINLEY COMMUNITY SVCS	CHICAGO	IL	$90,220.51
SIDDIQUI ZAKI	CHICAGO	IL	89,610.44
SUKAVACHANA ORAWAN	ELK GROVE VLGE	IL	89,457.14
ERIE HELPING HANDS HEALTH CTR	CHICAGO	IL	88,838.89
LIPPITZ STEFEN	BUFFALO GROVE	IL	87,977.55
ACCESS AT ST FRANCIS HLTH CTR	CHICAGO	IL	86,737.84
MS LAWNDALE CHRISTIAN HLTH CTR	CHICAGO	IL	86,042.92
CARDINAL GLENNON CHILDRENS HSP	SAINT LOUIS	MO	86,038.15
HAWTHORNE FAMILY HEALTH CENTER	CICERO	IL	83,805.64
SAINTS MARY AND ELIZABETH HP	CHICAGO	IL	83,614.24
FORTY SEVENTH STREET PHARMACY	CHICAGO	IL	83,407.51
AFFINITY BIOTECH	ELKHORN	NE	83,399.67
MORGAN SARA	CHICAGO	IL	82,116.75
PRIMECARE FULLERTON	CHICAGO	IL	81,969.61
CHANG RANDOLPH	CHICAGO	IL	81,624.71
CRUSADER CLINIC	ROCKFORD	IL	81,080.30
MATERNAL CHILD HLTHCAR STE 600	ARLINGTON HTS	IL	80,698.76
AUNT MARTHAS YOUTH SERVICE CTR	CHICAGO HEIGHTS	IL	79,874.95
LINCOLN PRAIRIE BEHAVIORAL HC	SPRINGFIELD	IL	79,685.47
INGALLS HOME CARE	HARVEY	IL	79,536.02
CENTRO MEDICO	CHICAGO	IL	79,029.34
ACCURATE HOME CARE	MOLINE	IL	79,014.07
CHESTNUT HEALTH SYSTEMS INC	MARYVILLE	IL	78,959.55
MERCY HOSPITAL MEDICAL CENTER	CHICAGO	IL	78,465.07
CYSTIC FIBROSIS SERVICES INC	CENTENNIAL	CO	76,922.72
SAN RAFAEL	CHICAGO	IL	76,793.96
PILLARS COMMUNITY SERVICES	BERWYN	IL	76,701.58
REHABTECH INC	LOMBARD	IL	75,738.22
MIDWEST HEALTHCARE ASSOCIATES	AURORA	IL	75,213.00
PHARMACY SOLUTIONS	ABBOTT PARK	IL	75,143.30
WEST CHICAGO FAMILY HEALTH CTR	WEST CHICAGO	IL	74,982.94
SOUTH LAWNDALE MCH CENTER	CHICAGO	IL	74,610.40
PREMIER KIDS CARE INC	HOLLYWOOD	FL	74,121.02
PROVENA ST JOSEPH MED CNT	JOLIET	IL	74,043.83
KIM PU	CHICAGO	IL	72,830.63
RUSH UNIVERSITY MEDICAL CENTER	CHICAGO	IL	$71,197.69

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2012

Provider Name	City	State	Total Amount Paid
KIM KYUNG	CHICAGO	IL	$71,123.98
WALGREEN CO 7100	ELGIN	IL	70,993.84
WALGREENS 13974	CHICAGO	IL	70,953.94
VISITING NURSE ASSN FOX VALLEY	ELGIN	IL	70,867.71
CHILDRENS HOSP OF WISCONSIN	MILWAUKEE	WI	70,227.26
NORTH SHORE HEALTH CENTER	HIGHLAND PARK	IL	69,928.20
BOND DRUG COMPANY OF IL 05103	CICERO	IL	69,585.92
INDEPENDENCE PLUS INC	OAK BROOK	IL	69,537.00
EDGEWATER UPTOWN COMM MHC	CHICAGO	IL	69,486.91
ERDMAN SPAIN SUSAN	CHICAGO	IL	69,401.65
CAREPLUS CVS PHARMACY 02831	CHICAGO	IL	68,903.17
ALDALLAL NADA	CHICAGO	IL	68,171.95
ROCK RIVER ACADEMY	ROCKFORD	IL	67,973.32
UIC MILE SQUARE HEALTH CENTER	CHICAGO	IL	67,950.96
BOND DRUG COMPANY OF IL 03729	HANOVER PARK	IL	67,813.08
EDWARDS TWANA	CHICAGO	IL	67,719.00
BOND DRUG COMPANY OF IL 04940	ROUND LAKE BEACH	IL	67,412.70
MELROSE PARK FAMILY HEALTH CTR	MELROSE PARK	IL	67,181.19
PROFESSIONAL BUILDING PHARMACY	CHICAGO	IL	66,664.25
SHALTOONI ABDELKARIM	HOFFMAN ESTATES	IL	66,436.07
CENTER FOR MEDICAL ARTS RH	CARBONDALE	IL	65,969.71
GATEWAY FOUNDATION	SPRINGFIELD	IL	65,455.30
VISTA MEDICAL CENTER EAST	WAUKEGAN	IL	65,362.45
THE 180 MEDICAL INC	OKLAHOMA CITY	OK	65,088.75
WALGREEN CO 0089	BRIDGEVIEW	IL	64,659.41
NORTH CHICAGO COMM HEALTH CTR	NORTH CHICAGO	IL	64,612.28
PILSEN FAMILY HEALTH CENTER	CHICAGO	IL	63,575.80
SWEDISHAMERICAN HOSPITAL	ROCKFORD	IL	63,470.11
CURASCRIPT PHARMACY INC	ORLANDO	FL	63,373.56
FAMILY CHRISTIAN HEALTH CENTER	HARVEY	IL	62,139.77
LUTHERAN GENERAL HOSPITAL	PARK RIDGE	IL	61,664.22
LAKE CO MNTL HLTH WAUKEGAN	WAUKEGAN	IL	61,303.62
EKTERA ALI	CHICAGO	IL	61,066.78
A2CL SERVICES LLC	WEST ALLIS	WI	60,927.54
SMITH FREDERICK	CHICAGO	IL	60,725.02
UNIFIED PHYSICIANS NETWORK	SKOKIE	IL	$60,332.58

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2012

Provider Name	City	State	Total Amount Paid
WILL COUNTY HEALTH DEPT	JOLIET	IL	$60,066.08
NATIONAL SEATING AND MOBILITY	LOMBARD	IL	59,499.85
NAPERVILLE PSYCH VENTURES	NAPERVILLE	IL	58,533.28
LAMBERGHINI FLAVIA	CHICAGO	IL	58,288.20
LAWNDALE CHRISTIAN HEALTH CTR	CHICAGO	IL	58,044.33
ELGIN CENTER PHARMACY INC	ELGIN	IL	57,822.36
MANGAHAS SUSAN	CARPENTERSVILLE	IL	57,515.23
WILL CO COMM HEALTH CTR	JOLIET	IL	57,465.49
PARUCHURI AJITHA	WEST CHICAGO	IL	56,205.60
TROPICAL OPTICAL	CHICAGO	IL	56,130.00
SALUD FAMILY HEALTH CENTER	CHICAGO	IL	55,589.79
LOGAN SQUARE HLTH CTR COOK CO	CHICAGO	IL	55,077.34
FAMILY SERVICE MHC OF CICERO	CICERO	IL	55,009.97
SCHWAB REHAB HOSP	CHICAGO	IL	54,221.71
HOME DELIVERY INCONTINENT SUPP	OLIVETTE	MO	54,196.77
OAK WEST PRIMARY PHYS ASSOC	MELROSE PARK	IL	54,083.24
WALGREENS 7769	SPRING GROVE	IL	53,996.84
EDWARD HOSPITAL	NAPERVILLE	IL	53,707.27
METROSOUTH MEDICAL CENTER	BLUE ISLAND	IL	53,516.80
CHILDRENS HOME ASSOC OF IL	PEORIA	IL	53,323.55
CRUSADER CLINIC BELVIDERE	BELVIDERE	IL	52,760.02
TRC CHILDRENS DIALYSIS CENTER	CHICAGO	IL	52,619.40
CHICAGO FAM HLTH CTR S CHICAGO	CHICAGO	IL	52,429.26
METHODIST MEDICAL CNTR	PEORIA	IL	52,281.81
CAREMARK KANSAS SPEC PHARM LLC	LENEXA	KS	52,101.96
WALL TIMOTHY	NAPERVILLE	IL	52,058.09
ANDES HEALTH MART	EFFINGHAM	IL	52,030.67
CHRIST HOSPITAL	OAK LAWN	IL	51,864.19
NORTHERN ILLINOIS MEDICAL CTR	MCHENRY	IL	51,691.11
ADVENTIST BOLINGBROOK HOSPITAL	BOLINGBROOK	IL	51,408.13
PINTO JUAN	JOLIET	IL	50,801.63
SAINT FRANCIS MEDICAL CENTER	PEORIA	IL	50,760.46
DOCTORS MEDICAL CENTER	CHICAGO	IL	50,433.21
LSSI MENTAL HEALTH SERVICE	CHICAGO	IL	50,232.66
NRI LABORATORIES INC	CHICAGO	IL	50,214.71
A MED HEALTH CARE	HUNTINGTN BCH	CA	$50,152.06

Appendix G
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2012

Provider Name	City	State	Total Amount Paid
NGUYEN KHANH	CHICAGO	IL	$50,034.71

Source: FY12 paid claim data provided by HFS.

APPENDIX H
Agency Responses

ILLINOIS DEPARTMENT OF
HFS Healthcare and Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

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

October 23, 2013

Honorable William G. Holland
Auditor General
State of Illinois

Dear Auditor General Holland:

The Department of Healthcare and Family Services (HFS) appreciates the work performed by your office in conducting the audit of the "Expanded All Kids" program.

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,

Julie Hamos
Director

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

Attachment Response
Report: Expanded All Kids Program

Recommendation Number 1: Redetermination of Eligibility
The Department of Healthcare and Family Services and the Department of Human Services should review one month's income for determining continued eligibility as required by Public Act 96-1501.

Response:
The Department accepts the recommendation. The Department is using the 'Work Number' and AWVS, which provides employment earnings and unemployment insurance benefit information as available on the Illinois Department of Employment Security files, to obtain income information for a full 30 day period. One month of income data is requested from the recipient if the information is not available electronically.

Recommendation Number 2: Non-Payment of Premiums
The Department of Healthcare and Family Services should:

- terminate ALL KIDS coverage to families that do not pay monthly premiums as required by 89 Ill. Adm. Code 123.340;
- ensure that prior to re-enrollment in ALL KIDS, families pay all premiums due, for periods in which a premium was owed and not paid, as required by 89 Ill. Adm. Code 123.210(0(2); and;
- ensure that before being re-enrolled, the first month's premium was paid if there was an unpaid premium on the date the child's previous coverage was cancelled as required by 89 Ill. Adm. Code 123.210(c)(4).

Response:
The Department accepts the recommendation. Administrative rules have been revised and a report was developed to identify cases that are approved in error.

Recommendation Number 3: ALL KIDS Data Reliability
The Department of Healthcare and Family Services should have controls in place to ensure that its ALL KIDS eligibility and claim data is accurate and reliable. This includes ensuring that enrollees over 18 years of age are identified as no longer eligible, ensuring that enrollees are not enrolled in ALL KIDS more than once, and ensuring the enrollees are no longer eligible for services after their end date.

Response:
The Department accepts the recommendation. A programming error that allowed a one day of eligibility the month following a child's 19th birthday has been corrected. A process to identify individuals assigned more than one identification number is in development.

Recommendation Number 4: Classification of Documented Immigrants
The Department of Healthcare and Family Services should:

- ensure that documented immigrants are classified correctly in its database;
- maintain the necessary information needed to identify documented immigrants such as social security numbers, alien registration numbers, and dates of entry; and,
- ensure that the State receives federal matching funds for all eligible claims.

Response:
The Department accepts the recommendation. New coding to more accurately record immigration status has been implemented. HFS received Federal approval to claim Federal matching funds for lawfully residing children under Section 214 of CHIPRA.

Recommendation Number 5: Duplicate Claims
The Department of Healthcare and Family Services should review the manual review process for rejected claims and strengthen the controls to prevent duplicate claims from being paid.

Response:
The Department accepts the recommendation. The Department continues to enhance the data warehouse query to identify duplicates and reviews the data monthly.

Recommendation Number 6: Eligibility Documentation
The Department of Healthcare and Family Services and the Department of Human Services should:

- ensure that all necessary eligibility documentation to support birth, identity, and residency is received in order to ensure that eligibility is determined accurately;
- require one month's worth of income verification for determining eligibility; and,
- implement better controls to verify whether individuals are self-employed and to ensure that adequate information is provided and eligibility is determined correctly

Response:
The Department accepts the recommendation. The Department has implemented electronic verification of citizenship, identity, residency, and income. Paper verification is requested when these items cannot be verified electronically. These procedural changes assure HFS is fully compliant with both State and Federal law.

Recommendation Number 7: Transportation Claims
The Department of Healthcare and Family Services should:

- ensure that proper electronic billing edits are in place to prevent payment of duplicate transportation claims. In addition, HFS should identify and recoup past duplicate payments made to providers; and,
- ensure that transportation providers submit accurate claim detail with their request for payment to ensure HFS has the information necessary for monitoring.

Response:
The Department accepts the recommendation. A Project Initialization Request was prepared to program a system edit that will only allow one round-trip per prior approval number per day. The Department is also working to place some restrictions on origin and destination times and require the input of address and city information by providers to help ensure more accurate claim detail.

Recommendation Number 8: Optical Edits
The Department of Healthcare and Family Services should ensure that electronic billing edits exist to identify potential abuse related to the ordering of eyeglass frames and for the billing of exams and fittings. Additionally, HFS should identify and recoup unallowable past optical payments made to providers.

Response:
The Department accepts the recommendation. OIG has specifically run data mining routines to determine the top 7 children with multiple eyeglass expenditures and they are limited to 3 practitioners tied to one alternate payee. OIG is requesting these charts to determine whether the provision of multiple eyeglasses to these children is medically necessary or evidence of fraud, waste or abuse for this alternate payee. A provider notice will be sent reminding providers to retain documentation that exams or glasses exceeding the benefit limitation are either medically necessary, due to a change in prescription, or the glasses were lost, stolen or broken beyond repair. It should be noted that for Title XIX and XXI over 99% of the exam claims were for two exams or less and over 99% of the claims for glasses were for one to two pairs in FY13.

Recommendation Number 9: Guidance over Preventive Medicine Service Claims
The Department of Healthcare and Family Services should more clearly define how providers should bill preventive medicine services and should distinguish between preventive services' and office visits for established patients. The Department should also ensure that electronic billing edits exist to identify potential abuse related to the billing of preventive medicine services.

Response:
The Department accepts the recommendation. The Department has issued a Provider Notice reminding providers of the proper use and frequency limits of preventive services codes. The Department is working to institute systematic edits to limit the number of preventive service billings.

Recommendation Number 10: Inconsistent Dental Policies
The Department of Healthcare and Family Services, should ensure that dental policies and other information available to the public accurately state frequency of benefits.

Response:
The Department accepts the recommendation. The Department will revise Administrative Rules to accurately state frequency of benefits. In addition, HFS will update the Dental Office Reference Manual as well as the website to be consistent with the Administrative Rules.

15 YEARS
PARTNERING WITH COMMUNITIES

Pat Quinn, *Governor*

Michelle R.B. Saddler, *Secretary*

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

Mr. Scott Wahlbrink
Performance Audit Manager
Office of the Auditor General
Iles Park Plaza
740 East Ash
Springfield, IL 62703-3154

Dear Mr. Wahlbrink:

Following is the response for the draft report of the recommendations assigned to the Department of Human Services as a result of the SFY2012, fourth annual audit of the Office of the Auditor General Covering ALL KIDS Health Insurance program:

Recommendation #1: The Department of Healthcare and Family Services and the Department of Human Services should review one month's income for determining continued eligibility as required by Public Act 96-1501.

Department Response: The Department agrees with the recommendation. In July 2012, the State of Illinois ceased generating administrative renewal notices, which advised families that they did not have to respond if nothing relevant to their child's eligibility, including income, had changed. Instead, eligibility is now reviewed by a third party vendor using electronic data matches when the Social Security numbers of the responsible relatives to the children are known and verified. Those eligibility reviews are used in making recommendations to the State of Illinois Department of Human Service (IDHS) and the Department of Healthcare and Family Services (HFS) employees, who then carry out the recommendation by either continuing eligibility, modifying eligibility, or canceling eligibility.

Effective with medical applications on or after 10/1/13, and to coincide with the implementation of the first phase of the Integrated Eligibility System (IES), policy has now been changed to clarify that as required under the Affordable Care Act, electronic data matches are the preferred means of verifying income in order to determine proper eligibility for medical programs, and that verification of 30 days of income is now required for all medical programs.

Recommendation #6: The Department of Healthcare and Family Services and the Department of Human Services should:

- ensure that all necessary eligibility documentation to support birth, identity, and residency is received in order to ensure that eligibility is determined accurately;
- require one month's worth income verification for determining eligibility; and
- implement better controls to verify whether individuals are self- employed and to ensure that adequate information is provided and eligibility is determined correctly

Department Response: The Department of Human Services (DHS) agrees with the recommendation.

1. DHS follows policy set forth by the Illinois Department of Healthcare and Family Services (HFS), the single state Medicaid agency. In March 2012, an automated Secretary of State residency clearance is generated for new medical applicants and requestors over the age of 16 registered in the Automated Intake System (AIS) or the Integrated Eligibility System (IES) in the All Kids unit, and in all DHS Family and Community Resource Centers (FCRCs).
   That clearance is to be filed in the case record. The Department currently follows policy created by HFS regarding eligibility documentation supporting birth and identity.

2. Effective with medical applications submitted on or after 10/1/13, and to coincide with the implementation of the first phase of the Integrated Eligibility System, policy has now changed to clarify that as required under the Affordable Care Act, electronic data matches are the preferred means of verifying income in order to determine proper eligibility for medical programs, and that verification of 30 days of income is now required for all medical programs.

3. DHS has not identified an alternative source to verify self employment income other than current policy of requiring business records of income and expenses. The Illinois Medicaid Redetermination Project contract with Maximus utilizes electronic income verification that may assist in identifying income that has not been disclosed by the recipient. DHS will request clarification from the federal Center for Medicare and Medicaid Services on the existence of any federal regulation on self-employment income verification, and whether we are currently in compliance.

If you have any questions, please contact Albert Okwuegbunam, Bureau Chief, Audit Liaisons at 217/785-7797.

Sincerely,

Michelle R.B. Saddler
Secretary

cc: Nelida Smyser-Deleon, Assistant Secretary-Programs
Matthew Hammoudeh, Assistant Secretary - Operations
Linda Saterfield, Director, Family and Community Services
Carol Kraus, Chief Financial Officer
Matthew A. Grady, Chief Operating Officer
Michael Layden, Director Office of Fiscal Services
Jennifer Hrycyna, Associate Director, Family and Community Services
Sharon Dyer-Nelson, Manger, Family and Community Services
Paul Thelen, Family and Community Services
Albert Okwuegbunam, Bureau Chief, Audit Liaisons