STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT
OF THE

COVERING ALL KIDS HEALTH INSURANCE PROGRAM

AUGUST 2014

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OFFICE OF THE AUDITOR GENERAL
WILLIAM G. HOLLAND

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

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

The audit was conducted pursuant to Section 170/63 of the Covering ALL KIDS Health Insurance Act. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
August 2014

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, 2013

Release Date: August 2014

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 **fifth annual audit** and covers FY13. The focus of this audit is on "EXPANDED ALL KIDS," which is the portion of the ALL KIDS program that serves uninsured children not previously covered by KidCare (children whose family income was greater than 200 percent of the federal poverty level or who were undocumented immigrants).

The population for this audit has decreased since the FY12 audit due to the passage of PA 96-1501, which made children whose families' household income was above 300 percent of the federal poverty level (FPL) ineligible for EXPANDED ALL KIDS.

This FY13 audit follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. Our audit found:

- In FY13, 84,563 children were enrolled in EXPANDED ALL KIDS.
- Services provided in FY13 for the EXPANDED ALL KIDS enrollees totaled $75.2 million.
- Of the 34,952 EXPANDED ALL KIDS recipients that required a redetermination of eligibility in FY13, we determined that 11,328 (32%) were not redetermined annually as required.
- HFS and DHS did not verify one month of income for determining continued eligibility as required by Public Act 96-1501.
- In FY13, 154 recipients received 1,966 services totaling $111,004 after the month of their 19th birthday. Additionally, there were 283 individuals who appeared to be enrolled with more than one identification number. We also compared the FY13 duplicates with the duplicates identified in our FY11 audit and **determined that 86 of the duplicates in FY11 were still duplicates in FY13**.
- During our review in FY13, we found the EXPANDED ALL KIDS data continued to have recipients who appear to be incorrectly coded as "undocumented." Many recipients had verified social security numbers, alien registration numbers, or a combination of both.
- During testing we found that residency was not documented as verified in 6 of 37 (16%) files sampled. We also found birth or identity documentation, such as a birth certificate, was not obtained for 11 of the 37 (30%) recipients tested.
- While HFS and DHS took some action to address the previous 10 recommendations, 8 of the recommendations are repeated.

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FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

BACKGROUND

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

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

Throughout this audit, we will refer to the portion of the ALL KIDS program that serves the uninsured children not previously covered by KidCare as "EXPANDED ALL KIDS."

Public Act 95-985 amended the Covering ALL KIDS Health Insurance Act [215 ILCS 170/63] directing the Auditor General to annually audit the EXPANDED ALL KIDS program beginning June 30, 2008, and each June 30th thereafter. The Public Act was effective June 1, 2009. This is the fifth annual audit (FY13). The first audit (FY09) was released in May 2010 and contained 13 recommendations. The second audit (FY10) was released in April 2011 and contained 14 recommendations. The third audit (FY11) was released in October 2012 and contained 11 recommendations. The fourth audit (FY12) was released in December 2013 and contained 10 recommendations.

This FY13 audit of the EXPANDED ALL KIDS program follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. While HFS and DHS took some action to address the previous recommendations, many were not implemented during this audit period (FY13). (pages 4-7, 14)

Recent Changes to the Covering ALL KIDS Health Insurance Program

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

Three events in recent years have had a significant impact on the EXPANDED ALL KIDS program and our audits. The first was the passage of Public Act 96-1501, which added an income limit for determining eligibility for the EXPANDED ALL KIDS program. Effective July 1, 2011, children whose families' household income was above 300 percent of the

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

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

Illinois was approved to receive federal reimbursement for citizens and documented immigrant children in a family with income up to 300 percent of the FPL under Title XXI of the Social Security Act.

The second event occurred on June 4, 2013. HFS received a notification from the federal Department of Health and Human Services (HHS) that Illinois was approved to receive federal reimbursement for citizens and documented immigrant children in a family with income up to 300 percent of the FPL under Title XXI of the Social Security Act, as reauthorized under the Children's Health Insurance Program Reauthorization Act of 2008 (CHIPRA). CHIPRA was formerly titled the State Children's Health Insurance Program.

Our prior EXPANDED ALL KIDS audits have only included children whose medical care was totally State-funded. Now, with this change, the federal government will reimburse for 65 percent of eligible costs for this population (children from families with income between 200 and 300 percent of FPL). Additionally, the State was granted retroactive reimbursement dating back to July 1, 2008. According to HFS officials, as of July 8, 2014, HFS had recouped $34.31 million. HFS reported it had requested recoupment of an additional $37.25 million; however, they were still waiting for approval.

HFS was also given retroactive reimbursement for documented immigrants back to April 1, 2009. This allowed federal reimbursement for documented immigrants regardless of their time in the country. Prior to this, for the State to receive federal reimbursement, documented immigrants had to be in the country for five years. We will follow up on HFS' recoupment of these retroactive funds during our FY14 audit.

The third event affecting our audit is changes in HFS' payment cycle for EXPANDED ALL KIDS claims. When we identified a large decrease in payments in FY12, HFS indicated that the decrease was due to the payment cycle and not a decrease in services. This means that the services were provided in FY12, but were not paid until after the end of the fiscal year. As a result, for this audit, we are reporting on all costs for services that occurred during the fiscal year regardless of when they were paid. (pages 7-8)

ALL KIDS Program

According to HFS, in FY13, Illinois' ALL KIDS program as a whole had a total of 1.9 million enrollees and HFS paid almost $3.6 billion in claims. In FY13, enrollees that were eligible at any point in the year as a result of the July 1, 2006, ALL KIDS expansion totaled 84,563. On June 30, 2013, there were 58,822 enrollees as a result of the expansion of which 39,859

(68%) were classified as undocumented immigrants in the HFS data.

Over the last three fiscal years, total enrollment has decreased from 74,975 at the end of FY11 to 58,822 at the end of FY13. The 16,153 enrollee decrease from FY11 to FY13 was due to the elimination of Levels 3 through 8 after June 30, 2012 as required by PA 96-1501 and a decrease in undocumented immigrants. Digest Exhibit 1 breaks out enrollment by fiscal year, by plan, and by whether the child had documentation for citizenship/immigration status or whether the child was undocumented. (pages 8-9)

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

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants		Undocumented Immigrants	
	FY12	FY13	FY12	FY13
Assist <134% FPL/$31,321.50[2]	n/a	n/a	44,623	37,938
Share 134%-150% FPL/$35,325[2]	n/a	n/a	1,323	806
Premium Level 1 151%-200% FPL/$47,100[2]	n/a	n/a	1,006	811
Premium Level 2 201%-300% FPL/$70,650[2]	18,402[4]	18,963[4]	301	304
Premium Level 3[1] 301%-400% FPL/$94,200[2]	1,469	n/a	20	n/a
Premium Level 4[1] 401%-500% FPL/$117,750[2]	366	n/a	5	n/a
Premium Level 5[1] 501%-600% FPL/$141,300[2]	82	n/a	4	n/a
Premium Level 6[1] 601%-700% FPL/$164,850[2]	8	n/a	0	n/a
Premium Level 7[1] 701%-800% FPL/$188,400[2]	2	n/a	0	n/a
Premium Level 8[1] >800% FPL/No limit[2]	5	n/a	0	n/a
Totals	**20,334**	**18,963**	**47,282**	**39,859**

Notes:

[1] Plan was 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 during FY13.

[3] Enrollment is the total number of enrollees that were eligible on June 30 of 2012 and 2013. There were 92,879 enrollees eligible at some point during FY12 and 84,563 enrollees eligible at some point during FY13.

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

Source: ALL KIDS enrollment data provided by HFS.

ALL KIDS Services Provided by Fiscal Year

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

According to claim data provided by HFS, the cost of services for EXPANDED ALL KIDS in FY09 totaled $78.8 million. The cost for services increased to $89 million in FY10 and to $89.3 million in FY11. The total cost for services dropped to $87.8 million in FY12 and to $75.2 million in FY13. The majority of the cost for services was for undocumented immigrants. Cost for services for undocumented immigrants totaled $55.1 million in FY09, $60.2 million in FY10, $54.9 million in FY11, $55.7 million in FY12, and $48.8 million in FY13. Therefore, in FY13 undocumented immigrants made up 65 percent of the total costs for EXPANDED ALL KIDS.

Digest Exhibit 2 breaks out the cost of services by whether the child had documentation for citizenship/immigration status or whether the child was undocumented for both FY12 and FY13. The Exhibit shows the cost of services decreased by $12.6 million from $87.8 million in FY12 to $75.2 million in FY13. (pages 10-11)

Digest Exhibit 2

EXPANDED ALL KIDS COST OF SERVICES PROVIDED BY ALL KIDS PLAN

Fiscal Years 2012 and 2013

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals	
	FY12	FY13	FY12	FY13	FY12	FY13
Assist <134% FPL/$31,321.50[1]	n/a	n/a	$52,923,796	$46,646,334	$52,923,796	$46,646,334
Share 134%-150% FPL/$35,325[1]	n/a	n/a	$1,242,744	$919,741	$1,242,744	$919,741
Premium Level 1 151%-200% FPL/$47,100[1]	n/a	n/a	$1,085,655	$885,206	$1,085,655	$885,206
Premium Level 2 201%-300% FPL/$70,650[1]	$24,922,858[3]	$26,409,537[3]	$332,515	$303,525	$25,255,373	$26,713,062
Premium Level 3[4] 301%-400% FPL/$94,200[1]	$3,809,884	$150	$78,912	n/a	$3,888,796	$150
Premium Level 4[4] 401%-500% FPL/$117,750[1]	$2,246,835	n/a	$11,994	n/a	$2,258,829	n/a
Premium Level 5[4] 501%-600% FPL/$141,300[1]	$812,254	n/a	$31,685	n/a	$843,940	n/a
Premium Level 6[4] 601%-700% FPL/$164,850[1]	$203,261	n/a	$1,099	n/a	$204,361	n/a
Premium Level 7[4] 701%-800% FPL/$188,400[1]	$10,200	n/a	$0	n/a	$10,200	n/a
Premium Level 8[4] >800% FPL/No limit[1]	$80,227	n/a	$0	n/a	$80,227	n/a
Totals[2]	**$32,085,520**	**$26,409,687**	**$55,708,401**	**$48,754,805**	**$87,793,921**	**$75,164,492**

Notes:

[1] Denotes the applicable federal poverty level income guidelines for the plan level and the maximum income for a family of four for that plan during FY13.

[2] Totals may not add due to rounding.

[3] HFS was notified on June 4, 2013, by the Centers for Medicare and Medicaid Services, that Illinois children up to 300 percent of the federal poverty level were approved to be covered by Title XXI of the Social Security Act (Medicaid). This has a retroactive effective date of July 1, 2008. The federal matching rate was 65 percent; therefore, the State's actual cost for the FY13 services was $9.2 million.

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

Source: ALL KIDS claim data provided by HFS.

Cost of Services and Premiums Collected

HFS received almost $10.5 million in premiums from enrollees in FY12, and received $7.7 million in FY13. As a result, the net cost of EXPANDED ALL KIDS after premium payments were applied was approximately $77.3 million in FY12 and $67.4 million in FY13. Digest Exhibit 3 shows both FY12 and FY13 cost of services and premiums collected from the EXPANDED ALL KIDS program. (page 13)

Digest Exhibit 3
COST OF SERVICES FOR EXPANDED ALL KIDS AND PREMIUM AMOUNTS COLLECTED
Fiscal Years 2012 and 2013

EXPANDED ALL KIDS Plan	FY12 Services	FY13 Services	FY12 Premiums Collected	FY13 Premiums Collected	FY12 Net Cost[3,4]	FY13 Net Cost[3,4]
Assist <134% FPL/$31,321.50[2]	$52,923,796	$46,646,334	n/a	n/a	$52,923,796	$46,646,334
Share 134%-150% FPL/$35,325[2]	$1,242,744	$919,741	$75	$0	$1,242,669	$919,741
Premium Level 1 151%-200% FPL/$47,100[2]	$1,085,655	$885,206	$157,163	$124,725	$928,492	$760,481
Premium Level 2[3] 201%-300% FPL/$70,650[2]	$25,255,373	$26,713,062	$8,109,776	$7,554,265	$17,145,597	$19,158,796
Premium Level 3[1] 301%-400% FPL/$94,200[2]	$3,888,796	$150	$1,447,912	$36,976	$2,440,884	($36,826)
Premium Level 4[1] 401%-500% FPL/$117,750[2]	$2,258,829	n/a	$517,210	$10,510	$1,741,619	($10,510)
Premium Level 5[1] 501%-600% FPL/$141,300[2]	$843,940	n/a	$197,661	$5,420	$646,279	($5,420)
Premium Level 6[1] 601%-700% FPL/$164,850[2]	$204,361	n/a	$29,280	$650	$175,081	($650)
Premium Level 7[1] 701%-800% FPL/$188,400[2]	$10,200	n/a	$11,180	$1,000	($980)	($1,000)
Premium Level 8[1] >800% FPL/No limit[2]	$80,227	n/a	$11,440	$1,215	$68,787	($1,215)
Totals[4]	**$87,793,921**	**$75,164,492**	**$10,481,697**	**$7,734,761**	**$77,312,224**	**$67,429,731**

Notes:

[1] Plan was 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 during FY13.

[3] This exhibit does not include any federal reimbursement for Level 2 enrollees, which would decrease the State's total actual cost by 65 percent.

[4] Totals may not add due to rounding.

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

While HFS and DHS took some action to address the previous 10 recommendations, 8 of the recommendations were not addressed and are repeated.

Follow up on FY12 Recommendations

While HFS and DHS took some action to address the previous 10 recommendations, 8 of the recommendations were not addressed and are repeated. We determined that HFS implemented past recommendations regarding premium payments and optical edits. We will continue to follow up on the eight recommendations that were not implemented during our FY14 annual audit. (pages 2-4, 14)

Redetermination of Eligibility

In the first annual EXPANDED ALL KIDS audit (FY09), auditors concluded that the annual reviews of ALL KIDS eligibility – also called redeterminations – required by the Illinois Administrative Code [89 Ill. Adm. Code 123.260] were not being adequately implemented by HFS. In this audit (FY13), auditors continued to find that redeterminations were not conducted as required.

HFS and DHS did not verify one month of income for determining continued eligibility as required by Public Act 96-1501.

30 Days of Income Verification

HFS and DHS did not verify one month of income for determining continued eligibility as required by Public Act 96-1501. The requirement for the verification of one month of income was effective October 1, 2011. In its response to the FY12 audit, DHS responded that verification of 30 days of income began on or after October 1, 2013, to coincide with the implementation of the first phase of the Integrated Eligibility System. Therefore, since the 30 day income verification requirement was implemented after the audit period for this audit, it will be reviewed as part of our next audit covering FY14.

Annual Eligibility Redeterminations

Public Act 97-0689, effective July 1, 2012, required HFS to contract with an external vendor to assist in completing eligibility redeterminations. HFS contracted with Maximus Health Services, Inc. (Maximus) to be the vendor. In January 2013, Maximus began performing electronic cross match eligibility verifications and requesting documentation from recipients in order to provide recommendations to DHS regarding eligibility. While reviewing the redetermination process conducted by Maximus, we determined before a recommendation was made, Maximus sent letters to recipients requesting information and in most cases attempted to contact the recipients via telephone.

During our review of all eligibility redeterminations for EXPANDED ALL KIDS recipients made in FY13, we found that HFS and DHS did not complete redeterminations of eligibility **annually** for all recipients as required by the

According to the data provided by HFS, 34,952 EXPANDED ALL KIDS recipients required a redetermination of eligibility in FY13. Our analysis of the data showed 23,624 of the 34,952 (68%) were redetermined in FY13. As a result, 11,328 (32%) were not redetermined annually as required by the Act.

Covering ALL KIDS Health Insurance Act. According to the data provided by HFS, 34,952 EXPANDED ALL KIDS recipients required a redetermination of eligibility in FY13. Our analysis of the data showed 23,624 of the 34,952 (68%) were redetermined in FY13. As a result, 11,328 (32%) were not redetermined annually as required by the Act. Maximus made recommendations for 2,874 of the 23,624 recipients. According to our review of HFS documentation, the remaining redeterminations were conducted by HFS or DHS employees. By not conducting annual redeterminations of eligibility, recipients may continue to receive services when they are no longer eligible.

Regarding the 2,874 redetermination recommendations completed by Maximus for EXPANDED ALL KIDS recipients, Maximus recommended 2,779 recipients be canceled, 75 be continued, and 20 be changed to a different eligibility level.

Using the recommendation and data collected by Maximus, State caseworkers made the final determination of eligibility. The review completed by State caseworkers took an average of 19 days. The longest was 196 days.

Our review showed that State caseworkers did not always follow the recommendation made by Maximus. Of the 2,874 recipients reviewed by both Maximus and State caseworkers, Maximus recommended 2,779 recipients be canceled, while State caseworkers canceled 2,275. State caseworkers also changed 143 to a different eligibility level and continued 456.

We randomly sampled 66 recipients where Maximus and State caseworkers agreed to cancel eligibility. We determined 65 of 66 (98%) recipients were recommended for cancellation for not providing the required documentation requested by Maximus.

We randomly sampled 66 recipients where Maximus and State caseworkers agreed to cancel eligibility. We determined 65 of 66 (98%) recipients were recommended for cancellation for not providing the required documentation requested by Maximus. In many instances, Maximus did not receive any response from the recipient. One of the 66 was recommended for cancellation due to aging out of the program and being no longer eligible. During the review, we also determined that 47 of the 65 (72%) recipients that were canceled had not re-enrolled by February 2014.

This audit focused on the redetermination recommendations performed by Maximus. In our next audit, we will examine the redeterminations conducted by HFS and DHS caseworkers. Given that redeterminations were not conducted for 32 percent of eligible EXPANDED ALL KIDS recipients, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2013, to June 30, 2014. (14-17)

Non-Payment of Premiums

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

During the FY11 audit, HFS noted that it was in discussion with DHS regarding system enhancements that could be made to the Automated Intake System so the proper coding would be automatically applied to these cases to prevent re-enrollment of children with outstanding premium debt. According to HFS officials, DHS has been providing reports to HFS for individuals that did not pay premiums since October 2012.

As part of this FY13 audit, we met with HFS officials and reviewed a newly developed report that identifies individuals re-enrolled with unpaid past premiums. According to HFS, due to human caseworker error some individuals are re-enrolled without paying past premiums; however, the report is designed to identify these individuals. HFS also addressed this by issuing an online Medical Morsel (written communication to staff) documenting how to check and enter information for past due premiums. Since this recommendation was addressed by HFS during the audit period, the status of this recommendation is **implemented**. (page 18)

ALL KIDS Data Reliability

Auditors identified issues associated with the eligibility data provided by HFS during recent audits dating back to FY09. These areas included individuals that were older than 18 years of age, 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 FY13 EXPANDED ALL KIDS eligibility data, we continued to find that eligibility data contained individuals who were enrolled in ALL KIDS more than once. In the FY13 data, we identified 283 individuals

We also compared the FY13 duplicates with the duplicates identified in our FY11 audit and determined that 86 of the duplicates in FY11 were still duplicates in FY13.

We also identified 154 recipients that received 1,966 services totaling $111,004 after the month of their 19th birthday.

who appeared to be enrolled with more than one identification number. We also compared the FY13 duplicates with the duplicates identified in our FY11 audit and **determined that 86 of the duplicates in FY11 were still duplicates in FY13**.

We also identified 154 recipients that received 1,966 services totaling $111,004 after the month of their 19th birthday. Therefore, the status of this part of the recommendation is also **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2013, to June 30, 2014. (pages 18-19)

Classification of Documented Immigrants

HFS and DHS continue to have problems correctly coding enrollees as documented immigrants and undocumented immigrants. During this FY13 audit, we identified numerous instances where recipients were erroneously coded as undocumented immigrants. Although some of the inaccurate coding may have been due to incorrect electronic matching of social security numbers, we determined a lack of specific policies and procedures for caseworkers is also causing miscoding.

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

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

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

During the FY12 audit, HFS indicated that the incorrect classification of immigrants was due to a matching problem with the Social Security Administration. We met with HFS to review the matching process. According to HFS, the matching process is done monthly to continuously improve its data. HFS officials noted that HFS continues to try to clean up problems with social security numbers as they are identified; however, it is hard to do without additional staff.

Although HFS reported the miscoding of undocumented immigrants to be implemented, during our review in FY13, we found the EXPANDED ALL KIDS data continued to have recipients who appear to be incorrectly 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. HFS noted the electronic match used to verify the social security number is not an exact match and as a result incorrect matches occur.

For recipients categorized by HFS and DHS as "undocumented," we determined the FY13 eligibility data contained:

- 8,602 recipients who had social security numbers that were verified, of which 1,201 also had an alien registration number; and
- 193 recipients who had an alien registration number, but did not have a verified social security number.

We reviewed the services provided to these "undocumented" recipients in FY13 and determined the 8,602 recipients had 177,269 services for a total cost of $6.4 million. If these recipients are classified as undocumented in error, the State is not receiving eligible matching federal funds.

We sampled 10 of the 1,201 undocumented recipients who had both a verified social security number and an alien registration number to determine whether the recipient should have been classified as undocumented. For the recipients sampled, **HFS confirmed that none of the 10 recipients should be undocumented**. As a result, HFS and DHS should ensure that children with verified social security numbers and/or alien registration numbers are coded properly and ensure that federal matching funds are received for these recipients.

During our review, we also identified 1,992 recipients that were classified as both U.S. citizens and undocumented immigrants at some point during FY13. The eligibility data showed that 1,891 of the 1,992 had verified social security numbers.

These 1,992 recipients had eligibility spans that changed from citizens to undocumented immigrants and back to citizens and spans that changed from undocumented immigrants to citizens and then back to undocumented immigrants.

We determined that 1,827 of the 1,992 recipients were changed from undocumented immigrant status to citizen or

documented immigrant status between August 1, 2012, and December 1, 2012. When we questioned HFS about the status changes, HFS officials noted HFS ran a list of recipients coded as undocumented immigrants that also had social security numbers through its electronic citizenship batch process and then had a worker update the citizenship code on the ones that came back with citizenship verified. According to HFS officials, HFS then started getting calls from DHS offices noting "they had something in the physical file indicating that the person was not a citizen or they had previously removed the SSN because it did not belong to the individual." The correct coding of these recipients is important to ensure the State is receiving all eligible matching federal funds and to ensure that matching funds are not received for ineligible recipients.

During our eligibility testing of 37 new cases, we identified 6 of 16 recipients coded as undocumented that were likely coded as undocumented in error. According to DHS, the recipients tested should have been coded as something other than undocumented. These individuals had visas or social security cards in the files we tested but were labeled in the eligibility system as "Noncitizen child under age 19 who does not have immigration documents," even though the recipients clearly had immigration documentation.

We reviewed HFS/DHS policies and procedures regarding the classification of citizenship status and found the policies and procedures to be deficient. For example, when an immigrant applies for ALL KIDS and provides documents such as an immigrant or non-immigrant visa or social security card, it is unclear from the policies and procedures what citizenship code should be used.

Although HFS reported that problems related to the coding of undocumented immigrants was corrected on October 29, 2010, we continue to have multiple issues in this area.

Although HFS reported that problems related to the coding of undocumented immigrants were corrected on October 29, 2010, we continue to have multiple issues in this area. Therefore, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2013, to June 30, 2014. Due to the incorrect classification of documented and undocumented immigrants, the enrollee and payment figures in this report are overstated for undocumented immigrants and are understated for documented immigrants. (pages 19-23)

Duplicate Claims

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

The judgmental sample of 20 possible duplicate claims was provided to HFS for explanation.

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

HFS officials indicated that implementation of this recommendation is still in progress. Since implementation of corrective action was not taken during the FY13 audit period, this recommendation is **repeated**. Detailed testing will be performed in the next audit cycle. (pages 23-24)

Eligibility Documentation

All four of the previous ALL KIDS audits found that, due to the way HFS implemented the Covering ALL KIDS Health Insurance Act, HFS and DHS did not obtain documentation to support eligibility in some instances.

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

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

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 eligibility and redetermination process for EXPANDED ALL KIDS, we determined that the effectiveness of the matching process is limited when reviewing eligibility for undocumented immigrants. By definition, these children and often their parents are **undocumented**. Electronic matches are conducted based on social security numbers, which this population does not have; therefore, searches based on social security numbers are ineffective. As a result, only actual copies of documents are sufficient to determine residency, income, and immigration/citizenship status for undocumented recipients.

According to both HFS and DHS officials, effective March 14, 2012, an automated Secretary of State clearance was implemented to verify residency. We selected 50 cases identified by DHS that had eligibility beginning in FY13.

HFS and DHS could not locate 10 of the recipient files, and 3 recipient files sampled were not new in FY13. Of the remaining 37 files reviewed, we found that residency was not verified in 6 of the 37 (16%) files tested. Of the 31 recipients verified, 17 had eligibility verified by the Secretary of State residency clearance and 14 were verified by various forms of documentation.

We also found that for 11 of the 37 (30%) recipients, birth or identity documentation such as a birth certificate was not obtained.

Both DHS and HFS provided electronic and paper files for our review. HFS and DHS could not locate 10 of the recipient files, and 3 recipient files sampled were not new in FY13. Of the remaining 37 files reviewed, we found that residency was not verified in 6 of the 37 (16%) files tested. Of the 31 recipients verified, 17 had eligibility verified by the Secretary of State residency clearance and 14 were verified by various forms of documentation. Documentation of residency verification included a social security number match with the Illinois Secretary of State's Office or hard copy documentation such as addresses on bills, Mexican Consular identification cards, driver's licenses, or pay stubs. Each of these documents contained the applicant's Illinois address. We also found that for 11 of the 37 (30%) recipients, birth or identity documentation such as a birth certificate was not obtained. Therefore, this part of the recommendation is **repeated** and will be followed up on in future audits.

In addition, HFS and DHS indicated that the new income requirement was not addressed in FY13. As a result, since HFS and DHS have not implemented the required one month's worth of income requirement, the status of this part of the recommendation is **repeated**. This recommendation will be followed up on during the next audit cycle.

During our FY10 review, auditors found that HFS and DHS did not properly determine whether individuals actually were or were not self-employed. Errors and inconsistencies in determining the income of self-employed individuals could again result in a family paying a higher premium or co-pay, or could result in the State paying for a greater portion of a child's medical services than necessary. According to both HFS and DHS, neither agency has addressed the portion of the recommendation related to applicants who are self-employed; therefore, the status of this part of the recommendation is **repeated**. (pages 24-26)

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 pick up or drop off times or locations.

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

In our FY12 audit, we reviewed transportation claims and continued to find duplicate transportation claims and claims with inaccurate details.

During this audit period, FY13, we identified three providers that billed 374 duplicate services totaling $3,074.

During this audit period, FY13, we identified three providers that billed 374 duplicate services totaling $3,074. In addition, we found claims with inaccurate details, including claims with no destination times and claims with incomplete origin and destination location details.

Since we continue to find issues with transportation claims, the status of this recommendation is **repeated**. This recommendation will be followed up on during the next audit cycle. (pages 27-28)

Optical Edits

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over optical claims. HFS allows children to receive as many eyeglasses as needed through the Department of Corrections – Illinois Correctional Industries 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 with a large number of recipients receiving multiple frames and fittings during FY10. Additionally, auditors also determined that HFS did not have effective controls in place over the number of eye exams billed for each recipient. Due to this provider's high correlation of customers with multiple pairs of frames received during FY10, auditors reported this provider to HFS and to the HFS-Office of the Inspector general (OIG) for further investigation. We followed up with the OIG in the FY11 audit; the OIG failed to act on our referral and noted it could not find a case on this provider.

During our FY12 review, the OIG had not completed a review, but indicated it was currently auditing the provider that was identified in the FY10 audit.

During our follow up in FY13, HFS noted the provider in question was investigated and "NO criminal fraud activity was found, and the issue with numerous glasses may have been due to quality issues (consistently breaking). Interview of recipients verified that the children were getting numerous pairs of eye glasses because they frequently broke beyond repair. The matter has been referred back to OIG, by law enforcement, for other educational and administrative actions." Since the steps were taken by the OIG to investigate this provider, the status of this recommendation is **implemented**. (page 28)

Guidance Over Preventive Medicine Service Claims

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

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

During our review of the FY12 data, auditors identified numerous EXPANDED ALL KIDS recipients that received preventive medicine services for healthy children during FY12 that exceeded the benefit limitation. The Handbook for Providers of Healthy Kids Services establishes the number of preventive medicine services allowed per year by age of the recipient. In FY12, we identified 2,255 recipients that received 2,732 preventive medicine services in excess of the limit.

According to HFS, controls were not set up to address this until December 2012. As a result, for our FY13 review, we only looked at preventive services with service dates after November 30, 2012. We continued to find recipients exceeding the benefit limit. As a result, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2013, to June 30, 2014. (page 29)

Inconsistent Dental Policies

During our review of FY10 EXPANDED ALL KIDS dental claims, we found deficiencies in controls related to dental billings. Auditors found instances in FY10 data where dental services were paid for in excess of the allowed benefit schedule. Auditors also found instances where the allowed benefit schedule differed from what officials said was allowed and from what was posted on HFS' ALL KIDS Dental

Services webpage. Additionally, we identified billing outliers within the dental claims. These irregularities were reported to DHS for follow up and/or investigation.

Additionally, in the FY10, FY11, and FY12 audits, we recommended that HFS ensure that dental policies or other information available to the public accurately state frequency of benefits. We found in our FY13 review, the ALL KIDS Dental Services webpage still states that children are limited to a periodic oral exam once every 12 months per dentist, whereas the Dental Office Reference Manual Schedule of Benefits still states that children can receive an oral exam once every 6 months in an office setting and once every 12 months in a school setting. HFS indicated that it was in the process of revising the Dental Office Manual and Administrative Rules to accurately state frequency and benefits. As a result, the status of this part of the recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2013, to June 30, 2014.

During this audit, we followed up on a provider that we referred to the HFS OIG during our FY10 audit and again in our FY12 audit. In past audits, this provider had a high average cost per client or other outliers. According to the OIG, the provider is currently being investigated by the Illinois State Police Medicaid Fraud Control Unit. (page 30)

RECOMMENDATIONS

The audit report contains 8 recommendations. Five 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 Healthcare and Family Services and the Department of Human Services agreed with all 8 recommendations. Appendix F to the audit report contains the agency responses.

WILLIAM G. HOLLAND
Auditor General

WGH:SAW

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

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COVERING ALL KIDS HEALTH INSURANCE PROGRAM

REPORT CONCLUSIONS

Public Act 95-985 amended the Covering ALL KIDS Health Insurance Act [215 ILCS 170/63] directing the Auditor General to annually audit the EXPANDED ALL KIDS program beginning June 30, 2008, and each June 30th thereafter (see Appendix A). The Public Act was effective June 1, 2009. This is the fifth annual audit (FY13), which follows up on the Department of Healthcare and Family Services' (HFS) and the Department of Human Services' (DHS) actions to address prior audit findings. The previous four annual audits covered FY09 through FY12.

- The first audit (FY09) was released in May 2010 and contained 13 recommendations.
- The second audit (FY10) was released in April 2011 and contained 14 recommendations.
- The third audit (FY11) was released in October 2012 and contained 11 recommendations.
- The fourth audit (FY12) was released in December 2013 and contained 10 recommendations.

ALL KIDS Program

According to HFS officials, during FY13, Illinois' ALL KIDS program as a whole had almost 1.9 million enrollees and HFS paid $3.6 billion in claims. In FY13, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion totaled 84,563. On June 30, 2013, there were 58,822 enrollees as a result of the expansion, of which, 39,859 (68%) were classified as undocumented immigrants in the HFS data.

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

In FY13, undocumented immigrants made up 65 percent of the total costs for the EXPANDED ALL KIDS program. Cost for services for undocumented immigrants totaled $54.9 million in FY11, $55.7 million in FY12, and $48.8 million in FY13. However, due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the payments for undocumented immigrants are overstated, while the payments for documented immigrants are understated.

Based on reports provided by HFS, in FY12, HFS received almost $10.5 million in premiums, and in FY13 HFS received $7.7 million in premiums. As a result, the net cost of the

EXPANDED ALL KIDS program after premium payments were applied was approximately $77.3 million in FY12 and $67.4 million in FY13.

Follow-up on Previous Recommendations

While HFS and DHS took some action to address the previous recommendations, many were not implemented during this audit period (FY13). We determined that two recommendations were implemented and eight were repeated. The following issues were repeated during the FY13 audit period:

- **Redetermination of Eligibility** – HFS and DHS did not complete redeterminations of eligibility **annually** for all recipients as required by the Covering ALL KIDS Health Insurance Act. According to the data provided by HFS, 34,952 EXPANDED ALL KIDS recipients required a redetermination of eligibility in FY13. Our analysis of the data showed 23,624 of the 34,952 (68%) were redetermined in FY13. As a result, 11,328 (32%) were not redetermined annually as required by the Act.

  HFS contracted with Maximus Health Services, Inc. (Maximus) to perform electronic cross match eligibility verifications and to request documentation from recipients in order to provide recommendations to DHS regarding eligibility. Beginning in January 2013, Maximus made redetermination recommendations for 2,874 of the 23,624 during FY13. According to our review of HFS documentation, the remaining redeterminations were conducted by HFS or DHS employees. By not conducting annual redeterminations of eligibility, recipients may continue to receive services when they are no longer eligible.

  Our review showed that State caseworkers did not always follow the recommendation made by Maximus. Of the 2,874 recipients reviewed by both Maximus and State caseworkers, Maximus recommended 2,779 recipients be canceled, while State caseworkers canceled 2,275. State caseworkers also changed 143 to a different eligibility level and continued 456.

  We randomly sampled 66 recipients where Maximus and State caseworkers agreed to cancel eligibility. We determined 65 of 66 (98%) recipients were recommended for cancellation for not providing the required documentation requested by Maximus. In many instances, Maximus did not receive any response from the recipient. One of the 66 was recommended for cancellation due to aging out of the program, making them no longer eligible. Forty seven of the 65 (72%) recipients that were canceled had not re-enrolled by February 2014.

  HFS and DHS did not verify one month of income for determining continued eligibility as required by Public Act 96-1501. The requirement for the verification of one month of income was effective October 1, 2011. In its response to the FY12 audit, DHS responded that verification of 30 days of income became effective on or after September 1, 2013, (which was after our audit period) to coincide with the implementation of the first phase of the Integrated Eligibility System.

- **ALL KIDS Data Reliability** - Eligibility data contained individuals who were enrolled in ALL KIDS more than once. In the FY13 data, we identified 283 individuals who appeared to be enrolled with more than one identification number. We also compared the FY13 duplicates with the duplicates identified in the FY11 audit and **determined that 86 of the duplicates in FY11 were still duplicates in FY13**. We also identified 154 recipients that received 1,966 services totaling $111,004 after the month of their 19th birthday when they were no longer eligible.

- **Classification of Documented Immigrants** - Although HFS reported the miscoding of undocumented immigrants to be resolved, during our review in FY13, we found the EXPANDED ALL KIDS data continued to have recipients coded incorrectly as "undocumented." Many "undocumented" 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. HFS noted the electronic match used to verify the social security number is not an exact match and as a result incorrect matches occur.

  We determined the FY13 eligibility data contained: 8,602 "undocumented" recipients who had social security numbers that were verified, of which 1,201 also had an alien registration number. We reviewed the services provided to these 8,602 "undocumented" recipients in FY13 and determined they had 177,269 services for a total cost of $6.4 million. If these recipients are classified as undocumented in error, the State is not receiving eligible matching federal funds.

  We also identified 1,992 recipients that were classified as both U.S. citizens and undocumented immigrants at some point during FY13. The eligibility data showed that 1,891 of the 1,992 had verified social security numbers.

  We determined that 1,827 of the 1,992 were changed from undocumented immigrant status to citizen or documented immigrant status between August 1, 2012, and December 1, 2012. When questioned by auditors about the status change, HFS officials noted HFS ran a list of recipients coded as undocumented immigrants who also had social security numbers through its electronic citizenship batch process and then had a worker update the citizenship code on the ones that came back with citizenship verified. According to HFS officials, HFS then started getting calls from DHS offices noting "they had something in the physical file indicating that the person was not a citizen or they had previously removed the SSN because it did not belong to the individual."

  During our testing of 37 new recipients in FY13, we identified 6 of 16 recipients coded as undocumented that were likely coded as undocumented in error. These individuals had visas or social security cards in the files we tested. DHS concurred and noted the recipients tested should have been coded as something other than undocumented.

- **Eligibility Documentation** - HFS and DHS use various data matching techniques to determine residency, income, and immigration/citizen status. During our review of the eligibility and redetermination process for EXPANDED ALL KIDS, we determined that the effectiveness of the process is limited when reviewing eligibility for undocumented immigrants. By definition, these children and often their parents are **undocumented**. Thus, the electronic data matches conducted by Maximus and by State caseworkers are not effective for this population. Electronic matches are conducted based on social security numbers, which this population does not have. As a result, only actual copies of documents are sufficient to determine residency, income, and immigration/citizenship status for undocumented recipients.

  We selected 50 cases identified by DHS that had eligibility beginning in FY13. Both DHS and HFS pulled electronic and paper files for our review. HFS and DHS could not locate 10 of the recipient files, and 3 recipient files sampled were not new in FY13. Of the remaining 37 files reviewed, we found that residency was not documented as verified in 6 of the 37 (16%) files tested. We also found that for 11 of the 37 (30%) recipients, birth or identity documentation, such as a birth certificate, was not obtained.

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

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

  - ✓ **Transportation** - Our review identified three providers that billed 374 duplicate services totaling $3,074 in FY13;

  - ✓ **Preventive Medicine** - According to HFS, controls were not set up to address this recommendation until December 2012. As a result, for our FY13 review, we only looked at preventive services with service dates after November 30, 2012. We continued to find recipients exceeding the benefit limit; and

  - ✓ **Dental** - We found that HFS was still in the process of revising the Dental Office Reference Manual and Administrative Rules to accurately state frequency and benefit limits.

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 focus of this audit is on "EXPANDED ALL KIDS," which is the portion of the ALL KIDS program that serves uninsured children not previously covered by KidCare (children whose family income was greater than 200 percent of the federal poverty level

or who were undocumented immigrants). This is the fifth annual audit (FY13). The first audit (FY09) was released in May 2010 and contained 13 recommendations. The second audit (FY10) was released in April 2011 and contained 14 recommendations. There were five new recommendations and three new areas added to the previous audit's recommendations. The third audit (FY11) was released in October 2012 and contained 11 recommendations. The fourth audit (FY12) was released in December 2013 and contained 10 recommendations. The Act requires that the audit include:

- payments for health services covered by the program; and
- contracts entered into by HFS in relation to the program.

CHANGES TO THE COVERING ALL KIDS HEALTH INSURANCE ACT

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

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

Public Act 96-1501 also added an income limit for determining eligibility for the EXPANDED ALL KIDS program. Effective July 1, 2011, children whose families' household income was above 300 percent of the federal poverty level were no longer eligible. Children enrolled as of July 1, 2011, were able to remain enrolled in the program until June 30, 2012.

Compliance with Public Act 96-1501

Although Public Act 96-1501 mandated changes to eligibility requirements effective July 1, 2011, neither agency complied with the new income verification eligibility requirement which was effective October 1, 2011. Additionally, both agencies indicated that the residency check requirement was not implemented until March 14, 2012.

According to HFS officials, the federal Centers for Medicare and Medicaid Services would not allow the State to require additional paper documents under the MOE (maintenance-of-effort) provisions of federal law. The Department pursued a strategy of enhancing electronic data matching for a full month of income which was allowed by CMS. Concurrent with implementation of the first phase of the Integrated Eligibility System on October 1, 2013, Illinois was able to issue policy requiring hard copy documents for a full month of income for those whose income could not be verified electronically. HFS' position has always been that it was not operationally feasible to require different verification procedures for undocumented children.

However, since ALL KIDS is funded entirely with State funds, HFS could request any required documentation from participants either at initial signup or during annual redeterminations without violating any federal guidelines. Noncompliance with Public Act 96-1501 was added as a new recommendation in the FY12 audit. Both HFS and DHS indicated that this recommendation was addressed using electronic data matches.

STATE STATUTES RELATED TO ALL KIDS

Effective July 1, 2006, Illinois' KidCare program, which included Medicaid and Children's Health Insurance Program (SCHIP) populations, **was expanded** by the Covering ALL KIDS Health Insurance Act [215 ILCS 170] (Act) to include all uninsured children not previously covered. The expansion added children whose family income was greater than 200 percent of the federal poverty level and all undocumented immigrant children. At that time, the KidCare program was renamed ALL KIDS.

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

1) must be a resident of the State of Illinois;
2) must be ineligible for medical assistance under the Illinois Public Aid Code or benefits under the Children's Health Insurance Program Act; and
3) must have been uninsured for an extended period of time as set forth by Department rule or meet certain exceptions such as losing insurance due to job loss.

The original Act expanded program benefits to cover all uninsured children in families regardless of family income. As of July 1, 2012, per PA 96-1501, children whose family income was greater than 300 percent of the federal poverty level were no longer eligible for EXPANDED ALL KIDS. Throughout this audit, we will refer to this newly expanded population as "EXPANDED ALL KIDS."

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

ILLINOIS ADMINISTRATIVE CODE FOR ALL KIDS

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

The rules reiterate some of the eligibility criteria set forth by the Act and expand on some of the eligibility exclusions and reasons for termination of coverage. The rules note that covered services are those that are covered by the Children's Health Insurance Program, minus service

exclusions that include non-emergency medical transportation and over-the-counter drugs. The rules also have several important provisions that specifically relate to this audit. These include:

- eligibility shall be reviewed annually;
- premiums will not increase during the eligibility period, unless the family adds children to the coverage or there is a regulatory change in cost sharing;
- family is defined as the child applying for the program and the following individuals who live with the child: the child's parents, the spouse of the child's parent, children under 19 years of age of the parents or the parent's spouse, the spouse of the child, the children of the child, and if any of the previously mentioned are pregnant, the unborn children;
- the family at any time may request a downward modification of the premium for any reason, including a change in income or change in family size; and
- there is a grace period through the end of the month of coverage to pay premiums, and failure to pay the full monthly premium by the last day of the grace period will result in termination of coverage.

RECENT CHANGES AFFECTING THE COVERING ALL KIDS HEALTH INSURANCE PROGRAM AUDIT

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

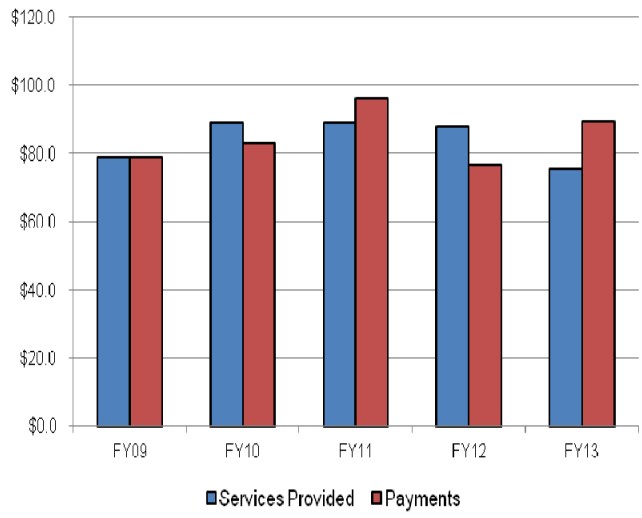
The second event occurred on June 4, 2013. HFS received a notification from the federal Department of Health and Human Services (HHS) that Illinois was approved to receive federal reimbursement for citizens and documented immigrant children in a family with income up to 300 percent of the FPL under Title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

Our prior EXPANDED ALL KIDS audits have only included children whose medical care was totally State-funded. Now, with this change, the federal government will reimburse for 65 percent of eligible costs for this population (children from families with income between 200 and 300 percent of FPL). Additionally, the State was granted retroactive reimbursement dating back to July 1, 2008. According to HFS officials, as of July 8, 2014, HFS had recouped $34.31 million. HFS reported it had requested recoupment of an additional $37.25 million; however, they were still waiting for approval.

HFS was also given retroactive reimbursement for documented immigrants back to April 1, 2009. This allowed federal reimbursement for documented immigrants regardless of their time in the country. Prior to this, for the State to receive federal reimbursement, documented immigrants had to be in the country for five years. We will follow up on HFS' recoupment of these retroactive funds during our FY14 audit.

The third event affecting our audit is changes in HFS' payment cycle for EXPANDED ALL KIDS claims. When we identified a large decrease in payments in FY12, HFS indicated that the decrease was due to the payment cycle and not a decrease in services. This means that the services were provided in FY12, but were not paid until after the end of the fiscal year. As a result, for this audit, we are reporting on all costs for services that occurred during the fiscal year regardless of when they were paid. The primary focus in this audit is on services provided since payments are impacted by cash flow issues and do not accurately depict program activity when there are payment cycle delays. Exhibit 1 is a comparison between total EXPANDED ALL KIDS services provided and total EXPANDED ALL KIDS payments by fiscal year.

Exhibit 1
COMPARISON BETWEEN ALL KIDS SERVICES PROVIDED AND PAYMENTS MADE BY FISCAL YEAR
In Millions



Source: ALL KIDS data provided by HFS.

ALL KIDS PROGRAM

According to HFS, in FY13, Illinois' ALL KIDS program as a whole had a total of 1.9 million enrollees and HFS paid almost $3.6 billion in claims. In FY13, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion totaled 84,563. On June 30, 2013, there were 58,822 enrollees as a result of the expansion of which 39,859 (68%) were classified as undocumented immigrants in the HFS data. Over the last three fiscal years, total enrollment has decreased from 74,975 at the end of FY11 to 58,822 at the end of FY13. There was a 16,153 enrollee decrease from FY11 to FY13, which is due to the elimination of Levels 3 through 8 after June 30, 2012, as required by PA 96-1501 and a decrease in undocumented immigrants. When asked why the number of undocumented immigrants decreased from 51,669

at the end of FY11 to 39,859 at the end of FY13, HFS indicated it was due to "the coding changes made for documented children to accommodate the federal claiming for 5 year bar kids, the increased focus on completing annual redeterminations, and the use of the USPS National Change of Address Service to help us better identify those who move out of state." Exhibit 2 breaks out enrollment by fiscal year, by plan, and by whether the child had documentation for citizenship/immigration status or whether the child was undocumented. Appendix B shows the ALL KIDS premium and co-pay requirements by plan during FY13.

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

EXPANDED ALL KIDS Plan	Citizens/ Documented Immigrants			Undocumented Immigrants		
	FY11	FY12	FY13	FY11	FY12	FY13
Assist <134% FPL/$31,321.50[2]	n/a	n/a	n/a	48,481	44,623	37,938
Share 134%-150% FPL/$35,325[2]	n/a	n/a	n/a	1,472	1,323	806
Premium Level 1 151%-200% FPL/$47,100[2]	n/a	n/a	n/a	1,253	1,006	811
Premium Level 2 201%-300% FPL/$70,650[2]	18,318[4]	18,402[4]	18,963[4]	382	301	304
Premium Level 3[1] 301%-400% FPL/$94,200[2]	4,028	1,469	n/a	59	20	n/a
Premium Level 4[1] 401%-500% FPL/$117,750[2]	765	366	n/a	14	5	n/a
Premium Level 5[1] 501%-600% FPL/$141,300[2]	134	82	n/a	6	4	n/a
Premium Level 6[1] 601%-700% FPL/$164,850[2]	35	8	n/a	2	0	n/a
Premium Level 7[1] 701%-800% FPL/$188,400[2]	13	2	n/a	0	0	n/a
Premium Level 8[1] >800% FPL/No limit[2]	13	5	n/a	0	0	n/a
Totals	**23,306**	**20,334**	**18,963**	**51,669**	**47,282**	**39,859**

Notes:

[1] Plan was 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 during FY13.

[3] Enrollment is the total number of enrollees that were eligible on June 30 of 2012 and 2013. There were 92,879 enrollees eligible at some point during FY12 and 84,563 enrollees eligible at some point during FY13.

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

Source: ALL KIDS enrollment data provided by HFS.

ALL KIDS Enrollment

Families interested in enrolling their children in the ALL KIDS program must fill out an application. This can be done online, through the mail, or by visiting a DHS local office. ALL KIDS applications are processed by HFS or DHS, depending on which agency receives the application. If the family qualifies by meeting the eligibility requirements, the family is sent an ALL KIDS member handbook explaining the ALL KIDS program and an ALL KIDS member card.

ALL KIDS SERVICES PROVIDED BY FISCAL YEAR

According to claim data provided by HFS, the cost of services for EXPANDED ALL KIDS in FY09 totaled $78.8 million. The cost for services increased to $89 million in FY10 and to $89.3 million in FY11. The total cost for services dropped to $87.8 million in FY12 and to $75.2 million in FY13. The majority of the cost for services was for undocumented immigrants. Cost for services for undocumented immigrants totaled $55.1 million in FY09, $60.2 million in FY10, $54.9 million in FY11, $55.7 million in FY12 and $48.8 million in FY13. Therefore, in FY13 undocumented immigrants made up 65 percent of the total costs for the EXPANDED ALL KIDS program.

Exhibit 3 breaks out the cost of services by whether the child had documentation for citizenship/immigration status or whether the child was undocumented for both FY12 and FY13. Exhibit 3 shows the cost of services decreased by $12.6 million from $87.8 million in FY12 to $75.2 million in FY13.

Exhibit 3
EXPANDED ALL KIDS COST OF SERVICES PROVIDED BY ALL KIDS PLAN
Fiscal Years 2012 and 2013

EXPANDED ALL KIDS Plan	Citizens/Documented Immigrants		Undocumented Immigrants		Totals	
	FY12	FY13	FY12	FY13	FY12	FY13
Assist <134% FPL/$31,321.50[1]	n/a	n/a	$52,923,796	$46,646,334	$52,923,796	$46,646,334
Share 134%-150% FPL/$35,325[1]	n/a	n/a	$1,242,744	$919,741	$1,242,744	$919,741
Premium Level 1 151%-200% FPL/$47,100[1]	n/a	n/a	$1,085,655	$885,206	$1,085,655	$885,206
Premium Level 2 201%-300% FPL/$70,650[1]	$24,922,858[3]	$26,409,537[3]	$332,515	$303,525	$25,255,373	$26,713,062
Premium Level 3[4] 301%-400% FPL/$94,200[1]	$3,809,884	$150	$78,912	n/a	$3,888,796	$150
Premium Level 4[4] 401%-500% FPL/$117,750[1]	$2,246,835	n/a	$11,994	n/a	$2,258,829	n/a
Premium Level 5[4] 501%-600% FPL/$141,300[1]	$812,254	n/a	$31,685	n/a	$843,940	n/a
Premium Level 6[4] 601%-700% FPL/$164,850[1]	$203,261	n/a	$1,099	n/a	$204,361	n/a
Premium Level 7[4] 701%-800% FPL/$188,400[1]	$10,200	n/a	$0	n/a	$10,200	n/a
Premium Level 8[4] >800% FPL/No limit[1]	$80,227	n/a	$0	n/a	$80,227	n/a
Totals[2]	**$32,085,520**	**$26,409,687**	**$55,708,401**	**$48,754,805**	**$87,793,921**	**$75,164,492**

Notes:

[1] Denotes the applicable federal poverty level income guidelines for the plan level and the maximum income for a family of four for that plan during FY13.

[2] Totals may not add due to rounding.

[3] HFS was notified on June 4, 2013, by the Centers for Medicare and Medicaid Services, that Illinois children up to 300 percent of the federal poverty level were approved to be covered by Title XXI of the Social Security Act (Medicaid). This has a retroactive effective date of July 1, 2008. The federal matching rate was 65 percent; therefore, the State's actual cost for the FY13 services was $9.2 million.

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

Source: ALL KIDS claim data provided by HFS.

COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE

According to data provided by HFS, 89 percent of the cost for services provided during FY13 for EXPANDED ALL KIDS was paid for 11 categories of services. Exhibit 4 shows that $67.1 million of the $75.2 million in total EXPANDED ALL KIDS payments were for the following services: Dental Services; Physician Services; Pharmacy; Inpatient Hospital Services (General); General Clinic Services; Outpatient Services (General); Capitation Services; Healthy Kids Services; Inpatient Hospital Services (Psychiatric); Mental Health Rehab Option Services; and Physical Therapy Services. The category with the highest percentage of payments was Dental Services at 17 percent. Appendix C shows the shows the total cost of services provided by category of service during FY13 and Appendix D shows the total cost of services provided in FY13 by plan and by category of service. Appendix E shows total ALL KIDS services provided by provider greater than $50,000.

Exhibit 4
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE FOR EXPANDED ALL KIDS PROGRAM

Category of Service	Total FY13 Cost of Services	Percent of Total FY13 Services
Dental Services	$12,615,325	17%
Physician Services	11,540,814	15%
Pharmacy	10,684,749	14%
Inpatient Hospital Services (General)	8,333,559	11%
General Clinic Services	5,372,736	7%
Outpatient Services (General)	5,268,235	7%
Capitation Services	3,751,132	5%
Healthy Kids Services	3,330,829	4%
Inpatient Hospital Services (Psychiatric)	3,282,462	4%
Mental Health Rehab Option Services	1,825,795	2%
Physical Therapy Services	1,058,986	1%
Total for categories with costs > than $1 million	**$67,064,622**	**89%**
Other categories totaling < than $1 million	8,099,870	11%
Total Payments for All Service Categories	**$75,164,492**	**100%**

Note: Totals may not add due to rounding.

Source: FY13 ALL KIDS data provided by HFS.

COST OF SERVICES AND PREMIUMS COLLECTED

HFS received almost $10.5 million in premiums from enrollees in FY12, and received $7.7 million in FY13. As a result, the net cost of EXPANDED ALL KIDS after premium payments were applied was approximately $77.3 million in FY12 and $67.4 million in FY13. Exhibit 5 shows both FY12 and FY13 cost of services and premiums collected from the EXPANDED ALL KIDS program.

Exhibit 5
COST OF SERVICES FOR EXPANDED ALL KIDS AND PREMIUM AMOUNTS COLLECTED
Fiscal Years 2012 and 2013

EXPANDED ALL KIDS Plan	FY12 Services Provided	FY12 Premiums Collected	FY12 Net Cost[3,4]	FY13 Services Provided	FY13 Premiums Collected	FY13 Net Cost[3,4]
Assist <134% FPL/$31,321.50[2]	$52,923,796	n/a	$52,923,796	$46,646,334	n/a	$46,646,334
Share 134%-150% FPL/$35,325[2]	$1,242,744	$75	$1,242,669	$919,741	$0	$919,741
Premium Level 1 151%-200% FPL/$47,100[2]	$1,085,655	$157,163	$928,492	$885,206	$124,725	$760,481
Premium Level 2[3] 201%-300% FPL/$70,650[2]	$25,255,373	$8,109,776	$17,145,597	$26,713,062	$7,554,265	$19,158,796
Premium Level 3[1] 301%-400% FPL/$94,200[2]	$3,888,796	$1,447,912	$2,440,884	$150	$36,976	($36,826)
Premium Level 4[1] 401%-500% FPL/$117,750[2]	$2,258,829	$517,210	$1,741,619	n/a	$10,510	($10,510)
Premium Level 5[1] 501%-600% FPL/$141,300[2]	$843,940	$197,661	$646,279	n/a	$5,420	($5,420)
Premium Level 6[1] 601%-700% FPL/$164,850[2]	$204,361	$29,280	$175,081	n/a	$650	($650)
Premium Level 7[1] 701%-800% FPL/$188,400[2]	$10,200	$11,180	($980)	n/a	$1,000	($1,000)
Premium Level 8[1] >800% FPL/No limit[2]	$80,227	$11,440	$68,787	n/a	$1,215	($1,215)
Totals[4]	**$87,793,921**	**$10,481,697**	**$77,312,224**	**$75,164,492**	**$7,734,761**	**$67,429,731**

Notes:

[1] Plan was 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 during FY13.

[3] This exhibit does not include any federal reimbursement for Level 2 enrollees, which would decrease the State's total actual cost by 65 percent.

[4] Totals may not add due to rounding.

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

FOLLOW UP ON FY12 AUDIT RECOMMENDATIONS

While HFS and DHS took some action to address the previous 10 recommendations, 8 of the recommendations were not addressed and are repeated. We determined that HFS implemented past recommendations regarding premium payments and optical edits. We will continue to follow up on the eight recommendations that were not implemented during our FY14 annual audit. Exhibit 6 shows the status of the recommendations from the FY12 audit.

Exhibit 6
STATUS OF PREVIOUS AUDIT RECOMMENDATIONS

Recommendation Area	FY12 Recommendation Number	Status of Recommendations Reported in FY12 Audit
Redetermination of ALL KIDS eligibility	1	Repeated
Non-payment of premiums	2	Implemented
ALL KIDS data reliability	3	Repeated
Classification of documented immigrants	4	Repeated
Duplicate claims	5	Repeated
Eligibility documentation	6	Repeated
Transportation claims	7	Repeated
Optical edits	8	Implemented
Guidance over preventive medicine service claims	9	Repeated
Inconsistent dental policies	10	Repeated

Source: Follow up on FY12 recommendations as seen below in the following sections.

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 EXPANDED ALL KIDS enrollees that fall in the Assist, Share, and Premium Level 1 categories (e.g., at or below 200 percent of the FPL), an annual "passive" redetermination was used by HFS. Prior to the end of the eligibility period, HFS sent each family an annual renewal notice. The renewal notice listed the eligibility information for the family and instructed the family to return the form **only** if any of the information had changed. If there were no changes, the family was instructed to do nothing. Therefore, a "passive" redetermination only required families to return the annual renewal form if there was a change in their information. In contrast, to continue coverage, enrollees in Premium Levels 2 through 8 were required to send in the annual redetermination form, which included updated eligibility information. According to HFS officials, the passive renewal process ended in July 2012, but corrective action did not begin until January 2013.

30 Days of Income Verification

HFS and DHS did not verify one month of income for determining continued eligibility as required by Public Act 96-1501. The requirement for the verification of one month of income was effective October 1, 2011. In its response to the FY12 audit, DHS responded that verification of 30 days of income began on or after October 1, 2013, to coincide with the implementation of the first phase of the Integrated Eligibility System. Therefore, since the 30 day income verification requirement was implemented after the audit period for this audit, it will be reviewed as part of our next audit covering FY14.

Annual Eligibility Redeterminations

Public Act 97-0689, effective July 1, 2012, required HFS to contract with an external vendor to assist in completing eligibility redeterminations. HFS contracted with Maximus Health Services, Inc. (Maximus) to be the vendor. In January 2013, Maximus began performing electronic cross match eligibility verifications and requesting documentation from recipients in order to provide recommendations to DHS regarding eligibility. While reviewing the redetermination process conducted by Maximus, we determined before a recommendation was made, Maximus sent letters to recipients requesting information and in most cases attempted to contact the recipients via telephone.

During our review of all eligibility redeterminations for EXPANDED ALL KIDS recipients made in FY13, we found that HFS and DHS did not complete redeterminations of eligibility **annually** for all recipients as required by the Covering ALL KIDS Health Insurance Act. According to the data provided by HFS, 34,952 EXPANDED ALL KIDS recipients required a redetermination of eligibility in FY13. Our analysis of the data showed 23,624 of the 34,952 (68%) were redetermined in FY13. As a result, 11,328 (32%) were not redetermined annually as required by the Act. Maximus made recommendations for 2,874 of the 23,624 recipients. According to our review of HFS documentation, the remaining redeterminations were conducted by HFS or DHS employees. By not conducting annual redeterminations of eligibility, recipients may continue to receive services when they are no longer eligible.

ANNUAL REDETERMINATIONS

According to the data provided by HFS, 34,952 EXPANDED ALL KIDS recipients required a redetermination of eligibility in FY13. Our analysis of the data showed 11,328 (32%) were not redetermined annually as required by the Act.

Regarding the 2,874 redetermination recommendations completed by Maximus for EXPANDED ALL KIDS recipients, Maximus recommended 2,779 recipients be canceled, 75 be continued, and 20 be changed to a different eligibility level.

Using the recommendation and data collected by Maximus, State caseworkers made the final determination of eligibility. The review completed by State caseworkers took an average of 19 days. The longest was 196 days.

Our review showed that State caseworkers did not always follow the recommendation made by Maximus. Of the 2,874 recipients reviewed by both Maximus and State caseworkers, Maximus recommended 2,779 recipients be canceled, while State caseworkers canceled 2,275.

State caseworkers also changed 143 to a different eligibility level and continued 456. Exhibit 7 shows a breakdown of the 2,874 recommendations by Maximus and the decision made by State caseworkers.

Exhibit 7
ALL KIDS ELIGIBILITY REDETERMINATIONS REVIEWED BY MAXIMUS AND STATE CASEWORKERS
For the 2,874 Recipients Reviewed in Fiscal Year 2013

	Cancel	Continue	Change	Total
Maximus Recommendation	2,779	75	20	2,874
State Caseworker Decision	2,275	456	143	2,874

Source: FY13 Maximus ALL KIDS redetermination data provided by HFS.

We analyzed the 2,275 recipients canceled from the reviews completed by State caseworkers in FY13 and determined 1,746 (77%) recipients were no longer enrolled in ALL KIDS as of February 2014. The cost for these 1,746 recipients in FY13, prior to them being canceled, was $934,339. For the 1,746 recipients that were canceled and were no longer enrolled, 769 had no services provided on their behalf in FY13. Of the 769, 745 with a total cost of $16,565 only had coordinated care payments to physicians on their behalf (no actual services were provided) in FY13 and 24 received no services in FY13. Therefore, 44 percent of the former recipients were not using the services in FY13.

We randomly sampled 66 recipients where Maximus and State caseworkers agreed to cancel eligibility. We determined 65 of 66 (98%) recipients were recommended for cancellation for not providing the required documentation requested by Maximus. In many instances, Maximus did not receive any response from the recipient. One of the 66 was recommended for cancellation due to aging out of the program and being no longer eligible. During the review, we also determined that 47 of the 65 (72%) recipients that were canceled had not re-enrolled by February 2014.

REDETERMINATION TESTING RESULTS

During our review, we determined 65 of 66 (98%) recipients were recommended for cancellation for not providing the required documentation. We also determined that 47 of the 65 (72%) recipients that were canceled had not re-enrolled by February 2014.

We also reviewed 20 recipients for which Maximus recommended continued eligibility and DHS determined that the recipient was no longer eligible. We found in many instances, State caseworkers required more income documentation to make their decision to cancel than Maximus used to recommend the case be continued. For these 20 recipients closed by DHS, 12 were re-enrolled in the program as of February 2014. Of those 12 that were re-enrolled, 4 were classified in the data in FY13 as undocumented immigrants even though the recipient had a social security number in the eligibility database. All four continued to have eligibility as of May 2014, and 3 of the 4 recipients' social security numbers were verified in the data.

This audit focused on the redetermination recommendations performed by Maximus. In our next audit, we will examine the redeterminations conducted by HFS and DHS caseworkers.

Given that redeterminations were not conducted for 32 percent of eligible EXPANDED ALL KIDS recipients, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2013, to June 30, 2014.

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;*** • ***ensure the immigration status for documented and undocumented immigrants is reviewed as part of the annual redetermination process; and*** • ***review one month's income for determining continued eligibility as required by Public Act 96-1501.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department has taken steps to correct the problems. As part of the revised Illinois Medicaid Redetermination Project (IMRP), the State has moved to the new-Max-IL system.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department agrees with the recommendation. Beginning 2/1/14, a new redetermination process began. The Department's contracted vendor, Maximus, has developed a redetermination system called Max-IL, which uses electronic data matching for recommending the continuance or cancelation of medical coverage. Max-IL also enhances the integrity of the program by using its ability to store copies of all redetermination forms mailed to the customer, returned redeterminations, electronic data matching results, requests for missing information and verifications provided by the client. A policy directive in the form of a policy manual release was issued in April 2009 regarding undocumented noncitizen children. Children coded as such are to have their immigration status reviewed at redetermination in order to ensure the maximization of federal reimbursement. The change that requires the review of a full month of income was implemented in October 2013.

NON-PAYMENT OF PREMIUMS

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

During the FY11 audit, HFS noted that it was in discussion with DHS regarding system enhancements that could be made to the Automated Intake System so the proper coding would be automatically applied to these cases to prevent re-enrollment of children with outstanding premium debt. According to HFS officials, DHS has been providing reports to HFS for individuals that did not pay premiums since October 2012.

As part of this FY13 audit, we met with HFS officials and reviewed a newly developed report that identifies individuals re-enrolled with unpaid past premiums. According to HFS, due to human caseworker error some individuals are re-enrolled without paying past premiums; however, the report is designed to identify these individuals. HFS also addressed this by issuing an online Medical Morsel (written communication to staff) documenting how to check and enter information for past due premiums. Since this recommendation was addressed by HFS during the audit period, the status of this recommendation is **implemented**.

ALL KIDS DATA RELIABILITY

Auditors identified issues associated with the eligibility data provided by HFS during recent audits dating back to FY09. These areas included individuals that were older than 18 years of age, 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 FY13 EXPANDED ALL KIDS eligibility data, we continued to find that eligibility data contained individuals who were enrolled in ALL KIDS more than once. In the FY13 data, we identified 283 individuals who appeared to be enrolled with more than one identification number. We also compared the FY13 duplicates with the duplicates identified in our FY11 audit and **determined that 86 of the duplicates in FY11 were still duplicates in FY13**.

We also identified 154 recipients that received 1,966 services totaling $111,004 after the month of their 19th birthday.

ALL KIDS DATA RELIABILITY

We identified 283 individuals who appeared to be enrolled with more than one identification number. We also compared the FY13 duplicates with the duplicates identified in the FY11 audit and determined that 86 of the duplicates in FY11 were still duplicates in FY13.

We also identified 154 recipients that received 1,966 services totaling $111,004 after the month of their 19th birthday.

Therefore, the status of this part of the recommendation is also **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2013, to June 30, 2014.

ALL KIDS DATA RELIABILITY	
RECOMMENDATION NUMBER **2**	***The Department of Healthcare and Family Services should have controls in place to ensure that its ALL KIDS eligibility and claim data is accurate and reliable. This includes ensuring that enrollees over 18 years of age are identified as no longer eligible and ensuring that enrollees are not enrolled in ALL KIDS more than once.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. A programming error that allowed a one day of eligibility the month following a child's 19th birthday has been corrected. A new eligibility system is in place that will help the caseworker staff identify the individuals already in the system.

CLASSIFICATION OF DOCUMENTED IMMIGRANTS

HFS and DHS continue to have problems correctly coding enrollees as documented immigrants and undocumented immigrants. During this FY13 audit, we identified numerous instances where recipients were erroneously coded as undocumented immigrants. Although some of the inaccurate coding may have been due to incorrect electronic matching of social security numbers, we determined a lack of specific policies and procedures for caseworkers is also causing miscoding.

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

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

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

During the FY12 audit, HFS indicated that the incorrect classification of immigrants was due to a matching problem with the Social Security Administration. We met with HFS to review the matching process. According to HFS, the matching process is done monthly to continuously improve its data. HFS officials noted that HFS continues to try to clean up problems with social

security numbers as they are identified; however, it is hard to do without additional staff. HFS officials noted changes are made when they identify an undocumented recipient with a social security number that is matched incorrectly.

Although HFS reported the miscoding of undocumented immigrants to be implemented, during our review in FY13, we found the EXPANDED ALL KIDS data continued to have recipients who appear to be incorrectly 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. HFS noted the electronic match used to verify the social security number is not an exact match and as a result incorrect matches occur. Recipients with verified social security numbers and/or alien registration numbers appear to be documented immigrants and are eligible for federal matching funds. Currently, in FY13, these recipients were coded as undocumented and thus were not eligible for matching funds.

CLASSIFICATION OF UNDOCUMENTED IMMIGRANTS

We found the EXPANDED ALL KIDS data continued to have recipients coded incorrectly as "undocumented." Many recipients had verified social security numbers, alien registration numbers, or a combination of both.

For recipients categorized by HFS and DHS as "undocumented," we determined the FY13 eligibility data contained:

- 8,602 recipients who had social security numbers that were verified, of which 1,201 also had an alien registration number; and
- 193 recipients who had an alien registration number, but did not have a verified social security number.

We reviewed the services provided to these "undocumented" recipients in FY13 and determined the 8,602 recipients had 177,269 services for a total cost of $6.4 million. If these recipients are classified as undocumented in error, the State is not receiving eligible matching federal funds.

We sampled 10 of the 1,201 undocumented recipients who had both a verified social security number and an alien registration number to determine whether the recipient should have been classified as undocumented. For the recipients sampled, **HFS confirmed that none of the 10 recipients should be undocumented**. As a result, HFS and DHS should ensure that children with verified social security numbers and/or alien registration numbers are coded properly and ensure that federal matching funds are received for these recipients.

During our review, we also identified 1,992 recipients that were classified as both U.S. citizens and undocumented immigrants at some point during FY13. The eligibility data showed that 1,891 of the 1,992 had verified social security numbers.

CLASSIFICATION OF CITIZENS AS UNDOCUMENTED IMMIGRANTS

During our review, we identified 1,992 recipients that were classified as both U.S. citizens and undocumented immigrants at some point during FY13.

These 1,992 recipients had eligibility spans that changed from citizens to undocumented immigrants and back to citizens and spans that changed from undocumented immigrants to citizens and then back to undocumented immigrants.

We determined that 1,827 of the 1,992 recipients were changed from undocumented immigrant status to citizen or documented immigrant status between August 1, 2012, and December 1, 2012. When we questioned HFS about the status changes, HFS officials noted HFS ran a list of recipients coded as undocumented immigrants that also had social security numbers through its electronic citizenship batch process and then had a worker update the citizenship code on the ones that came back with citizenship verified. According to HFS officials, HFS then started getting calls from DHS offices noting "they had something in the physical file indicating that the person was not a citizen or they had previously removed the SSN because it did not belong to the individual." The correct coding of these recipients is important to ensure the State is receiving all eligible matching federal funds and to ensure that matching funds are not received for ineligible recipients. The following are two examples of how the eligibility changed for these recipients, which were coded by caseworkers as U.S. citizens.

Example #1

Recipient was a citizen eligible for Medicaid from 1/1/96 until 3/31/09. On 4/1/09, recipient was changed to an undocumented immigrant until 8/31/12. Recipient was then changed back to a citizen on 9/1/12. As a result, HFS would have not received federal matching funds for this recipient from April 1, 2009 through August 31, 2012.

Eligibility Periods		Citizenship Status
Begin Date	End Date	
1/1/1996	4/30/1996	U.S. Citizen
5/1/1996	5/31/1996	U.S. Citizen
6/1/1996	9/30/1996	U.S. Citizen
10/1/1996	4/30/1997	U.S. Citizen
5/1/1997	6/30/1997	U.S. Citizen
1/1/1998	7/31/2002	U.S. Citizen
8/1/2002	3/31/2009	U.S. Citizen
4/1/2009	12/31/2010	Undocumented
1/1/2011	8/31/2012	Undocumented
9/1/2012	2/28/2013	U.S. Citizen
3/1/2013	4/30/2013	U.S. Citizen
5/1/2013	4/30/2014	U.S. Citizen
5/1/2014	8/31/2014	U.S. Citizen

Example #2

Recipient was classified as a child without immigration documents (undocumented immigrant) from 7/1/06 until 9/30/12. Then on 10/1/12, recipient was changed to a verified citizen per an electronic data match until 4/30/14. Recipient was then classified back to a child without immigration documents (undocumented immigrant) on 5/1/14, even though the eligibility database shows the recipient had a verified social security number. As a result, HFS likely received federal matching funds in error for this recipient from October 1, 2012 through April 30, 2014.

Eligibility Periods		Citizenship Status
Begin Date	End Date	
7/1/2006	1/31/2007	Undocumented
2/1/2007	1/31/2011	Undocumented
2/1/2011	9/30/2012	Undocumented
10/1/2012	4/30/2014	U.S. Citizen
5/1/2014	5/16/2015	Undocumented

During our eligibility testing of 37 new cases, we identified 6 of 16 recipients coded as undocumented that were likely coded as undocumented in error. According to DHS, the recipients tested should have been coded as something other than undocumented. These individuals had visas or social security cards in the files we tested but were labeled in the eligibility system as "Noncitizen child under age 19 who does not have immigration documents," even though the recipients clearly had immigration documentation.

INCORRECTLY CLASSIFIED AS UNDOCUMENTED IMMIGRANTS

We identified 6 of 16 recipients coded as undocumented that were likely coded as undocumented in error. These individuals had visas or social security cards in the files we tested.

We reviewed HFS/DHS policies and procedures regarding the classification of citizenship status and found the policies and procedures to be deficient. For example, when an immigrant applies for ALL KIDS and provides documents such as an immigrant or non-immigrant visa or social security card, it is unclear from the policies and procedures what citizenship code should be used.

Although HFS reported that problems related to the coding of undocumented immigrants were corrected on October 29, 2010, we continue to have multiple issues in this area. Therefore, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2013, to June 30, 2014. Due to the incorrect classification of documented and undocumented immigrants, the enrollee and payment figures in this report are overstated for undocumented immigrants and are understated for documented immigrants.

CLASSIFICATION OF DOCUMENTED IMMIGRANTS	
RECOMMENDATION NUMBER **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;*** • ***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. New coding to more accurately record immigration status has been implemented.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department agrees with the recommendation. Although DHS is not involved in federal reimbursement claiming responsibilities, we do accept that DHS does have a role in ensuring accurate data is passed to the entity which handles the federal reimbursement claiming. DHS will work to ensure caseworkers and the electronic systems they use contain sufficient tools and options in order to accurately classify the immigration and citizenship status of all clients receiving assistance administered by the Department. The implementation of the Department's new Integrated Eligibility System (IES) will enhance the accuracy of immigration and citizenship status coding by making it easier for staff to select the correct status using descriptions in drop down menu format, replacing the task of memorizing and/or searching for numerical codes which most appropriately represent the client's status. Additionally, the implementation of IES will enhance the integrity of the maintenance of immigration and citizenship documentation, as the new system includes scanning and electronic document storage functionality.

DUPLICATE CLAIMS

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

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

HFS officials indicated that implementation of this recommendation is still in progress. Since implementation of corrective action was not taken during the FY13 audit period, this recommendation is **repeated**. Detailed testing will be performed in the next audit cycle.

DUPLICATE CLAIMS	
RECOMMENDATION NUMBER **4**	***The Department of Healthcare and Family Services should review the manual review process for rejected claims and strengthen the controls to prevent duplicate claims from being paid.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department continues to enhance the data warehouse query to identify duplicates and reviews the data monthly.

ELIGIBILITY DOCUMENTATION

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

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

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 eligibility and redetermination process for EXPANDED ALL KIDS, we determined that the effectiveness of the matching process is limited when reviewing eligibility for undocumented immigrants. By definition, these children and often their parents are **undocumented**. Thus, the electronic data matches conducted by Maximus and by State caseworkers are ineffective for this population. Electronic matches are conducted based on social security numbers, which this population does not have; therefore, searches based on social security numbers are ineffective. As a result, only actual copies of documents are sufficient to determine residency, income, and immigration/citizenship status for undocumented recipients.

According to both HFS and DHS officials, effective March 14, 2012, an automated Secretary of State clearance was implemented to verify residency. We selected 50 cases identified by DHS that had eligibility beginning in FY13. Both DHS and HFS provided electronic and paper files for our review. HFS and DHS could not locate 10 of the recipient files, and 3 recipient files sampled were not new in FY13. Of the remaining 37 files reviewed, we found that residency was not verified in 6 of the 37 (16%) files tested. Of the 31 recipients verified, 17 had eligibility verified by the Secretary of State residency clearance and 14 were verified by various forms of documentation. Documentation of residency verification included a social security number match with the Illinois Secretary of State's Office or hard copy documentation such as addresses on bills, Mexican Consular identification cards, driver's licenses, or pay stubs. Each of these documents contained the applicant's Illinois address. We also found that for 11 of the 37 (30%) recipients, birth or identity documentation such as a birth certificate was not obtained. Therefore, this part of the recommendation is **repeated** and will be followed up on in future audits.

ELIGIBILITY DOCUMENTATION TESTING RESULTS

We found that residency was not verified in 6 of the 37 (16%) files tested. We also found that for 11 of the 37 (30%) recipients, birth or identity documentation such as a birth certificate was not obtained.

In addition, HFS and DHS indicated that the new income requirement was not addressed in FY13. As a result, since HFS and DHS have not implemented the required one month's worth of income requirement, the status of this part of the recommendation is **repeated**. This recommendation will be followed up on during the next audit cycle.

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

ELIGIBILITY DOCUMENTATION	
RECOMMENDATION NUMBER **5**	***The Department of Healthcare and Family Services and the Department of Human Services should:*** • ***ensure that all necessary eligibility documentation to support birth, identity, and residency is received in order to ensure that eligibility is determined accurately;*** • ***require one month's worth of income verification for determining eligibility; and*** • ***implement better controls to verify whether individuals are self-employed and to ensure that adequate information is provided and eligibility is determined correctly.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department has implemented electronic verification of citizenship, identity, residency, and income. Paper verification is requested when these items cannot be verified electronically.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department accepts the recommendation. DHS follows policy set forth by the Illinois Department of Healthcare and Family Services (HFS), the single state Medicaid agency. Beginning in March 2012 an automated Secretary of State residency clearance is generated for new medical applicants and requestors over the age of 16 registered in AIS or IES in the All Kids unit, and in all DHS Family and Community Resource Centers (FCRCs). That clearance, in addition to documentation to support birth and identity, was to be filed in the case record prior to the implementation of IES. Currently, for new cases that originate and are approved in IES, the above mentioned documentation can be electronically stored in the Electronic Case Record. Effective with medical applications submitted on or after 10/1/13, and to coincide with the implementation of the first phase of the Integrated Eligibility System, policy has now changed to clarify that as required under the Affordable Care Act, electronic data matches are the preferred means of verifying income in order to determine proper eligibility for medical programs, and that verification of 30 days of income is now required for all medical programs. Through January 2014 email communication with the Federal Center for Medicaid Services; DHS staff has confirmed that our policy is in compliance with the federal regulation. The Code of Federal Regulation 435.948 states that in order to verify the financial eligibility of individual, net earnings from self-employment must be obtained. Our policy requires staff to verity all self-employment income and business expenses, and that the client's records may serve as proof of income and expenses. The Illinois Medicaid Redetermination Project contract with Maximus utilizes electronic income verification that may assist in identifying income that has not been disclosed by the recipient.

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 pick up or drop off times or locations.

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

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

During this audit period, FY13, we identified three providers that billed 374 duplicate services totaling $3,074. In addition, we found claims with inaccurate details, including claims with no destination times and claims with incomplete origin and destination location details.

TRANSPORTATION CLAIMS

We identified three providers that billed 374 duplicate services totaling $3,074.

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

TRANSPORTATION CLAIMS	
RECOMMENDATION NUMBER **6** Continued on following page	***The Department of Healthcare and Family Services should:*** • ***ensure proper electronic billing edits are in place to prevent payment of duplicate transportation claims. In addition, HFS should identify and recoup past duplicate payments made to providers; and*** • ***ensure transportation providers submit accurate claim detail with their request for payment to ensure HFS has the information necessary for monitoring.***

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. A Project Initialization Request was prepared to program a system edit that only allows one round-trip per prior approval number per day. The Department is also working to place some restrictions on origin and destination times and require the input of address and city information by providers to help ensure more accurate claim detail. This change was implemented November 2013.

OPTICAL EDITS

During the review of FY10 EXPANDED ALL KIDS claim data, auditors determined that HFS did not have effective controls over optical claims. HFS allows children to receive as many eyeglasses as needed through the Department of Corrections – Illinois Correctional Industries (ICI) without prior approval. As a result, optical providers were able to bill for multiple frames and fittings for the same recipient during the year.

Specifically, auditors identified one provider with a large number of recipients receiving multiple frames and fittings during FY10. Additionally, auditors also determined that HFS did not have effective controls in place over the number of eye exams billed for each recipient. Due to this provider's high correlation of customers with multiple pairs of frames received during FY10, auditors reported this provider to HFS and to the HFS Office of the Inspector General (OIG) for further investigation. The HFS-OIG noted it was aware of this provider's billing patterns and was in the early stages of auditing this provider. We followed up with the OIG in the FY11 audit; the OIG failed to act on our referral and noted it could not find a case on this provider.

In its response to this recommendation in the FY11 audit, the OIG stated that it was in the process of developing predictive modeling routines related to optical care. The OIG also noted it ran data mining routines to determine children with multiple eyeglass expenditures, and requested charts to determine whether the multiple eyeglasses were medically necessary or if there was evidence of fraud, waste, or abuse. During our FY12 review, the OIG had not completed a review, but indicated it was currently auditing the provider that was identified in the FY10 audit.

During our follow up in FY13, HFS noted the provider in question was investigated and "NO criminal fraud activity was found, and the issue with numerous glasses may have been due to quality issues (consistently breaking). Interview of recipients verified that the children were getting numerous pairs of eye glasses because they frequently broke beyond repair. The matter has been referred back to OIG, by law enforcement, for other educational and administrative actions." Since the steps were taken by the OIG to investigate this provider, the status of this recommendation is **implemented**.

GUIDANCE OVER PREVENTIVE MEDICINE SERVICE CLAIMS

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

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

During our review of the FY12 data, auditors identified numerous EXPANDED ALL KIDS recipients that received preventive medicine services for healthy children during FY12 that exceeded the benefit limitation. The Handbook for Providers of Healthy Kids Services establishes the number of preventive medicine services allowed per year by age of the recipient. In FY12, we identified 2,255 recipients that received 2,732 preventive medicine services in excess of the limit.

According to HFS, controls were not set up to address this until December 2012. As a result, for our FY13 review, we only looked at preventive services with service dates after November 30, 2012. We continued to find recipients exceeding the benefit limit. As a result, the status of this recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2013, to June 30, 2014.

GUIDANCE OVER PREVENTIVE MEDICINE SERVICE CLAIMS	
RECOMMENDATION NUMBER **7**	***The Department of Healthcare and Family Services should more clearly define how providers should bill preventive medicine services and should distinguish between preventive services and office visits for established patients. The Department should also ensure that electronic billing edits exist to identify potential abuse related to the billing of preventive medicine services.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department issued a Provider Notice reminding providers of the proper use and frequency limits of preventive services codes, however, it needs to be updated. In addition, incorrect values were placed on the procedure diagnosis database for preventive medicine visit codes allowing payment for visits in excess of the program limits. The Department will correct the errors on the procedure diagnosis database and re-issue provider notice clarifying program limits and exceptions.

INCONSISTENT DENTAL POLICIES

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

Additionally, in the FY10, FY11, and FY12 audits, we recommended that HFS ensure that dental policies or other information available to the public accurately state frequency of benefits. We found in our FY13 review, the ALL KIDS Dental Services webpage still states that children are limited to a periodic oral exam once every 12 months per dentist, whereas the Dental Office Reference Manual Schedule of Benefits still states that children can receive an oral exam once every 6 months in an office setting and once every 12 months in a school setting. HFS indicated that it was in the process of revising the Dental Office Manual and Administrative Rules to accurately state frequency and benefits. As a result, the status of this part of the recommendation is **repeated** and will be followed up on during the next audit cycle, which covers the period July 1, 2013, to June 30, 2014.

During this audit, we followed up on a provider that we referred to the HFS OIG during our FY10 audit and again in our FY12 audit. In past audits, this provider had a high average cost per client or other outliers. According to the OIG, the provider is currently being investigated by the Illinois State Police Medicaid Fraud Control Unit.

INCONSISTENT DENTAL POLICIES	
RECOMMENDATION NUMBER **8**	***The Department of Healthcare and Family Services should ensure that dental policies and other information available to the public accurately state frequency of benefits.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department has submitted the emergency dental rules and proposed dental rules for review. The rules were published in the 2014 Illinois Register, Volume 38, Issue 29 on July 18, 2014. Once the rules are approved, the HFS website will be changed to match the administrative code. HFS will ensure that the Dental Office Reference Manual and the HFS website accurately state the frequency of dental benefits.

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

Since this is the fifth audit of the EXPANDED ALL KIDS program in the last five years and there have been significant changes to the Covering ALL KIDS Health Insurance Act that are effective during the FY13 audit period, this audit followed up on previous recommendations, determined if new laws and policies were properly implemented, and reviewed the eligibility redetermination process that was implemented during FY13.

During our audit, HFS officials reported that there were two new contracts related to the ALL KIDS Expansion for FY13. These contracts were with Datamation Imaging Services Corp. and with Maximus Health Services, Inc. EXPANDED ALL KIDS is only a small portion of the Maximus contract and the contract as a whole was reviewed during the Office of the Auditor General's FY13 Financial/Compliance Audit of HFS. The Datamation contract is directly related to ALL KIDS as a whole. Therefore, we met with HFS to determine the nature of the work completed by Datamation. The amount of the contract was $1,000,000; however, HFS officials noted the contract amount was for more than what was needed to complete the project. Datamation was to scan and shred documents. We reviewed the final bill from Datamation. The bill showed Datamation completed the project, which was based on a per item basis, at a cost of $330,535. As part of the contract, Datamation shredded all of the files after the files were scanned, therefore, we could not perform testing to determine if all documents were scanned.

Public Act 97-0689, effective June 14, 2012, required HFS to contract with an external vendor to assist in completing eligibility redeterminations. Maximus Health Services, Inc. (Maximus) was selected to be the vendor, and in January 2013, Maximus began performing electronic eligibility verifications by providing electronic cross match information and recommendations regarding eligibility. To determine Maximus' role, we met with Maximus officials, reviewed their data system, and reviewed training and policy documents. We also tested redeterminations as part of our follow up on Recommendation Number 1.

This FY13 audit of the EXPANDED ALL KIDS program follows up on HFS and DHS actions to address prior audit findings. During this audit period, the State hired a vendor to review eligibility. We reviewed eligibility determinations by testing in four areas. Since these

samples were of a narrowly defined group of recipients, none of these samples should be projected to the population. The four samples consisted of the following:

1) a randomly selected sample of 50 new EXPANDED ALL KIDS cases in FY13, from the 846 identified by DHS where we determined whether all necessary eligibility documentation to support birth, identity, and residency was received or verified in order to ensure that eligibility is determined accurately;

2) a sample of 66 randomly selected cases from a population of 2,180 cases in which Maximus and DHS both recommended cancellation where we reviewed documentation to determine whether the documentation supported the determination made;

3) a sample of 20 randomly selected cases from a population of 75 in which Maximus recommended to continue, but DHS recommended cancellation where we reviewed documentation to determine whether the documentation supported the determination made; and

4) a sample of 10 recipients from 1,201 undocumented recipients who had both a verified social security number and an alien registration number to determine whether the recipient should have been classified as documented.

Since the data system was reviewed during FY13 by the Auditor General's Information Systems Division, we did not review the data system during FY13. However, we did review the data for completeness by conducting limit tests and range tests. Any weaknesses in internal controls that have not been addressed from the previous audits are included as findings in this report.

APPENDICES

APPENDIX A

Covering ALL KIDS Health Insurance Act [215 ILCS 170]

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

Appendix A

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

(215 ILCS 170/1)

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

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

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

(215 ILCS 170/5)

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

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

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

(215 ILCS 170/7)

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

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

from the federal government, this Section shall be implemented:

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

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

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

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

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

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

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

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

(215 ILCS 170/10)

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

Sec. 10. Definitions. In this Act:

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

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

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

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

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

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

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

(215 ILCS 170/15)

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

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

not limited to, the provisions under Section 11-5.1 of the Code, and the Children's Health Insurance Program Act. The Department shall coordinate the Program with the existing children's health programs operated by the Department and other State agencies. Effective October 1, 2013, the determination of eligibility under this Act shall comply with the requirements of 42 U.S.C. 1397bb(b)(1)(B)(v) and applicable federal regulations. If changes made to this Section require federal approval, they shall not take effect until such approval has been received.
(Source: P.A. 98-104, eff. 7-22-13.)

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

(215 ILCS 170/21)

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

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

(215 ILCS 170/25)

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

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

(215 ILCS 170/30)

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

Sec. 30. Program outreach and marketing. The Department may provide grants to application agents and other community-based organizations to educate the public about the availability of the Program. The Department shall adopt rules regarding performance standards and outcomes measures expected of organizations that are awarded grants under this Section, including penalties for nonperformance of contract standards.

The Department shall annually publish electronically on a State website the premiums or other cost sharing requirements of the Program.

(Source: P.A. 97-689, eff. 6-14-12.)

(215 ILCS 170/35)

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

Sec. 35. Health care benefits for children.

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

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

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

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

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

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

(215 ILCS 170/36)
(Section scheduled to be repealed on July 1, 2016)
Sec. 36. Moratorium on eligibility expansions. Beginning on the effective date of this amendatory Act of the 96th General Assembly, there shall be a 2-year moratorium on the expansion of eligibility through increasing financial eligibility standards, or through increasing income disregards, or through the creation of new programs that would add new categories of eligible individuals under the medical assistance program under the Illinois Public Aid Code in addition to those categories covered on January 1, 2011. This moratorium shall not apply to expansions required as a federal condition of State participation in the medical assistance program.
(Source: P.A. 96-1501, eff. 1-25-11.)

(215 ILCS 170/40)
(Section scheduled to be repealed on July 1, 2016)
Sec. 40. Cost-sharing.
(a) Children enrolled in the Program under subsection (a) of Section 35 are subject to the following cost-sharing requirements:

(1) The Department, by rule, shall set forth requirements concerning co-payments and coinsurance for health care services and monthly premiums. This cost-sharing shall be on a sliding scale based on family income. The Department may periodically modify such cost-sharing.

(2) Notwithstanding paragraph (1), there shall be no co-payment required for well-baby or well-child health care, including, but not limited to, age-appropriate immunizations as required under State or federal law.

(b) Children enrolled in a privately sponsored health insurance plan under subsection (b) of Section 35 are subject to the cost-sharing provisions stated in the privately sponsored health insurance plan.
(c) Notwithstanding any other provision of law, rates paid by the Department shall not be used in any way to determine the usual and customary or reasonable charge, which is the

charge for health care that is consistent with the average rate or charge for similar services furnished by similar providers in a certain geographic area.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/41)
(Section scheduled to be repealed on July 1, 2016)
Sec. 41. Health care provider participation in State Employees Deferred Compensation Plan. Notwithstanding any other provision of law, a health care provider who participates under the Program may elect, in lieu of receiving direct payment for services provided under the Program, to participate in the State Employees Deferred Compensation Plan adopted under Article 24 of the Illinois Pension Code. A health care provider who elects to participate in the plan does not have a cause of action against the State for any damages allegedly suffered by the provider as a result of any delay by the State in crediting the amount of any contribution to the provider's plan account.
(Source: P.A. 96-806, eff. 7-1-10.)

(215 ILCS 170/45)
(Section scheduled to be repealed on July 1, 2016)
Sec. 45. Study; contracts.
(a) The Department shall conduct a study that includes, but is not limited to, the following:
(1) Establishing estimates, broken down by regions of the State, of the number of children with and without health insurance coverage; the number of children who are eligible for Medicaid or the Children's Health Insurance Program, and, of that number, the number who are enrolled in Medicaid or the Children's Health Insurance Program; and the number of children with access to dependent coverage through an employer, and, of that number, the number who are enrolled in dependent coverage through an employer.
(2) Surveying those families whose children have access to employer-sponsored dependent coverage but who decline such coverage as to the reasons for declining coverage.
(3) Ascertaining, for the population of children accessing employer-sponsored dependent coverage or who have access to such coverage, the comprehensiveness of dependent coverage available, the amount of cost-sharing currently paid by the employees, and the cost-sharing associated with such coverage.

(4) Measuring the health outcomes or other benefits for children utilizing the Covering ALL KIDS Health Insurance Program and analyzing the effects on utilization of healthcare services for children after enrollment in the Program compared to the preceding period of uninsured status.

(b) The studies described in subsection (a) shall be conducted in a manner that compares a time period preceding or at the initiation of the program with a later period.

(c) The Department shall submit the preliminary results of the study to the Governor and the General Assembly no later than July 1, 2008 and shall submit the final results to the Governor and the General Assembly no later than July 1, 2010.

(d) The Department shall submit copies of all contracts awarded for the administration of the Program to the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate.

(Source: P.A. 94-693, eff. 7-1-06; 95-985, eff. 6-1-09.)

(215 ILCS 170/47)

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

Sec. 47. Program Information. The Department shall report to the General Assembly no later than September 1 of each year beginning in 2007, all of the following information:

(a) The number of professionals serving in the primary care case management program, by licensed profession and by county, and, for counties with a population of 100,000 or greater, by geo zip code.

(b) The number of non-primary care providers accepting referrals, by specialty designation, by licensed profession and by county, and, for counties with a population of 100,000 or greater, by geo zip code.

(c) The number of individuals enrolled in the Covering ALL KIDS Health Insurance Program by income or premium level and by county, and, for counties with a population of 100,000 or greater, by geo zip code.

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

(215 ILCS 170/50)

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

Sec. 50. Consultation with stakeholders. The Department shall present details regarding implementation of the Program to the Medicaid Advisory Committee, and the Committee shall serve as the forum for healthcare providers, advocates,

consumers, and other interested parties to advise the Department with respect to the Program. The Department shall consult with stakeholders on the rules for healthcare professional participation in the Program pursuant to Sections 52 and 53 of this Act.
(Source: P.A. 94-693, eff. 7-1-06; 95-650, eff. 6-1-08.)

(215 ILCS 170/52)
(Section scheduled to be repealed on July 1, 2016)
Sec. 52. Adequate access to specialty care.
(a) The Department shall ensure adequate access to specialty physician care for Program participants by allowing referrals to be accomplished without undue delay.
(b) The Department shall allow a primary care provider to make appropriate referrals to specialist physicians or other healthcare providers for an enrollee who has a condition that requires care from a specialist physician or other healthcare provider. The Department may specify the necessary criteria and conditions that must be met in order for an enrollee to obtain a standing referral. A referral shall be effective for the period necessary to provide the referred services or one year, whichever is less. A primary care provider may renew and re-renew a referral.
(c) The enrollee's primary care provider shall remain responsible for coordinating the care of an enrollee who has received a standing referral to a specialist physician or other healthcare provider. If a secondary referral is necessary, the specialist physician or other healthcare provider shall advise the primary care physician. The primary care physician or specialist physician shall be responsible for making the secondary referral. In addition, the Department shall require the specialist physician or other healthcare provider to provide regular updates to the enrollee's primary care provider.
(Source: P.A. 95-650, eff. 6-1-08.)

(215 ILCS 170/53)
(Section scheduled to be repealed on July 1, 2016)
Sec. 53. Program standards.
(a) Any disease management program implemented by the Department must be or must have been developed in consultation with physician organizations, such as State, national, and specialty medical societies, and any available standards or guidelines of these organizations. These programs must be based on evidence-based, scientifically sound principles that are accepted by the medical community. An enrollee must be excused from participation in a disease

management program if the enrollee's physician licensed to practice medicine in all its branches, in his or her professional judgment, determines that participation is not beneficial to the enrollee.

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

(c) The Department shall adopt variance procedures for the application of any disease management program or any performance measures to an individual enrollee.
(Source: P.A. 95-650, eff. 6-1-08.)

(215 ILCS 170/54)

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

(215 ILCS 170/55)

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

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

(215 ILCS 170/56)

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

Sec. 56. Care coordination.

(a) At least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs or other health benefit programs administered by the Department, including the Children's Health Insurance Program Act and

the Covering ALL KIDS Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii) to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.

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

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

(d) The Department shall report to the General Assembly in a separate part of its annual medical assistance program report, beginning April, 2012 until April, 2016, on the progress and implementation of the care coordination program initiatives established by the provisions of this amendatory Act of the 96th General Assembly. The

Department shall include in its April 2011 report a full analysis of federal laws or regulations regarding upper payment limitations to providers and the necessary revisions or adjustments in rate methodologies and payments to providers under this Code that would be necessary to implement coordinated care with full financial risk by a party other than the Department.
(Source: P.A. 96-1501, eff. 1-25-11.)

(215 ILCS 170/60)
(Section scheduled to be repealed on July 1, 2016)
Sec. 60. Federal financial participation. The Department shall request any necessary state plan amendments or waivers of federal requirements in order to allow receipt of federal funds for implementing any or all of the provisions of the Program. The failure of the responsible federal agency to approve a waiver or other State plan amendment shall not prevent the implementation of any provision of this Act.
(Source: P.A. 94-693, eff. 7-1-06.)

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

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

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

(215 ILCS 170/97)
(Section scheduled to be repealed on July 1, 2016)
Sec. 97. Severability. If any provision of this Act or its application to any person or circumstance is held invalid, the invalidity of that provision or application does not affect other provisions or applications of this Act that can be given effect

without the invalid provision or application, and to this end the provisions of this Act are severable.
(Source: P.A. 94-693, eff. 7-1-06.)

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

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

APPENDIX B

Covering ALL KIDS Health Insurance Act Plans

Appendix B
COVERING ALL KIDS HEALTH INSURANCE ACT PLANS
Fiscal Year 2013

	Assist	Share	Premium Level 1	Premium Level 2
Premium	None	None	$15 (1) $25 (2) $30 (3) $35 (4) $40 (5+)	$40 per child
Max Monthly Premium	n/a	n/a	$40	$80
Physician Visit	None	$3.90	$5	$10
Emergency Room Visit (Emergency)	None	None	$5	$30
Emergency Room Visit (Non-Emergency)	None	None	$25	$30
Generic Drug	None	$2	$3	$3
Brand Name Drug	None	$3.90	$5	$7
Inpatient Admission	None	$3.90/day	$5/day	$100
Outpatient Service	None	$3.90/visit	$5/visit	5% of ALL KIDS payment rate
Annual Out-of-Pocket Max.	n/a	$100 per family	$100 per family	$250 per child

Source: Illinois Department of Healthcare and Family Services.

APPENDIX C

Total Cost of Services Provided by Category of Service During FY13

Appendix C
TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE
During FY13

Category of Service	FY13 Payment Amount	Percent of Total Payments
Dental Services	$12,615,325	17%
Physician Services	11,540,814	15%
Pharmacy Services	10,684,749	14%
Inpatient Hospital Services (General)	8,333,559	11%
General Clinic Services	5,372,736	7%
Outpatient Services (General)	5,268,235	7%
Capitation Services	3,751,132	5%
Healthy Kids Services	3,330,829	4%
Inpatient Hospital Services (Psychiatric)	3,282,462	4%
Mental Health Rehab Option Services	1,825,795	2%
Physical Therapy Services	1,058,986	1%
Medical Supplies	821,686	1%
Medical Equipment/Prosthetic Devices	798,883	1%
Alcohol and Substance Abuse Rehab. Services	781,404	1%
Clinical Laboratory Services	737,169	1%
Optical Supplies	702,386	<1%
Home Health Services	586,688	<1%
Anesthesia Services	411,597	<1%
Speech Therapy/Pathology Services	404,466	<1%
Psychiatric Clinic Services (Type 'A')	359,664	<1%
Targeted Case Management Service (Mental Health)	329,122	<1%
Nurse Practitioners Services	201,754	<1%
Occupational Therapy Services	199,997	<1%
Optometric Services	191,310	<1%
Outpatient Services (ESRD)	185,418	<1%
Emergency Ambulance Transportation	173,800	<1%
Inpatient Hospital Services (Physical Rehabilitation)	172,203	<1%
Targeted Case Management Service (Early Intervention)	168,293	<1%
Psychiatric Clinic Services (Type 'B')	161,682	<1%
Development Therapy, Orientation and Mobility Services (Waivers)	159,642	<1%
Podiatric Services	103,125	<1%
LTC--ICF/MR	80,834	<1%
Other Transportation	60,270	<1%
Service Car	54,040	<1%
Non-Emergency Ambulance Transportation	43,745	<1%

Appendix C

TOTAL COST OF SERVICES PROVIDED BY CATEGORY OF SERVICE

During FY13

Category of Service	FY13 Payment Amount	Percent of Total Payments
Social Work Service	$32,139	<1%
Early Intervention Services	30,717	<1%
Audiology Services	30,529	<1%
Nursing Service	29,921	<1%
Midwife Services	25,650	<1%
Psychologist Service	11,895	<1%
LTC - MR Recipient between ages 21-65	8,650	<1%
Chiropractic Services	7,894	<1%
Waiver Service (depends on HCPCS code)	7,405	<1%
Fluoride Varnish	6,890	<1%
Clinic Services (Physical Rehabilitation)	4,899	<1%
Family Planning Counseling	3,570	<1%
All Kids Application Agent (valid on provider file only)	3,431	<1%
Diagnostic Testing Services	2,219	<1%
Medicar Transportation	1,790	<1%
Taxicab Services	1,517	<1%
Physicians Psychiatric Services	1,322	<1%
Portable X-Ray Services	254	<1%
Total FY13 Cost of Services	**$75,164,492**	**100%**

Note: Totals may not add due to rounding.

Source: Summary of FY13 ALL KIDS data provided by HFS.

APPENDIX D

FY13 Total Cost of Services Provided by Plan and Category of Service

Appendix D

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

During FY13

Category of Service	Total	Assist	Share	Premium Undocumented	Level 2 Undocumented	Level 2
Dental Services	$12,615,325	$9,173,343	$224,534	$226,272	$78,670	$2,912,505
Physician Services	11,540,814	6,924,144	150,489	180,724	58,570	4,226,879
Pharmacy Services	10,684,749	4,440,714	139,633	78,563	38,576	5,987,263
Inpatient Hospital Services (General)	8,333,559	5,124,098	64,715	72,170	0	3,072,575
General Clinic Services	5,372,736	4,077,775	67,764	70,119	18,178	1,138,757
Outpatient Services (General)	5,268,235	3,283,009	60,022	54,609	21,210	1,849,386
Capitation Services	3,751,132	3,681,604	37,201	28,255	0	4,072
Healthy Kids Services	3,330,829	1,855,946	53,265	61,109	24,667	1,335,842
Inpatient Hospital Services (Psychiatric)	3,282,462	2,177,441	31,196	9,035	9,343	1,055,447
Mental Health Rehab Option Services	1,825,795	1,034,011	15,506	9,606	6,785	759,887
Physical Therapy Services	1,058,986	480,170	17,201	16,003	7,504	538,109
Medical Supplies	821,686	387,087	4,283	7,356	680	422,280
Medical Equipment/Prosthetic Devices	798,883	397,699	10,987	7,878	11,650	370,669
Alcohol and Substance Abuse Rehab. Services	781,404	521,642	578	9,480	0	249,704
Clinical Laboratory Services	737,169	571,118	8,035	11,822	3,372	142,822
Optical Supplies	702,386	522,891	9,104	11,083	4,698	154,610
Home Health Services	586,688	123,346	0	0	0	463,342
Anesthesia Services	411,597	246,950	4,375	5,956	737	153,580
Speech Therapy/Pathology Services	404,466	62,559	234	740	13	340,920
Psychiatric Clinic Services (Type 'A')	359,664	212,380	5,228	5,762	1,444	134,850
Targeted Case Management Service (Mental Health)	329,122	108,198	1,201	559	551	218,613
Nurse Practitioners Services	201,754	108,081	1,345	3,250	723	88,354
Occupational Therapy Services	199,997	47,032	442	53	1,689	150,782
Optometric Services	191,310	127,977	2,664	3,272	1,409	55,988
Outpatient Services (ESRD)	185,418	171,082	2,756	0	10,890	690
Emergency Ambulance Transportation	173,800	111,410	2,987	2,000	305	57,098
Inpatient Hospital Services (Physical Rehabilitation)	172,203	162,115	0	0	0	10,089
Targeted Case Management Service (Early Intervention)	168,293	22,475	0	584	0	145,234
Psychiatric Clinic Services (Type 'B')	161,682	102,113	0	2,826	0	56,743

Appendix D

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

During FY13

Category of Service	Total	Assist	Share	Premium Undocumented	Level 2 Undocumented	Level 2
Development Therapy, Orientation and Mobility Services (Waivers)	$159,642	$34,270	$0	$767	$167	$124,437
Podiatric Services	103,125	71,671	2,172	1,951	1,306	26,025
LTC--ICF/MR	80,834	80,834	0	0	0	0
Other Transportation	60,270	0	0	0	0	60,270
Service Car	54,040	51,404	0	1,048	0	1,589
Non-Emergency Ambulance Transportation	43,745	31,785	852	658	135	10,315
Social Work Service	32,139	19,164	214	300	0	12,461
Early Intervention Services	30,717	8,793	0	0	0	21,924
Audiology Services	30,529	11,151	301	352	102	18,623
Nursing Service	29,921	28,746	0	0	0	1,175
Midwife Services	25,650	22,034	69	116	0	3,431
Psychologist Service	11,895	4,821	50	100	0	6,924
LTC - MR Recipient between ages 21-65	8,650	5,089	0	149	0	3,411
Chiropractic Services	7,894	7,425	0	172	0	297
Waiver Service (depends on HCPCS code)	7,405	490	0	0	0	6,914
Fluoride Varnish	6,890	1,482	0	0	0	5,408
Clinic Services (Physical Rehabilitation)	4,899	1,204	0	131	0	3,563
Family Planning Counseling	3,570	1,410	90	30	0	2,040
All Kids Application Agent (valid on provider file only)	3,431	0	249	349	149	2,685
Diagnostic Testing Services	2,219	1,984	0	0	0	235
Medicar Transportation	1,790	1,790	0	0	0	0
Taxicab Services	1,517	1,517	0	0	0	0
Physicians Psychiatric Services	1,322	700	0	0	0	622
Portable X-Ray Services	254	158	0	0	0	96
Total Cost of Services	**$75,164,492**	**$46,646,334**	**$919,741**	**$885,206**	**$303,525**	**$26,409,537**

Source: Summary of FY13 ALL KIDS data provided by HFS.

APPENDIX E

Total ALL KIDS Services Provided by Provider Greater Than $50,000 Fiscal Year 2013

Note:

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

Source: FY13 paid claim data provided by HFS.

Appendix E
TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000
Fiscal Year 2013

Provider Name	City	State	Total Amount Paid
LURIE CHILDRENS HOSPITAL	CHICAGO	IL	$1,571,953.95
CHILDRENS MEMORIAL HOSPITAL	CHICAGO	IL	1,492,905.79
UNIVERSITY OF ILLINOIS HOSP	CHICAGO	IL	1,185,309.87
CENTRAL DUPAGE HOSPITAL	WINFIELD	IL	866,473.19
BHC STREAMWOOD HOSPITAL INC	STREAMWOOD	IL	634,486.55
HARTGROVE HOSPITAL	CHICAGO	IL	615,956.21
J H STROGER HOSP OF COOK CTY	CHICAGO	IL	547,431.22
RIVEREDGE HOSPITAL	FOREST PARK	IL	529,540.58
COMER CHILDRENS HOSPITAL	DARIEN	IL	393,545.93
ST MARY OF NAZARETH HOSPITAL	CHICAGO	IL	391,374.31
ILL CORRECTIONAL INDUSTRIES	SPRINGFIELD	IL	358,655.09
RUSH CHILDRENS SERVICES	CHICAGO	IL	344,040.18
LUTHERAN GENERAL CHILDRENS HOS	PARK RIDGE	IL	327,334.65
RONALD MCDONALDS CHILDRENS HSP	MAYWOOD	IL	322,246.09
LAWNDALE CHRISTIAN HLTH CTR	CHICAGO	IL	299,837.41
INFANT WELFARE SOCIETY OF CHGO	CHICAGO	IL	295,087.35
ST ALEXIUS MEDICAL CENTER	HOFFMAN ESTATES	IL	291,802.05
EVANSTON HOSPITAL	EVANSTON	IL	287,692.08
FANTUS HEALTH CENTER	CHICAGO	IL	281,863.50
ST LOUIS CHILDRENS HOSPITAL	SAINT LOUIS	MO	281,732.46
NASREEN TAIBA	ADDISON	IL	275,323.00
MARYVILLE SCOTT NOLAN CENTER	DES PLAINES	IL	269,624.51
BENJAMIN DALE	CHICAGO	IL	264,276.80
CHILDRENS HOSPITAL OF ILLINOIS	PEORIA	IL	252,391.71
ST ANTHONY HOSPITAL	CHICAGO	IL	247,455.17
MAXIM HEALTHCARE SERVICES INC	OAK PARK	IL	246,939.80
JOSHI ASHWINI	CHICAGO	IL	245,992.26
AQEL FADI	CHICAGO	IL	240,999.90
CAREMARK INC	MT PROSPECT	IL	239,155.74
HOPE CHILDRENS HOSPITAL	OAK LAWN	IL	237,783.91
GREATER ELGIN FAMILY CARE CTR	ELGIN	IL	230,032.61
ALEXIAN BROS BEHAVIORAL HLTH	HOFFMAN ESTATES	IL	228,654.84
LINCOLN PRAIRIE BEHAVIORAL HC	SPRINGFIELD	IL	219,803.16
ACCREDO HEALTH GROUP INC	MEMPHIS	TN	212,829.85
PROVENA ST JOSEPH MED CNT	JOLIET	IL	211,774.68
ROSECRANCE CENTER	ROCKFORD	IL	$203,638.67

Appendix E

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

Fiscal Year 2013

Provider Name	City	State	Total Amount Paid
ADVOCATE NORTHSIDE	CHICAGO	IL	$188,853.02
NORTHWEST COMMUNITY HOSPITAL	ARLINGTON HGTS	IL	186,866.41
WHITESMAN LOUIS	CHICAGO	IL	184,713.00
CARDINAL GLENNON CHILDRENS HSP	SAINT LOUIS	MO	177,068.37
VNA HEALTH CARE	AURORA	IL	176,903.32
VISTA MEDICAL CENTER EAST	WAUKEGAN	IL	176,706.36
SUKAVACHANA ORAWAN	ELK GROVE VILL	IL	171,679.84
VISTA CLINIC OF COOK COUNTY	PALATINE	IL	167,467.10
COMM COUNSEL CTRS C4 NORTH	CHICAGO	IL	164,908.98
THE GENESIS CENTER	DES PLAINES	IL	161,508.30
PROFESSIONAL BUILDING PHARMACY	CHICAGO	IL	160,320.20
SERVICIOS MEDICOS LA VILLITA	CHICAGO	IL	155,615.97
AMBER PHARMACY	CHICAGO	IL	155,461.55
WINE PAUL	CHICAGO	IL	153,507.05
CAREPLUS CVS PHARMACY 02831	CHICAGO	IL	149,731.42
ADVOCATE CONDELL MEDICAL CTR	LIBERTYVILLE	IL	147,475.91
CURASCRIPT PHARMACY INC	ORLANDO	FL	146,909.49
SINAI CHILDRENS HOSPITAL	CHICAGO	IL	146,853.31
COPLEY MEMORIAL HOSPITAL	AURORA	IL	146,618.16
REHABILITATION INSTITUTE	CHICAGO	IL	146,171.87
THE KENNETH W YOUNG CENTERS	ELK GROVE VLGE	IL	146,046.93
PROVENA MERCY CENTER	AURORA	IL	142,177.81
SILVER CROSS HOSPITAL	NEW LENOX	IL	141,736.24
CICERO HEALTH CENTER	CICERO	IL	141,480.70
LABORATORY CORPORATION AMERICA	DUBLIN	OH	141,450.10
APOGEE HEALTH PARTNERS INC	CHICAGO	IL	141,125.64
KEDZIE FAMILY HEALTH CENTER	CHICAGO	IL	139,641.33
VISTA MEDICAL CENTER WEST	WAUKEGAN	IL	136,997.58
MT SINAI HOSP MED CTR CHICAGO	CHICAGO	IL	134,704.64
MACNEAL HOSPITAL	BERWYN	IL	129,227.99
JHAM ANDRE	PEORIA	IL	128,755.60
LAWNDALE CHRISTIAN HLTH	CHICAGO	IL	128,270.17
C AND M PHARMACY LLC	GLENVIEW	IL	126,999.90
CENTURY PHO INC	CHICAGO	IL	126,227.22
CORNELL INTERVENTION WOODRIDGE	WOODRIDGE	IL	124,703.85
SHERMAN HOSPITAL	ELGIN	IL	$120,958.70

Appendix E

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

Fiscal Year 2013

Provider Name	City	State	Total Amount Paid
KID CARE MEDICAL STE 311	ARLINGTON HGHTS	IL	$120,467.47
CAREMARK KANSAS SPEC PHARM LLC	LENEXA	KS	118,357.75
PCC COMM WELLNESS CENTER	OAK PARK	IL	118,199.02
MEDSTAR LABORATORY INC	HILLSIDE	IL	118,124.32
UNITED SEATING AND MOBILITY	LOMBARD	IL	115,623.18
NDO	CHICAGO	IL	114,785.74
HUMBOLDT PARK FAMILY HLTH CTR	CHICAGO	IL	114,247.09
QUEST DIAGNOSTICS LLC IL	WOOD DALE	IL	113,939.23
ST JOHNS CHILDRENS HOSPITAL	SPRINGFIELD	IL	113,802.05
IPA OF KANE COUNTY	MOKENA	IL	109,101.36
OPTION CARE ENTERPRISES INC	WOOD DALE	IL	108,860.33
RUSH UNIVERSITY MEDICAL CENTER	CHICAGO	IL	108,422.48
CARLE FOUNDATION HOSPITAL	URBANA	IL	108,408.89
BALAKRISHNAN MEENAKSHI	DOWNERS GROVE	IL	107,509.80
NORWEGIAN AMERICAN HOSP GROUP	CHICAGO	IL	106,848.51
THE PAVILION FOUNDATION	CHAMPAIGN	IL	105,605.60
ALEXIAN BROTHERS MED CTR	ELK GROVE VLGE	IL	104,376.11
AURORA CHICAGO LAKESHORE HOSP	CHICAGO	IL	103,623.44
AFFINITY BIOTECH	ELKHORN	NE	102,579.24
SWEDISHAMERICAN HOSPITAL	ROCKFORD	IL	102,413.89
ALIVIO MEDICAL CENTER	CHICAGO	IL	100,565.34
LOGAN SQUARE HLTH CTR COOK CO	CHICAGO	IL	99,431.35
AUNT MARTHAS HEALTH CENTER	AURORA	IL	99,284.04
ROCKFORD MEMORIAL HOSPITAL	ROCKFORD	IL	98,301.15
MCC HEALTHCARE SERVICES INC	EVERGREEN PARK	IL	97,843.22
SIDDIQUI ZAKI	CHICAGO	IL	97,294.51
CRUSADER CLINIC BROADWAY	ROCKFORD	IL	97,111.61
LAKE CO H D WAUKEGAN CLINIC	WAUKEGAN	IL	96,863.65
RIVERSIDE MED CTR	KANKAKEE	IL	94,828.88
CHICAGO FAM HLTH CTR SO CHI	CHICAGO	IL	94,475.93
SWEDISH COVENANT HOSPITAL	CHICAGO	IL	93,668.73
REHABILITATION INSTITUTE	CHICAGO	IL	92,619.34
ERIE DENTAL HEALTH CENTER	CHICAGO	IL	89,646.18
NORTHWESTERN MEMORIAL HOSP	CHICAGO	IL	88,940.17
ERIE FAMILY HEALTH CENTER	CHICAGO	IL	88,323.85
HAWTHORNE FAMILY HEALTH CENTER	CHICAGO	IL	$88,227.00

Appendix E
TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000
Fiscal Year 2013

Provider Name	City	State	Total Amount Paid
MIDWEST HEALTHCARE ASSOCIATES	AURORA	IL	$87,887.42
DOUBEK MEDICAL SUPPLY INC	ALSIP	IL	87,124.05
THE 180 MEDICAL INC	OKLAHOMA CITY	OK	85,225.36
CHICAGO PROCURE MANAGEMENT	WARRENVILLE	IL	83,902.64
TSALIAGOS CHRISTOS	CHICAGO	IL	83,853.99
OCEAN BREEZE HEALTHCARE	STATEN ISLAND	NY	82,608.62
ADA S MCKINLEY COMMUNITY SVCS	CHICAGO	IL	82,546.74
ERDMAN SPAIN SUSAN	CHICAGO	IL	82,330.00
GREATER CHICAGO MEDICAL ASSOC	CHICAGO	IL	82,042.74
CLARK DAVID	CHICAGO	IL	81,924.71
PREMIER KIDS CARE INC	HOLLYWOOD	FL	81,817.89
ST ANTHONY HOSPITAL	CHICAGO	IL	81,482.54
LEYDEN FAMILY SERVICE AND MHC	FRANKLIN PARK	IL	81,098.93
ALIVIO MEDICAL CENTER	CHICAGO	IL	80,968.41
CHILDRENS HOSP OF WISCONSIN	MILWAUKEE	WI	80,936.81
ALDEN VILLAGE HEALTH FACILITY	BLOOMINGDALE	IL	80,833.74
NAPERVILLE PSYCH VENTURES	NAPERVILLE	IL	80,578.58
FOUNDATION CARE LLC	EARTH CITY	MO	80,362.70
GATEWAY FOUNDATION CARBONDALE	CARBONDALE	IL	80,206.28
BOND DRUG COMPANY OF ILLINOIS	CHICAGO	IL	80,057.72
GONZALEZ VICTOR	WHEELING	IL	79,858.86
SERVICIOS MEDICOS LA VILLITA	CHICAGO	IL	79,720.94
ACTIVSTYLE INC	MINNEAPOLIS	MN	79,497.77
PIONEER CENTER FOR HUMAN SRVCS	WOODSTOCK	IL	79,277.82
ERIE HELPING HANDS HEALTH CTR	CHICAGO	IL	78,992.24
ALDALLAL NADA	CHICAGO	IL	78,528.32
MIDLAKES CLINIC	ROUND LK BEACH	IL	78,144.81
WALGREEN CO 0089	BRIDGEVIEW	IL	77,516.08
BOND DRUG COMPANY OF IL 03729	HANOVER PARK	IL	76,744.96
ADVOCATE HOME CARE PRODUCTS IN	DOWNERS GROVE	IL	76,517.17
WALGREENS SPECIALTY 10997	CARNEGIE	PA	76,187.39
OUR LADY RES MED CTR	CHICAGO	IL	76,010.81
KEDZIE FAMILY HEALTH CENTER	CHICAGO	IL	75,786.87
AUNT MARTHAS CARPENTERSVILLE	CARPENTERSVILLE	IL	75,677.70
MILORO MICHAEL	BURR RIDGE	IL	74,848.90
ESPERANZA LITTLE VILLAGE	CHICAGO	IL	$73,526.20

Appendix E
TOTAL ALL KIDS SERVICES PROVIDED BY PROVIDER >$50,000
Fiscal Year 2013

Provider Name	City	State	Total Amount Paid
CENTRO DE SALUD ESPERANZA	CHICAGO	IL	$72,543.17
KIM PU	CHICAGO	IL	72,519.25
WALGREEN CO 12125	AURORA	IL	72,457.37
BELLUCCI JACKSON JENNIFER	WAUCONDA	IL	72,137.03
WALGREENS 13974	CHICAGO	IL	71,387.86
SHIELD DENVER HLT CARE CTR INC	ELMHURST	IL	70,792.69
CRUSADER CLINIC	ROCKFORD	IL	69,717.21
ELMHURST MEMORIAL HOSPITAL	ELMHURST	IL	67,488.10
WEST CHICAGO FAMILY HEALTH CTR	WEST CHICAGO	IL	67,082.64
SONIA SHANKMAN ORTHOGENIC SCHO	CHICAGO	IL	66,865.84
PIONEER CENTER OF MCHENRY CO	MCHENRY	IL	66,647.30
HAWTHORNE FAMILY HEALTH CENTER	CICERO	IL	66,198.55
MERCY HOSPITAL MEDICAL CENTER	CHICAGO	IL	65,557.71
LAKE VILLA GATEWAY FOUNDATION	LAKE VILLA	IL	65,030.59
WALGREENS 7769	SPRING GROVE	IL	64,756.12
TRC CHILDRENS DIALYSIS CENTER	CHICAGO	IL	64,558.21
VHS GENESIS LABORATORY	BERWYN	IL	64,336.40
SUPERIOR BIOLOGICS IL INC	SCHAUMBURG	IL	63,310.89
LSSI MENTAL HEALTH SERVICE	CHICAGO	IL	62,800.75
SHUKLA MANISH	CHICAGO	IL	62,169.85
FORTY SEVENTH STREET PHARMACY	CHICAGO	IL	61,610.77
TAHIR EJAZ	BERWYN	IL	61,440.00
UNITED SEATING AND MOBILITY	EARTH CITY	MO	61,244.66
A2CL SERVICES LLC	WEST ALLIS	WI	60,831.05
PINTO JUAN	JOLIET	IL	60,725.67
CRUSADER CLINIC BELVIDERE	BELVIDERE	IL	60,192.60
SAINTS MARY AND ELIZABETH HP	CHICAGO	IL	59,035.70
VHS WESTLAKE HOSPITAL INC	MELROSE PARK	IL	58,840.51
BOND DRUG COMPANY OF IL 03078	WAUKEGAN	IL	58,674.67
DOUBEK PHARMACY INC	ALSIP	IL	58,631.08
CHUNG DONN	NORTHBROOK	IL	58,235.10
UIC MILE SQUARE HEALTH CENTER	CHICAGO	IL	57,737.66
WALGREEN CO 7100	ELGIN	IL	57,407.38
CHANG RANDOLPH	CHICAGO	IL	57,171.91
SMITH FREDERICK	CHICAGO	IL	57,020.66
UNIFIED PHYSICIANS NETWORK	SKOKIE	IL	$56,911.38

Appendix E

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

Fiscal Year 2013

Provider Name	City	State	Total Amount Paid
EDWARDS TWANA	CHICAGO	IL	$56,577.00
MANGAHAS SUSAN	CARPENTERSVILLE	IL	56,473.19
MORGAN SARA	CHICAGO	IL	56,223.75
EKTERA ALI	CHICAGO	IL	56,220.84
GARCIA ELOISA	CHICAGO	IL	56,186.45
DUPAGE MNTL HLTH CRISIS UNIT	LOMBARD	IL	56,019.69
MICHELLES PHARMACY INC	CARLINVILLE	IL	55,424.00
KEDZIE FAMILY HEALTH CENTER	CHICAGO	IL	55,201.22
LAKE CO MNTL HLTH WAUKEGAN	WAUKEGAN	IL	54,826.32
LURIE CHILDRENS HOSPITAL	CHICAGO	IL	54,717.63
SIARGOS BARBARA	CHICAGO	IL	54,635.75
NORTH SHORE HEALTH CENTER	HIGHLAND PARK	IL	54,616.37
JAIN RENU	ADDISON	IL	54,613.92
FAMILY SERVICE ASSOCIATION	ELGIN	IL	54,567.52
KIM KYUNG	CHICAGO	IL	54,471.55
OAK WEST PRIMARY PHYS ASSOC	MELROSE PARK	IL	54,097.60
MS LAWNDALE CHRISTIAN HLTH CTR	CHICAGO	IL	53,482.12
NORTHWESTERN LAKE FOREST HSPTL	LAKE FOREST	IL	51,905.07
PARUCHURI AJITHA	WEST CHICAGO	IL	51,567.53
NORTHERN ILLINOIS MEDICAL CTR	MCHENRY	IL	50,963.42
ALAVI DEBRA	ELGIN	IL	50,947.30
MARTIN T RUSSO FAMILY HLTH CTR	BLOOMINGDALE	IL	50,941.66
WILLOWGLEN ACADEMY	GARY	IN	50,901.44
ACCESS AT ST FRANCIS HLTH CTR	CHICAGO	IL	50,877.05
ROSECRANCE INC	ROCKFORD	IL	50,395.43
DAVITA RX LLC	COPPELL	TX	50,169.93
CHICAGO FAMILY HEALTH CENTER	CHICAGO	IL	50,137.80
NORTH CHICAGO COMM HEALTH CTR	NORTH CHICAGO	IL	50,047.21
WILL COUNTY HEALTH DEPT	JOLIET	IL	50,041.48

Source: FY13 data provided by HFS.

APPENDIX F
Agency Responses

ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Pat Quinn, Governor
Julie Hamos, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

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

July 31, 2014

Honorable William G. Holland
Auditor General
State of Illinois

Dear Auditor General Holland:

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

Enclosed with this letter are detailed responses that address each of the recommendations.

If you have any questions or comments about our responses to the recommendations, please contact Amy Lyons, External Audit Liaison, at (217) 558-4347 or through email at amy.lyons@illinois.gov.

Sincerely,

Julie Hamos
Director

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

Attachment Response
Report: Expanded All Kids Program

Recommendation Number 1: Redetermination of Eligibility
The Department of Healthcare and Family Services and the Department of Human Services should:

- annually re-determine ALL KIDS eligibility as required by the Covering ALL KIDS Health Insurance Act;
- ensure immigration status for documented and undocumented immigrants is reviewed as part of the annual redetermination;
- review one month's income for determining continued eligibility as required by Public Act 96-1501.

Response:
The Department accepts the recommendation. The Department has taken steps to correct the problems. As part of the revised Illinois Medicaid Redetermination Project (IMRP), the State has moved to the new-Max-IL system.

Recommendation Number 2: ALL KIDS Data Reliability
The Department of Healthcare and Family Services should have controls in place to ensure that its ALL KIDS eligibility and claim data is accurate and reliable. This includes ensuring that enrollees over 18 years of age are identified as no longer eligible, ensuring that enrollees are not enrolled in ALL KIDS more than once.

Response:
The Department accepts the recommendation. A programming error that allowed a one day of eligibility the month following a child's 19th birthday has been corrected. A new eligibility system is in place that will help the caseworker staff identify the individuals already in the system.

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 or undocumented immigrant contain specific instructions for caseworkers to make accurate eligibility decisions;
- ensure that documented immigrants are classified correctly in its database;
- ensure that the State receives federal matching funds for all eligible recipients and ensure that federal matching funds are not received for ineligible recipients.

Response:
The Department accepts the recommendation. New coding to more accurately record immigration status has been implemented.

Recommendation Number 4: Duplicate Claims
The Department of Healthcare and Family Services should review the manual review process for rejected claims and strengthen the controls to prevent duplicate claims from being paid.

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

Recommendation Number 5: Eligibility Documentation
The Department of Healthcare and Family Services and the Department of Human Services should:

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

Response:
The Department accepts the recommendation. The Department has implemented electronic verification of citizenship, identity, residency, and income. Paper verification is requested when these items cannot be verified electronically.

Recommendation Number 6: Transportation Claims
The Department of Healthcare and Family Services should:

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

Response:
The Department accepts the recommendation. A Project Initialization Request was prepared to program a system edit that only allows one round-trip per prior approval number per day. The Department is also working to place some restrictions on origin and destination times and require the input of address and city information by providers to help ensure more accurate claim detail. This change was implemented November 2013.

Recommendation Number 7: Guidance over Preventive Medicine Service Claims
The Department of Healthcare and Family Services should more clearly define how providers should bill preventive medicine services and should distinguish between preventive services' and office visits for established patients. The Department should also ensure that electronic billing edits exist to identify potential abuse related to the billing of preventive medicine services.

Response:
The Department accepts the recommendation. The Department issued a Provider Notice reminding providers of the proper use and frequency limits of preventive services codes, however, it needs to be updated. In addition, incorrect values were placed on the procedure diagnosis database for preventive medicine visit codes allowing payment for visits in excess of the program limits. The Department will correct the errors on the procedure diagnosis database and re-issue provider notice clarifying program limits and exceptions.

Recommendation Number 8: Inconsistent Dental Policies
The Department of Healthcare and Family Services, should ensure that dental policies and other information available to the public accurately state frequency of benefits.

Response:
The Department accepts the recommendation. The Department has submitted the emergency dental rules and proposed dental rules for review. The rules were published in the 2014 Illinois Register, Volume 38, Issue 29 on July 18, 2014. Once the rules are approved, the HFS website will be changed to match the administrative code. HFS will ensure that the Dental Office Reference Manual and the HFS website accurately state the frequency of dental benefits.

15 YEARS
PARTNERING WITH COMMUNITIES

Pat Quinn, *Governor*

Illinois Department of Human Services

Michelle R.B. Saddler, *Secretary*

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

July 30, 2014

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

Dear Mr. Wahlbrink:

Following is the response to the draft report of the recommendations assigned to the Department of Human Services as a result of the fifth annual audit of the Office of the Auditor General (OAG) Covering ALL KIDS Health Insurance program:

Recommendation #1: The Department of Healthcare and Family Services and the Department of Human Services should:

- annually re-determine ALL KIDS eligibility as required by the Covering ALL KIDS Health Insurance ACT.
- ensure the immigration status for documented and undocumented immigrants is reviewed as part of the annual redetermination process.
- review one month's income for determining continued eligibility as required by Public Act 96-1501.

Department Response: The Department agrees with the recommendation. Beginning 2/1/14, a new redetermination process began. The Department's contracted vendor, Maximus, has developed a redetermination system called Max-IL, which uses electronic data matching for recommending the continuance or cancelation of medical coverage. Max-IL also enhances the integrity of the program by using its ability to store copies of all redetermination forms mailed to the customer, returned redeterminations, electronic data matching results, requests for missing information and verifications provided by the client.

A policy directive in the form of a policy manual release was issued in April 2009 regarding undocumented noncitizen children. Children coded as such are to have their immigration status reviewed at redetermination in order to ensure the maximization of federal reimbursement.

The change that requires the review of a full month of income was implemented in October 2013.

Recommendation #3: The Department of Heathcare and Family Services and the Departmrnt of Human Services should:

- ensure policies and procedures used to classify enrollees as documented immigrants and undocumented immigrants contain specific instructions for caseworkers to make accurate eligibility decisions;
- ensure that documented immigrants are classified correctly in its database.
- maintain the necessary information needed to identify documented immigrants such as social security numbers and alien registrstion numbers; and
- ensure that the state receives Federal matching funds for all the eligible recipients and ensure that federal matching are not received for ineligible recipients.

Department Response: The Department agrees with the recommendation. Although DHS is not involved in federal reimbursement claiming responsibilities, we do accept that DHS does have a role in ensuring accurate data is passed to the entity which handles the federal reimbursement claiming. DHS will work to ensure caseworkers and the electronic systems they use contain sufficient tools and options in order to accurately classify the immigration and citizenship status of all clients receiving assistance administered by the Department. The implementation of the Department's new Integrated Eligibility System (IES) will enhance the accuracy of immigration and citizenship status coding by making it easier for staff to select the correct status using descriptions in drop down menu format, replacing the task of memorizing and/or searching for numerical codes which most appropriately represent the client's status.

Additionally, the implementation of IES will enhance the integrity of the maintenance of immigration and citizenship documentation, as the new system includes scanning and electronic document storage functionality.

Recommendation #5: The Department of Heathcare and Family Services and the Departmrnt of Human Services should:

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

Department Response: The Department accepts the recommendation. DHS follows policy set forth by the Illinois Department of Healthcare and Family Services (HFS), the single state Medicaid agency. Beginning in March 2012, an automated Secretary of State residency clearance is generated for new medical applicants and requestors over the age of 16 registered in AIS or IES in the All Kids unit, and in all DHS Family and Community Resource Centers (FCRCs).

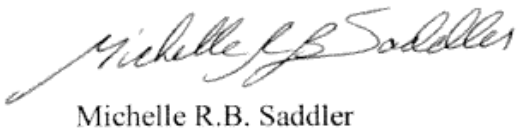
That clearance, in addition to documentation to support birth and identity, was to be filed in the case record prior to the implementation of IES. Currently, for new cases that originate and are approved in IES, the above mentioned documentation can be electronically stored in the Electronic Case Record.

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

Through January 2014 email communication with the Federal Center for Medicaid Services; DHS staff has confirmed that our policy is in compliance with the federal regulation. The Code of Federal Regulation 435.948 states that in order to verify the financial eligibility of individual, net earnings from self-employment must be obtained. Our policy requires staff to verify all self-employment income and business expenses, and that the client's records may serve as proof of income and expenses. The Illinois Medicaid Redetermination Project contract with Maximus utilizes electronic income verification that may assist in identifying income that has not been disclosed by the recipient.

If you have any questions, please contact Jane Hewitt, Chief Internal Auditor at 217/558-6931.

Sincerely,



Michelle R.B. Saddler
Secretary

cc: Nelida Smyser-Deleon, Assistant Secretary-Programs
Matthew Hammoudeh, Assistant Secretary-Operations
Dyahnne Ware, Director, Family and Community Services
Carol Kraus, Chief Financial Officer
Jennifer Wagner, Associate Director, Family and Community Services
Jane Hewitt, Chief Internal Auditor
Paul Thelen, Human Capital Development