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

SUMMARY REPORT DIGEST

COVERING ALL KIDS HEALTH INSURANCE PROGRAM

PROGRAM AUDIT
For the Year Ended: June 30, 2010

Release Date: April 2011

Summary of Findings:

Total this audit:	**14**
Total last audit:	**13**
Repeated from last audit:	**9**

SYNOPSIS

Public Act 95-985 amended the Covering ALL KIDS Health Insurance Act [215 ILCS 170/63] and directed the Auditor General to annually audit the ALL KIDS program. This is the second annual audit and covers FY10. The focus of this audit is on "EXPANDED ALL KIDS," which is the portion of the ALL KIDS program that serves uninsured children not previously covered by KidCare (i.e., those children whose family income was greater than 200 percent of the federal poverty level or who were undocumented immigrants). Our audit found:

- In FY10, 94,628 children were enrolled in the EXPANDED ALL KIDS program.
- Total claims paid in FY10 for the EXPANDED ALL KIDS enrollees were $84.2 million. The Department of Healthcare and Family Services (HFS) received approximately $9.8 million in premiums from enrollees, thus making the net cost of the ALL KIDS expansion approximately $74.4 million. The children added as a part of the expansion are not eligible for federal reimbursement and thus are funded entirely by the State.
- As in our prior audit, our testing identified documented immigrants that were misclassified as undocumented immigrants in HFS data. By not correctly classifying them, HFS did not submit and receive federal matching funds for these misclassified documented immigrants. HFS officials stated they found that a system error was causing the misclassifications and corrected it in October 2010.
- HFS does not terminate ALL KIDS coverage when the enrollees fail to pay premiums as required by 89 Ill. Adm. Code 123.340(a).
- HFS and the Department of Human Services (DHS) did not have controls in place to ensure that families who were previously terminated from coverage met re-enrollment requirements found in the Administrative Code.
- When determining ALL KIDS eligibility, HFS and DHS did not require individuals who are self-employed to provide detailed business records to verify income.
- FY10 claim data had billing irregularities in areas such as transportation, optical, preventive medicine, and dental claims. These irregularities may have been billing errors or may have been fraudulent. The irregularities were reported to HFS or to the HFS Office of the Inspector General (HFS-OIG) for follow-up and/or investigation.
- HFS paid for non-emergency transportation services that were excluded by the Illinois Administrative Code.
- HFS and DHS agreed with all 14 recommendations.

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FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

BACKGROUND

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

Effective July 1, 2006, Illinois' KidCare program, which included Medicaid and Children's Health Insurance Program (SCHIP) populations, **was expanded** by the Covering ALL KIDS Health Insurance Act (Act) to include all uninsured children not previously covered. The expansion added children whose family income was greater than 200 percent of the federal poverty level and all undocumented immigrant children. At that time, the KidCare program was renamed ALL KIDS.

Throughout this audit, we will refer to the portion of the ALL KIDS program that serves the uninsured children not previously covered by KidCare as "EXPANDED ALL KIDS." Since the EXPANDED ALL KIDS program is a subset of a much larger ALL KIDS program, **many of the recommendations in this report may be relevant to the program as a whole.**

The Covering ALL KIDS Health Insurance Act directs the Office of the Auditor General to annually audit the EXPANDED ALL KIDS program beginning June 30, 2008. The first annual audit was released in May 2010 covering FY09 (July 1, 2008 through June 30, 2009). This is the second annual audit and covers FY10 (July 1, 2009 through June 30, 2010). Many of the recommendations in this report are repeated from the FY09 report due to the fact that the FY09 report was not released until the end of FY10. As a result, these recommendations will again be followed up on in the FY11 audit. (pages 12-13)

PUBLIC ACT 96-1501

After fieldwork on this audit was completed in November 2010, the Senate and House held hearings on reforming the State's medical assistance program. The Auditor General testified at both hearings on the results of our 2010 audit of the EXPANDED ALL KIDS program. Legislation was passed by the General Assembly and Public Act 96-1501 was signed into law by the Governor on January 25, 2011. The Public Act amended the Covering ALL KIDS Health Insurance Act and addressed several matters raised in both our initial audit of the EXPANDED ALL KIDS program last year, as well as in this audit. These include:

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

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

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

Public Act 96-1501 also added an income limit to who is eligible for the EXPANDED ALL KIDS program. Effective July 1, 2011, children whose families' household income is above 300 percent of the federal poverty level are no longer eligible. Children enrolled as of July 1, 2011 may remain enrolled in the program for an additional 12 months. (page 22)

ALL KIDS EXPANSION

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 key changes noted were:

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

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

Throughout FY10, a total of 94,628 children were enrolled in the program. On June 30, 2010, there were 73,681 enrollees as a result of the expansion. This is less than the FY10 total of 94,628 enrollees since children are added and removed from the program throughout the year. Digest Exhibit 1 shows that of the 73,681 enrollees as of June 30, 2010, 53,607 (73%) were classified as undocumented immigrants in data provided by HFS. However, as discussed further in Chapter Two, the number of undocumented immigrants, as well as the costs associated with them, are overstated in data provided by HFS. Additionally, the number of documented immigrants, as well as the costs associated with them, are similarly understated.

As a result, the number of undocumented immigrants and their associated costs are overstated in this report. In our prior audit, we recommended that HFS accurately classify documented immigrants. As a result, HFS officials stated they researched these cases and found that a system error was causing the misclassifications. HFS noted the error was corrected on October 29, 2010. By not correctly classifying them, not only is HFS reporting incorrect data, it is also losing out on federal matching funds it could be receiving for documented immigrants.

Digest Exhibit 1
EXPANDED ALL KIDS ENROLLMENT BY PLAN [3, 4]
As of June 30

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants	
	FY09	FY10	FY09	FY10
Assist <134% FPL/$29,326.50[2]	n/a	n/a	50,009	49,920
Share 134%-150% FPL/$33,075[2]	n/a	n/a	1,931	1,644
Premium Level 1 151%-200% FPL/$44,100[2]	n/a	n/a	1,604	1,538
Premium Level 2 201%-300% FPL/$66,150[2]	14,514	16,400	429	418
Premium Level 3[1] 301%-400% FPL/$88,200[2]	2,558	2,997	76	62
Premium Level 4[1] 401%-500% FPL/$110,250[2]	406	520	19	20
Premium Level 5[1] 501%-600% FPL/$132,300[2]	70	105	3	2
Premium Level 6[1] 601%-700% FPL/$154,350[2]	19	26	2	3
Premium Level 7[1] 701%-800% FPL/$176,400[2]	10	9	0	0
Premium Level 8[1] >800% FPL/No limit[2]	15	17	0	0
Total	**17,592**	**20,074**	**54,073**	**53,607**

Notes:

[1] Plan is eliminated as of July 1, 2011 per PA 96-1501.

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

[3] Enrollment is the total number of enrollees that were eligible on June 30 of 2009 and 2010. There were 94,525 enrollees eligible at some point during FY09 and 94,628 enrollees eligible at some point during FY10.

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

Source: ALL KIDS enrollment data provided by HFS.

Digest Exhibit 2 shows that total claims paid in FY10 for the EXPANDED ALL KIDS enrollees were $84.2 million. In FY10, HFS received approximately $9.8 million in premiums from enrollees, thus making the net cost of the ALL KIDS expansion approximately $74.4 million (see Digest Exhibit 3). The children that were added as a part of the expansion are not eligible for federal reimbursement and thus are funded entirely by the State. (pages 13-20, 42-44)

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

Digest Exhibit 2

PAYMENTS FOR EXPANDED ALL KIDS SERVICES BY ALL KIDS PLAN [1, 3]

Fiscal Years 2009 and 2010

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals	
	FY09	FY10	FY09	FY10	FY09	FY10
Assist <134% FPL/$29,326.50[2]	n/a	n/a	$50,799,921	$55,613,496	$50,799,921	$55,613,496
Share 134%-150% FPL/$33,075[2]	n/a	n/a	$1,552,871	$1,632,762	$1,552,871	$1,632,762
Premium Level 1 151%-200% FPL/$44,100[2]	n/a	n/a	$1,745,546	$1,383,299	$1,745,546	$1,383,299
Premium Level 2 201%-300% FPL/$66,150[2]	$19,198,487	$19,052,723	$649,573	$384,275	$19,848,060	$19,436,998
Premium Level 3 301%-400% FPL/$88,200[2]	$3,814,370	$4,204,290	$115,548	$41,496	$3,929,917	$4,245,785
Premium Level 4 401%-500% FPL/$110,250[2]	$743,851	$1,098,537	$46,288	$13,039	$790,139	$1,111,576
Premium Level 5 501%-600% FPL/$132,300[2]	$287,785	$384,142	$6,322	$108,452	$294,107	$492,595
Premium Level 6 601%-700% FPL/$154,350[2]	$49,981	$108,145	$2,135	$1,746	$52,116	$109,892
Premium Level 7 701%-800% FPL/$176,400[2]	$14,979	$26,467	$8	$0	$14,987	$26,467
Premium Level 8 >800% FPL/No limit[2]	$40,408	$146,631	$263	$8	$40,670	$146,639
Totals	**$24,149,860**	**$25,020,934**	**$54,918,475**	**$59,178,574**	**$79,068,335**	**$84,199,508**

Notes:

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

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

[3] Totals may not add due to rounding.

Source: ALL KIDS claim data provided by HFS.

Documentation of Residency

Although the Covering ALL KIDS Health Insurance Act requires that children be residents of the State, the ALL KIDS application contains no requirement that residency be verified. Auditors could not identify any routine process used by HFS or DHS to verify residency in the 99 case files reviewed (one case file could not be located by HFS). According to HFS, HFS "must verify residence only if there is a reason to question the claim of Illinois residency." Public Act 96-1501 will require verification of Illinois residency effective July 1, 2011.

Digest Exhibit 3
EXPANDED ALL KIDS PAYMENTS VS. PREMIUMS [1]
Fiscal Years 2009 and 2010

EXPANDED ALL KIDS Plan	FY09 Payments	FY10 Payments	FY09 Premiums Collected	FY10 Premiums Collected	FY09 Net Cost	FY10 Net Cost
Assist <134% FPL/$29,326.50[2]	$50,799,921	$55,613,496	n/a	n/a	**$50,799,921**	**$55,613,496**
Share 134%-150% FPL/$33,075[2]	$1,552,871	$1,632,762	n/a	n/a	**$1,552,871**	**$1,632,762**
Premium Level 1 151%-200% FPL/$44,100[2]	$1,745,546	$1,383,299	$383,405	$218,488	**$1,362,141**	**$1,164,810**
Premium Level 2 201%-300% FPL/$66,150[2]	$19,848,060	$19,436,998	$6,045,951	$6,610,052	**$13,802,109**	**$12,826,946**
Premium Level 3 301%-400% FPL/$88,200[2]	$3,929,917	$4,245,785	$1,825,569	$2,151,192	**$2,104,348**	**$2,094,593**
Premium Level 4 401%-500% FPL/$110,250[2]	$790,139	$1,111,576	$427,847	$534,494	**$362,292**	**$577,082**
Premium Level 5 501%-600% FPL/$132,300[2]	$294,107	$492,595	$108,513	$130,510	**$185,594**	**$362,085**
Premium Level 6 601%-700% FPL/$154,350[2]	$52,116	$109,892	$46,380	$58,905	**$5,736**	**$50,987**
Premium Level 7 701%-800% FPL/$176,400[2]	$14,987	$26,467	$12,960	$13,530	**$2,027**	**$12,937**
Premium Level 8 >800% FPL/No limit[2]	$40,670	$146,639	$39,040	$35,820	**$1,630**	**$110,819**
Totals	**$79,068,335**	**$84,199,508**	**$8,889,664**	**$9,752,991**	**$70,178,671**	**$74,446,517**

Notes:

[1] Totals may not add due to rounding.

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

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

Birth or Identity Documentation

The ALL KIDS application does not require that any birth or identity documentation be provided by undocumented immigrants. According to HFS, children who do not meet citizenship/immigration requirements are not required to submit birth or identity documentation. Without such information, it is questionable how the Departments can verify that the child meets the Act's age requirements, as well as confirm the identity of the child.

During our review of the 99 cases sampled, 40 enrollees (17 citizen/documented immigrants and 23 undocumented immigrants) did not provide documentation of place of birth (e.g., birth certificate). Although actual documentation was not in the case file, HFS noted the birth records for the citizen/documented immigrants were verified through cross-matches or were verified electronically through the Illinois Department of Public Health. According to HFS officials, birth is not required to be verified for undocumented immigrants. While most of the cases reviewed contained proof of identity (e.g., driver's license, State issued ID card, school ID, or a parent's signature if under age 16), we could not find documentation of identity in 2 cases reviewed (2%).

Income

According to a policy provided by DHS, as of January 2004, only one pay stub was required to determine eligibility for all Family Health Plans which includes ALL KIDS.

According to a policy provided by DHS, as of January 2004, **only one pay stub** was required to determine eligibility for all Family Health Plans which includes ALL KIDS. This does not include individuals who are self employed. Self employed individuals are required to submit a month's worth of financial records. During our review, auditors questioned the validity of using only one pay stub to determine 12-month eligibility. Also, the Illinois Administrative Code [89 Ill. Adm. Code 123.230] requires HFS to take "the total gross monthly income of the family" when calculating eligibility. Since one pay stub typically covers less than one full month, collecting documentation of a full month's income would help ensure compliance with the Administrative Code. Public Act 96-1501 will require verification of one month's income for determining eligibility effective July 1, 2011.

Auditors found no additional controls in place at HFS to verify the income reported by enrollees. HFS receives reports from the Illinois Department of Employment Security (IDES) that would allow HFS to determine whether family income has increased. However, the analysis is based on the working parent's social security number which is information that is not required to be submitted to HFS. In 48 percent of the cases reviewed, social security numbers were not provided for one or both of the parents. According to HFS officials, the report provided by IDES **is not used to verify income** for the initial determination or annual redetermination.

Self-Employment

HFS and DHS did not require individuals who are self-employed to provide detailed business records to be used to verify income and expenses.

HFS and DHS did not require individuals who are self-employed to provide detailed business records to be used to verify income and expenses. The ALL KIDS application requires self-employed individuals to "provide 30 days of detailed business records that include income and expenses" to determine eligibility for ALL KIDS. However, many applicants sampled did not provide actual records. Of the 15 applicants tested who reported being self-employed, only 3 provided actual detailed business records for all income and expenses listed (e.g., check register reports and bank statements). The other applicants either provided a summary of income and expenses on a form made available by HFS or in a manner similar to the HFS form.

Without detailed records that document income and expenses, there is no way for HFS and DHS to verify the income reported or the expenses claimed. In addition, without actual records it is difficult to determine whether expenses claimed by applicants are used solely for their business and not for personal use.

After reviewing other state's children's medical programs and their requirements, auditors found that many other states require federal income tax returns and schedules from the previous year as proof of income for individuals who are self-employed. Nineteen of the 24 states we reviewed listed tax returns as a source of documentation to support income. (pages 50-56)

ANNUAL REDETERMINATION PROCESS

Auditors concluded that the annual reviews of ALL KIDS eligibility – also called redeterminations – required by the Illinois Administrative Code [89 Ill. Adm. Code 123.260] were not being adequately implemented by HFS. For ALL KIDS enrollees that are at or below 200 percent of the federal poverty level, a "passive" redetermination is used by HFS. A "passive" redetermination only requires families to return the annual renewal form if there is a change in their information. According to HFS officials, no other eligibility check is conducted by HFS on an annual basis to ensure that eligibility criteria have not changed. As a result, enrollees could remain eligible for "passive" redetermination until they turned 19 years of age without ever having more than one actual eligibility determination.

In its September 2010 report, the HFS Office of the Inspector General recommended that the passive redetermination process be discontinued. The HFS-OIG noted, "It is the position of the OIG that the passive redetermination process has failed to provide Illinois with a reliable and accurate measure of redetermining the eligibility of individuals who are enrolled in the Medicaid program." In contrast, to continue coverage, enrollees in Premium levels 2 through 8 are required to send in the annual redetermination form, which includes updated eligibility information. Public Act 96-1501 will require verification of one month's income for determining continued eligibility effective October 1, 2011. (pages 26-28)

PREMIUM PAYMENTS

The Covering ALL KIDS Health Insurance Act (215 ILCS 170/40(a)(1)) states that children enrolled in the program are subject to cost-sharing, which includes co-pays and monthly premiums. The Act states that HFS, by rule, shall set the requirements. The premium payment amounts are set by the Administrative Code and are calculated based on family income and family size. The premium payments are billed by and are payable to HFS, or its authorized agent, on a monthly basis.

During FY10, if an enrollee's membership was cancelled due to unpaid premiums, the family was ineligible for ALL KIDS coverage for three months. If the family reapplied for ALL

KIDS coverage, the family must pay all premiums past due before they can be re-enrolled. Public Act 96-1272 effective January 1, 2011, eliminated the three month ineligibility period.

Non-Payment of Premiums

Although the Act requires enrollees to pay monthly premiums, HFS' administrative rules allow for enrollees to receive services without ever making any premium payments. HFS' administrative rules contain specific requirements regarding when premiums for levels 2 through 8 must be paid and when coverage will be terminated due to lack of premium payment.

During the FY09 audit and in this audit, auditors found that HFS did not terminate ALL KIDS coverage when the enrollee failed to pay premiums timely as required by 89 Ill. Adm. Code 123.340(a).

During the FY09 audit and in this audit, auditors found that HFS did not terminate ALL KIDS coverage when the enrollee failed to pay premiums timely as required by 89 Ill. Adm. Code 123.340(a). We determined that enrollees who did not pay premiums received an extra month of coverage in addition to what is allowed by the Administrative Code. HFS officials concurred that they are using a two month grace period instead of the one month grace period prescribed by the Administrative Code, which is resulting in three months of coverage without payment of premiums.

We reviewed the March 2010 cancellation report, which contained 1,292 individuals. These individuals were in families that had not made past premium payments and were scheduled to be terminated on April 1, 2010. We determined that 418 individuals on the March cancellation report received services during March, after the required month grace period ended. Our analysis shows that the State paid for 1,400 services totaling $42,893 for these individuals during March 2010.

Additionally, auditors identified 1,897 recipients that received services totaling $289,549 in FY10 for which HFS' data indicated no premiums were ever paid. Although no premium payments had been received for these 1,897 recipients in FY10, HFS noted the outstanding debt will remain on file until collected.

Payment of Past Premiums

Auditors found that HFS and DHS did not have controls in place to ensure that families who were previously terminated from coverage met re-enrollment requirements found in the Administrative Code.

Auditors found that HFS and DHS did not have controls in place to ensure that families who were previously terminated from coverage met re-enrollment requirements found in the Administrative Code. The Administrative Code [89 Ill. Adm. Code 123.210(c)(2)] requires full payment of premiums due, for periods in which a premium was owed and not paid, before the child can be re-enrolled. Additionally, the Administrative Code [89 Ill. Adm. Code 123.210(c)(5)] requires the first month's premium be paid if there was an unpaid premium on the date the child's previous coverage was cancelled.

During our review of the March 11, 2010 cancellation report, auditors identified 21 families that appeared to have been re-enrolled in ALL KIDS without paying their past due premiums. HFS reviewed 7 of the 21 families identified and determined that they should not have been approved, but were approved due to caseworker error. Three of the families, which had previously unpaid premiums, received services during March without ever paying any past or current premiums. Once these families were re-enrolled, HFS subsequently identified them as being delinquent on previous premium payments and the family was placed on the cancellation report. HFS and DHS should ensure that during the enrollment process, case workers identify whether there are any prior delinquent premium payments before re-enrolling families into ALL KIDS. (pages 30-32)

RULES GOVERNING THE EXCHANGE OF INFORMATION

The Act, which became effective on July 1, 2006, requires HFS, in collaboration with the Department of Financial and Professional Regulation, Division of Insurance (now the Department of Insurance), to adopt rules governing the exchange of information under this section. However, even though over four years have passed since this requirement became effective, according to an HFS official, HFS has not adopted rules governing the exchange of health insurance information as required by the Act. According to HFS, a proposed rule was published on January 14, 2011. (pages 23-24)

PAYMENTS FOR NON-EMERGENCY TRANSPORTATION

We reviewed FY10 claims paid and determined that HFS paid for services that were excluded by the Illinois Administrative Code [89 Ill. Adm. Code 123.310]. During our review of the claims paid, auditors determined that HFS paid $22,474 for non-emergency medical transportation for enrollees in Premium levels 2 through 8. As a result of the same finding from the 2009 audit, which was released in May 2010, HFS noted it discovered a system error and implemented a change on June 15, 2010. (pages 48-49)

DUPLICATE PAYMENTS

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

HFS reviewed each of the 20 potential duplicate pairs of claims and determined that 7 were duplicates. Examples of the seven duplicates included: claims submitted by the physician and by the hospital or clinic; and claims submitted by two different physicians. The seven duplicate claims totaled $1,428. According to an HFS official, adjustments have been made. (pages 49-50)

HFS DATA ISSUES

Although HFS had difficulty providing accurate data in a timely manner for the FY09 audit, HFS provided data timely for the FY10 audit. However, the data provided in FY10 continued to have issues as discussed in the following sections.

Individuals Older Than 18 Years of Age

HFS and DHS did not have adequate controls in place to ensure that individuals over the age of 18 were terminated from ALL KIDS eligibility as required by 89 Ill. Adm. Code 123.200(b).

HFS and DHS did not have adequate controls in place to ensure that individuals over the age of 18 were terminated from ALL KIDS eligibility as required by 89 Ill. Adm. Code 123.200(b). According to HFS policy, enrollees have eligibility through the end of the month in which they reach 19 years of age. During FY10, there were 4,032 individuals in the EXPANDED ALL KIDS program that reached 19 years of age. Of those 4,032 individuals, 265 of the recipients received services **after** the month of their 19th birthday. These 265 individuals received 3,140 services after the month in which they reached 19 years of age totaling $159,990 during FY10.

Duplicate Enrollees

HFS and DHS did not have adequate controls in place to ensure that individuals are not enrolled in ALL KIDS more than once. In FY10, auditors identified 303 individuals that appeared to be enrolled with more than one identification number. Duplicate enrollees would overstate the number of children served by the program as well as indicate a weakness in internal controls associated with enrolling the children.

Classification of Documented Immigrants

As a result of the incorrect classification, HFS did not submit and receive federal matching funds for eligible enrollees.

Due to incorrect classification of documented and undocumented immigrants by HFS, the enrollee and cost figures in this report are overstated for undocumented immigrants and are understated for documented immigrants. Additionally, as a result of the incorrect classification, HFS did not submit and receive federal matching funds for eligible enrollees.

During the FY09 and FY10 audits, auditors determined that HFS did not accurately classify documented immigrants who receive ALL KIDS services. According to HFS officials, to ensure that federal matching funds were not requested for

documented immigrants who are ineligible for matching funds (i.e., those documented immigrants who had not been in the country for five years), those documented immigrants were classified as undocumented immigrants.

We reviewed 50 claims from FY10 in which enrollees were classified by HFS as undocumented immigrants. We found that 7 out of the 50 (14%) were **incorrectly classified** as undocumented immigrants. These seven individuals had documentation in the case file, such as permanent resident cards, social security cards, or alien registration numbers, to support their documented immigrant status. However, these seven individuals were classified in the eligibility data as having undocumented immigrant status. The seven individuals had not been in the country for five years when they enrolled in the ALL KIDS program.

In addition, we found 2 individuals out of the 50 (4%) with "B" visas (temporary visitor for business or pleasure) that indicate the child is not a resident of the State. According to HFS and DHS policy, individuals with "B" visas are not eligible for ALL KIDS.

Auditors expanded the testing in this area and requested either social security numbers or alien registration numbers for the recipients that were classified as undocumented in the eligibility data from HFS. HFS officials noted that HFS did not maintain such documentation. DHS provided either social security numbers or alien registration numbers for 12,601 of the 60,580 (21%) EXPANDED ALL KIDS recipients classified as undocumented.

These 12,601 recipients received 336,726 services totaling almost $12.4 million. Even though these recipients had either social security numbers or alien registration numbers, they were all classified as undocumented by HFS. Some of these misclassified undocumented immigrants may have been in the country for more than five years, and as a result, claims paid for these recipients would have been eligible for federal matching funds. None of the $12.4 million in services was submitted for federal matching funds. From the data provided by HFS and DHS, we could not determine how long these immigrants had been in the country.

A February 2009 change in federal law allows HFS to receive federal match for documented immigrants immediately (i.e., they do not have to be in the country for five years). As of November 17, 2010, the State's revised State Plan had not yet been approved to begin receiving these matching funds. The misclassification of documented immigrants as undocumented immigrants will have even greater financial significance once Illinois' State Plan is approved and it can start receiving matching federal funds for correctly classified documented immigrants. Once the State Plan is approved, Illinois could

receive as much as $7.7 million in federal matching funds from FY10 (61.88% increased Medicaid match on $12.4 million). We recommended that HFS ensure that the State receives federal matching funds for all eligible claims. (pages 40-44)

PAYMENTS FOR HEALTH SERVICES

We reviewed FY10 claim data and found billing irregularities in areas such as transportation, optical, preventive medicine, and dental claims. These irregularities may have been billing errors or may have been fraudulent.

We reviewed FY10 claim data and found billing irregularities in areas such as transportation, optical, preventive medicine, and dental claims. These irregularities may have been billing errors or may have been fraudulent. The irregularities that were identified were reported to the Department of Healthcare and Family Services or to the Department's Office of the Inspector General for follow-up and/or investigation.

Transportation Claims

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over transportation claims.

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

We identified 23 instances where transportation was double billed in a single day for a recipient. For these round trips, each origin time/location and destination time/location was identical. One provider billed 39 percent of these duplicate bills. We also identified instances where travel times overlapped. Auditors reported the provider to HFS and to the HFS-OIG. HFS-OIG noted it was aware of this provider and had initiated an audit of the provider's paid services.

HFS does not have effective controls in place to ensure that transportation providers provide accurate details on their claims. According to the HFS Handbook for Transportation Providers, providers must submit the facility name and city or street address and city for origin and destination locations. HFS officials noted that the system does not edit based on origin or destination times and locations. After reviewing the FY10 EXPANDED ALL KIDS claims data provided by HFS, we found that transportation providers, in some cases, did not submit accurate details for origin and destination locations and times for services provided to recipients under the EXPANDED ALL KIDS program, thereby limiting the ability to effectively review these billings. (pages 56-58)

Optical Claims

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over optical claims.

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over optical claims. HFS allows children to receive as many eyeglasses as needed through the Department of

Corrections – Illinois Correctional Industries (ICI) without prior approval. As a result, optical providers were able to bill for multiple frames and fittings for the same recipient during the year. Specifically, auditors identified one provider that billed multiple frames and fittings for a large number of recipients during FY10.

Auditors identified 44 EXPANDED ALL KIDS recipients that claims data showed received four or more frames during FY10. **Of the 44 recipients that received four or more frames during FY10, 41 (93%) had fittings for their frames at one specific optical provider.** These 41 recipients had 180 frames ordered by this one provider through ICI and had 186 fittings billed by this one provider during FY10. These 41 recipients received frames and lenses totaling $4,560 and fittings totaling $5,597. Auditors found that 2 recipients each received six frames, 12 recipients received five frames, and 27 recipients received four frames. Without effective edits to identify potential abuse, HFS must rely on post audits conducted by the HFS-OIG in order to identify abuse and to recover dollars that should not have been reimbursed to providers. Due to this provider's high correlation of customers with multiple pairs of frames received during FY10, auditors reported this provider to HFS and to the HFS-OIG. The HFS-OIG noted it was aware of this provider's billing patterns and is in the early stages of auditing this provider.

To determine whether this provider was billing multiple frames and lenses for ALL KIDS recipients as a whole (not for just the EXPANDED ALL KIDS program), auditors requested billing information from ICI for this provider. ICI provided calendar year 2010 billing data for this provider. During calendar year 2010, this provider ordered four or more frames and lenses for 307 ALL KIDS recipients. In total, the 307 recipients received 1,295 frames and 1,299 pairs of lenses for a total cost of $30,041.

In many instances, the provider ordered several pairs of complete glasses (frames and lenses) for multiple individuals with the same last name during 2010. These orders were often placed throughout the year and often were on the same days or within a few days.

Auditors also determined that HFS did not have effective controls in place over the number of eye exams billed for each recipient. HFS only allows for more than one examination per year "when the optometrist or physician documents the need for the additional examination. If more frequent care is medically necessary because of an unusual circumstance, the patient's record must be documented with an explanation of the special circumstances, and the services provided." According to an HFS official, the claims submitted by providers do not contain an explanation or documentation of special circumstances.

During the review of FY10 claims submitted for eye exams, auditors identified 376 recipients that received more than one eye exam during FY10. These 376 recipients received 793 exams from 198 different providers. Of the 11,496 recipients that received exams in FY10, 3 recipients received five exams, 6 recipients received four exams, 20 recipients received three exams, and 347 received two exams. (pages 58-60)

Preventive Medicine Service Claims

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over the billing of preventive medicine service claims.

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

Auditors identified 1,013 EXPANDED ALL KIDS recipients that received 3 or more preventive medicine services for healthy children during FY10. For these 1,013 recipients, providers billed 3,558 preventive medicine services totaling $268,930 during FY10. The analysis of the FY10 claims data showed that 3 recipients each had eight billings for preventive medicine service claims for healthy children, 7 recipients each had seven preventive medicine claims, 25 recipients each had six preventive medicine claims, 80 recipients each had five preventative medicine claims, 241 recipients each had four preventive medicine claims, and 657 recipients each had three preventive medicine claims. One provider billed three or more preventive medicine claims for 39 EXPANDED ALL KIDS recipients during FY10. (pages 60-61)

Dental Claims

During our review of FY10 EXPANDED ALL KIDS dental claims, we found deficiencies in controls related to dental billings.

During our review of FY10 EXPANDED ALL KIDS dental claims, we found deficiencies in controls related to dental billings. We found instances where the information in the benefit schedule differed from what services HFS officials said were provided and from what was posted on HFS' ALL KIDS Dental services webpage. For example, the dental benefit schedule states that a child can receive one teeth cleaning per six months. The ALL KIDS website also states that cleanings are allowed every six months. However, HFS and DentaQuest (the dental program administrator) said that recipients could get their teeth cleaned twice in a dentist's office and twice in a school setting for a total of four in a year. In another instance, the ALL KIDS Dental services webpage states that children are limited to a periodic oral exam once every 12 months per dentist, whereas, the Dental Office Reference Manual schedule of benefits states that children can

receive an oral exam once every 6 months in an office setting and once every 12 months in a school setting.

Auditors found paid claims for dental services that exceeded the benefit limits published in HFS'/DentaQuest's Dental Office Reference Manual. This would indicate a weakness in controls over dental claims. We found the following, which exceeded the allowed dental benefits:

- 1,149 recipients who received more than the allowed two prophylaxes (teeth cleanings) in FY10 (according to the dental benefit schedule, a child can receive one teeth cleaning every six months);

- 13 recipients who received more than the allowed eight sealants in FY10. Ten of the 13 occurred before a computer edit went into effect on January 28, 2010, which was intended to prevent billings for greater than eight sealants per patient; and

- 38 recipients who received fluoride varnishes beyond the frequency allowed during FY10.

We identified provider outliers within the FY10 dental billing claims. The outliers deviated from the average dental claims that were billed from the ALL KIDS expansion population. These include:

- 17 dentists billed 3 or more surface fillings for more than 40 percent of their billings in FY10, which was more than twice the average (19%) for 3 or more surface fillings by other dentists who billed more than 100 fillings during FY10;

- 2 dentists where claims with 3 or more surface fillings accounted for 80 percent of their total fillings, even though the average dentist who billed more than 100 fillings billed 19 percent of their claims for 3 or more surface fillings;

- 4 dentists charged, on average, double the number of services per recipient (11.8) or more. The dentist with the highest average number of services per recipient averaged 14.7 services per recipient. These four dentists also had the highest average cost per recipient in FY10 ranging from $430 to $584 (the average cost was $181);

- 2 dentists with a high number of recipients had higher average costs per recipient than the average $181. One provider had over 800 recipients with an average cost of $290, the other provider had over 500 recipients with an average cost of $270; and

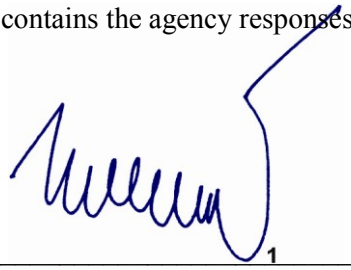
- 22 recipients that had seven or more tooth extractions in

one day. Six recipients had 10 or more, including one recipient with 31 extractions in one day.

These outliers were reported to HFS-OIG for their review. The HFS-OIG responded that it will utilize these findings to assess the impact across all Medical Assistance Programs and will take appropriate action as needed. (pages 61-66)

RECOMMENDATIONS

The audit report contains 14 recommendations. Ten recommendations were specifically for the Department of Healthcare and Family Services. Four recommendations were for both the Department of Healthcare and Family Services and the Department of Human Services. The Department of Healthcare and Family Services and the Department of Human Services agreed with all 14 recommendations. Appendix I to the audit report contains the agency responses.



WILLIAM G. HOLLAND
Auditor General

WGH:SAW

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