STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT
OF THE

# COVERING ALL KIDS HEALTH INSURANCE PROGRAM

FEBRUARY 2016

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OFFICE OF THE AUDITOR GENERAL
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*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.

SIGNED ORIGINAL ON FILE

Frank J. Mautino
Auditor General

Springfield, Illinois
February 2016

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

SUMMARY REPORT DIGEST

# COVERING ALL KIDS HEALTH INSURANCE PROGRAM

**PROGRAM AUDIT**
**For the Year Ended: June 30, 2014**

**Release Date: February 2016**

## 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 **sixth annual audit** and covers FY14. 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 FY14 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 FY14, 81,440 children were enrolled in EXPANDED ALL KIDS for a total cost of $70 million.
- Of the 28,695 EXPANDED ALL KIDS recipients that required an annual redetermination of eligibility in FY14, we found 6,625 (23%) were not redetermined annually as required.
- We tested 40 initial eligibility cases from FY14, and determined HFS and DHS were missing documentation needed to verify residency in 25% of cases, birth/age in 38% of cases, and one month's income in 54% of cases. In addition, we found income was incorrectly calculated in 18% of cases where income was reported.
- We tested 40 cases redetermined in FY14, and determined HFS and DHS were missing documentation needed to verify residency in 60% of cases, birth/age in 74% of cases, and one month's income in 14% of cases. In addition, we found income was incorrectly calculated in 21% of cases where income was reported.
- In FY14, 166 recipients received 1,653 services totaling $75,583 after the month of their 19th birthday. Additionally, there were 423 individuals who were enrolled with more than one identification number.
- We tested 40 initial eligibility cases and 40 cases redetermined during FY14. We found that 60 percent of the initial cases (24 of 40), and 43 percent of the redetermined cases (17 of 40), were coded as "undocumented" even though we found evidence supporting citizenship or documented immigrant status.
- We found the EXPANDED ALL KIDS data contained 5,536 recipients who were coded as "undocumented" even though their social security numbers were verified. In FY14, these 5,536 had 130,609 services for a total cost of $4.79 million. If these recipients were classified as undocumented in error, the State did not receive eligible matching federal funds.
- In 2011, HFS made the procedures for orthodontic services less stringent, which increased orthodontia claims from $322,892 in FY 2010 to $3.6 million by FY 2014. We recommended that HFS review and monitor eligibility for orthodontic services more effectively.
- DHS and HFS agreed with all the five recommendations made in the audit report.

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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 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 (FPL) 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.**

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."

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 sixth annual audit (FY14). 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 audit (FY11) was released in October 2012 and contained 11 recommendations. The fourth audit (FY12) was released in December 2013 and contained 10 recommendations. The fifth audit (FY13) was released in August 2014 and contained eight recommendations.

This FY14 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. HFS and DHS took some action to address the previous 8 recommendations, and as a result, only 4 of the 8 are repeated during this audit period (FY14). (pages 7-9, 20)

### RECENT CHANGES TO THE COVERING ALL KIDS HEALTH INSURANCE PROGRAM

Events in recent years have had a significant impact on the EXPANDED ALL KIDS program and our audits. These events include:

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

1. 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 was above 300 percent of the federal poverty level (FPL) were no longer eligible. As a result, there were a reduced number of EXPANDED ALL KIDS participants and expenditures to be audited;

**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.**

2. In 2013, 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);

   Our first four EXPANDED ALL KIDS audits only included children whose medical care was totally State-funded. Beginning with the last audit, we determined the federal government would reimburse the State for 65 percent of eligible costs for this population (children from families with income between 200 and 300 percent of FPL). Additionally, the State was granted retroactive reimbursement dating back to July 1, 2008. According to HFS officials, as of October 29, 2015, HFS had recouped a total of $40.4 million; and

**The Affordable Care Act required all states to apply a new budget methodology based on Modified Adjusted Gross Income (MAGI) to determine eligibility for certain households requesting or receiving medical assistance.**

3. The most recent change required a new budgeting methodology for determining ALL KIDS eligibility. The Affordable Care Act required all states to apply a new budget methodology based on Modified Adjusted Gross Income (MAGI) to determine eligibility for certain households requesting or receiving medical assistance. The purpose of using the MAGI budgeting methodology is to align financial eligibility rules with the Health Insurance Marketplace. Even though much of the EXPANDED ALL KIDS population is not federally funded, to avoid confusion, HFS uses the same budgeting methodology for all medical programs. Therefore, the new MAGI calculation methodology increased the ALL KIDS level from 300 percent of FPL to 318 percent of FPL, thus increasing the number of recipients eligible. (pages 10-13)

## ALL KIDS PROGRAM

According to HFS, in FY14, Illinois' ALL KIDS program as a whole had a total of 1.9 million enrollees and HFS paid almost $3.1 billion in claims. In FY14, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion totaled 81,440.

On June 30, 2014, there were 52,075 enrollees as a result of the expansion, of which 30,441 (58%) were classified as undocumented immigrants in the HFS data. Over the last four fiscal years, total enrollment has decreased from 74,975 at the end of FY11 to 52,075 at the end of FY14. There was a 22,900 enrollee decrease from FY11 to FY14, some of which was due to the elimination of Levels 3 through 8 after June 30, 2012, as required by PA 96-1501. Digest Exhibit 1 breaks out enrollment by fiscal year, by plan, and by whether the child was classified by HFS or DHS as a citizen or documented immigrant or whether the child was classified as undocumented.

During the last five years, while the number of citizens/documented immigrants has remained fairly steady, there has been a steady decrease in undocumented immigrants. The number of undocumented enrollees decreased from 54,073 in June 2009 to 30,441 in June 2014. (pages 13-16)

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

| EXPANDED ALL KIDS Plan | Citizens/ Documented Immigrants | | Undocumented Immigrants | |
|---|---|---|---|---|
| | FY13 | FY14 | FY13 | FY14 |
| **Assist** $35,064[1] | Part of Medicaid and not part of EXPANDED ALL KIDS | | 37,938 | 28,460 |
| **Share** $37,440[1] | | | 806 | 702 |
| **Premium Level 1** $49,848[1] | | | 811 | 965 |
| **Premium Level 2** $75,840[1] | 18,963[3] | 21, 634[3] | 304 | 314 |
| **Totals** | **18,963** | **21,634** | **39,859** | **30,441** |

Notes:

[1] Denotes the Modified Adjusted Gross Income (MAGI) equivalent income standard for the plan level and the maximum income for a family of four for that plan during FY14.

[2] Enrollment is the total number of enrollees that were eligible on June 30 of 2013 and 2014. There were 84,563 enrollees eligible at some point during FY13 and 81,440 enrollees eligible at some point during FY14.

[3] State received 65 percent reimbursement from Title XXI of the Social Security Act (Medicaid) for these recipients.

Source: ALL KIDS enrollment data provided by HFS.

## ALL KIDS SERVICES PROVIDED BY FISCAL YEAR

**The cost for services increased to $89 million in FY10, to $89.3 million in FY11. The total cost for services dropped to $87.8 million in FY12, to $75.2 million in FY13, and to $70 million in FY14.**

According to claim data provided by HFS, the cost of services for EXPANDED ALL KIDS in FY09 totaled $78.8 million. The cost for services increased to $89 million in FY10, and to $89.3 million in FY11. The total cost for services dropped to $87.8 million in FY12, to $75.2 million in FY13, and to $70 million in FY14.

Digest Exhibit 2 breaks out the payments for services by whether the child was classified as a citizen or documented immigrant or whether the child was classified as undocumented for both FY13 and FY14. The Exhibit shows the cost of services decreased by $5.1 million from $75.2 million in FY13 to $70 million in FY14. (page 17)

Digest Exhibit 2
**EXPANDED ALL KIDS COST OF SERVICES PROVIDED BY ALL KIDS PLAN**
Fiscal Years 2013 and 2014

| EXPANDED ALL KIDS Plan | Citizens/Documented Immigrants | | Undocumented Immigrants | | Totals | |
|---|---|---|---|---|---|---|
| | FY13 | FY13 | FY13 | FY14 | FY13 | FY14 |
| **Assist** $35,064[1] | Part of Medicaid and not part of EXPANDED ALL KIDS | | $46,646,334 | $39,546,799 | $46,646,334 | $39,546,799 |
| **Share** $37,440[1] | | | $919,741 | $971,681 | $919,741 | $971,681 |
| **Premium Level 1** $49,848[1] | | | $885,206 | $1,285,740 | $885,206 | $1,285,740 |
| **Premium Level 2** $75,840[1] | $26,409,537[3] | $27,766,776[3] | $303,525 | $473,790 | $26,713,062 | $28,240,566 |
| **Totals[2]** | **$26,409,537** | **$27,766,776** | **$48,754,805** | **$42,278,010** | **$75,164,343** | **$70,044,785** |

Notes:

[1] Denotes the Modified Adjusted Gross Income (MAGI) equivalent income standard for the plan level and the maximum income for a family of four for that plan during FY14.

[2] Totals may not add due to rounding.

[3] The federal matching rate was 65 percent; therefore, the State's share for FY13 services was $9.2 million and was $9.7 million for FY14 services.

Source: ALL KIDS data provided by HFS.

## COST OF SERVICES AND PREMIUMS COLLECTED

HFS received $7.7 million in premium payments from enrollees in FY13, and received $8.3 million in FY14. As a result, the net cost of EXPANDED ALL KIDS after premium payments were applied was approximately $67.5 million in FY13 and $61.7 million in FY14. Digest Exhibit 3 shows both FY13 and FY14 cost of services and premiums collected from the EXPANDED ALL KIDS program. (page 19)

Digest Exhibit 3
**COST OF SERVICES FOR EXPANDED ALL KIDS AND PREMIUM AMOUNTS COLLECTED**
Fiscal Years 2013 and 2014

| EXPANDED ALL KIDS Plan | FY13 Services | FY14 Services | FY13 Premiums Collected | FY14 Premiums Collected | FY13 Net Cost[3] | FY14 Net Cost[3] |
|---|---|---|---|---|---|---|
| **Assist** $35,064[1] | $46,646,334 | $39,546,799 | n/a | n/a | $46,646,334 | $39,546,799 |
| **Share** $37,440[1] | $919,741 | $971,681 | $0 | $30 | $919,741 | $971,651 |
| **Premium Level 1** $49,848[1] | $885,206 | $1,285,740 | $124,725 | $128,018 | $760,481 | $1,157,722 |
| **Premium Level 2**[2] $75,840[1] | $26,713,062 | $28,240,566 | $7,554,265 | $8,190,167 | $19,158,796 | $20,050,399 |
| **Totals**[3] | **$75,164,343** | **$70,044,785** | **$7,678,990** | **$8,318,215** | **$67,485,352** | **$61,726,571** |

Notes:

[1] Denotes the Modified Adjusted Gross Income (MAGI) equivalent income standard for the plan level and the maximum income for a family of four for that plan during FY14.

[2] This exhibit does not include any federal reimbursement for Level 2 enrollees, which would decrease the State's total actual cost by 65% or $17.4 million in FY13 and $18.4 million in FY14.

[3] Totals may not add due to rounding.

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

## ESTIMATED TOTAL COST OF EXPANDED ALL KIDS SERVICES TO THE STATE DURING FY14

To estimate the total cost of the EXPANDED ALL KIDS program to the State, we subtracted the allowable federal reimbursement for Level 2 enrollees (65%) and the premium payment amount HFS received during FY14 from the total cost for services provided during FY14. The cost of the program continues to decrease. In FY13, the estimated cost to the State was $50.1 million. (page 19)

## FOLLOW UP ON FY13 RECOMMENDATIONS

**HFS and DHS took some action to address the previous 8 recommendations, and as a result, only 4 of the 8 are repeated.**

HFS and DHS took some action to address the previous 8 recommendations, and as a result, only 4 of the 8 are repeated. We also added one new recommendation related to orthodontia. We found that HFS addressed the past recommendation relating to inconsistent dental policies by updating its website with a link to the correct policies. We also analyzed transportation claims and preventive medicine claims and found no exceptions. HFS officials indicated that the duplicate claims edit was manual and was too time consuming and costly to perform in the past; however, the new system currently being developed will include the edit. (page 20)

## REDETERMINATION OF ELIGIBILITY

In the first annual EXPANDED ALL KIDS audit (FY09), 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. In this audit (FY14), auditors continued to find that redeterminations were not conducted as required.

### Annual Eligibility Redeterminations

In February 2014, a new process for redetermining eligibility began under the Illinois Medicaid Redetermination Project. A new redetermination system called Max-IL was developed to record and store redetermination information for medical-only cases. Using the new Max-IL system, medical-only cases are redetermined annually by the central redetermination unit staff. The new Max-IL system records and stores all redetermination forms mailed to the recipient, returned redeterminations, electronic data matching results, requests for missing information, and verifications. Central redetermination staff is responsible for making eligibility decisions, coding the redetermination, and processing any changes on the cases. In addition, MAGI rules for redeterminations became effective on April 1, 2014.

During our review of all eligibility redeterminations for EXPANDED ALL KIDS recipients made in FY14, we found that HFS and DHS did not complete redeterminations of eligibility **annually** for all recipients as required by the Covering ALL KIDS Health Insurance Act. According to the data provided by HFS, 28,695 EXPANDED ALL KIDS recipients required a redetermination of eligibility in FY14. Our analysis of the data showed 22,070 of the 28,695 (77%) were redetermined in FY14. As a result, 6,625 (23%) were not redetermined annually as required by the Act. According to the data, 3,971 of the 6,625 were redetermined in FY15 and the remaining 2,654 were pending.

**Our analysis of the data showed 22,070 of the 28,695 (77%) were redetermined in FY14. As a result, 6,625 (23%) were not redetermined annually as required by the Act.**

Given that redeterminations were not conducted timely for 23 percent of eligible EXPANDED ALL KIDS recipients, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2014, to June 30, 2015. (pages 20-23)

## ALL KIDS ELIGIBILITY DATA

Auditors identified issues associated with the eligibility data provided by HFS dating back to FY09. These areas included individuals who were older than 18 years of age and who are no longer eligible, and eligibility data which included duplicate enrollees with two different recipient identification numbers and/or different birth dates or addresses.

During our review of the FY14 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 FY14 data, we identified 423 individuals who appeared to be enrolled with more than one identification number.

**We identified 423 individuals who appeared to be enrolled with more than one identification number.**

We also identified 166 recipients that received 1,653 services totaling $75,583 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, 2014, to June 30, 2015. (page 23)

**We also identified 166 recipients that received 1,653 services totaling $75,583 after the month of their 19th birthday.**

## CLASSIFICATION OF DOCUMENTED IMMIGRANTS

Although HFS reported the miscoding of documented immigrants had been corrected, during each of our last two audits, we found the EXPANDED ALL KIDS data continued to have recipients who appear to be incorrectly coded as "undocumented." Although some of the inaccurate coding may have been due to incorrect electronic matching of social security numbers as was previously reported by HFS, we determined a lack of specific policies and procedures for caseworkers is also causing miscoding.

During testing of eligibility determinations during this audit, we determined HFS and DHS did not identify the correct citizenship status for recipients, and as a result, the State is losing federal matching Medicaid funds. We found in past audits, and continue to find, EXPANDED ALL KIDS recipients coded as undocumented that should not be coded as undocumented. Many recipients had verified social security numbers, alien registration numbers, or a combination of both. According to DHS, "verified" means the social security number has been verified through an electronic match with the Social Security Administration. Recipients with verified social security numbers and/or alien registration numbers appear to be documented immigrants and would be eligible for federal matching funds.

For recipients categorized by HFS and DHS as "undocumented," we determined the FY14 eligibility data contained:

- 5,536 recipients who had social security numbers that were verified, of which 801 also had an alien registration number; and
- 138 recipients who had an alien registration number, but did not have a verified social security number.

**We reviewed the services provided to these "undocumented" recipients in FY14 and determined the 5,536 recipients had 130,609 services for a total cost of $4.79 million.**

We reviewed the services provided to these "undocumented" recipients in FY14 and determined the 5,536 recipients had 130,609 services for a total cost of $4.79 million. If these recipients were classified as undocumented in error, the State did not receive eligible matching federal funds.

### Initial Eligibility Testing

During our testing of 40 new cases that were approved during May and June 2014, we found 19 cases coded as undocumented even though the enrollees had a verified social security number. As a result, the enrollees likely should not have been classified as undocumented. In addition to these 19 cases, we found an additional 5 cases that also likely should not have been classified as undocumented based on immigration documentation, tax filer status, or birth information. Therefore, a total of 24 out of the 40 recipients sampled (60%) were coded as undocumented even though we found evidence supporting they were likely citizens or documented immigrants. We provided these 24 to DHS, and DHS officials agreed they were likely documented.

**A total of 24 out of the 40 initial eligibility recipients sampled (60%) were coded as undocumented even though we found evidence supporting they were likely citizens or documented immigrants.**

We met with a DHS official and discussed the issue of enrollees with verified social security numbers being classified in the Integrated Eligibility System (IES) by caseworkers as undocumented. The DHS official used IES to test a case and determined that in fact an individual with a verified social security number can be classified by a caseworker as undocumented. Caseworkers manually classify enrollees using a drop down menu. There is currently no edit within IES that would notify the caseworker that the enrollee was being classified as undocumented even though there is documentation to support citizenship or a documented immigrant status.

### Eligibility Testing for Redetermination

During our review of 40 recipients that were redetermined during May or June 2014, we found 8 coded as undocumented even though the enrollees had a verified social security number. As a result, the enrollees likely should not have been classified as undocumented. In addition to these 8 cases, we found 9 cases that also likely should not have been classified as undocumented based

**A total of 17 out of the 40 recipients sampled (43%) were coded as undocumented at redetermination even though we found evidence supporting they were likely citizens or documented immigrants.**

on immigration documentation or tax filer status. Therefore, a total of 17 out of the 40 recipients sampled (43%) were coded as undocumented even though we found evidence supporting they were likely citizens or documented immigrants. We provided these 17 to DHS, and DHS officials agreed they were likely documented.

Although HFS reported that problems related to the coding of undocumented immigrants were corrected on October 29, 2010, we continue to have multiple issues in this area. Therefore, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2014, to June 30, 2015. 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. (pages 24-26)

## ELIGIBILITY DOCUMENTATION

All five 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.

HFS and DHS attempt to determine eligibility for undocumented immigrants using various data matching techniques to determine residency, income, and immigration/citizen status. We determined the data matching component used by IES or the Illinois Medicaid Redetermination Project (IMRP) cannot be utilized for the undocumented recipients in the EXPANDED ALL KIDS program since by definition, these children and often their parents are **undocumented.** Electronic data matches and searches based on social security numbers are ineffective for this population because they do not have social security numbers. Therefore, in many instances, the auditors along with DHS officials, searched through IES for scanned copies of documents to determine residency, income, birth/age, and immigration/citizenship status for all recipients, including undocumented recipients.

### Initial Eligibility Testing

We selected 40 new cases that were approved during May and June 2014 and found significant issues. During our testing, we reviewed all 40 new cases in IES to determine whether all required eligibility documentation was obtained or reviewed.

We found residency was not verified in 10 of the 40 (25%) cases tested, and birth/age information was not verified in 15 of the 40 (38%) cases tested. We also found income eligibility documentation and calculation problems in the majority of the cases tested. Of the 40 cases tested, 28 reported having some income. We found 30 days of income was not reviewed in 54 percent (15 of 28) of the cases where income was reported. In addition to the 15 that were missing 30 days of income, we identified 5 other cases (18%) where caseworkers did not calculate the income correctly or did not determine the correct number of household members.

### Eligibility Redetermination Testing

We tested 40 redeterminations that occurred during May and June 2014 and found significant issues. Half of the cases were redetermined in Max-IL and half were determined in the Supplemental Nutrition Assistance Program (SNAP). We found 17 cases coded as undocumented even though we found evidence, such as verified social security numbers, supporting the enrollee was likely a citizen or documented immigrant. As a result, these 17 recipients are likely not eligible for the EXPANDED ALL KIDS program. One of the 40 cases was closed before it was redetermined, and therefore, was not included in the testing.

We found DHS and HFS did not obtain all required documentation to support birth, residency, and income. We found residency was not verified in 12 of the 20 (60%) cases tested, and birth/age information was not verified in 29 of the 39 (74%) cases tested. We also found income eligibility documentation and calculation problems in the cases tested. Of the 39 cases tested, 29 reported having some income. We found 30 days of income was not reviewed in 14 percent (4 of 29) of the cases where income was reported. In addition to the 4 that were missing 30 days of income, we identified 6 other cases (21%) where caseworkers did not calculate the income correctly or did not determine the correct number of household members. Therefore, this part of the recommendation is **repeated** and will be followed up on in future audits. (pages 26-33)

## POLICIES COVERING ORTHODONTIC TREATMENT

As part of this year's EXPANDED ALL KIDS audit, we examined the payments made to providers for orthodontic

services. Our review identified two issues. The first was a lack of documentation related to orthodontic claims. The second was whether sufficient documentation existed to support eligibility decisions.

### Lack of Documentation from DentaQuest

As a result of our review of policies and procedures related to the approval of orthodontia, we found that DentaQuest, the Dental Program Administrator for HFS, could not provide documents that were used to approve orthodontic claims. We requested documents used by DentaQuest for initial approval for 40 recipients that had orthodontic services during FY14. DentaQuest could not provide the documents for 9 of the 40 requested (23%). According to DentaQuest officials, 3 could not be provided because "NEA" (National Electronic Attachment) only retains records for three years, while 6 could not be provided due to a "system issue."

**DentaQuest could not provide the documents for 9 of the 40 requested (23%).**

### Orthodontic Eligibility Criteria

The Administrative Code (89 Ill. Adm. Code 140.421(a)(16)) provides the following guidance on orthodontic eligibility:

*Orthodontics. Medically necessary orthodontic treatment is approved only for patients ages 0-20 and is defined as:*

*A) treatment necessary to correct a condition which scores 42 points or more on the Salzmann Index; or*

*B) treatment necessary to correct a handicapping malocclusion (a condition that impairs or creates a hazard in eating, chewing, speaking, or breathing.)*

We found almost none of the recipients were approved for orthodontics in FY14 using the Salzmann Index score (89 Ill. Adm. Code 140.421(a)(16)(A)). Only 8 of 13,576 orthodontic cases approved by DentaQuest were approved using the Salzmann Index.

The majority of the recipients were approved using the medical necessity standard (89 Ill. Adm. Code 140.421(a)(16)(B)). A DentaQuest official noted that the scoring tool used by DentaQuest for orthodontic cases was changed in 2010 to capture medical necessity without requiring a written order from a physician.

The change in the scoring tool corresponded with a significant increase in orthodontia claims being paid by HFS. In FY10, the EXPANDED ALL KIDS program paid for only $322,892 in orthodontic services. By FY14, 4,020 EXPANDED ALL KIDS

**In FY10, the EXPANDED ALL KIDS program paid for only $322,892 in orthodontic services. By FY14, 4,020 EXPANDED ALL KIDS recipients had orthodontic services totaling $3.6 million.**

recipients had orthodontic services totaling $3.6 million. Similarly, orthodontic services increased dramatically for HFS' medical program as a whole. In FY10, payments for orthodontic services totaled $2.9 million. In FY 2012, the amount paid increased to $16.6 million, and by FY14, payments totaled $36.6 million.

**Review of Orthodontic Cases**

While the scoring tool was approved in FY11, the Administrative Code delineating eligibility criteria for orthodontic services was not changed. As noted above, few cases are approved using the Salzmann Index in the first section of the Administrative Code (89 Ill. Adm. Code 140.421(a)(16)(A)). Rather, most cases are approved pursuant to the second part of the Administrative Code which states: *treatment necessary to correct a handicapping malocclusion (a condition that impairs or creates a hazard in eating, chewing, speaking, or breathing.)*

It is HFS' position that the revised scoring tool continues to comply with the requirements of the Administrative Code. In December 2009, a DentaQuest dentist recommended Illinois adopt the Medical Necessity Scoring Tool, and if the recipient does not qualify, use the modified Salzmann. The Peer Review Committee minutes stated "the state regulations require that orthodontia should be approved if the Modified Salzmann is 42 points or higher or if the service is medically necessary. Using both tools will meet the state regulations and will not necessitate a rules change." All committee members approved the recommendation.

According to HFS, the change to the scoring tool received approval from two other HFS committees. HFS provided limited documentation showing that the change was approved by the Dental Program Policy Committee or the Policy Review System.

We noted there were a large number of dentists providing orthodontic services that were among the highest paid providers in the EXPANDED ALL KIDS program, and we approached the HFS Office of the Inspector General (OIG) for assistance reviewing eligibility documentation for a sample of the providers. We also noted that based on our review of 15 case files, we had questions regarding whether some recipients approved for orthodontic services met the need standards established in HFS' administrative rule or Dental Office Reference Manual (DORM).

The OIG agreed to have the OIG dental consultant review cases selected by us. We worked with the OIG and jointly visited four orthodontist offices. We obtained and reviewed the documentation for 10 recipients at each location for a total of 40 cases. As of October 27, 2014, there were 453 orthodontic claims paid for these 40 cases totaling $124,000. Auditors judgmentally

**Auditors found 1 of the 4 providers could not provide evidence to support all services provided.**

selected 10 cases for each provider where it appeared from the electronic data the treatment was completed during FY14 or in early FY15. Auditors found 1 of the 4 providers could not provide evidence to support all services provided. In all 10 cases reviewed for this provider, auditors could not find evidence for all of the services billed.

Auditors also determined that the scoring tool was completed by DentaQuest, and not by the recipient's dentist, as HFS had previously indicated to the auditors. Auditors asked HFS what monitoring is conducted by HFS related to the approval of orthodontics. HFS indicated it does not review eligibility decisions made by DentaQuest.

During our testing, we had discussions with the orthodontists related to the approval process. We were able to ask 3 of the 4 orthodontists specifically about the approval process. All three orthodontists indicated they could not follow the reasoning behind why some cases were approved by DentaQuest.

**Results from OIG Consultant's Review**

The OIG provided the OAG with a preliminary draft of its report which noted that due to the modifications made in 2011 to the medical necessity prior approval procedures, *"the threshold for medically necessary services was made less stringent increasing the number of prior approvals of orthodontic services."* During the review of the 40 sample cases, the OIG's dental consultant found that each of the 40 cases met the Department's medical necessity criteria using the new, less stringent scoring tool; however, the consultant found *"limited or no corroborating evidence of conditions of a handicapping malocclusion, including documentation establishing a condition that impairs or creates a hazard in eating, chewing, speaking or breathing, other than that which was documented in Attachment G."* Attachment G of the DORM is the Medical Necessity Scoring Tool (see Appendix F). The OIG recommended increasing the documentation required to establish medical necessity, such as a narrative report from the dentist as well as a certification from a medical professional certifying that the client meets the conditions of a medical need for orthodontic services.

The OIG found guidelines for providers of orthodontic services were unclear and inconsistent. The OIG recommended the definition of medical necessity be revised and more clearly defined. The OIG also recommended changes to either the Administrative Code, Department Handbooks or policies to include more specific examples of medical necessity.

**Conclusion**

Expenditures by the State for orthodontic services for children in EXPANDED ALL KIDS specifically, and HFS' medical program generally, increased dramatically from FY10 to FY14. This increase corresponds to the time when the scoring tool used to determine medical necessity for orthodontic services was revised. A review conducted by the OIG concluded that revisions and clarifications to policies establishing medical necessity should be made, as well as requiring additional documentation to support medical necessity. (pages 33-37)

**RECOMMENDATIONS**

The audit report contains five recommendations. Two recommendations were specifically for the Department of Healthcare and Family Services. Three recommendations were for both the Department of Healthcare and Family Services and the Department of Human Services. The Department of Human Services agreed with its three recommendations. Department of Healthcare and Family Services agreed with all five of its recommendations. Appendix G to the audit report contains the agency responses.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

FJM: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 (see Appendix A). The Public Act was effective June 1, 2009. This is the sixth annual audit (FY14), and follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. The previous five annual audits covered FY09 through FY13.

- 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 audit (FY11) was released in October 2012 and contained 11 recommendations.
- The fourth audit (FY12) was released in December 2013 and contained 10 recommendations.
- The fifth audit (FY13) was released in August 2014 and contained 8 recommendations.

## ALL KIDS PROGRAM

According to HFS officials, during FY14, Illinois' ALL KIDS program as a whole had almost 1.9 million enrollees and HFS paid $3.1 billion in claims. In FY14, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion totaled 81,440. On June 30, 2014, there were 52,075 enrollees as a result of the expansion, of which 30,441 (58%) were classified as undocumented immigrants in the HFS data.

According to claim data provided by HFS, the cost of services for EXPANDED ALL KIDS in FY09 totaled $78.8 million. The cost for services increased to $89 million in FY10, and to $89.3 million in FY11. The total cost for services dropped to $87.8 million in FY12, to $75.2 million in FY13, and to $70 million in FY14.

In FY14, undocumented immigrants made up 60 percent of the total costs for the EXPANDED ALL KIDS program. Cost for services for undocumented immigrants totaled $54.9 million in FY11, $55.7 million in FY12, $48.8 million in FY13, and $42.3 million in FY14. 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.

Based on reports provided by HFS, in FY13, HFS received $7.7 million in premium payments, and in FY14 HFS received $8.3 million in premium payments. As a result, the net cost of the EXPANDED ALL KIDS program after premium payments were applied was approximately $67.5 million in FY13 and $61.7 million in FY14.

## FOLLOW UP ON PREVIOUS RECOMMENDATIONS

HFS and DHS took some action to address the previous 8 recommendations, and as a result, only 4 of the 8 are repeated. We also added one new recommendation related to orthodontia. We found that HFS addressed the past recommendation relating to inconsistent dental policies by updating its website with a link to the correct policies. We also analyzed transportation claims and preventive medicine claims and found no exceptions. HFS officials indicated that the duplicate claims edit was manual and was too time consuming and costly to perform in the past; however, the new system currently being developed will include the edit. The following four issues were repeated during the FY14 audit period:

- **Redetermination of Eligibility** - During our review of all eligibility redeterminations for EXPANDED ALL KIDS recipients made in FY14, we found that HFS and DHS did not complete redeterminations of eligibility **annually** for all recipients as required by the Covering ALL KIDS Health Insurance Act. According to the data provided by HFS, 28,695 EXPANDED ALL KIDS recipients required a redetermination of eligibility in FY14. Our analysis of the data showed 22,070 of the 28,695 (77%) were redetermined in FY14. As a result, 6,625 (23%) were not redetermined annually as required by the Act. According to the data, 3,971 of the 6,625 were redetermined in FY15 and the remaining 2,654 were pending.

- **ALL KIDS Data Reliability** - During our review of the FY14 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 FY14 data, we identified 423 individuals who appeared to be enrolled with more than one identification number. We also identified 166 recipients that received 1,653 services totaling $75,582.81 after the month of their 19th birthday.

- **Classification of Documented Immigrants** - During testing of eligibility determinations during this audit, we determined HFS and DHS did not identify the correct citizenship status for recipients, and as a result, the State is losing federal matching Medicaid funds. We found in past audits, and continue to find, EXPANDED ALL KIDS recipients coded as undocumented that should not be coded as undocumented. Many recipients had verified social security numbers, alien registration numbers, or a combination of both. According to DHS, "verified" means the social security number has been verified through an electronic match with the Social Security Administration. Recipients with verified social security numbers and/or alien registration numbers appear to be documented immigrants and would therefore be eligible for federal matching funds. We reviewed records for one individual who was redetermined in April 2014 and was determined to be undocumented even though she was previously coded as Medicaid eligible (documented) since 2006.

  We determined the FY14 eligibility data contained 5,536 "undocumented" recipients who had social security numbers that were verified, of which 801 also had an alien registration number. We reviewed the services provided to the 5,536 "undocumented" recipients in FY14 and determined they had 130,609 services for a

total cost of $4.79 million. If these recipients were classified as undocumented in error, the State did not receive eligible matching federal funds.

**Initial Eligibility Testing**

During our testing of 40 new cases sampled that were approved during May and June 2014, we found 19 cases coded as undocumented even though the enrollees had a verified social security number. As a result, the enrollees likely should not have been classified as undocumented. In addition to these 19 cases, we found an additional 5 cases that also likely should not have been classified as undocumented based on immigration documentation, tax filer status, or birth information. Therefore, a total of 24 out of the 40 recipients sampled (60%) were coded as undocumented even though we found evidence supporting they were likely citizens or documented immigrants. We provided these 24 cases to DHS, and DHS officials agreed they were likely documented.

**Eligibility Testing for Redetermination**

During our review of 40 recipients sampled that were redetermined during May or June 2014, we found 8 coded as undocumented even though the enrollees had a verified social security number. As a result, the enrollees likely should not have been classified as undocumented. In addition to these 8 cases, we found 9 cases that also likely should not have been classified as undocumented based on immigration documentation or tax filer status. Therefore, a total of 17 out of the 40 recipients sampled (43%) were coded as undocumented even though we found evidence supporting they were likely citizens or documented immigrants. We provided these 17 cases to DHS, and DHS officials agreed they were likely documented.

- **Eligibility Documentation** - HFS and DHS attempt to determine eligibility for undocumented immigrants using various data matching techniques to determine residency, income, and immigration/citizen status. During our review of the new and continued eligibility process for EXPANDED ALL KIDS, we determined the data matching component used by the Integrated Eligibility System (IES) or the Illinois Medicaid Redetermination Project (IMRP) cannot be utilized for the undocumented recipients in the EXPANDED ALL KIDS program. Thus, electronic data matches and searches based on social security numbers are ineffective for this population because they do not have social security numbers. Therefore, in many instances, the auditors, along with DHS officials, searched through IES for scanned copies of documents to determine residency, income, birth/age, and immigration/citizenship status for all recipients, including undocumented recipients.

**Initial Eligibility Testing**

We selected 40 new cases that were approved during May and June 2014 and found significant issues. We found residency was not verified in 10 of the 40 (25%) cases tested, and birth/age information was not verified in 15 of the 40 (38%) cases tested. We also found income eligibility documentation and calculation problems in the

majority of the cases tested. Of the 40 cases tested, 28 reported having some income. We found 30 days of income was not reviewed in 54 percent (15 of 28) of the cases where income was reported. In addition to the 15 that were missing 30 days of income, we identified 5 other cases where caseworkers did not calculate the income correctly or did not determine the correct number of household members.

### Eligibility Redetermination Testing

We tested 40 redeterminations that occurred during May and June 2014 and found significant issues. We found residency was not verified in 12 of the 20 (60%) cases tested, and birth/age information was not verified in 29 of the 39 (74%) cases tested. We also found income eligibility documentation and calculation problems in the cases tested. Of the 39 cases tested, 29 reported having some income. We found 30 days of income was not reviewed in 14 percent (4 of 29) of the cases where income was reported. In addition to the 4 that were missing 30 days of income, we identified 6 other cases where caseworkers did not calculate the income correctly or did not determine the correct number of household members.

## POLICIES COVERING ORTHODONTIC TREATMENT

As part of this year's EXPANDED ALL KIDS audit, we examined the payments made to providers for orthodontic services. Our review identified two issues. The first was a lack of documentation related to orthodontic claims. The second was whether sufficient documentation existed to support eligibility decisions.

### Lack of Documentation from DentaQuest

As a result of our review of policies and procedures related to the approval of orthodontia, we found that DentaQuest, the Dental Program Administrator for HFS, could not provide documents that were used to approve orthodontic claims. We requested documents used by DentaQuest for initial approval for 40 recipients that had orthodontic services during FY14. DentaQuest could not provide the documents for 9 of the 40 requested (23%). According to DentaQuest officials, 3 could not be provided because "NEA" (National Electronic Attachment) only retains records for three years, while 6 could not be provided due to a "system issue."

### Orthodontic Eligibility Criteria

The Administrative Code (89 Ill. Adm. Code 140.421(a)(16)) provides the following guidance on orthodontic eligibility:

> *Orthodontics. Medically necessary orthodontic treatment is approved only for patients ages 0-20 and is defined as:*
>
> *A) treatment necessary to correct a condition which scores 42 points or more on the Salzmann Index; or*
>
> *B) treatment necessary to correct a handicapping malocclusion (a condition that impairs or creates a hazard in eating, chewing, speaking, or breathing.)*

We found almost none of the recipients were approved for orthodontics in FY14 using the Salzmann Index score (89 Ill. Adm. Code 140.421(a)(16)(A)). Only 8 of 13,576 orthodontic cases approved by DentaQuest were approved using the Salzmann Index.

The majority of the recipients were approved using the medical necessity standard (89 Ill. Adm. Code 140.421(a)(16)(B)). A DentaQuest official noted that the scoring tool used by DentaQuest for orthodontic cases was changed in 2010 to capture medical necessity without requiring a written order from a physician.

The change in the scoring tool corresponded with a significant increase in orthodontia claims being paid by HFS. In FY10, the EXPANDED ALL KIDS program paid for only $322,892 in orthodontic services. By FY14, 4,020 EXPANDED ALL KIDS recipients had orthodontic services totaling $3.6 million. Similarly, orthodontic services increased dramatically for HFS' medical program as a whole. In FY10, payments for orthodontic services totaled $2.9 million. In FY 2012, the amount paid increased to $16.6 million, and by FY14, payments totaled $36.6 million.

**Review of Orthodontic Cases**

While the scoring tool was approved in FY11, the Administrative Code delineating eligibility criteria for orthodontic services was not changed. As noted above, few cases are approved using the Salzmann Index in the first section of the Administrative Code (89 Ill. Adm. Code 140.421(a)(16)(A)). Rather, most cases are approved pursuant to the second part of the Administrative Code which states: *treatment necessary to correct a handicapping malocclusion (a condition that impairs or creates a hazard in eating, chewing, speaking, or breathing.)*

It is HFS' position that the revised scoring tool continues to comply with the requirements of the Administrative Code. In December 2009, a DentaQuest dentist recommended Illinois adopt the Medical Necessity Scoring Tool, and if the recipient does not qualify, use the modified Salzmann. The Peer Review Committee minutes stated "the state regulations require that orthodontia should be approved if the Modified Salzmann is 42 points or higher or if the service is medically necessary. Using both tools will meet the state regulations and will not necessitate a rules change." All committee members approved the recommendation.

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there were 453 orthodontic claims paid for these 40 cases totaling $124,000. Auditors judgmentally selected 10 cases for each provider where it appeared from the electronic data the treatment was completed during FY14 or in early FY15. Auditors found 1 of the 4 providers could not provide evidence to support all services provided. In all 10 cases reviewed for this provider, auditors could not find evidence for all of the services billed.

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**Results from OIG Dental Consultant's Review**

The OIG provided the OAG with a preliminary draft of its report which noted that due to the modifications made in 2011 to the medical necessity prior approval procedures, *"the threshold for medically necessary services was made less stringent increasing the number of prior approvals of orthodontic services."* During the review of the 40 sample cases, the OIG's dental consultant found that each of the 40 cases met the Department's medical necessity criteria using the new, less stringent scoring tool; however, the consultant found *"limited or no corroborating evidence of conditions of a handicapping malocclusion, including documentation establishing a condition that impairs or creates a hazard in eating, chewing, speaking or breathing, other than that which was documented in Attachment G."* Attachment G of the DORM is the Medical Necessity Scoring Tool (see Appendix F). The OIG recommended increasing the documentation required to establish medical necessity, such as a narrative report from the dentist as well as a certification from a medical professional certifying that the client meets the conditions of a medical need for orthodontic services.

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**Conclusion**

Expenditures by the State for orthodontic services for children in EXPANDED ALL KIDS specifically, and HFS' medical program generally, increased dramatically from FY10 to FY14. This increase corresponds to the time when the scoring tool used to determine medical necessity for orthodontic services was revised. A review conducted by the OIG concluded that revisions and clarifications to policies establishing medical necessity should be made, as well as requiring additional documentation to support medical necessity.

## 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 sixth annual audit (FY14), and follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. The previous five annual audits covered FY09 through FY13.

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## HISTORY OF THE ALL KIDS AUDITS CONDUCTED BY THE OAG

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. 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.

Throughout our audits, we refer to the portion of the ALL KIDS program that serves the uninsured children not previously covered by KidCare as "EXPANDED ALL KIDS." Since the EXPANDED ALL KIDS program is a subset of the ALL KIDS program as a whole, many of the recommendations are relevant to the program as a whole.

The Department of Healthcare and Family Services' July 2008 ALL KIDS Preliminary Report noted that "two key changes occurred" with the July 1, 2006, expansion pursuant to the Covering ALL KIDS Health Insurance Act [215 ILCS 170]. The report stated:

> *"First, children at any income level became eligible for healthcare benefits as long as they had been uninsured for an extended period of time or met certain exceptions established in rule. Second, in the rules implementing the expansion,*

*All Kids was made available to previously ineligible non-citizen children at any income level as authorized under the new law and the Public Aid Code."*

The Public Aid Code [305 ILCS 5/12-4.35], effective July 1, 1998, had authorized HFS to extend health care benefits to non-citizen children subject to the adoption of rules governing eligibility and other conditions of participation. No such rules were adopted until those establishing the Covering ALL KIDS Health Insurance program. Therefore, we included undocumented immigrants who first received health care benefits under these rules within the definition of the EXPANDED ALL KIDS program and within our audits.

**Five Years of Audit Recommendations**

Many of the recommendations during the five years have centered on problems with the eligibility determination and eligibility redetermination processes. Other recommendations have included areas such as:

- miscoding of documented immigrants;
- failure to terminate coverage when premiums were not paid;
- failure to require individuals who are self-employed to provide detailed business records;
- duplicate enrollees and enrollees over the allowable age of 18 within the data;
- billing irregularities with dental, optical, preventive medicine, and transportation claims; and
- payment for excluded non-emergency transportation services.

## STATE STATUTES RELATED TO ALL KIDS

The Covering ALL KIDS Health Insurance Act [215 ILCS 170] was effective July 1, 2006. The provisions in the Act defined a child as a person under the age of 19. The eligibility requirements for the program were as follows:

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.

The original Act expanded program benefits to cover all uninsured children in families regardless of family income.

Legislation was passed by the General Assembly and 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 audit of the EXPANDED ALL KIDS program. These changes to the Covering ALL KIDS Health Insurance Act include:

- 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.

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 was above 300 percent of the federal poverty level were no longer eligible. Children enrolled as of July 1, 2011, were able to remain enrolled in the program until June 30, 2012.

## 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 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.

# RECENT CHANGES AFFECTING THE COVERING ALL KIDS HEALTH INSURANCE PROGRAM AUDIT

Four events in recent years have had a significant impact on the EXPANDED ALL KIDS program and our audits. These events include:

1. The Covering ALL KIDS Health Insurance Act was changed and now limits the household income to be eligible for the EXPANDED ALL KIDS program;

2. Illinois was approved to receive federal reimbursement for some EXPANDED ALL KIDS program recipients;

3. Changes to HFS' payment cycle changed the audit methodology for reporting payments by fiscal year; and

4. HFS and DHS started using Modified Adjusted Gross Income budgeting to determine eligibility for certain households requesting or receiving medical assistance.

### Income Limit Added for ALL KIDS

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 was above 300 percent of the federal poverty level (FPL) were no longer eligible. Children enrolled as of July 1, 2011, were able to remain enrolled in the program until June 30, 2012. As a result, there were a reduced number of EXPANDED ALL KIDS participants and expenditures to be audited.

### Federal Reimbursement Approved for Premium Level 2 Enrollees

The second event 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' 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 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 first four EXPANDED ALL KIDS audits only included children whose medical care was totally State-funded. Beginning with the last audit, we determined the federal government would reimburse the State for 65 percent of eligible costs for this population (children from families with income between 200 and 300 percent of FPL). Additionally, the State was granted retroactive reimbursement dating back to July 1, 2008. According to HFS officials, as of October 29, 2015, HFS had recouped a total of $40.4 million.

HFS was also given retroactive reimbursement for documented immigrants back to April 1, 2009. This allowed federal reimbursement for documented immigrants regardless of their time in the country. Prior to this, for the State to receive federal reimbursement, documented immigrants had to be in the country for five years. HFS officials estimate $30 million was recouped as of June 30, 2015.

### Changes in Payment Cycles

The third event affecting our audit was changes in HFS' payment cycle for EXPANDED ALL KIDS claims. When we identified a large decrease in payments in FY12, HFS indicated that the decrease was due to the payment cycle and not a decrease in services. This means that the services were provided in FY12, but were not paid until after the end of the fiscal year. As a result, beginning with our FY13 audit, we began reporting on all costs for services that occurred during the fiscal year regardless of when they were paid. The primary focus now is on services provided during the fiscal year since payments are impacted by cash flow issues and do not accurately depict program activity when there are payment cycle delays.

### New Budgeting Methodology

The fourth and most recent change required a new budgeting methodology for determining ALL KIDS eligibility. The Affordable Care Act (ACA) required all states to apply a new budget methodology based on Modified Adjusted Gross Income (MAGI) to determine eligibility for certain households requesting or receiving medical assistance. The purpose of using the MAGI budgeting methodology is to align financial eligibility rules with the Health Insurance Marketplace. Even though much of the EXPANDED ALL KIDS population is not federally funded, to avoid confusion, HFS uses the same budgeting methodology for all medical programs. Therefore, the new MAGI calculation methodology increased the ALL KIDS level from 300 FPL to 318 FPL, thus increasing the number of recipients eligible.

Under the new MAGI calculation methodology, certain types of income are not counted as part of a family's income. These include: child support; workers' compensation; veterans' benefits; supplemental security income (SSI); portions of scholarships, awards or fellowship grants for education; and American Indian and Alaska Native income distributions, payments, ownership interests, real property usage rights, and student financial assistance provided by the Bureau of Indian Affairs.

As a result of the new MAGI requirements, the FPL used to determine eligibility is higher in this audit. Therefore, a family could earn more and be eligible for ALL KIDS in FY14. As seen in Exhibit 1, in FY13, a family of four would qualify for ALL KIDS Assist at 133 percent of the FPL ($31,321.50 annually); however, the same family of four would qualify at 147 percent of the FPL ($35,064 annually) in FY14. Therefore, the way DHS processed both new ALL KIDS applications and annual redeterminations changed during our FY14 audit period. Exhibit 1 shows the annual applicable federal poverty income guidelines for a family of four by program for each of the last two fiscal years. The FY13 figures are prior to the implementation of the MAGI standards.

Exhibit 1
**ANNUAL FPL FOR FAMILY OF FOUR COMPARISON**
Fiscal Years 2013 and 2014

| EXPANDED ALL KIDS Plan | FY13 Percent of FPL | Annual FY13 Maximum Income | FY14 Percent of FPL[1] | Annual FY14 Maximum Income[1] |
|---|---|---|---|---|
| Assist | 133% | $31,321.50 | 147% | $35,064 |
| Share | 150% | 35,325 | 157% | 37,440 |
| Premium Level 1 | 200% | 47,100 | 209% | 49,848 |
| Premium Level 2 | 300% | 70,650 | 318% | 75,840 |

Note: [1] Does not include certain types of excluded income (child support, workers' compensation, veterans' benefits, SSI, etc. –see text for complete list).

Source: DHS eligibility documentation.

**Revised Initial Eligibility Determination**

On October 1, 2013, HFS and DHS replaced the Automated Intake System with the newly created Integrated Eligibility System (IES). As part of the new IES, Illinois implemented the MAGI budgeting standards for new applications received as of October 1, 2013.

Applications for ALL KIDS can be submitted online, via telephone, by mail, or in person at a local DHS office. Once the application is uploaded into IES, the caseworker scans and uploads the supporting documentation. IES also uses electronic data matches to verify eligibility. Client social security numbers are used to extract information from the following sources:

- **Federal Data Hub** –used to verify U.S. citizenship and immigration status;
- **State Online Query (SOLQ)** –Social Security Administration information used to verify social security numbers, date of birth, date of death, and current federal benefits;
- **Automated Wage Verification System (AWVS)** –used to verify income and unemployment benefits from the Illinois Department of Employment Security;
- **Illinois Secretary of State** –used to verify Illinois residency;
- **Third Party Liability** –used to identify other health insurance coverage; and
- **The Work Number** –used to verify earned income found in the Equifax database.

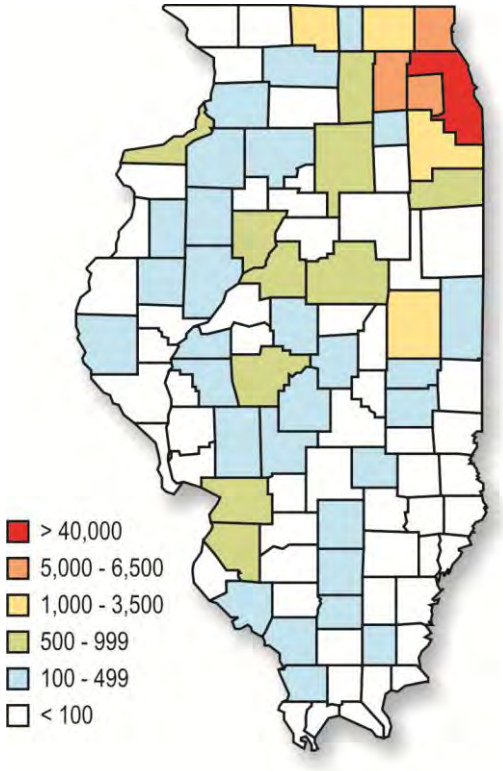
**Revised Redetermination of Eligibility**

Annual redeterminations for ALL KIDS are completed as part of the Illinois Medicaid Redetermination Project (IMRP), which began in February 2014. MAGI rules for redeterminations became effective on April 1, 2014. The IMRP uses the Max-IL system to store all: 1) redetermination forms mailed to the recipient; 2) returned redetermination documents; 3) electronic data matching results; 4) requests by the Department for missing information; and 5) verifications provided by the recipient.

Although Maximus no longer helps make eligibility redeterminations, Maximus mails the redetermination forms, pre-populates the redetermination form with known information, and stores electronic copies of forms, notices, and returned verifications.

The recipients receive a pre-populated redetermination form two months before it is due. They are asked to provide any new information (household members, income sources and amounts, etc.) and proof for any of the new information. Using electronic data matching, caseworkers make eligibility decisions based on verifications using social security numbers, income, residence, and citizenship.

Exhibit 2
**EXPANDED ALL KIDS ENROLLMENT BY COUNTY**
Fiscal Year 2014




Source: FY14 eligibility data provided by HFS.

## ALL KIDS PROGRAM

According to HFS, in FY14, Illinois' ALL KIDS program as a whole had a total of 1.9 million enrollees and HFS paid almost $3.1 billion in claims. In FY14, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion totaled 81,440. As seen in Exhibit 2, the majority of the FY14 enrollees live in Cook County (40,380). The other counties with large populations of EXPANDED ALL KIDS enrollees include: Kane (6,374); DuPage (5,921); Lake (5,301); and Will (3,414).

### ALL KIDS Enrollment

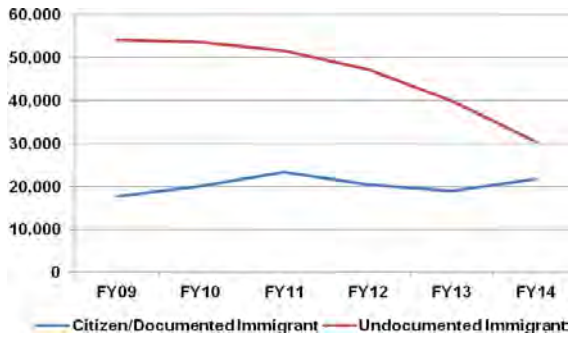
On June 30, 2014, there were 52,075 enrollees as a result of the expansion, of which 30,441 (58%) were classified as undocumented immigrants in the HFS data. Over the last four fiscal years, total enrollment has decreased from 74,975 at the end of FY11 to 52,075 at the end of FY14. There was a 22,900 enrollee decrease from FY11 to FY14, some of which was due to the elimination of Levels 3 through 8 after June 30, 2012, as required by PA 96-1501.

During the last five years, while the number of citizens/documented immigrants has remained fairly steady, there has been a steady decrease in undocumented immigrants. The number of undocumented enrollees decreased from 54,073 in June 2009 to 30,441 in June 2014 (see Exhibit 3).

During our last audit, we asked HFS why the number of undocumented immigrants has been decreasing. HFS indicated it was due to "the coding changes made for documented children to accommodate the federal claiming for 5 year bar kids, the increased focus on completing annual redeterminations, and the use of the USPS National Change of Address Service to help us better identify those who move out of state."

We analyzed the FY14 enrollment data provided by HFS and determined the number of undocumented immigrants had an age variable. We determined older enrollees made up the majority of the EXPANDED ALL KIDS population in FY14.

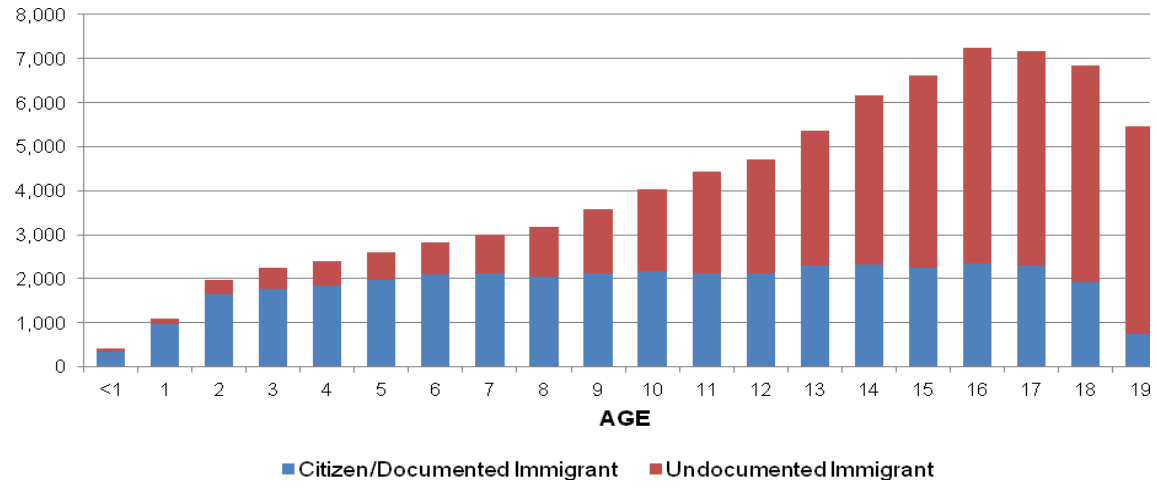
Exhibit 3
**EXPANDED ALL KIDS ENROLLMENT**
As of June 30 for Fiscal Years 2009 - FY14




Source: ALL KIDS enrollment data provided by HFS.

Exhibit 4 shows the EXPANDED ALL KIDS enrollment by the age the enrollee turned during fiscal year 2014. The Exhibit shows few undocumented children under the age of 8 were eligible during FY14. In FY14 the total 16 year old population was 7,252 (4,892 or 67% were undocumented), while the total five year old population was 2,611 (634 or 24% were undocumented).

Exhibit 4
**NUMBER OF EXPANDED ALL KIDS ENROLLEES BY AGE IN FISCAL YEAR 2014**

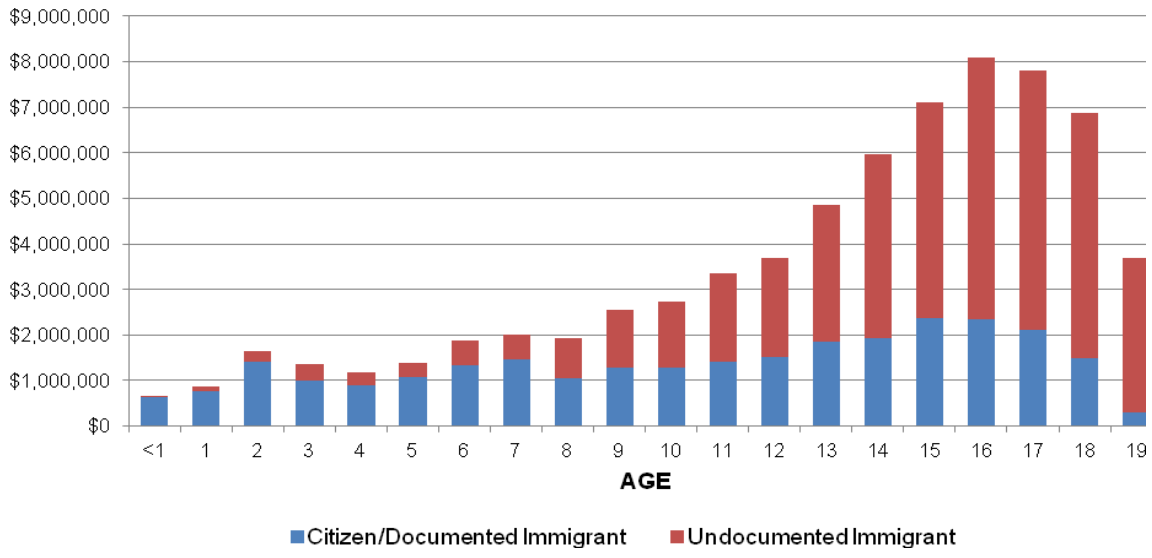



Source: ALL KIDS enrollment data provided by HFS.

Exhibit 5 shows the total costs for services follow the same pattern. The total cost for older enrollees was substantially more than for the younger enrollees. For example, the total FY14 cost for the 16 year old population was $8.1 million ($5.75 million was for

undocumented), while the cost for the five year old population was $1.4 million ($312,984 was for undocumented). The average annual cost for a 16 year old was $1,115, while the average annual cost for a five year old was $533.

Exhibit 5
**COST OF EXPANDED ALL KIDS ENROLLEES BY AGE IN FISCAL YEAR 2014**




Source: ALL KIDS data provided by HFS.

### FY14 Enrollment by ALL KIDS Plan

Exhibit 6 breaks out enrollment by fiscal year, by plan, and by whether the child was classified as a citizen/documented immigrant or as undocumented. Appendix B shows the ALL KIDS premium and co-pay requirements by plan during FY14. There was a 6,747 decrease in ALL KIDS enrollees from June 30, 2013 to June 30, 2014. We analyzed all eligible enrollees at any time during FY13 with enrollees eligible as of July 1, 2014 (the first day of FY14). As seen in Exhibit 7, we determined 26,267 enrollees who were eligible at some point during FY13 were not eligible on the first day of FY14.

Exhibit 6
**EXPANDED ALL KIDS ENROLLMENT BY PLAN [2]**
As of June 30

| EXPANDED ALL KIDS Plan | Citizens/ Documented Immigrants | | Undocumented Immigrants | |
|---|---|---|---|---|
| | FY13 | FY14 | FY13 | FY14 |
| **Assist** $35,064[1] | Part of Medicaid and not part of EXPANDED ALL KIDS | | 37,938 | 28,460 |
| **Share** $37,440[1] | | | 806 | 702 |
| **Premium Level 1** $49,848[1] | | | 811 | 965 |
| **Premium Level 2** $75,840[1] | 18,963[3] | 21,634[3] | 304 | 314 |
| **Totals** | **18,963** | **21,634** | **39,859** | **30,441** |

Notes:

[1] Denotes the Modified Adjusted Gross Income (MAGI) equivalent income standard for the plan level and the maximum income for a family of four for that plan during FY14.

[2] Enrollment is the total number of enrollees that were eligible on June 30 of 2013 and 2014. There were 84,563 enrollees eligible at some point during FY13 and 81,440 enrollees eligible at some point during FY14.

[3] State received 65 percent reimbursement from Title XXI of the Social Security Act (Medicaid) for these recipients.

Source: ALL KIDS enrollment data provided by HFS.

## Decrease in Enrollment

We used cancellation codes found within the HFS data to look at why there was a decrease in enrollment from FY13 to FY14. We determined that 8,370 recipients changed to a program other than ALL KIDS (for example, Family Care or Medicaid). Additionally, 5,594 recipients reached the maximum age of 19 years old prior to July 1, 2014. The data showed that failure to pay premiums accounted for another 3,270 recipients being cancelled and having income that exceeded the ALL KIDS limit accounted for 2,619 cancellations. A large number of recipients either did not provide the requested verifications (1,955) or did not return the renewal form (1,773). Exhibit 7 lists the reasons the enrollees were no longer enrolled from FY13 to FY14.

Exhibit 7
**ANALYSIS OF THE DECREASE IN ELIGIBILITY FROM FY13 TO FY14**

| | |
|---|---|
| Changed to Another HFS Program | 8,370 |
| Aged out of ALL KIDS | 5,594 |
| Failure to Pay Premium | 3,270 |
| Income Exceeds Limits | 2,619 |
| Did Not Provide Verification | 1,955 |
| Did Not Return Renewal Form | 1,773 |
| Unable to Locate | 765 |
| Not an Illinois Resident | 513 |
| Requested Cancellation | 364 |
| Approved in Error | 169 |
| Other or Unknown | 875 |
| **Total** | **26,267** |

Source: OAG analysis of HFS data.

## ALL KIDS SERVICES PROVIDED BY FISCAL YEAR

According to claim data provided by HFS, the cost of services for EXPANDED ALL KIDS in FY09 totaled $78.8 million. The cost for services increased to $89 million in FY10, and to $89.3 million in FY11. The total cost for services dropped to $87.8 million in FY12, to $75.2 million in FY13, and to $70 million in FY14. Much of the decrease in the program in FY13 was due to the change in eligibility criteria, which eliminated Premium Level 3 through Level 8.

A large portion of the cost for services for the EXPANDED ALL KIDS Program was for undocumented immigrants. Cost for services for undocumented immigrants totaled $55 million in FY09, $60.2 million in FY10, $54.9 million in FY11, $55.7 million in FY12, $48.8 million in FY13, and $42.3 million in FY14. Therefore, in FY14 undocumented immigrants made up 60 percent of the total costs for the EXPANDED ALL KIDS program.

Exhibit 8 breaks out the payments for services by whether the child was classified by HFS or DHS as a citizen or documented immigrant or whether the child was classified as undocumented for both FY13 and FY14. Additionally, Exhibit 8 shows the cost of services decreased by $5.1 million from $75.2 million in FY13 to $70 million in FY14.

Exhibit 8
**EXPANDED ALL KIDS COST OF SERVICES PROVIDED BY ALL KIDS PLAN**
Fiscal Years 2013 and 2014

| EXPANDED ALL KIDS Plan | Citizens/Documented Immigrants | | Undocumented Immigrants | | Totals | |
|---|---|---|---|---|---|---|
| | FY13 | FY14 | FY13 | FY14 | FY13 | FY14 |
| **Assist** $35,064[1] | Part of Medicaid and not part of EXPANDED ALL KIDS | | $46,646,334 | $39,546,799 | $46,646,334 | $39,546,799 |
| **Share** $37,440[1] | | | $919,741 | $971,681 | $919,741 | $971,681 |
| **Premium Level 1** $49,848[1] | | | $885,206 | $1,285,740 | $885,206 | $1,285,740 |
| **Premium Level 2** $75,840[1] | $26,409,537[3] | $27,766,776[3] | $303,525 | $473,790 | $26,713,062 | $28,240,566 |
| **Totals[2]** | **$26,409,537** | **$27,766,776** | **$48,754,805** | **$42,278,010** | **$75,164,343** | **$70,044,785** |

Notes:

[1] Denotes the Modified Adjusted Gross Income (MAGI) equivalent income standard for the plan level and the maximum income for a family of four for that plan during FY14.

[2] Totals may not add due to rounding.

[3] The federal matching rate was 65 percent; therefore, the State's share for FY13 services was $9.2 million and was $9.7 million for FY14 services.

Source: ALL KIDS data provided by HFS.

## COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE

According to data provided by HFS, 88 percent of the cost for services provided during FY14 for EXPANDED ALL KIDS was paid for 11 categories of services. Exhibit 9 shows that $61.3 million of the $70 million in total EXPANDED ALL KIDS payments were for the following services: Dental Services; Pharmacy; Physician Services; Inpatient Hospital Services (General); Outpatient Services (General); General Clinic Services; Inpatient Hospital Services (Psychiatric); Capitation Services; Healthy Kids Services; Mental Health Rehab Option Services; and Physical Therapy Services. The category with the highest percentage of payments was Dental Services at 17 percent. Appendix C shows EXPANDED ALL KIDS costs for services provided in FY14 by plan, and Appendix D shows EXPANDED ALL KIDS costs for services provided in FY14 by plan and by category of service. Appendix E shows FY14 providers that provided more than $50,000 in services for EXPANDED ALL KIDS.

Exhibit 9
**TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE FOR EXPANDED ALL KIDS PROGRAM**
Totaling more than $1 million during FY14

| Category of Service | Total FY14 Cost | Percent of Total FY14 Cost |
|---|---|---|
| Dental Services | $11,991,107 | 17% |
| Pharmacy | 10,141,180 | 14% |
| Physician Services | 9,500,286 | 14% |
| Inpatient Hospital Services (General) | 7,794,326 | 11% |
| Outpatient Services (General) | 5,057,116 | 7% |
| General Clinic Services | 4,369,368 | 6% |
| Inpatient Hospital Services (Psychiatric) | 3,555,303 | 5% |
| Capitation Services | 3,493,306 | 5% |
| Healthy Kids Services | 2,579,257 | 4% |
| Mental Health Rehab Option Services | 1,814,323 | 3% |
| Physical Therapy Services | 1,016,913 | 1% |
| **Total for categories costing > than $1 million** | **$61,312,485** | **88%** |
| Other categories totaling < than $1 million | 8,732,300 | 12% |
| **Total Cost for All Service Categories** | **$70,044,785** | **100%** |

Note: Totals may not add due to rounding.

Source: FY14 ALL KIDS data provided by HFS.

# COST OF SERVICES AND PREMIUMS COLLECTED

HFS received $7.7 million in premium payments from enrollees in FY13, and received $8.3 million in FY14. As a result, the net cost of EXPANDED ALL KIDS after premium payments were applied was approximately $67.5 million in FY13 and $61.7 million in FY14. Exhibit 10 shows both FY13 and FY14 payments and premiums collected from the EXPANDED ALL KIDS programs.

Exhibit 10
**COST OF SERVICES FOR EXPANDED ALL KIDS AND PREMIUM AMOUNTS COLLECTED**
Fiscal Years 2013 and 2014

| EXPANDED ALL KIDS Plan | FY13 Services Provided | FY13 Premiums Collected | FY13 Net Cost | FY14 Services Provided | FY14 Premiums Collected | FY14 Net Cost |
|---|---|---|---|---|---|---|
| **Assist** $35,064[1] | $46,646,334 | n/a | $46,646,334 | $39,546,799 | n/a | $39,546,799 |
| **Share** $37,440[1] | $919,741 | $0 | $919,741 | $971,681 | $30 | $971,651 |
| **Premium Level 1** $49,848[1] | $885,206 | $124,725 | $760,481 | $1,285,740 | $128,018 | $1,157,722 |
| **Premium Level 2**[2] $75,840[1] | $26,713,062 | $7,554,265 | $19,158,796 | $28,240,566 | $8,190,167 | $20,050,399 |
| **Totals**[3] | **$75,164,343** | **$7,678,990** | **$67,485,352** | **$70,044,785** | **$8,318,215** | **$61,726,571** |

Notes:

[1] Denotes the Modified Adjusted Gross Income (MAGI) equivalent income standard for the plan level and the maximum income for a family of four for that plan during FY14.

[2] This exhibit does not include any federal reimbursement for Level 2 enrollees, which would decrease the State's total actual cost by 65% or $17.4 million in FY13 and $18.4 million in FY14.

[3] Totals may not add due to rounding.

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

### Estimated Total Cost of EXPANDED ALL KIDS Services to the State during FY14

To estimate the total cost of the EXPANDED ALL KIDS program to the State, we subtracted the allowable federal reimbursement for Level 2 enrollees (65%) and the premium payment amount HFS received during FY14 from the total cost for services provided during FY14. Exhibit 11 shows an estimated cost to the State for EXPANDED ALL KIDS of $43.4 million in FY14. The cost of the program continues to decrease. In FY13, the estimated cost to the State was $50.1 million.

Exhibit 11
**ESTIMATED TOTAL STATE COST OF EXPANDED ALL KIDS SERVICES**
Provided during Fiscal Year 2014

| | |
|---|---|
| Actual Cost of Services Provided -FY14 | $70,044,785 |
| - Federal Funds for Level 2 Enrollees | -18,356,368 |
| - Premium Payments Received | -8,318,215 |
| **Total FY14 State Cost of Services** | **$43,370,202** |

# FOLLOW-UP ON FY13 RECOMMENDATIONS

HFS and DHS took some action to address the previous 8 recommendations, and as a result, only 4 of the 8 are repeated. We also added one new recommendation related to orthodontia. We found that HFS addressed the past recommendation relating to inconsistent dental policies by updating its website with a link to the correct policies. We also analyzed transportation claims and preventive medicine claims and found no exceptions. HFS officials indicated that the duplicate claims edit was manual and was too time consuming and costly to perform in the past; however, the new system currently being developed will include the edit. Exhibit 12 shows the status of the FY13 recommendations.

Exhibit 12
**STATUS OF PREVIOUS AUDIT RECOMMENDATIONS**

| Recommendation Area | FY13 Recommendation Number | Status of Recommendations as Reported in FY13 Audit |
|---|---|---|
| Redetermination of ALL KIDS Eligibility | 1 | Repeated |
| ALL KIDS data Reliability | 2 | Repeated |
| Classification of Documented Immigrants | 3 | Repeated |
| Duplicate Claims | 4 | Implemented |
| Eligibility Documentation | 5 | Repeated |
| Transportation Claims | 6 | Implemented |
| Guidance Over Preventive Medicine Service Claims | 7 | Implemented |
| Inconsistent Dental Policies | 8 | Implemented |

# 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). Therefore, the recommendation was repeated and the text was changed to reflect the new one month of income requirement. 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 during the last audit period (FY13).

During this FY14 audit, the process for redetermining eligibility changed again. In February 2014, a new process for redetermining eligibility began under the Illinois Medicaid Redetermination Project. A new redetermination system called Max-IL was developed to record and store redetermination information for medical-only cases. Using the new Max-IL system, medical-only cases are redetermined annually by the central redetermination unit staff. The new Max-IL system records and stores all redetermination forms mailed to the recipient, returned redeterminations, electronic data matching results, requests for missing information, and verifications. Central redetermination staff is responsible for making eligibility decisions, coding the redetermination, and processing any changes on the cases. In addition, MAGI rules for redeterminations became effective on April 1, 2014.

**Redeterminations Not Completed During FY14**

During our review of all eligibility redeterminations for EXPANDED ALL KIDS recipients made in FY14, we found that HFS and DHS did not complete redeterminations of eligibility **annually** for all recipients as required by the Covering ALL KIDS Health Insurance Act. According to the data provided by HFS, 28,695 EXPANDED ALL KIDS recipients required a redetermination of eligibility in FY14. Our analysis of the data showed 22,070 of the 28,695 (77%) were redetermined in FY14. As a result, 6,625 (23%) were not redetermined annually as required by the Act. According to the data, 3,971 of the 6,625 were redetermined in FY15 and the remaining 2,654 were pending.

**ANNUAL REDETERMINATIONS**

According to the data provided by HFS, 28,695 EXPANDED ALL KIDS recipients required a redetermination of eligibility in FY14. Our analysis of the data showed 22,070 of the 28,695 (77%) were redetermined in FY14. As a result, 6,625 (23%) were not redetermined annually as required by the Act.

Given that redeterminations were not conducted timely for 23 percent of eligible EXPANDED ALL KIDS recipients, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2014, to June 30, 2015.

| REDETERMINATION OF ELIGIBILITY | |
|---|---|
| **RECOMMENDATION NUMBER**<br><br>**1** | ***The Department of Healthcare and Family Services and the Department of Human Services should annually redetermine ALL KIDS eligibility as required by the Covering ALL KIDS Health Insurance Act.*** |
| **DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE** | The Department accepts the recommendation. HFS and DHS lack the staff to complete all of the redeterminations that are due each month. The new Integrated Eligibility System (IES) Phase 2 implementation will incorporate case maintenance activities into IES. Having both new application processing, redeterminations and other case maintenance activities in one system will be more efficient and allow more flexibility to complete of all of the work. After Phase 2 is implemented it will take time to catch up on delayed redeterminations. |
| **DEPARTMENT OF HUMAN SERVICES' RESPONSE**<br><br>Continued on following page | The Department agrees with the recommendation. In State Fiscal Year 2014, DHS faced several significant challenges that affected our ability to re-determine eligibility in a timely manner. First, the attrition of a large number of field staff in the previous years had not been replaced. During FY 2014, a concerted effort was made to begin replacing these staff and several hundred staffs were hired. Although on board, these staffs, having no previous background in our program policies, required substantial programmatic training in order to fulfil their job duties, negatively affecting timeliness of redeterminations.<br><br>Also, beginning during this audit period, specifically 2/1/14, a new redetermination process began. The Department's contracted vendor, Maximus, developed the Max-IL system, which uses electronic data matching to verify income, residency, citizenship status, and SSN. Max-IL also enhances the integrity of the program by using its ability to store copies of all redetermination forms mailed to the customer, returned redeterminations, electronic data matching results, requests for missing information and verifications provided by the client.<br><br>During the same time period, DHS began to implement the new Integrated Eligibility System to complete initial applications. All staff had to be out of the office again in order to learn the new functionality of the system and be able to process applications. Additionally, in November 2013, we began open enrollment for the first ever Affordable Care Act medical insurance program which inflated our application volume to unprecedented levels. This new system combined with a new program and budgeting methodology created huge backlogs in processing which took over a year to reduce. These delays in intake processing also required that we allocate resources from the service coordination departments to assist which left fewer people to process redeterminations. |

| | |
|---|---|
| | Our development of the new Integrated Eligibility System (IES) has created enhancements for initial applications and when fully implemented, will also provide increased redetermination efficiencies. As the development of IES is completed, many medical cases that can have eligibility factors determined electronically will be automatically re-determined, allowing casework staff to perform redetermination tasks on other types of cases.<br><br>The Department continues to search for ways in which to improve. Although many of the issues described above contributed to the unsatisfactory redetermination performance in FY14, they will result in better performance in the future. The long term benefits of developing and implementing the new systems, and the investment in ensuring staff are properly trained, outweigh the short term performance results. |

## ALL KIDS ELIGIBILITY DATA

Auditors identified issues associated with the eligibility data provided by HFS dating back to FY09. These areas included individuals who were older than 18 years of age and who are no longer eligible, and eligibility data which included duplicate enrollees with two different recipient identification numbers and/or different birth dates or addresses.

During our review of the FY14 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 FY14 data, we identified 423 individuals who appeared to be enrolled with more than one identification number. We also identified 166 recipients that received 1,653 services totaling $75,582.81 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, 2014, to June 30, 2015.

| **ALL KIDS ELIGIBILITY DATA** | |
|---|---|
| **RECOMMENDATION NUMBER**<br><br>**2** | ***The Department of Healthcare and Family Services should have controls in place to ensure that its ALL KIDS eligibility data is accurate and reliable. This includes ensuring that enrollees over 18 years of age are identified as no longer eligible and ensuring that enrollees are not enrolled in ALL KIDS more than once.*** |
| **DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE** | The Department accepts the recommendation. While coverage is ended systematically for most children when they turn 19, there are some situations, such as pregnancy due date coded on the case, that allow coverage as a child to continue until it is manually reviewed by a caseworker. Implementation of Phase 2 of the Integrated Eligibility System will remove the need for a manual review to end or change coverage in most situations that have resulted in covering individuals as children beyond the month they turn 19. |

# CLASSIFICATION OF DOCUMENTED IMMIGRANTS

Although HFS reported the miscoding of documented immigrants had been corrected, during each of our last two audits, we found the EXPANDED ALL KIDS data continued to have recipients who appear to be incorrectly coded as "undocumented." Although some of the inaccurate coding may have been due to incorrect electronic matching of social security numbers as was previously reported by HFS, we determined a lack of specific policies and procedures for caseworkers is also causing miscoding.

**CLASSIFICATION OF DOCUMENTED IMMIGRANTS**

We found the EXPANDED ALL KIDS data continued to have recipients who appear to be incorrectly coded as "undocumented."

## Miscoded Citizenship Status

During testing of eligibility determinations during this audit, we determined HFS and DHS did not identify the correct citizenship status for recipients, and as a result, the State is losing federal matching Medicaid funds. We found in past audits, and continue to find, EXPANDED ALL KIDS recipients coded as undocumented that should not be coded as undocumented. Many recipients had verified social security numbers, alien registration numbers, or a combination of both. According to DHS, "verified" means the social security number has been verified through an electronic match with the Social Security Administration. Recipients with verified social security numbers and/or alien registration numbers appear to be documented immigrants and would therefore be eligible for federal matching funds. We reviewed records for one individual who was redetermined in April 2014 and was determined to be undocumented even though she was previously coded as Medicaid eligible (documented) since 2006.

**CITIZENSHIP STATUS**

HFS and DHS did not identify the correct citizenship status for recipients during the process of determining new and continued eligibility, and as a result, the State is losing federal matching Medicaid funds.

For recipients categorized by HFS and DHS as "undocumented," we determined the FY14 eligibility data contained:

- 5,536 recipients coded as undocumented who had social security numbers that were verified, of which 801 also had an alien registration number; and
- 138 recipients coded as undocumented who had an alien registration number, but did not have a verified social security number.

We reviewed the services provided to these "undocumented" recipients in FY14 and determined the 5,536 recipients had 130,609 services for a total cost of $4.79 million. If these recipients were classified as undocumented in error, the State did not receive eligible matching federal funds.

During our testing of cases, we concluded that during the process of renewing cases or approving new cases, caseworkers should have either followed up with the recipients by requesting additional documentation or clarification or should have changed the citizenship status to a documented immigrant or citizen.

## Initial Eligibility Testing

During our testing of 40 new cases that were approved during May and June 2014, we found 19 cases coded as undocumented even though the enrollees had a verified social security number. As a result, the enrollees likely should not have been classified as undocumented. In addition to these 19 cases, we found an additional 5 cases that also likely should not have been classified as undocumented based on immigration documentation, tax filer status, or birth information. Therefore, a total of 24 out of the 40 recipients sampled (60%) were coded as undocumented even though we found evidence supporting they were likely citizens or documented immigrants. We provided these 24 to DHS, and DHS officials agreed they were likely documented.

**INITIAL ELIGIBILITY**

We identified 24 of the 40 new recipients (60%) that were coded as undocumented even though we found evidence supporting they were likely citizens or documented immigrants.

We met with a DHS official and discussed the issue of enrollees with verified social security numbers being classified in IES by caseworkers as undocumented. The DHS official used IES to test a case and determined that in fact an individual with a verified social security number can be classified by a caseworker as undocumented. Caseworkers manually classify enrollees using a drop down menu. There is currently no edit within IES that would notify the caseworker that the enrollee was being classified as undocumented even though there is documentation to support citizenship or a documented immigrant status.

## Eligibility Testing for Redetermination

During our review of 40 recipients that were redetermined during May or June 2014, we found 8 coded as undocumented even though the enrollees had a verified social security number. As a result, the enrollees likely should not have been classified as undocumented. In addition to these 8 cases, we found 9 cases that also likely should not have been classified as undocumented based on immigration documentation or tax filer status. Therefore, a total of 17 out of the 40 recipients sampled (43%) were coded as undocumented even though we found evidence supporting they were likely citizens or documented immigrants. We provided these 17 to DHS, and DHS officials agreed they were likely documented.

**REDETERMINATION OF ELIGIBILITY**

We identified 17 of the 40 recipients (43%) that were coded as undocumented even though we found evidence supporting they were likely citizens or documented immigrants.

Although HFS reported that problems related to the coding of undocumented immigrants were corrected on October 29, 2010, we continue to have multiple issues in this area. Therefore, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2014, to June 30, 2015. 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**<br><br>**3** | ***The Department of Healthcare and Family Services and the Department of Human Services should:***<br><br>• ***ensure policies and procedures used to classify enrollees as a documented immigrant or undocumented immigrant contain specific instructions for caseworkers to make accurate eligibility decisions;***<br>• ***consider implementing an electronic edit within the Integrated Eligibility System (IES) that prevents enrollees with citizenship or immigration documentation from being classified as undocumented;***<br>• ***ensure that documented immigrants are classified correctly in its database; and***<br>• ***ensure that the State receives federal matching funds for all eligible recipients and ensure that federal matching funds are not received for ineligible recipients.*** |
| **DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE** | The Department accepts the recommendation. Additional instructions related to clearances and verifications, including those for related to immigration status, have been provided to staff. In addition, edits within IES regarding immigration status will be reviewed after Phase 2 implementation. |
| **DEPARTMENT OF HUMAN SERVICES' RESPONSE** | The Department agrees with the recommendation. As a result of the audit, the Department will issue clarifications on the proper classifications of undocumented and documented immigrants. We will also explore the feasibility of creating a messaging system to alert a worker that the classification may conflict with another piece of information entered into the eligibility system. This will require the cooperation of Deloitte, the system development contractor.<br><br>The Department will develop a mandatory refresher training for casework staff that specifically addresses the proper classification of the immigration status of our applicants. |

## ELIGIBILITY DOCUMENTATION

All five 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 changes to eligibility documentation requirements.

These changes required one month's worth of income verification for determining new and continued eligibility and required verification of Illinois residency. These changes were effective on July 1, 2011.

The Affordable Care Act required all states apply a new budget methodology based on Modified Adjusted Gross Income (MAGI) to determine eligibility for certain households requesting or receiving medical assistance. Therefore, on October 1, 2013, HFS and DHS began using MAGI income standards for new applications received. The new eligibility process is now completed using the Integrated Eligibility System (IES). IES automatically calculates the income and other eligibility factors from a series of matches and from information entered by the caseworker. Additionally, annual redeterminations for continued eligibility are completed as part of the Illinois Medicaid Redetermination Project (IMRP), which began in February 2014. MAGI rules for redeterminations became effective on April 1, 2014. Caseworkers make eligibility decisions using electronic data matching based on verifications using social security numbers, income, residency, and citizenship. When electronic verifications are not available, hard copy documentation is requested and is scanned into IES.

HFS and DHS attempt to determine eligibility for undocumented immigrants using various data matching techniques to determine residency, income, and immigration/citizen status. During our review of the new and continued eligibility process for EXPANDED ALL KIDS, we determined the data matching component used by IES or the IMRP cannot be utilized for the undocumented recipients in the EXPANDED ALL KIDS program. By definition, these children and often their parents are **undocumented**. If these recipients had the necessary social security numbers needed for the electronic matching component, these recipients would not be eligible for the EXPANDED ALL KIDS program unless they are eligible for Premium Level 2. Undocumented recipients in Assist, Share, or Premium Level 1 with verified social security numbers would be eligible for Title XIX and would not be included as part of this audit. Thus, electronic data matches and searches based on social security numbers are ineffective for this population because they do not have social security numbers. Therefore, in many instances, the auditors along with DHS officials searched through IES for scanned copies of documents to determine residency, income, birth/age, and immigration/citizenship status for all recipients, including undocumented recipients.

### Initial Eligibility Testing

We selected 40 new cases that were approved during May and June 2014 and found significant issues. As discussed in the previous section, we found 24 cases coded as undocumented even though we found evidence, such as verified social security numbers, supporting the enrollee was likely a citizen or documented immigrant. As a result, these 24 recipients are likely not eligible for the EXPANDED ALL KIDS program, but would be eligible for Medicaid for which the State receives federal matching funds.

During our testing, we reviewed all 40 new cases in IES to determine whether all required eligibility documentation was obtained or reviewed. Of the 40 cases reviewed, 30 were missing at least one piece of required documentation (verification of residency, birth/age, or income).

**Illinois Residency Verification (Initial Eligibility)**

Illinois residency verification is required for ALL KIDS by 215 ILCS 170/7(a)(3). According to both HFS and DHS officials, effective March 14, 2012, an automated Secretary of State clearance was implemented to verify residency.

During our testing of new cases, we found residency was mainly verified in one of two ways. If one of the recipient's parents or guardians provided a social security number, we found residency was verified using an electronic match with the Illinois Secretary of State. If there was no social security number provided, a copy of a bill (cable bill, phone bill, etc.) or other mail with the name and address was utilized.

Exhibit 13
**RESULTS OF EXPANDED ALL KIDS RESIDENCY DOCUMENTATION TESTING**
(Initial Eligibility)

| | Eligible for EXP ALL KIDS | Not Eligible for EXP ALL KIDS | Totals |
|---|---|---|---|
| Number Tested | 16 | 24 | 40 |
| Number Missing Documentation | 9 | 1 | 10 |
| Percent Missing Documentation | 56% | 4% | 25% |

As seen in Exhibit 13, we found residency was not verified in 10 of the 40 (25%) cases we tested. Most of the cases where residency was not verified were recipients who were eligible for EXPANDED ALL KIDS (9 of 16). Only 1 of the 24 recipients who were not eligible for EXPANDED ALL KIDS was missing residency documentation.

**Birth/Age Information (Initial Eligibility)**

In order to be eligible for ALL KIDS, the Covering ALL KIDS Health Insurance Act (215 ILCS 170/10) defines a child as "a person under the age of 19." As part of our testing of new cases, we looked to see if documentation of birth, such as a birth certificate, was present to verify age.

Exhibit 14
**RESULTS OF EXPANDED ALL KIDS BIRTH/AGE DOCUMENTATION TESTING**
(Initial Eligibility)

| | Eligible for EXP ALL KIDS | Not Eligible for EXP ALL KIDS | Totals |
|---|---|---|---|
| Number Tested | 16 | 24 | 40 |
| Number Missing Documentation | 11 | 4 | 15 |
| Percent Missing Documentation | 69% | 17% | 38% |

As seen in Exhibit 14, we found birth/age information was not verified in 15 of the 40 (38%) cases we tested. Similar to residency verification discussed above, most of the cases where birth date was not verified were for recipients who were eligible for EXPANDED ALL KIDS (11 of 16). Only 4 of the 24 recipients who were not eligible for EXPANDED ALL KIDS were missing birth/age documentation.

**Income Documentation (Initial Eligibility)**

Beginning on July 1, 2011, 215 ILCS 170/7(a)(2) required verification of one month's income from all sources for determining eligibility. Although HFS and DHS have implemented the required one month's worth of income requirement, we found caseworkers did not review 30 days of income documents as required.

Exhibit 15
**RESULTS OF EXPANDED ALL KIDS 30 DAYS OF INCOME DOCUMENTATION TESTING**
(Initial Eligibility)

| | Eligible for EXP ALL KIDS | Not Eligible for EXP ALL KIDS | Totals |
|---|---|---|---|
| Number Tested [1] | 10 | 18 | 28 |
| Number Missing Documentation | 5 | 10 | 15 |
| Percent Missing Documentation | 50% | 56% | 54% |

Note: [1] In 12 cases tested, no income was reported.

In cases where income was reported, we found income eligibility documentation and calculation problems in the majority of the cases tested. Of the 40 cases tested, 28 reported having some income. As seen in Exhibit 15, 30 days of income was not reviewed in 54 percent (15 of 28) of the cases where income was reported. In addition to the 15 that were missing 30 days of income, we identified 5 other cases (18%) where caseworkers did not calculate the income correctly or did not determine the correct number of household members.

**Eligibility Redetermination Testing**

We tested 40 redeterminations that occurred during May and June 2014 and found significant issues. Half of the cases were redetermined in Max-IL and half were determined in the Supplemental Nutrition Assistance Program (SNAP). We found 17 cases coded as undocumented even though we found evidence, such as verified social security numbers, supporting the enrollee was likely a citizen or documented immigrant. As a result, these 17 recipients are likely not eligible for the EXPANDED ALL KIDS program. One of the 40 cases was closed before it was redetermined, and therefore, was not included in the testing.

We found DHS and HFS did not obtain all required documentation to support birth, residency, and income. During our testing, we reviewed all 39 redeterminations to determine whether all required eligibility redetermination documentation was obtained or reviewed. Of the 39 cases reviewed, 32 were missing at least one piece of required documentation (verification of residency, birth/age, or income).

**Illinois Residency Verification (Redetermination)**

Illinois residency verification is required for ALL KIDS by 215 ILCS 170/7(a)(3). According to both HFS and DHS officials, effective March 14, 2012, an automated Secretary of State clearance was implemented to verify residency. During testing, we determined that residency verification was not required for Supplemental Nutrition Assistance Program (SNAP) recipients. Therefore, we did not review the SNAP cases for our redetermination residency testing.

Exhibit 16
**RESULTS OF EXPANDED ALL KIDS RESIDENCY DOCUMENTATION TESTING**
(Redetermination)

| | Eligible for EXP ALL KIDS | Not Eligible for EXP ALL KIDS | Totals[1] |
|---|---|---|---|
| Number Tested | 12 | 8 | 20 |
| Number Missing Documentation | 9 | 3 | 12 |
| Percent Missing Documentation | 75% | 38% | 60% |

Note: [1] Does not include SNAP cases.

During our testing of new cases, we found residency was mainly verified in one of two ways. If one of the recipient's parents or guardians provided a social security number, we found residency was verified using an electronic match with the Illinois Secretary of State. If there was no social security number provided, a copy of a bill (cable bill, phone bill, etc.) or other mail with the name and address was utilized.

As seen in Exhibit 16, we found residency was not verified in 12 of the 20 (60%) cases we tested. Most of the cases where residency was not verified were recipients who were eligible for EXPANDED ALL KIDS (9 of 12). Only 3 of the 8 recipients who were not eligible for EXPANDED ALL KIDS were missing residency documentation.

**Birth/Age Information (Redetermination)**

In order to be eligible for ALL KIDS, the Covering ALL KIDS Health Insurance Act (215 ILCS 170/10) defines a child as "a person under the age of 19." As part of our testing of redetermination files, we looked to see if documentation of birth, such as a birth certificate, was present to verify age.

Exhibit 17
**RESULTS OF EXPANDED ALL KIDS BIRTH/AGE DOCUMENTATION TESTING**
(Redetermination)

| | Eligible for EXP ALL KIDS | Not Eligible for EXP ALL KIDS | Totals |
|---|---|---|---|
| Number Tested | 22 | 17 | 39 |
| Number Missing Documentation | 21 | 8 | 29 |
| Percent Missing Documentation | 95% | 47% | 74% |

As seen in Exhibit 17, we found birth/age information was not verified in 29 of the 39 (74%) cases we tested. Similar to residency verification discussed above, most of the cases where birth was not verified were for recipients who were eligible for EXPANDED ALL KIDS (21 of 22). Eight of the 17

recipients who were not eligible for EXPANDED ALL KIDS were missing birth/age documentation.

**Income Documentation (Redetermination)**

Beginning on October 1, 2011, 215 ILCS 170/7(a)(2) required verification of one month's income from all sources for determining continued eligibility. We found caseworkers did not review 30 days of income documents as required.

Exhibit 18
**RESULTS OF EXPANDED ALL KIDS 30 DAYS OF INCOME DOCUMENTATION TESTING**
(Redetermination)

| | Eligible for EXP ALL KIDS | Not Eligible for EXP ALL KIDS | Totals |
|---|---|---|---|
| Number Tested [1] | 15 | 14 | 29 |
| Number Missing Documentation | 3 | 1 | 4 |
| Percent Missing Documentation | 20% | 7% | 14% |

Note: [1] In 11 cases tested, no income was reported.

In cases where income was reported, we found income eligibility documentation and calculation problems in the cases tested. Of the 39 cases tested, 29 reported having some income. As seen in Exhibit 18, 30 days of income was not reviewed in 14 percent (4 of 29) of the cases where income was reported. In addition to the 4 that were missing 30 days of income, we identified 6 other cases (21%) where caseworkers did not calculate the income correctly or did not determine the correct number of household members. Therefore, this part of the recommendation is **repeated** and will be followed up on in future audits.

| ELIGIBILITY DOCUMENTATION | |
|---|---|
| **RECOMMENDATION NUMBER**<br><br>**4** | ***The Department of Healthcare and Family Services and the Department of Human Services should:***<br>• ***ensure all necessary eligibility documentation to support birth, identity, and residency is received in order to ensure that eligibility is determined accurately;***<br>• ***ensure one month's worth of income verification is reviewed for determining eligibility; and***<br>• ***implement better controls to verify whether individuals are self-employed and to ensure that adequate information is provided and that eligibility is determined correctly.*** |
| **DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE** | The Department accepts the recommendation. While electronic means of verification implemented over the past few years have helped, they only work for those who provide an SSN. The Department will promulgate rules to require verification of date of birth for children. The Department will also provide regular reminders to caseworkers regarding income verification requirements including checking electronic sources for wage data report by employers for individuals reporting they are self-employed. |
| **DEPARTMENT OF HUMAN SERVICES' RESPONSE**<br><br>Continued on following page | The Department agrees with the recommendation. Eligibility documentation continues to be an important piece of training for new casework staff. Several factors contributed to the lack of documentation of eligibility factors in some of the tested cases.<br><br>The population tested has been a historically difficult population to test. The population is defined as children with no immigration status documentation, now receiving All Kids medical coverage. Many of their parents don't qualify for coverage, nor do they have SSNs, which results in the reliance of paper documentation.<br><br>In May and/or June 2014, both systems used in new approvals and redeterminations – IES and MAX-IL – were relatively new. Training of new staff and re-training of existing staff was still being executed, equipment and software was still being delivered and learned, and at that time the Department was in the midst of intense transition to new systems that are replacing decades old systems.<br><br>Changing the direction of the Department's eligibility and redetermination of eligibility processes for a statewide program that assists approximately 3.3 million people arrived with challenges, including the gathering, indexing, scanning, and uploading of eligibility documentation for a small population for which we cannot use the new system's electronic verification enhancement. Other recent audits that have tested cases within the new system have shown that after the initial start up challenges, documentation within the system is still not without the potential for improvement, but significantly better than during the time period for this audit. |

| | |
|---|---|
| | There was also evidence of improvement seen during the audit, but for a timeframe outside of the audit. As mentioned before, the audit period was May/June 2014. When the cases were tested in August of 2015, there were cases that had the necessary documentation present, however it was not present during the audit period of May/June 2014.<br><br>The systems tested in the audit were developed to handle the majority of the Department's clientele, who have SSNs and have some type of documented citizenship status. The audit reviewed a sample of cases from a small population (the undocumented immigration status children) that consists of approximately 1.5% of the total DHS client population. Although we agree that all populations that we serve are important, system designs and system training prudently focuses more heavily on the bulk of the population served.<br><br>The Department will develop refresher training for casework staff that specifically addresses proper eligibility documentation, including scanning and uploading of eligibility documents into the new systems. |

## POLICIES COVERING ORTHODONTIC TREATMENT

As part of this year's EXPANDED ALL KIDS audit, we examined the payments made to providers for orthodontic services. Our review identified two issues. The first was a lack of documentation related to orthodontic claims. The second was improvements in HFS orthodontic policies and documentation of medical necessity.

### Lack of Documentation from DentaQuest

As a result of our review of policies and procedures related to the approval of orthodontia, we found that DentaQuest, the Dental Program Administrator for HFS, could not provide documents that were used to approve orthodontic claims. We requested documents used by DentaQuest for initial approval for 40 recipients that had orthodontic services during FY14. DentaQuest could not provide the documents for 9 of the 40 requested (23%). According to DentaQuest officials, 3 could not be provided because "NEA" (National Electronic Attachment) only retains records for three years, while 6 could not be provided due to a "system issue."

### Orthodontic Eligibility Criteria

The Administrative Code (89 Ill. Adm. Code 140.421(a)(16)) provides the following guidance on orthodontic eligibility:

> *Orthodontics. Medically necessary orthodontic treatment is approved only for patients ages 0-20 and is defined as:*
>
> *A) treatment necessary to correct a condition which scores 42 points or more on the Salzmann Index; or*

*B) treatment necessary to correct a handicapping malocclusion (a condition that impairs or creates a hazard in eating, chewing, speaking, or breathing.)*

We also reviewed HFS' Dental Office Reference Manual in effect for FY14, and found similar requirements, which stated:

*Participants between the ages of 2 and 20 may qualify for orthodontic care under the program. Participants must have a severe, dysfunctional, handicapping malocclusion as determined by a score of 42 points or greater on the modified salzmann index, or objective documentation that the malocclusion is an impairment of, or a hazard to the ability to eat, chew, speak, or breathe. [emphasis added]*

*Since a case must be dysfunctional to be accepted for treatment, Participants whose molars and bicuspids are in good occlusion seldom qualify. Interceptive orthodontics is not a covered benefit. Crowding alone is usually not dysfunctional in spite of the aesthetic considerations. The participant must have lost all primary teeth and have permanent teeth erupting or in occlusion to be considered. [emphasis added]*

Furthermore, HFS' State Plan under Title XIX of the Social Security Act (Medicaid), submitted to, and approved by, the Centers for Medicare & Medicaid Services, notes that covered procedures are specified in the Department's Dental Office Reference Manual or Provider Notices. The State Plan also states: "Coverage of orthodontia is limited to case[s] which present a severe handicapping malocclusion or a handicapping dentofacial deformity" and "Dental services performed only for cosmetic reasons are not covered."

We found almost none of the recipients were approved for orthodontics in FY14 using the Salzmann Index score (89 Ill. Adm. Code 140.421(a)(16)(A)). Only 8 of 13,576 orthodontic cases approved by DentaQuest were approved using the Salzmann Index. We discussed the severity of these requirements with DentaQuest officials. A DentaQuest official noted that a 42 on the Salzmann Index was a very high score (i.e., is a severe condition). The official noted a score of 42 is a higher requirement compared to what other states use.

The majority of the recipients were approved using the medical necessity standard (89 Ill. Adm. Code 140.421(a)(16)(B)). According to DentaQuest, once an orthodontist submits pictures, x-rays (if necessary) to DentaQuest, DentaQuest completes the scoring tool and either approves the service, denies the service, or requests additional information. Based on the HFS Dental Office Reference Manual, completion of the Salzmann Index is only necessary if the recipient does not qualify due to the medical necessity requirement found in the Administrative Code (89 Ill. Adm. Code 140.421(a)(16)(B)).

The official noted that the scoring tool used by DentaQuest for orthodontic cases was changed in 2010. We reviewed documents provided by HFS that addressed the change in the scoring tool. A change to the scoring tool was discussed at several meetings of the DentaQuest Peer Review Committee in 2008, 2009, and 2010. These meetings were attended by officials from DentaQuest, member dentists, and HFS officials. The Committee recommended keeping the Salzmann Index score requirement, but recommended adopting a new Medical Necessity Scoring Tool to capture medical necessity without requiring a written order from a physician (see Appendix F).

According to DentaQuest, another reason for changing the scoring tool was recipients were appealing DentaQuest denials in order to get necessary orthodontia. At the December 19, 2009 Committee meeting, a DentaQuest official stated that it is difficult to uphold a denial at a fair hearing if the appellant produces a doctor's order stating that the patient's malocclusion causes a disability impacting eating, speaking, chewing or breathing. We requested, but HFS was unable to provide, information on how many orthodontia cases were being overturned during the fair hearing process.

The change in the scoring tool corresponded with a significant increase in orthodontia claims being paid by HFS. In FY10, the EXPANDED ALL KIDS program paid for only $322,892 in orthodontic services. By FY14, 4,020 EXPANDED ALL KIDS recipients had orthodontic services totaling $3.6 million. Similarly, orthodontic services increased dramatically for HFS' medical program as a whole. In FY10, payments for orthodontic services totaled $2.9 million. In FY 2012, the amount paid increased to $16.6 million, and by FY14, payments totaled $36.6 million.

**Review of Orthodontic Cases**

While the scoring tool was approved in FY11, the Administrative Code delineating eligibility criteria for orthodontic services was not changed. As noted above, few cases are approved using the Salzmann Index in the first section of the Administrative Code (89 Ill. Adm. Code 140.421(a)(16)(A)). Rather, most cases are approved pursuant to the second part of the Administrative Code which states: *treatment necessary to correct a handicapping malocclusion (a condition that impairs or creates a hazard in eating, chewing, speaking, or breathing.)*

It is HFS' position that the revised scoring tool continues to comply with the requirements of the Administrative Code. In December 2009, a DentaQuest dentist recommended Illinois adopt the Medical Necessity Scoring Tool, and if the recipient does not qualify, use the modified Salzmann. The Peer Review Committee minutes stated "the state regulations require that orthodontia should be approved if the Modified Salzmann is 42 points or higher or if the service is medically necessary. Using both tools will meet the state regulations and will not necessitate a rules change." All committee members approved the recommendation.

According to HFS, the change to the scoring tool received approval from two other HFS committees. HFS provided limited documentation showing that the change was approved by the Dental Program Policy Committee or the Policy Review System.

We noted there were a large number of dentists providing orthodontic services that were among the highest paid providers in the EXPANDED ALL KIDS program, and we approached the HFS Office of the Inspector General (OIG) for assistance reviewing eligibility documentation for a sample of the providers. We also noted that based on our review of 15 case files, we had questions regarding whether some recipients approved for orthodontic services met the need standards established in HFS' administrative rule or Dental Office Reference Manual.

The OIG agreed to have the OIG dental consultant review cases selected by us. We worked with the OIG and jointly visited four orthodontist offices. We obtained and reviewed the documentation for 10 recipients at each location for a total of 40 cases. As of October 27, 2014,

there were 453 orthodontic claims paid for these 40 cases totaling $124,000. Auditors judgmentally selected 10 cases for each provider where it appeared from the electronic data the treatment was completed during FY14 or in early FY15. Auditors found 1 of the 4 providers could not provide evidence to support all services provided. In all 10 cases reviewed for this provider, auditors could not find evidence for all of the services billed.

Auditors also determined that the scoring tool was completed by DentaQuest, and not by the recipient's dentist, as HFS had previously indicated to the auditors. Auditors asked HFS what monitoring is conducted by HFS related to the approval of orthodontics. HFS indicated it does not review eligibility decisions made by DentaQuest.

During our testing, we had discussions with the orthodontists related to the approval process. We were able to ask 3 of the 4 orthodontists specifically about the approval process. All three orthodontists indicated they could not follow the reasoning behind why some cases were approved by DentaQuest.

**Results from OIG Dental Consultant's Review**

The OIG provided the OAG with a preliminary draft of its report which noted that due to the modifications made in 2011 to the medical necessity prior approval procedures, *"the threshold for medically necessary services was made less stringent increasing the number of prior approvals of orthodontic services."* During the review of the 40 sample cases, the OIG's dental consultant found that each of the 40 cases met the Department's medical necessity criteria using the new, less stringent scoring tool; however, the consultant found *"limited or no corroborating evidence of conditions of a handicapping malocclusion, including documentation establishing a condition that impairs or creates a hazard in eating, chewing, speaking or breathing, other than that which was documented in Attachment G."* Attachment G of the DORM is the Medical Necessity Scoring Tool (see Appendix F). The OIG recommended increasing the documentation required to establish medical necessity, such as a narrative report from the dentist as well as a certification from a medical professional certifying that the client meets the conditions of a medical need for orthodontic services.

The OIG found guidelines for providers of orthodontic services were unclear and inconsistent. The OIG recommended the definition of medical necessity be revised and more clearly defined. The OIG also recommended changes to either the Administrative Code, Department Handbooks or policies to include more specific examples of medical necessity.

**Conclusion**

Expenditures by the State for orthodontic services for children in EXPANDED ALL KIDS specifically, and HFS' medical program generally, increased dramatically from FY10 to FY14. This increase corresponds to the time when the scoring tool used to determine medical necessity for orthodontic services was revised. A review conducted by the OIG concluded that revisions and clarifications to policies establishing medical necessity should be made, as well as requiring additional documentation to support medical necessity.

| POLICIES COVERING ORTHODONTIC TREATMENT | |
|---|---|
| **RECOMMENDATION NUMBER**<br><br>**5** | ***The Department of Healthcare and Family Services should:***<br>• ***ensure DentaQuest is receiving and maintaining documentation needed to support orthodontia approvals;***<br>• ***examine and address the issues raised by the OIG in its review of orthodontic claims; and***<br>• ***more effectively monitor the actions taken by DentaQuest (the State's contractual Dental Program Administrator).*** |
| **DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE** | The Department accepts the recommendation. The Department conducts various monitoring activities for the DentaQuest contract and also receives and reviews an annual Service Control Organization report outlining any control issues noted by independent auditors; however, there have been significant changes in staff in the bureau that oversees the dental program. The Department will remind DentaQuest that they must maintain documentation according to our record retention policies. The Department will also review the issues raised by the OIG and take appropriate action. |

# 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 sixth annual audit directed by the Covering ALL KIDS Health Insurance Act.

Since this is the sixth audit of the EXPANDED ALL KIDS program in the last six years and there have been significant changes to the Covering ALL KIDS Health Insurance Act that were effective during the FY14 audit period, this audit followed up on previous recommendations, determined if new laws and policies were properly implemented, and reviewed the eligibility determination and redetermination process that was implemented during FY14. During this audit, we also reviewed the orthodontia approval process. During our audit, HFS officials reported that there were no new contracts related to the ALL KIDS Expansion for FY14.

During this audit, we met with both HFS and DHS officials and determined that initial and redetermination of eligibility procedures changed. On October 1, 2013, HFS and DHS replaced the Automated Intake System and the Automated Case Management System with the newly created Integrated Eligibility System (IES). As a result, initial ALL KIDS eligibility began being processed through IES during FY14. Additionally, annual redeterminations for ALL KIDS are completed as part of the Illinois Medicaid Redetermination Project (IMRP), began in February 2014. Due to these changes, we conducted testing in these areas to ensure compliance with applicable laws, rules, and policies. Since these samples were of a narrowly defined group of recipients, neither sample should be projected to the population. Additionally, these recipients were classified as undocumented immigrants, and therefore, did not qualify for Medicaid. We took two samples consisting of the following:

1) a sample of 40 randomly selected cases that were redetermined during either May or June 2014. Half of the cases were redetermined in Max-IL and half were determined in the Supplemental Nutrition Assistance Program. We reviewed the cases electronically with assistance from DHS officials. During the review, we determined whether all necessary eligibility documentation to support birth, residency, citizenship status, and income was received or verified in order to ensure that continued eligibility was determined accurately; and

2) a sample of 40 randomly selected new EXPANDED ALL KIDS cases in FY14, that were reviewed during either May or June 2014. We reviewed the cases electronically with assistance from DHS officials. During the review, we determined whether all necessary eligibility documentation to support birth, residency, citizenship status, and income was received or verified in order to ensure that eligibility was determined accurately.

During the testing of our two eligibility samples, we reviewed the recipient's eligibility documentation found in IES for the initial eligibility review and documentation found in the Max-IL system for the redetermination sample. Our review consisted mainly of locating and reviewing hard copy documents that were scanned into one of the two systems. Since our audit population, as defined by the Covering ALL KIDS Health Insurance Act, covers mainly undocumented immigrants who do not have social security numbers, the data matching criteria embedded within IES and Max-IL were not utilized by caseworkers. Therefore, the electronic data matches were not tested as part of our review. As a result, the findings in this report pertaining to eligibility determinations and redeterminations are not applicable to the Title XIX (Medicaid) population as a whole.

We also identified large payments going to individual providers. Most of these providers were providing orthodontic services. We reviewed the policies and procedures related to orthodontics and conducted joint visits to four provider offices with the HFS Office of the Inspector General. We sampled 10 recipients at each of the four offices to determine whether DentaQuest made the appropriate eligibility decision and whether the provider had documentation for each visit/payment. We also attempted to verify whether the treatment was complete. In order to determine whether DentaQuest made the correct eligibility decision, we relied on the expertise of the OIG and one of its consultants. Our sample was judgmentally

selected in an effort to select recipients that had completed their treatment in FY14 or early FY15, and therefore, the sample should not be projected to the population.

Since the data system was reviewed during FY13 by the Auditor General's Information Systems Division, we did not review the data system during FY14. 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]

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

**Appendix A**

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

INSURANCE

(215 ILCS 170/) Covering ALL KIDS Health Insurance Act.

(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 third month following the last date of coverage (or longer period if required by federal regulations). 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. 98-651, eff. 6-16-14.)

(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. Effective October 1, 2013, the determination of eligibility under this Act shall comply with the requirements of 42 U.S.C. 1397bb(b)(1)(B)(v) and applicable federal regulations. If changes made to this Section require federal approval, they shall not take effect until such approval has been received.
(Source: P.A. 98-104, eff. 7-22-13.)

(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) who (i) effective July 1, 2014, in accordance
with 42 CFR 457.805 (78 FR 42313, July 15, 2013) or any other federal requirement necessary to obtain federal financial participation for expenditures made under this Act, has been without health insurance coverage for 90 days; (ii) is a newborn whose responsible relative does not have available affordable private or employer-sponsored health insurance; or (iii) 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,
effective October 1, 2013, by the Department, is at or below 300% of the federal poverty level as determined in compliance with 42 U.S.C. 1397bb(b)(1)(B)(v) and applicable federal regulations.
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 may impose an administrative penalty as provided under Section 12-4.45 of the Illinois Public Aid Code on entities that have established a pattern of failure to provide the information required under this Section.
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. 98-130, eff. 8-2-13; 98-651, eff. 6-16-14.)

(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 the premiums or other cost sharing requirements of the Program.
(Source: P.A. 97-689, eff. 6-14-12.)

(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.
(f) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Act or the Illinois Public Aid Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e of the Illinois Public Aid Code.
(Source: P.A. 97-689, eff. 6-14-12.)

(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**
Fiscal Year 2014

| | Assist | Share | Premium Level 1 | Premium Level 2 |
|---|---|---|---|---|
| **Premium** | None | None | $15 (1)<br>$25 (2)<br>$30 (3)<br>$35 (4)<br>$40 (5+) | $40 per child |
| **Max Monthly Premium** | n/a | n/a | $40 | $80 |
| **Physician Visit** | None | $3.90 | $5 | $10 |
| **Emergency Room Visit (Emergency)** | None | None | $5 | $30 |
| **Emergency Room Visit (Non-Emergency)** | None | None | $25 | $30 |
| **Generic Drug** | None | $2 | $3 | $3 |
| **Brand Name Drug** | None | $3.90 | $5 | $7 |
| **Inpatient Admission** | None | $3.90/day | $5/day | $100 |
| **Outpatient Service** | None | $3.90/visit | $5/visit | 5% of ALL KIDS payment rate |
| **Annual Out-of-Pocket Max.** | n/a | $100 per family | $100 per family | $500 per child |

Source: Illinois Department of Healthcare and Family Services.

# APPENDIX C

# FY14 Total Cost of Services Provided by Category of Service

Appendix C
**TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE**
During FY14

| Category of Service | FY14 Payment Amount | Percent of Total Payments |
|---|---|---|
| Dental Services | $11,991,107 | 17% |
| Pharmacy Services (Drug and OTC) | 10,141,180 | 14% |
| Physician Services | 9,500,286 | 14% |
| Inpatient Hospital Services (General) | 7,794,326 | 11% |
| Outpatient Services (General) | 5,057,116 | 7% |
| General Clinic Services | 4,369,368 | 6% |
| Inpatient Hospital Services (Psychiatric) | 3,555,303 | 5% |
| Capitation Services | 3,493,306 | 5% |
| Healthy Kids Services | 2,579,257 | 4% |
| Mental Health Rehab Option Services | 1,814,323 | 3% |
| Physical Therapy Services | 1,016,913 | 1% |
| Speech Therapy/Pathology Services | 967,828 | 1% |
| Alcohol and Substance Abuse Rehab Services | 857,304 | 1% |
| Clinical Laboratory Services | 704,124 | 1% |
| Medical Equipment/Prosthetic Devices | 673,216 | 1% |
| Optical Supplies | 635,271 | <1% |
| Medical Supplies | 622,690 | <1% |
| Home Health Services | 515,835 | <1% |
| Anesthesia Services | 385,651 | <1% |
| Psychiatric Clinic Services (Type 'A') | 346,666 | <1% |
| Occupational Therapy Services | 345,198 | <1% |
| Waiver Service (Depends on HCPCS Code) | 235,389 | <1% |
| Psychiatric Clinic Services (Type 'B') | 219,034 | <1% |
| Targeted Case Management Service (Mental Health) | 217,573 | <1% |
| Emergency Ambulance Transportation | 205,618 | <1% |
| Targeted Case Management Service (Early Intervention) | 198,563 | <1% |
| Optometric Services | 186,801 | <1% |
| Development Therapy, Orientation and Mobility Services (Waivers) | 182,793 | <1% |
| Nurse Practitioners Services | 181,077 | <1% |
| Other Transportation | 173,200 | <1% |
| Social Work Service | 160,234 | <1% |
| Outpatient Services (ESRD) | 125,039 | <1% |
| Nursing Service | 112,468 | <1% |
| Podiatric Services | 77,554 | <1% |
| Psychologist Service | 63,021 | <1% |

Appendix C
**TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE**
During FY14

| Category of Service | FY14 Payment Amount | Percent of Total Payments |
|---|---|---|
| Non-Emergency Ambulance Transportation | $60,804 | <1% |
| Early Intervention Services | 49,899 | <1% |
| Service Car | 48,163 | <1% |
| Audiology Services | 31,855 | <1% |
| LTC--ICF/MR | 30,689 | <1% |
| Inpatient Hospital Services (Physical Rehabilitation) | 29,359 | <1% |
| Midwife Services | 27,547 | <1% |
| Home Care | 15,163 | <1% |
| Licensed Clinical Professional Counselor | 9,359 | <1% |
| Fluoride Varnish | 8,060 | <1% |
| Chiropractic Services | 6,749 | <1% |
| Family Planning Counseling | 6,000 | <1% |
| FFS Procedure to Implement Contraceptive Devices for PT 040, 048 | 4,374 | <1% |
| Medicar Transportation | 2,966 | <1% |
| Physicians Psychiatric Services | 2,637 | <1% |
| Taxicab Services | 2,628 | <1% |
| Independent Diagnostic Testing | 2,073 | <1% |
| Clinic Services (Physical Rehabilitation) | 1,760 | <1% |
| Portable X-Ray Services | 65 | <1% |
| **Total FY14 Cost of Services** | **$70,044,785** | **100%** |

Note: May not add due to rounding.

Source: Summary of FY14 ALL KIDS data provided by HFS.

# APPENDIX D

# FY14 Total Cost of Services Provided by Plan and Category of Service

Appendix D

**TOTAL COST OF SERVICES PROVIDED BY PLAN AND BY CATEGORY OF SERVICE**

During FY14

| Category of Service | Total | Assist | Share | Premium Undocumented | Level 2 Undocumented | Level 2 |
|---|---|---|---|---|---|---|
| Dental Services | $11,991,107 | 8,266,341 | $210,152 | $271,078 | $87,911 | $3,155,624 |
| Pharmacy Services (Drug and OTC) | 10,141,180 | 3,752,415 | 108,469 | 70,397 | 91,847 | 6,118,051 |
| Physician Services | 9,500,286 | 5,298,414 | 139,409 | 165,683 | 66,416 | 3,830,365 |
| Inpatient Hospital Services (General) | 7,794,326 | 4,024,897 | 21,563 | 378,114 | 95,408 | 3,274,345 |
| Outpatient Services (General) | 5,057,116 | 2,927,363 | 122,147 | 63,886 | 31,136 | 1,912,584 |
| General Clinic Services | 4,369,368 | 3,138,002 | 64,804 | 69,229 | 15,394 | 1,081,941 |
| Inpatient Hospital Services (Psychiatric) | 3,555,303 | 2,383,871 | 102,047 | 19,391 | 0 | 1,049,993 |
| Capitation Services | 3,493,306 | 3,393,642 | 48,381 | 36,748 | 0 | 14,535 |
| Healthy Kids Services | 2,579,257 | 1,295,227 | 40,596 | 46,852 | 22,387 | 1,174,195 |
| Mental Health Rehab Option Services | 1,814,323 | 957,022 | 28,999 | 20,598 | 2,464 | 805,241 |
| Physical Therapy Services | 1,016,913 | 415,486 | 14,653 | 20,600 | 15,690 | 550,483 |
| Speech Therapy/Pathology Services | 967,828 | 63,329 | 3,461 | 2,109 | 182 | 898,747 |
| Alcohol and Substance Abuse Rehab Services | 857,304 | 479,185 | 3,134 | 39,793 | 0 | 335,192 |
| Clinical Laboratory Services | 704,124 | 524,919 | 9,206 | 12,073 | 3,490 | 154,436 |
| Medical Equipment/Prosthetic Devices | 673,216 | 304,374 | 10,615 | 15,850 | 20,541 | 321,836 |
| Optical Supplies | 635,271 | 451,226 | 8,602 | 12,663 | 4,094 | 158,686 |
| Medical Supplies | 622,690 | 275,977 | 6,230 | 6,351 | 5,581 | 328,551 |
| Home Health Services | 515,835 | 72,651 | 0 | 0 | 0 | 443,184 |
| Anesthesia Services | 385,651 | 213,575 | 3,945 | 5,112 | 3,046 | 159,974 |
| Psychiatric Clinic Services (Type 'A') | 346,666 | 181,442 | 3,540 | 7,525 | 1,378 | 152,782 |
| Occupational Therapy Services | 345,198 | 46,004 | 565 | 929 | 1,442 | 296,258 |
| Waiver Service (Depends on HCPCS Code) | 235,389 | 0 | 0 | 0 | 0 | 235,389 |
| Psychiatric Clinic Services (Type 'B') | 219,034 | 153,942 | 3,411 | 3,659 | 0 | 58,021 |
| Targeted Case Management Service (Mental Health) | 217,573 | 111,801 | 1,471 | 1,167 | 0 | 103,134 |
| Emergency Ambulance Transportation | 205,618 | 117,672 | 1,687 | 3,402 | 798 | 82,060 |
| Targeted Case Management Service (Early Intervention) | 198,563 | 25,374 | 1,212 | 973 | 0 | 171,004 |
| Optometric Services | 186,801 | 116,598 | 3,042 | 3,919 | 1,300 | 61,943 |
| Development Therapy, Orientation and Mobility Services (Waivers) | 182,793 | 27,480 | 1,944 | 934 | 0 | 152,435 |
| Nurse Practitioners Services | 181,077 | 90,432 | 2,505 | 1,885 | 317 | 85,938 |

Appendix D

**TOTAL COST OF SERVICES PROVIDED BY PLAN AND BY CATEGORY OF SERVICE**

During FY14

| Category of Service | Total | Assist | Share | Premium Undocumented | Level 2 Undocumented | Level 2 |
|---|---|---|---|---|---|---|
| Other Transportation | $173,200 | $0 | $0 | $0 | $0 | $173,200 |
| Social Work Service | 160,234 | 15,197 | 0 | 597 | 84 | 144,356 |
| Outpatient Services (ESRD) | 125,039 | 123,686 | 1,353 | 0 | 0 | 0 |
| Nursing Service | 112,468 | 0 | 0 | 0 | 0 | 112,468 |
| Podiatric Services | 77,554 | 52,152 | 791 | 2,083 | 1,761 | 20,767 |
| Psychologist Service | 63,021 | 5,137 | 0 | 0 | 0 | 57,885 |
| Non-Emergency Ambulance Transportation | 60,804 | 43,619 | 1,415 | 1,234 | 0 | 14,536 |
| Early Intervention Services | 49,899 | 15,857 | 604 | 0 | 0 | 33,438 |
| Service Car | 48,163 | 46,882 | 825 | 20 | 0 | 437 |
| Audiology Services | 31,855 | 9,493 | 279 | 366 | 208 | 21,509 |
| LTC--ICF/MR | 30,689 | 30,689 | 0 | 0 | 0 | 0 |
| Inpatient Hospital Services (Physical Rehabilitation) | 29,359 | 28,458 | 0 | 0 | 0 | 901 |
| Midwife Services | 27,547 | 23,322 | 315 | 88 | 627 | 3,194 |
| Home Care | 15,163 | 15,163 | 0 | 0 | 0 | 0 |
| Licensed Clinical Professional Counselor | 9,359 | 4,881 | 148 | 150 | 0 | 4,180 |
| Fluoride Varnish | 8,060 | 1,014 | 0 | 0 | 0 | 7,046 |
| Chiropractic Services | 6,749 | 6,369 | 110 | 0 | 0 | 269 |
| Family Planning Counseling | 6,000 | 2,490 | 30 | 0 | 0 | 3,480 |
| FFS Procedure to Implement Contraceptive Devices for PT 040, 048 | 4,374 | 4,374 | 0 | 0 | 0 | 0 |
| Medicar Transportation | 2,966 | 2,966 | 0 | 0 | 0 | 0 |
| Physicians Psychiatric Services | 2,637 | 1,836 | 0 | 0 | 0 | 801 |
| Taxicab Services | 2,628 | 2,325 | 0 | 0 | 0 | 303 |
| Independent Diagnostic Testing. | 2,073 | 1,374 | 21 | 21 | 289 | 369 |
| Clinic Services (Physical Rehabilitation) | 1,760 | 811 | 0 | 262 | 0 | 687 |
| Portable X-Ray Services | 65 | 44 | 0 | 0 | 0 | 21 |
| **Total Cost of Services** | **$70,044,785** | **$39,546,799** | **$971,681** | **$1,285,740** | **$473,790** | **$27,766,776** |

Note: May not add due to rounding.
Source: Summary of FY14 ALL KIDS data provided by HFS.

# APPENDIX E

# Total ALL KIDS Services Provided by Provider Greater Than $50,000 Fiscal Year 2014

**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 may be some providers that appear more than once in this Appendix.**

Appendix E

**TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000**

Fiscal Year 2014

| Provider Name | City | State | Total Amount Paid |
|---|---|---|---|
| LURIE CHILDRENS HOSPITAL | CHICAGO | IL | $2,513,953.04 |
| HARMONY HEALTH PLAN | CHICAGO | IL | 1,109,513.41 |
| BHC STREAMWOOD HOSPITAL INC | STREAMWOOD | IL | 1,076,685.06 |
| UNIVERSITY OF ILLINOIS HOSP | CHICAGO | IL | 912,617.18 |
| HARTGROVE HOSPITAL | CHICAGO | IL | 715,601.67 |
| COMER CHILDRENS HOSPITAL | DARIEN | IL | 691,499.57 |
| J H STROGER HOSP OF COOK CTY | CHICAGO | IL | 614,853.06 |
| CENTRAL DUPAGE HOSPITAL | WINFIELD | IL | 520,929.24 |
| CARLE FOUNDATION HOSPITAL | URBANA | IL | 489,736.43 |
| RIVEREDGE HOSPITAL | FOREST PARK | IL | 479,669.48 |
| LUTHERAN GENERAL CHILDRENS HOS | PARK RIDGE | IL | 460,882.11 |
| RONALD MCDONALDS CHILDRENS HSP | MAYWOOD | IL | 420,987.92 |
| ACCREDO HEALTH GROUP INC | MEMPHIS | TN | 410,793.22 |
| CAREMARK INC | MT PROSPECT | IL | 409,884.76 |
| ILL CORRECTIONAL INDUSTRIES | SPRINGFIELD | IL | 326,942.95 |
| ALEXIAN BROS CHILDRENS HOSP | HOFFMAN ESTATES | IL | 318,020.48 |
| LA RABIDA CHILDRENS HOSP | CHICAGO | IL | 288,917.69 |
| CHILDRENS HOSPITAL OF ILLINOIS | PEORIA | IL | 288,909.09 |
| MERIDIAN HEALTH PLAN INC VMC | CHICAGO | IL | 276,603.53 |
| RUSH CHILDRENS SERVICES | CHICAGO | IL | 267,714.40 |
| ROCKFORD MEMORIAL HOSPITAL | ROCKFORD | IL | 263,519.84 |
| BENJAMIN DALE | CHICAGO | IL | 255,914.15 |
| HOPE CHILDRENS HOSPITAL | OAK LAWN | IL | 252,622.51 |
| INFANT WELFARE SOCIETY OF CHGO | CHICAGO | IL | 241,313.70 |
| FANTUS HEALTH CENTER | CHICAGO | IL | 240,415.01 |
| CHICAGO SCHOOL DIST 299 | CHICAGO | IL | 237,521.43 |
| JOSHI ASHWINI | CHICAGO | IL | 232,289.97 |
| NASREEN TAIBA | ADDISON | IL | 229,700.48 |
| CAREMARK KANSAS SPEC PHARM LLC | LENEXA | KS | 221,281.02 |
| PRESENCE SAINT MARY NAZARETH | CHICAGO | IL | 220,741.55 |
| GARFIELD PARK HOSPITAL | CHICAGO | IL | 219,826.35 |
| AQEL FADI | CHICAGO | IL | 216,300.47 |
| CAREPLUS CVS PHARMACY 02831 | CHICAGO | IL | 215,317.46 |
| ROSECRANCE CENTER | ROCKFORD | IL | 205,367.31 |
| EVANSTON HOSPITAL | EVANSTON | IL | 204,687.61 |
| SAGUN MATTHEW | OAK LAWN | IL | 199,095.30 |
| GREATER ELGIN FAMILY CARE CTR | ELGIN | IL | 197,887.13 |
| ST ANTHONY HOSPITAL | CHICAGO | IL | 184,178.84 |
| VNA HEALTH CARE | AURORA | IL | 181,756.21 |
| AMBER PHARMACY | CHICAGO | IL | 176,631.37 |
| ST LOUIS CHILDRENS HOSPITAL | SAINT LOUIS | MO | 175,327.14 |
| FOUNDATION CARE LLC | EARTH CITY | MO | 174,924.85 |
| LINCOLN PRAIRIE BEHAVIORAL HC | SPRINGFIELD | IL | 174,467.62 |
| ADVOCATE NORTHSIDE | CHICAGO | IL | 161,982.25 |
| LABORATORY CORPORATION AMERICA | DUBLIN | OH | 158,477.16 |
| NORTHWEST COMMUNITY HOSPITAL | ARLINGTON HGTS | IL | 155,791.71 |
| COMM COUNSEL CTRS C4 NORTH | CHICAGO | IL | 153,608.23 |
| C AND M PHARMACY LLC | GLENVIEW | IL | 151,195.93 |
| PROFESSIONAL BUILDING PHARMACY | CHICAGO | IL | 146,364.09 |

Appendix E

**TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000**

Fiscal Year 2014

| Provider Name | City | State | Total Amount Paid |
|---|---|---|---|
| COPLEY MEMORIAL HOSPITAL | AURORA | IL | $145,344.52 |
| ALEXIAN BROS BEHAVIORAL HLTH | HOFFMAN ESTATES | IL | 145,157.98 |
| MARYVILLE BEHAVIORAL HLTH HOSP | DES PLAINES | IL | 143,041.02 |
| THE KENNETH W YOUNG CENTERS | ELK GROVE VLGE | IL | 142,836.22 |
| ADVOCATE CONDELL MEDICAL CTR | LIBERTYVILLE | IL | 142,038.30 |
| MCC HEALTHCARE SERVICES INC | EVERGREEN PARK | IL | 138,707.31 |
| THE GENESIS CENTER | DES PLAINES | IL | 136,902.90 |
| CARDINAL GLENNON CHILDRENS HSP | SAINT LOUIS | MO | 134,125.77 |
| RUSH UNIVERSITY MEDICAL CENTER | CHICAGO | IL | 130,915.23 |
| ST MARY OF NAZARETH HOSPITAL | CHICAGO | IL | 130,591.53 |
| LAWNDALE CHRISTIAN HLTH CTR | CHICAGO | IL | 127,896.14 |
| ROWAN SUSAN | CHICAGO | IL | 125,742.71 |
| QUEST DIAGNOSTICS LLC IL | WOOD DALE | IL | 121,639.36 |
| VISTA MEDICAL CENTER EAST | WAUKEGAN | IL | 121,505.98 |
| VISTA CLINIC OF COOK COUNTY | PALATINE | IL | 120,357.64 |
| HUMBOLDT PARK FAMILY HLTH CTR | CHICAGO | IL | 119,410.01 |
| CORNELL INTERVENTIONS DUPAGE | HINSDALE | IL | 116,359.63 |
| YARMOLYUK YAROSLAV | ARLINGTON HTS | IL | 114,833.40 |
| LAWNDALE CHRISTIAN HLTH | CHICAGO | IL | 114,585.87 |
| JHAM ANDRE | PEORIA | IL | 113,105.15 |
| PRESENCE SAINT JOSEPH HOSPITAL | ELGIN | IL | 110,015.60 |
| VISTA MEDICAL CENTER WEST | WAUKEGAN | IL | 108,228.77 |
| WINE PAUL | CHICAGO | IL | 106,566.40 |
| RIVERSIDE MEDICAL CENTER | MANTENO | IL | 105,670.62 |
| MEDSTAR LABORATORY INC | HILLSIDE | IL | 104,788.90 |
| GARCIA ELOISA | CHICAGO | IL | 104,155.55 |
| THE BLEEDING AND CLOTTING | PEORIA | IL | 103,784.41 |
| MAXIM HEALTHCARE SERVICES INC | BRIDGEVIEW | IL | 103,555.06 |
| MACNEAL HOSPITAL | BERWYN | IL | 103,277.57 |
| ELMHURST MEMORIAL HOSPITAL | ELMHURST | IL | 102,250.63 |
| UNITED SEATING AND MOBILITY | LOMBARD | IL | 99,410.29 |
| MAXIM HEALTHCARE SERVICES INC | ROSEMONT | IL | 98,359.51 |
| BOND DRUG COMPANY OF IL 03729 | HANOVER PARK | IL | 97,929.70 |
| WALGREEN CO 0089 | BRIDGEVIEW | IL | 95,150.90 |
| WALGREENS SPECIALTY PHRM 15438 | CANTON | MI | 91,768.59 |
| SWEDISH AMERICAN HOSPITAL | ROCKFORD | IL | 91,511.07 |
| SINAI CHILDRENS HOSPITAL | CHICAGO | IL | 89,784.60 |
| WEBER ROBERT | WHEELING | IL | 89,718.55 |
| VILLALOBOS FRANCISCO | CHICAGO | IL | 89,507.50 |
| BALAKRISHNAN MEENAKSHI | DOWNERS GROVE | IL | 89,156.15 |
| AURORA CHICAGO LAKESHORE HOSP | CHICAGO | IL | 88,940.34 |
| CICERO HEALTH CENTER | CICERO | IL | 88,810.10 |
| NAPERVILLE PSYCH VENTURES | NAPERVILLE | IL | 88,728.33 |
| NORWEGIAN AMERICAN HOSP GROUP | CHICAGO | IL | 87,997.35 |
| ST ANTHONY HOSPITAL | CHICAGO | IL | 87,006.02 |
| CHICAGO FAM HLTH CTR SO CHI | CHICAGO | IL | 86,882.95 |
| ALIVIO MEDICAL CENTER | CHICAGO | IL | 86,842.79 |
| OPTION CARE ENTERPRISES INC | WOOD DALE | IL | 86,619.59 |
| CRUSADER CLINIC BROADWAY | ROCKFORD | IL | 84,575.36 |

Appendix E

**TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000**

Fiscal Year 2014

| Provider Name | City | State | Total Amount Paid |
|---|---|---|---|
| MT SINAI HOSP MED CTR CHICAGO | CHICAGO | IL | $84,183.32 |
| ST JOHNS CHILDRENS HOSPITAL | SPRINGFIELD | IL | 84,051.26 |
| WALGREENS 13974 | CHICAGO | IL | 81,971.99 |
| LAKE CO H D WAUKEGAN CLINIC | WAUKEGAN | IL | 81,508.49 |
| PIONEER CENTER OF MCHENRY CO | MCHENRY | IL | 80,812.80 |
| ERIE FAMILY HEALTH CENTER | CHICAGO | IL | 80,672.87 |
| TSALIAGOS CHRISTOS | CHICAGO | IL | 80,392.67 |
| SWEDISH COVENANT HOSPITAL | CHICAGO | IL | 78,698.36 |
| ALEXIAN BROTHERS MED CTR | ELK GROVE VLGE | IL | 78,599.41 |
| CORAM ALTERNATE SITE SERVS INC | MT PROSPECT | IL | 78,219.73 |
| COPPER BEND PHARMACY | BELLEVILLE | IL | 78,100.29 |
| LEYDEN FAMILY SERVICE AND MHC | FRANKLIN PARK | IL | 78,062.28 |
| MAHAIRI AMJAD | ELGIN | IL | 78,049.29 |
| NDO | CHICAGO | IL | 77,305.98 |
| ACTIVSTYLE INC | MINNEAPOLIS | MN | 77,264.06 |
| PIONEER CENTER FOR HUMAN SRVCS | WOODSTOCK | IL | 77,168.70 |
| DOUBEK MEDICAL SUPPLY INC | ALSIP | IL | 75,987.42 |
| ALAVI DEBRA | ELGIN | IL | 75,941.75 |
| GLENOAKS HOSPITAL | GLENDALE HGTS | IL | 75,697.33 |
| SERVICIOS MEDICOS LA VILLITA | CHICAGO | IL | 74,000.22 |
| COMMUNITY HEALTHCARE SERVICES | LOMA LINDA | CA | 73,809.26 |
| MERCY HOSPITAL MEDICAL CENTER | CHICAGO | IL | 73,468.10 |
| MIDLAKES CLINIC | ROUND LK BEACH | IL | 72,701.73 |
| GONZALEZ VICTOR | WHEELING | IL | 72,155.98 |
| PAKRAVAN DARREN | CHICAGO | IL | 71,526.50 |
| MILORO MICHAEL | BURR RIDGE | IL | 71,071.15 |
| RIVERSIDE MED CTR | KANKAKEE | IL | 70,855.44 |
| SHERMAN HOSPITAL | ELGIN | IL | 70,523.06 |
| CORNELL INTERVENTION WOODRIDGE | WOODRIDGE | IL | 70,515.99 |
| ESPERANZA LITTLE VILLAGE | CHICAGO | IL | 69,121.26 |
| ERIE HELPING HANDS HEALTH CTR | CHICAGO | IL | 68,893.48 |
| ST ALEXIUS MEDICAL CENTER | HOFFMAN ESTATES | IL | 67,906.53 |
| DUPAGE MNTL HLTH CRISIS UNIT | LOMBARD | IL | 67,662.02 |
| REHABILITATION INSTITUTE | CHICAGO | IL | 65,912.79 |
| ROSECRANCE INC | ROCKFORD | IL | 65,849.39 |
| PRESENCE MERCY MEDICAL CENTER | AURORA | IL | 65,367.48 |
| FAMILY SERVICE ASSOCIATION | ELGIN | IL | 65,020.34 |
| COMM UNIT SCH DIST 300 | CARPENTERSVILLE | IL | 64,726.21 |
| BOND DRUG COMPANY OF ILLINOIS | CHICAGO | IL | 64,046.82 |
| CRUSADER CLINIC | ROCKFORD | IL | 64,012.24 |
| MIDWEST HEALTHCARE ASSOCIATES | AURORA | IL | 64,008.95 |
| A2CL SERVICES LLC | WEST ALLIS | WI | 63,735.41 |
| AUNT MARTHAS HEALTH CENTER | AURORA | IL | 62,605.73 |
| SIDDIQUI ZAKI | CHICAGO | IL | 62,224.59 |
| THE PAVILION FOUNDATION | CHAMPAIGN | IL | 61,578.23 |
| AUNT MARTHAS CARPENTERSVILLE | CARPENTERSVILLE | IL | 61,271.99 |
| DOUBEK PHARMACY INC | ALSIP | IL | 61,218.30 |
| WILLIAMS JILADA | MAYWOOD | IL | 60,875.39 |
| CHACON JOSE | AURORA | IL | 60,120.70 |

Appendix E

**TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000**

Fiscal Year 2014

| Provider Name | City | State | Total Amount Paid |
|---|---|---|---|
| BOND DRUG COMPANY OF IL 03078 | WAUKEGAN | IL | $59,884.87 |
| ERIE DENTAL HEALTH CENTER | CHICAGO | IL | 59,686.77 |
| ADA S MCKINLEY COMMUNITY SVCS | CHICAGO | IL | 59,364.08 |
| KEDZIE FAMILY HEALTH CENTER | CHICAGO | IL | 59,070.92 |
| EDWARDS HEALTHCARE SERVICES | HUDSON | OH | 58,748.94 |
| LURIE CHILDRENS HOSPITAL | CHICAGO | IL | 58,737.17 |
| LAKE CO MNTL HLTH WAUKEGAN | WAUKEGAN | IL | 58,723.17 |
| CRUSADER CLINIC BELVIDERE | BELVIDERE | IL | 57,856.14 |
| EDWARD HOSPITAL | NAPERVILLE | IL | 57,685.64 |
| LURIE CHILDRENS HOSPITAL | CHICAGO | IL | 56,949.54 |
| SHIELD DENVER HLT CARE CTR INC | ELMHURST | IL | 56,615.71 |
| PCC COMM WELLNESS CENTER | OAK PARK | IL | 55,175.72 |
| BOND DRUG COMPANY OF IL 4502 | CARPENTERSVILLE | IL | 55,138.59 |
| CHUNG DONN | NORTHBROOK | IL | 54,949.95 |
| CONTINUUM PEDIATRIC NURSING | ROLLING MEADOWS | IL | 54,943.50 |
| ALIVIO MEDICAL CENTER | CHICAGO | IL | 54,912.69 |
| KEDZIE FAMILY HEALTH CENTER | CHICAGO | IL | 54,653.97 |
| SUKAVACHANA ORAWAN | ELGIN | IL | 54,457.69 |
| CENTRAL DUPAGE HOSPITAL | WINFIELD | IL | 54,136.03 |
| LOGAN SQUARE HLTH CTR COOK CO | CHICAGO | IL | 53,889.25 |
| KEDZIE FAMILY HEALTH CENTER | CHICAGO | IL | 53,861.78 |
| LABORATORY CORPORATION AMERICA | BURLINGTON | NC | 53,685.33 |
| GANDELSMAN GENRIKH | LINDENHURST | IL | 53,441.65 |
| ADVOCATE SHERMAN HOSPITAL | ELGIN | IL | 53,217.79 |
| SIARGOS BARBARA | CHICAGO | IL | 52,912.10 |
| MS LAWNDALE CHRISTIAN HLTH CTR | CHICAGO | IL | 52,735.39 |
| ALDALLAL NADA | CHICAGO | IL | 52,473.30 |
| APOGEE HEALTH PARTNERS INC | CHICAGO | IL | 51,735.23 |
| WEST CHICAGO FAMILY HEALTH CTR | WEST CHICAGO | IL | 51,657.09 |
| CENTRO DE SALUD ESPERANZA | CHICAGO | IL | 51,195.52 |
| VNA HEALTH CARE | AURORA | IL | 50,741.58 |
| SAINTS MARY AND ELIZABETH HP | CHICAGO | IL | 50,398.51 |
| ADVENTIST BOLINGBROOK HOSPITAL | BOLINGBROOK | IL | 50,295.11 |

Note: Duplicate providers found on this list had different provider numbers within the data provided, and therefore, were not combined in this appendix.

Source: FY14 data provided by HFS.

# APPENDIX F
# Illinois Orthodontic Criteria Index Form

DentaQuest

First Review ___
Second Review ___

IL HFS Dental Program

Models ___
Orthocad ___
Ceph Films ___
X-Rays ___
Photos ___
Narrative ___

DENTAQUEST

ORTHODONTIC CRITERIA INDEX FORM – COMPREHENSIVE D8080

Patient Name: _____ DOB: _____

| ABBREVIATIONS | CRITERIA for Permanent Dentition | YES | NO |
|---|---|---|---|
| DO | Deep impinging overbite that shows palatal impingement causing tissue trauma with the majority of lower incisors. | | |
| AO | True anterior openbite. (Not including one or two teeth slightly out of occlusion or where the incisors have not fully erupted and not correctable by habit therapy). | | |
| AP | Demonstrates a large anterior –posterior discrepancy. (Class II and Class III malocclusions that are virtually a full tooth Class II or Class III). | | |
| AX | Anterior crossbite. (Involves more than two teeth and in cases where gingival stripping from the crossbite is demonstrated and not correctable by limited ortho treatment). | | |
| PX | Posterior transverse discrepancies. (Involves several posterior teeth in crossbite, one of which must be a molar and not correctable by limited ortho treatment). | | |
| PO | Significant posterior openbites. (Not involving partially erupted teeth or one or two teeth slightly out of occlusion and not correctable by habit therapy). | | |
| IMP | Impacted incisors or canines that will not erupt into the arches without orthodontic or surgical intervention. (Does not include cases where incisors or canines are going to erupt ectopically). | | |
| CR | Crowding of 7 – 8 mm in either the maxillary or mandibular arch. | | |
| OJ | Overjet in excess of 9 mm. | | |
| CDD | Dentition exhibits a profound impact from a congenital or developmental disorder. | | |
| FAS | Significant facial asymmetry requiring a combination orthodontic and orthognathic surgery for correction. | | |

APPROVED: ☐

When all are answered "NO", please refer to the Salzmann ☐

Kathie Arena, DDS David Bogenschutz, DDS Thomas Gengler, DDS James Thommes, DDS

Richard Nellen, DDS Paul Schulze, DDS B.N Marchese, DDS Scott Charmoli, DDS

# APPENDIX G
# Agency Responses

ILLINOIS DEPARTMENT OF
HFS Healthcare and Family Services

Bruce Rauner, Governor
Felicia F. Norwood, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
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November 19, 2015

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 "Covering ALL KIDS Health Insurance 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,

SIGNED ORIGINAL ON FILE

Felicia F. Norwood
Director

E-mail: hfs.webmaster@illinois.gov

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**Attachment Response**
**Report: Covering ALL KIDS Health Insurance Program**

**Recommendation Number 1: Redeterminations not completed in FY14**

The Department of Healthcare and Family Services and the Department of Human Services should annually redetermine ALL KIDS eligibility as required by the Covering ALL KIDS Health Insurance Act.

**Response:**
The Department accepts the recommendation. HFS and DHS lack the staff to complete all of the redeterminations that are due each month. The new Integrated Eligibility System (IES) Phase 2 implementation will incorporate case maintenance activities into IES. Having both new application processing, redeterminations and other case maintenance activities in one system will be more efficient and allow more flexibility to complete of all of the work. After Phase 2 is implemented it will take time to catch up on delayed redeterminations.

**Recommendation Number 2: 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 and ensuring that enrollees are not enrolled in ALL KIDS more than once.

**Response:**
The Department accepts the recommendation. While coverage is ended systematically for most children when they turn 19, there are some situations, such as pregnancy due date coded on the case, that allow coverage as a child to continue until it is manually reviewed by a caseworker. Implementation of Phase 2 of the Integrated Eligibility System will remove the need for a manual review to end or change coverage in most situations that have resulted in covering individuals as children beyond the month they turn 19.

**Recommendation Number 3: Classification of Documented Immigrants**

The Department of Healthcare and Family Services and the Department of Human Services should:

- ensure policies and procedures used to classify enrollees as a documented immigrant or undocumented immigrant, contain specific instructions for caseworkers to make accurate eligibility decisions;

- consider implementing an electronic edit within the Integrated Eligibility System (IES) that prevents enrollees with citizenship or immigration documentation from being classified as undocumented;

- ensure that documented immigrants are classified correctly in its database; and,

- ensure that the State receives federal matching funds for all eligible recipients and ensure that federal matching funds are not received for ineligible recipients.

**Response:**
The Department accepts the recommendation. Additional instructions related to clearances and verifications, including those for related to immigration status, have been provided to staff. In addition, edits within IES regarding immigration status will be reviewed after Phase 2 implementation.

**Recommendation Number 4: Eligibility Documentation**

Department of Healthcare and Family Services and the Department of Human Services should:

- ensure 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 that eligibility is determined correctly.

**Response:**
The Department accepts the recommendation. While electronic means of verification implemented over the past few years have helped, they only work for those who provide an SSN. The Department will promulgate rules to require verification of date of birth for children. The Department will also provide regular reminders to caseworkers regarding income verification requirements including checking electronic sources for wage data report by employers for individuals reporting they are self-employed.

**Recommendation Number 5: Policies over Orthodontic Treatment**

The Department of Healthcare and Family Services should:

- ensure DentaQuest is receiving and maintaining documentation needed to support orthodontia approvals;

- examine and address the issues raised by the OIG in its review of orthodontic claims; and

- more effectively monitor the actions taken by DentaQuest (the State's contractual Dental Program Administrator).

**Response:**
The Department accepts the recommendation. The Department conducts various monitoring activities for the DentaQuest contract and also receives and reviews an annual Service Control Organization report outlining any control issues noted by independent auditors; however, there have been significant changes in staff in the bureau that oversees the dental program. The Department will remind DentaQuest that they must maintain documentation according to our record retention policies. The Department will also review the issues raised by the OIG and take appropriate action.

Illinois Department of Human Services

**Bruce Rauner,** *Governor*

**James T. Dimas,** *Secretary-designate*

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

November 19, 2015

William G. Holland,
Auditor General
Office of the Auditor General
740 East Ash
Springfield, Illinois 62703-3154

Dear Mr. Holland:

Attached is the Department of Human Services' (DHS) response to the recommendations included in the draft report of the sixth annual audit of the Covering ALL KIDS Health Insurance program:

**Finding Statement: REDETERMINATION OF ELIGIBILITY**
During our review of all eligibility redeterminations for EXPANDED ALL KIDS recipients made in FY14, we found that HFS and DHS did not complete redeterminations of eligibility **annually** for all recipients as required by Covering ALL KIDS Health Insurance Act.

**Recommendation Number - 1:**
The Department of Healthcare and Family Services and the Department of Human Services should annually re-determine ALL KIDS eligibility as required by Covering ALL KIDS Health Insurance Act.
**Department Response:**
The Department agrees with the recommendation. In State Fiscal Year 2014, DHS faced several significant challenges that affected our ability to re-determine eligibility in a timely manner. First, the attrition of a large number of field staff in the previous years had not been replaced. During FY 2014, a concerted effort was made to begin replacing these staff and several hundred staffs were hired. Although on board, these staffs, having no previous background in our program policies, required substantial programmatic training in order to fulfil their job duties, negatively affecting timeliness of redeterminations.

Also, beginning during this audit period, specifically 2/1/14, a new redetermination process began. The Department's contracted vendor, Maximus, developed the Max-IL system, which uses electronic data matching to verify income, residency, citizenship status, and SSN. Max-IL also enhances the integrity of the program by using its ability to store copies of all redetermination forms mailed to the customer, returned redeterminations, electronic data matching results, requests for missing information and verifications provided by the client.

During this same time period, DHS began to implement the new Integrated Eligibility System (IES) to complete initial applications. All staff had to be out of the office again in order to learn the new functionality of the system and be able to process applications. Additionally, in November 2013, we began open enrollment for the first ever Affordable Care Act medical insurance program which inflated our application volume to unprecedented levels. This new system combined with a new program and budgeting methodology created huge backlogs in processing which took over a year to reduce. These delays in intake processing also required that we allocate resources from the service coordination departments to assist which left fewer people to process redeterminations.

Our development of the IES has created enhancements for initial applications and when fully implemented, will also provide increased redetermination efficiencies. As the development of IES is completed, many medical cases that can have eligibility factors determined electronically will be automatically re-determined, allowing casework staff to perform redetermination tasks on other types of cases.

The Department continues to search for ways in which to improve the redetermination process. Although many of the issues described above contributed to the unsatisfactory redetermination performance in FY14, they will result in better performance in the future. The long term benefits of developing and implementing the new systems, and the investment in ensuring staff are properly trained, outweigh the short term performance results.

**Finding Statement: CLASSIFICATION OF DOCUMENTED IMMIGRANTS**

During our review of 40 recipients that were re-determined during May or June 2014, we found eight coded as undocumented even though the enrollees had a verified social security number. As a result, the enrollees likely should not have been classified as undocumented.

**Recommendation Number - 3:**

The Department of healthcare and family Services and the Department of Human Services should:

- Ensure policies and procedures used to classify immigrant contain specific instructions for caseworkers to make accurate eligibility decisions;
- Consider implementing an electronic edit within the Integrated Eligibility System (IES) that prevents enrollees with citizenship or immigration documentation from being classified as undocumented;
- Ensure that undocumented immigrants are classified correctly in its database; and
- Ensure that the State receives federal matching funds for all eligible recipients and ensure that federal matching funds are not received for ineligible recipients.

**Department Response:**

The Department agrees with the recommendation. As a result of the audit, the Department will issue clarifications on the proper classifications of undocumented and documented immigrants. We will also explore the feasibility of creating a messaging system to alert a worker that the classification may conflict with another piece of information entered into the eligibility system. This will require the cooperation of Deloitte, the system development contractor.

The Department will develop a mandatory refresher training for casework staff that specifically addresses the proper classification of the immigration status of our applicants.

**Finding Statement: ELIGIBILITY DOCUMENTATION**
During our testing, we reviewed all 40 new cases in IES to determine whether all required eligibility documentation was obtained or reviewed. Of the 40 cases reviewed, 31 were missing at least one piece of required documentation (verification of residency, birth/age, or income).

**Recommendation Number - 4:**
The Department of Healthcare and Family Services and the Department of Human Services should:

- Ensure 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 that eligibility is determined correctly

**Department Response:**
The Department agrees with the recommendation. Eligibility documentation continues to be an important piece of training for new casework staff. Several factors contributed to the lack of documentation of eligibility factors in some of the tested cases.

The population tested has been a historically difficult population to test. The population is defined as children with no immigration status documentation, now receiving All Kids medical coverage. Many of their parents don't qualify for coverage, nor do they have SSNs, which results in the reliance of paper documentation.

In May and/or June 2014, both systems used in new approvals and redeterminations – IES and MAX-IL - were relatively new. Training of new staff and re-training of existing staff was still being executed, equipment and software was still being delivered and learned, and at that time the Department was in the midst of intense transition to new systems that are replacing decades old systems.

Changing the direction of the Department's eligibility and redetermination of eligibility processes for a statewide program that assists approximately 3.3 million people arrived with challenges, including the gathering, indexing, scanning, and uploading of eligibility documentation for a small population for which we cannot use the new system's electronic verification enhancement. Other recent audits that have tested cases within the new system have shown that after the initial start up challenges, documentation within the system is still not without the potential for improvement, but significantly better than during the time period for this audit.

There was also evidence of improvement seen during the audit, but for a timeframe outside the audit. As mentioned before, the audit period was May/June 2014. When the cases were tested in August of 2015, there were cases that had the necessary documentation present, however it was not present during the audit period of May/June 2014.

The systems tested in the audit were developed to handle the majority of the Department's clientele, who have SSNs and have some type of documented citizenship status. The audit reviewed a sample of cases from a small population (the undocumented immigration status children) that consists of approximately 1.5% of the total DHS client population. Although we agree that all populations that we serve are important, system designs and system training prudently focuses more heavily on the bulk of the population served.

The Department will develop refresher training for casework staff that specifically addresses proper eligibility documentation, including scanning and uploading of eligibility documents into the new systems.

If you have any questions, please contact Jane Hewitt, Chief Internal Auditor at 217/558-6931 or jane.hewitt@illinois.gov.

Sincerely,

SIGNED ORIGINAL ON FILE

James T. Dimas,
Secretary - designate

cc: Jane Hewitt
Diane Grigsby-Jackson
Paul Thelen