STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT OF THE COVERING ALL KIDS HEALTH INSURANCE PROGRAM

APRIL 2011

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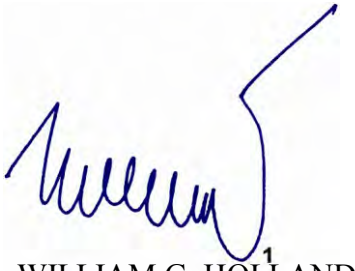
To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

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

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

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



WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
April 2011

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

SUMMARY REPORT DIGEST

COVERING ALL KIDS HEALTH INSURANCE PROGRAM

PROGRAM AUDIT
For the Year Ended: June 30, 2010

Release Date: April 2011

Summary of Findings:

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

SYNOPSIS

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

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

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FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

BACKGROUND

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

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

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

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

PUBLIC ACT 96-1501

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

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

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

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

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

ALL KIDS EXPANSION

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

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

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

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

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

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

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

Notes:

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

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

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

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

Source: ALL KIDS enrollment data provided by HFS.

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

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

Digest Exhibit 2

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

Fiscal Years 2009 and 2010

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

Notes:

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

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

[3] Totals may not add due to rounding.

Source: ALL KIDS claim data provided by HFS.

Documentation of Residency

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

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

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

Notes:

[1] Totals may not add due to rounding.

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

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

Birth or Identity Documentation

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

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

Income

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

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

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

Self-Employment

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

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

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

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

ANNUAL REDETERMINATION PROCESS

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

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

PREMIUM PAYMENTS

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

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

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

Non-Payment of Premiums

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

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

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

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

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

Payment of Past Premiums

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

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

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

RULES GOVERNING THE EXCHANGE OF INFORMATION

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

PAYMENTS FOR NON-EMERGENCY TRANSPORTATION

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

DUPLICATE PAYMENTS

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

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

HFS DATA ISSUES

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

Individuals Older Than 18 Years of Age

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

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

Duplicate Enrollees

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

Classification of Documented Immigrants

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

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

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

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

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

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

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

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

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

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

PAYMENTS FOR HEALTH SERVICES

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

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

Transportation Claims

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

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

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

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

Optical Claims

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

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

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

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

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

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

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

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

Preventive Medicine Service Claims

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

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

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

Dental Claims

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

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

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

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

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

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

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

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

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

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

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

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

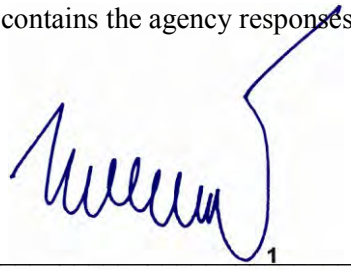
- 22 recipients that had seven or more tooth extractions in

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

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

RECOMMENDATIONS

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



WILLIAM G. HOLLAND
Auditor General

WGH:SAW

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

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Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

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

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

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

Public Act 96-1501

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

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

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

ALL KIDS Expansion

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

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

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

Throughout FY10, a total of 94,628 children were enrolled in the program. Total claims paid in FY10 for the EXPANDED ALL KIDS enrollees were $84.2 million. In FY10, HFS received approximately $9.8 million in premiums from enrollees, thus making the net cost of the ALL KIDS expansion approximately $74.4 million. **The children that were added as a part of the expansion are not eligible for federal reimbursement and thus are funded entirely by the State**.

On June 30, 2010, there were 73,681 enrollees as a result of the expansion. This is less than the FY10 total of 94,628 enrollees since children are added and removed from the program throughout the year. Of the 73,681 enrollees as of June 30, 2010, 53,607 (73%) were classified as undocumented immigrants in data provided by HFS. However, as discussed further in Chapter Two, the number of undocumented immigrants, as well as the costs associated with them, are overstated in data provided by HFS. Additionally, the number of documented immigrants, as well as the costs associated with them, are similarly understated. As a result, the number of undocumented immigrants and their associated costs are overstated in this report. In our prior audit, we recommended that HFS accurately classify documented immigrants. As a result, HFS officials stated they researched these cases and found that a system error was causing the misclassifications. HFS noted the error was corrected on October 29, 2010. By not correctly classifying them, not only is HFS reporting incorrect data, it is also losing out on federal matching funds it could be receiving for documented immigrants.

Eligibility Issues

Due to the way HFS implemented the Covering ALL KIDS Health Insurance Act, HFS and the Department of Human Services (DHS) are not obtaining documentation to support eligibility in some instances. As a result, auditors could not determine whether eligibility was determined correctly by HFS and DHS. Many of the eligibility issues discussed below may be relevant to the ALL KIDS program as a whole.

Documentation of Residency

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

Birth or Identity Documentation

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

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

Income

According to a policy provided by DHS, as of January 2004, **only one pay stub** was required to determine eligibility for all Family Health Plans which includes ALL KIDS. This does not include individuals who are self employed. Self employed individuals are required to submit a month's worth of financial records. During our review, auditors questioned the validity of using only one pay stub to determine 12-month eligibility. Also, the Illinois Administrative Code [89 Ill. Adm. Code 123.230] requires HFS to take "the total gross monthly income of the family" when calculating eligibility. Since one pay stub typically covers less than one full month, collecting documentation of a full month's income would help ensure compliance with the Administrative Code. Additionally, since many of the enrollees are eligible for "passive" redetermination, a single pay stub may be used to determine eligibility for multiple years. Public

Act 96-1501 will require verification of one month's income for determining eligibility effective July 1, 2011.

Auditors found no additional controls in place at HFS to verify the income reported by enrollees. HFS receives reports from the Department of Employment Security (IDES) that would allow HFS to determine whether family income has increased. However, the analysis is based on the working parent's social security number which is information that is not required to be submitted to HFS. In 48 percent of the cases reviewed, social security numbers were not provided for one or both of the parents. According to HFS officials, the report provided by IDES **is not used to verify income** for the initial determination or annual redetermination. As a result, for the 99 files reviewed, auditors could not verify whether all sources of family income were provided by the applicant.

Self-Employment

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

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

After reviewing other State's children's medical programs and their requirements, auditors found that many other states require federal income tax returns and schedules from the previous year as proof of income for individuals who are self-employed. Nineteen of the 24 states we reviewed listed tax returns as a source of documentation to support income. Although not required by Illinois law, federal income tax returns and schedules would be beneficial in determining the income of individuals.

ALL KIDS Eligibility

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

Passive Redetermination

Without some form of verification from the enrollee, auditors were unable to determine whether the enrollment criteria for these individuals continued to be met. In its September 2010 report, the HFS Office of the Inspector General recommended that the passive redetermination process be discontinued. The HFS-OIG noted, "It is the position of the OIG that the passive redetermination process has failed to provide Illinois with a reliable and accurate measure of redetermining the eligibility of individuals who are enrolled in the Medicaid program." In contrast, to continue coverage, enrollees in Premium levels 2 through 8 are required to send in the annual redetermination form, which includes updated eligibility information. Public Act 96-1501 will require verification of one month's income for determining continued eligibility effective October 1, 2011.

Premium Payments

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

During FY10, if an enrollee's membership was cancelled due to unpaid premiums, the family was ineligible for ALL KIDS coverage for three months. If the family reapplied for ALL KIDS coverage, the family must pay all premiums past due before they can be re-enrolled. Public Act 96-1272 effective January 1, 2011, eliminated the three month ineligibility period.

Non-Payment of Premiums

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

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

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

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

Payment of Past Premiums

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

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

Rules Governing the Exchange of Information

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

Payments for Non-Emergency Transportation

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

Duplicate Payments

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

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

HFS Data Issues

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

Individuals Older Than 18 Years of Age

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

Duplicate Enrollees

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

Classification of Documented Immigrants

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

During the FY09 and FY10 audits, auditors determined that HFS did not accurately classify documented immigrants who receive ALL KIDS services. According to HFS officials, to ensure that federal matching funds were not requested for documented immigrants who are ineligible for matching funds (i.e., those documented immigrants who had not been in the

country for five years), those documented immigrants were classified as undocumented immigrants.

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

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

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

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

A February 2009 change in federal law allows HFS to receive federal match for documented immigrants immediately (i.e., they do not have to be in the country for five years). As of November 17, 2010, the State's revised State Plan had not yet been approved to begin receiving these matching funds. The misclassification of documented immigrants as undocumented immigrants will have even greater financial significance once Illinois' State Plan is approved and it can start receiving matching federal funds for correctly classified documented immigrants. Once the State Plan is approved, Illinois could receive as much as $7.7 million in federal matching funds from FY10 (61.88% increased Medicaid match on $12.4 million). We recommended that HFS ensure that the State receives federal matching funds for all eligible claims.

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

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

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

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

Optical Claims

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

Auditors identified 44 EXPANDED ALL KIDS recipients that claims data showed received four or more frames during FY10. **Of the 44 recipients that received four or more frames during FY10, 41 (93%) had fittings for their frames at one specific optical provider.** These 41 recipients had 180 frames ordered by this one provider through ICI and had 186 fittings billed by this one provider during FY10. These 41 recipients received frames and lenses totaling $4,560 and fittings totaling $5,597. Auditors found that 2 recipients each received 6 frames, 12 recipients received 5 frames, and 27 recipients received 4 frames. Without effective edits to identify potential abuse, HFS must rely on post audits conducted by the HFS-OIG in order to identify abuse and to recover dollars that should not have been reimbursed to providers. Due to this provider's high correlation of customers with multiple pairs of frames received during FY10, auditors reported this provider to HFS and to the HFS-OIG. The HFS-OIG noted it was aware of this provider's billing patterns and is in the early stages of auditing this provider.

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

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

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

During the review of FY10 claims submitted for eye exams, auditors identified 376 recipients that received more than one eye exam during FY10. These 376 recipients received 793 exams from 198 different providers. Of the 11,496 recipients that received exams in FY10, 3 recipients received 5 exams, 6 recipients received 4 exams, 20 recipients received 3 exams, and 347 received 2 exams.

Preventive Medicine Service Claims

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

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

Dental Claims

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

During the review of policies related to dental claims, auditors found instances where the information in the benefit schedule differed from what services HFS officials said were provided and from what was posted on HFS' ALL KIDS Dental services webpage. For example, the dental benefit schedule states that a child can receive one teeth cleaning per six months. The ALL KIDS website also states that cleanings are allowed every six months. However, HFS and DentaQuest officials said that recipients could get their teeth cleaned twice in a dentist's office and twice in a school setting for a total of four in a year. In another instance, the ALL KIDS Dental services webpage states that children are limited to a periodic oral exam once every 12 months per dentist, whereas, the Dental Office Reference Manual schedule of benefits states that children can receive an oral exam once every 6 months in an office setting and once every 12 months in a school setting.

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

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

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

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

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

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

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

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

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

- 22 recipients that had seven or more tooth extractions in one day. Six recipients had 10 or more, including one recipient with 31 extractions in one day.

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 first audit was released in May 2010 and contained 13 recommendations. This is the second annual audit and covers FY10 beginning on July 1, 2009. 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.

The FY09 audit reviewed two contracts that were related to ALL KIDS. According to HFS, there were no new ALL KIDS contracts during FY10. As a result, the only work conducted in this audit on contracts entered into by HFS was a review of the results of the survey conducted by the University of Illinois for compliance with contract requirements.

ALL KIDS PROGRAM

According to HFS' website, the ALL KIDS health insurance program provides Illinois families with affordable and comprehensive healthcare for children, regardless of family income, immigration status, or medical condition. Families with higher incomes have co-pays and premiums based on reported family income. ALL KIDS is administered by the Department of Healthcare and Family Services with assistance from the Department of Human Services. In FY10, the ALL KIDS program as a whole provided coverage for about 1.8 million children and paid almost $2.9 billion in claims.

ALL KIDS EXPANSION

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

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

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

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

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

Throughout FY10, a total of 94,628 children were enrolled in the program. Total claims paid in FY10 for the EXPANDED ALL KIDS enrollees were $84.2 million. According to documentation provided by HFS, in FY10, HFS received $9.8 million in premiums from enrollees. Therefore, the cost of the expansion in FY10 was approximately $74.4 million, which was $4.2 million more than in FY09. In addition, HFS estimates the administrative costs for the EXPANDED ALL KIDS program to be $7.1 million for FY10.

Children who became eligible for ALL KIDS after the expansion include: children whose family income exceeded 200 percent of the federal poverty level (i.e., exceed the income requirements of Medicaid and the Children's Health Insurance Program), and all other children that were not covered prior to July 1, 2006. These other children consist of undocumented immigrants who did not receive KidCare prior to the expansion. **The children that were added as a part of the expansion are not eligible for federal reimbursement and thus are funded entirely by the State.**

EXPANDED ALL KIDS PLANS

To be eligible for ALL KIDS services, children must live in Illinois and must be 18 years of age or younger. As part of the ALL KIDS expansion on July 1, 2006, seven new premium levels were added for children in families with income greater than 200 percent of the federal poverty level (FPL). The type of ALL KIDS program level children qualify for depends on certain countable income guidelines. As required by rule, these countable income guidelines are based on Federal Poverty Level Guidelines. Exhibit 1-1 shows the 2010 Federal Poverty Level Guidelines. The FY10 Federal Poverty Level Guidelines were unchanged from FY09.

Exhibit 1-1
2010 POVERTY LEVEL GUIDELINES BY FAMILY SIZE
All States except Alaska, Hawaii, and Washington D.C.

Family Size	100%	133%	150%	200%	300%	400%	500%	600%	700%	800%
1	$10,830	$14,403.90	$16,245	$21,660	$32,490	$43,320	$54,150	$64,980	$75,810	$86,640
2	14,570	19,378.10	21,855	29,140	43,710	58,280	72,850	87,420	101,990	116,560
3	18,310	24,352.30	27,465	36,620	54,930	73,240	91,550	109,860	128,170	146,480
4	22,050	29,326.50	33,075	44,100	66,150	88,200	110,250	132,300	154,350	176,400
5	25,790	34,300.70	38,685	51,580	77,370	103,160	128,950	154,740	180,530	206,320
6	29,530	39,274.90	44,295	59,060	88,590	118,120	147,650	177,180	206,710	236,240
7	33,270	44,249.10	49,905	66,540	99,810	133,080	166,350	199,620	232,890	266,160
8	37,010	49,223.30	55,515	74,020	111,030	148,040	185,050	222,060	259,070	296,080

Source: Federal Register.

In addition, Illinois expanded coverage to include undocumented immigrant children who were not covered by KidCare prior to the expansion on July 1, 2006. These children became eligible for ALL KIDS Assist, ALL KIDS Share, and ALL KIDS Premium level 1 plans in addition to the newly created Premium levels 2-8. A summary of the plans can be found in Appendix C. The following are detailed descriptions of the EXPANDED ALL KIDS plans.

ALL KIDS Assist

The EXPANDED ALL KIDS **Assist** program began providing coverage for undocumented children in families with countable **income at or below 133 percent of the FPL** on July 1, 2006. **(In FY10, 133 percent of the FPL for a family of four was $29,326.50.)** This coverage is provided at no cost to the enrollee.

ALL KIDS Share

The EXPANDED ALL KIDS **Share** program began providing coverage for undocumented children in families with countable **income that is more than 133 percent of the FPL but less than or equal to 150 percent of the FPL** on July 1, 2006. **(In FY10, 150 percent of the FPL for a family of four was $33,075.)** There are no premiums paid for Share services; however, co-pays are required as follows:

- ✓ $2 for each physician office visit;

- ✓ $2 for each nonemergency visit to an emergency room;
- ✓ $2 for each generic or brand name prescription drug;
- ✓ $2 for each inpatient hospital admission;
- ✓ $2 for each outpatient hospital service; and
- ✓ $100 annual out-of-pocket maximum on co-pays for the family.

ALL KIDS Premium Level 1

The EXPANDED ALL KIDS **Premium level 1** program began providing coverage for undocumented children in families with countable **income that is more than 150 percent of the FPL but less than or equal to 200 percent of the FPL** on July 1, 2006. **(In FY10, 200 percent of the FPL for a family of four was $44,100.)** Premiums are as follows: $15 per month for one family member; $25 per month for two family members; $30 per month for three family members; $35 per month for four family members; and $40 per month for five or more family members. Co-pays are listed below:

- ✓ $5 for each physician office visit;
- ✓ $25 for each nonemergency visit to an emergency room;
- ✓ $3 for each generic and $5 for each brand name prescription drug;
- ✓ $5 for each inpatient hospital admission;
- ✓ $5 for each outpatient hospital service; and
- ✓ $100 annual out-of-pocket maximum on co-pays for the family.

ALL KIDS Premium Level 2 (New on July 1, 2006)

The EXPANDED ALL KIDS **Premium level 2** program was established to provide coverage for children in families with countable **income that is more than 200 percent of the FPL but less than or equal to 300 percent of the FPL**. **(In FY10, 300 percent of the FPL for a family of four was $66,150.)** Premiums are $40 per month for each child with a maximum monthly premium of $80 for two or more children. Co-pays are listed below:

- ✓ $10 for each physician office visit;
- ✓ $30 for each emergency room visit;
- ✓ $3 for each generic and $7 for each brand name prescription drug;
- ✓ $100 for each inpatient hospital admission;
- ✓ 5% of the ALL KIDS payment rate for each outpatient hospital service; and
- ✓ $500 annual out-of-pocket maximum on co-pays for hospital inpatient and outpatient services per child each plan year.

ALL KIDS Premium Level 3 (New on July 1, 2006)

The EXPANDED ALL KIDS **Premium level 3** program was established to provide coverage for children in families with countable **income that is more than 300 percent of the FPL but less than or equal to 400 percent of the FPL**. **(In FY10, 400 percent of the FPL for a family of four was $88,200.)** Premiums are $70 per month for each child with a maximum monthly premium of $140 for two or more children. Co-pays are listed below:

- ✓ $15 for each physician office visit;
- ✓ $50 for each emergency room visit;
- ✓ $6 for each generic and $14 for each brand name prescription drug;

- ✓ $150 for each inpatient hospital admission;
- ✓ 10% of the ALL KIDS payment rate for each outpatient hospital service; and
- ✓ $750 annual out-of-pocket maximum on co-pays for hospital inpatient and outpatient services per child each plan year.

ALL KIDS Premium Level 4 (New on July 1, 2006)

The EXPANDED ALL KIDS **Premium level 4** program was established to provide coverage for children in families with countable **income that is more than 400 percent of the FPL but less than or equal to 500 percent of the FPL**. **(In FY10, 500 percent of the FPL for a family of four was $110,250.)** Premiums are $100 per month for each child with a maximum monthly premium of $200 for two or more children. Co-pays are listed below:

- ✓ $20 for each physician office visit;
- ✓ $75 for each emergency room visit;
- ✓ $9 for each generic and $21 for each brand name prescription drug;
- ✓ $200 for each inpatient hospital admission;
- ✓ 15% of the ALL KIDS payment rate for each outpatient hospital service; and
- ✓ $1,000 annual out-of-pocket maximum on co-pays for hospital inpatient and outpatient services per child each plan year.

ALL KIDS Premium Level 5 (New on July 1, 2006)

The EXPANDED ALL KIDS **Premium level 5** program was established to provide coverage for children in families with countable **income that is more than 500 percent of the FPL but less than or equal to 600 percent of the FPL**. **(In FY10, 600 percent of the FPL for a family of four was $132,300.)** Premiums are $150 per month for each child with no maximum monthly premium. Co-pays are listed below:

- ✓ $25 for each physician office visit;
- ✓ $100 for each emergency room visit;
- ✓ $12 for each generic and $28 for each brand name prescription drug;
- ✓ 10% of the ALL KIDS payment rate for each inpatient hospital admission;
- ✓ 20% of the ALL KIDS payment rate for each outpatient hospital service; and
- ✓ $5,000 annual out-of-pocket maximum on co-pays for hospital inpatient and outpatient services per child each plan year.

ALL KIDS Premium Level 6 (New on July 1, 2006)

The EXPANDED ALL KIDS **Premium level 6** program was established to provide coverage for children in families with countable **income that is more than 600 percent of the FPL but less than or equal to 700 percent of the FPL**. **(In FY10, 700 percent of the FPL for a family of four was $154,350.)** Premiums are $200 per month for each child with no maximum monthly premium. Co-pays are listed below:

- ✓ $25 for each physician office visit;
- ✓ $100 for each emergency room visit;
- ✓ $12 for each generic and $28 for each brand name prescription drug;
- ✓ 10% of the ALL KIDS payment rate for each inpatient hospital admission;
- ✓ 20% of the ALL KIDS payment rate for each outpatient hospital service; and

- ✓ $5,000 annual out-of-pocket maximum on co-pays for hospital inpatient and outpatient services per child each plan year.

ALL KIDS Premium Level 7 (New on July 1, 2006)

The EXPANDED ALL KIDS **Premium level 7** program was established to provide coverage for children in families with countable **income that is more than 700 percent of the FPL but less than or equal to 800 percent of the FPL**. **(In FY10, 800 percent of the FPL for a family of four was $176,400.)** Premiums are $250 per month for each child with no maximum monthly premium. Co-pays are listed below:

- ✓ $25 for each physician office visit;
- ✓ $100 for each emergency room visit;
- ✓ $12 for each generic and $28 for each brand name prescription drug;
- ✓ 10% of the ALL KIDS payment rate for each inpatient hospital admission;
- ✓ 20% of the ALL KIDS payment rate for each outpatient hospital service; and
- ✓ $5,000 annual out-of-pocket maximum on co-pays for hospital inpatient and outpatient services per child each plan year.

ALL KIDS Premium Level 8 (New on July 1, 2006)

The EXPANDED ALL KIDS **Premium level 8** program was established to provide coverage for children in families with countable **income that is more than 800 percent of the FPL**. **(In FY10, 800 percent of the FPL for a family of four was $176,400.)** Premiums are $300 per month for each child with no maximum monthly premium. Co-pays are listed below:

- ✓ $25 for each physician office visit;
- ✓ $100 for each emergency room visit;
- ✓ $12 for each generic and $28 for each brand name prescription drug;
- ✓ 25% of the ALL KIDS payment rate for each inpatient hospital admission;
- ✓ 25% of the ALL KIDS payment rate for each outpatient hospital service; and
- ✓ There is no annual out-of-pocket maximum per child each plan year.

As a result of Public Act 96-1501, beginning on July 1, 2011, children whose household income is above 300 percent of the federal poverty level (i.e., Premium levels 3-8) are no longer eligible for EXPANDED ALL KIDS. Children enrolled as of July 1, 2011 may remain enrolled in the program for an additional 12 months.

ALL KIDS Enrollment

Families interested in enrolling their children in the ALL KIDS program must fill out an application. See Appendix D for a copy of the ALL KIDS application. This can be done online, through the mail, by visiting a DHS local office, or by working with an ALL KIDS Application Agent. ALL KIDS Application Agents are paid $50 for each completed application that results in new coverage. Appendix E includes a list of Application Agents, the number of approved applications, and the amount each Application Agent was paid in FY10. 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.

In FY10, Illinois' ALL KIDS program had 1.8 million enrollees. In FY10, enrollees that were eligible at any point in the year as a result of the July 1, 2006 ALL KIDS expansion totaled 94,628. On June 30, 2010, there were 73,681 enrollees as a result of the expansion of which 53,607 (73%) were classified as undocumented immigrants in the HFS data. As discussed further in Chapter Two, due to incorrect categorization by HFS of some documented immigrants, the enrollment for undocumented immigrants is overstated, while the enrollment for documented immigrants is understated. Exhibit 1-2 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.

Exhibit 1-2
EXPANDED ALL KIDS ENROLLMENT BY PLAN [3, 4]
As of June 30

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

Notes:

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

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

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

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

Source: ALL KIDS enrollment data provided by HFS.

According to 89 Ill. Adm. Code 123.240(j), children eligible for ALL KIDS are guaranteed initial coverage for 12 months, unless the family experiences a change that renders them ineligible for the program. According to the ALL KIDS EXPANSION Policy Manual, an increase in income does not have to be reported until the annual renewal/redetermination. Prior to the end of the 12-month eligibility period, HFS is required to send the family an annual renewal notice.

Payments for ALL KIDS Services

According to claim data provided by HFS, in FY09 the cost for services that were added as a result of the July 1, 2006 expansion totaled $79,068,335. In FY10, the cost for services increased to $84,199,508. The majority of the costs for services were for undocumented immigrants. Costs for undocumented immigrants totaled $54.9 million in FY09 and $59.2 million in FY10. Therefore, undocumented immigrants make up approximately 70 percent of the total costs for the EXPANDED ALL KIDS program over the last two fiscal years. Exhibit 1-3 breaks out the payments for services by whether the child had documentation for citizenship/immigration status or whether the child was undocumented for both FY09 and FY10. However, due to HFS incorrectly categorizing some documented immigrants as undocumented immigrants, the costs for undocumented immigrants are overstated, while the costs for documented immigrants are understated.

Payments vs. Premiums Collected

In FY10, HFS received approximately $9.8 million in premiums from enrollees, thus making the net cost of the ALL KIDS expansion approximately $74.4 million, an increase of approximately $4.3 million from FY09. Exhibit 1-4 shows both FY09 and FY10 payments and premiums collected from the EXPANDED ALL KIDS program.

Exhibit 1-3
PAYMENTS FOR EXPANDED ALL KIDS SERVICES BY ALL KIDS PLAN [1, 3]
Fiscal Years 2009 and 2010

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

Notes:

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

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

[3] Totals may not add due to rounding.

Source: ALL KIDS claim data provided by HFS.

Covered Services

ALL KIDS covers numerous services for children in Illinois. These services include:

-Inpatient/outpatient hospital services
-Physician services
-Inpatient/outpatient surgical services
-Clinic services
-Prescription drugs
-Laboratory and x-ray services
-Inpatient/outpatient mental health services
-Inpatient/outpatient substance abuse treatment services
-Early Intervention services including case management
-Audiology services
-Optical services and supplies
-Optometrist (eye) services
-Family planning services and supplies
-Podiatric services
-Chiropractic services
-Services for Intermediate Care Facilities
-Skilled pediatric nursing facilities
-Dental services

-Medical supplies, equipment, prosthesis, and orthoses
-Nursing care services
-Physical therapy, occupational therapy, speech therapy
-Hospice care
-Transportation (emergency and non-emergency)
-Home health care services
-Maternity care
-Hospital emergency room
-Long term care (Nursing Home)
-Healthy Kids services
-Renal dialysis services
-Respiratory equipment and supplies

Exhibit 1-4
EXPANDED ALL KIDS PAYMENTS VS. PREMIUMS [1]
Fiscal Years 2009 and 2010

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

Notes:

[1] Totals may not add due to rounding.

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

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

STATE STATUTES RELATED TO ALL KIDS

The Covering ALL KIDS Health Insurance Act [215 ILCS 170] was effective July 1, 2006. The Act defines a child as a person under the age of 19. The Act has 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 Act expanded program benefits to cover all uninsured children in families regardless of family income. This included adding children whose family income was greater than 200 percent of the federal poverty level and undocumented immigrant children at any income level. Throughout this audit, we will refer to this newly expanded population as "EXPANDED ALL KIDS."

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

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

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

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

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

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. The ALL KIDS program, as defined by HFS, operates under the authority of three separate State laws. These laws are:

- the **Illinois Public Aid Code (Medicaid)** [305 ILCS 5/5 and 5/12] which provides benefits for children in families with income up to 133 percent of the federal poverty level and non-citizen children from families with income up to 200 percent of the federal poverty level. The Administrative Code (89 Ill. Adm. Code 120/310(b)) lists eligible non-citizens which include: refugees; asylees; permanent residents; and nationals of Haiti or Cuba. Federal reimbursement is received for the majority of these children under Title XIX of the Social Security Act (Medicaid).

- the **Children's Health Insurance Program Act (SCHIP)** [215 ILCS 106] which provides benefits for children from families with income above 133 percent of the federal poverty level up to and including 200 percent of the federal poverty level. Federal reimbursement is received for these children under Title XXI of the Social Security Act; and
- the **Covering ALL KIDS Health Insurance Act** [215 ILCS 170] which expands program benefits to cover all children in uninsured families with income above 200 percent of the federal poverty level, and children that are not covered by the Illinois Public Aid Code or by the Children's Health Insurance Program Act.

The Covering ALL KIDS Health Insurance Act

The Covering ALL KIDS Health Insurance Act mandates the Department of Healthcare and Family Services to provide various types of information to the General Assembly. HFS did not meet all of the requirements found in the Act in FY09. Specifically, HFS did not report program information that included the number of individuals enrolled in the Covering ALL KIDS Health Insurance Program by income or premium level in its annual report, and HFS did not submit copies of all contracts awarded to the leaders of the General Assembly. Both issues identified in the FY09 audit were corrected by HFS for FY10.

For this audit, HFS provided the ALL KIDS Primary Care Case Management and Disease Management Report that reported the number of individuals enrolled in the ALL KIDS program by income or premium level as required by 215 ILCS 170/47(c). Additionally, HFS noted that it submitted copies of contracts to the General Assembly for the FY09 audit period and HFS did not award any contracts for the administration of the ALL KIDS program during FY10.

Exchange of Health Insurance Information

The Act [215 ILCS 170/20(a)(3)], which became effective on July 1, 2006, also requires HFS in collaboration with the Department of Financial and Professional Regulation, Division of Insurance (now the Department of Insurance) to adopt rules governing the exchange of information under this section. However, as of October 2010, HFS has not adopted rules governing the exchange of health insurance information as required by the Act. According to HFS, after our audit period, a proposed rule was published on January 14, 2011. As a result, this recommendation will be repeated.

COVERING ALL KIDS HEALTH INSURANCE ACT REQUIREMENTS	
RECOMMENDATION NUMBER **1**	***The Department of Healthcare and Family Services should comply with the rulemaking requirement found in the Covering ALL KIDS Health Insurance Act [215 ILCS 170].***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation and began the implementation process. The Department promulgated a rule to comply with the requirements governing the exchange of health insurance information under 215 ILCS 170/20(a)(3) of the Covering All Kids Health Insurance Act. The proposed rule was published on January 14, 2011 in the Illinois Register. The second notice is anticipated to be published on April 8, 2011 and public notification of rule adoption is anticipated to be published by July 8, 2011.

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 limits for the premium levels and the cost for premiums that were discussed earlier in this chapter are set according to these rules.

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.

ALL KIDS POLICIES AND PROCEDURES

During the FY09 audit, auditors determined that policies and procedures utilized by HFS and DHS for the administration of the EXPANDED ALL KIDS program were confusing and difficult to follow. As a result, client eligibility could be determined differently or incorrectly. We found policies with conflicting information and directions and others that were duplicative. We also found that the policies contained outdated case examples, which in these instances make the examples incorrect.

Auditors requested policies and procedures from HFS. HFS provided links to policies that can be accessed through DHS' website. Not only were these policies hard to find, but it was difficult to determine which policies related to ALL KIDS. According to a DHS official, there is not one chapter that covers this, and elements of policy are incorporated throughout the manual in numerous sections and in policy memoranda. Many of the policies related to ALL KIDS do not have ALL KIDS in the title making it difficult to search for information by topic area.

During the current audit period, HFS and DHS noted that they were in the process of updating the medical sections of the policy manual by incorporating policy memos. HFS also noted they were establishing a procedure regarding standard practice to release policy changes as updates to the manual and not in memorandum format. As of October 1, 2010, HFS was still in the process of implementing these revisions. As a result, this recommendation will be repeated and we will follow-up on this recommendation in the FY11 audit.

ALL KIDS POLICIES AND PROCEDURES	
RECOMMENDATION NUMBER **2**	***The Department of Healthcare and Family Services and the Department of Human Services should work together to organize the policies in one section that contains only policies relevant to ALL KIDS and the EXPANDED ALL KIDS program. Additionally, the agencies should ensure that policies are consistent with applicable laws and rules and are up to date.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE Continued on following page	The Department accepts the recommendation and it has been implemented. The All Kids Manual Release was issued on December 6, 2010. Most of the policy pertaining to the expanded All Kids program is contained in one chapter of the manual. This chapter contains links to other sections of the manual that pertain to the All Kids program. The manual is designed to be used by staff who determine eligibility for cash and SNAP as well as all of the Department's medical programs. For this reason it is organized in such a way that eligibility criteria, procedures, and casework actions that are common to more than one program appear together.

DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department agrees with the recommendation. The Illinois Department of Human Services (DHS) will continue to work with the Illinois Department of Healthcare and Family Services (HFS) to incorporate policies contained in memo format into the manual. The DHS manual has recently been updated with the distribution of Manual Release #10.31 and #11.04, which contained All Kids policies previously held within policy memoranda. The DHS Policy Manual has also been organized by eligibility topic and formatted to be consistent with the integrated caseloads that caseworkers maintain.

ANNUAL REDETERMINATION PROCESS

In the FY09 audit, auditors concluded that the annual reviews of ALL KIDS eligibility – also called redeterminations – required by the Illinois Administrative Code [89 Ill. Adm. Code 123.260] were not being adequately implemented by HFS. For ALL KIDS enrollees that fall in the Assist, Share, and Premium level 1 categories (i.e., at or below 200 percent of the FPL), an annual "passive" redetermination is used by HFS. Prior to the end of the eligibility period, HFS sends each family an annual renewal notice. The renewal notice lists the eligibility information for the family and instructs the family to return the form **only** if any of the information has changed. If there have been no changes, the family is instructed to do nothing. Therefore, a "passive" redetermination only requires families to return the annual renewal form if there is a change in their information. In contrast, to continue coverage, enrollees in Premium levels 2 through 8 are required to send in the annual redetermination form, which includes updated eligibility information.

Auditors determined that on June 30, 2010, there were 53,102 enrollees with family income at or below 200 percent of the federal poverty level out of the 73,681 total EXPANDED ALL KIDS enrollees. Therefore, at the end of FY10, 72 percent of the EXPANDED ALL KIDS enrollees were eligible for "passive" redetermination. These individuals were classified as undocumented immigrants, and therefore, payments for services do not qualify for matching federal funds. In FY10, $58.4 million in net costs for services was paid by HFS for individuals with income at or below 200 percent of the federal poverty level for the EXPANDED ALL KIDS program. According to HFS officials, no other eligibility check is conducted by HFS on an annual basis to ensure that eligibility criteria have not changed.

In its September 2010 report, the HFS Office of the Inspector General recommended that the passive redetermination process be discontinued. The HFS-OIG noted "It is the position of the OIG that the passive redetermination process has failed to provide Illinois with a reliable and accurate measure of redetermining the eligibility of individuals who are enrolled in the Medicaid program." The OIG reviewed 1,089 cases and found that 34 percent contained eligibility errors. The OIG also found that 82 percent of the errors were in the areas of income, primarily wages and salaries. Additionally, HFS' use of passive redeterminations for its Medicaid and SCHIP programs has been a finding in past Statewide Single Audits conducted by Auditor General's Office.

The Illinois Administrative Code [89 Ill. Adm. Code 123.260] requires HFS to annually review eligibility. Simply sending a renewal notice to a family, and not requiring them to submit updated eligibility information, or at minimum, a signed statement attesting or affirming that eligibility factors have not changed, neither appears to comply with the intent of the Code, nor provide an effective control to prevent families who are ineligible to receive State-funded health insurance from continuing to receive it. Auditors were unable to determine whether the enrollment criteria for these individuals continues to be met. Without requiring enrollees to submit periodic eligibility documentation, enrollees could remain eligible based on "passive" redeterminations until they turn 19 years of age without ever having more than one actual eligibility determination.

For the current audit, we reviewed the applications for programs that provide medical coverage for children in 24 other states. These states include: Alabama, California, Colorado, Florida, Georgia, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Michigan, Mississippi, Montana, Nebraska, Nevada, North Carolina, Pennsylvania, South Carolina, Tennessee, Utah, Virginia, Washington, West Virginia, and Wisconsin. None of the other 24 states we reviewed had a process in which the family was not required to submit any information to the state and still received benefits. Some states require the family to sign and return a renewal packet even if there is no change (e.g., Alabama); while other states require families to provide updated proof of income (e.g., Pennsylvania).

During the current audit period, HFS reported that it is reviewing the legal, financial, and operational issues associated with making restrictive changes in the redetermination process for children in families with income at or below 200 percent of the federal poverty level. HFS also noted they are in the process of developing a reporting structure to more closely monitor the results of the renewal process.

DHS reported they are reviewing federal and State material that authorizes the passive renewal process and will recommend any changes needed to HFS as a result of the review. DHS also noted it is exploring with HFS the possibility of establishing a maximum number of 12 month eligibility periods for which a child can continue to be eligible without documentation that the child continues to meet the eligibility criteria.

As of October 1, 2010, HFS and DHS were still in the process of implementing these revisions. As a result of the passage of Public Act 96-1501, one month's income verification will be required for determining continued eligibility as of October 1, 2011.

REDETERMINATION OF ELIGIBILITY	
RECOMMENDATION NUMBER **3**	***The Department of Healthcare and Family Services and the Department of Human Services should:*** • ***review the current process for performing eligibility redeterminations to ensure compliance with the Covering ALL KIDS Health Insurance Act and the Illinois Administrative Code;*** • ***at a minimum, require EXPANDED ALL KIDS enrollees with family income at or below 200 percent of the federal poverty level to return an annual redetermination to verify that there were no changes to their eligibility information; and*** • ***establish a maximum number of 12-month eligibility periods for which a child with family income at or below 200 percent of the federal poverty level can be eligible for coverage without providing updated eligibility documentation.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. As of October 2011, passive renewal for all children in families with income at or below 200 percent of the federal poverty level will end. Also as of October 2011, families at all income levels will have to respond at annual determination, either verifying a full month's income or actively confirming information obtained electronically by the Department.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department agrees with the recommendation. As a result of the passage of Public Act 96-1501, the Administrative Renewal process will be obsolete in October 2011. The Department of Human Services (DHS) will continue to cooperate with the Department of Healthcare and Family Services (HFS) in the establishment of new procedure that will require active participation from customer in obtaining medical eligibility documentation.

Income Calculation

During the review of HFS and DHS policies during the FY09 audit, auditors determined that DHS **did not** calculate family income for EXPANDED ALL KIDS eligibility as required by the Administrative Code. The Administrative Code [89 Ill. Adm. Code 123.110] defines family as the child applying for the program and individuals who live with the child, which includes "the spouse of the child's parent" (i.e., the child's stepparent). Therefore, the income calculation for any child receiving services under the Covering ALL KIDS Health Insurance Act (i.e., those children whose services are totally State funded) should include the income of the stepparent.

When determining family income when a stepparent is present, HFS counts the income of the stepparent. However, for families with income at or below 133 percent of the federal poverty level, DHS does not include the stepparent in the income calculation. Policy regarding HFS'

Central ALL KIDS Unit application processing states, "In addition, families who want to have eligibility determined without considering stepparent or children's income must also apply through their local DHS office." Also, on the application, families with a stepparent in the home are instructed "it may be better for you to apply at your DHS Family Community Resource Center." (See page 98 in Appendix D.) As a result, families with stepparents that apply through DHS may pay lower co-pays or premiums in order to receive coverage. HFS, as the administrator of the ALL KIDS program, should not promote inconsistent treatment of stepparent income, or non-compliance with its own administrative rules.

During this audit, HFS reported that it is analyzing options for changing the income-counting methodology for covered children under the ALL KIDS EXPANSION program as established by State policy and practice. DHS noted it will meet with HFS in order to review the Administrative Code, the Illinois Compiled Statutes, and current ALL KIDS policy to ensure that all required income is used in the eligibility calculations for EXPANDED ALL KIDS programs.

As of October 1, 2010, HFS and DHS were still in the process of implementing these revisions. As a result, this recommendation will be repeated and we will follow-up on this recommendation in the FY11 audit.

INCOME OF STEPPARENT	
RECOMMENDATION NUMBER **4**	***The Department of Healthcare and Family Services and the Department of Human Services should ensure that the income of the stepparent is included in the income calculation for the EXPANDED ALL KIDS program as required by 89 Ill. Adm. Code 123.110.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department will revise policy to ensure that income of the stepparent is included in the income calculation for undocumented noncitizen children in households of all income levels.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department agrees with the recommendation. The Department of Human Services will continue to work with the Illinois Department of Healthcare and Family Services (HFS) to ensure that all required elements are considered and documented in the eligibility determination as required by Administrative Code.

PREMIUM PAYMENTS

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

During FY10, if an enrollee's membership was cancelled due to unpaid premiums, the family was ineligible for ALL KIDS coverage for three months. If the family reapplied for ALL KIDS coverage, the family must pay all premiums past due before they can be re-enrolled. Public Act 96-1272 effective January 1, 2011, eliminated the three month ineligibility period.

Non-Payment of Premiums

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

- individuals are required to pay premiums on a monthly basis and **the payments are due on the last day of the month preceding the month of coverage (**89 Ill. Adm. Code 123.330);

- children will have a **grace period through the end of the month** of coverage to pay the premium and **failure to pay by the end of the last day of the grace period will result in termination of coverage** (89 Ill. Adm. Code 123.340); and

- when termination of coverage is recorded by the 15th day of the month, the termination will be effective the first day of the following month, and if termination is recorded after the 15th day of the month, the termination will be effective no later than the first day of the second month following that determination (89 Ill. Adm. Code 123.340).

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

We reviewed the March 2010 cancellation report, which contained 1,292 individuals. These individuals were in families that had not made past premium payments and were scheduled to be terminated on April 1, 2010. We determined that 418 individuals on the March cancellation report received services during March, after the required month grace period ended.

Our analysis shows that the State paid for 1,400 services totaling $42,893 for these individuals during March 2010.

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

Case Example 1

A recipient became eligible for ALL KIDS premium level 6 on April 1, 2010. According to HFS rules, the first premium should have been paid by March 31. Although no premium payments were made for this recipient for April, May, or June of 2010, $15,169 in services were paid on the recipient's behalf. In June, the recipient was placed on HFS' Cancellation Report and the recipient's eligibility was cancelled effective July 1, 2010.

Re-enrollment without Payment of Past Due Premiums

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

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

During this audit, HFS officials responded that policies and options related to grace periods for non-payment of premiums are being reviewed. HFS also noted that alternatives and enforcement methods for collection of delinquent premiums are being analyzed.

NON-PAYMENT OF PREMIUMS	
RECOMMENDATION NUMBER **5**	***The Department of Healthcare and Family Services should:*** • ***terminate ALL KIDS coverage to families that do not pay monthly premiums as required by 89 Ill. Adm. Code 123.340;*** • ***ensure that prior to re-enrollment in ALL KIDS, families pay all premiums due, for periods in which a premium was owed and not paid, as required by 89 Ill. Adm. Code 123.210(c)(2); and*** • ***ensure that before being re-enrolled, the first month's premium was paid if there was an unpaid premium on the date the child's previous coverage was cancelled as required by 89 Ill. Adm. Code 123.210(c)(5).***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department will terminate All Kids coverage to families that do not pay monthly premiums as required by 89 Ill. Adm. Code 123.340, barring any violation of the federal Maintenance of Eligibility requirements. A reminder will be sent to staff at both agencies regarding the appropriate coding of applications to prevent re-enrollment of children who have outstanding premium debt.

UNIVERSITY OF ILLINOIS ALL KIDS CONTRACT

The Covering ALL KIDS Health Insurance Act requires the Auditor General to review contracts entered into by HFS related to the ALL KIDS program. The only contract identified by HFS in FY10 that relates to the ALL KIDS program was a contract with the University of Illinois (University) to conduct a statutorily required survey of the health insurance status of Illinois children.

The All Kids Final Report completed by the University of Illinois did not include all information and analysis required by the contract. During our previous audit, we identified and reviewed the procurement of the contract between HFS and the University and found no exceptions.

The contract required the University to conduct a survey to assess the health insurance status of Illinois children and determine the following:

- The number of children under the age of 19 years in the household;
- The health insurance coverage, if any, for those children, including publicly funded benefits;
- The household size and income;

- The availability and cost of employer-sponsored health insurance;
- If employer-sponsored health insurance is available but not utilized, the reasons for this decision;
- If employer-sponsored health insurance is available but not utilized, the scope of benefits provided and the cost sharing requirements of such insurance; and
- Health outcomes for children, whether utilizing private insurance, utilizing public benefits, or uninsured.

After reviewing the All Kids Final Report, auditors determined that the University only assessed the costs of premiums and benefits of employer-sponsored insurance for those who **utilized** the employer-sponsored insurance. However, the contract required the University to determine the scope of benefits provided and the cost sharing requirements for those who **did not utilize** employer-sponsored insurance. The report states, "Respondents with employer-sponsored or group-based coverage in which dependents were enrolled were asked about a variety of plan characteristics." The report did not address whether any questions about plan characteristics were asked to respondents who did not utilize the employer-sponsored insurance. According to an HFS official, this information was purposefully excluded. The HFS official stated, "This decision was based on pre-testing results indicating very high levels of missing data on those items. Briefly, it is very difficult or impossible for many respondents to recall information about plans to which they do not have access or do not utilize."

Additionally, the contract states, "UIC will compare data it collects to existing state-specific sources, including a 1998/1999 Population Survey of Low Income Families, a 2001 Illinois Population Survey of the Uninsured and Newly Insured and a 2002 Population Survey of parents with children enrolled in KidCare, and the All Kids Preliminary Report." However, the University compared its data **only** to the All Kids Preliminary Report. The All Kids Final Report states, "Results of this 2009/2010 survey were compared to existing state-specific data sources. These existing sources and reports include data from the 2005/2006 Current Population Surveys as reported by Mathematica Policy Research in the *All Kids Preliminary Report, July 2008*." According to HFS officials, "during the course of UIC's work, the University and the department jointly determined that the contract language did not adequately address the requirement in the law." UIC proposed an alternate comparison which HFS accepted.

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

During the fieldwork phase, we followed up on the previous audit's recommendations. Since the FY09 audit was released in May 2010, more than 10 months into the FY10 audit period, many of the steps that HFS and DHS are taking to address the recommendations were not implemented as of October 2010. Therefore, most of the follow-up on these recommendations will be conducted during the FY11 audit. Due to no further ALL KIDS contracts, HFS had no specific updates to these recommendations. However, HFS noted it will ensure the recommendations/responses are addressed if there are future ALL KIDS contracts. In future audits of the EXPANDED ALL KIDS program, we will follow-up on these contract recommendations as new ALL KIDS contracts are executed. Exhibit 1-5 summarizes the status of the FY09 audit recommendations as of October 1, 2010.

Exhibit 1-5
STATUS OF PREVIOUS AUDIT RECOMMENDATIONS
As of October 1, 2010

Recommendation Number	Recommendation Area	Status
1	Compliance with the Covering ALL KIDS Health Insurance Act	Partially Implemented
2	ALL KIDS policies and procedures	Not Implemented
3	Redetermination of ALL KIDS eligibility	Not Implemented [1]
4	Stepparent income	Not Implemented
5	Non-payment of premiums	Not Implemented
6	Timely submission of information to the Auditor General	Implemented
7	ALL KIDS data reliability	Not Implemented
8	Classification of documented immigrants	Not Implemented
9	Payment of non-emergency transportation	Not Implemented [2]
10	Eligibility documentation	Not Implemented [1]
11	Increases in contractual obligations	[3]
12	Procurement process	[3]
13	Monitoring process of ALL KIDS marketing contract	[3]

Notes:

[1] Not implemented as of October 2010. However, Public Act 96-1501, signed in January 2011, requires HFS to take steps that address some or all of the portions of the recommendation.

[2] A programming change was implemented by HFS on June 15, 2010 which will be tested as part of the next audit.

[3] Due to no further ALL KIDS contracts, HFS had no specific updates to these recommendations. However, HFS noted it will ensure the recommendations/responses are addressed if there are future ALL KIDS contracts.

Source: OAG Program Audit of the Covering ALL KIDS Health Insurance Program - May 2010.

In addition to the recommendations from the last audit (FY09), the FY10 audit identified eight additional areas for recommendations. Some of these additional recommendations were added to related existing recommendations from the previous audit. Exhibit 1-6 summarizes the new recommendation areas by recommendation number.

Fieldwork for this audit was conducted in August through November 2010. During the audit, we met with representatives from the Department of Human Services, the Department of Healthcare and Family Services, the Department of Healthcare and Family Services Office of the Inspector General, and the State Police Medicaid Fraud Control Bureau. We requested EXPANDED ALL KIDS claim and enrollment data for FY10. Auditors determined that due to incorrect categorization of documented immigrants within the enrollment data provided by HFS, this report overstates the number of undocumented immigrants and their associated cost and understates the number of documented immigrants and their associated costs.

Exhibit 1-6
SUMMARY OF NEW RECOMMENDATIONS
Fiscal Year 2010

Recommendation Number	Recommendation Area
5 *	Payment of past and first month's premiums prior to re-enrollment
7 *	Maintain necessary information for documented immigrants in database
9	Edits to identify duplicate medical claims
10 *	Controls over applicants who are self-employed
11	Edits to identify duplicate transportation claims
12	Edits to identify potential abuse to optical claims
13	Guidance over preventive medicine service claims
14	Payments beyond dental benefit limitations

Note: * recommendations were added to related existing recommendations from the last audit.

In conducting this audit we reviewed applicable State and federal laws and regulations as well as DHS and HFS policy manuals and action guides. Compliance requirements were reviewed and tested to the extent necessary to meet audit objectives. Instances of non-compliance are included in this report. We also determined whether any issues with the data or identified by the data are a result of a lack of management controls. Additionally, we tested management controls over the premiums that are paid by enrollees.

During the audit, we performed testing on several areas. The main sample for the audit was a review of client files. Our sample was stratified to ensure inclusion of all program plan levels and a relatively equal number of citizens/documented immigrants versus undocumented immigrants. We then randomly selected claims by program plan level to obtain our sample of 100 paid claims during FY10 to test, and as a result, the results cannot be projected to the population. During testing, we compared electronic data to the hard copy file to check for reliability, and we reviewed the claim to ensure that it wasn't a duplicate payment. We also tested:

- whether the child was eligible at the time the service was provided;
- whether the child's premium was paid at the time of the service;
- whether the necessary documentation was obtained by HFS/DHS to determine eligibility;
- whether documentation in the case file matched what is found in the database;
- whether the child was placed in the appropriate ALL KIDS program;
- whether the redetermination notice was sent to enrollees as required by administrative rule; and
- whether the redetermination was returned (if required).

We also analyzed payment and eligibility data to determine:

- whether individuals listed on the HFS March 2010 cancellation report received services after the 30 day grace period, and the cost of the services after the 30 day grace period; and
- whether enrollees received services after the month of their 19th birthday.

HFS officials reported that there were no contracts specific to the ALL KIDS Expansion for FY10. We have, however, reviewed the deliverable for the U of I contract that was received in FY10. The deliverable, a report of survey information gathered regarding health insurance coverage for children in Illinois, was reviewed during fieldwork for completeness/compliance with the contract requirements.

We reviewed risk and internal controls related to the EXPANDED ALL KIDS program related to the audit objectives. Any weaknesses in internal controls are included as findings in this report. For a more detailed sampling and analytical methodology, see Appendix B.

REPORT ORGANIZATION

The remainder of this report is organized into the following chapters:

- Chapter Two – ALL KIDS Data; and
- Chapter Three – ALL KIDS Payments and Eligibility.

Chapter Two

ALL KIDS DATA

CHAPTER CONCLUSIONS

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

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

During the FY09 and FY10 audits, auditors determined that HFS did not accurately classify documented immigrants who receive ALL KIDS services. According to HFS officials, to ensure that federal matching funds were not requested for documented immigrants who are ineligible for matching funds (i.e., those documented immigrants who had not been in the country for five years), those documented immigrants were classified as undocumented immigrants.

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

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

Auditors expanded the testing in this area and requested either social security numbers or alien registration numbers for the recipients that were classified as undocumented in the eligibility data from HFS. HFS officials noted that HFS did not maintain such documentation.

DHS provided either social security numbers or alien registration numbers for 12,601 of the 60,580 (21%) EXPANDED ALL KIDS recipients classified as undocumented.

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

A February 2009 change in federal law allows HFS to receive federal match for documented immigrants immediately (i.e., they do not have to be in the country for five years). As of November 17, 2010, the State's revised State Plan had not yet been approved to begin receiving these matching funds. The misclassification of documented immigrants as undocumented immigrants will have even greater financial significance once Illinois' State Plan is approved and it can start receiving matching federal funds for correctly classified documented immigrants. Once the State Plan is approved, Illinois could receive as much as $7.7 million in federal matching funds from FY10 (61.88% increased Medicaid match on $12.4 million).

EXPANDED ALL KIDS DATA

Although HFS had difficulty providing accurate data in a timely manner for the FY09 audit, HFS provided data timely for the FY10 audit. In FY09, HFS also failed to provide other requested information, which contributed to delays in conducting the audit. During the FY10 audit, auditors experienced no problems obtaining requested information from HFS. However, the data provided in FY10 continued to have issues as discussed in the following sections. Since controls were not in place for the EXPANDED ALL KIDS program, it is likely that many of these issues would also be relevant for the ALL KIDS program as a whole.

Issues with EXPANDED ALL KIDS Data

Auditors identified five specific issues associated with the both the FY09 and FY10 data provided by HFS. These five areas were: 1) eligibility data included individuals that were older than 18 years of age; 2) eligibility data included duplicate enrollees with two different recipient identification numbers, and/or different birth dates or addresses; 3) eligibility data included end dates that were not accurate; 4) irregularities between claims and eligibility data; and 5) some documented immigrants were categorized as undocumented immigrants. Additionally, due to the eligibility data including individuals over 18 years of age, the data provided by HFS overstates the enrollee and payment figures for the EXPANDED ALL KIDS program. Finally, the number of undocumented immigrants as well as the cost associated with them in the EXPANDED ALL KIDS program is overstated due to the incorrect categorizing of documented immigrants.

Individuals Older Than 18 Years of Age

HFS and DHS did not have adequate controls in place to ensure that individuals over the age of 18 were terminated from ALL KIDS eligibility as required by 89 Ill. Adm. Code 123.200(b). According to HFS policy, enrollees have eligibility through the end of the month in which they reach 19 years of age. During FY09, there were 3,027 individuals in the EXPANDED ALL KIDS program that reached 19 years of age. Of these, 128 individuals received 1,035 services totaling $49,690 after the month in which they turned 19 years of age.

During FY10, there were 4,032 individuals in the EXPANDED ALL KIDS program that reached 19 years of age. Of those 4,032 individuals, 265 of the recipients received services **after** the month of their 19th birthday. These 265 individuals received 3,140 services after the month in which they reached 19 years of age totaling $159,990 during FY10.

Duplicate Enrollees

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

Inaccurate End Dates

During the last audit, the data provided by HFS contained 30 cases where an individual's end date was not until the first day of the month following the month in which the enrollee turned 19 years of age. The eligibility period ends on the last day of the month in which the enrollee turns 19 years of age. In these instances, eligibility should have ended on the last day of the month; however, services were provided and claims were submitted and accepted on the following day even though the enrollee was no longer eligible for coverage. Although the dollar amount may be insignificant, this demonstrates a weakness in internal controls.

This was brought to HFS' attention during the FY09 audit and HFS noted that "This occurs when an action is taken on a case earlier in the processing month that is effecting the same month that the child who turned 19 is to be deleted. The first action puts eligibility on MMIS [Medicaid Management Information System]. The deletion action doesn't completely override the first action. The Department is drafting a system request to correct the problem." We followed up on this during the FY10 audit and HFS noted that it had not implemented any system changes to correct the problem.

Irregularities Between Claims and Eligibility Data

Similar to the FY09 data provided by HFS, the data from FY10 had irregularities when comparing the claims data with the eligibility data. We again found claims for services provided during FY10 for individuals that were not found in the eligibility data provided by HFS. The FY09 claims data contained 4,923 claims, totaling $176,426, for 1,158 recipients who were not included in the EXPANDED ALL KIDS recipient eligibility data.

In FY10, there were 3,810 claims for 1,020 recipients who were not included in the recipient eligibility data for that year. Those FY10 claims totaled $124,056. As a result, either the total recipients reported in this audit are understated by 1,020, the cost of the EXPANDED ALL KIDS program is overstated by $124,056 if the recipients were not eligible for coverage during FY10, or a combination of both.

ALL KIDS DATA RELIABILITY	
RECOMMENDATION NUMBER **6**	***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, and ensuring that enrollees are no longer eligible for services after their end date.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. A system error that allowed coverage for the first day of the month following the month of the child's 19th birthday has been identified and is in the process of being corrected. Both Departments continue to perform case reviews and work with staff to improve quality and reduce duplicate enrollees.

Classification of Documented Immigrants

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

During the FY09 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 are ineligible for matching funds (i.e., those documented immigrants who had not been in the country for five years), those documented immigrants were classified as undocumented immigrants.

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

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

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

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

According to HFS officials, prior to February 2009, claims for documented immigrants were not eligible for federal matching funds until the documented immigrant had been in the country for five years. In February 2009, the Children's Health Insurance Program Reauthorization Act of 2009 eliminated the five year waiting period and states could receive federal match for documented immigrants immediately. As of November 17, 2010, the State had not received approval of its State Plan to allow Illinois to begin receiving matching funds for the individuals. The misclassification of documented immigrants as undocumented immigrants will have even greater financial significance once Illinois' State Plan is approved and it can start receiving matching federal funds for correctly classified documented immigrants. Once the State Plan is approved, Illinois could receive as much as $7.7 million in federal matching funds from FY10 (61.88% increased Medicaid match on $12.4 million).

During the current audit period, 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. HFS also noted that it is working with DHS to provide training to staff to assure individuals are classified correctly. HFS noted it is still working with the federal government to approve the State Plan and is preparing draft rules to permit qualified aliens to qualify for federal matching funds regardless of how long they have been in the country.

As of October 1, 2010, HFS was still in the process of implementing these revisions.

CLASSIFICATION OF DOCUMENTED IMMIGRANTS	
RECOMMENDATION NUMBER **7** Continued on following page	***The Department of Healthcare and Family Services should:*** • ***ensure that documented immigrants are classified correctly in its database;*** • ***maintain the necessary information needed to identify documented immigrants such as social security numbers, alien registration numbers, and dates of entry; and***

	• ***ensure that the State receives federal matching funds for all eligible claims.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation and it has been implemented. As a result of the previous OAG audit, the Department discovered that the eligibility system was not properly carrying forward the entries made by casework staff. This system error was corrected on October 29, 2010.

Chapter Three

ALL KIDS PAYMENTS AND ELIGIBILITY

CHAPTER CONCLUSIONS

According to claim data provided by the Department of Healthcare and Family Services (HFS), in FY09 the cost for services that were added as a result of the July 1, 2006 expansion totaled $79,068,335. In FY10, the cost for services increased to $84,199,508. The majority of the costs for services were for undocumented immigrants. Costs for undocumented immigrants totaled $54.9 million in FY09 and $59.2 million in FY10. However, as discussed in Chapter Two, these costs are overstated due to the incorrect categorizing of documented immigrants.

As part of the FY10 audit, we reviewed FY10 claims paid, and determined that HFS paid for services that were excluded by Illinois Administrative Code [89 Ill. Adm. Code 123.310]. During our review of the claims paid, auditors determined that HFS paid $22,474 for non-emergency medical transportation for enrollees in Premium levels 2 through 8.

As part of our review of EXPANDED ALL KIDS payments, auditors analyzed FY10 claim data and identified potential duplicate payments. A sample of 20 pairs of potential duplicate claims was chosen because the claims had the same recipient, same service date, same procedure, and both providers were paid the State maximum rate for the procedure. HFS reviewed each of the 20 potential duplicate pairs of claims and determined that 7 were duplicates. Examples of the seven duplicates included: claims submitted by the physician and by the hospital or clinic; and claims submitted by two different physicians. The seven duplicate claims totaled $1,428. According to an HFS official, adjustments have been made.

Due to the way HFS implemented the Covering ALL KIDS Health Insurance Act, HFS and the Department of Human Services (DHS) are not obtaining documentation to support eligibility in some instances. As a result, auditors could not determine whether eligibility was determined correctly by HFS and DHS.

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

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

During our review of the 99 cases sampled (one case file could not be located by HFS), 40 enrollees (17 citizen/documented immigrants and 23 undocumented immigrants) did not provide documentation of place of birth (e.g., birth certificate). Although actual documentation was not in the case file, HFS noted the birth records for the citizen/documented immigrants were verified through cross-matches or were verified electronically through the Illinois Department of Public Health. According to HFS officials, birth is not required to be verified for undocumented immigrants. While most of the cases reviewed contained proof of identity (i.e., driver's license, State issued ID card, school ID, or a parent's signature if under age 16), we could not find documentation of identity for 2 (2%). Additionally, for the 99 files reviewed, auditors could not verify whether all sources of family income were provided by the applicant. Without documentation of income, it was not possible to determine whether eligibility was determined correctly.

According to a policy provided by DHS, as of January 2004, only one pay stub was required to determine eligibility for all Family Health Plans which includes ALL KIDS. This does not include individuals who are self employed. Self employed individuals are required to submit a month's worth of financial records.

Since many of the enrollees are eligible for "passive" redetermination, multiple years of eligibility for children may be based on a single pay stub. Auditors questioned the validity of using only one pay stub to determine 12-month eligibility. Families that are paid hourly wages may have income that fluctuates weekly. Additionally, income, such as bonuses or commissions, may not be captured by one pay stub. As a result, eligibility based on a single pay stub may not be an accurate representation of actual income. This could 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.

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

HFS and DHS did not require individuals who are self-employed to provide 30 days of detailed business records to be used to verify income and expenses. The ALL KIDS application requires self-employed individuals to "provide 30 days of detailed business records that include income and expenses" to determine eligibility for ALL KIDS. However, many applicants sampled did not provide actual business records.

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

PAYMENTS FOR ALL KIDS SERVICES

According to claim data provided by HFS, in FY09 the cost for services that were added as a result of the July 1, 2006 expansion totaled $79,068,335. In FY10, the cost for services increased to $84,199,508. The majority of the costs for services were for undocumented immigrants. Costs for undocumented immigrants totaled $54.9 million in FY09 and $59.2 million in FY10. Therefore, undocumented immigrants make up approximately 70 percent of the total costs for the EXPANDED ALL KIDS program over the last two fiscal years.

In FY10, HFS received approximately $9.8 million in premiums from enrollees, thus making the net cost of the ALL KIDS expansion approximately $74.4 million, an increase of approximately $4.3 million from FY09.

Like FY09, the largest recipient of expansion dollars in FY10 was Children's Memorial Hospital in Chicago with payments totaling $4.75 million. There were 235 providers that had more than $50,000 in payments in FY10 as a result of the expansion. Appendix H lists the 235 providers and the total amounts they were paid in FY10.

Payments by Category of Service

According to data provided by HFS, 90 percent of the payments during FY10 for EXPANDED ALL KIDS services were paid for 11 categories of services. Exhibit 3-1 shows that $75.9 million of the $84.2 million in total EXPANDED ALL KIDS payments were for the following services: inpatient hospital (general); dental; physician; pharmacy; general clinic; outpatient (general); healthy kids; capitation services; inpatient hospital (psychiatric); mental health rehab option; and alcohol and substance abuse rehab. The category with the highest percentage of payments was inpatient hospital (general) at 16 percent. Dental and physician services each accounted for 14 percent of the overall total. Appendix F shows the total FY10 payments by category of service. Additionally, Appendix G shows the FY10 EXPANDED ALL KIDS payments by plan and by category of service.

Exhibit 3-1
TOTAL PAYMENTS BY CATEGORY OF SERVICE FOR EXPANDED ALL KIDS PROGRAM
Totaling more than $1 million during FY10

Category of Service	Total FY10 Payments	Percent of Total FY10 Payments
Inpatient Hospital Services (General)	$13,595,254	16%
Dental Services	$12,105,107	14%
Physician Services	$12,055,130	14%
Pharmacy (Drug and OTC)	$10,672,656	13%
General Clinic Services	$ 7,514,750	9%
Outpatient Services (General)	$ 6,297,383	7%
Healthy Kids Services	$ 3,672,154	4%
Capitation Services	$ 3,551,098	4%
Inpatient Hospital Services (Psychiatric)	$ 3,442,003	4%
Mental Health Rehab. Option Services	$ 1,606,578	2%
Alcohol and Substance Abuse Rehab. Services	$ 1,357,121	2%
Total for categories with payments > than $1 million	**$75,869,233**	**90%**
Other categories totaling < than $1 million	$ 8,330,276	10%
Total Payments for All Service Categories	**$84,199,508**	**100%**

Note: Totals do not add due to rounding.

Source: FY10 ALL KIDS data provided by HFS.

Payment of Non-Emergency Transportation

As part of the FY09 audit, we reviewed FY09 claims paid, and determined that HFS paid for services that were excluded by Illinois Administrative Code [89 Ill. Adm. Code 123.310]. The Administrative Code specifically excludes coverage for non-emergency medical transportation for enrollees in Premium levels 2 through 8. Although payments for non-emergency are excluded, auditors found 1,159 payments totaling $27,393 for non-emergency transportation services in FY09. In FY10, we found 575 payments totaling $22,474.

HFS officials indicated that they reviewed the exceptions and "discovered an error in the programming that caused some claims to pay improperly." HFS officials noted that a programming change was implemented on June 15, 2010 to prevent payments for non-emergency transportation for children in Premium levels 2-8. HFS noted that since these claims were pre-approved, it had not recouped any of the $49,867 in unallowable payments from FY09 or FY10. Since the programming change was not implemented until the end of FY10, this recommendation was repeated and will be tested as part of the next audit.

PAYMENT OF NON-EMERGENCY TRANSPORTATION	
RECOMMENDATION NUMBER **8**	***The Department of Healthcare and Family Services should have controls in place to ensure that no payments are made for non-emergency transportation services that are excluded from coverage by 89 Ill. Adm. Code 123.310.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation and it has been implemented. On June 15, 2010 a programming change was implemented to prevent payments for non-emergency transportation for children in premium levels 2-8.

REVIEW OF EXPANDED ALL KIDS PAYMENTS

As part of this audit, auditors sampled payments from the FY10 claim data that appeared to be duplicates and conducted a sample of 100 paid claims from FY10. The FY10 claim data provided by HFS for the EXPANDED ALL KIDS program included 2,223,850 services totaling just over $84 million.

Duplicate Payment Sample

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. A 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. Case Example 2 shows claims submitted by two different physicians for the State maximum rate. The seven duplicate claims totaled $1,428. According to an HFS official, adjustments have been made.

Case Example 2

Two different physicians each billed the State maximum rate of $806.10 for the removal of a recipient's small intestine. According to HFS, these were duplicate claims and one claim should not have been paid.

DUPLICATE CLAIMS	
RECOMMENDATION NUMBER **9**	***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. In addition to the manual review process the Department has in place for all rejected duplicate claims, a monthly monitoring report will be developed to further target specific claim detail that will identify potential duplicate claims that may have been erroneously approved following the initial manual review process.

Paid Claims Sample

Like in the FY09 audit, auditors randomly selected a sample of 100 paid claims during FY10 to test. We selected 100 claims to ensure a sampling of all programs that contain a relatively equal number of citizens/documented immigrants versus undocumented immigrants. The FY10 methodology was the same methodology that was used for the FY09 audit. During testing, auditors compared electronic data to the hard copy file to check for reliability, and reviewed the claim to ensure that it wasn't a duplicate payment. Auditors also tested:

- whether the child was eligible at the time the service was provided;
- whether the child's premiums were paid at the time of the service;
- whether the necessary documentation was obtained by HFS/DHS to determine eligibility;
- whether documentation in the case file matched what is found in the database;
- whether the child was placed in the appropriate ALL KIDS program; and
- whether a redetermination notice was sent to the recipient as required.

During the review, auditors did not note any exceptions related to premiums paid at the time of service or with documentation in the case file matching what was found in the database. Auditors did note exceptions related to the documentation being obtained and used to determine eligibility, which is discussed in the following sections.

Lack of Eligibility Documentation

Due to the way HFS has implemented the Covering ALL KIDS Health Insurance Act, HFS and DHS are not obtaining documentation to support eligibility in some instances. As a result, auditors could not determine whether eligibility was determined correctly by HFS and DHS.

Proof of Age, Identity, Residency, and Family Size

To be eligible for the ALL KIDS program, a child must be under 19 years of age and must be a resident of the State of Illinois. Neither the Covering ALL KIDS Health Insurance Act

nor the Administrative Code provides any guidance on how proof of age, identity, or residency is to be verified. The ALL KIDS application asks U.S. citizens to provide documentation to support place of birth (such as a birth certificate) and identity (such as driver's license, State ID card, or school ID card). Identity for children under age 16 can be documented with school or day care records, a report card, or with a parent or guardian's signature. If the child is not a citizen, the application asks applicants to provide a valid alien registration number and to provide proof. Proof of immigration status includes: alien registration card, green card, permanent resident card, passport, or court-ordered notice for asylees.

Additionally, the ALL KIDS application does not require that any birth or identity documentation be provided by undocumented immigrants. According to HFS, children who do not meet citizenship/immigration requirements are not required to submit birth or identity documentation. During our review of the 99 cases sampled (one case file could not be located by HFS), 40 enrollees (17 citizen/documented immigrants and 23 undocumented immigrants) did not provide documentation of place of birth (e.g., birth certificate). Although actual documentation was not in the case file, HFS noted the birth records for the citizen/documented immigrants were verified through cross-matches or were verified electronically through the Illinois Department of Public Health. According to HFS officials, birth is not required to be verified for undocumented immigrants. While most of the cases reviewed contained proof of identity (e.g., driver's license, State issued ID card, school ID, or a parent's signature if under age 16), we could not find documentation of identity for 2 (2%). Without such information, it is questionable how the Departments can verify that the child meets the Act's age requirements, as well as confirm the identity of the child.

Exhibit 3-2 breaks out the missing documents by whether the enrollee was a citizen/documented immigrant or was an undocumented immigrant.

Although the Covering ALL KIDS Health Insurance Act requires that children be residents of the State, the ALL KIDS application contains no requirement that residency be verified. Auditors could not identify any routine process used by HFS or DHS to verify residency in the 99 case files reviewed. According to HFS, HFS "must verify residence only if there is a reason to question the claim of Illinois residency."

Although the Covering ALL KIDS Health Insurance Act requires that children be residents of the State, the ALL KIDS application contains no requirement that residency be verified. Auditors could not identify any routine process used by HFS or DHS to verify residency in the 99 case files reviewed. According to HFS, HFS "must verify residence only if there is a reason to question the claim of Illinois residency."

The determination used for placing enrollees into an ALL KIDS program is based on income and on family size. Auditors attempted to identify family size in order to determine who had countable income. The family size is also used to determine which federal poverty level category a family qualifies for. Auditors did not identify any routine process used by either HFS or DHS to verify family size. Additionally, auditors found it difficult to determine which family members identified on the application to include in the income and family size calculations.

Exhibit 3-2
MISSING DOCUMENTATION FROM SAMPLE OF 100 ALL KIDS FILES
Fiscal Year 2010

	Number of Sample Cases Missing Documentation			Total Sample Cases
	Birth	**Identity**	**Income** [2]	
Citizen/Documented Immigrant	17 [1]	0	0	58 [3]
Undocumented Immigrant	23	2	0	41
Totals	**40**	**2**	**0**	**99**

Notes:

[1] Birth documentation was not in the file. However, HFS noted that birth records for these individuals were verified through cross-matches or were verified electronically from birth records at the Illinois Department of Public Health.

[2] The files contained documentation for the income listed on the application. However, auditors could not determine whether all sources of family income was listed.

[3] One case file could not be located by HFS.

Source: Summary of a sample of 100 FY10 EXPANDED ALL KIDS claims.

Proof of Income

Auditors could not verify whether all sources of family income were provided by the applicant for the 99 files reviewed. Without documentation of income, it was not possible to determine whether eligibility was determined correctly. Enrollees are required to submit a copy of one pay stub received in the last 30 days from each job. Eligibility determinations are based on household income and the amount of income determines the amount of cost sharing by the enrollee. Cost sharing includes the co-pays and premium payments by enrollees to offset the cost of the services provided.

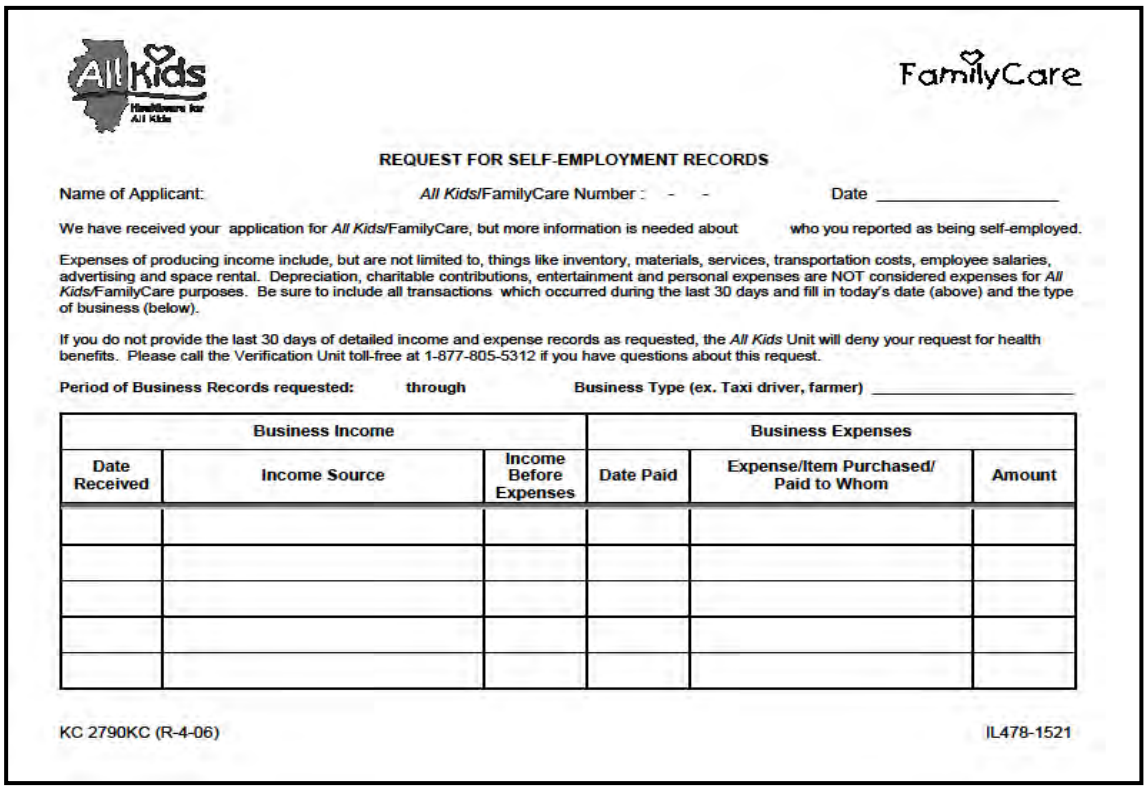
According to a policy provided by DHS, as of January 2004, only one pay stub was required to determine eligibility for all Family Health Plans which includes ALL KIDS. This does not include individuals who are self employed. Self employed individuals are required to submit a month's worth of financial records. During our review, auditors questioned the validity of using only one pay stub to determine 12-month eligibility. Also, the Illinois Administrative Code [89 Ill. Adm. Code 123.230] requires HFS to take "the total gross monthly income of the family" when calculating eligibility. Since one pay stub typically covers less than one full month, collecting documentation of a full month's income would help ensure compliance with the Administrative Code. Additionally, since many of the enrollees are eligible for "passive" redetermination, a single pay stub may be used to determine eligibility for multiple years.

Eligibility based on a single pay stub may not be an accurate representation of actual income. Families that are paid hourly wages may have income that fluctuates weekly. Additionally, income such as bonuses or commissions may not be captured by one pay stub.

This could 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.

Self-Employment

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



All Kids
Healthcare for All Kids

FamilyCare

REQUEST FOR SELF-EMPLOYMENT RECORDS

Name of Applicant: *All Kids*/FamilyCare Number : - - Date _____

We have received your application for *All Kids*/FamilyCare, but more information is needed about who you reported as being self-employed.

Expenses of producing income include, but are not limited to, things like inventory, materials, services, transportation costs, employee salaries, advertising and space rental. Depreciation, charitable contributions, entertainment and personal expenses are NOT considered expenses for *All Kids*/FamilyCare purposes. Be sure to include all transactions which occurred during the last 30 days and fill in today's date (above) and the type of business (below).

If you do not provide the last 30 days of detailed income and expense records as requested, the *All Kids* Unit will deny your request for health benefits. Please call the Verification Unit toll-free at 1-877-805-5312 if you have questions about this request.

Period of Business Records requested: **through** **Business Type (ex. Taxi driver, farmer)** _____

Business Income			Business Expenses		
Date Received	Income Source	Income Before Expenses	Date Paid	Expense/Item Purchased/ Paid to Whom	Amount

KC 2790KC (R-4-06) IL478-1521

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

Since eligibility based on a single month may not be an accurate representation of actual income, we reviewed other State's children's medical programs and their requirements. Auditors found that many other states use federal income tax returns and schedules from the previous year as proof of income for individuals who are self-employed. Nineteen of the 24 states we reviewed listed tax returns as a source of documentation to support income. Although not required by Illinois law, federal income tax returns and schedules would be beneficial in determining the income of individuals. This especially applies to individuals who are self-employed in a seasonal profession whose monthly income does not reflect their annual earnings. Eligibility based on a single month could 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. Case Example 3 shows how a family owning a seasonal business received free healthcare for their children by having their income recalculated during a month in which no income was earned.

Case Example 3

An individual submitted self-employment records from her business during the month of March, 2010 as proof of income. From those records, the HFS caseworker determined that based on a family of four, her children were eligible for ALL KIDS Premium level 7 ($500 monthly premium plus co-pays).

In June 2010, the individual submitted new self-employment records for an income recalculation based on May 2010 income, indicating that her business is seasonal and she received little to no income from April until January. Since the individual had very little income for the month in which she requested the recalculation, the HFS caseworker determined her children were eligible for ALL KIDS Assist (No monthly premium payment or co-pays).

During our review, auditors found that HFS and DHS did not properly determine whether individuals actually were or were not self employed. Auditors found 2 cases in the sample of 99 where individuals originally indicated they were self employed on the application, but later indicated they were not self employed when asked to submit 30 days of detailed records (see Case Example 4). Auditors found an additional case where an individual was self employed, but did not indicate that on the application. In these three cases, the applicants submitted pay stubs from businesses that auditors found to be owned by the applicants, as opposed to providing 30 days of detailed business records as required. 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.

Case Example 4

An applicant stated on her original application that she and her husband were self employed and a 1040 tax return was submitted as proof of income. After a HFS caseworker requested 30 days of detailed records, the applicant withdrew the application.

Less than two months later, the applicant reapplied and stated on her application that she and her husband were both employed by the same company, both receiving the same salary. The individual submitted pay stubs from the company's payroll journal as proof of income.

Auditors found that the individual and her husband were listed as the company's president and secretary in business filings provided to the Secretary of State.

Social Security Numbers

According to HFS officials, enrollees are not required to submit social security numbers to be eligible for ALL KIDS. During the review, auditors determined that 31 of 99 enrollees did not provide social security numbers for either of the enrollee's parents. Of these 31 enrollees, 28 were undocumented immigrants. In 17 of 99 files reviewed, a social security number was provided for only one parent. Of these 17 applicants, 8 were undocumented immigrants.

Auditors found no control in place at HFS to verify the income reported by enrollees other than requiring the enrollee to provide a single pay stub or one month of financial records for the self-employed. HFS receives reports from the Department of Employment Security (IDES) that would allow HFS to determine whether family income has increased. However, the analysis is based on the working parent's social security number which is information that is not required to be submitted to HFS. In 48 percent of the cases reviewed, social security numbers were not provided for one or both of the parents. According to HFS officials, the report provided by IDES **is not used to verify income** for the initial determination or annual redetermination. As a result, there is no income verification process in place to determine whether all family income was reported on the ALL KIDS application.

During this audit, HFS officials responded that HFS planned to implement the new federal option under CHIPRA to use social security records to verify citizenship and identity. HFS also noted it planned to "Review the legal, financial and operational issues associated with adding verification requirements to those already in policy." As of October 1, 2010, HFS and DHS were still in the process of implementing these revisions. DHS agreed to work with HFS and noted it will review with casework staff the importance of proper documentation of eligibility factors.

As a result of the passage of Public Act 096-1501 on January 25, 2011, two changes were made related to eligibility documentation requirements. These changes required one month's worth of income verification for determining eligibility and requiring verification of Illinois residency. These changes are effective on July 1, 2011.

ELIGIBILITY DOCUMENTATION	
RECOMMENDATION NUMBER **10** Continued on following page	***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;*** • ***develop a system to verify eligibility criteria such as family size and family income to ensure that complete and accurate information was provided by the applicant; 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 is in the process of implementing the federally approved method of verifying citizenship and identity of anyone with a social security number. Verification of Illinois residence and a full month's income will be an eligibility requirement beginning July 1, 2011. The Department is also assessing the current verification requirements for self employment income to determine what other documentation should be required.
DEPARTMENT OF HUMAN SERVICES' RESPONSE	The Department agrees with the recommendation. As a result of the passage of Public Act 96-1501, effective July 1, 2011, verification of Illinois residency and one month of income will be required for eligibility redetermination. The Department follows current policy and procedure as created by the Department of Healthcare and Family Services (HFS) regarding eligibility documentation supporting birth, residency and identity. The Department will continue to work with HFS to review current written policy and operational issues related to verification of eligibility documentation.

REVIEW OF PAYMENT FOR HEALTH SERVICES

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

Controls Over Transportation Claims

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

Duplicate Transportation Bills

We identified 23 instances where transportation was double billed in a single day for a recipient (see Case Example 5). For these round trips, each origin time/location and destination time/location was identical. One provider billed 39 percent of these duplicate bills. As a result, auditors reported the provider to HFS and to the HFS-OIG. HFS-OIG noted it was aware of this provider and had initiated an audit of the provider's paid services. We also identified instances where

Case Example 5

A transportation provider submitted **two bills** to HFS for transportation of a recipient from their residence to a treatment facility on multiple occasions. For example, on one occasion, the provider submitted duplicate bills for transportation between 8:30 and 9:00 a.m. on the same day for the same recipient. Duplicate bills were also submitted for the same person for the return trip between 3:30 and 4:30 p.m. HFS did not identify the bills as duplicate and all the claims were paid.

travel times overlapped.

We discussed these issues with HFS officials. HFS provided a copy of project initiation request (PIR) that was submitted on July 21, 2008, which modified the HFS payment system to only allow one round trip claim per day per prior approval. According to HFS officials, once this is implemented the issue will be resolved.

Inaccurate Transportation Claim Details

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

- Transportation providers did not provide complete origin and destination locations, including only a street address or a city;
- Two recipients were picked up at locations which are 29 miles apart by the same vehicle at the exact same time;
- The origin and destination time were identical for every service provided in a day;
- A vehicle's destination time was the same as its origin time for another stop 14 miles away; and
- The origin times were later than the destination times.

Without accurate locations and times, there is no way to determine if the bills submitted are legitimate. Additionally, if controls are not in place for the EXPANDED ALL KIDS program, it is likely this issue would also be relevant to the ALL KIDS program as a whole.

TRANSPORTATION CLAIMS	
RECOMMENDATION NUMBER **11** Continued on following page	***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.***

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. A Project Initialization Request has been prepared to program an MMIS edit that will only allow one round-trip per prior approval number per day. The Department will also implement restrictions on origin and destination times and require the input of address and city information by providers to help ensure more accurate claim detail. A notice will also be sent to transportation providers reminding them to submit accurate claim details or they may be subject to recoupment. Additionally, the Department's OIG has a robust series of data analysis routines to identify aberrant billing patterns for transportation providers. Questionable transportation services are audited by the OIG, resulting in the establishment of overpayments and termination of the transportation provider, if appropriate.

Controls Over Optical Claims

Frames and Fittings

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 same recipient during the year. Specifically, auditors identified one provider with a large number of recipients receiving multiple frames and fittings during FY10.

Auditors identified 44 EXPANDED ALL KIDS recipients that claims data showed received four or more frames during FY10. Of the 44 recipients, 41 (93%) had fittings for their frames at one specific optical provider. These 41 recipients had 180 frames ordered through ICI and had 186 fittings billed by this one provider during FY10. As a result, these 41 recipients received frames and lenses totaling $4,560 and fittings totaling $5,597. Auditors found that 2 recipients each received 6 frames, 12 recipients received 5 frames, and 27 recipients received 4 frames.

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

In many instances, the provider ordered several pairs of complete glasses (frames and lenses) for multiple individuals with the same last name during 2010. These orders were often placed throughout the year and often were on the same days or within a few days. Case Example 6 shows where three individuals with the same last name all received four pairs of glasses all with the same services dates.

Without effective edits to identify potential abuse, HFS must rely on post audits conducted by the HFS-OIG in order to identify abuse and to recover dollars that should not have been reimbursed to providers. Due to this provider's high correlation of customers with multiple pairs of frames received during FY10, auditors reported this provider to HFS and to the HFS-OIG for further investigation. The HFS-OIG noted it was aware of this provider's billing patterns and is in the early stages of auditing this provider.

Case Example 6

Three individuals received four pairs of glasses each ordered by this provider from Illinois Correctional Industries during 2010. These individuals all had the same last name and the four pairs of glasses for each were ordered on the same four days. These individuals had service dates at the provider where the glasses were ordered on March 1, 2010, April 5, 2010, July 12, 2010, and November 1, 2010.

Eye Exams

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

During the review of FY10 claims submitted for eye exams, auditors identified 376 recipients that received more than one eye exam during FY10. These 376 recipients received 793 exams from 198 different providers. Of the 11,496 recipients that received exams in FY10, 3 recipients received 5 exams, 6 recipients received 4 exams, 20 recipients received 3 exams, and 347 received 2 exams. According to an HFS official, HFS did not receive an explanation from the provider as to why the additional exams were necessary. The official also noted that the only time the need for the additional examination would be reviewed by HFS is if the OIG conducts a post audit of the provider(s).

In some instances, these exams were billed by the same provider. In other instances, two or more providers billed for the exams. Auditors identified two providers that billed eye exams for seven EXPANDED ALL KIDS recipients on consecutive days during FY10. All seven of those recipients received an exam by Provider A and then received the same exam from Provider B on the following day. Although this occurred on a small scale, this appeared to be an outlier and was referred to HFS for review.

OPTICAL EDITS	
RECOMMENDATION NUMBER **12**	***The Department of Healthcare and Family Services should ensure that electronic billing edits exist to identify potential abuse related to the ordering of eyeglass frames and for the billing of exams and fittings. Additionally, HFS should identify and recoup unallowable past optical payments made to providers.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department will review the exceptions identified by the auditors and determine whether electronic billing edits should be implemented to help prevent optical claims abuse. If the Department finds providers have submitted fraudulent claims, payments will be recouped. Currently, providers identified with aberrant behaviors are referred to the Department's OIG for investigation.

Guidance and Controls 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. For example, a preventive medicine service claim for an adolescent between the age of 12 and 17 years old costs $84.62, while a 5 minute office visit for an established patient costs $12.88, a 10 minute office visit costs $25.65, a 15 minute office visit costs $46.56, and a 25 minute office visit costs $72.97.

Auditors identified 1,013 EXPANDED ALL KIDS recipients that received 3 or more preventive medicine services for healthy children during FY10. For these 1,013 recipients, providers billed 3,558 preventive medicine services totaling $268,930 during FY10. The analysis of the FY10 claims data showed that 3 recipients each had eight billings for preventive medicine service claims for healthy children, 7 recipients each had seven preventive medicine claims, 25 recipients each had six preventive medicine claims, 80 recipients each had five preventive medicine claims, 241 recipients each had four preventive medicine claims, and 657 recipients each had three preventive medicine claims. One provider billed three or more preventive medicine claims for 39 EXPANDED ALL KIDS recipients during FY10. Auditors reviewed billing instructions used by providers and found it difficult to determine whether billing multiple preventive medicine claims for healthy children is allowable. Although the American Medical Association's 2009 CPT (Current Procedural Terminology) manual does not say preventive medicine services are for annual preventive appointments, the intent of preventive medicine services appears to be for comprehensive annual reevaluations for healthy children.

GUIDANCE OVER PREVENTIVE MEDICINE SERVICE CLAIMS	
RECOMMENDATION NUMBER **13**	***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 will remind providers of the proper use and frequency limits of preventative services CPT codes. The Department will also initiate a manual review of claims that exceed the frequency requirements of these codes.

Controls Over Dental Billings

During our review of FY10 ALL KIDS Expansion 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.

Expenditures for dental services totaled $12.1 million in FY10 for EXPANDED ALL KIDS recipients. Dental service expenditures were second highest behind general inpatient hospital services (see Exhibit 3-2). HFS contracts with DentaQuest (previously Doral Dental) to be the dental adminsitrator for the State of Illinois. As part of this contract, DentaQuest provides adminsitrative, client, and provider services, which includes managing control edits over dental claims and paying and adjudicating these claims.

Inconsistencies in Dental Benefit Frequency Policies

During the review of policies related to dental claims, auditors found instances where the information in the benefit schedule differed from what services HFS officials said was provided and from what was posted on HFS' ALL KIDS Dental services webpage. For example, the dental benefit schedule states that a child can receive one teeth cleaning per six months. The ALL KIDS website also states that cleanings are allowed every six months. However, HFS and DentaQuest officials said that recipients could get their teeth cleaned twice in a dentist's office and twice in a school setting for a total of four in a year. In another instance, the ALL KIDS Dental services webpage states that children are limited to a periodic oral exam once every 12 months per dentist, whereas the Dental Office Reference Manual schedule of benefits states that children can receive an oral exam once every 6 months in an office setting and once every 12 months in a school setting.

Services in Excess of the Allowed Dental Benefit Schedule

Auditors found paid claims for dental services that exceeded the benefit limits published in HFS'/DentaQuest's Dental Office Reference Manual. This would indicate a weakness in controls over dental claims. Exhibit 3-3 shows some of the benefit limits for dental services.

Exhibit 3-3
DENTAL BENEFIT SCHEDULE
Fiscal Year 2010

Dental Service	Maximum benefit per benefit schedule		Rate of Reimbursement
	Practitioner's Office	School Setting	
Prophylaxis (cleaning)	**1** (per 6 months)		$41.00
Sealants	**8** (per lifetime)		$36.00
Initial/comprehensive oral evaluation	**1** (per lifetime per provider/location)		$21.05
Periodic oral evaluation	**1** (per 6 months)	**1** (per 12 months)	$28.00
Initial orthodontic evaluation	**1** (per lifetime)		$47.05
Topical fluoride varnish	**1** (per 12 months)	**1** (per 12 months)	$26.00

Source: DentaQuest Dental Office Reference Manual.

Prophylaxis (Teeth Cleaning)

We found 1,149 recipients that received more than the allowed two prophylaxes (teeth cleanings) in FY10. Case Example 7 shows an example of four cleanings received by one recipient in FY10. The HFS ALL KIDS website also notes that cleanings are allowed once every 6 months. When we discussed this with HFS and DentaQuest officials, officials noted that recipients can get their teeth cleaned twice in a dentist's office and twice in a school setting for a total of four in a year. For other services (such as topical application of fluoride and periodic oral exams), the Dental Office Reference Manual notes an additional benefit can be provided in a school setting. However, there is no such note for cleanings. HFS officials noted, "It is mentioned in the School-based Program FAQ section, but is not clearly stated elsewhere in the Dental Office Reference Manual

Case Example 7

One recipient received four teeth cleanings in FY10. The recipient had two in a school setting, and two in a dentist's office. Two of these cleanings were in August 2009, one in a school setting and one in a dentist's office. These cleanings were 16 days apart.

The same recipient received two more cleanings, one in February 2010 and one in March 2010. Once again, one cleaning was in a school setting and one in a dentist's office. These cleanings were 33 days apart.

(DORM)." HFS officials noted that they will work on making the language clearer in the DORM and include it in the next manual update.

Sealants

Auditors identified 13 recipients that received more than the allowed eight sealants in FY10. Ten of the 13 occurred before an edit went into effect on January 28, 2010, which was intended to prevent billings for greater than eight sealants per patient. Three of the 13 happened after the edit went into effect. For 2 of the 3 recipients, the excess sealant billings were recouped. For one, the provider realized their billing error and the claims were manually voided before the corrected claims were submitted.

Fluoride Varnishes

Auditors identified 38 recipients that received fluoride varnishes beyond the frequency allowed during FY10. Although recipients are allowed one topical fluoride varnish per 12 months in an office setting and one per 12 months in a school setting, we identified 38 that had two, both of which occurred in the same setting. In addition, 9 of the 38 had service dates that were between 1 and 56 days apart. Three of the 9 had service dates that were less than four days apart.

Billing Outliers

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

- Dentists with the highest costs per recipient;
- Dentists with high numbers of resins or amalgams per recipient;
- Dentists who performed a high number of three or four surface resins or amalgams;
- Dentists with high average number of services billed per visit;
- Dentists with high number services billed per day; and
- Recipients for which more than eight sealants were billed.

Some dentists fell into one or more of these categories. We met with and provided the HFS-OIG with examples of outliers from the FY09 data. Of the seven dentists we identified and provided to the HFS-OIG, three had already been reviewed by the HFS-OIG. One of the three had quality of care concerns identified. Three others were undergoing an audit as of August 2010.

We reviewed the FY10 dental claim data and found similar outliers as those in FY09. Following are examples of outliers we identified. We provided these outliers to HFS-OIG for their review. The HFS-OIG responded that it will utilize these findings to assess the impact across all Medical Assistance Programs and will take appropriate action as needed.

Resins and Amalgams (Fillings)

We reviewed FY10 claims for resins and amalgams (fillings) for the possibility of upcoding. Upcoding is the practice of billing for a higher level of service than what was performed, resulting in enhanced compensation. Fillings bill at different rates depending on how many sides of the tooth are filled. For example, as seen in Exhibit 3-4, a 1 surface amalgam is billed at $30.85; a 2 surface amalgam is billed at $48.15; and a 3 or 4 surface amalgam bills at $58.05.

Exhibit 3-4
COST OF FILLINGS BY TYPE
Fiscal Year 2010

Filling Type	Cost for Filling [1]
1 surface	$30.85
2 surface	$48.15
3 surface	$58.05
4 or more surface	$58.05

Note:

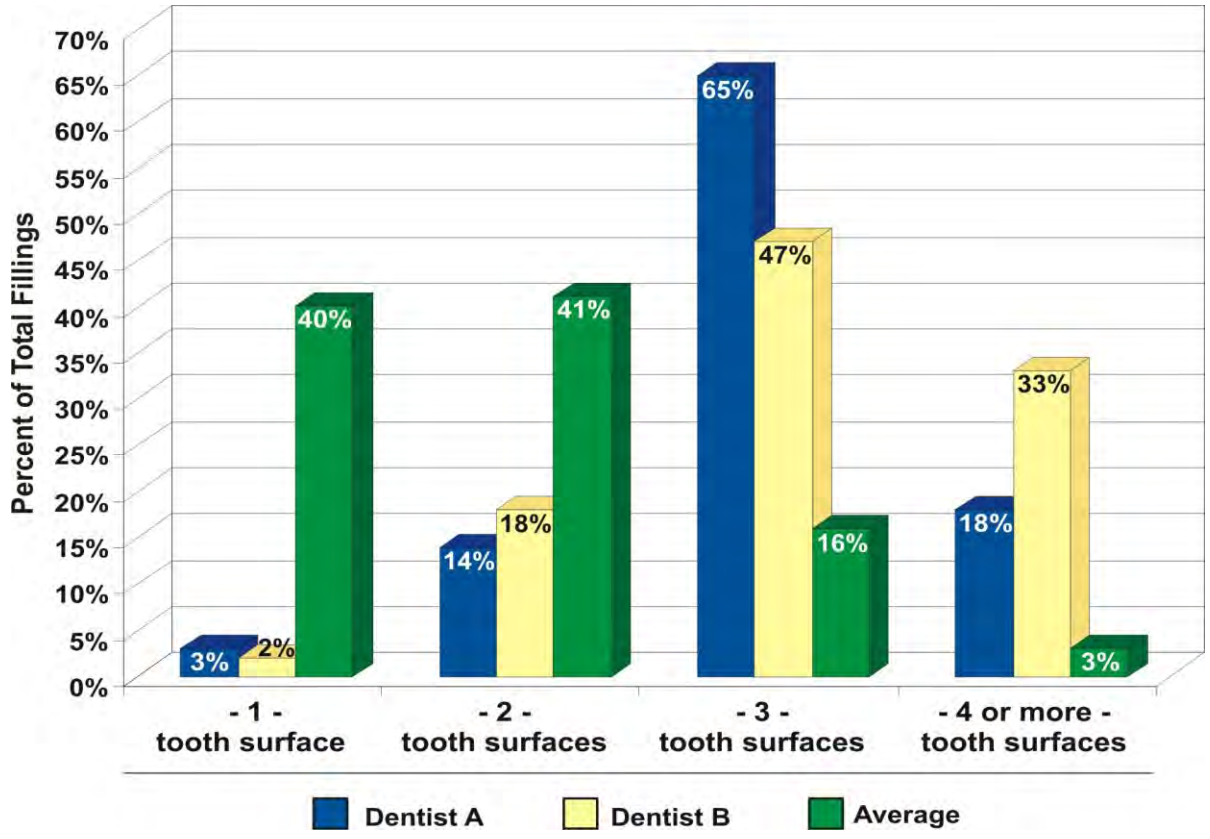
[1] Cost is for primary or permanent amalgams and posterior resin-based composites. Anterior resins bill at a slightly higher rate.

Source: FY10 claim data provided by HFS.

During our review of FY10 EXPANDED ALL KIDS dental claims, we reviewed dental billings for the 179 dentists who billed 100 or more fillings. Of these 179, we identified 17 dentists that billed 3 or more surface fillings for more than 40 percent of their billing in FY10. This was more than twice the average (19%) for 3 or more surface fillings by the other dentists who billed more than 100 fillings during FY10. For two dentists, 3 or more surface fillings accounted for 80 percent of their total fillings. Exhibit 3-5 is a chart of these two dentists compared to the average percents of total fillings.

On average for dentists who billed more than 100 fillings in FY10, 1 surface fillings and 2 surface fillings each accounted for approximately 40 percent of the fillings billed during FY10. The average number of 3 surface fillings for the population of dentists was 16 percent and the average number of 4 or more surface fillings was 3 percent of their total fillings.

Exhibit 3-5
FY10 FILLING OUTLIER EXAMPLES



Source: OAG analysis of HFS data.

Average Cost and Services per Recipient Outliers

Auditors found dentists that had average number of services and average costs per recipient that were significantly higher than the average dental provider. For example, the average number of services per recipient for FY10 was 5.9; however, four dentists charged, on average, double the number of services per recipient (11.8) or more. The dentist with the highest average number of services per recipient had 44 recipients and charged on average 14.7 services per recipient. All four dentists had 30 or more recipients.

The same four dentists with the highest average number of services per recipient also had the four highest cost per recipient ratios. In FY10, the average cost per recipient was $181. The average for these four dentists ranged from approximately $430 to $584.

Auditors identified one dentist with over 800 recipients that had an average cost per recipient of $290, when the average cost per recipient was $181. Similarly, another dentist, with over 500 recipients had an average cost per recipient of $270 compared to the $181 average.

Auditors also identified 22 recipients that had seven or more tooth extractions in one day. Six recipients had 10 or more, including one recipient with 31 extractions in one day.

PAYMENTS BEYOND DENTAL BENEFIT LIMITATIONS	
RECOMMENDATION NUMBER **14**	***The Department of Healthcare and Family Services should:*** • ***strengthen controls to ensure that dental providers are not paid for services beyond benefit limitation;*** • ***ensure that dental policies or other information available to the public accurately states frequency of benefits; and*** • ***identify and recoup unallowable past dental payments made to providers.***
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department accepts the recommendation. The Department is requiring DentaQuest, the contracted vendor responsible for administration of the dental claims processing, to have an audit performed to ensure the business rules of their claims processing system are properly configured as detailed in the Dental Office Reference Manual. DentaQuest's Quality Assurance team will test the edits and continue to audit claims on an ongoing basis to ensure that processing policies are working according to the Department's Dental Program requirements. The Dental Office Reference Manual will be reviewed by the Department's dental program staff and DentaQuest and any policies that are unclear or incorrect will be updated. The Department has reduced DentaQuest's March 2011 administrative payment to recover the funds that were overpaid to dental providers in 2009 and 2010.

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, 2011)
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, 2011)
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 170/10)
(Section scheduled to be repealed on July 1, 2011)
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, 2011)
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 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.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/20)
(Section scheduled to be repealed on July 1, 2011)
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; and
(2) who is ineligible for medical assistance under the Illinois Public Aid Code or benefits under the Children's Health Insurance Program Act; and
(3) either (i) who has been without health insurance coverage for a period set forth by the Department in rules, but not less than 6 months during the first month of operation of the Program, 7 months during the second month of operation, 8 months during the third month of operation, 9 months during the fourth month of operation, 10 months during the fifth month of operation, 11 months during the sixth month of operation, and 12 months thereafter, (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.
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 for the purpose of determining eligibility for the Program under this Act.
The Department of Healthcare and Family Services, in collaboration with the Department of Financial and Professional Regulation, Division 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; if the required monthly premium is not paid, the child is ineligible for re-enrollment for a minimum period of 3 months; 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 shall adopt eligibility rules, including, but not limited to: rules regarding annual renewals of eligibility for the Program; 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.

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

(215 ILCS 170/25)

(Section scheduled to be repealed on July 1, 2011)

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)
(Text of Section before amendment by P.A. 95-985)
(Section scheduled to be repealed on July 1, 2011)
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.
(Source: P.A. 94-693, eff. 7-1-06.)

(Text of Section after amendment by P.A. 95-985)
(Section scheduled to be repealed on July 1, 2011)
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 and in no less than 2 newspapers in the State the premiums or other cost sharing requirements of the Program.
(Source: P.A. 94-693, eff. 7-1-06; 95-985, eff. 6-1-09.)

(215 ILCS 170/35)
(Section scheduled to be repealed on July 1, 2011)
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.

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

(215 ILCS 170/40)

(Section scheduled to be repealed on July 1, 2011)

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 170/45)

(Text of Section before amendment by P.A. 95-985)

(Section scheduled to be repealed on July 1, 2011)

Sec. 45. Study.

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

(Text of Section after amendment by P.A. 95-985)

(Section scheduled to be repealed on July 1, 2011)

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, 2011)

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, 2011)

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, 2011)

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, 2011)

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 170/55)

(Section scheduled to be repealed on July 1, 2011)

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 170/60)

(Section scheduled to be repealed on July 1, 2011)

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)
(This Section may contain text from a Public Act with a delayed effective date)
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, 2011)
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, 2011)
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, 2011)
Sec. 98. Repealer. This Act is repealed on July 1, 2011.
(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/99)
(Section scheduled to be repealed on July 1, 2011)
Sec. 99. Effective date. This Act takes effect July 1, 2006.
(Source: P.A. 94-693, eff. 7-1-06.)

APPENDIX B

Sampling & Analytical Methodology

Appendix B

SAMPLING & ANALYTICAL 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 second annual audit directed by the Covering ALL KIDS Health Insurance Act.

During the fieldwork phase, we followed up on the previous audit's recommendations. Since the FY09 audit was released in May 2010, more than 10 months into the FY10 audit period, many of the steps that HFS and DHS are taking to address the recommendations were not implemented as of October 2010. Therefore, most of the follow-up on these recommendations will be conducted during the FY11 audit. Due to no further ALL KIDS contracts, HFS had no specific updates to these recommendations. However, HFS noted it will ensure the recommendations/responses are addressed if there are future ALL KIDS contracts. In future audits of the EXPANDED ALL KIDS program, we will follow-up on these contract recommendations as new ALL KIDS contracts are executed.

In addition to the recommendations from the last audit (FY09), the FY10 audit identified eight additional areas for recommendations. Some of these additional recommendations were added to related existing recommendations from the previous audit.

Fieldwork for this audit was conducted in August through November 2010. During the audit, we met with representatives from the Department of Human Services, the Department of Healthcare and Family Services, the Department of Healthcare and Family Services Office of the Inspector General, and the State Police Medicaid Fraud Control Bureau. We requested EXPANDED ALL KIDS claim and enrollment data for FY10. Auditors determined that due to incorrect categorization of documented immigrants within the enrollment data provided by HFS, this report overstates the number of undocumented immigrants and their associated cost and understates the number of documented immigrants and their associated costs.

In conducting this audit we reviewed applicable State and federal laws and regulations as well as DHS and HFS policy manuals and action guides. Compliance requirements were reviewed and tested to the extent necessary to meet audit objectives. Instances of non-compliance are included in this report. We also determined whether any issues with the data or identified by the data are a result of a lack of management controls. Additionally, we tested management controls over the premiums that are paid by enrollees.

During the audit, we performed testing on several areas. The main sample for the audit was a review of client files. Our sample was stratified to ensure inclusion of all program plan levels and a relatively equal number of citizens/documented immigrants versus undocumented immigrants. We then randomly selected claims by program plan level to obtain our sample of 100 paid claims during FY10 to test. See exhibit for the specific number of claims tested within each plan. None of the sample results in this audit can be projected to the population.

CLAIMS TESTED BY PLAN
Fiscal Year 2010

ALL KIDS Plan	Citizens/ Documented Immigrants Sample Size	Undocumented Immigrants Sample Size
Assist	n/a	20
Share	n/a	10
Premium	n/a	10
Premium Level 2	25	3
Premium Level 3	7	2
Premium Level 4	5	2
Premium Level 5	4	1
Premium Level 6	3	1
Premium Level 7	3	0
Premium Level 8	3	1
Total	**50**	**50**

During testing, we compared electronic data to the hard copy file to check for reliability, and we reviewed the claim to ensure that it wasn't a duplicate payment. We also tested:

- whether the child was eligible at the time the service was provided;
- whether the child's premium was paid at the time of the service;
- whether the necessary documentation was obtained by HFS/DHS to determine eligibility;
- whether documentation in the case file matched what is found in the database;
- whether the child was placed in the appropriate ALL KIDS program;
- whether the redetermination notice was sent to enrollees as required by administrative rule; and
- whether the redetermination was returned (if required).

We also analyzed payment and eligibility data to determine:

- whether individuals listed on the HFS March 2010 cancellation report received services after the 30 day grace period, and the cost of the services after the 30 day grace period; and
- whether enrollees received services after the month of their 19th birthday.

HFS officials reported that there were no contracts specific to the ALL KIDS Expansion for FY10. We have, however, received the deliverable for the U of I contract that was received in FY10. The deliverable, a report of survey information gathered regarding health insurance coverage for children in Illinois, was reviewed during fieldwork for completeness/compliance with the contract requirements.

We reviewed risk and internal controls related to the EXPANDED ALL KIDS program related to the audit objectives. Weaknesses in internal controls are included as findings in this report.

APPENDIX C

Covering ALL KIDS Health Insurance Act Plans

Appendix C
COVERING ALL KIDS HEALTH INSURANCE ACT PLANS

	Premium	Max Monthly Premium	Physician Visit	Emergency Room Visit	Generic/ Brand Name Drug	Inpatient Admission	Outpatient Service	Annual Out-of-Pocket Max.
Assist	None	n/a	None	None	None	None	None	None
Share	None	n/a	$2	$2	$2	$2	$2	$100 per family
Premium Level 1	$15 (1) $25 (2) $30 (3) $35 (4) $40 (5+)	$40	$5	$25	$3/$5	$5	$5	$100 per family
Premium Level 2	$40 per child	$80	$10	$30	$3/$7	$100	5% of ALL KIDS payment rate	$500 per child
Premium Level 3	$70 per child	$140	$15	$50	$6/$14	$150	10% of ALL KIDS payment rate	$750 per child
Premium Level 4	$100 per child	$200	$20	$75	$9/$21	$200	15% of ALL KIDS payment rate	$1,000 per child
Premium Level 5	$150 per child	None	$25	$100	$12/$28	10% of ALL KIDS payment rate	20% of ALL KIDS payment rate	$5,000 per child
Premium Level 6	$200 per child	None	$25	$100	$12/$28	10% of ALL KIDS payment rate	20% of ALL KIDS payment rate	$5,000 per child
Premium Level 7	$250 per child	None	$25	$100	$12/$28	10% of ALL KIDS payment rate	20% of ALL KIDS payment rate	$5,000 per child
Premium Level 8	$300 per child	None	$25	$100	$12/$28	25% of ALL KIDS payment rate	25% of ALL KIDS payment rate	None

Source: ALL KIDS Final Report –July 2010.

APPENDIX D
ALL KIDS Application

State of Illinois
Illinois Department of Healthcare and Family Services

All Kids Healthcare for All Kids

FamilyCare

Moms & Babies

Application

for All Kids, FamilyCare, and Moms & Babies Health Insurance

Nothing is more important than making sure your family has access to healthcare. Programs like these make that possible. Thank you for taking the time to complete this application. You can also apply online at www.allkids.com.

- **All Kids** covers children who need health insurance. Some families who pay for private health insurance for their children may qualify for help to pay their premiums.
- **FamilyCare** covers parents living with their children age 18 or younger. FamilyCare also covers grandparents or other relatives who are raising children in place of their parents. Some families who pay for private health insurance may qualify for help to pay their premiums.
- **Moms & Babies** covers pregnant women and their babies.

Apply now! Print in ink. Answer all the questions. If you need more space use an extra sheet of paper. If someone in your family already gets All Kids, FamilyCare or Moms & Babies, you do not need to file a new application. Call your customer service representative or caseworker.

Tell us about the applicant.

The applicant is usually the person filling out this form. The applicant should be the parent, guardian, or relative a child lives with, or a pregnant woman.

Applicant's name _____
Last First

Birth date __ __ / __ __ / __ __ __ __ (m m / d d / y y y y) **Social Security Number** __ __ __ - __ __ - __ __ __ __ Optional

Address _____ **Apt. #** _____

City _____ **State** _____ **Zip** _____ **County** _____

Phone (_____) _____ Home, (_____) _____ Work

If you do not have a phone and we can reach you by calling someone else, tell us who.

Name _____, Phone ( ) _____

How many people live with you? _____ **How many of them want health insurance or help paying premiums?** _____

What language do you use the most? ☐ English ☐ Spanish ☐ Other _____

You can help us by answering the next two questions, but you do not have to tell us.

Are you of Hispanic or Latino origin? ☐ Yes ☐ No

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown (Mark **all** that apply.)

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

Tell us about the people who want health insurance or want help to pay premiums.

Be sure to list yourself if you want health insurance or want help to pay premiums.

Person #1	Person #2	Person #3
1. Name		
(Last, First)	(Last, First)	(Last, First)
2. Sex		
☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
3. Birth date		
__ __/__ __/__ __ __ __ (mm/dd/yyyy)	__ __/__ __/__ __ __ __ (mm/dd/yyyy)	__ __/__ __/__ __ __ __ (mm/dd/yyyy)
4. Tell us the Social Security Number, if the person has one. If they applied for one, tell us the date. ✔ Send proof they applied. **For anyone else, write N/A.**		
__ __ __-__ __-__ __ __ __ ☐ This person applied for a number on _____. (mm/dd/yyyy)	__ __ __-__ __-__ __ __ __ ☐ This person applied for a number on _____. (mm/dd/yyyy)	__ __ __-__ __-__ __ __ __ ☐ This person applied for a number on _____. (mm/dd/yyyy)
5. How is this person related to the applicant?		
☐ Son ☐ Daughter ☐ Self ☐ Spouse ☐ Other: _____	☐ Son ☐ Daughter ☐ Self ☐ Spouse ☐ Other: _____	☐ Son ☐ Daughter ☐ Self ☐ Spouse ☐ Other: _____
6. Is this person an American Indian or Alaska Native?		
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Has this person received medical care in the past 3 months that you want us to pay for? If yes, tell us which months. ✔ Send proof of income for each month, if different from your current income.		
☐ Yes ☐ No 1. _____ 2. _____ 3. _____	☐ Yes ☐ No 1. _____ 2. _____ 3. _____	☐ Yes ☐ No 1. _____ 2. _____ 3. _____
8. Is this person pregnant or has this person been pregnant in the last 3 months? ✔ If yes, send a signed statement from a doctor or health clinic with the expected date of delivery and the number of the babies expected.		
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

Person #1	Person #2	Person #3
9. Is this person a U.S. citizen? If yes, tell us where they were born.		
☐ Yes City:_____ State:_____ ☐ No	☐ Yes City:_____ State:_____ ☐ No	☐ Yes City:_____ State:_____ ☐ No

✔ If yes, provide one of the following documents: U.S. Passport, Certificate of Naturalization (N-550 or N-570) or Certificate of Citizenship (N-560 or N-561).
If these are not available, provide one item from each column:

Place of birth –

- Certified copy of a birth certificate from the state or county where the person was born;
- Final Adoption Decree;
- Official military record that shows a place of birth;
- Papers showing the person was employed by the U.S. government before 1976.

Identity –

- Driver's license;
- State issued ID card;
- School ID;
- U.S. military ID;
- U.S. military dependent card; or
- Other government ID (city, county or U.S. state issued).
- For children under age 16:
  - School or day care records or a report card, OR
  - A parent or guardian's signature on page 7 of this application

Read page 9 for more information on how to get your birth certificate.

10. If this person has a valid Alien Registration Number, write it below and provide proof. Pregnant women and children who do not have an Alien Registration Number may still get health insurance.

✔ Send a copy of one of the items listed below as proof for each Alien Registration Number you list on this form.

- Alien Registration Receipt Card, Permanent Resident Card or Green Card
- Passport with the following stamps or attachments: Arrival-Departure Record (I-94) including the stamp showing status, Resident Alien Form (I-551) or Temporary Resident Card (I-688)
- A court-ordered notice for asylees
- Other proof of lawful immigration status

Receiving most public health benefits should not affect a person's immigration status. The U.S. Citizenship and Immigration Service may consider someone to be a public charge if they live in long-term care, like a nursing home or mental health facility that the government pays for.

Person #1	Person #2	Person #3
11. Has this person had health insurance or Medicare any time in the last 12 months? If yes, complete all of the following.		
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Month, Day and Year Coverage Began __ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __
If the insurance ended, tell us the month, day and year it ended and why. __ __ / __ __ / __ __ __ __ ☐ Someone's job ended ☐ Met lifetime limit ☐ Other: _____	__ __ / __ __ / __ __ __ __ ☐ Someone's job ended ☐ Met lifetime limit ☐ Other: _____	__ __ / __ __ / __ __ __ __ ☐ Someone's job ended ☐ Met lifetime limit ☐ Other: _____
Insurance Company		
Name of Policyholder		
Policyholder's SSN (optional) __ __ __ - __ __ - __ __ __ __	__ __ __ - __ __ - __ __ __ __	__ __ __ - __ __ - __ __ __ __
Employer Name		
Phone Number ( )	( )	( )
Policy Number		
Group Number		
Are both physician and hospital services covered? ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is this COBRA insurance? COBRA is group insurance you buy from a former job. ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Relationship to policyholder		
If this person cannot use the insurance, tell us why.		

12. For anyone 18 or younger, we need their parents' names. You can help us by answering the other questions, but you do not have to tell us. **For anyone without this information, write N/A.**

Mother's full name: SSN: __ __ __ - __ __ - __ __ __ __ Employer: ☐ Full-time ☐ Part-time	**Mother's** full name: SSN: __ __ __ - __ __ - __ __ __ __ Employer: ☐ Full-time ☐ Part-time	**Mother's** full name: SSN: __ __ __ - __ __ - __ __ __ __ Employer: ☐ Full-time ☐ Part-time
Father's full name: SSN: __ __ __ - __ __ - __ __ __ __ Employer: ☐ Full-time ☐ Part-time	**Father's** full name: SSN: __ __ __ - __ __ - __ __ __ __ Employer: ☐ Full-time ☐ Part-time	**Father's** full name: SSN: __ __ __ - __ __ - __ __ __ __ Employer: ☐ Full-time ☐ Part-time

Person #1	Person #2	Person #3

13. For anyone who is married, tell us about their spouse. You can help us by answering these questions, but you do not have to tell us. **For anyone without this information, write N/A.**

Spouse's full name:	**Spouse's** full name:	**Spouse's** full name:
SSN: __ __ __-__ __-__ __ __ __	SSN: __ __ __-__ __-__ __ __ __	SSN: __ __ __-__ __-__ __ __ __
Employer:	Employer:	Employer:
☐ Full-time ☐ Part-time	☐ Full-time ☐ Part-time	☐ Full-time ☐ Part-time

Tell us about other people in your family and your income.

14. We need to know about your family group to decide if you can get health insurance.
Family group means people in your family who live with you. You, your spouse, any children 18 or younger and their parents, if they also live with you, make up your family group.

Tell us about anyone in your family group who is NOT asking for health insurance.

Name _____ SSN (optional) __ __ __-__ __-__ __ __ __

Birth date __ __/__ __/__ __ __ __ Relationship to applicant _____

Name _____ SSN (optional) __ __ __-__ __-__ __ __ __

Birth date __ __/__ __/__ __ __ __ Relationship to applicant _____

Name _____ SSN (optional) __ __ __-__ __-__ __ __ __

Birth date __ __/__ __/__ __ __ __ Relationship to applicant _____

15. Is any adult, parent, stepparent, spouse or pregnant woman named on this form currently employed? ☐ Yes ☐ No

Is anyone named on this form self-employed or own their own business? ☐ Yes ☐ No

If yes, complete the following. If you own your own business or are self-employed, enter "self" for employer.

✔ Send a copy of one pay stub (including tips) received in the last 30 days from each job.
If anyone is self-employed, provide 30 days of detailed business records that include income and expenses. For a sample form, visit www.allkids.com.

Name _____ Employer _____

Employer address _____ Phone (_____)_____

Number of hours worked weekly _____ Amount paid before taxes (include tips, bonuses, commissions) _____ How often paid _____

Name _____ Employer _____

Employer address _____ Phone (_____)_____

Number of hours worked weekly _____ Amount paid before taxes (include tips, bonuses, commissions) _____ How often paid _____

Name _____ Employer _____

Employer address _____ Phone (_____)_____

Number of hours worked weekly _____ Amount paid before taxes (include tips, bonuses, commissions) _____ How often paid _____

16. Is anyone named on this form GETTING money from any source other than employment (such as Social Security, child support, spousal support, rental property, unemployment benefits, pensions, trusts)? ☐ Yes ☐ No **If yes, tell us about them.**

✔ Send proof of one payment received in the last 30 days for each source of income you list.

Name _____ Source _____

Payment amount _____ How often paid _____

If this is rental property income, does the person receiving the income manage the property? ☐ Yes ☐ No

Name _____ Source _____

Payment amount _____ How often paid _____

If this is rental property income, does the person receiving the income manage the property? ☐ Yes ☐ No

Name _____ Source _____

Payment amount: _____ How often paid _____

If this is rental property income, does the person receiving the income manage the property? ☐ Yes ☐ No

17. Is anyone named on this form PAYING child support or spousal support? ☐ Yes ☐ No **If yes, tell us how much they paid in the last month.**

✔ Send proof of one payment made to each person in the last 30 days.

Name _____ Amount _____ How often paid _____

Name _____ Amount _____ How often paid _____

18. Is anyone named on this form PAYING for child care so they can work? ☐ Yes ☐ No **If yes, tell us how much they paid in the last month for each child.**

Name of child in child care _____ **Name** of care giver _____

Person paying for care _____ Payment amount _____

Relationship of care giver to child (if any) _____ How often paid _____

Name of child in child care _____ **Name** of care giver _____

Person paying for care _____ Payment amount _____

Relationship of care giver to child (if any) _____ How often paid _____

Name of child in child care _____ **Name** of care giver _____

Person paying for care _____ Payment amount _____

Relationship of care giver to child (if any) _____ How often paid _____

19. Please tell us how you heard about All Kids.

Check all the boxes that apply.

- ☐ Radio ad
- ☐ TV ad
- ☐ Billboard
- ☐ Newspaper ad or story
- ☐ Mail sent to my home
- ☐ Internet or Website
- ☐ Doctor's office
- ☐ Clinic
- ☐ Hospital
- ☐ Friend or relative
- ☐ Employer
- ☐ School
- ☐ Government office or agency
- ☐ W.I.C. site
- ☐ Labor union
- ☐ Other: _____

Read and sign.

Read carefully, then sign and date the application below.

1. We will keep what you tell us private as required by law.
2. Some families have to make a payment each month for this health insurance. This payment is called a premium. The amount of the premium depends on the family's income.
3. Some families have to pay part of the bill when they visit the doctor, go into the hospital or get a prescription filled. These payments are called co-payments. The amount of co-payment depends on the family's income.
4. You agree the state may seek reimbursement for services the state covered for your family if those services should have been paid for by any other health coverage your family may have.
5. Be sure to answer the questions correctly. We may check all information on this form. You must help us if we ask you to prove that your information is right.
6. We will **not** share any information about immigration of any person who does not have an Alien Registration Number. We **will** verify the immigration status of any person if you gave us their Alien Registration Number. To do that, we will check the number with the U.S. Citizenship and Immigration Service (USCIS). We may send other information to USCIS, such as copies of proof you sent of an Alien Registration Number and the person's Social Security Number, if they have one.
7. You must tell your All Kids or FamilyCare representative within 10 days if any of the following happens:
   - Your income changes.
   - The number of people in your family who live with you changes.
   - Your address or phone number changes.
   - Someone who gets health benefits moves out of Illinois, dies, or goes to jail or prison.
8. If we pay medical bills for you, you give your right to collect medical support payments to the State of Illinois. You must help us if we ask you to establish paternity or obtain medical support payments for members of your family. You may not have to do this if you have a good reason not to. Your children can get health insurance even if you do not help us when we ask you to help.
9. Anyone who misuses our health insurance card may be committing a crime.

I declare under penalty of perjury that I have read all statements on this form and the information I give is true, correct and complete to the best of my knowledge. I understand that I could be penalized if I knowingly give false information.

Applicant's signature _____ Date _____
(Make a mark and have another adult sign next to your mark if you cannot sign your name.)

If you completed this application on behalf of the Applicant, sign and complete the following.

Signature _____ Date _____ Phone (____)_____

Name (print) _____ Relationship to applicant _____

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

Final checklist

- Did you answer all the questions on the application?
- Did you sign and date the application?
- Do you have copies of all the proofs we said you would need? All the information that needs proof is marked with a ✔ .
- If you want to apply for rebates, did you get both sides of the Rebate Form completed and signed?

Mail your application along with copies of any proof to:

All Kids Unit
P. O. Box 19122
Springfield, IL 62794-9122

If you use the envelope that came with this application, you do not need to use a stamp.

Next steps

- If any information changes after you send the application, call toll-free 1-866-All-Kids (1-866-255-5437) to tell us what changed. If you use a TTY, call 1-877-204-1012.
- We will review your application as quickly as possible.
- If we find something is missing, we will send you a letter telling you what else to send.
- Please allow 45 days for us to make a decision.
- We will send you a notice to tell you if you can get All Kids, FamilyCare or Moms & Babies. If you do not qualify, we will also send a notice and tell you why.

Other important information

- If your children already have an All Kids card, do not apply again. If you want to add someone to your All Kids, FamilyCare or Moms & Babies health plan, you do not have to send a new application. Call your caseworker at the Illinois Department of Human Services (DHS) or call your All Kids customer service representative to add another family member.

- If your family has child support or Social Security income, a stepparent in the home, high medical bills, or you are applying for a disabled family member or one who is 65 or older, it may be better for you to apply at your DHS Family Community Resource Center. For more information, call toll-free 1-866-All-Kids (1-866-255-5437). If you use a TTY, call 1-877-204-1012.

- If you are not satisfied with the actions taken on your application, you have the right to a fair hearing. You can ask for a fair hearing by writing your local office, or by writing the Department at Bureau of Administrative Hearings, 401 South Clinton Street, Sixth Floor, Chicago, Illinois 60607 or by calling 1-800-435-0774. If you use a TTY, call 1-877-734-7429. **Use these numbers only to file an appeal.** All other calls and inquiries should be directed to 1-866-All-Kids (1-866-255-5437). If you use a TTY, call 1-877-204-1012.

- All Kids, FamilyCare and Moms & Babies are open and accessible without regard to sex, race, disability, national origin, religion or age. The State of Illinois is an equal opportunity employer that practices affirmative action. The State of Illinois provides reasonable accommodations according to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

U.S. citizenship documents

Because of a new federal law, we must ask people who are United States citizens to send us documents that prove they are citizens. This new law affects all children and adults who apply for medical benefits if they are U.S. citizens.

If you do not have these documents for anyone in your family who is a U.S. citizen, you must try to get them.

You can get birth certificates from the state or county where the person was born. You may have to pay for official copies of birth certificates. Usually, you need to know the person's name, date of birth and parents' names to order their birth certificate.

- Persons who were born in Illinois can get their birth certificate from the county where they were born. Here are a few county phone numbers and websites:

County	Phone	Website
Champaign	1-217-384-3720	www.champaigncountyclerk.com/vitals
Cook	1-312-603-7799	www.cookctyclerk.com
DuPage	1-630-682-7035	www.co.dupage.il.us
Jackson	1-618-687-7360	www.co.jackson.il.us/elected/co_clerk.htm
Kane	1-630-232-5950	www.co.kane.il.us/coc
Lake	1-847-377-2411	www.co.lake.il.us/cntyclk/vital
Peoria	1-309-672-6059	www.co.peoria.il.us (Select "Get Vital Records")
Rock Island	1-309-786-4451	www.co.rock-island.il.us
St. Clair	1-618-277-6600	www.co.st-clair.il.us (Select "B")
Will	1-815-740-4615	www.willclrk.com/vitalrecords.htm

You can get a complete list of where to go for a birth certificate for any county in Illinois on the Internet at **www.idph.state.il.us/vitalrecords/countylisting.htm**. The Illinois Department of Public Health can help you find a county office if you call **1-217-782-6553**. If you use a TTY, call 1-800-547-0466. The call is free.

- Persons who were born in Illinois can also get birth certificates from the Illinois Department of Public Health by calling **1-217-782-6553**. You can order your birth certificate over the Internet at **www.idph.state.il.us/vitalrecords** if you use a credit card.
- The National Center for Health Statistics can help you find out where to get birth certificates for people who were born in a state other than Illinois. Call **1-866-441-6247**. The call is free. If you can use a computer, visit **www.cdc.gov/nchs**.

If you cannot get these documents, call 1-866-All-Kids to tell us why. If you use a TTY, call 1-877-204-1012. The call is free. There may be other documents that you can use to show that you or your family member is a U.S. citizen.

Other benefit programs offered by the State of Illinois

Veterans Care offers access to affordable, comprehensive healthcare to veterans across Illinois. Veterans pay an affordable monthly premium of $40 or $70 and receive medical, dental and vision coverage. For additional information, please visit www.illinoisveteranscare.com or call 1-877-4VETS-RX. If you use a TTY, call 1-877-204-1012.

Illinois Cares Rx provides a safety net for seniors and persons with disabilities so they won't have to pay more out of pocket under the Medicare drug plan. To find out more, visit www.illinoiscaresrx.com or call the Illinois Health Benefits hotline at 1-800-226-0768. If you use a TTY, call 1-877-204-1012.

The **Illinois Rx Buying Club** provides an average discount of 24% at many Illinois pharmacies. To get more information or to enroll visit www.illinoisrxbuyingclub.com or call 1-866-215-3462. If you use a TTY, call 1-866-215-3479.

Health Benefits for Workers with Disabilities is a comprehensive healthcare program for employed persons with disabilities. Working individuals between the ages of 16 and 64 may be eligible. To download an application, visit www.hbwdillinois.com or call 1-800-226-0768. If you use a TTY, call 1-866-675-8440.

HFS Medical Benefits provides comprehensive healthcare for low-income seniors and persons of any age with disabilities. To apply, visit a local Department of Human Services office. To find an office nearby, call 1-800-843-6154. If you use a TTY, call 1-800-447-6404. You can download a mail-in application by visiting www.health.illinois.gov.

The **Low Income Home Energy Assistance Program (LIHEAP)** helps qualified households pay for winter energy services. The amount of the benefit depends on income, household size, fuel type and geographic location. Visit www.liheapillinois.com/community.html.

The **Illinois Department of Human Services' Child Care Program** provides low-income, working families with access to quality, affordable child care. Parents can learn about child care in their community and see if they qualify for a subsidy by contacting their local Child Care Resource and Referral agency (CCR&R). Visit www.ilchildcare.org or call 1-800-649-1884 to find your local CCR&R.

The **HFS Division of Child Support Enforcement (DCSE)** will help anyone who needs support for a child. DCSE helps parents and caretakers locate the parent who does not live with the child, legally establish the child's father, get child support or medical coverage and change the amount a parent has to pay for child support. Services are free. You can apply for services by visiting www.ilchildsupport.com, by calling 1-800-447-4278 or by visiting a DCSE office. If you use a TTY, call 1-800-526-5812. The call is free.

If you are interested in registering to vote, please go to www.elections.il.gov/ or call the Department of Human Services Helpline at 1-800-843-6154 or 1-800-447-6404 (for TTY). If you would like assistance or need translation services, please contact your DHS Family Community Resource Center.

Rebate Form for All Kids and FamilyCare

Use this form if you want All Kids or FamilyCare Rebate.

A rebate is a monthly amount we will pay you if you already pay for health insurance for yourself, your spouse or your children. If you choose to get rebates, you will use your current insurance card to get healthcare.

Only families who have health insurance can get rebate payments. Also, only families with a certain amount of income can get rebates. You may be able to get rebates for your children if your family is like one in the list below. The income amounts for adults are lower.

- ☐ You are the **only** person in your family → You may qualify for rebates if the income you get each month is between $1,201 and $1,805.
- ☐ You have **two** people in your family → You may qualify for rebates if the income you get each month is between $1,616 and $2,428.
- ☐ You have **three** people in your family → You may qualify for rebates if the income you get each month is between $2,030 and $3,052.
- ☐ You have **four** people in your family → You may qualify for rebates if the income you get each month is between $2,445 and $3,675.

Add $623.00 for each additional person.

To ask for rebates, you must send this form **with** the rest of your application.

Part A

The main person whose name is on the insurance must sign this part of the form. Often this person is called the policyholder. This person may get the health insurance from a job.

Policyholder's name _____
Last First

Home Address _____ **Apt. #** _____

City _____ **State** _____ **Zip** _____

SSN __ __ __ - __ __ - __ __ __ __ **Phone** (_____) _____

We must have the SSN (Social Security Number) so we can pay the rebate to this person.

Policy Number _____ **Group Number** _____

Tell us the names of the family members you want rebates for.

_____

_____

I agree to call All Kids/FamilyCare right away if this health insurance ends, someone is added or taken off the health insurance, the amount paid for the insurance changes, covered benefits change or someone else becomes the policyholder.

I authorize my employer, plan administrator and insurance company to provide the information requested in Part B on the next page for the purpose of determining whether I qualify for All Kids/FamilyCare. I also authorize my employer, plan administrator and insurance company to verify my coverage and any of the information below for any time when I get All Kids/ FamilyCare Rebate.

Signature of Employee/Policyholder _____

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

Part B

This part of the form must be completed by the employer providing the health insurance or the insurance agent.

Note to Employer/Insurance Agent: The employee/policyholder named on the front of this form is applying for help to cover the cost of their family's health insurance premiums. Please assist them by completing the information below and returning the form to the employee/policyholder as soon as possible. (As used below, "employee" applies to an employee or private policyholder.) For help in completing this form, call toll-free 1-877-805-5312.

Employer (if employer policy) _____

Employer address _____

City _____ **State** _____ **Zip** _____

Person completing this form _____

Phone (_____) _____ **Fax** (_____) _____

Insurance company _____ **Policy Number** _____ **Group Number** _____

What benefits are covered? ☐ Physician Services ☐ Hospital Inpatient Services
Check all that apply.

Amount of premium paid by employee $_____
Include amounts paid for dental, vision and prescription coverage.

Premiums are paid ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ monthly
☐ every 2 months ☐ quarterly ☐ semi-annually ☐ annually

Persons covered by the employee premium contribution:

_____

_____

Does the employer pay 100% of the cost of the employee's coverage? ☐ Yes ☐ No
If no, how much of the amount listed above is for coverage of the employee only (single rate)?

$_____ Include amounts for dental, vision and prescription coverage.

Enrollment period for policy _____

Date the premium listed above began or begins _____

Date of next scheduled change in premium _____

Authorized signature of employer/agent _____ **Date** _____

Return the completed rebate form to the employee for submission with the All Kids / FamilyCare application.

Need help? Visit www.allkids.com or call toll-free: 1-866-All-Kids (1-866-255-5437).
If you use a TTY, call 1-877-204-1012.

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APPENDIX E

Application Agents, Number of Approved Applications, and the Amount Paid

Appendix E
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2010

Name	City	Approved Applications	Total Amount Paid
LAKE CO H D WAUKEGAN CLINIC	WAUKEGAN	1,099	$54,950
WCHD WIC PROGRAM	JOLIET	861	43,050
GREATER ELGIN FAMILY CARE CTR	ELGIN	698	34,900
UPTOWN NEIGHBORHOOD H CENTER	CHICAGO	566	28,300
VNA HEALTH CENTER	AURORA	553	27,650
POLISH AMERICAN ASSN NRTH SIDE	CHICAGO	509	25,450
MIDLAKES CLINIC	ROUND LK BEACH	489	24,450
DUPAGE MENTAL HLTH NORTH PHC	ADDISON	454	22,700
CHAMPAIGN URBANA PUBLIC HLTH	CHAMPAIGN	418	20,900
DUPAGE CTY HEALTH DEPT	WHEATON	402	20,100
BHS FANTUS HEALTH CENTER	CHICAGO	401	20,050
AURORA PUBLIC HEALTH CENTER	AURORA	396	19,800
WINNEBAGO HLTH DEPT MILLENNIUM	ROCKFORD	383	19,150
AUNT MARTHAS YOUTH SRVC CENTER	CHICAGO HEIGHTS	376	18,800
INFANT WELFARE SOCIETY OF CHGO	CHICAGO	376	18,800
ALIVIO MEDICAL CENTER	CHICAGO	371	18,550
MCHENRY COUNTY DEPT OF HEALTH	WOODSTOCK	360	18,000
PREGNANCY TESTING CENTER	CICERO	337	16,850
ROCK ISLAND COUNTY HLTH DEPT	ROCK ISLAND	317	15,850
DUPAGE MENTAL HEALTH EAST PHC	LOMBARD	313	15,650
ELGIN PUBLIC HEALTH CENTER	ELGIN	289	14,450
ERIE FAMILY HEALTH CENTER	CHICAGO	278	13,900
MCLEAN COUNTY HEALTH DEPT	BLOOMINGTON	258	12,900
ERIE FAMILY HEALTH CENTER	CHICAGO	257	12,850
LAWNDALE CHRISTIAN HLTH	CHICAGO	233	11,650
GILEAD OUTREACH AND REFERRAL C	CHICAGO	232	11,600
ARAB AMERICAN FAMILY SERVICES	BRIDGEVIEW	216	10,800
ALIVIO MEDICAL CENTER	CHICAGO	212	10,600
THE GENESIS CENTER	DES PLAINES	210	10,500
DEKALB COUNTY HLTH DEPT	DEKALB	205	10,250
NORTH CHICAGO COMM HEALTH CTR	NORTH CHICAGO	204	10,200
KOREAN AMERICAN COMM SERVICES	CHICAGO	201	10,050
CHICAGO FAM HLTH CTR SO CHI	CHICAGO	199	9,950
DUPAGE MNTL HLTH WESTMONT PHC	WESTMONT	199	9,950
ASIAN HUMAN SERVICES FAMILY	CHICAGO	196	9,800
KANKAKEE COUNTY HEALTH DEPT	KANKAKEE	196	9,800
MELROSE PARK FAMILY HEALTH CTR	MELROSE PARK	194	9,700
WHITESIDE COUNTY HEALTH DEPT	MORRISON	183	9,150
WEST TOWN NEIGHBORHOOD H CTR	CHICAGO	179	8,950
PRIMECARE WEST TOWN	CHICAGO	177	8,850
POLISH AMERICN ASSN SOUTH SIDE	CHICAGO	175	8,750
HENRY BOOTH HOUSE	CHICAGO	168	8,400

Appendix E
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2010

Name	City	Approved Applications	Total Amount Paid
ENGLEWOOD NEIGHBORHOOD H CTR	CHICAGO	161	8,050
SIHF MOTHER AND CHILD CTR	CENTREVILLE	158	7,900
SERVICIOS MEDICOS LA VILLITA	CHICAGO	154	7,700
RESURRECTION MEDICAL CENTER	DES PLAINES	153	7,650
MILE SQUARE HEALTH CENTER	CHICAGO	150	7,500
DUPAGE COUNTY HEALTH DEPT	WEST CHICAGO	146	7,300
MACON COUNTY HEALTH DEPT	DECATUR	143	7,150
KNOX COUNTY HEALTH DEPT	GALESBURG	141	7,050
AUNT MARTHAS YOUTH SERVICE CTR	HAZEL CREST	138	6,900
JACKSON COUNTY HEALTH DEPT	MURPHYSBORO	138	6,900
SWEDISH COVENANT HOSPITAL	CHICAGO	123	6,150
NORWEGIAN AMERICAN HOSP	CHICAGO	119	5,950
SO CHICAGO MCH HEALTH CLINIC	CHICAGO	116	5,800
CHINESE AMERICAN SERV LEAGUE	CHICAGO	114	5,700
PROGRAMA CIELO	CHICAGO	113	5,650
SUWADA MARIA	ELK GROVE VLG	105	5,250
ERIE HELPING HANDS HEALTH CTR	CHICAGO	103	5,150
ST JOSEPH HOSP LAKEVIEW CLINIC	CHICAGO	103	5,150
AUNT MARTHAS YOUTH SERVICE CTR	CHICAGO HEIGHTS	100	5,000
CICERO HEALTH CENTER	CICERO	100	5,000
PEORIA CITY COUNTY HLTH DEPT	PEORIA	100	5,000
COMMUNITY HEALTH CARE INC	DAVENPORT	99	4,950
CENTRO DE SALUD ESPERANZA	CHICAGO	98	4,900
GRUDZINSKI ANNA	CHICAGO	96	4,800
WESTLAKE HOSPITAL	MELROSE PARK	95	4,750
LOWER WEST SIDE HEALTH CENTER	CHICAGO	95	4,750
DR JORGE PRIETO HEALTH CENTER	CHICAGO	92	4,600
ACCESS NORTHWEST FMLY HLTH CTR	ARLINGTON HTS	90	4,500
COORDINATED YOUTH WIC PROGRAM	WOOD RIVER	90	4,500
UNIVERSITY OF IL AT CHIC HOSP	CHICAGO	90	4,500
KEDZIE FAMILY HEALTH CENTER	CHICAGO	88	4,400
FAMILY HEALTH SOCIETY	CHICAGO HEIGHTS	80	4,000
FRANKLIN WILLIAMSON HLTH DEPT	MARION	79	3,950
HANUL FAMILY ALLIANCE SUBURBAN	MT PROSPECT	78	3,900
WOMENS HEALTH SERVICES	OAK LAWN	75	3,750
SIHF W BELLEVILLE HEALTH CTR	BELLEVILLE	75	3,750
FRIEND FAMILY HEALTH CENTER	CHICAGO	73	3,650
VERMILION COUNTY HEALTH DEPT	DANVILLE	71	3,550
AUNT MARTHA YTH SERV HLTHY KID	AURORA	70	3,500
CIRCLE FAMILY HEALTHCARE NETWK	CHICAGO	70	3,500
EVANSTON ROGERS PARK FAM HLTH	CHICAGO	70	3,500
LIVINGSTON CO PUBLIC HLTH DEPT	PONTIAC	70	3,500

Appendix E
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2010

Name	City	Approved Applications	Total Amount Paid
MARTIN T RUSSO FAMILY HLTH CTR	BLOOMINGDALE	68	3,400
THE CLINIC IN ALTGELD INC	CHICAGO	67	3,350
HAWTHORNE FAMILY HEALTH CENTER	CICERO	66	3,300
MACOUPIN COUNTY HEALTH DEPT	CARLINVILLE	65	3,250
RUSH ADOLESCENT FAMILY CENTER	CHICAGO	64	3,200
ADVOCATE NORTHSIDE	CHICAGO	64	3,200
COMMUNITY ALTERNATIVES UNLTD	CHICAGO	63	3,150
EVANSTON HEALTH DEPT	EVANSTON	62	3,100
CHINESE MUTUAL AID ASSOCIATION	CHICAGO	60	3,000
KLING PROFESSIONAL CENTER	CHICAGO	60	3,000
FRANCES NELSON HEALTH CENTER	CHAMPAIGN	60	3,000
EDGAR COUNTY HEALTH DEPT	PARIS	59	2,950
PCC COMMUNITY WELLNESS CENTER	OAK PARK	58	2,900
BHS JOHN SENGSTACKE PROF BLDG	CHICAGO	58	2,900
COORDINATED YOUTH SERVICES	GRANITE CITY	58	2,900
SALUD FAMILY HEALTH CENTER	CHICAGO	57	2,850
GRUNDY COUNTY HEALTH DEPT	MORRIS	56	2,800
CHRISTIAN COUNTY HEALTH DEPT	TAYLORVILLE	56	2,800
ST CLAIR COUNTY HEALTH DEPT	BELLEVILLE	56	2,800
FAMILY FOCUS AURORA	AURORA	54	2,700
MUSLIM WOMEN RESOURCE CTR	CHICAGO	54	2,700
AUNT MARTHA YTH SERV CTR INC	HARVEY	53	2,650
MERCY DIAGNOSTIC TREATMENT CTR	CHICAGO	53	2,650
WILL CO HEALTH DEPT NORTHERN B	BOLINGBROOK	53	2,650
LOGAN SQUARE HLTH CTR COOK CO	CHICAGO	52	2,600
FAYETTE COUNTY HLTH DEPT	VANDALIA	52	2,600
DES PLAINES VALLEY HEALTH CTR	SUMMIT	51	2,550
SOUTH LAWNDALE MCH CENTER	CHICAGO	51	2,550
WEST CHICAGO FAMILY HEALTH CTR	WEST CHICAGO	46	2,300
CHICAGO HLTH OUTREACH HOMELESS	CHICAGO	46	2,300
JERSEY COUNTY HEALTH DEPT	JERSEYVILLE	46	2,300
SAN RAFAEL	CHICAGO	44	2,200
CENTRO DE INFORMACION	ELGIN	43	2,150
SHAHBAZ AKHTAR	CHICAGO	42	2,100
SOUTH SUBURBAN HOSPITAL	HAZEL CREST	42	2,100
OGLE COUNTY HEALTH DEPT	OREGON	42	2,100
BOND CO HEALTH DEPT	GREENVILLE	42	2,100
RONALD MCDONALD CARE MOBILE	ROCKFORD	40	2,000
ALIA SIDDIQI MD	CHICAGO	40	2,000
NEAR NORTH HEALTH SERV KOMED	CHICAGO	40	2,000
HEARTLAND HEALTH OUTREACH	CHICAGO	40	2,000
CHILD AND FAMILY CONNECTIONS	LISLE	39	1,950

Appendix E
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2010

Name	City	Approved Applications	Total Amount Paid
CARE CENTER OF SPRINGFIELD INC	SPRINGFIELD	39	1,950
LEE COUNTY HEALTH DEPT	DIXON	38	1,900
STREAMWOOD BEHAVIORAL HLTH CTR	STREAMWOOD	38	1,900
CLAY COUNTY HEALTH DEPT	FLORA	37	1,850
CLINTON COUNTY HEALTH DEPT	CARLYLE	37	1,850
RIVEREDGE HOSPITAL	FOREST PARK	36	1,800
PRIMECARE NORTHWEST	CHICAGO	36	1,800
CHRISTIAN COMMUNITY HLTH CTR	CHICAGO	35	1,750
HANCOCK COUNTY HEALTH DEPT	CARTHAGE	34	1,700
DECATUR OB GYN ASSOCIATES	DECATUR	34	1,700
PRIMECARE FULLERTON	CHICAGO	33	1,650
CENTRO MEDICO	CHICAGO	32	1,600
SIHF WASHINGTON PARK CTR	WASHINGTON PARK	32	1,600
DROZD BEATA	NILES	31	1,550
KARWINSKI MALGORZATA	CHICAGO	31	1,550
NORTH SHORE HEALTH CENTER	HIGHLAND PARK	31	1,550
ERIE FAMILY HEALTH CENTER	CHICAGO	30	1,500
STICKNEY PUBLIC HEALTH DIST	BURBANK	30	1,500
SIHF FAIRMONT CITY HEALTH CTR	FAIRMONT CITY	30	1,500
ADVANCED MEDICAL GROUP	WHEELING	29	1,450
BIRUTE PAULAUSKAITE	MUNDELEIN	28	1,400
COMMUNITY NURSE HEALTH ASSN	LAGRANGE	28	1,400
SIHF KOCH HEALTH CTR	GRANITE CITY	28	1,400
HENDERSON CO HEALTH DEPT	MONMOUTH	28	1,400
ADVENTIST BOLINGBROOK HOSPITAL	BOLINGBROOK	28	1,400
AUNT MARTHAS CARPENTERSVILLE	CARPENTERSVILLE	27	1,350
NEW LIFE EDUCATION CENTER	KANKAKEE	27	1,350
SIHF BELLEVILLE FP HEALTH CTR	BELLEVILLE	26	1,300
SOUTHWEST FAMILY HEALTH CENTER	CHICAGO	25	1,250
HUMBOLT PARK FAM HLTH CENTER	CHICAGO	25	1,250
CHILD AND FAMILY CONNECTIONS	CRYSTAL LAKE	25	1,250
ZABIEROWSKI URSULA	HOFFMAN ESTATES	24	1,200
PLAZA MEDICAL CENTER	CHICAGO	24	1,200
SIHF STATE STREET CTR	EAST ST LOUIS	24	1,200
CENTRAL COUNTIES HEALTH CTR	SPRINGFIELD	24	1,200
TAZEWELL COUNTY HLTH DEPT	TREMONT	24	1,200
WAYNE COUNTY HEALTH DEPT	FAIRFIELD	24	1,200
BRANDON FAMILY HEALTH CENTER	CHICAGO	23	1,150
PETERSON FAMILY HEALTH CENTER	CHICAGO	23	1,150
CARROLL COUNTY HEALTH DEPT	MT CARROLL	23	1,150
JO DAVIESS CO HEALTH DEPT	GALENA	23	1,150
FORD IROQUOIS PUB HLTH DEPT	WATSEKA	23	1,150

Appendix E
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2010

Name	City	Approved Applications	Total Amount Paid
COLES COUNTY PUBLIC HLTH DEPT	CHARLESTON	22	1,100
PADOWSKI BOGUMILA	DES PLAINES	20	1,000
TKACZ JOANNA	CHICAGO	20	1,000
EGYPTIAN HEALTH DEPT	CARMI	20	1,000
CHICAGO CTR FOR TORAH AND CHES	CHICAGO	19	950
PANTIRU MIHAELA	CHICAGO	19	950
SPANISH CTR LYRP OUTREACH PROJ	JOLIET	19	950
RESEARCH AND EDUCATION FOUND	BLUE ISLAND	19	950
LAKE CO H D ZION CLINIC	ZION	19	950
GREENE COUNTY HEALTH DEPT	CARROLLTON	19	950
BOBROWSKA IZABELLA	CHICAGO	18	900
SAINTS MARY AND ELIZ MED CEN N	CHICAGO	18	900
CHILD AND FAMILY CONNECTION 1	LOVES PARK	18	900
CHICAGO DEPARTMENT OF HEALTH	CHICAGO	18	900
HENRY COUNTY HEALTH DEPT	KEWANEE	18	900
INFANT WELFARE CLINIC	OAK PARK	18	900
HAMILTON COUNTY HEALTH DEPT	MCLEANSBORO	18	900
PIKE COUNTY HEALTH DEPT	PITTSFIELD	18	900
RANDOLPH COUNTY HEALTH DEPT	CHESTER	18	900
HR STUDIO INC	CHICAGO	17	850
LAKE COUNTY KIDCARE APP	WAUKEGAN	17	850
ALEXIAN CENTER FOR MENTAL HLTH	ARLINGTON HGTS	17	850
ONE THOUSAND ONE INS AND FINAN	CHICAGO	17	850
KOZIOL MARIUSZ	ELK GROVE VLG	16	800
LUTHERAN GENERAL HOSPITAL	PARK RIDGE	16	800
EASTER SEALS CHILD FAM CONN 12	TINLEY PARK	16	800
OMNI YOUTH SERVICES PROS HGHTS	PROSPECT HTS	16	800
CHICAGO HISPANIC HEALTH COALI	CHICAGO	16	800
EVANSTON SCHOOL BASED HLTH CTR	EVANSTON	16	800
KASZOWSKA ELZBIETA	NAPERVILLE	15	750
SIHF CAHOKIA HEALTH CTR	CAHOKIA	15	750
JASPER CO HEALTH DEPT	NEWTON	15	750
UPLIFT SCHOOL HEALTH CENTER	CHICAGO	14	700
BEACON THERAPEUTIC DIAGNOSTIC	CHICAGO	14	700
ASHLAND FAMILY HEALTH CENTER	CHICAGO	14	700
SERVICE OF WILL GRUNDY KANKAKE	JOLIET	14	700
SOUTH EAST ASIA CENTER	CHICAGO	13	650
WINFIELD MOODY HEALTH CENTER	CHICAGO	13	650
ADOLESCENT HEALTH CENTER	CARBONDALE	13	650
SOUTHERN SEVEN HEALTH DEPT	VIENNA	13	650
A G FAMILY CARE LTD	BUFFALO GROVE	12	600
HORB NADIA	CHICAGO	12	600

Appendix E
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2010

Name	City	Approved Applications	Total Amount Paid
MADISON MEDICAL CENTER	CHICAGO	12	600
SUBURBAN ACCESS INC	HILLSIDE	12	600
MERCER COUNTY HEALTH DEPT	ALEDO	12	600
SIHF ALTON WOMENS HEALTH CTR	ALTON	12	600
EFFINGHAM COUNTY HEALTH DEPT	EFFINGHAM	12	600
LINCOLN SQUARE	CHICAGO	11	550
MANO A MANO FAMILY RESOURCE	ROUND LAKE BCH	11	550
MARION COUNTY HEALTH DEPT	SALEM	11	550
OZDROVSKA NADIA	CHICAGO	10	500
HANUL FAMILY ALLIANCE CHICAGO	CHICAGO	10	500
ART OF INSURANCE	WHEELING	10	500
MURPHYSBORO HEALTH CENTER	MURPHYSBORO	10	500
SIHF WINDSOR HEALTH CTR	EAST SAINTLOUIS	10	500
KULPA ANNA	LK IN THE HLS	9	450
ADVOCATE CHRIST MEDICAL CENTER	OAK LAWN	9	450
SINAI HEALTH SYSTEM	CHICAGO	9	450
DISTRICT 62 SPARK	DES PLAINES	9	450
OAK PARK HEALTH DEPT	OAK PARK	9	450
OAK FOREST HOSPITAL	OAK FOREST	9	450
KENDALL CO HLTH AND HUMAN SERV	YORKVILLE	9	450
WCHD EASTERN BRANCH OFFICE	UNIVERSITY PARK	9	450
LINCOLN PRAIRIE BEHAVIORAL HC	SPRINGFIELD	8	400
JEWISH CHILD AND FAMILY SRVS	CHICAGO	8	400
VILLAGE OF HOFFMAN ESTATES	HOFFMAN ESTATES	8	400
PUI TAK CENTER	CHICAGO	8	400
MASON COUNTY HEALTH DEPARTMENT	HAVANA	8	400
COMM COUNS CTR CHGO BROADWAY	CHICAGO	7	350
FIRMANS MT CH HLTH PROG WORTH	WORTH	7	350
DR WU WOMEN HEALTH CENTER	CHICAGO	7	350
ROGERS PARK HIHC	CHICAGO	7	350
CITY OF ROLLING MEADOWS	ROLLING MEADOWS	7	350
DD SERVICES OF METRO EAST	BELLEVILLE	7	350
MOULTRIE COUNTY HEALTH DEPT	SULLIVAN	6	300
STAR DENTAL CENTER	WHEELING	6	300
CHURCH OF THE HOLY SPIRIT	SCHAUMBURG	6	300
YOUTH SVCS GLENVIEW NORTHBROOK	GLENVIEW	6	300
AUBURN GRESHAM FAMILY HLTH CTR	CHICAGO	6	300
PEDIATRICS CLINIC	DES PLAINES	6	300
MENARD CO HEALTH DEPT	PETERSBURG	6	300
MACNEAL HEALTH NETWORK	BERWYN	6	300
FIRMANS MT CH HLTH PROG CICERO	CHICAGO	5	250
ERIE TEEN HEALTH CENTER	CHICAGO	5	250

Appendix E
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2010

Name	City	Approved Applications	Total Amount Paid
PILSEN FAMILY HEALTH CENTER	CHICAGO	5	250
ALBANY CHILD CARE CENTER	CHICAGO	5	250
CARTERVILLE FAMILY PRACTICE	CARTERVILLE	5	250
HENDERSON CO HEALTH DEPT	GLADSTONE	5	250
MONTGOMERY CO HLTH DEPT	HILLSBORO	5	250
BETHANY CHRISTIAN SRVCS OF MO	COLUMBIA	5	250
TRIPLE CARE	CHICAGO	5	250
EDUARDO V BARRIUSO MD	CHICAGO	4	200
LONG TIM	WOODRIDGE	4	200
MALISZEWSKI MARZENA	ALGONQUIN	4	200
CHILD AND FAMILY CONNECTIONS	CHICAGO	4	200
FIRMAN MT CH HLTH PROG ROL MED	ROLLING MEADOWS	4	200
SEIU LOCAL 4 HEALTH FUND	CHICAGO	4	200
CLEARBROOK CFC 6	ARLINGTON HTS	4	200
HANOVER TOWNSHIP	HANOVER PARK	4	200
ALMA MEDICAL CENTER	MAYWOOD	4	200
ACCESS CABRINI HEALTH CENTER	CHICAGO	4	200
COM HLTH PARTNERSHIP HOOPESTEN	HOOPESTON	4	200
INSTITUTO DEL PROGRESO LATINO	CHICAGO	4	200
THE SUCCESS CENTER	LANSING	4	200
PERRY CO HLTH DEPT	PINCKNEYVILLE	4	200
SANGAMON CO DEPT PUBLIC HEALTH	SPRINGFIELD	4	200
FOLLIS TERESA	CHANNAHON	3	150
BONDAROWICZ RENATA	SCHAUMBURG	3	150
OMNI YOUTH SERVICES WHEELING	WHEELING	3	150
CHILD AND FAMILY CONNECTIONS	FREEPORT	3	150
CHICAGO FAM HLTH CTR HOMELESS	CHICAGO	3	150
HOWARD AREA COMMUNITY CENTER	CHICAGO	3	150
GRAND BOULEVARD HEALTH CENTER	CHICAGO	3	150
ALIVIO MEDICAL CENTER	CHICAGO	3	150
CHRISTIAN COMMUNITY HLTH CTR	CALUMET CITY	3	150
ELGIN DUNDEE	ELGIN	3	150
PEORIA CNTY BRD CARE DEV DISBL	PEORIA	3	150
CFC 19	DECATUR	3	150
RURAL HEALTH INC	ANNA	3	150
SOUTHERN SEVEN HEALTH DEPT	JONESBORO	3	150
SOUTHERN IL CASE COORDINATION	CENTRALIA	3	150
MADISON COUNTY HEALTH DEPT	WOOD RIVER	3	150
DEWITT PIATT BI CO HLTH DEPT	CLINTON	3	150
PINKNEY HARVEY	ALSIP	3	150
YONG MIMI	PLAINFIELD	2	100
BOCHENEK BEATA	CHICAGO	2	100

Appendix E
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2010

Name	City	Approved Applications	Total Amount Paid
HUDSON BERNARD	BELLEVILLE	2	100
JANICE FRIDH	POPLAR GROVE	2	100
CHANG MICHAEL	MORTON GROVE	2	100
BRIDGEPORT CHILD DEVELOPMENT	CHICAGO	2	100
TRINITY SERVICES INC	JOLIET	2	100
VIETNAMESE ASSOC OF ILLINOIS	CHICAGO	2	100
CHICAGO FAM CASE MGMNT SOUTH	CHICAGO	2	100
ACCESS SULLIVAN HIGH SCHOOL HC	CHICAGO	2	100
SUBURBAN ACCESS CFC 7	HOMEWOOD	2	100
CHRISTIAN COMMUNITY HLTH CTR	SOUTH HOLLAND	2	100
ERIE COURT HEALTH CENTER	OAK PARK	2	100
BERWYN PUBLIC HEALTH DIST	BERWYN	2	100
KCAS ENTERPRISES INC	MARENGO	2	100
SCHOOL HEALTH LINK INC	ROCK ISLAND	2	100
CHARLES HAYES CENTER	CHICAGO	2	100
DUPAGE TRANS SERVICES CENTER	WHEATON	2	100
STEPHENSON CO HEALTH DEPT	FREEPORT	2	100
CATHOLIC SOCIAL SERVICE	BELLEVILLE	2	100
SOUTHERN SEVEN HD	ULLIN	2	100
SIHF ALTON HEALTH CTR	ALTON	2	100
DAY ONE NETWORK INC	GENEVA	2	100
MACOUPIN CO COMM CARE HEALTH	GILLESPIE	2	100
ST ANTHONY HOSPITAL	CHICAGO	2	100
KLIEWER PAULA	WINTHROP	1	50
BELOVED COMM FMLY WELLNESS CTR	CHICAGO	1	50
LAUPER ROBERT	OSWEGO	1	50
WASHINGTON SEADRA	RICHTON PARK	1	50
SULTAN SHEIKH	CHICAGO	1	50
THE PAVILION FOUNDATION	CHAMPAIGN	1	50
ACTS	CHICAGO	1	50
BOKOTU	CHICAGO	1	50
COMM HEALTH IMPROVEMENT CTR	DECATUR	1	50
RAIZ DEBBIE	AURORA	1	50
HYMAN JOY	MT PROSPECT	1	50
ASSOCIATION HOUSE OF CHICAGO	CHICAGO	1	50
SHERMAN HOSPITAL	ELGIN	1	50
ST SABINA EMERGENCY SRVCS CTR	CHICAGO	1	50
CATHOLIC CHARITIES AURORA	AURORA	1	50
FAMILY SVC CMHC OF MCHENRY CTY	MCHENRY	1	50
ROGERS PARK COMMUNITY COUNCIL	CHICAGO	1	50
ROCK ISLAND OUTREACH	ROCK ISLAND	1	50
JANET WATTLES CENTER	BELVIDERE	1	50

Appendix E
TOTAL PAYMENTS TO ALL KIDS APPLICATION AGENTS
Fiscal Year 2010

Name	City	Approved Applications	Total Amount Paid
ERIE HENSON HEALTH CENTER	CHICAGO	1	50
ARMITAGE FAMILY HEALTH CENTER	CHICAGO	1	50
AUSTIN FAMILY HEALTH CENTER	CHICAGO	1	50
CGH MEDICAL CENTER	STERLING	1	50
HOOPESTON COMM MEMORIAL HOSP	HOOPESTON	1	50
INTERFAITH MINISTRIES WAUKEGAN	WAUKEGAN	1	50
PCC AUSTIN FAMILY HEALTH CNT	CHICAGO	1	50
WOODRIDGE COMMUNITY PANTRY	WOODRIDGE	1	50
SCHOOL HEALTH LINK INC	SILVIS	1	50
OAK PARK OFFICE	OAK PARK	1	50
KANKAKEE SCHOOL BASED HLTH CTR	KANKAKEE	1	50
CCDPH SOUTH DISTRICT OFFICE	MARKHAM	1	50
SOUTHEASTERN HLTH CTR COOK CNT	SOUTH HOLLAND	1	50
DUPAGE COUNTY HUMAN RESOURCES	WHEATON	1	50
FARMWORKER HEALTH CENTER	COBDEN	1	50
SOUTHERN SEVEN HEALTH DEPT	ROSICLARE	1	50
COMMUNITY HLTH EMERGENCY SERV	CAIRO	1	50
CASS CO HEALTH DEPT VIRGINIA	VIRGINIA	1	50
SIHF BELLEVILLE PEDIATRIC CTR	BELLEVILLE	1	50
SIHF SOUTHERN HEALTH CTR	BELLEVILLE	1	50
SIHF EFFINGHAM HEALTH CTR I	EFFINGHAM	1	50
SIHF CUMBERLAND CO HEALTH CTR	GREENUP	1	50
PRAIRIELAND SVCS COORDINATION	DECATUR	1	50
WASHINGTON COUNTY HEALTH DEPT	NASHVILLE	1	50
DIVINE MERCY POLISH MISSION	LOMBARD	1	50
ODOM GERALD	FLOSSMOOR	1	50
RIVERA ENRIQUE	BOLINGBROOK	1	50
		Total	**$1,175,500**

Source: HFS data.

APPENDIX F

FY10 Total Payments by Category of Service

Appendix F
TOTAL PAYMENTS BY CATEGORY OF SERVICE
During FY10

Category of Service	FY10 Payment Amount	Percent of Total Payments
Inpatient Hospital Services (General)	$13,595,253.94	16.15%
Dental Services	12,105,107.23	14.38%
Physician Services	12,055,130.47	14.32%
Pharmacy Services (Drug and OTC)	10,672,655.62	12.68%
General Clinic Services	7,514,749.87	8.92%
Outpatient Services (General)	6,297,382.81	7.48%
Healthy Kids Services	3,672,153.62	4.36%
Capitation Services	3,551,097.73	4.22%
Inpatient Hospital Services (Psychiatric)	3,442,002.95	4.09%
Mental Health Rehab. Option Services	1,606,577.75	1.91%
Alcohol and Substance Abuse Rehab. Services	1,357,120.71	1.61%
Home Health Services	842,355.17	1.00%
Optical Supplies	763,022.04	0.91%
Medical Equipment/Prosthetic Devices	733,205.62	0.87%
Medical Supplies	721,878.86	0.86%
Clinical Laboratory Services	618,660.36	0.73%
Anesthesia Services	509,445.00	0.61%
Speech Therapy/Pathology Services	459,855.58	0.55%
Outpatient Services (ESRD)	374,997.77	0.45%
Psychiatric Clinic Services (Type 'A')	374,755.65	0.45%
Inpatient Hospital Services (Physical Rehabilitation)	306,251.99	0.36%
Occupational Therapy Services	224,261.75	0.27%
Physical Therapy Services	206,916.44	0.25%
Development Therapy, Orientation and Mobility Services (Waivers)	197,153.21	0.23%
Targeted Case Management Service (Early Intervention)	187,549.02	0.22%
Clinic Services (Physical Rehabilitation)	181,345.55	0.22%
Emergency Ambulance Transportation	176,328.73	0.21%
Optometric Services	174,655.66	0.21%
Targeted Case Management Service (Mental Health)	159,751.92	0.19%
Podiatric Services	147,923.86	0.18%
Nurse Practitioners Services	143,381.96	0.17%
Service Car	123,208.59	0.15%
Nursing Service	120,059.76	0.14%
Psychiatric Clinic Services (Type 'B')	119,973.10	0.14%
All Kids Application Agent (Valid on Provider File Only)	111,700.00	0.13%

Appendix F
TOTAL PAYMENTS BY CATEGORY OF SERVICE
During FY10

Category of Service	FY10 Payment Amount	Percent of Total Payments
Early Intervention Services	70,094.06	0.08%
Non-Emergency Ambulance Transportation	68,455.40	0.08%
LTC--ICF/MR	64,295.74	0.08%
Audiology Services	36,210.13	0.04%
Home Care	22,471.07	0.03%
Midwife Services	22,313.40	0.03%
Social Work Service	18,950.39	0.02%
Taxicab Services	17,514.78	0.02%
Medicar Transportation	10,483.96	0.01%
Chiropractic Services	8,486.49	0.01%
LTC - MR Recipient between ages 21-65	5,169.52	0.01%
Psychologist Service	4,979.93	0.01%
Fluoride Varnish	1,352.00	0.00%
Auto Transportation (Private)	570.24	0.00%
Waiver Service (Depends on HCPCS Code)	176.00	0.00%
Portable X-Ray Services	114.95	0.00%
Total FY10 Payments	**$84,199,508.35**	**100.00%**

Note: Totals may not add due to rounding.

Source: Summary of FY10 ALL KIDS data provided by HFS.

APPENDIX G

FY10 EXPANDED ALL KIDS Payments

Appendix G

FY10 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Alcohol and Substance Abuse Rehab Services	All Kids Application Agent (Valid on Provider File Only)	Anesthesia Services	Audiology Services	Auto Transportation (Private)	Capitation Services	Chiropractic Services	Clinic Services (Physical Rehabilitation)	Clinical Laboratory Services
Assist Undocumented	$637,772	$65,000	$325,052	$19,161	$0	$3,380,278	$7,132	$133,800	$480,920
Share Undocumented	0	2,700	7,506	323	0	65,532	768	5,070	13,378
Level 1 Undocumented	661	6,300	7,290	670	0	43,503	53	5,466	12,931
Level 2	539,425	28,500	131,242	12,458	570	55,793	530	27,795	87,720
Level 2 Undocumented	0	2,500	1,458	195	0	1,723	3	2,860	2,157
Level 3	122,540	4,900	30,517	3,129	0	3,864	0	3,640	14,965
Level 3 Undocumented	0	450	338	0	0	41	0	0	476
Level 4	21,147	950	5,167	275	0	242	0	504	3,323
Level 4 Undocumented	0	50	92	0	0	0	0	0	253
Level 5	137	250	599	0	0	121	0	0	454
Level 5 Undocumented	0	0	0	0	0	0	0	1,170	0
Level 6	15,079	100	184	0	0	0	0	1,040	55
Level 6 Undocumented	0	0	0	0	0	0	0	0	21
Level 7	0	0	0	0	0	0	0	0	0
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	20,361	0	0	0	0	0	0	0	2,005
Level 8 Undocumented	0	0	0	0	0	0	0	0	0
Totals by Category	**$1,357,121**	**$111,700**	**$509,445**	**$36,210**	**$570**	**$3,551,098**	**$8,486**	**$181,346**	**$618,660**

Note: Totals may not add due to rounding.

Source: Summary of FY10 ALL KIDS data provided by HFS.

Appendix G

FY10 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Dental Services	Development Therapy, Orientation and Mobility Services (Waivers)	Early Intervention Services	Emergency Ambulance Transportation	Fluoride Varnish	General Clinic Services	Healthy Kids Services	Home Care	Home Health Services
Assist Undocumented	$9,156,555	$25,099	$16,022	$115,370	$572	$6,142,523	$2,200,641	$19,205	$118,569
Share Undocumented	325,252	250	0	3,211	0	151,570	96,055	0	859
Level 1 Undocumented	317,986	1,080	0	2,290	26	128,977	100,440	0	0
Level 2	1,861,447	126,171	44,075	43,370	520	875,048	990,038	3,266	129,641
Level 2 Undocumented	90,459	0	0	1,612	0	26,613	29,057	0	0
Level 3	284,447	32,287	7,453	9,005	208	148,394	202,024	0	211,737
Level 3 Undocumented	12,485	42	0	0	0	2,784	6,790	0	0
Level 4	46,161	3,912	0	1,472	26	22,967	37,486	0	105,682
Level 4 Undocumented	3,175	0	0	0	0	1,281	1,540	0	0
Level 5	4,726	5,209	494	0	0	2,330	5,061	0	120,952
Level 5 Undocumented	226	0	0	0	0	11,407	186	0	0
Level 6	1,593	812	333	0	0	465	1,411	0	48,801
Level 6 Undocumented	289	0	0	0	0	115	188	0	0
Level 7	265	2,107	1,717	0	0	138	260	0	0
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	41	183	0	0	0	136	978	0	106,115
Level 8 Undocumented	0	0	0	0	0	0	0	0	0
Totals by Category	**$12,105,107**	**$197,153**	**$70,094**	**$176,329**	**$1,352**	**$7,514,750**	**$3,672,154**	**$22,471**	**$842,355**

Note: Totals may not add due to rounding.

Source: Summary of FY10 ALL KIDS data provided by HFS.

Appendix G

FY10 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Inpatient Hospital Services (General)	Inpatient Hospital Services (Physical Rehabilitation)	Inpatient Hospital Services (Psychiatric)	LTC - MR Recipient between ages 21-65	LTC--ICF/MR	Medical Equipment/Prosthetic Devices	Medical Supplies	Medicar Transportation	Mental Health Rehab Option Services
Assist Undocumented	$9,845,374	$227,547	$2,239,676	$3,516	$64,296	$385,683	$374,308	$10,465	$885,318
Share Undocumented	74,986	8,948	40,524	0	0	9,174	7,925	19	21,569
Level 1 Undocumented	106,904	0	27,936	0	0	8,765	14,250	0	24,623
Level 2	2,592,084	69,758	874,149	1,608	0	232,079	248,027	0	519,966
Level 2 Undocumented	37,798	0	0	0	0	7,834	2,754	0	2,217
Level 3	760,768	0	136,479	46	0	59,140	47,635	0	110,178
Level 3 Undocumented	0	0	0	0	0	199	1,116	0	0
Level 4	85,109	0	106,848	0	0	15,608	14,531	0	32,493
Level 4 Undocumented	0	0	0	0	0	0	0	0	0
Level 5	21,818	0	16,390	0	0	1,653	327	0	9,445
Level 5 Undocumented	65,083	0	0	0	0	132	0	0	0
Level 6	5,329	0	0	0	0	0	7,106	0	214
Level 6 Undocumented	0	0	0	0	0	0	0	0	0
Level 7	0	0	0	0	0	6,305	1,133	0	0
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	0	0	0	0	0	6,635	2,767	0	555
Level 8 Undocumented	0	0	0	0	0	0	0	0	0
Totals by Category	**$13,595,254**	**$306,252**	**$3,442,003**	**$5,170**	**$64,296**	**$733,206**	**$721,879**	**$10,484**	**$1,606,578**

Note: Totals may not add due to rounding.

Source: Summary of FY10 ALL KIDS data provided by HFS.

Appendix G

FY10 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Midwife Services	Non-Emergency Ambulance Transportation	Nurse Practitioners Services	Nursing Service	Occupational Therapy Services	Optical Supplies	Optometric Services	Outpatient Services (ESRD)	Outpatient Services (General)
Assist Undocumented	$21,898	$48,856	$61,981	$117,873	$58,645	$583,716	$125,125	$371,844	$4,143,465
Share Undocumented	0	152	4,412	0	3,551	18,649	4,224	0	276,526
Level 1 Undocumented	0	589	4,464	0	1,015	17,126	4,607	0	97,691
Level 2	416	14,276	60,936	0	114,900	118,934	33,869	3,153	1,331,083
Level 2 Undocumented	0	416	648	0	1,228	5,427	1,260	0	22,071
Level 3	0	2,899	9,429	0	29,267	16,132	4,644	0	271,055
Level 3 Undocumented	0	0	32	0	0	636	66	0	2,328
Level 4	0	815	1,335	2,186	7,561	2,075	669	0	89,677
Level 4 Undocumented	0	0	0	0	160	52	18	0	1,088
Level 5	0	451	120	0	4,890	224	119	0	27,475
Level 5 Undocumented	0	0	0	0	0	0	0	0	27,216
Level 6	0	0	22	0	753	0	18	0	7,222
Level 6 Undocumented	0	0	0	0	0	0	0	0	243
Level 7	0	0	0	0	2,239	0	0	0	243
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	0	0	3	0	53	51	37	0	0
Level 8 Undocumented	0	0	0	0	0	0	0	0	0
Totals by Category	**$22,313**	**$68,455**	**$143,382**	**$120,060**	**$224,262**	**$763,022**	**$174,656**	**$374,998**	**$6,297,383**

Note: Totals may not add due to rounding.

Source: Summary of FY10 ALL KIDS data provided by HFS.

Appendix G

FY10 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Pharmacy Services (Drug and OTC)	Physical Therapy Services	Physician Services	Podiatric Services	Portable X-Ray Services	Psychiatric Clinic Services (Type 'A')	Psychiatric Clinic Services (Type 'B')	Psychologist Service	Service Car
Assist Undocumented	$4,753,791	$45,490	$7,673,679	$105,439	$115	$222,536	$67,839	$4,676	$114,724
Share Undocumented	186,898	2,433	274,190	5,265	0	10,132	2,626	0	5,177
Level 1 Undocumented	157,735	1,709	268,740	3,405	0	6,460	2,121	149	263
Level 2	4,090,258	116,349	3,049,764	24,428	0	109,174	37,792	156	3,046
Level 2 Undocumented	57,862	601	82,382	855	0	102	1,212	0	0
Level 3	958,024	22,665	546,442	6,206	0	22,272	7,171	0	0
Level 3 Undocumented	2,180	27	10,818	369	0	102	0	0	0
Level 4	330,091	7,693	109,609	1,891	0	2,414	1,212	0	0
Level 4 Undocumented	2,295	0	2,686	29	0	0	0	0	0
Level 5	114,903	6,606	25,317	36	0	1,088	0	0	0
Level 5 Undocumented	2,611	0	422	0	0	0	0	0	0
Level 6	8,887	871	3,851	0	0	272	0	0	0
Level 6 Undocumented	417	0	474	0	0	0	0	0	0
Level 7	2,458	2,473	5,271	0	0	0	0	0	0
Level 7 Undocumented	0	0	0	0	0	0	0	0	0
Level 8	4,247	0	1,478	0	0	204	0	0	0
Level 8 Undocumented	0	0	8	0	0	0	0	0	0
Totals by Category	**$10,672,656**	**$206,916**	**$12,055,130**	**$147,924**	**$115**	**$374,756**	**$119,973**	**$4,980**	**$123,209**

Note: Totals may not add due to rounding.

Source: Summary of FY10 ALL KIDS data provided by HFS.

Appendix G

FY10 EXPANDED ALL KIDS PAYMENTS BY PLAN AND BY CATEGORY OF SERVICE

ALL KIDS Plan	Social Work Service	Speech Therapy/Pathology Services	Targeted Case Management Service (Early Intervention)	Targeted Case Management Service (Mental Health)	Taxicab Services	Waiver Service (Depends on HCPCS Code)	Total Payments
Assist Undocumented	$15,841	$71,374	$22,157	$84,885	$17,515	$176	**$55,613,496**
Share Undocumented	53	770	363	1,722	0	0	**1,632,762**
Level 1 Undocumented	53	4,973	585	1,463	0	0	**1,383,299**
Level 2	2,819	268,788	121,775	55,531	0	0	**19,052,723**
Level 2 Undocumented	0	646	0	324	0	0	**384,275**
Level 3	184	73,735	30,865	9,945	0	0	**4,204,290**
Level 3 Undocumented	0	218	0	0	0	0	**41,496**
Level 4	0	27,255	6,132	4,020	0	0	**1,098,537**
Level 4 Undocumented	0	320	0	0	0	0	**13,039**
Level 5	0	7,054	4,396	1,496	0	0	**384,142**
Level 5 Undocumented	0	0	0	0	0	0	**108,452**
Level 6	0	3,359	335	33	0	0	**108,145**
Level 6 Undocumented	0	0	0	0	0	0	**1,746**
Level 7	0	916	941	0	0	0	**26,467**
Level 7 Undocumented	0	0	0	0	0	0	**0**
Level 8	0	449	0	333	0	0	**146,631**
Level 8 Undocumented	0	0	0	0	0	0	**8**
Totals by Category	**$18,950**	**$459,856**	**$187,549**	**$159,752**	**$17,515**	**$176**	**$84,199,508**

Note: Totals may not add due to rounding.

Source: Summary of FY10 ALL KIDS data provided by HFS.

APPENDIX H

Providers that Received more than $50,000 from the ALL KIDS Expansion During FY10

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: FY10 paid claim data provided by HFS.

Appendix H

PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000

Fiscal Year 2010

Provider Name	City	State	Total Amount Paid
CHILDRENS MEMORIAL HOSPITAL	CHICAGO	IL	$4,747,871.82
J H STROGER HOSP OF COOK CTY	CHICAGO	IL	1,795,270.65
CENTRAL DUPAGE HOSPITAL	WINFIELD	IL	1,432,235.00
UNIVERSITY OF ILLINOIS HOSP	CHICAGO	IL	821,484.01
COMER CHILDRENS HOSPITAL	DARIEN	IL	786,471.82
BHC STREAMWOOD HOSPITAL INC	STREAMWOOD	IL	725,786.46
HARTGROVE HOSPITAL	CHICAGO	IL	657,432.96
FANTUS HEALTH CENTER	CHICAGO	IL	647,111.25
CHILDRENS HOSP OF WISCONSIN	MILWAUKEE	WI	563,266.54
THERACOM LLC	ROCKVILLE	MD	554,464.14
ADVOCATE NORTHSIDE	CHICAGO	IL	536,802.24
RIVEREDGE HOSPITAL	FOREST PARK	IL	506,027.23
LUTHERAN GENERAL CHILDRENS HOS	PARK RIDGE	IL	504,575.05
ACCREDO HEALTH GROUP INC	MEMPHIS	TN	460,642.50
ILL CORRECTIONAL INDUSTRIES	SPRINGFIELD	IL	389,572.86
ST MARY OF NAZARETH HOSPITAL	CHICAGO	IL	386,068.19
MT SINAI HOSP MED CTR CHICAGO	CHICAGO	IL	372,025.71
SERVICIOS MEDICOS LA VILLITA	CHICAGO	IL	367,381.03
GREATER ELGIN FAMILY CARE CTR	ELGIN	IL	362,866.86
MARYVILLE SCOTT NOLAN CENTER	DES PLAINES	IL	359,580.42
COMPREHENSIVE BLEEDING	PEORIA	IL	353,705.46
RONALD MCDONALDS CHILDRENS HSP	MAYWOOD	IL	352,870.22
CHILDRENS HOS MED CTR CH	CINCINNATI	OH	348,366.01
ST ANTHONY HOSPITAL	CHICAGO	IL	346,992.85
HOPE CHILDRENS HOSPITAL	OAK LAWN	IL	343,944.40
LAWNDALE CHRISTIAN HLTH CTR	CHICAGO	IL	335,014.85
VISITING NURSE ASSN FOX VALLEY	AURORA	IL	333,400.18
NORTHWEST COMMUNITY HOSPITAL	ARLINGTON HGTS	IL	329,279.15
KEDZIE FAMILY HEALTH CENTER	CHICAGO	IL	322,812.67
ST ALEXIUS MEDICAL CENTER	HOFFMAN ESTATES	IL	312,749.71
SINAI CHILDRENS HOSPITAL	CHICAGO	IL	311,243.80
ALIVIO MEDICAL CENTER	CHICAGO	IL	290,048.67
RUSH CHILDRENS SERVICES	CHICAGO	IL	282,914.21
CHILDRENS HOSPITAL OF ILLINOIS	PEORIA	IL	282,323.99
BOND DRUG COMPANY OF ILLINOIS	CHICAGO	IL	271,969.59
THE GENESIS CENTER	DES PLAINES	IL	271,134.13

Appendix H
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2010

Provider Name	City	State	Total Amount Paid
AUNT MARTHAS HEALTH CENTER	AURORA	IL	$268,616.65
ERIE FAMILY HEALTH CENTER	CHICAGO	IL	259,742.13
PERFECT MANAGED CARE	CHICAGO	IL	250,131.63
AQEL FADI	CHICAGO	IL	246,380.61
INFANT WELFARE SOCIETY OF CHGO	CHICAGO	IL	241,684.02
EVANSTON HOSPITAL	EVANSTON	IL	238,968.35
CARDINAL GLENNON CHILDRENS HSP	SAINT LOUIS	MO	237,928.83
ROSECRANCE CENTER	ROCKFORD	IL	228,464.03
RUSH UNIVERSITY MEDICAL CENTER	CHICAGO	IL	227,635.78
ST JOHNS CHILDRENS HOSPITAL	SPRINGFIELD	IL	218,003.51
PROVENA MERCY CENTER	AURORA	IL	216,652.33
LAKE VILLA GATEWAY FOUNDATION	LAKE VILLA	IL	214,603.04
NORTHWESTERN MEMORIAL HOSP	CHICAGO	IL	202,929.89
LAWNDALE CHRISTIAN HLTH	CHICAGO	IL	197,201.68
ADVOCATE CONDELL MEDICAL CTR	LIBERTYVILLE	IL	194,776.02
CAREMARK INC	MT PROSPECT	IL	191,430.81
AUNT MARTHAS YOUTH SERVICE CTR	HANOVER PARK	IL	185,944.08
SHERMAN HOSPITAL	ELGIN	IL	185,511.74
AMBER PHARMACY	CHICAGO	IL	185,161.60
MACNEAL HOSPITAL	BERWYN	IL	181,525.34
BLOODCENTER OF WISCONSIN INC	MILWAUKEE	WI	180,407.94
VISTA MEDICAL CENTER EAST	WAUKEGAN	IL	178,451.42
SWEDISH COVENANT HOSPITAL	CHICAGO	IL	175,942.15
LAKE CO H D WAUKEGAN CLINIC	WAUKEGAN	IL	171,074.36
CORNELL INTERVENTIONS CONTACT	WAUCONDA	IL	170,892.78
COMM COUNSEL CTRS C4 NORTH	CHICAGO	IL	170,019.57
MARTIN T RUSSO FAMILY HLTH CTR	BLOOMINGDALE	IL	168,027.66
ALEXIAN BROTHERS MED CTR	ELK GROVE VLGE	IL	167,516.03
IPA OF KANE COUNTY	MOKENA	IL	158,178.47
ADVANTAGE NURSING SVCS INC	OAK FOREST	IL	153,047.00
ALEXIAN BROS BEHAVIORAL HLTH	HOFFMAN ESTATES	IL	152,991.20
SOUTH LAWNDALE MCH CENTER	CHICAGO	IL	149,951.41
CENTRO DE SALUD ESPERANZA	CHICAGO	IL	146,912.11
AUNT MARTHAS CARPENTERSVILLE	CARPENTERSVILLE	IL	146,104.49
REHABILITATION INSTITUTE	CHICAGO	IL	145,233.93
OPTION CARE ENTERPRISES INC	WOOD DALE	IL	143,123.79

Appendix H
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2010

Provider Name	City	State	Total Amount Paid
ELMHURST MEMORIAL HOSPITAL	ELMHURST	IL	$142,467.44
LINCOLN PRAIRIE BEHAVIORAL HC	SPRINGFIELD	IL	141,896.80
CRUSADER CLINIC BROADWAY	ROCKFORD	IL	138,638.42
QUEST DIAGNOSTICS LLC IL	WOOD DALE	IL	138,634.18
NORWEGIAN AMERICAN HOSP GROUP	CHICAGO	IL	137,764.07
PCC COMM WELLNESS CENTER	OAK PARK	IL	136,874.36
PARUCHURI AJITHA	WEST CHICAGO	IL	136,313.26
COPLEY MEMORIAL HOSPITAL	AURORA	IL	135,565.02
CENTURY PHO INC	CHICAGO	IL	132,911.18
SWEDISHAMERICAN HOSPITAL	ROCKFORD	IL	130,947.77
ROCKFORD MEMORIAL HOSPITAL	ROCKFORD	IL	130,946.95
MIDLAKES CLINIC	ROUND LK BEACH	IL	130,912.77
ERIE DENTAL HEALTH CENTER	CHICAGO	IL	130,880.27
PRIVATE HOME CARE UNLIMITED	CHICAGO	IL	130,023.70
HINSDALE HOSPITAL	HINSDALE	IL	129,764.93
PROVENA ST JOSEPH HOSP	ELGIN	IL	128,777.85
CHRIST HOSPITAL	OAK LAWN	IL	128,601.47
GREATER CHICAGO MEDICAL ASSOC	CHICAGO	IL	128,127.53
APOGEE HEALTH PARTNERS INC	CHICAGO	IL	126,521.45
TRC CHILDRENS DIALYSIS CENTER	CHICAGO	IL	124,482.06
AURORA CHICAGO LAKESHORE HOSP	CHICAGO	IL	123,263.16
HUMBOLDT PARK FAMILY HLTH CTR	CHICAGO	IL	121,480.97
VISTA CLINIC OF COOK COUNTY	PALATINE	IL	121,011.04
NDO	CHICAGO	IL	120,939.81
HAWTHORNE FAMILY HEALTH CENTER	CHICAGO	IL	120,930.25
DSCC	SPRINGFIELD	IL	120,218.40
HAWTHORNE FAMILY HEALTH CENTER	CICERO	IL	116,721.27
RIVERSIDE MED CTR	KANKAKEE	IL	113,670.95
ST LOUIS CHILDRENS HOSPITAL	SAINT LOUIS	MO	113,283.29
UNIVERSITY OF CHICAGO HOSPITAL	CHICAGO	IL	111,736.70
SIDDIQUI ZAKI	CHICAGO	IL	110,206.04
LUTHERAN GENERAL HOSPITAL	PARK RIDGE	IL	108,983.29
NORWEGIAN AMERICAN HOSP	CHICAGO	IL	108,421.46
PLAZA MEDICAL CENTER	CHICAGO	IL	108,130.97
CICERO HEALTH CENTER	CICERO	IL	105,865.94
MARIANJOY REHABILITATION HOSP	WHEATON	IL	104,155.17

Appendix H
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2010

Provider Name	City	State	Total Amount Paid
NASREEN TAIBA	ADDISON	IL	$104,013.55
EVANSTON ROGERS PARK FAM HLTH	CHICAGO	IL	103,344.18
BIOPARTNERS IN CARE	LENEXA	KS	102,823.40
MARYVILLE ACADEMY SCOTT NOLAN	DES PLAINES	IL	102,800.28
SAINTS MARY AND ELIZ MED CEN N	CHICAGO	IL	102,125.14
GOTTLIEB MEMORIAL HOSPITAL	MELROSE PARK	IL	100,223.19
CLARK DAVID	CHICAGO	IL	100,093.94
FORTY SEVENTH STREET PHARMACY	CHICAGO	IL	99,817.48
OSTOMY CENTER	CHICAGO	IL	98,368.68
A PLUS HOME HEALTHCARE SERVICE	MOLINE	IL	98,355.50
NORTH SHORE HEALTH CENTER	HIGHLAND PARK	IL	98,121.02
PROVENA ST JOSEPH MED CNT	JOLIET	IL	95,489.09
MEMORIAL MEDICAL CENTER	WOODSTOCK	IL	93,948.13
IBT TRANSPORTATION	STICKNEY	IL	93,695.63
ACCESS NORTHWEST FMLY HLTH CTR	ARLINGTON HTS	IL	93,653.91
GATEWAY FOUNDATION CARBONDALE	CARBONDALE	IL	93,527.74
LAMBERGHINI FLAVIA	CHICAGO	IL	93,002.79
SAN RAFAEL	CHICAGO	IL	92,956.15
NAPERVILLE PSYCH VENTURES	NAPERVILLE	IL	92,795.96
ADVENTIST BOLINGBROOK HOSPITAL	BOLINGBROOK	IL	92,434.18
MS LAWNDALE CHRISTIAN HLTH CTR	CHICAGO	IL	92,023.88
THE KENNETH W YOUNG CENTERS	ELK GROVE VLGE	IL	91,756.53
C AND M PHARMACY LLC	GLENVIEW	IL	91,200.81
PINTO JUAN	JOLIET	IL	91,192.11
SHALTOONI ABDELKARIM	HOFFMAN ESTATES	IL	90,898.49
ST FRANCIS HOSPITAL	EVANSTON	IL	90,678.29
ALDALLAL NADA	CHICAGO	IL	90,586.33
MELROSE PARK FAMILY HEALTH CTR	MELROSE PARK	IL	89,384.61
MERCY HOSPITAL MEDICAL CENTER	CHICAGO	IL	88,566.57
FOSTER G MCGAW HOSPITAL	MAYWOOD	IL	86,607.03
OUR LADY RES MED CTR	CHICAGO	IL	85,685.64
LABORATORY CORPORATION AMERICA	DUBLIN	OH	85,541.59
SAINTS MARY AND ELIZABETH HP	CHICAGO	IL	85,353.28
SILVER CROSS HOSPITAL	JOLIET	IL	85,307.36
CENTRO MEDICO	CHICAGO	IL	84,926.09
LA RABIDA CHILDRENS HOSP	CHICAGO	IL	84,822.20

Appendix H
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2010

Provider Name	City	State	Total Amount Paid
CHICAGO FAM HLTH CTR SO CHI	CHICAGO	IL	$84,800.45
WESTLAKE HOSPITAL	MELROSE PARK	IL	84,094.81
MEDSTAR LABORATORY INC	RIVER FOREST	IL	83,200.64
HALSTED AND 79TH ST PHARMACY I	MELROSE PARK	IL	81,362.88
EDWARD HOSPITAL	NAPERVILLE	IL	80,896.68
FAMILY MEDICAL NETWORK	CHICAGO	IL	80,083.77
BIOSCRIP PHARMACY SERVICES	COLUMBUS	OH	79,750.74
CHESTNUT HEALTH SYSTEMS WOMEN	BLOOMINGTON	IL	79,544.20
MIDWEST HEALTHCARE ASSOCIATES	AURORA	IL	79,263.68
LSSI ADD NACHUSA	NACHUSA	IL	78,564.40
NORTH CHICAGO COMM HEALTH CTR	NORTH CHICAGO	IL	78,473.60
VISTA MEDICAL CENTER WEST	WAUKEGAN	IL	78,025.02
GATEWAY FOUNDATION L STAR	CHICAGO	IL	77,646.08
TANDEZ CORNELIA	ELGIN	IL	77,439.83
ST JAMES HOSP AND HLTH CTRS	OLYMPIA FIELDS	IL	76,931.61
GOOD SAMARITAN HOSPITAL	DOWNERS GROVE	IL	76,155.11
ADA S MCKINLEY COMMUNITY SVCS	CHICAGO	IL	75,875.61
ULTRA CARE HOME MEDICAL PHARM	NORTHLAKE	IL	75,302.78
EKTERA ALI	CHICAGO	IL	74,679.37
CRUSADER CLINIC	ROCKFORD	IL	74,377.98
LEYDEN FAMILY SERVICE AND MHC	FRANKLIN PARK	IL	74,320.76
LOWER WEST SIDE HEALTH CENTER	CHICAGO	IL	73,817.86
WILL CO COMM HEALTH CTR	JOLIET	IL	73,695.39
CARLE FOUNDATION HOSPITAL	URBANA	IL	71,744.37
PRIMECARE FULLERTON	CHICAGO	IL	71,351.04
UNIFIED PHYSICIANS NETWORK	SKOKIE	IL	71,145.46
LAKE FOREST HOSPITAL	LAKE FOREST	IL	70,009.19
UPTOWN NEIGHBORHOOD H CENTER	CHICAGO	IL	69,852.20
RESURRECTION MEDICAL CENTER	CHICAGO	IL	69,450.57
MINIMED DISTRIBUTION CORP	NORTHRIDGE	CA	69,429.99
LAKE CO MNTL HLTH WAUKEGAN	WAUKEGAN	IL	66,905.49
KIM PU	CHICAGO	IL	65,716.19
ALDEN VILLAGE HEALTH FACILITY	BLOOMINGDALE	IL	64,295.74
BRUNELLE JORGE	AURORA	IL	64,254.91
KRASYUK ZHANA	BUFFALO GROVE	IL	63,808.65
WALGREEN CO 0089	BRIDGEVIEW	IL	63,413.34

Appendix H
PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000
Fiscal Year 2010

Provider Name	City	State	Total Amount Paid
INDEPENDENCE PLUS INC	OAK BROOK	IL	$63,241.00
LINCOLN SQUARE	CHICAGO	IL	63,027.55
PILSEN FAMILY HEALTH CENTER	CHICAGO	IL	62,819.90
REHABTECH INC	NAPERVILLE	IL	62,801.33
AUNT MARTHAS YOUTH SERVICE CTR	CHICAGO HEIGHTS	IL	62,790.32
SALUD FAMILY HEALTH CENTER	CHICAGO	IL	62,715.41
SHIELD DENVER HLT CARE CTR INC	ELMHURST	IL	62,606.41
CHIEMMONGKOLTIP PANITA	EAST DUNDEE	IL	62,593.82
MARTINEZ CHARLES	MT PROSPECT	IL	61,980.72
THE 180 MEDICAL INC	OKLAHOMA CITY	OK	61,527.12
SMITH FREDERICK	CHICAGO	IL	61,345.60
DEWAARD DAVID D	CHICAGO	IL	61,149.29
CORNELL INTERVENTIONS DUPAGE	HINSDALE	IL	60,740.08
WALGREEN CO STORE 215	CHICAGO	IL	60,521.95
CHANG RANDOLPH	CHICAGO	IL	59,547.77
TROPICAL OPTICAL	CHICAGO	IL	59,100.00
BOND DRUG COMPANY OF IL 03078	WAUKEGAN	IL	58,899.87
SCHWAB REHAB HOSP	CHICAGO	IL	58,489.16
ADVANTAGE NURSING SERVICES INC	MARION	IL	58,452.08
INGALLS HOME CARE	HARVEY	IL	58,336.00
DUPAGE MENTAL HEALTH WEST PHC	WHEATON	IL	58,328.22
WILL COUNTY HEALTH DEPT	JOLIET	IL	57,854.35
KIM KYUNG	NILES	IL	57,805.04
DULCE HUGO	ADDISON	IL	57,626.94
ST MARY OF NAZARETH PHO	CHICAGO	IL	56,940.73
BOND DRUG COMPANY OF IL 05103	CICERO	IL	56,903.87
OAK FOREST HOSPITAL	OAK FOREST	IL	56,601.95
MURAD SANDY	ARLINGTON HTS	IL	56,517.61
CHHIKARA SONIA	HANOVER PARK	IL	56,109.73
PHARMACY SOLUTIONS	ABBOTT PARK	IL	56,038.37
KLING PROFESSIONAL CENTER	CHICAGO	IL	55,484.41
NORTHERN ILLINOIS MEDICAL CTR	MCHENRY	IL	55,091.35
PEREZ WALTER	CHICAGO	IL	54,993.97
ANUMULA SAILA	JOLIET	IL	54,981.19
RAIS DANA JALAL	CHICAGO	IL	54,133.71
FAMILY CHRISTIAN HEALTH CENTER	HARVEY	IL	54,038.32

Appendix H

PROVIDERS RECEIVING TOTAL ALL KIDS PAYMENTS OF >$50,000

Fiscal Year 2010

Provider Name	City	State	Total Amount Paid
SHEIKH DILMUBARAK	MELROSE PARK	IL	$53,930.10
JAIN RENU	ADDISON	IL	53,861.82
ABTAHI MOHAMMAD	DES PLAINES	IL	53,830.42
CRUSADER CLINIC BELVIDERE	BELVIDERE	IL	53,631.42
WEST TOWN NEIGHBORHOOD H CTR	CHICAGO	IL	53,619.38
ANIOL HALINA	CHICAGO	IL	53,365.54
ZHANG LIQING	CHICAGO	IL	53,045.50
LAWNDALE CHRISTIAN HEALTH CTR	CHICAGO	IL	52,993.82
LSSI MENTAL HEALTH SERVICE	CHICAGO	IL	52,319.92
CYSTIC FIBROSIS SERVICES INC	CENTENNIAL	CO	52,307.57
KISHWAUKEE COMM HOSP	DEKALB	IL	52,033.88
CENTER FOR MEDICAL ARTS RH	CARBONDALE	IL	51,688.64
ACCESS ADDISON FMLY HLTH CTR	ADDISON	IL	51,602.40
ANDERSON MEDICAL CENTER LLC	WHEELING	IL	51,468.57
CHOKSI RAJENDRA M	JOLIET	IL	51,169.63
LELCHUK BORIS	WHEELING	IL	51,085.48
ACCESS CABRINI HEALTH CENTER	CHICAGO	IL	50,851.38
ALEXANDRE MICHELLE	MELROSE PARK	IL	50,650.05
TSALIAGOS CHRISTOS	CHICAGO	IL	50,432.04

Source: FY10 paid claim data provided by HFS.

APPENDIX I
Agency Responses

ILLINOIS DEPARTMENT OF
HFS 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

March 16, 2011

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 Jamie Nardulli, External Audit Liaison, at (217) 558-2527 or through email at jamie.nardulli@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: Covering All Kids Health Insurance Act Requirements

The Department of Healthcare and Family Services should comply with the rulemaking requirement found in the Covering All Kids Health Insurance Act [215 ILCS 170].

Response:

The Department accepts the recommendation and began the implementation process. The Department promulgated a rule to comply with the requirements governing the exchange of health insurance information under 215 ILCS 170/20(a)(3) of the Covering All Kids Health Insurance Act. The proposed rule was published on January 14, 2011 in the Illinois Register. The second notice is anticipated to be published on April 8, 2011 and public notification of rule adoption is anticipated to be published by July 8, 2011.

Recommendation Number 2: All Kids Policies and Procedures

The Department of Healthcare and Family Services and the Department of Human Services should work together to organize all policies in one section that contains only policies relevant to ALL KIDS and the EXPANDED ALL KIDS program. Additionally, the agencies should ensure that policies are consistent with applicable laws and rules and are up to date.

Response:

The Department accepts the recommendation and it has been implemented. The All Kids Manual Release was issued on December 6, 2010. Most of the policy pertaining to the expanded All Kids program is contained in one chapter of the manual. This chapter contains links to other sections of the manual that pertain to the All Kids program. The manual is designed to be used by staff who determine eligibility for cash and SNAP as well as all of the Department's medical programs. For this reason it is organized in such a way that eligibility criteria, procedures, and casework actions that are common to more than one program appear together.

Recommendation Number 3: Redetermination of Eligibility

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

- review the current process for performing eligibility redeterminations to ensure compliance with the Covering ALL KIDS Health Insurance Act and the Illinois Administrative Code;
- at a minimum, require EXPANDED ALL KIDS enrollees with family income at or below 200 percent of the federal poverty level to return an annual redetermination to verify that there were no changes to their eligibility information; and
- establish a maximum number of 12-month eligibility periods for which a child with family income at or below 200 percent of the federal poverty level can be eligible for coverage without providing updated eligibility documentation.

Response:

The Department accepts the recommendation. As of October 2011, passive renewal for all children in families with income at or below 200 percent of the federal poverty level will end. Also as of October 2011, families at all income levels will have to respond at annual determination, either verifying a full month's income or actively confirming information obtained electronically by the Department.

Recommendation Number 4: Income of Stepparent

The Department of Healthcare and Family Services and the Department of Human Services should ensure that the income of the stepparent is included in the income calculation for the expanded All Kids program as required by 89 Ill. Adm. Code 123.110.

Response:

The Department accepts the recommendation. The Department will revise policy to ensure that income of the stepparent is included in the income calculation for undocumented noncitizen children in households of all income levels.

Recommendation Number 5: Non Payment of Premiums

The Department of Healthcare and Family Services should:

- terminate All Kids coverage to families that do not pay monthly premiums as required by 89 Ill. Adm. Code 123.340,
- ensure that prior to re-enrollment in All Kids, families pay all premiums due for periods in which a premium was owed and not paid, as required by 89 Ill. Adm. Code 123.210(c)(2);
- ensure that before being re-enrolled, the first month's premium was paid if there was an unpaid premium on the date the child's previous coverage was cancelled as required by 89 Ill. Adm. Code 123.210(c)(5).

Response:

The Department accepts the recommendation. The Department will terminate All Kids coverage to families that do not pay monthly premiums as required by 89 Ill. Adm. Code 123.340, barring any violation of the federal Maintenance of Eligibility requirements. A reminder will be sent to staff at both agencies regarding the appropriate coding of applications to prevent re-enrollment of children who have outstanding premium debt.

Recommendation Number 6: 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, and ensuring that enrollees are no longer eligible for services after their end date.

Response:

The Department accepts the recommendation. A system error that allowed coverage for the first day of the month following the month of the child's 19th birthday has been identified and is in the process of being corrected. Both Departments continue to perform case reviews and work with staff to improve quality and reduce duplicate enrollees.

Recommendation Number 7: Classification of Documented Immigrants

The Department of Healthcare and Family Services should:

- ensure that documented immigrants are classified correctly in its database
- maintain the necessary information needed to identify documented immigrants such as social security numbers, alien registration numbers, and dates of entry; and
- ensure that the State receives federal matching funds for all eligible claims.

Response:

The Department accepts the recommendation and it has been implemented. As a result of the previous OAG audit, the Department discovered that the eligibility system was not properly carrying forward the entries made by casework staff. This system error was corrected on October 29, 2010.

Recommendation Number 8: Payment of Non-Emergency Transportation

The Department of Healthcare and Family Services should have controls in place to ensure that no payments are made for non-emergency transportation services that are excluded from coverage by 89 Ill. Adm. Code 123.310.

Response:

The Department accepts the recommendation and it has been implemented. On June 15, 2010 a programming change was implemented to prevent payments for non-emergency transportation for children in premium levels 2-8.

Recommendation Number 9: 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. In addition to the manual review process the Department has in place for all rejected duplicate claims, a monthly monitoring report will be developed to further target specific claim detail that will identify potential duplicate claims that may have been erroneously approved following the initial manual review process.

Recommendation Number 10: 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;
- develop a system to verify eligibility criteria such as family size and family income to ensure that complete and accurate information was provided by the applicant; 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 is in the process of implementing the federally approved method of verifying citizenship and identity of anyone with a social security number. Verification of Illinois residence and a full month's income will be an eligibility requirement beginning July 1, 2011. The Department is also assessing the current verification requirements for self employment income to determine what other documentation should be required.

Recommendation Number 11: 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 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 has been prepared to program an MMIS edit that will only allow one round-trip per prior approval number per day. The Department will also implement restrictions on origin and destination times and require the input of address and city information by providers to help ensure more accurate claim detail. A notice will also be sent to transportation providers reminding them to submit accurate claim details or they may be subject to recoupment. Additionally, the Department's OIG has a robust series of data analysis routines to identify aberrant billing patters for transportation providers. Questionable transportation services are audited by the OIG, resulting in the establishment of overpayments and termination of the transportation provider, if appropriate.

Recommendation Number 12:

The Department of Healthcare and Family Services should ensure that electronic billing edits exist to identify potential abuse related to the ordering of eyeglass frames and for the billing of exams and fittings. Additionally, HFS should identify and recoup unallowable past optical payments made to providers.

Response:

The Department accepts the recommendation. The Department will review the exceptions identified by the auditors and determine whether electronic billing edits should be implemented to help prevent optical claims abuse. If the Department finds providers have submitted fraudulent claims, payments will be recouped. Currently, providers identified with aberrant behaviors are referred to the Department's OIG for investigation.

Recommendation 13:

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 will remind providers of the proper use and frequency limits of preventative services CPT codes. The Department will also initiate a manual review of claims that exceed the frequency requirements of these codes.

Recommendation 14:

The Department of Healthcare and Family Services should strengthen controls to ensure that dental providers are not paid for services beyond benefit limitation; ensure that dental policies or other information available to the public accurately states frequency of benefits; and identify and recoup unallowable past dental payments made to providers.

Response:

The Department accepts the recommendation. The Department is requiring DentaQuest, the contracted vendor responsible for administration of the dental claims processing, to have an audit performed to ensure the business rules of their claims processing system are properly configured as detailed in the Dental Office Reference Manual. DentaQuest's Quality Assurance team will test the edits and continue to audit claims on an ongoing basis to ensure that processing policies are working according to the Department's Dental Program requirements. The Dental Office Reference Manual will be reviewed by the Department's dental program staff and Dentaquest and any policies that are unclear or incorrect will be updated. The Department has reduced DentaQuest's March 2011 administrative payment to recover the funds that were overpaid to dental providers in 2009 and 2010.

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

March 17, 2011

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 for the draft report of the recommendations assigned to the Department of Human Services as a result of the SFY2010 second annual audit of the Office of the Auditor General Covering ALL KIDS Health Insurance program:

Recommendation #2: The Department of Healthcare and Family Services and the Department of Human Services should work together to organize the policies in one section that contain only policies relevant to ALL KIDS and the EXPANDED ALL KIDS program. Additionally, the agencies should ensure that policies are consistent with applicable laws and rules and are up to date.

Department Response: The Department agrees with the recommendation. The Department of Human Services (DHS) will continue to work with the Department of Healthcare and Family Services (HFS) to incorporate policies contained in memo format into the manual. The DHS manual has recently been updated with the distribution of Manual Release #10.31 and #11.04, which contained All Kids policies previously held within policy memoranda. The DHS Policy Manual has also been organized by eligibility topic and formatted to be consistent with the integrated caseloads that caseworkers maintain.

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

- review the current process for performing eligibility redeterminations to ensure compliance with the Covering Administrative Code;
- at a minimum, require EXPANDED ALL KIDS enrollees with family income at or below 200 percent of the federal poverty level to return an annual redetermination to verify that there were no changes to their eligibility information; and

- establish a maximum number of 12-month eligibility periods for which a child with family income at or below 200 percent of the federal poverty level can be eligible for coverage without providing updated eligibility documentation.

Department Response: The Department agrees with the recommendation. As a result of the passage of Public Act 96-1501, the Administrative Renewal process will be obsolete in October 2011. The Department of Human Services will continue to cooperate with the Department of Healthcare and Family Services in the establishment of new procedure that will require active participation from customer in obtaining medical eligibility documentation.

Recommendation #4: The Department of Healthcare and Family Services and the Department of Human services should ensure that the income of the stepparent is included in the income calculation for the EXPANDED ALL KIDS program as required by 89 Ill. Adm. Code 123.110.

Department Response: The Department agrees with the recommendation. The Department of Human Services will continue to work with the Department of Healthcare and Family Services to ensure that all required elements are considered and documented in the eligibility determination as required by Administrative Code.

Recommendation #10: 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 acurately; develop a system to verify eligibility criteria such as family size and family income to ensure that complete and accurate information was provided by the applicant; 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 Response: The Department agrees with the recommendation. As a result of the passage of Public Act 96-1501, effective July 1, 2011, verification of Illinois residency and one month of income will be required for eligibility redetermination. The Department follows current policy and procedure as created by the Department of Healthcare and Family Services regarding eligibility documentation supporting birth, residency and identity. The Department will continue to work with the Department of Healthcare and Family Services to review current written policy and operational issues related to verification of eligibility documentation.

If you have any questions, please contact Albert Okwuegbunam, Bureau Chief, Audit Liaisons, at (217) 785-7797.

Sincerely,

Michelle R.B. Saddler
Secretary

cc: Grace Hou, Assistant Secretary
Linda Saterfield, Acting Director, Human Capital Development
Carol Kraus, Chief Financial Officer
Matthew A. Grady, Director, Office of Fiscal Services
Jennifer Hrycyna, Associate Director, Human Capital Development
Joseph Mason, Associate Director, Human Capital Development
Sharon Dyer-Nelson, Manger, Human Capital Development
Paul Thelen, Human Capital Development
Albert Okwuegbunam, Bureau Chief, Audit Liaisons