STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT OF THE COVERING ALL KIDS HEALTH INSURANCE PROGRAM

DECEMBER 2017

FRANK J. MAUTINO

AUDITOR GENERAL

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OFFICE OF THE AUDITOR GENERAL
FRANK J. MAUTINO

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

This is our 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
December 2017

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

REPORT DIGEST

PROGRAM AUDIT

For the Year Ended:
June 30, 2016

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EXECUTIVE SUMMARY

Covering ALL KIDS Health Insurance Program

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. This is the **eighth** annual audit (FY16), 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. HFS and DHS agreed with all five recommendations in the audit report.

1. In FY16, there were 106,447 enrollees at any point in EXPANDED ALL KIDS and the total cost of services provided was $97.2 million.
2. The total number of recipients as of June 30th was 66,258 in FY15 and 67,776 in FY16. In FY16, the number of citizen/documented immigrants slightly increased while the number of undocumented immigrants slightly decreased.
3. Of the 28,588 EXPANDED ALL KIDS recipients that required an annual redetermination of eligibility in FY16, we found 2,104 (7%) were not redetermined annually as required.
4. In FY16, 159 recipients received 793 services totaling $111,029 after the month of their 19th birthday. Additionally, there were 437 individuals who appeared to be enrolled with more than one identification number.
5. HFS and DHS did not identify the correct citizenship status for 4,521 recipients, and as a result, the State lost $2.4 million in federal matching Medicaid funds in FY16. The State also lost $2.8 million in federal reimbursement in FY15 – for a total of $5.2 million lost in federal reimbursement over the last two fiscal years. This issue has been reported since the first ALL KIDS audit, which was for FY09.
6. We tested 40 initial eligibility cases and 40 redetermined cases in FY16. We found 30 percent of initial cases, and 20 percent of redetermined cases, were coded as "undocumented" even though we found evidence supporting citizenship or documented immigrant status. We also found the following documentation problems.
   - HFS and DHS were missing at least one piece of required documentation in 78 percent of the initial eligibility cases reviewed in FY16. Of these cases, 23 percent were missing documentation to verify residency, 40 percent were missing documentation to verify birth/age, and 10 percent were missing documentation to verify one month's income.
   - HFS and DHS were missing at least one piece of required documentation in 100 percent of the redetermined cases reviewed in FY16. Of these cases, 33 percent were missing documentation to verify residency, 80 percent were missing documentation to verify birth/age, and 8 percent were missing documentation to verify one month's income.
7. We repeated the recommendation that HFS should review and monitor eligibility for orthodontic services more effectively. On January 19, 2017, HFS updated the Administrative Code related to orthodontics and the scoring tool. Since the updates occurred after FY16, follow-up will be completed during the next audit (FY17).

AUDIT SUMMARY AND RESULTS

Effective July 1, 2006, Illinois' KidCare program, which included Medicaid and State 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.

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."

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.

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.**

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 eighth annual audit (FY16).

This FY16 audit of the EXPANDED ALL KIDS program follows up on the Department of Healthcare and Family Services' and the Department of Human Services' actions to address prior audit findings. (pages 1-3)

ALL KIDS PROGRAM

The program included 106,447 EXPANDED ALL KIDS enrollees at any point during FY16, a slight increase of 4% from the previous year (FY15) when there were 102,182 enrollees.

According to HFS, in FY16, Illinois' ALL KIDS program as a whole had a total of 1.7 million enrollees and HFS paid $3.2 billion in claims. The program included 106,447 EXPANDED ALL KIDS enrollees at any point in FY16, which is a slight increase (4%) from FY15 when there were 102,182 enrollees. On June 30, 2016, there were 67,776 enrollees. Thirty-eight percent or 25,438 of the enrollees were classified as undocumented immigrants in the HFS data. Digest Exhibit 1 breaks out enrollment by fiscal year, by plan, and by whether the child was classified as a citizen/documented immigrant or as undocumented.

EXPANDED ALL KIDS PROGRAM STATISTICS		
	FY15	FY16
Enrollees at any point	102,182	106,447
Enrollees on June 30	66,258	67,776
Total Cost of Services Provided	$86,483,128	$97,230,941
Total Net Cost of Services after Premium Payments	$73,115,178	$80,793,336

Digest Exhibit 1 ENROLLMENT BY PLAN [2] For EXPANDED ALL KIDS as of June 30				
EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants	
	FY15	FY16	FY15	FY16
Assist $35,724[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		23,757	22,494
Share $38,148[1]			466	535
Premium Level 1 $50,784[1]			1,279	1,615
Premium Level 2 $77,280[1]	40,075	42,338	681	794
Totals	40,075	42,338	26,183	25,438

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 FY16.
[2] Enrollment is the total number of enrollees that were eligible on June 30 of 2015 and 2016. There were 102,182 enrollees eligible at some point during FY15 and 106,447 enrollees eligible at some point during FY16.
Source: ALL KIDS enrollment data provided by HFS.

The cost of services for EXPANDED ALL KIDS has fluctuated over the years ranging from a low of $70.0 million in FY14 to a high of $97.2 million in FY16.

According to claim data provided by HFS, the cost of services for EXPANDED ALL KIDS has fluctuated over the years ranging from a low of $70.0 million in FY14 to a high of $97.2 million in FY16. 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. The total cost for undocumented immigrants has continued to decrease each year since FY12. The total cost decreased from $55.7 million in FY12 to $38.2 million in FY16.

The cost of services has increased by more than $10 million from $86.5 million in FY15 to $97.2 million in FY16.

Digest Exhibit 2 breaks out the payments for services by whether the child had documentation for citizenship/immigration status or whether the child was classified by HFS as undocumented for both FY15 and FY16. Additionally, Digest Exhibit 2 shows the cost of services increased by more than $10 million from $86.5 million in FY15 to $97.2 million in FY16.

In the past, a large portion of the cost for services for the EXPANDED ALL KIDS program was for undocumented immigrants; however, that has not been the case the last two years. In FY09, undocumented immigrants accounted for 70 percent of the total cost for the EXPANDED ALL KIDS program. This percentage has declined since FY09 with undocumented immigrants accounting for only 39 percent of the total cost in FY16. (pages 7-16)

Digest Exhibit 2
COST OF SERVICES PROVIDED BY PLAN
For EXPANDED ALL KIDS during Fiscal Years 2015 and 2016

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals	
	FY15	FY16	FY15	FY16	FY15	FY16
Assist $35,724[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		$35,590,141	$34,836,337	$35,590,141	$34,836,337
Share $38,148[1]			$607,404	$663,817	$607,404	$663,817
Premium Level 1 $50,784[1]			$1,422,136	$1,940,735	$1,422,136	$1,940,735
Premium Level 2 $77,280[1]	$48,197,260[3]	$59,034,547[3]	$666,187	$755,504	$48,863,447	$59,790,051
Totals[2]	$48,197,260	$59,034,547	$38,285,868	$38,196,393	$86,483,128	$97,230,941

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 FY16.
[2] Totals may not add due to rounding.
[3] The federal matching rate was 88.62 percent in FY15 and FY16; therefore, the State's share for services was $5.5 million in FY15 and $6.7 million in FY16.
Source: ALL KIDS data provided by HFS.

FY16 AUDIT FINDINGS AND RECOMMENDATIONS

All five issues from our previous FY15 audit were repeated during the FY16 audit. These five recommendations included areas related to redeterminations, data reliability, classification of documented immigrants, eligibility documentation, and policies covering orthodontic treatment.

1. Redetermination of Eligibility

2,104 of the 28,588 (7%) were not redetermined annually as required by the Act.

During our review of all eligibility redeterminations for EXPANDED ALL KIDS recipients made in FY16, 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, 28,588 EXPANDED ALL KIDS recipients required a redetermination of eligibility in FY16. Our analysis of the data showed that 2,104 of the 28,588 (7%) were not redetermined annually as required by the Act. (pages 17-19)

2. ALL KIDS Eligibility Data

437 individuals appeared to be enrolled with more than one identification number.

During our review of the FY16 EXPANDED ALL KIDS eligibility data, we continued to find that eligibility data contained individuals who were over the age of 18 and who were enrolled in ALL KIDS more than once. In the FY16 data, we identified 159 recipients that received 793 services totaling $111,029 after the month of their 19th birthday. We also identified 437 individuals who appeared to be enrolled with more than one identification number. If recipients maintain eligibility after reaching the age of 19, or if recipients have eligibility under more than one recipient identification

number, the State may provide services for non-eligible recipients. (pages 19-20)

3. Classification of Documented Immigrants

During testing of eligibility determinations, 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.

As a result of the miscoding errors, the State is annually losing federal matching dollars. A total of $5.2 million was lost in federal reimbursement over the last two fiscal years (FY15 and FY16).

We determined the FY16 eligibility data contained 4,521 "undocumented" recipients who had social security numbers that were verified, of which 139 also had an alien registration number. We reviewed the services provided to the 4,521 "undocumented" recipients in FY16 and determined they had 63,001 services for a total cost of almost $4.6 million. This recommendation related to the miscoding of documented immigrant status has been an issue since the first ALL KIDS audit, which was for FY09. It continues to be an issue that has not been adequately addressed by either HFS or DHS. As a result of the miscoding errors, the State is annually losing federal matching dollars. In FY16, the total federal reimbursement lost was $2.4 million. Additionally, the State at a minimum did not collect $2.8 million in federal reimbursement in FY15 – for a total of **$5.2 million** lost in federal reimbursement over the last two fiscal years.

Initial Eligibility Testing

12 of the 40 new recipients sampled (30%) were coded as undocumented but were likely citizens or documented immigrants.

During our testing of 40 new cases that were approved during May and June 2016, we found that 12 of the cases were coded as undocumented but likely should have been coded as citizens/documented immigrants, as there was documentation to support citizenship or documented immigrant status for each of the 12 classified as undocumented. Many of the cases had documentation verifying the recipient's social security number and/or alien status. Therefore, a total of 12 of 40 recipients sampled (30%) who were coded as undocumented were likely citizens or documented immigrants. We provided these 12 to DHS, and DHS officials agreed they were likely documented.

Eligibility Testing for Redetermination

8 of the 40 redetermined recipients sampled (20%) were coded as undocumented but were likely citizens or documented immigrants.

During our review of 40 recipients that were redetermined during May or June 2016, we found 8 of the 40 recipients sampled (20%) were coded as undocumented even though the enrollees had a verified social security number supporting they were likely citizens or documented immigrants. We

provided these eight to DHS, and DHS officials agreed they were likely documented. (pages 20-22)

4. 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 cannot be utilized for the undocumented recipients in the EXPANDED ALL KIDS program. Electronic data matches and searches based on social security numbers are ineffective for the undocumented portion of 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

Residency was not verified in 9 of the 40 (23%) of the initial eligibility cases tested, and birth/age information was not verified in 16 of the 40 (40%) cases tested.

We randomly selected 40 of the 500 new cases approved during May and June 2016 and found significant issues. Residency was not verified in 9 of the 40 (23%) cases tested, and birth/age information was not verified in 16 of the 40 (40%) cases tested. Of the 40 cases tested, 21 reported having income. We found 30 days of income was not reviewed in 10 percent (2 of 21) of the cases where income was reported. Of the 40 cases reviewed, 78% were missing at least one piece of required documentation (verification of residency, birth/age, or income).

Eligibility Redetermination Testing

Residency was not verified in 13 of the 40 (33%) of the redetermination cases tested, and birth/age information was not verified in 32 of the 40 (80%) cases tested.

We also tested 40 of the medical only redeterminations that occurred during May and June 2016 and found issues regarding Illinois residency, birth/age, and income documentation. Residency was not verified in 13 of the 40 (33%) cases tested, and birth/age information was not verified in 32 of the 40 (80%) cases tested. We found 30 days of income was not reviewed in 8 percent (3 of 37) of the cases where income was reported. Of the 40 cases reviewed, 100% were missing at least one piece of required documentation (verification of residency, birth/age, or income). (pages 23-26)

5. Policies Covering Orthodontic Treatment

We repeated the recommendation that HFS should review and monitor eligibility for orthodontic services more effectively since updates occurred after the audit period for this FY16 audit. From FY10 to FY14, expenditures by the State for orthodontic services for children in EXPANDED ALL KIDS increased dramatically. 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. 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 HFS Office of the Inspector General concluded that revisions and clarifications to policies establishing medical necessity should be made, as well as requiring additional documentation to support medical necessity.

HFS agreed with this recommendation and indicated it would review the issues raised and take appropriate action. Since the FY14 audit was released in February 2016, and the audit period for the FY15 audit ended earlier on June 30, 2015, this recommendation was repeated in FY15. On January 19, 2017, HFS updated the Administrative Code related to orthodontics and the scoring tool. Since the updates occurred after FY16, follow-up will be completed during the next FY17 audit. (pages 27-29)

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. The Department of Healthcare and Family Services agreed with all five of its recommendations. Appendix F to the audit report contains the agency responses.

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

SIGNED ORIGINAL ON FILE

Ameen Dada
Division Director

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

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

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TABLE OF CONTENTS

GLOSSARY OF ACRONYMS

ACA - The Patient Protection and Affordable Care Act

AIS - Automated Intake System

AWVS - Automated Wage Verification System

CHIPRA - Children's Health Insurance Program Reauthorization Act

DHS - Illinois Department of Human Services

FPL - Federal Poverty Level

HFS - Illinois Department of Healthcare and Family Services

HHS - Federal Department of Health and Human Services

IES - Integrated Eligibility System

IMRP - Illinois Medicaid Redetermination Project

MAGI - Modified Adjusted Gross Income

OIG - Illinois HFS Office of the Inspector General

SCHIP - State Children's Health Insurance Program

SNAP - Supplemental Nutrition Assistance Program

SOLQ - State Online Query

COVERING ALL KIDS HEALTH INSURANCE PROGRAM

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. The Act requires that the audit include:

- payments for health services covered by the program; and
- contracts entered into by the Department of Healthcare and Family Services (HFS) in relation to the program.

This is the eighth annual audit (FY16), and follows up on HFS' and the Department of Human Services' (DHS) actions to address prior audit findings. The previous seven annual audits covered FY09 through FY15.

- 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; it had five new recommendations and three new areas added to previous 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.
- The sixth audit (FY14) was released in February 2016 and contained 5 recommendations.
- The seventh audit (FY15) was released in August 2016 and contained 5 recommendations.

Seven Years of Audit Recommendations

Many of the recommendations during the past seven years have centered on eligibility and annual eligibility redeterminations. Other recommendations have included areas such as:

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

The recommendation related to the miscoding of documented immigrants has been an issue since the first ALL KIDS audit, which was for FY09 and was released in May 2010. As a result of the miscoding errors, the State is annually losing federal matching dollars. The total reimbursement lost was $2.8 million in FY15 and $2.4 million in FY16 – for a total of **$5.2 million** lost in federal reimbursement over the last two fiscal years.

HISTORY OF THE ALL KIDS AUDITS CONDUCTED BY THE OAG

Effective July 1, 2006, Illinois' KidCare program, which included Medicaid and State 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**.

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 (prior to FY07) 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 ALL KIDS 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, 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 rules were established for 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.

STATE STATUTES RELATED TO ALL KIDS

The Covering ALL KIDS Health Insurance Act (215 ILCS 170) was effective July 1, 2006. The Act expanded program benefits to cover **all uninsured children** in families regardless of family income. The provisions in the Act prior to the passage of Public Act 96-

1501 **defined a child as a person under the age of 19**. The eligibility requirements for the program prior to PA 96-1501 (signed on January 25, 2011) 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 (July 1, 2006) expanded program benefits to cover all uninsured children in families regardless of family income. Thus, children whose family income was greater than 200 percent of the FPL and undocumented immigrant children at any income level were eligible. As discussed later, the Act was amended in January 2011 to limit some of the children originally added.

Note: the Covering ALL KIDS Health Insurance Act is scheduled to be repealed on October 1, 2019.

ILLINOIS ADMINISTRATIVE CODE FOR ALL KIDS

The Illinois Administrative Code (89 Ill. Adm. Code 123) implements the Covering ALL KIDS Health Insurance Act. The administrative 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.

CHANGES AFFECTING THE AUDIT

Public Act 96-1501 was passed by the General Assembly and 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 Act included:

- effective July 1, 2011, requiring verification of Illinois **residency**;
- 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); and
- effective October 1, 2011, requiring verification of one month's income for **determining continued eligibility** (instead of using passive redetermination).

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 FPL were no longer eligible. However, children enrolled as of July 1, 2011, could remain enrolled in the program until June 30, 2012.

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 the following, which are detailed below.

1) The Covering ALL KIDS Health Insurance Act was changed to limit the household income to be eligible for the EXPANDED ALL KIDS program.

The first was the passage of Public Act 96-1501, which added an income limit for determining eligibility for the EXPANDED ALL KIDS program. Effective July 1, 2011, children whose families' household income was above 300 percent of the 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 are fewer EXPANDED ALL KIDS participants and expenditures to be audited.

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

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). 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 the federal 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).

Until the FY13 audit, our prior EXPANDED ALL KIDS audits had only included children whose medical care was totally State-funded. In FY13 and FY14, with this change, the federal government reimbursed 65 percent of eligible costs for this population (children from families with income between 200 and 300 percent of FPL). Additionally, in FY13, the State was granted retroactive reimbursement dating back to July 1, 2008. Now, in FY16, the reimbursement rate for the Premium Level 2 recipients increased to 88.62 percent due to provisions found in the Patient Protection and Affordable Care Act (ACA). According to HFS officials, as of June 30, 2016, HFS had recouped a total of **$64.6 million** from the federal HHS.

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 **$35.6 million** was recouped from the federal HHS as of June 30, 2016.

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

The third event affecting our audit is 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.

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

The fourth and most recent change requires a new budgeting methodology for determining ALL KIDS eligibility. The ACA 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. 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 its medical programs. On October 1, 2013, HFS and DHS began using MAGI budgeting standards for new applications received. In addition, MAGI rules for redeterminations became effective on April 1, 2014. The MAGI methodology applies to several groups including children under 19 in ALL KIDS Assist, Share, and Premium.

The ACA required states to convert income standards and take into account that certain types of income (i.e., child support, worker's compensation, educational scholarships and grants, veteran's benefits, and supplemental security income (SSI)) that will no longer apply under the MAGI budgeting methodology. Additionally, standards must be based on FPLs that were in effect in March 2010. According to DHS officials, the hardest part of determining eligibility is

applying the MAGI budgeting methodology. MAGI budgeting determines how to count income and who to include in the income standard or Eligibility Determination Group (EDG). The MAGI budgeting methodology documents:

- how to count income is based on federal tax rules for determining adjusted gross income with some modifications; and

- who to include in each person's EDG is determined by one of two sets of rules: tax filer rules or relationship rules.

As shown in Exhibit 1, in FY13, a family of four qualified for ALL KIDS Assist at 133 percent of the federal poverty level (FPL) ($31,321.50 annually); however, the same family of four qualified at 147 percent of the FPL in subsequent years ($35,064 annually in FY14, $35,652 annually in FY15, $35,724 annually in FY16). 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 FPL income guidelines for a family of four by plan for each of the last four fiscal years. The FY13 figures are prior to the implementation of the MAGI standards.

Exhibit 1
ANNUAL FEDERAL POVERTY LEVEL (FPL) FOR FAMILY OF FOUR
Fiscal Years 2013 – 2016

EXPANDED ALL KIDS Plan	FY13 Percent of FPL	Annual FY13 Maximum Income	FY14 - FY16 Percent of FPL[1]	Annual Maximum Income[1]		
				FY14	FY15	FY16
Assist	133%	$31,321	147%	$35,064	$35,652	$35,724
Share	150%	$35,325	157%	$37,440	$38,076	$38,148
Premium Level 1	200%	$47,100	209%	$49,848	$50,688	$50,784
Premium Level 2	300%	$70,650	318%	$75,840	$77,112	$77,280

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

Source: DHS eligibility documentation.

Revised Initial Eligibility Determination

On October 1, 2013, HFS and DHS replaced the Automated Intake System (AIS) with the newly created 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. 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 or clearances (listed below) to verify eligibility. Client social security numbers are used to extract information. The following sources are examples where information can be extracted.

- **Federal Data Hub** –used to verify U.S. citizenship and immigration status;
- **State Online Query (SOLQ)** –used to verify social security numbers, date of birth, date of death, and current federal benefits from Social Security Administration information; and
- **Automated Wage Verification System (AWVS)** –used to verify income and unemployment benefits from the Illinois Department of Employment Security.

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. The Max-IL system collects electronic data from various sources about the case and makes an automated recommendation about ongoing eligibility.

Although the third party vendor no longer helps make eligibility redeterminations, the vendor 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 to determine income, residence, and citizenship.

ALL KIDS PROGRAM

According to HFS, in FY16, Illinois' ALL KIDS program as a whole had a total of 1.7 million enrollees and HFS paid $3.2 billion in claims. The program included 106,447 EXPANDED ALL KIDS enrollees **at any point** in FY16, which is a slight increase (4%) from FY15 when there were 102,182 enrollees (see text box.)

EXPANDED ALL KIDS PROGRAM STATISTICS

	FY15	FY16
Enrollees at any point	102,182	106,447
Enrollees on June 30	66,258	67,776
Total Cost of Services Provided	$86,483,128	$97,230,941
Total Net Cost of Services after Premium Payments	$73,115,178	$80,793,336

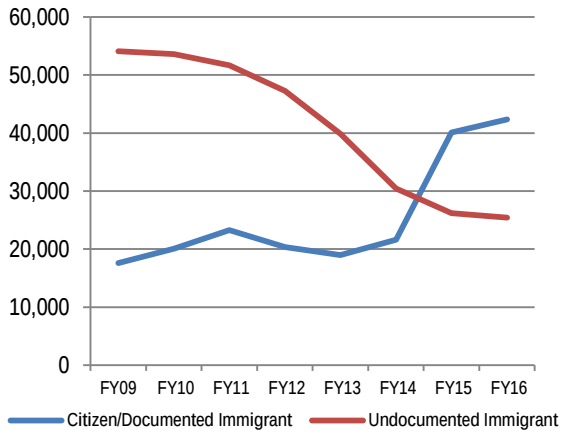
The number of EXPANDED ALL KIDS enrollees at the end of the fiscal year did not significantly change from FY15 to FY16. On June 30, 2015, there were 66,258 enrollees. On June 30, 2016, there were 67,776 enrollees. Therefore, there was only a slight increase of 1,518 in enrollees.

ALL KIDS Enrollment

As shown in Exhibits 2 and 3, the number of undocumented immigrants enrolled as of June 30 declined each year after 2009. Conversely, the number of citizen/documented immigrant EXPANDED ALL KIDS recipients (Premium Level 2) increased each year after 2013. The number of citizen/documented immigrants remained fairly consistent at around 20,000 from FY09 through FY14.

The number of citizen/documented immigrant recipients (Premium Level 2) increased significantly from 21,634 in FY14 to 40,075 in FY15. Although DHS and HFS provided explanations for this increase, the FY15 ALL KIDS audit performed additional testing in this area and found no clear reason why this increase occurred. In FY16, the increase in the number of citizen/documented immigrant recipients was not as significant. The number of citizen/documented immigrant recipients (Premium Level 2) only slightly increased from 40,075 recipients in FY15 to 42,338 recipients in FY16.

Exhibit 2
EXPANDED ALL KIDS ENROLLMENT
As of June 30 for Fiscal Years 2009 - 2016



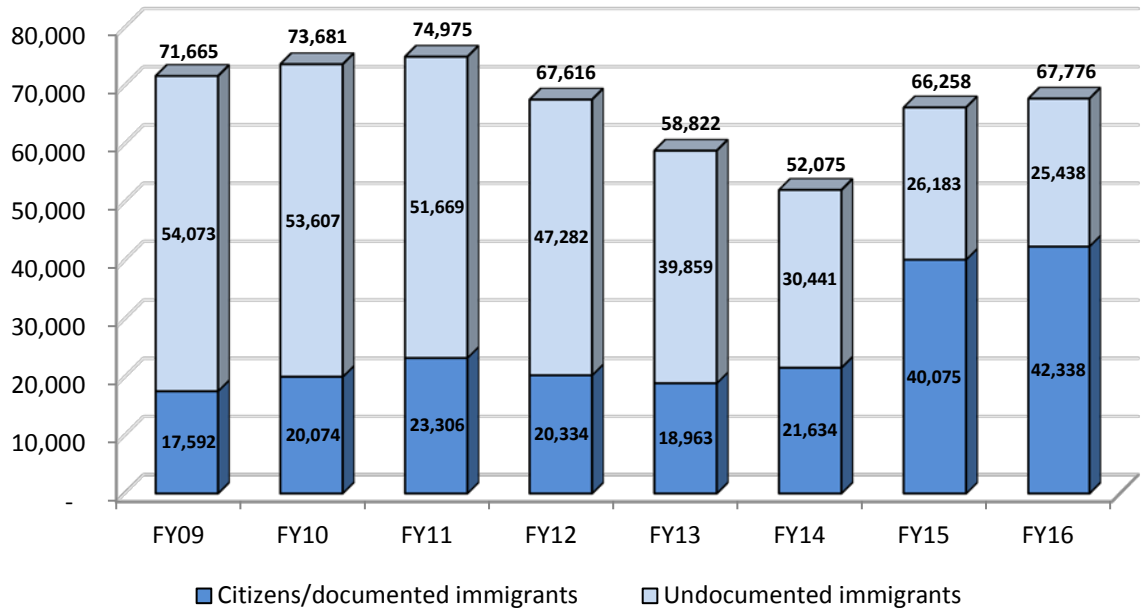
Source: ALL KIDS enrollment data provided by HFS.

Until the number of citizen/documented immigrant recipients increased in FY15, total enrollment had decreased from FY11 until FY15. There was a 22,900 enrollee decrease from FY11 to FY14, some of which was due to the elimination of Premium Levels 3 through 8 after June 30, 2012, as required by PA 96-1501. Premium Levels 1 and 2 were not eliminated by PA 96-1501.

In total, as seen in Exhibit 3, the number of citizen/documented immigrant recipients increased while the total number of undocumented recipients decreased from FY09 to FY16.

- The number of citizen/documented immigrant recipients **increased** from 17,592 in FY09 to 42,338 in FY16 (141%).
- The number of undocumented recipients **decreased** from 54,073 in FY09 to 25,438 in FY16 (53%).

Exhibit 3
ENROLLEES AS OF JUNE 30
For EXPANDED ALL KIDS during Fiscal Years 2009 - 2016

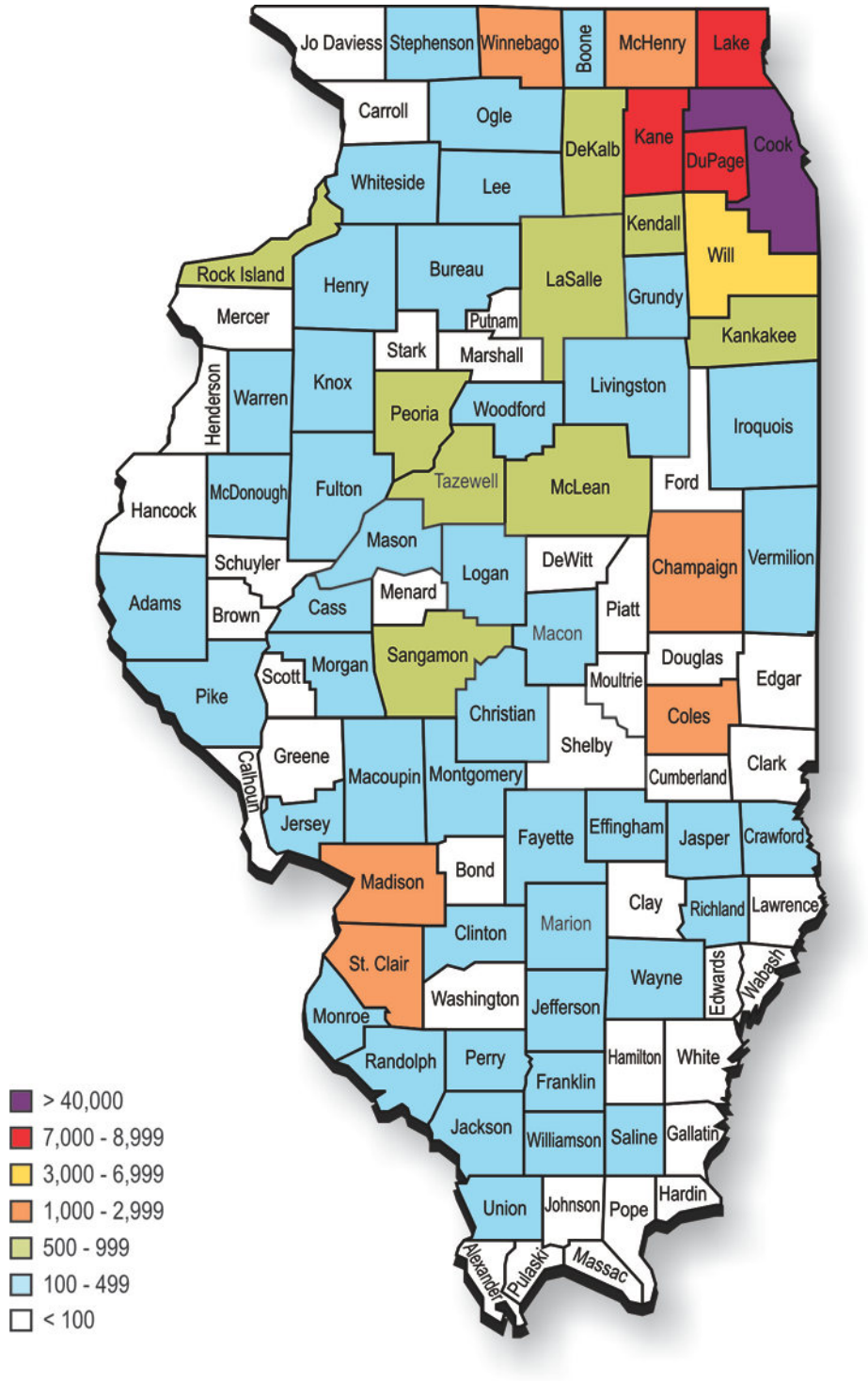


Source: ALL KIDS data provided by HFS.

ALL KIDS Enrollees by County

Exhibit 4 shows the number of EXPANDED ALL KIDS enrollees by county. As seen in this exhibit, the majority of enrollees in FY16 lived in Cook County (48,121). The other counties with large populations of EXPANDED ALL KIDS enrollees included: DuPage (8,582), Lake (7,751), Kane (7,552), and Will (4,891).

Exhibit 4
EXPANDED ALL KIDS ENROLLMENT BY COUNTY
Fiscal Year 2016



Source: FY16 eligibility data provided by HFS.

Enrollment by ALL KIDS Plan

Exhibit 5 breaks out enrollment by plan, fiscal year, and by whether the child was classified as a citizen/documented immigrant or as undocumented for FY15 and FY16. As noted previously, the total number of EXPANDED ALL KIDS enrollees slightly increased from 66,258 in FY15 to 67,776 in FY16. Although the total number increased, there was a slight decrease in the number of undocumented immigrants from FY15 to FY16. The HFS data classified 26,183 (40%) as undocumented immigrants in FY15 and 25,438 (38%) as undocumented immigrants in FY16. Appendix B shows the ALL KIDS premium and co-pay requirements by plan during FY16.

Exhibit 5
ENROLLMENT BY PLAN [2]
For EXPANDED ALL KIDS as of June 30

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants		Totals	
	FY15	FY16	FY15	FY16	FY15	FY16
Assist $35,724[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		23,757	22,494	23,757	22,494
Share $38,148[1]			466	535	466	535
Premium Level 1 $50,784[1]			1,279	1,615	1,279	1,615
Premium Level 2 $77,280[1]	40,075	42,338	681	794	40,756	43,132
Totals	40,075	42,338	26,183	25,438	66,258	67,776

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 FY16.

[2] Enrollment is the total number of enrollees that were eligible on June 30 of 2015 and 2016. There were 102,182 enrollees eligible at some point during FY15 and 106,447 enrollees eligible at some point during FY16.

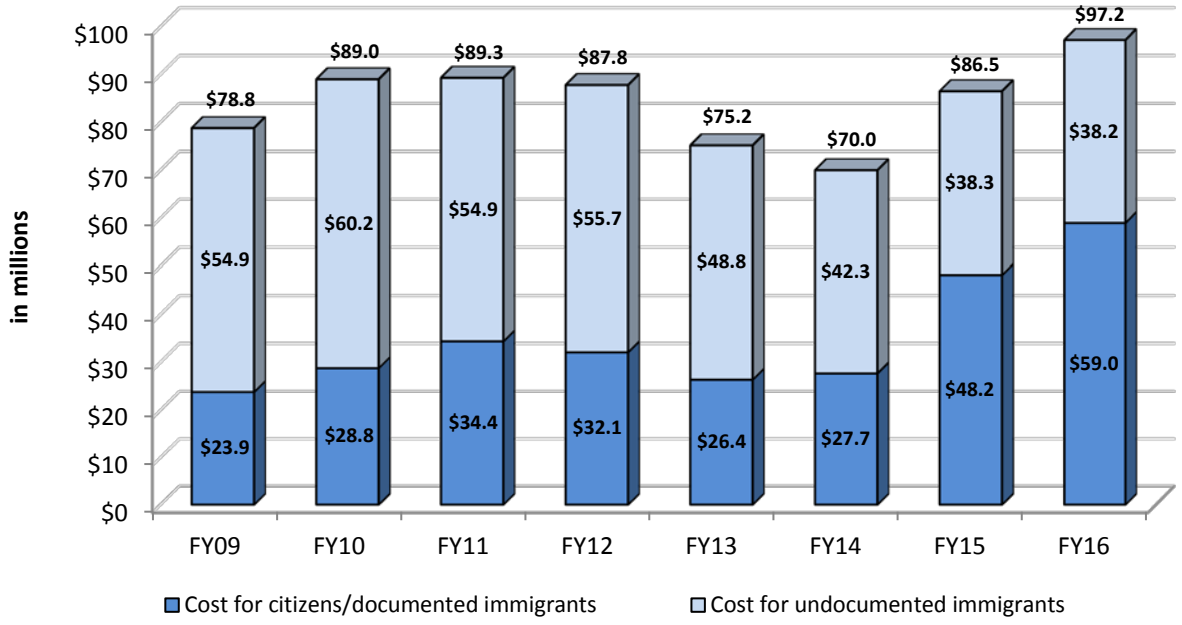
Source: ALL KIDS enrollment data provided by HFS.

COST OF ALL KIDS SERVICES PROVIDED

According to claim data provided by HFS, the cost of services for EXPANDED ALL KIDS has fluctuated over the years ranging from a low of $70.0 million in FY14 to a high of $97.2 million in FY16. Exhibit 6 shows the total cost of services for each year as well as the cost broken down between two categories: 1) citizens and documented immigrants; and 2) undocumented immigrants.

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. The total cost for undocumented immigrants has continued to decrease each year since FY12. The total cost decreased from $55.7 million in FY12 to $38.2 million in FY16.

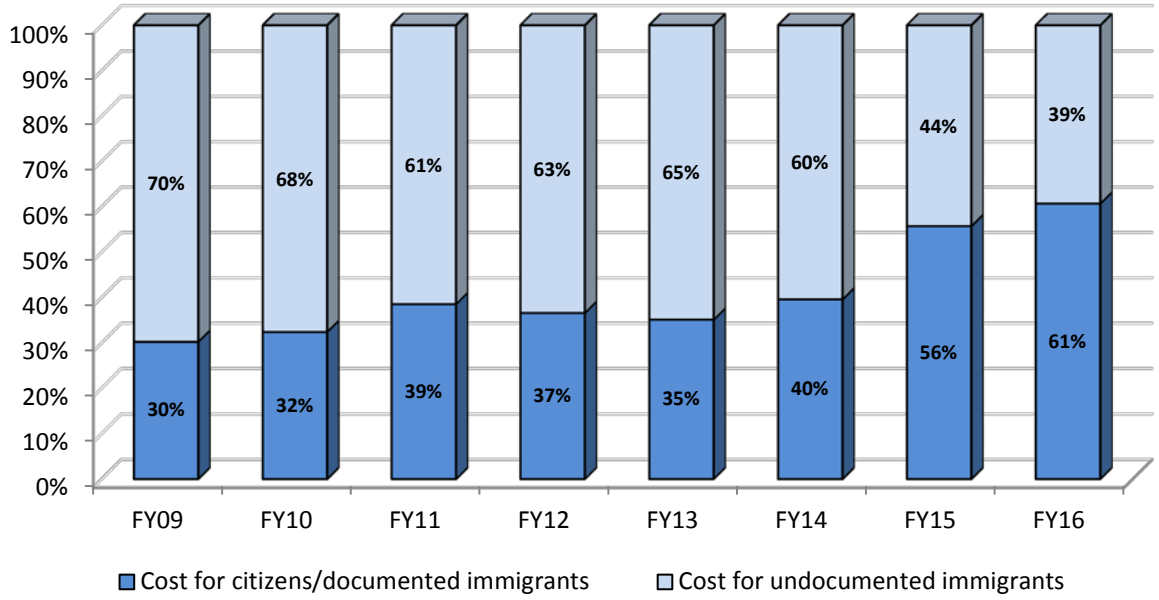
Exhibit 6
COST OF SERVICES
For EXPANDED ALL KIDS during Fiscal Years 2009 - 2016



Source: ALL KIDS data provided by HFS.

In the past, a large portion of the cost for services for the EXPANDED ALL KIDS program was for undocumented immigrants; however, that has not been the case the last two years. Exhibit 7 shows the percentage of total cost for the two categories mentioned above: 1) citizens and documented immigrants; and 2) undocumented immigrants. In FY09, undocumented immigrants accounted for 70 percent of the total cost for the EXPANDED ALL KIDS program. This percentage has declined since FY09 with undocumented immigrants accounting for only 39 percent of the total cost in FY16.

Exhibit 7
PERCENTAGE OF TOTAL COST OF SERVICES
For EXPANDED ALL KIDS during Fiscal Years 2009 - 2016



Source: ALL KIDS data provided by HFS.

Exhibit 8 breaks out the payments for services by whether the child had documentation for citizenship/immigration status or whether the child was classified by HFS as undocumented for both FY15 and FY16. Additionally, Exhibit 8 shows the cost of services increased by more than $10 million from $86.5 million in FY15 to $97.2 million in FY16.

Exhibit 8
COST OF SERVICES PROVIDED BY PLAN
For EXPANDED ALL KIDS during Fiscal Years 2015 and 2016

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals	
	FY15	FY16	FY15	FY16	FY15	FY16
Assist $35,724[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		$35,590,141	$34,836,337	$35,590,141	$34,836,337
Share $38,148[1]			$607,404	$663,817	$607,404	$663,817
Premium Level 1 $50,784[1]			$1,422,136	$1,940,735	$1,422,136	$1,940,735
Premium Level 2 $77,280[1]	$48,197,260[3]	$59,034,547[3]	$666,187	$755,504	$48,863,447	$59,790,051
Totals[2]	$48,197,260	$59,034,547	$38,285,868	$38,196,393	$86,483,128	$97,230,941

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 FY16.

[2] Totals may not add due to rounding.

[3] The federal matching rate was 88.62 percent in FY15 and FY16; therefore, the State's share for services was $5.5 million in FY15 and $6.7 million in FY16.

Source: ALL KIDS data provided by HFS.

COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE

According to data provided by HFS, 90 percent of the cost for services provided during FY16 for EXPANDED ALL KIDS was paid for 12 categories of services each totaling more than $1 million. Exhibit 9 shows the 12 categories of services which totaled $87.9 million of the $97.2 million in total EXPANDED ALL KIDS payments.

The category with the highest percentage of payments was Capitation Services at 28 percent. This category has increased since the FY15 audit when it only accounted for 15 percent of payments. HFS officials explained that this increase was due to FY16 being the first full year of mandatory managed care enrollment for all regions after beginning implementation in FY15 as a result of Public Act 96-1501. Public Act 96-1501 mandated a transition from paying for services on a fee-for-service basis to paying a per member per month capitation rate to managed care organizations for care coordination. This resulted in the increase in payments in capitation services in FY16 as seen in Exhibit 9.

The appendices for this report show additional information on the cost of services provided as follows:

- Appendix C shows EXPANDED ALL KIDS total cost of services provided by category of service during FY16.
- Appendix D shows EXPANDED ALL KIDS total cost of services provided by plan and by category of service during FY16.

- Appendix E shows FY16 providers that were paid more than $50,000 from EXPANDED ALL KIDS in FY16.

Exhibit 9
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE
Totaling more than $1 million during FY16 for the EXPANDED ALL KIDS Program

Category of Service	Total FY16 Cost	Percent of Total FY16 Cost
1. Capitation Services	$27,579,549	28%
2. Pharmacy Services (Drug and OTC)	14,912,033	15%
3. Dental Services	9,588,003	10%
4. Inpatient Hospital Services (General)	8,655,293	9%
5. Physician Services	8,181,009	8%
6. Outpatient Services (General)	6,299,423	7%
7. General Clinic Services	3,466,057	4%
8. Healthy Kids Services	2,657,056	3%
9. Inpatient Hospital Services (Psychiatric)	2,262,032	2%
10. Speech Therapy/Pathology Services	1,850,811	2%
11. Mental Health Rehab Option Services	1,369,958	1%
12. Physical Therapy Services	1,035,737	1%
Total for categories costing > than $1 million	$87,856,960	90%
Other categories totaling < than $1 million	9,373,980	10%
Total Cost for All Service Categories	$97,230,941	100%

Note: Totals may not add due to rounding.

Source: FY16 ALL KIDS data provided by HFS.

COST OF SERVICES AND PREMIUMS COLLECTED

HFS received almost $13.4 million in premiums from enrollees in FY15, and $16.4 million in FY16. As a result, the net cost of EXPANDED ALL KIDS after premium payments was $73.1 million in FY15 and almost $80.8 million in FY16. Exhibit 10 shows both FY15 and FY16 payments and premiums collected from the EXPANDED ALL KIDS programs.

Exhibit 10
COST OF SERVICES AND PREMIUM AMOUNTS COLLECTED[2]
For the EXPANDED ALL KIDS Program during Fiscal Years 2015 and 2016

EXPANDED ALL KIDS Plan	FY15 Services Provided	FY15 Premiums Collected	FY15 Net Cost	FY16 Services Provided	FY16 Premiums Collected	FY16 Net Cost
Assist $35,724[1]	$35,590,141	n/a	$35,590,141	$34,836,337	n/a	$34,836,337
Share $38,148[1]	$607,404	n/a	$607,404	$663,817	$640	$663,177
Premium Level 1 $50,784[1]	$1,422,136	$157,255	$1,264,881	$1,940,735	$213,112	$1,727,623
Premium Level 2 $77,280[1]	$48,863,447	$13,210,695	$35,652,752	$59,790,051	$16,223,852	$43,566,199
Totals[3]	$86,483,128	$13,367,950	$73,115,178	$97,230,941	$16,437,604	$80,793,336

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 FY16.

[2] This exhibit includes the cost of services before any federal reimbursement for Level 2 enrollees.

[3] Totals may not add due to rounding.

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

FY16 AUDIT FINDINGS AND RECOMMENDATIONS

All five issues from our previous FY15 audit were repeated during the FY16 audit. The next several sections of the report discuss these recommendations. As shown in Exhibit 11, the five recommendations were for areas related to redeterminations, data reliability, classification of documented immigrants, eligibility documentation, and policies covering orthodontic treatment.

Exhibit 11
STATUS OF PREVIOUS AUDIT RECOMMENDATIONS

Recommendation Area	Status of Recommendations as Reported in FY15 Audit	Follow-up Testing Necessary
1. Redetermination of ALL KIDS eligibility	Repeated	Yes
2. ALL KIDS data reliability	Repeated	Yes
3. Classification of Documented Immigrants	Repeated	Yes
4. Eligibility documentation	Repeated	Yes
5. Policies Covering Orthodontic Treatment [1]	Repeated	Yes

Note: [1] Since the Administrative Code related to orthodontics and the scoring tool became effective **after** FY16, follow-up will be completed during the next audit.

As part of our fieldwork testing for this audit, we took two samples from the EXPANDED ALL KIDS program which consisted of the following:

1) a sample of 40 randomly selected new EXPANDED ALL KIDS cases from FY16, that were reviewed by DHS or HFS during either May or June 2016. We reviewed the cases electronically with assistance from DHS officials. During the review, we determined whether all necessary eligibility documentation to support residency, birth/age, income, and citizenship/immigration status was received or verified in order to ensure that eligibility was determined accurately; and

2) a sample of 40 randomly selected cases whose medical eligibility was redetermined during either May or June 2016. The total number of redeterminations in May and June 2016 was 2,485; however, not all were medical only. We determined that more than half of the cases were redetermined by the Supplemental Nutrition Assistance Program (SNAP). As a result, we excluded these SNAP cases from our sample and randomly selected 40 cases from the medical only cases. We reviewed the cases electronically with assistance from DHS officials. During the review, we determined whether all necessary eligibility documentation to residency, birth/age, income, and citizenship/immigration status was received or verified in order to ensure that continued eligibility was determined accurately.

During the testing of our two eligibility samples, we reviewed the recipient's eligibility documentation found in the Integrated Eligibility System (IES) for the initial eligibility review and documentation found in the Max-IL system for the redetermination sample. Since our audit population, as defined by the Covering ALL KIDS Health Insurance Act, contains undocumented immigrants (who do not have social security numbers needed to verify identity, citizenship, and income), the data matching criteria embedded within IES and Max-IL could not be utilized by caseworkers. Therefore, the electronic data matches were not specifically 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.

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 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.

- Passive redetermination consisted of sending each family an annual renewal notice prior to the end of the eligibility period.

- The renewal notice listed the eligibility information for the family and instructed the family to return the form only if any information had changed. If there were no changes, the family was instructed to do nothing.

- In contrast, to continue coverage, enrollees in Premium levels 2 through 8 were required to send in the annual redetermination form, which included updated eligibility information.

This recommendation to adequately implement eligibility redeterminations was repeated in our FY10 and FY11 audits. Effective October 1, 2011, Public Act 96-1501 required verification of one month's income for determining continued eligibility (instead of passive redetermination). 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 and corrective action began in 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 our FY13 audit period.

During the 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. This process was also used during FY15 and FY16.

- A redetermination system called Max-IL was developed for medical-only cases. Using the Max-IL system, medical-only cases are redetermined annually by the central redetermination unit staff.

- The Max-IL system records and stores all redetermination forms mailed to the recipient, returned redetermination forms, electronic data matching results, requests for missing information, and verifications.

- Central redetermination staff is responsible for annually making eligibility decisions, coding the redetermination, and processing any changes on the cases.

- Staff also began using MAGI rules for redeterminations effective on April 1, 2014.

During our review of all eligibility redeterminations for EXPANDED ALL KIDS in FY15 and FY16, we found that HFS and DHS did not complete redeterminations of eligibility **annually** as required by the Covering ALL KIDS Health Insurance Act. In FY15, HFS indicated that staffing levels were the main reason redeterminations were not completed timely.

- In FY15, HFS and DHS completed 88 percent of the required annual redeterminations for the EXPANDED ALL KIDS program. Our FY15 audit found that 3,715 of the 29,881 recipients (12%) were not redetermined annually.

- In FY16, HFS and DHS completed 93 percent of the required annual redeterminations for the EXPANDED ALL KIDS program. Our FY16 audit found that 2,104 of the 28,588 recipients were not redetermined annually. As a result, seven percent were not determined annually as required by the Act.

ANNUAL REDETERMINATIONS

In FY16, HFS and DHS completed 93 percent of the required annual redeterminations for the EXPANDED ALL KIDS program. Our FY16 audit found that 2,104 of 28,588 were not redetermined annually as required. As a result, seven percent were not redetermined annually as required by the Act.

If annual redeterminations of eligibility are not conducted, the State may provide services for non-eligible recipients. Given that redeterminations were not conducted timely for seven percent of eligible EXPANDED ALL KIDS recipients in FY16, the status of this recommendation is **repeated** and will be followed up on during the next audit, which covers the period July 1, 2016, to June 30, 2017.

REDETERMINATION OF ELIGIBILITY	
RECOMMENDATION NUMBER **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 all of the work. Although IES Phase 2 has now been implemented, it will take time to update the converted case information and catch up on delayed redeterminations.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department of Human Services agrees with the recommendation. The redetermination process will be enhanced with the implementation of the newly updated processing system in IES Phase 2, which went live on Oct 24, 2017. The IES Phase 2 system will assist in tracking and auto initiating renewal notices to eligible customers using a three step process. Online and classroom training venues are available to all staff using the new system.

ALL KIDS ELIGIBILITY DATA

Due to a lack of internal controls to identify duplicate recipients or recipients that age out of the program, 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 FY16 EXPANDED ALL KIDS eligibility data, we continued to find that eligibility data contained individuals who were over the age of 18 and who were enrolled in ALL KIDS more than once.

- We identified 159 recipients that received 793 services totaling $111,029 after the month of their 19th birthday. According to the Covering ALL KIDS Health Insurance Act, children eligible for the program must be under the age of 19.

- We also identified 437 individuals who appeared to be enrolled with more than one identification number; therefore, the proper clearance to identify previous eligibility was not completed by the case workers. According to DHS policy, caseworkers are to identify former case identification numbers.

If recipients maintain eligibility after reaching the age of 19, or if recipients have eligibility under more than one recipient identification number, the State may provide services for non-eligible recipients. Therefore, the status of this part of the recommendation is also **repeated** and will be followed up on during the next audit, which covers the period July 1, 2016 to June 30, 2017.

ALL KIDS ELIGIBILITY DATA	
RECOMMENDATION NUMBER **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 (IES) 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 that they turn 19.

CLASSIFICATION OF DOCUMENTED IMMIGRANTS

CLASSIFICATION OF DOCUMENTED IMMIGRANTS

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

The proper classification of immigration status has been an issue since the first ALL KIDS audit, which was for FY09 and was released in May 2010. Although HFS reported the miscoding of documented immigrants had been corrected in both FY12 and FY13, we found the EXPANDED ALL KIDS data continued to have recipients who are incorrectly coded as "undocumented." Although some of the inaccurate coding may have occurred 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.

Miscoded Citizenship Status

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.

LOSS OF FEDERAL MATCHING FUNDS

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 FY16 eligibility data contained:

- 4,521 recipients coded as undocumented who had social security numbers that were verified, of which 139 also had an alien registration number; and
- 11 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 FY16 and determined the 4,521 recipients had 63,001 services for a total cost of almost $4.6 million. If these recipients were classified as undocumented in error, the State did not receive the eligible matching federal rate funds in FY16. Therefore, the State at a minimum did not collect $2.4 million in federal reimbursement for the $4.6 million in services in FY16. Additionally, the State at a minimum did not collect $2.8 million in federal reimbursement in FY15 – for a total of **$5.2 million** lost in federal reimbursement over the last two fiscal years. 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 2016, we found that 12 of the cases were coded as undocumented but likely should have been coded as citizens/documented immigrants, as we found documentation to support citizenship or documented immigrant status for each of the 12 classified as undocumented. For many of the cases, we found documentation verifying the recipient's social security number and/or alien status. Therefore, a total of 12 out of the 40 recipients sampled (30%) who were coded as undocumented were likely citizens or documented immigrants. We provided these 12 cases to DHS, and DHS officials agreed they were likely documented.

INITIAL ELIGIBILITY

12 out of the 40 recipients sampled (30%) who were coded as undocumented were likely citizens or documented immigrants. We provided these 12 to DHS, and DHS officials agreed they were likely documented.

Eligibility Testing for Redetermination

During our review of 40 recipients that were redetermined during May or June 2016, we found 8 of the 40 recipients sampled (20%) were coded as undocumented even though they had a verified social security number supporting they were likely citizens or documented immigrants. We provided these eight cases to DHS, and DHS officials agreed they were likely documented.

REDETERMINATION OF ELIGIBILITY

8 of the 40 recipients sampled (20%) were coded as undocumented even though they had a verified social security number supporting they were likely citizens or documented immigrants.

We continue to have multiple issues related to the coding of undocumented immigrants. Therefore, the status of this recommendation is **repeated** and will be followed up on during the next audit, which covers the period July 1, 2016 to June 30, 2017. Due to the incorrect classification of documented and undocumented immigrants, the number of enrollees and payment figures in this report are overstated for undocumented immigrants and are understated for documented immigrants. Additionally, due to the miscoding, the State is losing federal matching Medicaid funds.

CLASSIFICATION OF DOCUMENTED IMMIGRANTS	
RECOMMENDATION NUMBER **3**	***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.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. Edits within IES regarding immigration status will be reviewed after IES Phase 2 implementation.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department of Human Services agrees with the recommendation. Conversion to an updated single processing system with the implementation of IES Phase 2 was completed in October 2017 and will allow for improved classification of documented immigrants and electronic storage of verifications supporting the immigration status for noncitizens.

ELIGIBILITY DOCUMENTATION

All seven 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 required documentation to support eligibility in some instances, such as: residency, birth/age, 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 effective on July 1, 2011.

The Patient Protection and Affordable Care Act (ACA) required all states apply a new budget methodology based on Modified Adjusted Gross Income (MAGI). 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 citizenship/immigration 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 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 (Medicaid) and would not be included as part of this audit. Thus, electronic data matches and searches based on social security numbers are ineffective for the undocumented portion of this population because they do not have social security numbers. Therefore, in these instances, the auditors along with DHS officials searched through IES for scanned copies of documents to determine residency, birth/age, income, and citizenship/immigration status for all recipients, including undocumented recipients.

Initial Eligibility Testing

We randomly selected 40 of the 500 new cases approved during May and June 2016 and found significant issues. As discussed previously, 12 of the 40 cases (30%) were coded as undocumented even though evidence, such as verified social security numbers, supported the enrollee was likely a citizen or documented immigrant. As a result, these 12 recipients were

likely not eligible for the EXPANDED ALL KIDS program, but would have been eligible for Medicaid for which the State receives federal matching funds. Our testing results from the last audit (FY15) found 17 of 39 cases (44%) were likely incorrectly coded as undocumented.

During our FY16 testing, we reviewed all 40 new cases in IES to determine whether all the required eligibility documentation was obtained or reviewed. Of the 40 cases reviewed, **31 cases (78%)** 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, at a minimum, 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 to verify residency. As shown in Exhibit 12, in FY16, we found residency was not verified in 9 of the 40 cases tested (23%).

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. As shown in Exhibit 12, in FY16, auditors determined that birth/age information was not verified in 16 of the 40 (40%) cases we tested.

Income Documentation (Initial Eligibility)

Beginning on July 1, 2011, the Covering ALL KIDS Health Insurance Act (215 ILCS 170/7(a)(1)) began requiring 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, caseworkers did not always review 30 days of income documents as required.

In the FY16 cases from our sample of 40 where income was reported, we identified instances where 30 days of income documentation was not reviewed. Of the 40 cases tested, 21 reported having income. For the 21 cases with income reported, 30 days of income was not reviewed in 2 of the cases (10%). Two additional FY16 cases contained income calculation errors. See Exhibit 12 for a summary of the FY15 and FY16 testing results.

Conclusion

Without documentation to support the eligibility decisions, auditors are unable to determine whether eligibility decisions were completed accurately. Since we continued to

identify issues during our FY16 initial eligibility testing, this part of the recommendation is **repeated** and will be followed up on in future audits.

Exhibit 12
RESULTS OF ELIGIBILITY TESTING
(Initial Eligibility)

	Residency Verified		Age Verified		30 Days Income Verified[1]	
	FY15	FY16	FY15	FY16	FY15	FY16
Number Tested	40	40	40	40	13	21
Number Missing Documentation	12	9	15	16	5	2
Percent Missing Documentation	30%	23%	38%	40%	38%	10%

Note: [1] In FY15, 27 of 40 cases tested reported no income. In FY16, 19 of 40 cases tested reported no income.

Source: OAG FY16 Eligibility Testing Results for Initial Eligibility.

Eligibility Redetermination Testing

We tested 40 of the medical only redeterminations that occurred during May and June 2016 and found issues regarding Illinois residency, birth/age, and income documentation. The total number of redeterminations for medical only cases in May and June 2016 was 2,485. We determined that more than half of the cases were redetermined by the Supplemental Nutrition Assistance Program (SNAP) and excluded these SNAP cases from our random sample. As discussed previously, 8 of the 40 cases (20%) were coded as undocumented even though evidence, such as verified social security numbers, supported that the enrollee was likely a citizen or documented immigrant. As a result, these eight recipients were likely not eligible for the EXPANDED ALL KIDS program, but would have been eligible for Medicaid for which the State receives federal matching funds.

During our FY16 testing, we reviewed all 40 redetermined cases to determine whether all required eligibility redetermination documentation was obtained or reviewed. Of the 40 cases reviewed, all **40 cases (100%)** 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 (SOS) clearance was implemented to verify residency. The clearance matches the recipient's social security number with SOS records. 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, 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 shown in Exhibit 13, residency was not verified in 13 of the 40 (33%) cases we tested in FY16.

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." We looked to see if documentation of birth, such as a birth certificate, was present to verify age. As shown in Exhibit 13, birth/age information was not verified in 32 of the 40 (80%) cases we tested in FY16.

Income Documentation (Redetermination)

Beginning on October 1, 2011, the Covering ALL KIDS Health Insurance Act (215 ILCS 170/7(a)(2)) began requiring verification of one month's income from all sources for determining continued eligibility. However, caseworkers did not always review 30 days of income documents as required.

In cases where income was reported, we found income eligibility documentation and calculation problems in the cases tested. Of the 40 cases tested, 37 reported having income. For the 37 cases with income reported, 30 days of income was not reviewed in 3 of the cases with income reported (8%). Additionally, we identified one other case where the income was not calculated correctly. See Exhibit 13 for a summary of the FY15 and FY16 testing results.

Conclusion

Without documentation to support the eligibility decisions, auditors are unable to determine whether eligibility decisions were completed accurately. Due to the missing documentation identified during our FY16 eligibility testing of redeterminations, this part of the recommendation is **repeated** and will be followed up on in future audits.

Exhibit 13
RESULTS OF ELIGIBILITY TESTING
(Redetermination)

	Residency Verified		Age Verified		30 Days Income Verified[1]	
	FY15	FY16	FY15	FY16	FY15	FY16
Number Tested	40	40	40	40	35	37
Number Missing Documentation	8	13	31	32	0	3
Percent Missing Documentation	20%	33%	78%	80%	0%	8%

Note: [1] In FY15, 5 of 40 cases tested reported no income. In FY16, 3 of 40 cases tested reported no income.

Source: OAG FY16 Eligibility Testing Results for Redeterminations.

ELIGIBILITY DOCUMENTATION	
RECOMMENDATION NUMBER **4**	***The Department of Healthcare and Family Services and the Department of Human Services should:*** • ***ensure all necessary eligibility documentation to support residency and birth/age is received in order to ensure that eligibility is determined accurately; and*** • ***ensure one month's worth of income verification is reviewed for determining eligibility.***
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. Implementation of IES Phase 2 brings redeterminations and other case maintenance activities into IES, making electronic verification and income calculation more automated.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department of Human Services agrees with the recommendation. Implementation of IES Phase 2 makes electronic verification and income calculation more automated, and allows for electronic document storage, reducing the risk of missing eligibility documentation that may have already been obtained. The Department will consult with the Illinois Department of Healthcare and Family Services regarding the incorporation of rules requiring the verification of dates of birth for children. The Department will continue to provide ongoing policy clarification regarding income eligibility determinations as needed.

POLICIES COVERING ORTHODONTIC TREATMENT

As part of the FY14 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, and the second was the need for improvements in HFS orthodontic policies and documentation of medical necessity.

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 received 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."

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 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 rules or Dental Office Reference Manual.

A DentaQuest official noted that the scoring tool used by DentaQuest for orthodontic cases was changed in 2010. 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 FY12, the amount paid increased to $16.6 million, and by FY14, payments totaled $36.6 million.

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 of the four locations for a total of 40 cases. 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.

The FY14 audit concluded that 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.

HFS agreed with this recommendation and indicated it would review the issues raised and take appropriate action. Since the FY14 audit was released in February 2016, and the audit period for the FY15 audit ended earlier on June 30, 2015, this recommendation was repeated in FY15.

During this FY16 audit, HFS updated the Administrative Code and scoring tool. HFS officials noted that the new Administrative Code and scoring tool addressed the problems identified in the previous audit recommendation. More specifically, 89 Ill. Adm. Code 140.421 updated the Administrative Code related to orthodontics. Effective January 19, 2017, medically necessary orthodontic treatment became approved only for patients under the age of 21 and defined as:

- treatment necessary to correct a condition that scores 28 points or more on the Handicapping Labio-Lingual Deviation Index (HLD); or

- treatment necessary to correct the following conditions: (i) cleft palate, (ii) deep impinging bite with signs of tissue damage (not just touching palate), (iii) anterior crossbite with gingival recession; and (iv) severe traumatic deviation (i.e. accidents, tumors, etc.).

Since the Administrative Code related to orthodontics and the scoring tool became effective **after** FY16, follow-up will be completed during the next audit. The finding will be repeated for this FY16 audit.

POLICIES COVERING ORTHODONTIC TREATMENT	
RECOMMENDATION NUMBER **5**	***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).***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. Effective January 19, 2017, the Department updated the qualifications for medically necessary orthodontic treatment for patients under the age of 21 and adopted a corresponding scoring tool.

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.

Audit Objectives

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

Since this is the eighth audit of the EXPANDED ALL KIDS program in the last eight years and there have been significant changes to the Covering ALL KIDS Health Insurance Act that were effective prior to the FY16 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 FY16. During our audit, HFS officials reported that there were no new contracts related to the ALL KIDS expansion for FY16.

We met with both HFS and DHS officials and determined that initial and redetermination of eligibility procedures had not changed since the FY14 audit. Therefore, initial ALL KIDS eligibility was processed through the Integrated Eligibility System (IES). Additionally, annual redeterminations for ALL KIDS were completed as part of the Illinois Medicaid Redetermination Project (IMRP). As a result, 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, many of these recipients were classified as undocumented immigrants, and therefore, did not qualify for Medicaid.

Fieldwork

As discussed earlier in this report, sample testing was conducted. The methodologies for each are outlined in the section titled "Follow-up of FY15 Recommendations." The areas in which detailed testing were conducted included: initial eligibility and redetermination of eligibility.

Since the data system was reviewed during FY16 by the Auditor General's Information Systems Division, we did not review the data system for this audit during FY16. 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.

APPENDIX A

The 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)

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)

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)

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)
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)
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)
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)
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)
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)
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)
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)
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)
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)
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)
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)
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)
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)
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)
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)
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)
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)
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)
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)
Sec. 90. (Amendatory provisions; text omitted).
(Source: P.A. 94-693, eff. 7-1-06; text omitted.)

(215 ILCS 170/97)
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)
Sec. 98. Repealer. This Act is repealed on July 1, 2016.
(Source: P.A. 96-1501, eff. 1-25-11.)

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

Note: In FY17, the Covering ALL KIDS Health Insurance Act was repealed effective 6-30-16. It is scheduled to be repealed again on October 1, 2019.

APPENDIX B

Covering ALL KIDS Health Insurance Act Plans

Appendix B
COVERING ALL KIDS HEALTH INSURANCE ACT PLANS
Fiscal Year 2016

	Assist	Share	Premium Level 1	Premium Level 2
Premium	None	None	$15 (1) $25 (2) $30 (3) $35 (4) $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 HFS 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

FY16 Total Cost of Services Provided by Category of Service

Appendix C
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE
During FY16

Category of Service	FY16 Payment Amount	Percent of Total Payments
Capitation Services	$27,579,549	28%
Pharmacy Services (Drug and OTC)	14,912,033	15%
Dental Services	9,588,003	10%
Inpatient Hospital Services (General)	8,655,293	9%
Physician Services	8,181,009	8%
Outpatient Services (General)	6,299,423	6%
General Clinic Services	3,466,057	4%
Healthy Kids Services	2,657,056	3%
Inpatient Hospital Services (Psychiatric)	2,262,032	2%
Speech Therapy/Pathology Services	1,850,811	2%
Mental Health Rehab Option Services	1,369,958	1%
Physical Therapy Services	1,035,737	1%
Nursing service	990,403	1%
Medical Supplies	788,328	1%
Medical equipment/prosthetic devices	785,569	1%
Clinical Laboratory Services	561,909	1%
Occupational Therapy Services	552,866	1%
Other Transportation	551,051	1%
Case Management	462,512	<1%
Waiver service (depends on HCPCS code)	460,039	<1%
Optical Supplies	374,974	<1%
Anesthesia Services	359,954	<1%
Targeted case management service (early intervention)	348,190	<1%
Alcohol and Substance Abuse Rehab Services	336,221	<1%
Development Therapy, Orientation and Mobility Services (Waivers)	306,462	<1%
Social work service	302,712	<1%
Psychiatric Clinic Services (Type 'A')	260,131	<1%
Targeted case management service (mental health)	258,341	<1%
Nurse Practitioners Services	247,131	<1%
Psychiatric Clinic Services (Type 'B')	217,849	<1%
Home Health Services	193,423	<1%
Emergency Ambulance Transportation	178,972	<1%
Optometric Services	172,676	<1%
Psychologist service	155,185	<1%
Inpatient Hospital Services (Physical Rehabilitation)	119,434	<1%

Appendix C

TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE

During FY16

Category of Service	FY16 Payment Amount	Percent of Total Payments
Early Intervention Services	82,359	<1%
LTC--ICF/MR	73,412	<1%
Podiatric Services	52,129	<1%
Audiology Services	44,920	<1%
Non-Emergency Ambulance Transportation	35,233	<1%
Outpatient Services (ESRD)	27,538	<1%
Fluoride varnish	14,317	<1%
Midwife Services	12,491	<1%
Service Car	10,326	<1%
Licensed Clinical Professional Counselor	9,940	<1%
Home Care	5,452	<1%
Family Planning Counseling	4,980	<1%
Independent Diagnostic Testing	4,002	<1%
SOPF--MI recipient under 22 years of age	3,993	<1%
Physicians Psychiatric Services	2,663	<1%
FFS procedure to implement contraceptive devices for PT 040, 048	2,441	<1%
Clinic Services (Physical Rehabilitation)	2,011	<1%
Chiropractic Services	873	<1%
Taxicab Services	316	<1%
Portable X-Ray Services	196	<1%
Medicar Transportation	54	<1%
Total FY16 Cost of Services	**$97,230,941**	**100%**

Note: May not add due to rounding.
Source: Summary of FY16 ALL KIDS data provided by HFS.

APPENDIX D

FY16 Total Cost of Services Provided by Plan and by Category of Service

Appendix D

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

During FY16

Category of Service	Total	Assist	Share	Premium Undocumented	Level 2 Undocumented	Level 2
Capitation Services	$27,579,549	$24,026,872	$507,218	$1,470,456	$36,793	$1,538,211
Pharmacy Services (Drug and OTC)	14,912,033	811,260	12,828	36,098	69,851	13,981,996
Dental Services	9,588,003	1,768,829	41,505	143,189	213,714	7,420,766
Inpatient Hospital Services (General)	8,655,293	2,421,798	2,302	22,835	29,394	6,178,964
Physician Services	8,181,009	1,203,736	21,544	65,521	101,537	6,788,672
Outpatient Services (General)	6,299,423	1,027,905	14,259	58,171	79,564	5,119,523
General Clinic Services	3,466,057	986,309	16,341	37,476	62,124	2,363,807
Healthy Kids Services	2,657,056	350,021	8,070	21,676	37,888	2,239,401
Inpatient Hospital Services (Psychiatric)	2,262,032	515,560	0	3,636	21,631	1,721,205
Speech Therapy/Pathology Services	1,850,811	64,793	777	6,034	1,708	1,777,500
Mental Health Rehab Option Services	1,369,958	167,910	5,141	6,688	22,545	1,167,674
Physical Therapy Services	1,035,737	110,780	236	6,729	$8,888	909,104
Nursing service	990,403	0	0	0	0	990,403
Medical Supplies	788,328	93,376	2,304	2,144	4,706	685,798
Medical equipment/prosthetic devices	785,569	101,121	12,742	7,891	9,423	654,392
Clinical Laboratory Services	561,909	172,738	3,328	7,471	13,618	364,754
Occupational Therapy Services	552,866	35,007	0	3,454	675	513,730
Other Transportation	551,051	0	0	0	0	551,051
Case Management	462,512	346,011	8,241	19,433	1,503	87,324
Waiver service (depends on HCPCS code)	460,039	0	0	0	0	460,039
Optical Supplies	374,974	71,766	1,628	4,897	8,284	288,400
Anesthesia Services	359,954	67,635	890	3,577	4,644	283,209
Targeted case management service (early intervention)	348,190	34,409	239	1,925	2,470	309,148
Alcohol and Substance Abuse Rehab Services	336,221	92,530	0	267	1,595	241,830
Development Therapy, Orientation and Mobility Services (Waivers)	306,462	30,955	645	2,762	1,725	270,376
Social work service	302,712	8,247	97	98	582	293,688
Psychiatric Clinic Services (Type 'A')	260,131	23,438	0	123	4,017	232,553
Targeted case management service (mental health)	258,341	30,087	1,204	453	1,297	225,300
Nurse Practitioners Services	247,131	26,627	582	1,434	1,949	216,540

Appendix D

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

During FY16

Category of Service	Total	Assist	Share	Premium Undocumented	Level 2 Undocumented	Level 2
Psychiatric Clinic Services (Type 'B')	$217,849	$27,054	0	$1,524	$3,658	$185,614
Home Health Services	193,423	72	0	0	0	193,351
Emergency Ambulance Transportation	178,972	27,240	322	849	4,235	146,326
Optometric Services	172,676	27,887	837	1,959	3,238	138,754
Psychologist service	155,185	2,016	0	46	134	152,989
Inpatient Hospital Services (Physical Rehabilitation)	119,434	7,023	0	0	0	112,411
Early Intervention Services	82,359	19,647	0	56	0	62,656
LTC--ICF/MR	73,412	73,412	0	0	0	0
Podiatric Services	52,129	5,740	168	476	274	45,472
Audiology Services	44,920	2,753	263	149	489	41,266
Non-Emergency Ambulance Transportation	35,233	10,495	0	434	559	23,745
Outpatient Services (ESRD)	27,538	18,983	0	0	0	8,555
Fluoride varnish	14,317	780	52	130	234	13,121
Midwife Services	12,491	6,704	0	0	102	5,684
Service Car	10,326	6,232	36	0	0	4,057
Licensed Clinical Professional Counselor	9,940	1,288	0	647	0	8,006
Home Care	5,452	5,452	0	0	0	0
Family Planning Counseling	4,980	690	0	30	30	4,230
Independent Diagnostic Testing	4,002	504	0	0	102	3,395
SOPF--MI recipient under 22 years of age	3,993	0	0	0	0	3,993
Physicians Psychiatric Services	2,663	124	0	0	0	2,539
FFS procedure to implement contraceptive devices for PT 040, 048	2,441	1,507	0	0	325	609
Clinic Services (Physical Rehabilitation)	2,011	0	0	0	0	2,011
Chiropractic Services	873	603	19	0	0	251
Taxicab Services	316	316	0	0	0	0
Portable X-Ray Services	196	41	0	0	0	154
Medicar Transportation	54	54	0	0	0	0
Total Cost of Services	**$97,230,941**	**$34,836,337**	**$663,817**	**$1,940,735**	**$755,504**	**$59,034,547**

Note: May not add due to rounding.
Source: Summary of FY16 ALL KIDS data provided by HFS.

APPENDIX E

Total ALL KIDS Services Provided by Provider Greater Than $50,000 Fiscal Year 2016

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 2016

Provider Name	City	State	Total Amount Paid
FAMILY HEALTH NETWORK	CHICAGO	IL	$5,308,128.34
MERIDIAN HEALTH PLAN INC VMC	CHICAGO	IL	5,152,146.98
BLUE CROSS BLUE SHIELD IL FHP	CHICAGO	IL	5,121,720.29
LURIE CHILDRENS HOSPITAL	CHICAGO	IL	4,327,657.18
ILLINICARE HEALTH PLAN INC FHP	WESTMONT	IL	2,989,802.36
COUNTYCARE FHP	CHICAGO	IL	2,968,182.85
AETNA BETTER HEALTH INC FHP	CHICAGO	IL	2,198,302.13
HARMONY HEALTH PLAN	CHICAGO	IL	1,931,290.35
MOLINA HEALTHCARE OF ILL FHP	OAK BROOK	IL	1,282,785.82
LUTHERAN GENERAL HOSPITAL	PARK RIDGE	IL	807,191.78
DSCC	SPRINGFIELD	IL	700,391.47
COMER CHILDRENS HOSPITAL	DARIEN	IL	688,711.67
UNIVERSITY OF ILLINOIS HOSP	CHICAGO	IL	675,400.89
ACCREDO HEALTH GROUP INC	MEMPHIS	TN	648,599.95
CAREMARK INC	MT PROSPECT	IL	608,707.19
HEALTH ALLIANCE CONNECT FHP	URBANA	IL	588,864.65
CHICAGO PUBLIC SCHOOLS DIST299	CHICAGO	IL	576,067.70
BHC STREAMWOOD HOSPITAL INC	STREAMWOOD	IL	560,997.25
J H STROGER HOSP OF COOK CTY	CHICAGO	IL	560,309.21
WALGREENS SPECIALTY PHRM 15438	CANTON	MI	559,727.88
CHRIST HOSPITAL	OAK LAWN	IL	539,492.74
ST JOHNS CHILDRENS HOSPITAL	SPRINGFIELD	IL	471,081.61
CHILDRENS HOSPITAL OF ILLINOIS	PEORIA	IL	462,822.02
RONALD MCDONALDS CHILDRENS HSP	MAYWOOD	IL	406,514.03
PROFESSIONAL BUILDING PHARMACY	CHICAGO	IL	388,459.36
ST LOUIS CHILDRENS HOSPITAL	SAINT LOUIS	MO	302,343.47
RIVEREDGE HOSPITAL	FOREST PARK	IL	290,373.72
COMMUNITY HEALTHCARE SERVICES	LOMA LINDA	CA	270,330.73
LURIE CHILDRENS HOSPITAL	CHICAGO	IL	262,368.48
GARFIELD PARK HOSPITAL	CHICAGO	IL	258,925.61
WALGREENS #13974	CHICAGO	IL	258,644.60
HARTGROVE HOSPITAL	CHICAGO	IL	242,120.28
LINCOLN PRAIRIE BEHAVIORAL HC	SPRINGFIELD	IL	234,496.66
SSM HEALTH CARDINAL GLENNON CH	SAINT LOUIS	MO	233,113.60
OPTION CARE	COLUMBIA	MO	226,325.40
CENTRAL DUPAGE HOSPITAL	WINFIELD	IL	211,572.13
CARLE FOUNDATION HOSPITAL	URBANA	IL	211,215.01
ADVOCATE CONDELL MEDICAL CTR	LIBERTYVILLE	IL	209,402.38
FOUNDATION CARE LLC	EARTH CITY	MO	206,207.16
PRESENCE SAINT MARY NAZARETH	CHICAGO	IL	200,545.89
ILL CORRECTIONAL INDUSTRIES	SPRINGFIELD	IL	190,706.15
LUTHERAN GENERAL HOSPITAL	PARK RIDGE	IL	189,554.88
ROCKFORD MEMORIAL HOSPITAL	ROCKFORD	IL	179,683.24
EVANSTON HOSPITAL	EVANSTON	IL	178,311.50
YARMOLYUK YAROSLAV	CHICAGO	IL	173,720.06
ADVOCATE ILLINOIS MASONIC MEDI	CHICAGO	IL	170,088.79
CAREMARK KANSAS SPEC PHARM LLC	LENEXA	KS	169,129.98
COMM UNIT SCH DIST 300	ALGONQUIN	IL	150,885.81
ALEXIAN BROS BEHAVIORAL HLTH	HOFFMAN ESTATES	IL	147,715.60

Appendix E

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

Fiscal Year 2016

Provider Name	City	State	Total Amount Paid
OPTION CARE	WOOD DALE	IL	$141,676.68
DOHMEN LIFE SCIENCE SRVCS LLC	CHESTERFIELD	MO	136,723.66
CVS/SPECIALTY	MONROEVILLE	PA	134,665.45
INFANT WELFARE SOCIETY OF CHIC	CHICAGO	IL	132,903.50
NORTHWEST COMMUNITY HOSPITAL	ARLINGTON HEIGH	IL	128,309.54
ALEXIAN BROTHERS CHILDRENS HOS	HOFFMAN ESTATES	IL	127,853.83
COPLEY MEMORIAL HOSPITAL	AURORA	IL	125,043.68
THE BLEEDING AND CLOTTING	PEORIA	IL	123,178.95
DOUBEK MEDICAL SUPPLY INC	ALSIP	IL	120,210.73
SWEDISHAMERICAN HOSPITAL	ROCKFORD	IL	119,896.25
ADVOCATE ACCOUNTABLE CARE	ROLLING MEADOWS	IL	118,467.00
QUEST DIAGNOSTICS LLC IL	WOOD DALE	IL	118,270.75
LABORATORY CORPORATION AMERICA	DUBLIN	OH	116,234.71
ST ANTHONY HOSPITAL	CHICAGO	IL	116,097.13
ARBOLEDA CLEIDY	NILES	IL	113,985.56
FANTUS HEALTH CENTER	CHICAGO	IL	112,763.45
STEVENS KATHARINE	MELROSE PARK	IL	112,692.14
ADVOCATE SHERMAN HOSPITAL	ELGIN	IL	111,230.38
BENJAMIN DALE	CHICAGO	IL	110,087.05
NUMOTION	LOMBARD	IL	106,750.71
VISTA MEDICAL CENTER EAST	WAUKEGAN	IL	106,623.52
OSWEGO SCHOOL DISTRICT 308	OSWEGO	IL	105,994.69
CONTINUUM PEDIATRIC NURSING	ROLLING MEADOWS	IL	104,692.96
EDWARD HOSPITAL	NAPERVILLE	IL	103,849.67
DOUBEK PHARMACY INC	ALSIP	IL	102,389.59
WALGREENS #05711	DES PLAINES	IL	100,223.79
THE PAVILION FOUNDATION	CHAMPAIGN	IL	99,722.28
NASREEN TAIBA	ADDISON	IL	98,076.90
ACCREDO HEALTH GROUP INC	NASHVILLE	TN	97,206.42
BARNES JEWISH HOSPITAL	SAINT LOUIS	MO	96,552.67
AQEL FADI	CHICAGO	IL	93,552.42
LAMBERGHINI FLAVIA	CHICAGO	IL	93,500.49
SENECA HEALTH CENTER	ELGIN	IL	89,865.86
LAWNDALE CHRISTIAN HLTH	CHICAGO	IL	89,454.44
SHIELD DENVER HEATH CARE CENTE	ELMHURST	IL	87,403.27
EDWARDS HEALTH CARE SERVICES	HUDSON	OH	85,267.14
BARYSENKA PIOTR	MELROSE PARK	IL	82,293.45
THE GENESIS CENTER	DES PLAINES	IL	82,224.96
SWEDISH COVENANT HOSPITAL	CHICAGO	IL	81,972.75
THE KENNETH W YOUNG CENTERS	ELK GROVE VLG	IL	80,906.60
REHABILITATION INSTITUTE	CHICAGO	IL	78,632.60
RUSH UNIVERSITY MEDICAL CENTER	CHICAGO	IL	78,197.78
CHICAGO BEHAVIORAL HOSPITAL	DES PLAINES	IL	78,099.89
CHACON JOSE	AURORA	IL	77,604.10
THE 180 MEDICAL INC	OKLAHOMA CITY	OK	77,030.44
CORAM CVS/SPECIALTY INFUSION S	MT PROSPECT	IL	76,939.72
SILVER CROSS HOSPITAL	NEW LENOX	IL	76,206.73
WEBER ROBERT	WHEELING	IL	75,845.75
SMARTPLAN CHOICE	DES PLAINES	IL	74,907.00

Appendix E

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

Fiscal Year 2016

Provider Name	City	State	Total Amount Paid
PILLARS COMMUNITY SERVICES	WESTERN SPRINGS	IL	$74,883.20
VNA HEALTH CARE	AURORA	IL	74,374.02
UNIVERSITY OF WISCONSIN HOSP	MADISON	WI	74,151.33
LAKE COUNTY HEALTH DEPARTMENT	WAUKEGAN	IL	73,894.49
ALDEN VILLAGE HEALTH FACILITY	BLOOMINGDALE	IL	73,412.28
REHABILITATION INSTITUTE	CHICAGO	IL	72,525.63
SCHWARTZ ROBERT	MELROSE PARK	IL	72,457.56
C AND M PHARMACY	GLENVIEW	IL	72,287.08
BOND DRUG COMPANY OF IL 05103	CICERO	IL	71,771.23
MACNEAL HOSPITAL	BERWYN	IL	71,694.54
FAMILY SERVICE ASSOCIATION	ELGIN	IL	71,550.76
ROWAN SUSAN A	CHICAGO	IL	71,408.61
A2CL SERVICES LLC	WEST ALLIS	WI	71,012.62
CYSTIC FIBROSIS SERVICES INC	FRISCO	TX	70,895.27
ALEXIAN BROTHERS MEDICAL CENTE	ELK GROVE VLG	IL	70,441.08
ACCREDO HEALTH GROUP INC	ORLANDO	FL	70,011.16
DUAIBIS RAMZI	ROSELLE	IL	69,615.14
PRESENCE MERCY MEDICAL CENTER	AURORA	IL	68,602.97
AURORA CHICAGO LAKESHORE CHILD	CHICAGO	IL	68,287.48
SCHOOL DISTRICT U 46	ELGIN	IL	67,428.99
ERIE EVANSTON HEALTH CENTER	EVANSTON	IL	67,398.46
WALMART PHARMACY 10-0481	MATTOON	IL	67,196.79
WAL MART STORES EAST LP 105315	ORLANDO	FL	67,028.31
WALGREENS #07100	ELGIN	IL	66,988.01
GATEWAY FOUNDATION CARBONDALE	CARBONDALE	IL	66,238.32
BOND DRUG COMPANY OF IL 03729	HANOVER PARK	IL	66,197.64
CENTER FOR MEDICAL ARTS RH	CARBONDALE	IL	65,569.73
NAPERVILLE PSYCHIATRIC VENTURE	NAPERVILLE	IL	65,115.40
NORTHWESTERN LAKE FOREST HSPTL	LAKE FOREST	IL	64,203.17
CENTRAL DUPAGE HOSPITAL	WINFIELD	IL	63,932.86
WILLIAMS JILADA B	MAYWOOD	IL	63,280.76
ERIE FAMILY HEALTH CENTER	CHICAGO	IL	63,136.29
ANCHOR HOME HEALTH CARE	GLEN CARBON	IL	63,026.25
MERCY HOSPITAL AND MEDICAL CEN	CHICAGO	IL	62,961.85
LI QINGSHAN	OAK FOREST	IL	62,258.60
ALLENDALE ASSOCIATION BRADLEY	WAUKEGAN	IL	62,091.37
BOND DRUG COMPANY OF IL 4502	CARPENTERSVILLE	IL	62,087.60
PRESENCE SAINT JOSEPH MED CTR	JOLIET	IL	61,338.66
MYCARE CHICAGO LLC	CHICAGO	IL	61,065.00
BOND DRUG COMPANY OF ILLINOIS	NORMAL	IL	60,138.17
RIVERSIDE MED CTR	KANKAKEE	IL	59,911.74
HUMBOLDT PARK FAMILY HLTH CTR	CHICAGO	IL	59,434.48
NAJJAR ANAS	CHICAGO	IL	58,813.97
BOND DRUG COMPANY OF IL 04940	ROUND LAKE BCH	IL	58,711.41
SARAH BUSH LINCOLN H C	MATTOON	IL	58,381.18
BOND DRUG COMPANY OF IL 03212	DANVILLE	IL	58,302.89
STOSICH MICHAEL	GRAYSLAKE	IL	58,087.85
ADVENTIST HINSDALE HOSPITAL	HINSDALE	IL	57,580.62
COMMUNITY UNIT SCH DIST 200	WHEATON	IL	57,575.25

Appendix E

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

Fiscal Year 2016

Provider Name	City	State	Total Amount Paid
PIONEER CENTER FOR HUMAN SERVI	MCHENRY	IL	$57,429.94
ACTIVSTYLE INC	MINNEAPOLIS	MN	57,170.20
ALAMIR GEORGE	MCHENRY	IL	57,029.95
CLEARBROOK CFC 6	ARLINGTON HTS	IL	56,310.86
MAHAIRI AMJAD	ELGIN	IL	55,455.34
SULLIVAN DRUGS	MOUNT OLIVE	IL	55,147.19
SINAI CHILDRENS HOSPITAL	CHICAGO	IL	55,057.92
WALGREENS #11542	CHARLESTON	IL	54,986.91
COMMUNITY CARE PARTNERS	EVANSTON	IL	54,873.00
PERLMAN ELIZABETH	CHICAGO	IL	54,577.79
CYSTIC FIBROSIS PHARMACY INC	ORLANDO	FL	54,093.30
BLESSING HOSPITAL	QUINCY	IL	53,943.51
BOND DRUG COMPANY OF IL 4150	BELVIDERE	IL	53,482.49
WALGREENS #09358	LINCOLNWOOD	IL	52,887.91
GARCIA ELOISA	CHICAGO	IL	52,778.25
MIDLAKES CLINIC	ROUND LAKE BEAC	IL	52,738.39
METHODIST MEDICAL CNTR	PEORIA	IL	52,697.12
ELMHURST MEMORIAL HOSPITAL	ELMHURST	IL	52,071.96
ACCREDO HEALTH GROUP INC	ELMHURST	IL	51,620.52
BELTRAN LISET	MELROSE PARK	IL	51,240.75
AMBER PHARMACY	CHICAGO	IL	51,189.34
THE PHARMACIE SHOPPE	CASEY	IL	51,008.68
ROSECRANCE BERRY CAMPUS	ROCKFORD	IL	50,853.59
REHABTECH SUPPLY CORPORATION	ELMHURST	IL	50,501.79
WINE PAUL	CHICAGO	IL	50,200.30

Source: FY16 data provided by HFS.

APPENDIX F
Agency Responses

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Bruce Rauner, Governor
Felicia F. Norwood, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

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

November 22, 2017

Honorable Frank J. Mautino
Auditor General
State of Illinois

Dear Auditor General Mautino:

The Department of Healthcare and Family Services (HFS) appreciates the work performed by your office in conducting the audit of the "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 **Internet:** http://www.hfs.illinois.gov/

Attachment Response
Report: Covering ALL KIDS Health Insurance Program

Recommendation Number 1: Redetermination of Eligibility
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 all of the work. Although IES Phase 2 has now been implemented, it will take time to update the converted case information and catch up on delayed redeterminations.

Recommendation Number 2: All Kids Data Reliability
The Department of Halthcare 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 eligibile 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 (IES) 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 that 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 IES that prevents enrollees with citizenship or immigration documentation from being classified as undocumented;
- Ensure that documented immigrants are classified correcting in its database; and
- Ensure that the State receives federal matching funds for all eligible recipients and ensure that federal matching fund are not received for ineligible recipients.

Response:
The Department accepts the recommendation. Edits within IES regarding immigration status will be reviewed after IES Phase 2 implementation.

Recommendation Number 4: Eligibility Documentation
The Department of Healthcare and Family Services and the Department of Human Services should: *ensure all necessary eligibility documentation to support residency and birth/age is received in order to ensure that eligibility is determined accurately; and *ensure one month's worth of income verification is reviewed for determining eligibility.

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. Implementation of IES Phase 2 brings redeterminations and other case maintenance activities into IES, making electronic verification and income calculation more automated.

Recommendation Number 5: Policies over Orthodontic Treatment
The Department of Healthcare and Family Servces 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. Effective January 19, 2017, the Department updated the qualifications for medically necessary orthodontic treatment for patients under the age of 21 and adopted a corresponding scoring tool.

IDHS

Bruce Rauner, *Governor* • James T. Dimas *Secretary*

November, 27, 2017

Mr. Frank J. Mautino
Auditor General
Office of the Auditor General
740 East Ash Street
Springfield, IL 62703

Dear Auditor General Mautino:

Attached please find the Department of Human Services' official response to the findings identified during the eighth annual audit of the Covering ALL KIDS Health Insurance program for fiscal year 2017.

Please contact me at Amy.DeWeese@illinois.gov or 217-558-6931 with any questions or concerns.

Sincerely,

SIGNED ORIGINAL ON FILE

Amy De Weese, CPA
Chief Internal Auditor

cc: James T. Dimas, Secretary
Robert Brock, Chief Financial Officer
Fred Flather, General Counsel
Internal Audit File

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

Recommendation #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.*

DHS Response: The Department of Human Services agrees with the recommendation. The redetermination process will be enhanced with the implementation of the newly updated processing system in IES Phase 2, which went live on Oct 24, 2017. The IES Phase 2 system will assist in tracking and auto initiating renewal notices to eligible customers using a three step process. Online and classroom training venues are available to all staff using the new system.

Recommendation #3: *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 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.*

DHS Response: The Department of Human Services agrees with the recommendation. Conversion to an updated single processing system with the implementation of IES Phase 2 was completed in October 2017 and will allow for improved classification of documented immigrants and electronic storage of verifications supporting the immigration status for noncitizens.

Recommendation #4: *The Department of Healthcare and Family Services and the Department of Human Services should: *ensure all necessary eligibility documentation to support residency and birth/age is received in order to ensure that eligibility is determined accurately; and *ensure one month's worth of income verification is reviewed for determining eligibility.*

DHS Response: The Department of Human Services agrees with the recommendation. Implementation of IES Phase 2 makes electronic verification and income calculation more automated, and allows for electronic document storage, reducing the risk of missing eligibility documentation that may have already been obtained. The Department will consult with the Illinois Department of Healthcare and Family Services regarding the incorporation of rules requiring the verification of dates of birth for children. The Department will continue to provide ongoing policy clarification regarding income eligibility determinations as needed.

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