STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT OF THE COVERING ALL KIDS HEALTH INSURANCE PROGRAM

MARCH 2019

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
March 2019

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

REPORT DIGEST

PROGRAM AUDIT

For the Year Ended:
June 30, 2017

Release Date:
March 2019

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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 **ninth** annual audit (FY17), 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 FY17, there were 104,856 enrollees at any point in EXPANDED ALL KIDS and the total cost of services provided was $103.1 million.
2. The total number of recipients as of June 30th was 67,776 in FY16 and 66,353 in FY17. In FY17, the number of citizen/documented immigrants slightly increased while the number of undocumented immigrants slightly decreased.
3. Of the 33,531 recipients that required an annual redetermination of eligibility in FY17, we found 2,411 (7%) were not redetermined annually as required.
4. In FY17, 134 recipients received 740 services totaling $166,338 after the month of their 19th birthday. Additionally, there were 428 individuals who appeared to be enrolled with more than one identification number.
5. HFS and DHS did not identify the correct citizenship status for 4,949 recipients, and as a result, the State lost an estimated $2.9 million in federal matching Medicaid funds in FY17. The State also lost federal matching Medicaid funds in FY15 and FY16 – for an estimated total of $8.1 million lost in federal reimbursement over the last three fiscal years. This issue has been reported since the FY09 ALL KIDS audit.
6. We tested 40 initial eligibility cases and 40 redetermined cases in FY17. We found 43 percent of initial cases, and 23 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 50 percent of the initial eligibility cases reviewed in FY17. Of these cases, 18 percent were missing documentation to verify residency, 35 percent were missing documentation to verify birth/age, and 8 percent were missing documentation to verify one month's income.
   - HFS and DHS were missing at least one piece of required documentation in 73 percent of the redetermined cases reviewed in FY17. Of these cases, 33 percent were missing documentation to verify residency, 63 percent were missing documentation to verify birth/age, and 20 percent were missing documentation to verify one month's income.
7. The recommendation on policies covering orthodontic treatment was partially repeated in FY17. We found that HFS should review the membership requirements for the Dental Policy Review Committee and more effectively monitor the recipients receiving care under the MCO part of the program to ensure these recipients are receiving the same access to care as the recipients under the FFS part of the program.

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 to include all uninsured children not previously covered. The expansion added children whose family income was greater than 200 percent of the federal poverty level (FPL) and all undocumented immigrant children. At that time, the KidCare program was renamed ALL KIDS.

Since the EXPANDED ALL KIDS program is a subset of a much larger ALL KIDS program, many of the recommendations in this report may be relevant to the program as a whole.

Throughout our audits, we refer to the portion of the ALL KIDS program that serves the uninsured children not previously covered by KidCare as "EXPANDED ALL KIDS." Since the EXPANDED ALL KIDS program is a subset of 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 ninth annual audit (FY17).

This FY17 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 1-2)

ALL KIDS Program

The program included 104,856 EXPANDED ALL KIDS enrollees at any point during FY17, a slight decrease of 1.5% from the previous year (FY16) when there were 106,447 enrollees.

According to HFS, in FY17, 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 104,856 EXPANDED ALL KIDS enrollees at any point in FY17, which is a slight decrease (1.5%) from FY16 when there were 106,447 enrollees. On June 30, 2017, there were 66,353 enrollees. Thirty-six percent or 23,918 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		
	FY16	FY17
Enrollees at any point	106,447	104,856
Enrollees on June 30	67,776	66,353
Total Cost of Services Provided	$97,230,941	$103,054,764
Total Net Cost of Services after Premium Payments	$80,793,336	$85,068,952

Digest Exhibit 1
ENROLLMENT BY PLAN [2]
For EXPANDED ALL KIDS as of June 30

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants	
	FY16	FY17	FY16	FY17
Assist $36,168[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		22,494	21,132
Share $38,628[1]			535	574
Premium Level 1 $51,420[1]			1,615	1,516
Premium Level 2 $78,228[1]	42,338	42,435	794	696
Totals	42,338	42,435	25,438	23,918

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 effective 4/2017. Although the monthly income standards changed during FY17, these were the most recent effective amounts and were utilized during the months tested for the audit.

[2] Enrollment is the total number of enrollees that were eligible on June 30 of 2016 and 2017. There were 106,447 enrollees eligible at some point during FY16 and 104,856 enrollees eligible at some point during FY17.

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 $103.1 million in FY17.

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 $103.1 million in FY17. 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 $37.0 million in FY17.

The cost of services has increased by nearly $6 million from $97.2 million in FY16 to $103.1 million in FY17.

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 FY16 and FY17. Additionally, Digest Exhibit 2 shows the cost of services increased by nearly $6 million from $97.2 million in FY16 to $103.1 million in FY17.

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 three 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 36 percent of the total cost in FY17. (pages 8-15)

Digest Exhibit 2
COST OF SERVICES PROVIDED BY PLAN
For EXPANDED ALL KIDS during Fiscal Years 2016 and 2017

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals[2]	
	FY16	FY17	FY16	FY17	FY16	FY17
Assist $36,168[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		$34,836,337	$33,034,213	$34,836,337	$33,034,213
Share $38,628[1]			$663,817	$767,717	$663,817	$767,717
Premium Level 1 $51,420[1]			$1,940,735	$2,374,695	$1,940,735	$2,374,695
Premium Level 2 $78,228[1]	$59,034,547[3]	$66,075,439[3]	$755,504	$802,701	$59,790,051	$66,878,139
Totals[2]	$59,034,547	$66,075,439	$38,196,393	$36,979,325	$97,230,941	$103,054,764

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 effective 4/2017. Although the monthly income standards changed during FY17, these were the most recent effective amounts and were utilized during the months tested for the audit.

[2] Totals may not add due to rounding.

[3] The federal matching rate was 88.62 percent in FY16 and 88.91 percent in FY17; therefore, the State's estimated share for services was $6.7 million in FY16 and $7.3 million in FY17.

Source: ALL KIDS data provided by HFS.

FY17 Audit Findings and Recommendations

All five issues from our previous FY16 audit were repeated or partially repeated during this FY17 audit. The five recommendations were related to redeterminations, data reliability, classification of documented immigrants, eligibility documentation, and policies covering orthodontic treatment.

1. Redetermination of Eligibility

2,411 of the 33,351 (7%) were not redetermined annually as required by the Act.

During our review of all eligibility redeterminations for EXPANDED ALL KIDS recipients made in FY17, we found that redeterminations of eligibility were not completed **annually** for all recipients as required by the Covering ALL KIDS Health Insurance Act. According to the data provided by HFS, 33,531 EXPANDED ALL KIDS recipients required a redetermination of eligibility in FY17. Our data analysis showed that 2,411 of the 33,531 (7%) were not redetermined annually as required by the Act. (pages 1-2, 17-20)

2. ALL KIDS Eligibility Data

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

During our review of the FY17 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 FY17 data, we identified 134 recipients that received 740 services totaling $166,338 after the month of their 19th birthday. We also identified 428 individuals who appeared to be enrolled with more than one identification number. If recipients maintain eligibility after 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 20-21)

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. An estimated total of $8.1 million in federal reimbursement was lost over the last three fiscal years (FY15 through FY17).

We determined the FY17 eligibility data contained 4,949 "undocumented" recipients who had social security numbers that were verified, of which 165 also had an alien registration number. We reviewed the services provided to the 4,949 "undocumented" recipients in FY17 and determined they had 50,223 services for a total cost of almost $5.4 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. As a result of the miscoding errors, the State is annually losing federal matching dollars. In FY17, we estimated that the State at a minimum did not collect $2.9 million in federal reimbursement for the $5.4 million in services in FY17. Additionally, we estimated that the State at a minimum did not collect $2.4 million in federal reimbursement in FY16 and $2.8 million in federal reimbursement in FY15 – for a total estimated loss of **$8.1 million** in federal reimbursement over the last three fiscal years.

Initial Eligibility Testing

17 of the 40 new recipients sampled (43%) were coded as undocumented but were likely citizens or documented immigrants.

During our review of 40 new cases that were approved during May and June 2017, we found that 17 of the cases (43%) 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 17 classified as undocumented. Many of the cases had documentation verifying the recipient's social security number and/or alien status. We provided these 17 to DHS, and DHS agreed they were likely documented.

Redetermination of Eligibility Testing

9 of the 40 redetermined recipients sampled (23%) were coded as undocumented but were likely citizens or documented immigrants.

During our review of 40 recipients that were redetermined during May and June 2017, we found 9 of the recipients (23%) 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 nine to DHS, and DHS agreed they were likely documented. (pages 21-24)

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 these 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 7 of the 40 (18%) of the initial eligibility cases tested, and birth/age information was not verified in 14 of the 40 (35%) cases tested.

We randomly selected 40 of the 435 new cases approved during May and June 2017 and found significant issues. Residency was not verified in 7 of the 40 (18%) cases tested, and birth/age information was not verified in 14 of the 40 (35%) cases tested. Of the 40 cases tested, 24 reported having income. We found 30 days of income was not reviewed in 2 of the 24 cases (8%) where income was reported. Of the 40 cases reviewed, 20 cases (50%) 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 25 of the 40 (63%) cases tested.

We also tested 40 of the medical only redeterminations that occurred during May and June 2017 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 25 of the 40 (63%) cases tested. Of the 40 cases tested, 35 reported having income. We found 30 days of income was not reviewed in 7 of the 35 cases (20%) where income was reported. Of the 40 cases reviewed, 29 cases (73%) were missing at least one piece of required documentation (verification of residency, birth/age, or income). (pages 24-29)

5. Policies Covering Orthodontic Treatment

The FY14 EXPANDED ALL KIDS audit concluded that the State's expenditures for orthodontic services for children in EXPANDED ALL

KIDS increased dramatically from FY10 to FY14. The HFS Office of the Inspector General (OIG) conducted a review during this FY14 audit, which concluded that revisions and clarifications to policies establishing medical necessity should be made and additional documentation to support medical necessity should be required. The FY14 EXPANDED ALL KIDS audit also identified a lack of documentation related to orthodontic claims and the need for improvements in HFS orthodontic policies and documentation of medical necessity.

To address these issues, HFS updated the Administrative Code and also revised the scoring tool. Since the Administrative Code related to orthodontics and the scoring tool became effective on January 19, 2017, this recommendation was not followed up on until this FY17 audit.

In order to follow up for this audit, we tested a random sample of 25 EXPANDED ALL KIDS recipients who submitted documentation for approval for orthodontic services in June 2017. For the 25 cases reviewed, we concluded that the issues identified in the first bullet of the FY14 audit recommendation (see text box) had been resolved during FY17. We found that DentaQuest was receiving and maintaining documentation needed to support orthodontia approvals for EXPANDED ALL KIDS recipients receiving care under the fee-for-service (FFS) part of the program.

FY14 Audit Recommendation on Policies Covering Orthodontic Treatment

We recommended that the Department of Healthcare and Family Services should:

- ensure DentaQuest is receiving and maintaining documentation 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).

In addition, according to the OIG, the actions taken by HFS were sufficient to meet the problems identified in the second bullet of the FY14 EXPANDED ALL KIDS audit recommendation (see text box). However, the OIG further stated that although the actions taken by HFS were sufficient for the EXPANDED ALL KIDS recipients receiving orthodontic care under the FFS part of the program, the OIG could not comment on the status of the EXPANDED ALL KIDS recipients receiving care under the Managed Care Organization (MCO) part of the program.

We found that the member requirements in the FY17 Dental Policy Review Committee bylaws were not met for FY17.

The FY14 EXPANDED ALL KIDS audit also recommended that HFS more effectively monitor the actions taken by DentaQuest (see text box). We followed up and concluded that HFS was more effectively monitoring the actions taken by DentaQuest through required reports and meetings for the FFS part of the program. However, we did identify an issue related to the membership requirements listed in the Dental Policy Review Committee

(Committee) bylaws. We found that the member requirements in the FY17 Committee's bylaws were not met for FY17.

We found that HFS needs to more effectively monitor the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program and ensure that these recipients are receiving the same access to services as the EXPANDED ALL KIDS orthodontic recipients receiving care under the FFS part of the program.

Furthermore, although sufficient monitoring information was provided for the EXPANDED ALL KIDS orthodontic recipients receiving care under the FFS part of the program, HFS was unable to provide similar monitoring information for the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program. Due to the fact that a significant percentage of recipients in the EXPANDED ALL KIDS program were receiving orthodontic care under the MCO part of the program in FY17 and the number of these recipients continues to grow every year, we found that HFS needs to more effectively monitor the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program and ensure that these recipients are receiving the same access to services as the EXPANDED ALL KIDS orthodontic recipients receiving care under the FFS part of the program. (pages 29-39)

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 I 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

Joe Butcher
Division Assistant Director

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

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

FJM:SEC

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APPENDICES

GLOSSARY OF ACRONYMS

DHS – Illinois Department of Human Services

DORM – Dental Office Reference Manual

FFS – Fee-for-Service

FPL – Federal Poverty Level

HFS – Illinois Department of Healthcare and Family Services

HHS – Federal Department of Health and Human Services

HLD – Handicapping Labio-Lingual Deviation Index

IES – Integrated Eligibility System

MAGI – Modified Adjusted Gross Income

MCO – Managed Care Organization

OIG – Illinois HFS Office of the Inspector General

SNAP – Supplemental Nutrition Assistance Program

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 Public 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 ninth annual audit (FY17), and follows up on HFS' and the Department of Human Services' (DHS) actions to address prior audit findings. The previous eight audits covered FY09 through FY16. These annual audits contained as many as 14 audit recommendations. The last three annual audits (FY14 through FY16) contained the same five audit recommendations. As shown in Exhibit 1, the five recommendation areas were related to redeterminations, data reliability, classification of documented immigrants, eligibility documentation, and policies covering orthodontic treatment.

Eight Years of Audit Recommendations

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

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

Exhibit 1
STATUS OF PREVIOUS AUDIT RECOMMENDATIONS

Recommendation Area	Audits Recommended	Status of Recommendations as Reported in This FY17 Audit	Follow-up Testing
1. Redetermination of ALL KIDS Eligibility	FY09-FY16	Repeated	Yes
2. ALL KIDS Data Reliability	FY09-FY16	Repeated	Yes
3. Classification of Documented Immigrants	FY09-FY16	Repeated	Yes
4. Eligibility Documentation	FY09-FY16	Repeated	Yes
5. Policies Covering Orthodontic Treatment [1]	FY14-FY16	Partially Repeated	Yes

[1] The Administrative Code related to orthodontics and the scoring tool became effective during FY17 on January 19, 2017. Therefore, this audit recommendation was not followed up on until this FY17 audit.

Source: FY17 Program Audit of the Covering ALL KIDS Health Insurance Program.

FY17 Audit Findings and Recommendations

We followed up on each of the five previous audit recommendations during this FY17 audit. All five issues from our previous FY16 audit were repeated or partially repeated during this audit. Although the number of audit recommendations for this audit has decreased significantly since the first ALL KIDS audit covering Fiscal Year 2009, the first four audit recommendations have been repeated since the first ALL KIDS audit. One of these recommendations is the third audit recommendation, which includes the miscoding of documented immigrants. As a result of these miscoding errors, the State is annually losing federal matching dollars. We estimated that the total reimbursement lost was $2.8 million in FY15, $2.4 million in FY16, and $2.9 million in FY17 – for an estimated total of **$8.1 million** lost in federal reimbursement over the last three fiscal years.

The fifth audit recommendation was not recommended until the FY14 audit. This audit recommendation was not followed up on until this FY17 audit because the Administrative Code (89 Ill. Adm. Code 140.421) related to orthodontics and the scoring tool did not become effective until January 19, 2017 (FY17). This audit recommendation was partially repeated in this audit.

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 as "EXPANDED ALL KIDS." Since the EXPANDED ALL KIDS program is a subset of the ALL KIDS program as a whole, many of the recommendations are relevant to the program as a whole.

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

> *"First, children at any income level became eligible for healthcare benefits as long as they had been uninsured for an extended period of time or met certain exceptions established in rule. Second, in the rules implementing the expansion, All Kids was made available to previously ineligible non-citizen children at any income level as authorized under the new law and the Public Aid Code."*

The Public Aid Code (305 ILCS 5/12-4.35), effective July 1, 1998, 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 Public Act 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 that authorizes HFS to administer an insurance program that offers access to health insurance to all uninsured children in Illinois.

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 Covering ALL KIDS Health Insurance 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).

Changes Affecting the Covering ALL KIDS Program Audit

Four events in recent years have had a significant impact on the EXPANDED ALL KIDS program and our audits. These events are outlined 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.** Effective July 1, 2011, children whose families' household income was above 300 percent of the FPL were no longer eligible for the program. 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.** 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). 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). In FY17, the reimbursement rate was 88.91 percent. According to HFS officials, as of June 30, 2017, HFS had recouped a total of **$90.66 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. HFS officials estimate **$31.35 million** was recouped from the federal HHS as of June 30, 2017. Exhibit 2 provides a summary of the federal reimbursement recoupments for the ALL KIDS program for fiscal years 2014 through 2017. This information was provided by HFS as of June 30th of the fiscal year being reported.

Exhibit 2
ALL KIDS FEDERAL REIMBURSEMENT RECOUPMENTS (IN MILLIONS)
Fiscal Years 2014 – 2017

		Children 200-300% of FPL		Documented Immigrants	
Fiscal Year [1]	Reimbursement % [2]	FY Total	Cumulative Total	FY Total	Cumulative Total
FY14	65.00%	$10.44	$25.72	$6.57	$14.85
FY15	65.53%	$15.83	$41.55	$5.15	$20.00
FY16	88.62%	$23.69	$65.24	$5.65	$25.65
FY17	88.91%	$25.42	$90.66	$5.70	$31.35

Notes:

[1] This information was provided by HFS as of June 30th of the fiscal year being reported.

[2] The federal fiscal year runs from October 1 until September 30 so the reimbursement percentage listed is the percentage that covered most of the State fiscal year being reported.

Source: ALL KIDS federal reimbursement recoupment data provided by HFS.

3) **Changes to HFS' payment cycle changed the audit methodology for reporting payments by fiscal year.** 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 Patient Protection and Affordable Care Act required all states apply a new budget methodology based on MAGI to determine eligibility for certain households requesting or receiving medical assistance. 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 Patient Protection and Affordable Care Act required states to convert income standards and take into account that certain types of income (child support, workers' compensation, educational scholarships and grants, veterans' benefits, supplemental security income, etc.) will no longer apply under the MAGI budgeting methodology. Additionally, standards must be based on FPLs that were in effect in March 2010. MAGI budgeting determines how to count income and who to include in the income standard or Eligibility Determination Group. 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 Eligibility Determination Group is determined by one of two sets of rules: tax filer rules or relationship rules.

As shown in Exhibit 3, in FY13, a family of four qualified for ALL KIDS Assist at 133 percent of the federal poverty level (FPL) ($31,321 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, $36,168 in FY17). Therefore, the way DHS processed both new ALL KIDS applications and annual redeterminations changed during our FY14 audit period. Exhibit 3 shows the annual applicable FPL income guidelines for a family of four by plan for each of the last five fiscal years. The FY13 figures are prior to the implementation of the MAGI standards.

Exhibit 3
ANNUAL FEDERAL POVERTY LEVEL (FPL) FOR FAMILY OF FOUR
Fiscal Years 2013 – 2017

EXPANDED ALL KIDS Plan	FY13 Percent of FPL	Annual FY13 Maximum Income	FY14 -FY17 Percent of FPL[1]	Annual Maximum Income[1]			
				FY14	FY15	FY16	FY17
Assist	133%	$31,321	147%	$35,064	$35,652	$35,724	$36,168
Share	150%	$35,325	157%	$37,440	$38,076	$38,148	$38,628
Premium Level 1	200%	$47,100	209%	$49,848	$50,688	$50,784	$51,420
Premium Level 2	300%	$70,650	318%	$75,840	$77,112	$77,280	$78,228

[1] Does not include certain types of excluded income (child support, workers' compensation, veterans' benefits, social security income, 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, which began in February 2014. MAGI rules for redeterminations became effective on April 1, 2014. The Illinois Medicaid Redetermination Project 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.

According to DHS officials, preparation was in progress in FY17 for the implementation of IES Phase 2 (implemented October 24, 2017) and the completion of Max-IL (ended January 17, 2018). DHS officials note that these changes impacted the revised initial eligibility determination process and the revised redetermination of eligibility process in FY18. Since both of these changes occurred in FY18, we will discuss these changes more during the next annual audit, which covers the period July 1, 2017, to June 30, 2018.

ALL KIDS PROGRAM

According to HFS, in FY17, 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 104,856 EXPANDED ALL KIDS enrollees **at any point** in FY17, which is a slight decrease (1.5%) from FY16 when there were 106,447 enrollees (see text box.)

EXPANDED ALL KIDS PROGRAM STATISTICS		
	FY16	FY17
Enrollees at any point	106,447	104,856
Enrollees on June 30	67,776	66,353
Total Cost of Services Provided	$97,230,941	$103,054,764
Total Net Cost of Services after Premium Payments	$80,793,336	$85,068,952

The number of EXPANDED ALL KIDS enrollees at the end of the fiscal year did not significantly change from FY16 to FY17. On June 30, 2016, there were 67,776 enrollees. On June 30, 2017, there were 66,353 enrollees. Therefore, there was only a slight decrease of 1,423 in enrollees.

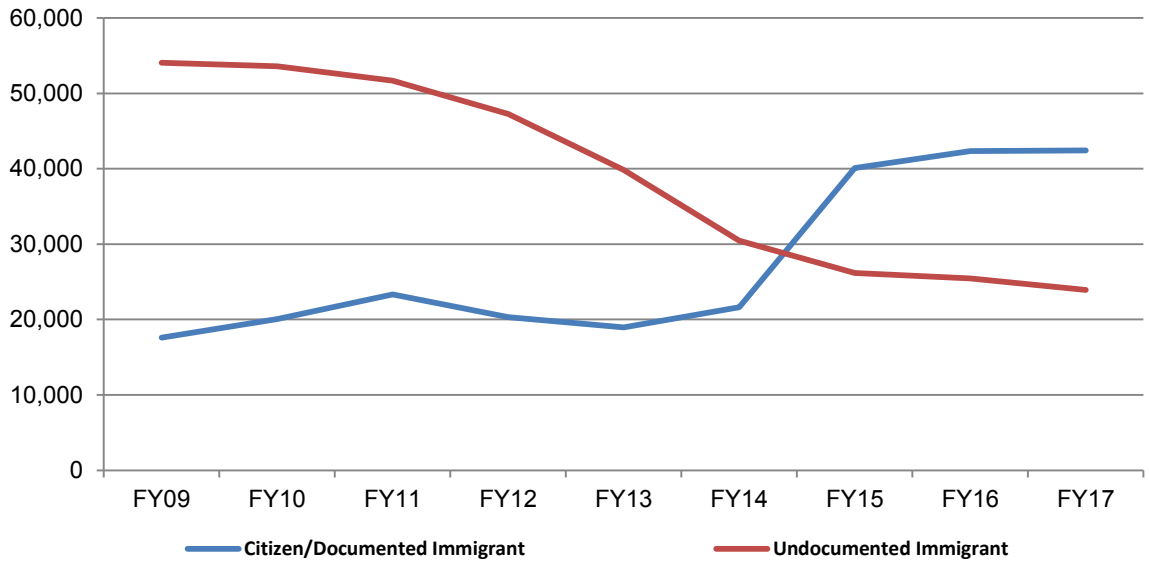
We followed up with the agencies regarding why the cost of services increased from FY16 to FY17 when the number of enrollees decreased from FY16 to FY17. According to DHS officials, the increase in the cost of services in FY17 may be due to the increase in the cost of MCO capitation payments but deferred to HFS for confirmation. According to HFS officials, the increase in the cost of services in FY17 may be due to utilization rates and/or rate increases.

ALL KIDS Enrollment

As shown in Exhibits 4 and 5, the number of undocumented immigrants enrolled as of June 30 has declined each year since 2009. Conversely, the number of citizen/documented immigrant EXPANDED ALL KIDS recipients (Premium Level 2) has increased each year since 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 FY17, the number of citizen/documented immigrant recipients remained fairly consistent. The number of citizen/documented immigrant recipients (Premium Level 2) only slightly increased from 42,338 recipients in FY16 to 42,435 recipients in FY17.

Exhibit 4
EXPANDED ALL KIDS ENROLLMENT
As of June 30 for Fiscal Years 2009 – 2017



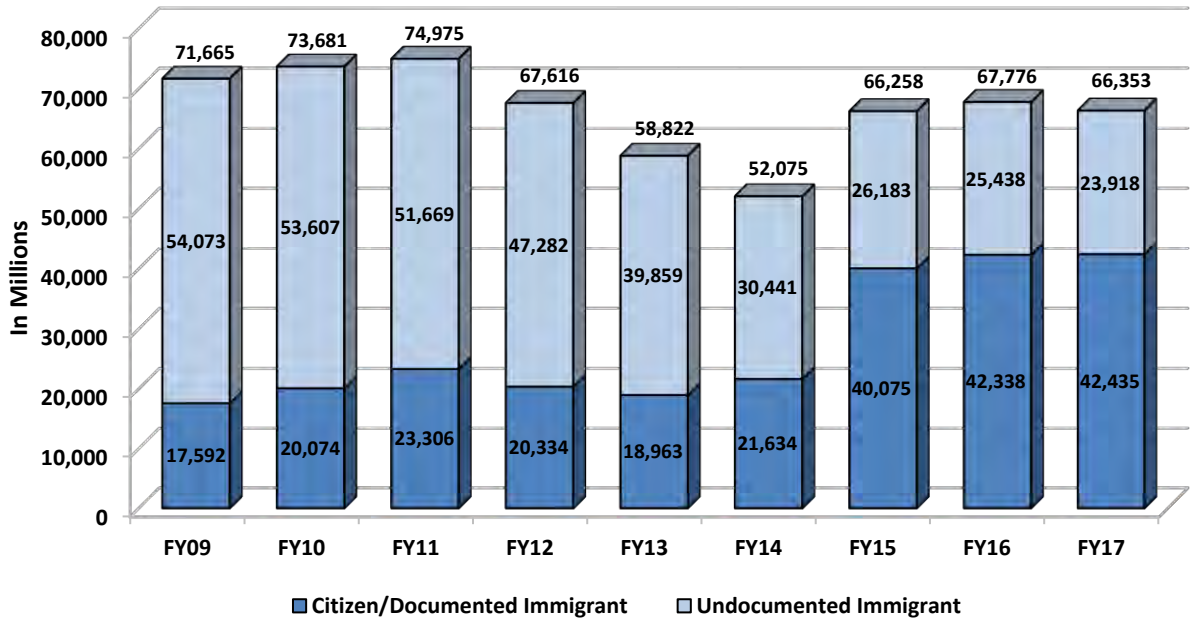
Source: ALL KIDS enrollment data provided by HFS.

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 Public Act 96-1501. Premium Levels 1 and 2 were not eliminated by Public Act 96-1501.

In total, as seen in Exhibit 5, the number of citizen/documented immigrant recipients increased while the total number of undocumented recipients decreased from FY09 to FY17.

- The number of citizen/documented immigrant recipients **increased** from 17,592 in FY09 to 42,435 in FY17 (141%).
- The number of undocumented recipients **decreased** from 54,073 in FY09 to 23,918 in FY17 (56%).

Exhibit 5
ENROLLEES AS OF JUNE 30
For EXPANDED ALL KIDS during Fiscal Years 2009 – 2017

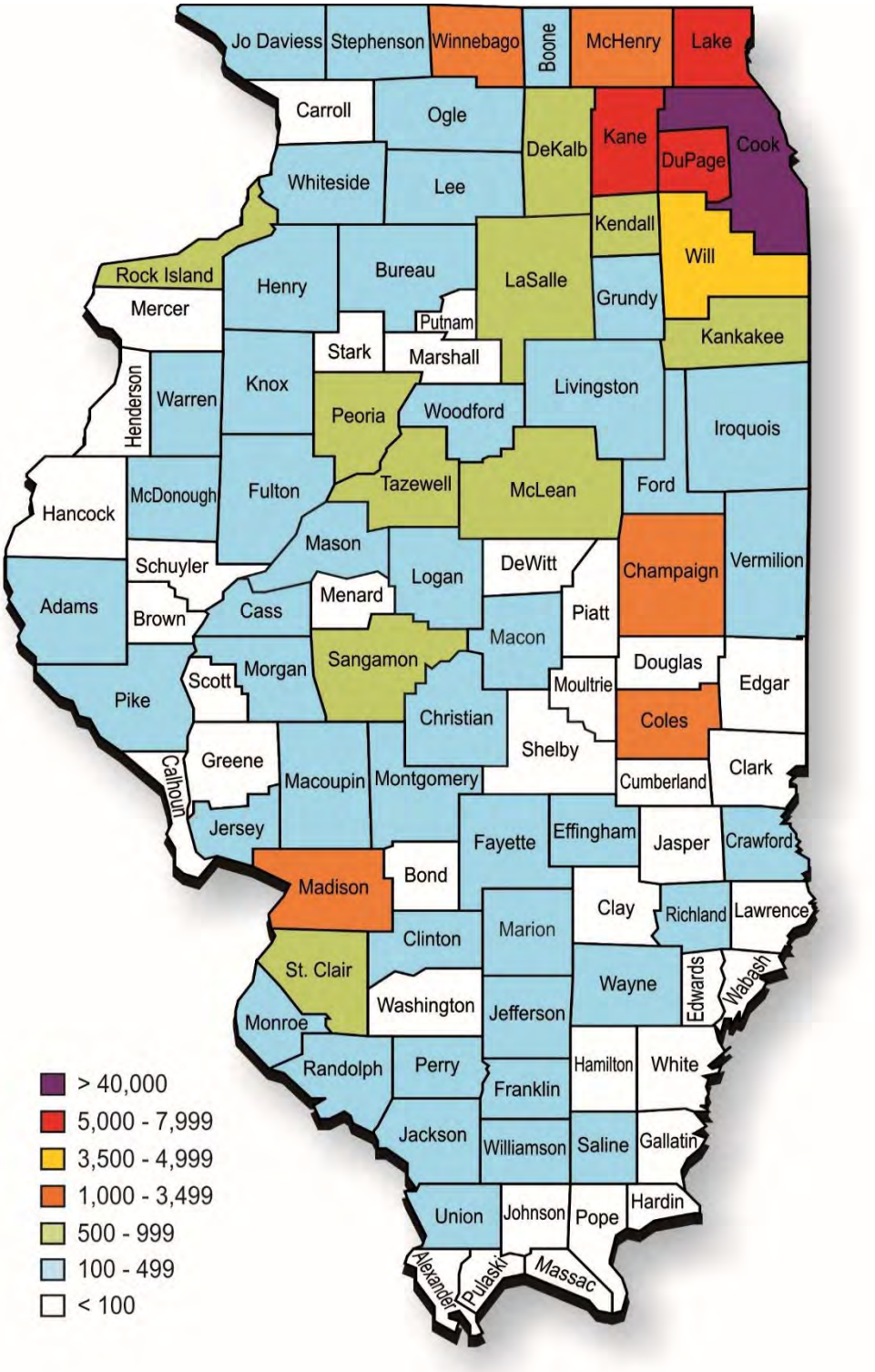


Source: ALL KIDS data provided by HFS.

ALL KIDS Enrollees by County

Exhibit 6 shows the number of EXPANDED ALL KIDS enrollees by county. As seen in this exhibit, the majority of enrollees in FY17 lived in Cook County (47,462). The other counties with large populations of EXPANDED ALL KIDS enrollees included: DuPage (8,584), Lake (7,575), Kane (7,438), and Will (4,762).

Exhibit 6
EXPANDED ALL KIDS ENROLLMENT BY COUNTY
Fiscal Year 2017



Source: FY17 eligibility data provided by HFS.

Enrollment by ALL KIDS Plan

Exhibit 7 breaks out enrollment by plan, fiscal year, and by whether the child was classified as a citizen/documented immigrant or as undocumented for FY16 and FY17. As noted previously, the total number of EXPANDED ALL KIDS enrollees slightly decreased from 67,776 in FY16 to 66,353 in FY17. There was also a decrease in the number of undocumented immigrants from FY16 to FY17. The HFS data classified 25,438 (38%) as undocumented immigrants in FY16 and 23,918 (36%) as undocumented immigrants in FY17. Appendix C shows the ALL KIDS premium and co-pay requirements by plan during FY17.

Exhibit 7
ENROLLMENT BY PLAN [2]
For EXPANDED ALL KIDS as of June 30

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants		Totals	
	FY16	FY17	FY16	FY17	FY16	FY17
Assist $36,168[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		22,494	21,132	22,494	21,132
Share $38,628[1]			535	574	535	574
Premium Level 1 $51,420[1]			1,615	1,516	1,615	1,516
Premium Level 2 $78,228[1]	42,338	42,435	794	696	43,132	43,131
Totals	42,338	42,435	25,438	23,918	67,776	66,353

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 effective 4/2017. Although the monthly income standards changed during FY17, these were the most recent effective amounts and were utilized during the months tested for the audit.

[2] Enrollment is the total number of enrollees that were eligible on June 30 of 2016 and 2017. There were 106,447 enrollees eligible at some point during FY16 and 104,856 enrollees eligible at some point during FY17.

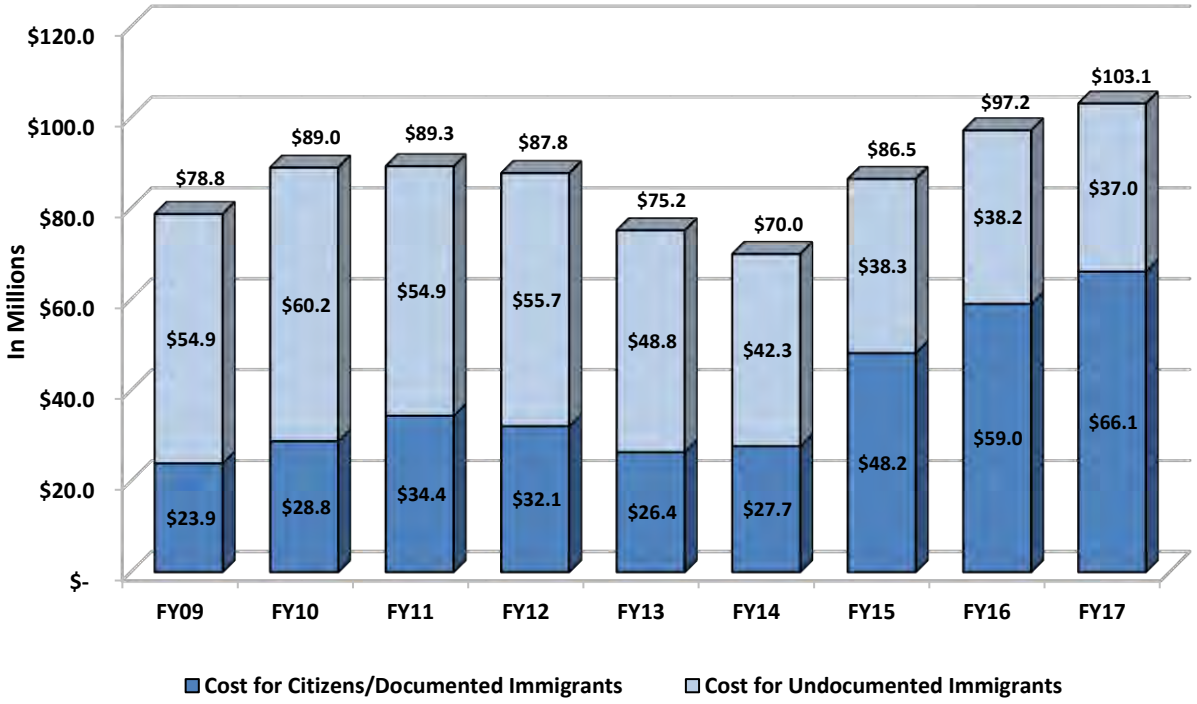
Source: ALL KIDS enrollment data provided by HFS.

COST OF SERVICES PROVIDED BY FISCAL YEAR

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 $103.1 million in FY17. Exhibit 8 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 Levels 3 through Level 8. The total cost for undocumented immigrants has continued to decrease each year since FY12 – from $55.7 million in FY12 to $37.0 million in FY17.

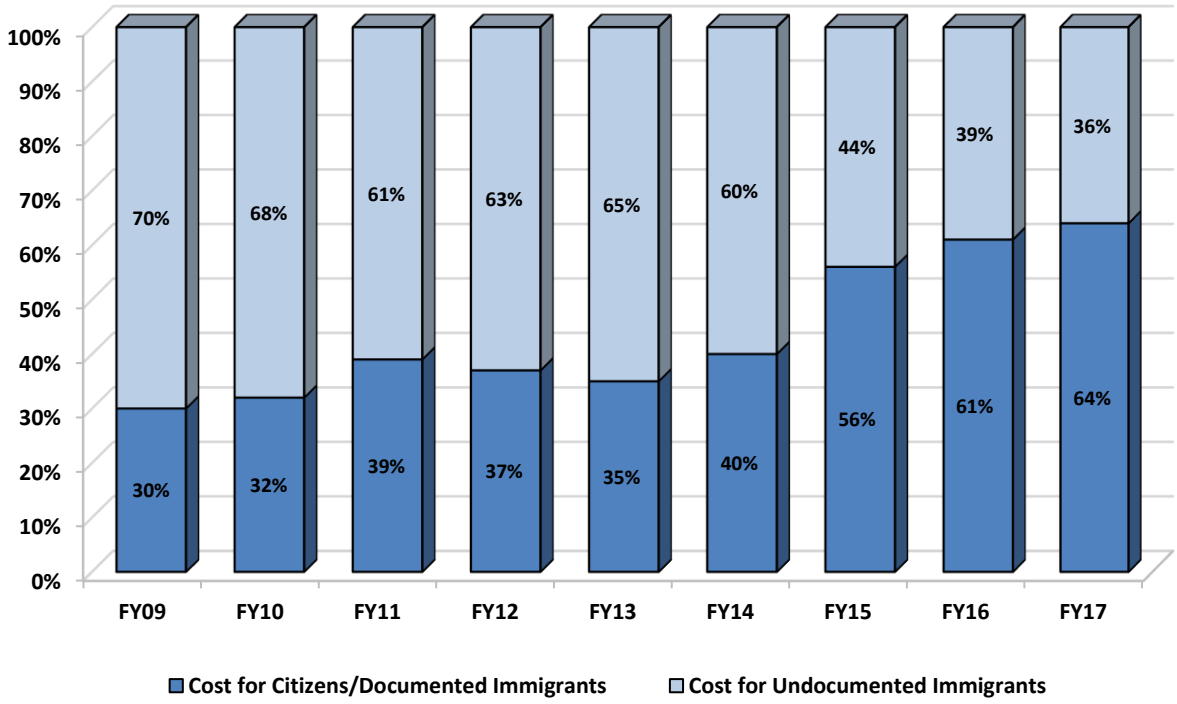
Exhibit 8
COST OF SERVICES
For EXPANDED ALL KIDS during Fiscal Years 2009 – 2017



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 three years. Exhibit 9 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 costs for the EXPANDED ALL KIDS program. This percentage has declined each year with undocumented immigrants accounting for only 36 percent of the total cost in FY17.

Exhibit 9
PERCENTAGE OF COST OF SERVICES
For EXPANDED ALL KIDS during Fiscal Years 2009 – 2017



Source: ALL KIDS data provided by HFS.

Exhibit 10 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 FY16 and FY17. Additionally, Exhibit 10 shows the cost of services increased by almost $6 million (6%) from $97.2 million in FY16 to $103.1 million in FY17.

Exhibit 10
COST OF SERVICES PROVIDED BY PLAN
For EXPANDED ALL KIDS during Fiscal Years 2016 and 2017

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals[2]	
	FY16	FY17	FY16	FY17	FY16	FY17
Assist $36,168[1]	Part of Medicaid and not part of EXPANDED ALL KIDS		$34,836,337	$33,034,213	$34,836,337	$33,034,213
Share $38,628[1]			$663,817	$767,717	$663,817	$767,717
Premium Level 1 $51,420[1]			$1,940,735	$2,374,695	$1,940,735	$2,374,695
Premium Level 2 $78,228[1]	$59,034,547[3]	$66,075,439[3]	$755,504	$802,701	$59,790,051	$66,878,139
Totals[2]	$59,034,547	$66,075,439	$38,196,393	$36,979,325	$97,230,941	$103,054,764

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 effective 4/2017. Although the monthly income standards changed during FY17, these were the most recent effective amounts and were utilized during the months tested for the audit.

[2] Totals may not add due to rounding.

[3] The federal matching rate was 88.62 percent in FY16 and 88.91 percent in FY17; therefore, the State's estimated share for services was $6.7 million in FY16 and $7.3 million in FY17.

Source: ALL KIDS data provided by HFS.

COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE

According to data provided by HFS, 92 percent of the cost for services provided during FY17 for EXPANDED ALL KIDS was paid for 13 categories of services each totaling more than $1 million. Exhibit 11 shows the 13 categories of services which totaled $94.4 million of the $103.1 million in total EXPANDED ALL KIDS payments.

The category with the highest percentage of payments was Capitation Services at 30 percent (see Exhibit 11). This category has continued to increase since the FY15 audit when it only accounted for 15 percent of payments. During the FY16 audit, 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 (FFS) 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 and FY17.

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

- Appendix D shows EXPANDED ALL KIDS total cost of services provided by category of service during FY17.

- Appendix E shows EXPANDED ALL KIDS total cost of services provided by plan and by category of service during FY17.

- Appendix F shows total services provided by providers that were paid more than $50,000 from EXPANDED ALL KIDS in FY17.

Exhibit 11
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE
Totaling more than $1 million during FY17 for the EXPANDED ALL KIDS Program

Category of Service	Total FY17 Cost	Percent of Total FY17 Cost
1. Capitation Services	$30,933,434	30%
2. Pharmacy Services	16,744,106	16%
3. Dental Services	9,195,062	9%
4. Inpatient Hospital Services (General)	7,947,373	8%
5. Physician Services	7,403,106	7%
6. Outpatient Services (General)	6,232,217	6%
7. Healthy Kids Services	4,122,097	4%
8. General Clinic Services	3,470,900	3%
9. Inpatient Hospital Services (Psychiatric)	2,350,876	2%
10. Speech Therapy/Pathology Services	2,292,697	2%
11. Mental Health Rehab Option Services	1,509,173	1%
12. Nursing Service	1,205,523	1%
13. Medical Supplies	1,008,572	1%
Total for categories costing > than $1 million	**$94,415,136**	**92%**
Other categories totaling < than $1 million	8,639,628	8%
Total Cost for All Service Categories	**$103,054,764**	**100%**

Note: Totals may not add due to rounding.

Source: FY17 ALL KIDS data provided by HFS.

COST OF SERVICES AND PREMIUMS COLLECTED

HFS received $16.4 million in premiums from enrollees in FY16, and $18.0 million in FY17. As a result, the net cost of EXPANDED ALL KIDS after premium payments was approximately $80.8 million in FY16 and $85.1 million in FY17. Exhibit 12 shows payments and premiums collected from the EXPANDED ALL KIDS programs.

Exhibit 12
COST OF SERVICES AND PREMIUM AMOUNTS COLLECTED[2]
For the EXPANDED ALL KIDS Program during Fiscal Years 2016 and 2017

EXPANDED ALL KIDS Plan	FY16 Services Provided	FY16 Premiums Collected	FY16 Net Cost	FY17 Services Provided	FY17 Premiums Collected	FY17 Net Cost
Assist $36,168[1]	$34,836,337	n/a	$34,836,337	$33,034,213	n/a	$33,034,213
Share $38,628[1]	$663,817	$640	$663,177	$767,717	$110	$767,607
Premium Level 1 $51,420[1]	$1,940,735	$213,112	$1,727,623	$2,374,695	$208,021	$2,166,674
Premium Level 2 $78,228[1]	$59,790,051	$16,223,852	$43,566,199	$66,878,139	$17,777,681	$49,100,458
Totals[3]	$97,230,941	$16,437,604	$80,793,336	$103,054,764	$17,985,812	$85,068,952

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 effective 4/2017. Although the monthly income standards changed during FY17, these were the most recent effective amounts and were utilized during the months tested for the audit.

[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.

FOLLOW-UP ON PRIOR AUDIT RECOMMENDATIONS

This FY17 audit of the EXPANDED ALL KIDS program followed up on HFS and DHS actions to address prior audit findings. All five issues from our previous FY16 audit were repeated or partially repeated during the FY17 audit. The next several sections of the report discuss these recommendations. We have reviewed the FY17 data provided by HFS for completeness and found no significant issues.

As part of our fieldwork testing for this audit, we took three 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 FY17, that were reviewed by DHS or HFS during either May or June 2017. 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 2017. The total number of redeterminations in May and June 2017 was 2,037; however, not all were medical

only. We determined that more than half of the cases were redetermined by the Supplemental Nutrition Assistance Program (SNAP). Since these SNAP cases are redetermined differently than those that are medical only, we excluded the 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 support residency, birth/age, income, and citizenship/immigration status was received or verified in order to ensure that continued eligibility was determined accurately.

3) a sample of 25 randomly selected EXPANDED ALL KIDS cases who submitted documentation for approval for orthodontic services in June 2017 and compared their documentation with the criteria in the HFS Dental Office Reference Manual. This sample only covered the EXPANDED ALL KIDS cases receiving care under the fee-for-service (FFS) part of the program, which is administered by DentaQuest.

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.

A recommendation to adequately implement eligibility redeterminations was included in our FY09 audit and 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 through FY17.

- 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 through FY17, 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 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 as required.

- 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 (7%) were not redetermined annually as required.

- In FY17, HFS and DHS completed 93 percent of the required annual redeterminations for the EXPANDED ALL KIDS program. Our FY17 audit found that 2,411 of the 33,531 recipients (7%) were not redetermined annually as required.

ANNUAL REDETERMINATIONS

Our FY17 audit found that 2,411 of 33,531 (7%) were not redetermined annually as required for the EXPANDED ALL KIDS program.

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 FY17, the status of this recommendation is **repeated** and will be followed up on during the next audit, which covers the period July 1, 2017, to June 30, 2018.

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 that was implemented on October 24, 2017, incorporates case maintenance activities, in addition to new application processing and redeterminations. Phase 2 of IES will be more efficient and allow more flexibility to complete all of the work, but at this time conversion of case information is still being completed.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department of Human Services agrees with the recommendation. The redetermination process has been enhanced with the implementation of the new updated processing system in the Integrated Eligibility System (IES) Phase 2, which went live on October 24, 2017. The IES Phase 2 system will assist in tracking and auto initiating renewal notices to eligible customers. 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 FY17 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 134 recipients that received 740 services totaling $166,338 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 428 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, 2017, to June 30, 2018.

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 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. An HFS 643A is sent to 19 year olds aging out of All Kids medical benefits. The notice is triggered separately from the current redetermination process, two months prior to the individuals birth month.

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.

Social Security Numbers

For recipients categorized by HFS and DHS as "undocumented," we determined the FY17 eligibility data contained 4,949 recipients coded as undocumented who had social security numbers that were verified. Of these 4,949 "undocumented" recipients, 165 of them also had alien registration numbers.

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. As a result, the State is losing federal matching Medicaid funds - a total estimated loss of $8.1 million in federal reimbursement over the last three fiscal years.

We reviewed the services provided to these 4,949 "undocumented" recipients in FY17 and determined these recipients had 50,223 services for a total cost of almost $5.4 million. If these recipients were classified as undocumented in error, the State did not receive the eligible matching federal rate funds in FY17. Therefore, we used the federal reimbursement rates (51.30% for Title XIX in FY17 and 88.91% for Title XXI in FY17) and estimated the total amount lost in federal reimbursement. We estimated that the State at a minimum did not collect $2.9 million in federal reimbursement for the $5.4 million in services in FY17. Additionally, we estimated that the State at a minimum did not collect $2.4 million in federal reimbursement in FY16 and $2.8 million in federal reimbursement in FY15 – for a total estimated loss of **$8.1 million** in federal reimbursement over the last three 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.

Alien Registration Numbers

For recipients categorized by HFS and DHS as "undocumented," we determined the FY17 eligibility data contained 118 recipients coded as undocumented who had an alien registration number, but did not have a verified social security number.

The number of recipients coded as undocumented who had an alien registration number increased significantly from 11 in FY16 to 118 in FY17. We followed up with DHS and HFS to determine why this number had increased significantly. DHS officials could not provide an explanation for this increase. According to HFS officials, during the time frame indicated, IES was experiencing alien status errors that have since been resolved. HFS officials also discussed verification and coding errors during that time but noted that any remaining case changes were updated in IES. In addition, we reviewed a discovery sample of 10 of the 118 recipients. For these cases, we found that generally the cases appeared to start FY17 coded as undocumented but were then updated later in FY17 to add an alien registration number and change the status code from undocumented to another code. We will follow up and review the number of recipients

coded as undocumented who had an alien registration number during the next audit, which covers the period July 1, 2017, to June 30, 2018.

Testing Results

During our testing of 40 new cases and 40 redetermined cases that were approved during May and June of 2017, we reviewed the citizenship status for these recipients. We found documentation to support citizenship and/or documented immigrant status for recipients classified as undocumented in both the new and redetermined samples. These testing results are discussed below.

Initial Eligibility Testing

During our FY17 review of 40 new cases, we found that 17 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 17 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 17 out of the 40 recipients sampled (43%) who were coded as undocumented were likely citizens or documented immigrants. We provided these 17 cases to DHS, and DHS officials agreed they were likely documented.

INITIAL ELIGIBILITY

17 out of the 40 recipients sampled (43%) who were coded as undocumented were likely citizens or documented immigrants. We provided these 17 to DHS, and DHS officials agreed they were likely documented.

Redetermination of Eligibility Testing

During our FY17 review of 40 redetermined cases, we found 9 of the 40 recipients sampled (23%) were coded as undocumented even though they had a verified social security number supporting they were likely citizens or documented immigrants. We provided these nine cases to DHS, and DHS officials agreed they were likely documented.

REDETERMINATION OF ELIGIBILITY

9 of the 40 redetermined recipients sampled (23%) were coded as undocumented even though they had a verified social security number supporting they were likely citizens or documented immigrants.

Conclusion

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, 2017, to June 30, 2018. 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 are still being reviewed after IES Phase 2 implementation. A Medical Morsel titled, "When is a Noncitizen Child Considered Undocumented?", was sent to staff on July 11, 2018. The Medical Morsel lists the steps to take in IES to ensure noncitizen children are coded correctly.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department of Human Services agrees with the recommendation. Conversion and implementation of IES Phase 2 was completed in October 2017, and allows for improved classification of documented immigrants and electronic storage of verifications supporting the immigration status for noncitizens. Given the confusion surrounding the proper classification of documented and undocumented immigrants, additional training and/or communication to staff is needed. Additionally, the population of documented and undocumented immigrants is relatively small compared to the remainder of the population, so related policy is not as widely and confidently understood as policy related to the programs administered to our U.S. Citizen population. DHS will explore the possibility of modifying IES to assist with the proper classification of immigrants as much as possible.

ELIGIBILITY DOCUMENTATION

All eight 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 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 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, 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 Illinois Medicaid Redetermination Project 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 435 new cases approved during May and June 2017 and found significant issues. As discussed previously, 17 of the 40 cases (43%) 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 17 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 (FY16) found 12 of 40 cases (30%) were likely incorrectly coded as undocumented.

During our FY17 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, **20**

cases (50%) 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 13, in FY17, we found residency was not verified in 7 of the 40 cases tested (18%).

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 13, in FY17, auditors determined that birth/age information was not verified in 14 of the 40 (35%) 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 FY17 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, 24 reported having income. For the 24 cases with income reported, 30 days of income was not reviewed in 2 of the cases (8%). Six additional FY17 cases contained income calculation errors. See Exhibit 13 for a summary of the FY16 and FY17 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 FY17 initial eligibility testing, this part of the recommendation is **repeated** and will be followed up on in future audits.

Exhibit 13
RESULTS OF ELIGIBILITY TESTING
(Initial Eligibility)

	Residency Verified		Age Verified		30 Days Income Verified[1]	
	FY16	FY17	FY16	FY17	FY16	FY17
Number Tested	40	40	40	40	21	24
Number Missing Documentation	9	7	16	14	2	2
Percent Missing Documentation	23%	18%	40%	35%	10%	8%

[1] In FY16, 19 of 40 cases tested reported no income. In FY17, 16 of 40 cases tested reported no income.

Source: OAG FY17 Eligibility Testing Results for Initial Eligibility.

Eligibility Redetermination Testing

We tested 40 of the medical only redeterminations that occurred during May and June 2017 and found issues regarding Illinois residency, birth/age, and income documentation. The total number of redeterminations in May and June 2017 was 2,037. Since more than half of these cases were redetermined by the Supplemental Nutrition Assistance Program (SNAP) and SNAP cases are redetermined differently than those that are medical only, we excluded the SNAP cases (1,133) from our random sample of 40 cases. As discussed previously, 9 of the 40 cases (23%) 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 nine 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 FY17 testing, we reviewed all 40 redetermined cases to determine whether all required eligibility redetermination documentation was obtained or reviewed. Of the 40 cases reviewed, **29 cases (73%)** were missing at least one piece of required documentation (verification of residency, birth/age, or income).

Illinois Residency Verification (Redetermination)

Illinois residency verification is required for ALL KIDS by 215 ILCS 170/7(a)(3). According to both HFS and DHS officials, effective March 14, 2012, an automated Secretary of State clearance was implemented to verify residency. The clearance matches the recipient's social security number with Secretary of State 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 14, residency was not verified in 13 of the 40 (33%) cases we tested in FY17.

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 14, birth/age information was not verified in 25 of the 40 (63%) cases we tested in FY17.

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, 35 reported having income. For the 35 cases with income reported, 30 days of income was not reviewed in 7 of the cases with income reported (20%). Additionally, we identified seven other cases where the income was not calculated correctly. See Exhibit 14 for a summary of the FY16 and FY17 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 FY17 eligibility testing of redeterminations, this part of the recommendation is **repeated** and will be followed up on in future audits.

Exhibit 14
RESULTS OF ELIGIBILITY TESTING
(Redetermination)

	Residency Verified		Age Verified		30 Days Income Verified[1]	
	FY16	FY17	FY16	FY17	FY16	FY17
Number Tested	40	40	40	40	37	35
Number Missing Documentation	13	13	32	25	3	7
Percent Missing Documentation	33%	33%	80%	63%	8%	20%

Note: [1] In FY16, 3 of 40 cases tested reported no income. In FY17, 5 of 40 cases tested reported no income.

Source: OAG FY17 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 plans to propose 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. The Department implemented Phase 2 of IES, which 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 agrees to continue to remind staff of the various requirements for these cases.

POLICIES COVERING ORTHODONTIC TREATMENT

As part of the FY14 EXPANDED ALL KIDS audit, we noted that there were a large number of dentists providing orthodontic services that were among the highest paid providers in the EXPANDED ALL KIDS program. During the examination of orthodontic services, a DentaQuest official informed us that the scoring tool used by DentaQuest for orthodontic cases was revised in 2010. The change in the scoring tool corresponded with a significant increase in orthodontia claims being paid by HFS.

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. 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 while payments for orthodontic services totaled $36.6 million in FY14.

As a result, we approached the HFS Office of the Inspector General (OIG) for assistance reviewing eligibility documentation for a sample of providers and conducted joint visits with

them. The 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. Moreover, the FY14 EXPANDED ALL KIDS audit identified a lack of documentation related to orthodontic claims and the need for improvements in HFS orthodontic policies and documentation of medical necessity. We recommended that HFS ensure DentaQuest is receiving and maintaining documentation needed to support orthodontia approvals and more effectively monitor the actions taken by DentaQuest (the Dental Program Administrator for HFS). We also recommended that HFS examine and address the issues raised by the OIG.

HFS agreed with this recommendation and indicated it would review the issues raised and take appropriate action. To address the recommendation, HFS updated the Administrative Code and also revised the scoring tool. Since the Administrative Code related to orthodontics and the scoring tool became effective on January 19, 2017 (FY17), this recommendation was repeated for the previous two audits (FY15 and FY16) and was not followed up on until this FY17 audit.

Issues Raised by the HFS OIG on Orthodontic Claims

As part of the FY14 EXPANDED ALL KIDS audit, we worked with the OIG and questioned whether some recipients approved for orthodontic services met the need standards established in HFS' administrative rule or Dental Office Reference Manual (DORM). Through this review, the OIG found guidelines for providers for orthodontic services to be unclear, inconsistent, and recommended changes to the Administrative Code, Department Handbooks, or other policies. The review concluded that revisions and clarifications to policies establishing medical necessity should be made, as well as requiring additional documentation to support medical necessity.

During FY17, HFS updated the Administrative Code and scoring tool (see Appendix G and Appendix H for copies of the updated Code and scoring tool). HFS officials noted that the new Administrative Code and scoring tool addressed problems identified from our 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) (see scoring tool in Appendix H); 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.).

We received and reviewed the new Administrative Code and the HLD scoring tool, which were updated for use in determining if EXPANDED ALL KIDS orthodontic applicants were eligible for services in FY17. According to the FY14 EXPANDED ALL KIDS audit, when

the previous scoring tool was approved in FY11, the Administrative Code delineating eligibility criteria for orthodontic services was not changed. However, during this FY17 review, we found that both the new Administrative Code and scoring tool were updated effective on January 19, 2017.

We followed up with the OIG during this audit and discussed HFS's actions to update the Code and scoring tool. According to the OIG, the actions taken by HFS were sufficient to meet the problems identified in the second bullet of the FY14 EXPANDED ALL KIDS audit recommendation, which stated that HFS should "examine and address the issues raised by the OIG in its review of orthodontic claims." However, the OIG further stated that although the actions taken by HFS were sufficient for the EXPANDED ALL KIDS recipients receiving orthodontic care under the fee-for-service (FFS) part of the program, the OIG could not comment on the status of the EXPANDED ALL KIDS recipients receiving care under the Managed Care Organization (MCO) part of the program. This issue is discussed later under the section entitled "EXPANDED ALL KIDS Orthodontic Recipients Receiving Care under MCOs."

FY14 Audit Recommendation on Policies Covering Orthodontic Treatment

We recommended that the Department of Healthcare and Family Services should:

- ensure DentaQuest is receiving and maintaining documentation 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).

Necessary Documentation to Support Orthodontic Claims

During the FY14 EXPANDED ALL KIDS audit, we reviewed policies and procedures related to the approval of orthodontia and found that DentaQuest 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. We found that DentaQuest could not provide the documents for 9 of the 40 requested (23%). As a result, the FY14 audit recommended that HFS ensure DentaQuest is receiving and maintaining documentation needed to support orthodontic approvals.

In order to follow up for this audit, we tested a random sample of 25 EXPANDED ALL KIDS recipients who submitted documentation for approval for orthodontic services in June 2017 and compared it with the documentation requirements found in the HFS DORM. According to the HFS DORM, the following documentation is required to be submitted for prior authorization for orthodontics:

- Standard approved claim form, marking the box in the top left corner noting it as a prior authorization request and listing requested services;
- Completed Handicapping Labio-Lingual Deviation Index (HLD) ;
- X-rays, photographs, plaster or digital models; and
- A written narrative of medical necessity.

This sample only covered the EXPANDED ALL KIDS cases receiving care under the FFS part of the program, which is administered by DentaQuest. Unfortunately, when we followed up with HFS on the EXPANDED ALL KIDS recipients receiving care under MCO part of the program, we could not obtain additional information regarding how HFS is ensuring the MCOs are receiving and maintaining the required documentation needed to support orthodontic approvals. Specifically, we asked how HFS is ensuring the MCOs are following the new Administrative Code and utilizing the new scoring tool. However, HFS officials could not provide this additional information as of November 2018. Therefore, we will follow up on this issue during the subsequent annual audits of the EXPANDED ALL KIDS program beginning with the next annual audit, which will cover the period of July 1, 2017, to June 30, 2018. This issue is discussed later under the section entitled "EXPANDED ALL KIDS Orthodontic Recipients Receiving Care under MCOs."

Testing Results for Orthodontic Approvals

For the 25 cases reviewed, only two (8%) were approved. These two cases contained all four of the documentation requirements listed above. The remaining 23 cases tested were denied. Four of these denied cases were missing the required HLD scoring tools but their denial letters contained notes listing the scores that were received on these tools. These scores did not meet the minimum score required to be approved for services and the cases were denied. One of these cases was also missing the required x-rays, photographs, or models to be approved but since the case was not approved, this was not considered to be significant.

For the 25 cases reviewed, we concluded that the documentation requirements had improved since the testing performed in FY14. We also concluded that the documentation provided to HFS by DentaQuest had improved. Since the two cases that were approved contained all required documentation, we found this to be sufficient to meet the documentation requirements listed above. Therefore, the issues identified in the first bullet of the FY14 audit recommendation had been resolved during FY17. The first bullet of the FY14 audit recommendation on policies covering orthodontic treatment stated that HFS should ensure DentaQuest was receiving and maintaining documentation needed to support orthodontia approvals for EXPANDED ALL KIDS recipients. We found that DentaQuest was receiving and maintaining documentation needed to support orthodontia approvals for EXPANDED ALL KIDS recipients receiving care under the FFS part of the program.

More Effective Monitoring of DentaQuest

In addition to ensuring DentaQuest is receiving and maintaining documentation for orthodontia approvals, the FY14 EXPANDED ALL KIDS audit also recommended that HFS more effectively monitor the actions taken by DentaQuest. We followed up to determine how HFS is more effectively monitoring the actions taken by DentaQuest in FY17. According to HFS officials, HFS uses monthly prior authorization reports which now address orthodontics. In addition, HFS also requires meetings with DentaQuest and the Dental Policy Review Committee (Committee).

We followed up on these areas and concluded that HFS was more effectively monitoring the actions taken by DentaQuest through these required reports and meetings. However, we did

identify an issue related to the membership requirements listed in the Committee bylaws. We found that the member requirements in the FY17 Committee's bylaws were not met for FY17. As a result, we are recommending that HFS review the membership requirements for the Committee and update the bylaws accordingly.

In addition, although these required reports and meetings allow HFS to more effectively monitor the actions for the EXPANDED ALL KIDS recipients receiving orthodontic care under the FFS part of the program, the required reports and meetings do not allow HFS to more effectively monitor the actions for EXPANDED ALL KIDS recipients receiving orthodontic care under the MCO part of the program. HFS could not provide similar monthly prior authorization reports for the EXPANDED ALL KIDS recipients receiving orthodontic care under the MCO part of the program. In addition, although we identified minimal discussions about MCOs at the meetings outlined below, HFS could not provide similar detailed meetings or discussions about the status of the MCOs and/or the vendors providing care to the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program. Therefore, we will follow up on this issue during the subsequent annual audits of the EXPANDED ALL KIDS program beginning with the next annual audit, which will cover the period of July 1, 2017, to June 30, 2018. This issue is discussed later under the section entitled "EXPANDED ALL KIDS Orthodontic Recipients Receiving Care under MCOs."

Monthly Prior Authorization Reports

In FY15, HFS began requiring DentaQuest to submit prior authorization reports to HFS on a monthly basis. The HFS contract with DentaQuest (effective 01/01/15 through 06/30/19), Section 1.1.1.V.2 entitled "Monthly Prior Authorization Reports," requires eleven components to be included in the monthly prior authorization reports. Examples of these eleven components include:

- the total number of prior authorizations received;
- the total number of prior authorizations approved;
- the total number of prior authorizations denied;
- the total number of prior authorizations returned to the provider because of insufficient documentation;
- the total number of prior authorizations determined within 30 days after receipt; and
- the percentage of prior authorizations determined within 30 days after receipt.

We requested and reviewed all FY17 monthly prior authorization reports and found that DentaQuest submitted these reports for all months required. In addition, we reviewed the reports for the required eleven components listed in the contract. We found that all twelve monthly prior authorization reports contained all required components listed in the HFS contract with DentaQuest. By establishing the requirement and receipt of these prior monthly authorization reports since the FY14 EXPANDED ALL KIDS audit, we found that HFS is more effectively monitoring the actions taken by DentaQuest for the EXPANDED ALL KIDS recipients receiving care under the FFS part of the program in FY17.

Required Meetings

In FY15, HFS began requiring DentaQuest to meet monthly with HFS. The HFS contract with DentaQuest (effective 01/01/15 through 06/30/19), Section 1.1.1.R entitled "Meeting Requirements," states that DentaQuest and HFS shall meet at least monthly throughout the term of the contract. As a result, we requested these FY17 monthly meeting minutes and reviewed them to determine if HFS was meeting with DentaQuest on a monthly basis as required. We found that HFS met with DentaQuest for 11 of the 12 months required. Although HFS officials noted there were no meetings in June of 2017 due to other meetings, HFS provided support for ongoing communication with DentaQuest and instructed DentaQuest staff to contact HFS if there were any issues. As a result, we concluded that DentaQuest's monthly meeting requirement with HFS was sufficient in FY17.

The HFS contract also requires DentaQuest to meet on an ongoing basis with statewide or local dental coalitions. According to HFS officials, Dental Policy Review Committee (Committee) meetings are held quarterly to meet this requirement. The Committee's FY17 bylaws require: regular meetings shall be held up to four times per year, quorum is considered to be 51% of the appointed members present, and required members shall include up to 15 voting members for this committee. These members include:

- Eight members who will represent dentists/hygienists actively involved in rendering services to Medical Assistance and ALL KIDS clients, and
- Seven members with standing appointments from HFS. These seven members shall be made in writing and include:
  - Two dental consultants employed by HFS;
  - DentaQuest's current Dental Director;
  - The Illinois Dental Director;
  - The Illinois Department of Public Health's Division of Oral Health's Dental Director;
  - One representative from the Illinois State Dental Society; and
  - One member from a local component dental society of the Illinois State Dental Society.

We requested and received these ongoing committee meeting minutes. We reviewed them to verify if the meetings were ongoing as required, if the quorum was met as required, and if the committee members were present as required. We found that the meetings were ongoing and the quorum was met for all committee meetings. However, we found that the member requirements in the FY17 Committee's bylaws were not met for FY17.

The FY17 Committee bylaws require eight members representing dentists/hygienists rendering services and seven members with standing appointments by HFS. During FY17, the Committee did have eight members representing dentists/hygienists rendering services. However, four of the seven required members with standing appointments (57%) were not made by HFS. HFS officials explained that the four missing appointments were for two positions no longer employed by HFS (the two dental consultants employed by HFS) and for two positions where the same employee had two of the position titles listed above. In FY17, the Illinois Dental Director and DentaQuest's current Dental Director were represented by the same employee on

the Committee while the representative from the Illinois State Dental Society and the member from a local component dental society of the Illinois State Dental Society were represented by the same employee on the Committee. Therefore, based on the membership requirements listed in the FY17 Committee bylaws, HFS did not appoint seven members with standing appointments to be on the Committee in FY17. According to HFS officials, HFS is in the process of updating these requirements in the Committee bylaws for FY19.

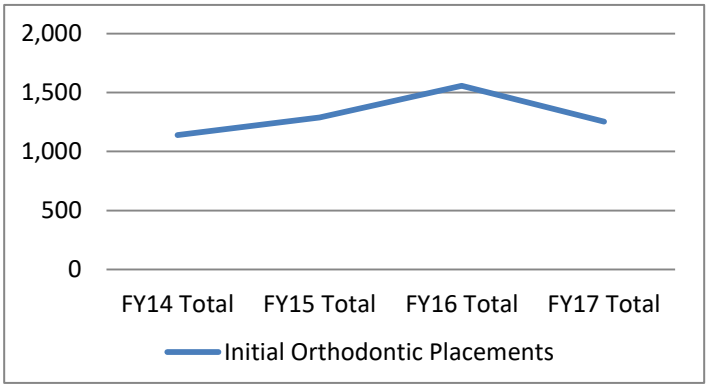
In addition, the Committee bylaws designate that about half of the members should be represented by dentists/hygienists rendering services and about half of the members should be represented by standing appointments from HFS. Since four of the seven appointed members are missing, there is an unbalance of representation for those being appointed by HFS. If HFS believes that these four designated appointments cannot be made, then HFS should consider designating additional representation from HFS to allow for a more balanced committee. Since the FY17 Committee membership requirements were not met or updated in FY17 and there is an unbalanced representation of committee members under the current situation, we are recommending that HFS review the membership requirements for the Committee and update the bylaws accordingly. Therefore, we will follow up on this issue during the subsequent annual audits of the EXPANDED ALL KIDS program beginning with the next annual audit, which will cover the period of July 1, 2017, to June 30, 2018.

EXPANDED ALL KIDS Orthodontic Recipients Receiving Care under MCOs

The FY14 audit concluded that the State's expenditures and services had increased dramatically from FY10 to FY14 for orthodontic recipients in the EXPANDED ALL KIDS program. We attempted to follow up on the status of these numbers in FY17. Since Public Act 96-1501 (with implementation beginning in FY15) mandated a transition from paying for services on a FFS basis to paying a per member per month capitation rate to managed care organizations for care coordination, we found that EXPANDED ALL KIDS orthodontic recipients changed from being FFS in FY14 to also being covered by MCOs in FY15 though FY17. As a result, we requested data for EXPANDED ALL KIDS orthodontic recipients from HFS for both the FFS and MCO parts of the program.

More specifically, we requested the number of initial orthodontic placements for both FFS and MCO parts of the program so we could review the total number of newly approved EXPANDED ALL KIDS

Exhibit 15
TOTAL NUMBER OF EXPANDED ALL KIDS INITIAL ORTHODONTIC PLACEMENTS
Fiscal Years 2014 – 2017



Note: This includes the total number of EXPANDED ALL KIDS initial orthodontic placements for FFS and MCO programs. For the MCO data, only between 85% and 93% of the encounter data was reported for FY15 through FY17.

Source: ALL KIDS orthodontic data provided by HFS.

orthodontic recipients for FY14 through FY17. As seen in Exhibit 15, the number of initial placements grew steadily from FY14 to FY16 before dropping in FY17. Initial orthodontic placements were 1,138 in FY14, 1,287 in FY15, 1,557 in FY16, and 1,252 in FY17. As a result, we concluded that these numbers were not dramatically increasing during FY17 as was identified during the FY14 EXPANDED ALL KIDS audit. We also concluded that the decrease in the number of initial orthodontic placements in FY17 may have been due to the new policy and scoring tool that were implemented in January 2017.

According to HFS officials, only 93 percent of the encounter data was reported by MCOs in FY17. Therefore, this data does not include all MCO data. In addition, a full fiscal year of data was not available for review yet since the Administrative Code and scoring tool were not updated until January 2017 (about half way through FY17). We requested this data for FY18 but HFS stated that this data will not be available until April 2019. Therefore, we will follow up and try to obtain this data during the next annual audit, which will cover the period of July 1, 2017, to June 30, 2018.

Since the EXPANDED ALL KIDS orthodontic recipients were covered by both FFS and MCO programs beginning in FY15 through FY17, we wanted to take a closer look at the breakdown of these recipients. We requested the number of initial orthodontic placements and the number of current orthodontic recipients for both the FFS and MCO programs for FY15 through FY17. As seen in Exhibit 16, we found that the MCOs covered a significant number of orthodontic recipients receiving care under the EXPANDED ALL KIDS program in FY17. Additionally, the number of recipients receiving care under MCOs had increased significantly from FY15 to FY17.

Exhibit 16
RECIPIENTS RECEIVING ORTHODONTIC SERVICES
By Fee-For-Service and Managed Care Organizations
Fiscal Years 2015 – 2017

		Initial Placements	%	Current Recipients	%
FY15	FFS	1,069	83%	4,514	79%
	MCO	218	17%	1,188	21%
FY16	FFS	934	60%	3,906	60%
	MCO	623	40%	2,657	40%
FY17	FFS	705	56%	3,836	58%
	MCO	547	44%	2,834	42%

Note: For the MCO data, only between 85% and 93% of the encounter data was reported for FY15 through FY17.

Source: ALL KIDS orthodontic data provided by HFS.

- In FY15, 17 percent of the initial orthodontic placements and 21 percent of the current orthodontic recipients were covered by MCOs (with 85% of the encounter data reported in FY15).
- In FY16, 40 percent of the initial orthodontic placements as well as 40 percent of the current orthodontic recipients were covered by MCOs (with 91% of the encounter data reported in FY16).
- In FY17, 44 percent of the initial orthodontic placements as well as 42 percent of the current orthodontic recipients were covered by MCOs (with 93% of the encounter data reported in FY17).

Since the number of recipients receiving care under the MCO part of the program was significant in FY17 and had increased every year since the implementation of Public Act 96-1501 in FY15, we requested all monitoring information available for these recipients in FY17.

Lack of Monitoring of EXPANDED ALL KIDS Orthodontic Recipients under MCOs

Although sufficient monitoring information was provided for the EXPANDED ALL KIDS orthodontic recipients receiving care under the FFS part of the program, HFS was unable to provide similar monitoring information for the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program. This included monthly prior authorization reports, meeting minutes, or any other similar monitoring information that we received for recipients receiving care under the FFS part of the program. We also could not confirm how HFS ensures the implementation of the requirements associated with the updated Administrative Code and new scoring tool for all of the EXPANDED ALL KIDS orthodontic recipients.

When we followed up with the OIG on HFS's implementation of the issues raised in its review of orthodontic claims, the OIG stated that the actions taken by HFS were sufficient to correct the problems identified in the FY14 audit recommendation on orthodontics for FFS recipients. However, the OIG stated that it could not comment on the status of the EXPANDED ALL KIDS recipients receiving care under the MCO part of the program and directed us to follow up with HFS's Bureau of Managed Care. We followed up with HFS and specifically HFS's Bureau of Managed Care, but did not receive any additional monitoring information specifically related to the EXPANDED ALL KIDS recipients receiving care under the MCO part of the program.

According to HFS, the EXPANDED ALL KIDS recipients receiving care under the MCO part of the program were covered by 13 MCO health plan providers and their 13 dental subcontractors in FY17. Although the HFS Bureau of Managed Care provided FY17 dental administrator subcontracts (13), administrative reviews (12 - one terminated participation 12/31/16), and annual reports (13) for the MCOs, this information was not specific to ensuring the implementation of the updated Administrative Code or the new scoring tool for the EXPANDED ALL KIDS recipients receiving orthodontic care under the MCO part of the program. When we asked how HFS is ensuring that the MCOs are following the new Administrative Code and scoring tool, HFS responded that "the MCOs contract with dental administrators to provide dental services to their enrollees. Dental administrators are aware of and have implemented this requirement." However, HFS could not provide support for how HFS was actually ensuring that all MCO dental subcontractors had implemented these requirements in FY17. The only additional documentation provided by the HFS Bureau of Managed Care that was effective during FY17 was the Dental Office Reference Manual (DORM) for one of the dental administrator subcontractors. The DORM for this dental administrator subcontractor did include new guidelines from the Administrative Code and the updated scoring tool.

We reviewed the 13 dental administrator subcontracts provided by the HFS Bureau of Managed Care for FY17. Although 9 of these 13 subcontracts were with the same dental subcontractor (DentaQuest), we found that the format used for most of the 13 subcontracts was

not consistent. These dental subcontracts dated back to FY11 with most containing a provision to automatically renew every year. We found that the majority of these FY17 subcontracts were written prior to the release of our FY14 EXPANDED ALL KIDS audit. We reviewed these 13 subcontracts for the following requirements: monthly prior authorization reporting requirements, meeting requirements, and requirements to follow the DORM. We found that these subcontracts contained some general relevant requirements in these areas but that the requirements were not as specific as the requirements for these three areas in HFS's contract with DentaQuest for ALL KIDS recipients receiving orthodontic care under the FFS part of the program. While HFS's FFS contract with DentaQuest contained specific sections for each of these three areas, these 13 dental administrator subcontracts did not. Since we found that HFS is more effectively monitoring the actions taken by DentaQuest for the EXPANDED ALL KIDS recipients receiving orthodontic care under the FFS part of the program, it may be beneficial for monitoring the EXPANDED ALL KIDS recipients receiving orthodontic care under the MCO part of the program if a similar contract format was used for these 13 dental administrator subcontracts.

During discussions with the HFS Bureau of Managed Care, HFS stated that HFS does not receive monthly prior authorization reports or any other monitoring information for these recipients receiving orthodontic care under the MCO part of the program. HFS stated that, "the MCOs are contractually required to perform delegated oversight of their subcontractors, including dental." Further, the Bureau could not confirm if the MCOs are receiving such monitoring information from their dental subcontractors stating that "the MCOs may require those from their dental administrators." Although HFS could not provide support for how HFS is ensuring the implementation of these requirements or provide specific monitoring information for the MCO orthodontic recipients, the HFS Bureau of Managed Care stated that HFS is willing "to change how we monitor MCOs in this regard" and work internally with the HFS officials responsible for the oversight of the EXPANDED ALL KIDS recipients in the FFS part of the program.

Due to the fact that a significant percentage of recipients in the EXPANDED ALL KIDS program were receiving orthodontic care under the MCO part of the program in FY17 and the number of these recipients continues to grow every year (see Exhibit 16), we found that HFS needs to more effectively monitor the EXPANDED ALL KIDS recipients receiving care under the MCO part of the program. HFS needs to ensure that the State's dental subcontractors are following the same requirements in the new Administrative Code and the scoring tool for all EXPANDED ALL KIDS orthodontic recipients. As a result, we are recommending that HFS needs to more effectively monitor the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program and ensure that these recipients are receiving the same access to services as the EXPANDED ALL KIDS orthodontic recipients receiving care under the FFS part of the program. The status of this recommendation is **partially repeated**. Therefore, we will follow up on this issue during the subsequent annual audits of the EXPANDED ALL KIDS program beginning with the next annual audit, which will cover the period of July 1, 2017, to June 30, 2018.

POLICIES COVERING ORTHODONTIC TREATMENT	
RECOMMENDATION NUMBER **5**	***The Department of Healthcare and Family Services should:*** • ***review the membership requirements for the Dental Policy Review Committee and update the Dental Policy Review Committee bylaws accordingly; and*** • ***more effectively monitor the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program and ensure that these recipients are receiving the same access to services as the EXPANDED ALL KIDS orthodontic recipients receiving care under the FFS part of the program.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department is in the process of updating the requirements in the Committee bylaws for FY19. All of the managed care plans use the HLD tool and the DORM guidelines for orthodontia. The Department will monitor the orthodontic recipients receiving care under the MCO part of the program.

APPENDICES

APPENDIX A

COVERING ALL KIDS HEALTH INSURANCE ACT (215 ILCS 170)

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

Appendix A

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. 99-1501, eff. 6-30-16.)

(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
AUDIT SCOPE AND METHODOLOGY

Appendix B

AUDIT SCOPE AND METHODOLOGY

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

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

Since this is the ninth audit of the EXPANDED ALL KIDS program in the last nine years and there have been significant changes to the Covering ALL KIDS Health Insurance Act that were effective prior to the FY17 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 FY17. During our audit, HFS officials reported that there were no new contracts related to the ALL KIDS expansion for FY17.

We met with both HFS and DHS officials and determined that initial and redetermination of eligibility procedures had not significantly changed since the FY14 audit for this FY17 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. 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 Title XIX (Medicaid). Although these recipients may be eligible for medical assistance, they would not be eligible under Title XIX (Medicaid).

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

Since the data system was reviewed during FY17 by the Auditor General's Information Systems Division, we did not review the data system for this audit during FY17. 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.

During Fieldwork, we reviewed the following Office of the Auditor General audits as part of our review: the FY17 HFS Financial and Compliance audits, the FY17 DHS Financial and Compliance audits, and the FY16 Medicaid Managed Care Organizations Performance audit. Since these audits reviewed the monitoring of the capitation payments made by HFS to the MCOs, our audit did not duplicate these reviews. Although our FY17 fieldwork sample of 40 new and 40 redetermined cases contained both FFS and MCO cases, most of these cases reviewed were MCO.

Draft reports were sent to HFS and DHS and exit conferences were held with them as well. The dates of the exit conferences, along with the principal attendees, are noted below:

Date: January 22, 2019

Agency	**Name and Title**
Department of Healthcare and Family Services	• Theresa Eagleson, Director • Amy Lyons, Audit Liason • Lynn Thomas, Deputy Administrator for Eligibility Policy • Mike Casey, HFS Finance Administrator • Robert Mendonsa, Deputy Administrator of Care Coordination Rate and Finance • Christina McCutchan, Bureau of Professional and Ancillary Services • Lisa Barnes, Acting Chief, Bureau of Professional and Ancillary Services • George Jacaway, Chief, ALL KIDS Bureau • Sherri Sadala, Bureau of Managed Care • Laura Ray, Chief, Bureau of Managed Care
Office of the Auditor General	• Sarah Cors, Audit Manager • Patrick Rynders, Audit Supervisor • Geoffrey Piehl, Audit Staff • Brian Bratton, Audit Staff • Scott Wahlbrink, Audit Manager

Date: January 22, 2019

Agency	**Name and Title**
Department of Human Services	• Amy DeWeese, Chief Internal Auditor • Albert Okwuegbunam, Audit Liaison • Tim Verry, Associate Director, Family & Community Services • Diane Grigsby-Jackson, Director, Family & Community Services • Paul Thelen, Family & Community Services • Trina Vinson, Family & Community Services
Office of the Auditor General	• Sarah Cors, Audit Manager • Patrick Rynders, Audit Supervisor • Geoffrey Piehl, Audit Staff • Brian Bratton, Audit Staff

APPENDIX C

COVERING ALL KIDS HEALTH INSURANCE ACT PLANS

Appendix C
COVERING ALL KIDS HEALTH INSURANCE ACT PLANS
Fiscal Year 2017

	Assist	Share	Premium Level 1	Premium Level 2
Premium	None	None	1 child $15 2 children $25 Each add'l child: $5	$40 per child
Max Monthly Premium	n/a	n/a	$40 for 5 or more children	$80 for 2 or more children
Physician Visit	$0	$3.90	$5.00	$10.00
Emergency Room Visit (Emergency)	$0	$3.90	$5.00	$30.00
Emergency Room Visit (Non-Emergency)	$0	$10.00	$25.00	$30.00
Generic Drug	$0	$2.00	$3.00	$3.00
Brand Name Drug	$0	$3.90	$5.00	$7.00
Inpatient Admission	$0	$3.90/Day	$5.00/Day	$100/Admission
Outpatient Service	No Co-Pay	No Co-Pay	No Co-Pay	5%
Annual Out-of-Pocket Max.	No co-payments	$100 per family for all services	$100 per family for all services	$500 per child for hospital services

Source: Illinois Department of Healthcare and Family Services.

APPENDIX D

FY17 TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE

Appendix D
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE
During FY17

Category of Service	FY17 Payment Amount	Percent of Total Payments
Capitation Services	$30,933,434	30%
Pharmacy Services (Drug and OTC)	$16,744,106	16.2%
Dental Services	$9,195,062	8.9%
Inpatient Hospital Services (General)	$7,947,373	7.7%
Physician Services	$7,403,106	7.2%
Outpatient Services (General)	$6,232,217	6.0%
Healthy Kids Services	$4,122,097	4.0%
General Clinic Services	$3,470,900	3.4%
Inpatient Hospital Services (Psychiatric)	$2,350,876	2.3%
Speech Therapy/Pathology Services	$2,292,697	2.2%
Mental Health Rehab Option Services	$1,509,173	1.5%
Nursing service	$1,205,523	1.2%
Medical Supplies	$1,008,572	1.0%
Physical Therapy Services	$965,465	<1%
Other Transportation	$860,000	<1%
Waiver service (depends on HCPCS code)	$754,948	<1%
Medical equipment/prosthetic devices	$733,646	<1%
Occupational Therapy Services	$640,112	<1%
Clinical Laboratory Services	$544,119	<1%
Social work service	$493,890	<1%
Alcohol and Substance Abuse Rehab. Services	$400,880	<1%
Optical Supplies	$356,802	<1%
Development Therapy, Orientation and Mobility Services (Waivers)	$334,239	<1%
Anesthesia Services	$321,618	<1%
Nurse Practitioners Services	$313,118	<1%
Targeted case management service (mental health)	$290,481	<1%
Psychiatric Clinic Services (Type 'B')	$269,912	<1%
Psychiatric Clinic Services (Type 'A')	$249,455	<1%
Psychologist service	$241,514	<1%
Emergency Ambulance Transportation	$188,245	<1%
Optometric Services	$171,125	<1%
Inpatient Hospital Services (Physical Rehabilitation)	$133,480	<1%
Early Intervention Services	$110,230	<1%
Podiatric Services	$53,715	<1%
Audiology Services	$49,853	<1%
Home Care	$38,818	<1%

Appendix D
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE
During FY17

Category of Service	FY17 Payment Amount	Percent of Total Payments
Non-Emergency Ambulance Transportation	$34,538	<1%
Fluoride varnish	$14,296	<1%
Home Health Services	$12,988	<1%
Midwife Services	$11,785	<1%
Licensed Clinical Professional Counselor	$11,556	<1%
Outpatient Services (ESRD)	$8,110	<1%
Service Car	$5,347	<1%
Taxicab Services	$5,049	<1%
Independent Diagnostic Testing	$4,890	<1%
Family Planning Counseling	$4,500	<1%
Physicians Psychiatric Services	$3,720	<1%
FFS procedure to implement contraceptive devices for PT 040, 048	$3,587	<1%
Clinic Services (Physical Rehabilitation)	$2,238	<1%
Chiropractic Services	$1,251	<1%
Portable X-Ray Services	$104	<1%
Medicar Transportation	$5	<1%
Total FY17 Cost of Services	**$103,054,764**	**100%**

Note: May not add due to rounding.

Source: Summary of FY17 ALL KIDS data provided by HFS.

APPENDIX E

FY17 TOTAL COST OF SERVICES PROVIDED BY PLAN AND CATEGORY OF SERVICE

Appendix E
TOTAL COST OF SERVICES PROVIDED BY PLAN AND BY CATEGORY OF SERVICE
During FY17

Category of Service	Total	Assist	Share	Premium Undocumented	Level 2 Undocumented	Level 2
Capitation Services	$30,933,434	$27,740,553	$714,367	$2,039,300	$11,105	$428,108
Pharmacy Services (Drug and OTC)	16,744,106	350,354	4,344	25,454	110,658	16,253,296
Dental Services	9,195,062	719,450	16,223	56,913	203,151	8,199,325
Inpatient Hospital Services (General)	7,947,373	1,332,758	0	89,339	48,683	6,476,592
Physician Services	7,403,106	465,483	7,583	29,649	101,347	6,799,045
Outpatient Services (General)	6,232,217	618,537	8,101	29,444	87,078	5,489,056
Healthy Kids Services	4,122,097	303,467	1,964	14,400	54,223	3,748,043
General Clinic Services	3,470,900	654,062	9,128	19,152	59,149	2,729,410
Inpatient Hospital Services (Psychiatric)	2,350,876	201,122	0	8,304	27,988	2,113,462
Speech Therapy/Pathology Services	2,292,697	79,308	689	11,857	3,708	2,197,135
Mental Health Rehab Option Services	1,509,173	47,253	738	4,449	24,812	1,431,921
Nursing service	1,205,523	17,499	0	0	0	1,188,023
Medical Supplies	1,008,572	43,745	0	4,588	4,340	955,899
Physical Therapy Services	965,465	39,155	888	10,069	12,000	903,354
Other Transportation	860,000	0	0	0	0	860,000
Waiver service (depends on HCPCS code)	754,948	0	0	0	0	754,948
Medical equipment/prosthetic devices	733,646	31,357	0	3,815	2,775	695,699
Occupational Therapy Services	640,112	27,038	689	2,322	1,394	608,668
Clinical Laboratory Services	544,119	84,660	514	3,013	11,723	444,210
Social work service	493,890	4,955	154	383	729	487,668
Alcohol and Substance Abuse Rehab. Services	400,880	2,851	0	2,776	11,400	383,854
Optical Supplies	356,802	20,880	656	2,148	7,219	325,900
Development Therapy, Orientation and Mobility Services (Waivers)	334,239	42,110	612	4,451	445	286,621
Anesthesia Services	321,618	31,902	215	967	5,188	283,346
Nurse Practitioners Services	313,118	17,424	309	1,290	3,446	290,649
Targeted case management service (mental health)	290,481	3,863	0	240	730	285,648
Psychiatric Clinic Services (Type 'B')	269,912	6,563	0	6,460	0	256,889
Psychiatric Clinic Services (Type 'A')	249,455	894	81	748	499	247,233
Psychologist service	241,514	1,356	0	0	48	240,110
Emergency Ambulance Transportation	188,245	22,589	0	623	3,314	161,719

Appendix E
TOTAL COST OF SERVICES PROVIDED BY PLAN AND BY CATEGORY OF SERVICE
During FY17

Category of Service	Total	Assist	Share	Premium Undocumented	Level 2 Undocumented	Level 2
Optometric Services	$171,125	$10,827	$323	$959	$3,775	$155,240
Inpatient Hospital Services (Physical Rehabilitation)	133,480	45,968	0	0	0	87,512
Early Intervention Services	110,230	33,131	28	260	493	76,318
Podiatric Services	53,715	1,930	0	70	552	51,163
Audiology Services	49,853	1,682	110	437	51	47,573
Home Care	38,818	0	0	0	0	38,818
Non-Emergency Ambulance Transportation	34,538	7,242	0	0	307	26,990
Fluoride varnish	14,296	468	0	26	104	13,698
Home Health Services	12,988	288	0	0	0	12,700
Midwife Services	11,785	7,115	0	95	0	4,574
Licensed Clinical Professional Counselor	11,556	1,143	0	0	92	10,321
Outpatient Services (ESRD)	8,110	8,110	0	0	0	0
Service Car	5,347	998	0	695	0	3,654
Taxicab Services	5,049	744	0	0	0	4,305
Independent Diagnostic Testing	4,890	592	0	0	0	4,298
Family Planning Counseling	4,500	120	0	0	30	4,350
Physicians Psychiatric Services	3,720	403	0	0	144	3,173
FFS procedure to implement contraceptive devices for PT 040, 048	3,587	1,345	0	0	0	2,242
Clinic Services (Physical Rehabilitation)	2,238	0	0	0	0	2,238
Chiropractic Services	1,251	914	0	0	0	336
Portable X-Ray Services	104	0	0	0	0	104
Medicar Transportation	5	5	0	0	0	0
Total Cost of Services	**$103,054,764**	**$33,034,213**	**$767,717**	**$2,374,695**	**$802,701**	**$66,075,439**

Note: May not add due to rounding.

Source: Summary of FY17 ALL KIDS data provided by HFS.

APPENDIX F

TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER GREATER THAN $50,000 Fiscal Year 2017

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 F
TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000
Fiscal Year 2017

Provider Name	City	State	Total Amount Paid
MERIDIAN HEALTH PLAN INC VMC	CHICAGO	IL	$6,442,242.03
BLUE CROSS BLUE SHIELD IL FHP	CHICAGO	IL	$6,384,571.40
FAMILY HEALTH NETWORK	CHICAGO	IL	$5,541,999.56
LURIE CHILDRENS HOSPITAL	CHICAGO	IL	$3,919,344.62
ILLINICARE HEALTH PLAN INC FHP	WESTMONT	IL	$2,949,026.56
AETNA BETTER HEALTH INC FHP	CHICAGO	IL	$2,625,591.02
COUNTYCARE FHP	CHICAGO	IL	$2,369,351.93
HARMONY HEALTH PLAN	CHICAGO	IL	$1,858,422.87
MOLINA HEALTHCARE OF ILL FHP	OAK BROOK	IL	$1,829,681.83
ALLIANCERX WALGREENS PRIME #15	CANTON	MI	$1,177,114.69
CAREMARK INC	MT PROSPECT	IL	$976,491.41
CHILDRENS HOSPITAL OF ILLINOIS	PEORIA	IL	$891,426.51
UNIVERSITY OF ILLINOIS HOSP	CHICAGO	IL	$795,857.20
COMER CHILDRENS HOSPITAL	CHICAGO	IL	$759,316.18
CHICAGO PUBLIC SCHOOLS DIST299	CHICAGO	IL	$753,294.69
DSCC	SPRINGFIELD	IL	$667,286.64
PROFESSIONAL BUILDING PHARMACY	CHICAGO	IL	$622,536.15
NEXTLEVEL HEALTH PARTNERS FHP	CHICAGO	IL	$596,748.17
CHRIST HOSPITAL	OAK LAWN	IL	$545,032.61
LINCOLN PRAIRIE BEHAVIORAL HC	SPRINGFIELD	IL	$483,131.37
BHC STREAMWOOD HOSPITAL INC	STREAMWOOD	IL	$469,281.23
ACCREDO HEALTH GROUP INC	NASHVILLE	TN	$384,456.99
LUTHERAN GENERAL HOSPITAL	PARK RIDGE	IL	$370,658.68
HEALTH ALLIANCE CONNECT FHP	URBANA	IL	$335,798.19
RONALD MCDONALDS CHILDRENS HSP	MAYWOOD	IL	$326,797.02
ACCREDO HEALTH GROUP INC	MEMPHIS	TN	$315,613.93
J H STROGER HOSP OF COOK CTY	CHICAGO	IL	$274,559.58
CENTRAL DUPAGE HOSPITAL	WINFIELD	IL	$250,675.98
FOUNDATION CARE LLC	EARTH CITY	MO	$242,452.13
CAREMARK KANSAS SPEC PHARM LLC	LENEXA	KS	$231,635.87
RIVEREDGE HOSPITAL	FOREST PARK	IL	$229,874.68
ST LOUIS CHILDRENS HOSPITAL	SAINT LOUIS	MO	$209,262.48
ADVOCATE ILLINOIS MASONIC MEDI	CHICAGO	IL	$198,322.00
WALGREENS #13974	CHICAGO	IL	$195,186.46
ALEXIAN BROTHERS CHILDRENS HOS	HOFFMAN ESTATES	IL	$187,596.22
SPECIALTYTHERAPEUTIC CARE, LP	HOUSTON	TX	$185,233.66
ST JOHNS CHILDRENS HOSPITAL	SPRINGFIELD	IL	$182,761.92
ILL CORRECTIONAL INDUSTRIES	SPRINGFIELD	IL	$179,964.79
RUSH CHILDRENS SERVICES	CHICAGO	IL	$177,414.72
SSM HEALTH CARDINAL GLENNON CH	SAINT LOUIS	MO	$176,316.82
HARTGROVE HOSPITAL	CHICAGO	IL	$169,971.92
WAL MART STORES EAST LP 105315	ORLANDO	FL	$169,934.98
AURORA CHICAGO LAKESHORE CHILD	CHICAGO	IL	$166,215.89
CARLE FOUNDATION HOSPITAL	URBANA	IL	$165,196.71
ROSECRANCE GRIFFIN WILLIAMSON	ROCKFORD	IL	$162,835.18
CHICAGO BEHAVIORAL HOSPITAL	DES PLAINES	IL	$159,319.90
ADVENTIST HINSDALE HOSPITAL	HINSDALE	IL	$159,198.21
COMMUNITY UNIT SCH DIST 200	WHEATON	IL	$157,896.05
ALEXIAN BROS BEHAVIORAL HLTH	HOFFMAN ESTATES	IL	$157,862.87
ALLIANCERX WALGREENS PRIME #16	FRISCO	TX	$155,758.33
THE PAVILION FOUNDATION	CHAMPAIGN	IL	$151,093.47

Appendix F
TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000
Fiscal Year 2017

Provider Name	City	State	Total Amount Paid
DOUBEK MEDICAL SUPPLY INC	ALSIP	IL	$150,724.20
THE 180 MEDICAL INC	OKLAHOMA CITY	OK	$145,740.23
ERIE FAMILY HEALTH CENTER	CHICAGO	IL	$145,181.37
LURIE CHILDRENS HOSPITAL	CHICAGO	IL	$143,174.52
EDWARD HOSPITAL	NAPERVILLE	IL	$142,612.66
PRESENCE SAINT MARY NAZARETH	CHICAGO	IL	$137,800.22
SENECA HEALTH CENTER	ELGIN	IL	$134,569.52
RML HEALTH PROVIDERS LTD PTSHP	HINSDALE	IL	$134,292.53
ROCKFORD MEMORIAL HOSPITAL	ROCKFORD	IL	$130,563.26
GARFIELD PARK HOSPITAL	CHICAGO	IL	$129,988.19
WALGREENS #05711	DES PLAINES	IL	$125,139.93
LABORATORY CORPORATION AMERICA	DUBLIN	OH	$124,402.24
ARBOLEDA CLEIDY	NILES	IL	$122,641.80
THRESHOLDS	CHICAGO	IL	$122,526.00
SHIRLEY RYAN ABILITY LAB	CHICAGO	IL	$120,498.67
COMMUNITY HEALTHCARE SERVICES	LOMA LINDA	CA	$119,986.28
OPTION CARE	WOOD DALE	IL	$118,695.31
EDWARDS HEALTH CARE SERVICES,	HUDSON	OH	$118,084.06
ADVOCATE CONDELL MEDICAL CTR	LIBERTYVILLE	IL	$116,347.95
CVS/SPECIALTY	MONROEVILLE	PA	$116,223.52
LEGACY MEDICAL CARE INC	ARLINGTON HEIGH	IL	$114,398.88
ST ANTHONY HOSPITAL	CHICAGO	IL	$112,146.63
LAWNDALE CHRISTIAN HLTH	CHICAGO	IL	$111,063.34
INFANT WELFARE SOCIETY OF CHIC	CHICAGO	IL	$110,740.57
RIVERSIDE MED CTR	KANKAKEE	IL	$106,486.75
QUEST DIAGNOSTICS LLC IL	WOOD DALE	IL	$106,015.38
DOUBEK PHARMACY INC	ALSIP	IL	$104,910.66
THE BLEEDING AND CLOTTING	PEORIA	IL	$104,844.45
SHRINERS HOSPITALS FOR CHILDRE	CHICAGO	IL	$101,742.42
STEVENS KATHARINE	MELROSE PARK	IL	$101,438.05
COMM UNIT SCH DIST 300	ALGONQUIN	IL	$101,337.14
COPLEY MEMORIAL HOSPITAL	AURORA	IL	$100,789.39
KENNETH YOUNG CENTER AT PHILHA	ARLINGTON HEIGH	IL	$100,173.18
NW SUBURBAN SPEC EDUC ORG	MT PROSPECT	IL	$100,116.77
CAREPOINT PHARMACY	SCHAUMBURG	IL	$93,744.27
SUPERIOR PHARMACY SOLUTIONS	SCHAUMBURG	IL	$92,266.50
SSM HEALTH ST MARYS HOSPITAL S	SAINT LOUIS	MO	$92,112.08
HUNTLEY COMMUNITY SCHOOL DISTR	ALGONQUIN	IL	$89,433.14
YARMOLYUK YAROSLAV	CHICAGO	IL	$86,692.45
SWEDISHAMERICAN HOSPITAL	ROCKFORD	IL	$86,131.50
NORTHWEST COMMUNITY HOSPITAL	ARLINGTON HEIGH	IL	$86,072.17
MACNEAL HOSPITAL	BERWYN	IL	$85,115.69
FANTUS HEALTH CENTER	CHICAGO	IL	$84,909.47
ZHANG TAORAN	CHICAGO	IL	$84,704.15
BOND DRUG COMPANY OF IL 03749	WAUKEGAN	IL	$82,736.15
ADVOCATE SHERMAN HOSPITAL	ELGIN	IL	$82,721.94
VNA HEALTH CARE	AURORA	IL	$82,592.77
MCKESSON PATIENT CARE SOLUTION	MOON TWP	PA	$81,815.70
SCHAUMBURG CCSD 54	SCHAUMBURG	IL	$81,025.99
BOND DRUG COMPANY OF IL 03014	AURORA	IL	$78,878.90
SCHOOL DISTRICT U 46	ELGIN	IL	$78,130.19

Appendix F
TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000
Fiscal Year 2017

Provider Name	City	State	Total Amount Paid
LAMBERGHINI FLAVIA	CHICAGO	IL	$76,872.12
CRUSADER CLINIC	ROCKFORD	IL	$76,132.25
CENTER FOR MEDICAL ARTS RH	CARBONDALE	IL	$75,856.68
ROCKFORD PUBLIC SCHOOLS DIS205	ROCKFORD	IL	$74,640.57
TRINITY ROCK ISLAND	ROCK ISLAND	IL	$74,125.97
EVANSTON HOSPITAL	EVANSTON	IL	$73,882.44
NORTHWESTERN MEMORIAL HOSPITAL	CHICAGO	IL	$73,677.14
A2CL SERVICES LLC	WEST ALLIS	WI	$71,204.77
OSWEGO SCHOOL DISTRICT 308	OSWEGO	IL	$71,092.70
CHACON JOSE	AURORA	IL	$70,430.60
SAINT FRANCIS MEDICAL CENTER	PEORIA	IL	$70,377.64
FOSTER G MCGAW HOSPITAL	MAYWOOD	IL	$69,984.25
PLAINFIELD SCHOOL DIST 202	PLAINFIELD	IL	$68,333.89
THE GENESIS CENTER	DES PLAINES	IL	$68,230.43
VISTA MEDICAL CENTER EAST	WAUKEGAN	IL	$67,422.76
ALEXIAN BROTHERS MEDICAL CENTE	ELK GROVE VLG	IL	$66,053.36
NUMOTION	LOMBARD	IL	$65,089.48
SHIELD DENVER HEATH CARE CENTE	ELMHURST	IL	$64,885.80
JOSHI ASHWINI	CHICAGO	IL	$64,632.70
ADA S MCKINLEY COMMUNITY SVCS	CHICAGO	IL	$64,509.54
BLOODCENTER OF WISCONSIN INC	MILWAUKEE	WI	$64,497.56
WALMART PHARMACY 10-0481	MATTOON	IL	$63,852.24
SINAI CHILDRENS HOSPITAL	CHICAGO	IL	$63,296.57
PANA CUSD 8	PANA	IL	$63,223.17
NASREEN TAIBA	ADDISON	IL	$62,882.80
BOND DRUG COMPANY OF ILLINOIS	NORMAL	IL	$62,111.20
BOND DRUG COMPANY OF IL 03729	HANOVER PARK	IL	$61,467.88
ALLIANCERX WALGREENS PRIME #15	FRISCO	TX	$61,086.64
PCC COMMUNITY WELLNESS CENTER	OAK PARK	IL	$60,534.89
BOND DRUG COMPANY OF IL 04940	ROUND LAKE BCH	IL	$60,523.73
SILVER CROSS HOSPITAL	NEW LENOX	IL	$60,409.79
WILLIAMS JILADA B	BOLINGBROOK	IL	$60,345.41
SULLIVAN DRUGS	MOUNT OLIVE	IL	$60,214.91
SHIRLEY RYAN ABILITY LAB	CHICAGO	IL	$59,594.23
NORTHWESTERN ILLINOIS ASSOCIAT	STERLING	IL	$59,264.24
NORTHWESTERN LAKE FOREST HSPTL	LAKE FOREST	IL	$59,226.87
ROSECRANCE BERRY CAMPUS	ROCKFORD	IL	$58,463.37
BOND DRUG COMPANY OF IL 03212	DANVILLE	IL	$58,421.30
RUSH UNIVERSITY MEDICAL CENTER	CHICAGO	IL	$58,148.01
CENTRAL DUPAGE HOSPITAL	WINFIELD	IL	$57,955.19
BOND DRUG COMPANY OF IL 04935	CHICAGO	IL	$57,253.61
BOND DRUG COMPANY OF IL 05602	JACKSONVILLE	IL	$57,095.33
DUPAGE COUNTY HEALTH DEPARTMEN	WHEATON	IL	$56,923.82
FAMILY SERVICE ASSOCIATION	ELGIN	IL	$56,857.72
CENTER FOR FAMILY HEALTH	SYCAMORE	IL	$56,759.89
CENTEGRA HOSPITAL - MCHENRY	MCHENRY	IL	$56,668.23
WALGREENS #01249	CICERO	IL	$56,518.65
HEARTLAND INTERNATIONAL HEALTH	CHICAGO	IL	$56,443.78
BOND DRUG COMPANY OF IL 4150	BELVIDERE	IL	$56,442.35
SSM HEALTH SAINT LOUIS UNIVERS	SAINT LOUIS	MO	$56,435.60
CHRIST HOSPITAL	OAK LAWN	IL	$56,247.67

Appendix F
TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000
Fiscal Year 2017

Provider Name	City	State	Total Amount Paid
GOOD SAMARITAN HOSPITAL	DOWNERS GROVE	IL	$55,898.89
MIDLAKES CLINIC	ROUND LAKE BEAC	IL	$55,871.59
EVANSTON CC SCHOOL DIST 65	EVANSTON	IL	$55,839.57
THE PHARMACIE SHOPPE	CASEY	IL	$55,399.04
PRESENCE RESURRECTION MED CTR	CHICAGO	IL	$55,304.30
NORTHERN ILLINOIS ACADEMY	AURORA	IL	$55,163.37
NAJJAR ANAS	CHICAGO	IL	$55,028.05
SWEDISH COVENANT HOSPITAL	CHICAGO	IL	$54,918.58
BOND DRUG COMPANY OF ILLINOIS	MONTGOMERY	IL	$54,475.54
BOND DRUG COMPANY OF ILLINOIS	BELLEVILLE	IL	$54,180.30
COMMUNITY COUNSELING CENTERS O	CHICAGO	IL	$54,053.60
LAKE COUNTY HEALTH DEPARTMENT	WAUKEGAN	IL	$53,515.07
WALL TIMOTHY R	NAPERVILLE	IL	$53,031.91
HUMBOLDT PARK FAMILY HLTH CTR	CHICAGO	IL	$52,940.16
SANGAMON AREA SPEC ED DIST	SPRINGFIELD	IL	$52,934.38
INDIAN PRAIRIE SCHOOL DISTRICT	AURORA	IL	$52,800.98
FRANCES NELSON HEALTH CENTER	CHAMPAIGN	IL	$52,427.48
ACCREDO HEALTH GROUP INC	ORLANDO	FL	$52,386.85
MEMORIAL HOSP CARBONDALE	CARBONDALE	IL	$52,095.93
WALGREENS #07754	PALATINE	IL	$51,961.44
SAV MOR PHARMACY	TUSCOLA	IL	$51,392.81
BOND DRUG COMPANY OF IL 4502	CARPENTERSVILLE	IL	$51,173.97
ELMHURST MEMORIAL HOSPITAL	ELMHURST	IL	$50,989.02
LI QINGSHAN	ORLAND PARK	IL	$50,862.15
SIHF BETHALTO HEALTH CTR	EAST ALTON	IL	$50,288.11
YANG MONA	DOLTON	IL	$50,076.25
SARAH BUSH LINCOLN H C	MATTOON	IL	$50,073.39
PRESENCE MERCY MEDICAL CENTER	AURORA	IL	$50,017.71

Source: FY17 data provided by HFS.

APPENDIX G

UPDATED ADMINISTRATIVE CODE (89 Ill. Adm. Code 140.421)

Appendix G

UPDATED ADMINISTRATIVE CODE [89 ILL. ADM. CODE 140.421]

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER d: MEDICAL PROGRAMS
PART 140 MEDICAL PAYMENT
SECTION 140.421 LIMITATIONS ON DENTAL SERVICES

Section 140.421 Limitations on Dental Services

Effective for dates of service on or after July 1, 2014:

a) The Department shall impose prior approval requirements to determine the medical necessity of dental services listed in this Section. Prior approval is required for:

1) Crowns;

2) Partial Pulpotomy;

3) Periodontal services, except full mouth debridement for diagnostic purposes, ages 0-20;

4) Apexification and recalcification;

5) Apicoectomy;

6) Dentures, partial dentures and denture relines;

7) Maxillofacial prosthetics;

8) Prosthodontics;

9) Removal of impacted teeth;

10) Surgical removal of residual roots;

11) Surgical exposure to aid eruption;

12) Alveoloplasty;

13) Incision and drainage of abscess;

14) Removal of cysts or tumors;

15) Frenulectomy;

16) Orthodontics. Effective January 1, 2017, medically necessary orthodontic treatment is approved only for patients under the age of 21 and is defined as:

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

B) 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.; attach description);

17) General anesthesia, conscious sedation or deep sedation;

18) Therapeutic drug injection;

19) Other drugs and medicaments;

20) Unspecified miscellaneous adjunctive general services or procedures;

21) Dental services not listed in Table D.

b) The dentist may request post-approval when a dental procedure requiring prior approval is provided on an emergency basis. Approval of the procedures shall be given if the dental procedure is medically necessary.

(Source: Amended at 41 Ill. Reg. 999, effective January 19, 2017)

APPENDIX H

UPDATED SCORING TOOL (HANDICAPPING LABIO-LINGUAL DEVIATION INDEX)

Appendix H

UPDATED SCORING TOOL [HANDICAPPING LABIO-LINGUAL DEVIATION INDEX]

DentaQuest of Illinois, LLC

First Review____
Second Review____

Models ____
Orthocad ____
Ceph Film ____
X-Rays ____
Photos ____
Narrative ____

Attachment H

HANDICAPPING LABIO-LINGUAL DEVIATION INDEX (HLD) SCORE SHEET

Name (Last, First): _____ Medicaid ID: _____ DOB: _____

All necessary dental work completed? Yes ___ No ___ *Patient oral hygiene:* Excellent___ Good___ Poor___
(all dental work must be completed and oral hygiene must be good BEFORE orthodontic treatment is approved)

PROCEDURE (use this score sheet and a Boley Gauge or disposable ruler):

- **Indicate by checkmark next to A or B which criteria you are submitting for review**
- Position the patient's teeth in centric occlusion;
- Record all measurements in the order given and round off to the nearest millimeter (mm);
- ENTER SCORE "0" IF CONDITION IS ABSENT

A.____CONDITIONS 1-4 ARE AUTOMATIC QUALIFIERS (indicate with an "X" if condition is present)

1. **Cleft palate** _____
2. Deep impinging bite **with** signs of tissue damage, not just touching palate _____
3. Anterior crossbite **with** gingival recession _____
4. **Severe traumatic deviation** (i.e., accidents, tumors, etc. attach description) _____

B.____CONDITIONS 5-13 MUST SCORE 28 POINTS OR MORE TO QUALIFY

5. **Overjet** (one upper central incisor to labial of the most labial lower incisor) mm____x 1 = _____
6. **Overbite** (maxillary central incisor relative to lower anteriors) mm ____ x 1 = _____
7. Mandibular protrusion (reverse overjet, **"underbite"**) mm ____ x 5 = _____
8. **Openbite** (measure from a maxillary central incisor to mandibular incisors) mm ____ x 4 = _____
9. **Ectopic teeth** (excluding third molars, see note below) # teeth ____ x 3 = _____

Note**: If anterior crowding and ectopic eruption are present in the anterior portion of the mouth, score only the most severe condition; **do not score both

10. **Anterior crowding of maxilla** (greater than 3.5 mm) if present score __1__x 5 = _____
11. **Anterior crowding of mandible** (greater than 3.5 mm) if present score __1__x 5 = _____
12. **Labio-lingual** spread (either measure a displaced tooth from the normal arch form or labial-lingual distance between adjacent anterior teeth) mm ____x 1 = _____
13. Posterior **crossbite** (1 must be a molar), score only 1 time – if present score __1_ x 4 = _____

TOTAL SCORE (must score 28 points or more to qualify) _____

Provider Signature_____ Date_____

Updated 10/24/2016

GUIDELINES AND RULES FOR APPLYING THE HLD INDEX

The provider is encouraged to score the case and exclude any case that obviously would *not* qualify for treatment. Upon completion of the HLD Index score sheet, review all measurements and calculations for accuracy.

1. Indicate by checkmark next to A or B which criteria you are submitting for review.
2. Position the patient's teeth in centric occlusion.
3. Record all measurements in the order given and round off to the nearest millimeter.
4. Enter the score "0" if condition is absent.

A. CONDITIONS 1 - 4 ARE AUTOMATIC QUALIFIERS

1. Cleft palate deformities—the deformity *must* be demonstrated on the study model, if the deformity *cannot* be demonstrated on the study model, the condition *must* be diagnosed by properly credentialed experts and the diagnosis *must* be supported by documentation. If present, enter an "X".
2. Deep impinging overbite—tissue damage of the palate *must* be clearly visible in the mouth. On study models, the lower teeth *must* be clearly touching the palate and the tissue indentations or evidence of soft tissue damage *must* be clearly visible. If present, enter an "X".
3. Crossbite of individual anterior teeth—damage of soft tissue *must* be clearly visible in the mouth and reproducible and visible on the study models. Gingival recession *must* be at least 1½ mm deeper than the adjacent teeth. If present, enter an "X". In the case of a canine, the amount of gingival recession should be compared to the opposite canine.
4. Severe traumatic deviations—these might include, for example, loss of a premaxillary segment by burns or accident, the result of osteomyelitis, or other gross pathology. If present, enter an "X".

B. CONDITIONS 5 -13 MUST SCORE 28 POINTS OR MORE TO QUALIFY

5. Overjet—this is recorded with the patient's teeth in centric occlusion and is measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Measure parallel to the occlusal plan. Do *not* use the upper lateral incisors or cuspids. The measurement may apply to only one (1) tooth if it is severely protrusive. Do *not* record overjet and mandibular protrusion (reverse overjet) on the same patient. Enter the measurement in millimeters.
6. Overbite—a pencil mark on the tooth indicating the extent of the overlap assists in making this measurement. Hold the pencil parallel to the occlusal plane when marking and use the incisal edge of one of the upper central incisors. Do *not* use the upper lateral incisors or cuspids. The measurement is done on the lower incisor from the incisal edge to the pencil mark. "Reverse" overbite may exist and should be measured on an upper central incisor – from the incisal edge to the pencil mark. Do *not* record overbite and open bite on the same patient. Enter the measurement in millimeters.

7. Mandibular (dental) protrusion or reverse overjet—measured from the labial surface of a lower incisor to the labial surface of an upper central incisor. Do *not* use the upper lateral incisors or cuspids for this measurement. Do *not* record mandibular protrusion (reverse overjet) and overjet on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by five (5).

8. Open bite—measured from the incisal edge of an upper central incisor to the incisal edge of a lower incisor. Do *not* use the upper lateral incisors or cuspids for this measurement. Do *not* record overbite and open bite on the same patient. The measurement in millimeters is entered on the score sheet and multiplied by four (4).

9. Ectopic eruption—count each tooth excluding third molars. Enter the number of teeth on the score sheet and multiply by three (3).

10. Anterior crowding of maxilla—anterior arch length insufficiency *must* exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point for a maxillary arch with anterior crowding and one (1) point for a mandibular arch with anterior crowding and multiply by five (5).

11. Anterior crowding of mandible— anterior arch length insufficiency *must* exceed 3.5 mm. Mild rotations that may react favorably to stripping or mild expansion procedures are *not* to be scored as crowded. Score one (1) point for mandibular arch with anterior crowding and multiply by five (5).

NOTE: If condition No. 10 and/or 11, anterior crowding, is also present with No. 9, an ectopic eruption in the anterior portion of the mouth, score only the most severe condition (the condition represented by the most points). DO NOT SCORE BOTH CONDITIONS.

12. Labio-lingual spread—use a Boley gauge (or disposable ruler) to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to a line representing the normal arch. Otherwise, the total distance between the most protruded tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations should be measured for labio-lingual spread but only the most severe individual measurement should be entered on the on the score sheet. Enter the measurement in mm.

13. Posterior crossbite—this condition involves one (1) or more posterior teeth, one (1) of which *must* be a molar. The crossbite *must* be one in which the maxillary posterior teeth involved may be palatal to normal relationships or completely buccal to the mandibular posterior teeth. The presence of posterior crossbite is indicated by a score of four (4) on the score sheet.

APPENDIX I
AGENCY RESPONSES

ILLINOIS DEPARTMENT OF Healthcare and Family Services

JB Pritzker, Governor
Theresa A. Eagleson, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

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

February 1, 2019

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

Dear Auditor General Mautino:

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

Theresa A. Eagleson
Director

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

Attachment Responses
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 that was implemented on October 24, 2017, incorporates case maintenance activities, in addition to new application processing and redeterminations. Phase 2 of IES will be more efficient and allow more flexibility to complete all of the work, but at this time conversion of case information is still being completed.

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 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. An HFS 643A is sent to 19 year olds aging out of All Kids medical benefits. The notice is triggered separately from the current redetermination process, two months prior to the individuals birth month.

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 are still being reviewed after IES Phase 2 implementation. A Medical Morsel titled, "When is a Noncitizen Child Considered Undocumented?", was sent to staff on July 11, 2018. The Medical Morsel lists the steps to take in IES to ensure noncitizen children are coded correctly.

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 plans to propose 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 Services should:

- review the membership requirements for the Dental Policy Review Committee and update the Dental Policy Review Committee bylaws accordingly; and
- more effectively monitor the EXPANDED ALL KIDS orthodontic recipients receiving care under the MCO part of the program and ensure these recipients are receiving the same access to services as the EXPANDED ALL KIDS orthodontic recipients receiving care under the FFS part of the program.

Response:
The Department accepts the recommendation. The Department is in the process of updating the requirements in the Committee bylaws for FY19. All of the managed care plans use the HLD tool and the DORM guidelines for orthodontia. The Department will monitor the orthodontic recipients receiving care under the MCO part of the program.

Bruce Rauner, Governor • James T. Dimas, Secretary

January 30, 2019

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

Dear Ms. Cors,

Attached, please find the Department's official responses to the findings identified during the ninth annual audit of the Covering ALL KIDS Health Insurance program.

Please review the attached Departmental responses and let me know if you have any questions or concerns.

You can reach me at Amy.DeWeese@Illinois.gov or (217) 558-6931.

Sincerely,

SIGNED ORIGINAL ON FILE

Amy De Weese, CPA
Chief Internal Auditor

cc: Diane GrigsbyJackson, Director Division of Family and Community Services
Corey-Anne Gulkewicz, Chief of Staff
James Dimas, Secretary

RECOMMENDATION-1: REDETERMINATION OF ELIGIBILITY.

AUDIT RECOMMENDATION:

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 RESPONSE:

The Department of Human Services agrees with the recommendation. The redetermination process has been enhanced with the implementation of the new updated processing system in the Integrated Eligibility System (IES) Phase 2, which went live on October 24, 2017. The IES Phase 2 system will assist in tracking and auto initiating renewal notices to eligible customers. Online and classroom training venues are available to all staff using the new system.

RECOMMENDATION-3: CLASSIFICATION OF DOCUMENTED IMMIGRANTS

AUDIT RECOMMENDATION:

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 Intergrated Eligibility System (IES) that prevents enrollees with citizenship or immigation documentation from being classified as undocumented;

- Ensure that the documented immigrants are classified correctly in its database; and

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

DEPARTMENT RESPONSE:

The Department of Human Services agrees with the recommendation. Conversion and implementation of IES Phase 2 was completed in October 2017, and allows for improved classification of documented immigrants and electronic storage of verifications supporting the immigration status for noncitizens. Given the confusion surrounding the proper classification of documented and undocumented immigrants, additional training and/or communication to staff is needed. Additionally, the population of documented and undocumented immigrants is relatively small compared to the remainder of the population, so related policy is not as widely and confidently understood as policy related to the programs administered to our U.S. Citizen population. DHS will explore the possibilty of modifying IES to assist with the proper classification of immigrants as much as possible.

RECOMMENDATION-4: ELIGIBILITY DOCUMENTATION

AUDIT RECOMMENDATION:

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 RESPONSE:

The Department of Human Services agrees with the recommendation. The Department implemented Phase 2 of IES, which 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 agrees to continue to remind staff of the various requirements for these cases.

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